PRINTED: 04/10/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165537	B. WING		03/14/2019	
	ROVIDER OR SUPPLIER A CARE CENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 05 NORTH 15TH AVENUE HAWATHA, IA 52233		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		NC
F 000	health survey and face #81842. The facility reported in	4 15 19 ncies relate to the annual	F 000	This shall serve as a credible allegation of c All deficiancies will be corrected by the com date.	ompliance. 4/15/201 oletion	9
F 644 SS=D	483. Subpart B-C. Coordination of PASA CFR(s): 483.20(e)(1) §483.20(e) Coordinat A facility must coordir pre-admission screen (PASARR) program u of this part to the max	ARR and Assessments (2)	F 644	Hiawatha Care Center will continue to coording assessments using the PASARR screening policy Hiawatha Care Center will incorporate the recommendations from the PASARR level II, residents will be referred to the appropriate erequired. The QA&A committee shall assure compliance by periodically reviewing the PAS, process to assure compliance.	rocess, All level II ntity as	9
	from the PASARR lev PASARR evaluation r assessment, care pla care.	rating the recommendations tel II determination and the eport into a resident's nning, and transitions of all level II residents and ly evident or possible				
	serious mental disord related condition for la a significant change in This REQUIREMENT by: Based on record revifacility failed to identif	er, intellectual disability, or a evel II resident review upon				
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE Administrator	(X6) DATE 4/11/2019	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: 54ZB11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165537	B. WING			0.3	/14/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 NORTH 15TH AVENUE HIAWATHA, IA 52233				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 644	Screening and Resi of 1 sampled (Resid a census of 105 res Findings include: The Minimum Data 8/18/19 revealed Re dementia, psychotic disturbance. Reside impairments. The MDS dated 8/1 Resident # 2 not cor PASARR process to and/or intellectual di The PASARR dated #2 had a negative le documented Reside psychotic/delusiona situational depression the event of an exact illness, a status cha the states-designate evaluation. The Diagnosis Report Resident #2 had a d with delusions due t condition as of 10/10 During an interview Staff U (Care Plan of (Social Services) had During an interview (Assistant Director of	dent Review (PASARR) for 1 dent # 2). The facility reported idents. Set (MDS) assessment dated esident #2 had diagnoses of e disorder and behavioral ent #2 had severe cognitive. 8/19 revealed PASARR for ensidered by the state level II is have serious mental illness isability. 9/19/14 revealed Resident evel one screen. The PASARR ent # 2 had no il disorder and mild or en. The PASARR directed in cerbation related to mental enge should be submitted to end authority for further ent dated 3/13/18 revealed diagnosis of psychotic disorder o known physiological	F	544				

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F 644	Continued From page	e 2 a new PASARR related to a	F 644			
F 656 SS=D	Resident # 2 needed changes. Develop/Implement CCFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a compreh care plan for each resresident rights set fort §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identificassessment. The complement acromaintain the reside physical, mental, and required under §483.24, §483. provided due to the resunder §483.24, §483. provided due to the resunder §483.10, including treatment under §483.30 (iii) Any specialized screhabilitative services provide as a result of	a new PASARR related to a comprehensive Care Plans comprehensive Care Plans comprehensive Care Plans comprehensive develop and comprehensive person-centered comprehensive mental and psychosocial ed in the comprehensive care plan must increase of comprehensive care plan must increase	F 656	Hiawatha Care Center will continue to develo implement comprehensive care plans. Comp shall be maintained by the QA&A team period Reviewing the comprehensive care plans to a compliance is maintained.	liance lically.	4/15/2019
	future discharge. Fac	ive(s)- als for admission and rerence and potential for	The state of the s			

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	local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, irequirements set forth section. This REQUIREMENT by: Based on record revifacility failed to create for 2 of 23 sampled (Ffacility reported a centricular facility facility reported a centricular facility facili	ssed and any referrals to and/or other appropriate se. In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced ew and interviews the comprehensive care plans Residents #1 and #9). The sus of 105 residents. Set (MDS) assessment direction of Resident #1 had a seximate and allow and always and bladder. In MDS documented extensive staff assistance living and always and bladder. In MDS documented extensive staff assistance living and always and bladder. In MDS documented extensive staff assistance living and always and bladder. In MDS documented extensive staff assistance living and always and bladder. In MDS documented extensive staff assistance living and always and bladder. In MDS documented extensive staff assistance living and always and bladder. In MDS documented extensive staff assistance living and always are remained. It was a staff assistance and the staff notified the physician and the physician are the staff notified the staff notified	F6	56			
	During an interview or	1 3/12/19 at 2:49 p.m., Staff					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 NORTH 15TH AVENUE HIAWATHA, IA 52233		_		
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F 656	history of constipation milk of magnesia and know who updated the reported is was not in on the care plans. So expect constipation to on the care plan. During an interview of R (Licensed Practical completed the admiss of 2018. Staff R door required laxatives. So be addressed on the was unfamiliar with the During an interview of Resident #1's family and the was unfamiliar with the During an interview of Resident #1 had suppositories every 3 daily. 2. The Minimum Data dated 2/23/19 revealed diagnosis of Parkinson had moderate cognitic documented Resident assistance of one state transfers, dressing and an indwelling cate. The physician's order Resident #9 had an interention.	reported Resident #1 had a n and the staff administered I Dulcolax. Staff J did not be care plans. Staff J her job description to work taff J reported she would be identified as a problem on 3/13/19 at 9:54 a.m., Staff I Nurse) reported she ission assessment in October tumented Resident #1 taff R reported that should care plan. However, Staff R he process the facility used. In 3/12/19 at 2:24 p.m., member reported Resident for constipation when she by. The family reported in the lorders for Dulcolax days and a stool softener I Set MDS) assessment as de Resident #9 had a son's disease. Resident #9 we impairments. The MDS at #2 required extensive ff with bed mobility, and toilet use. Resident #2	F6	556				
ì	The Care Plan talled	to renect resident #9.5 field						

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F 656	F (Assistant Director of should be on the care During an interview or Administrator stated th	n 3/12/19 at 1:32 p.m., Staff of Nursing) stated catheters o plan. n 3/12/19 at 2:50 p.m., the	F 65	6			
SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)(i §483.21(b) Comprehe §483.21(b)(2) A comprehe (i) Developed within 7 the comprehensive as (ii) Prepared by an interinctudes but is not limit (A) The attending physical (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the real explanation must be medical record if the pand their resident reprinct practicable for the resident's care plan. (F) Other appropriates disciplines as determinor as requested by the (iii)Reviewed and revise.	ensive Care Plans brehensive care plan must days after completion of esessment. erdisciplinary team, that ited to sician. with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined development of the staff or professionals in ned by the resident's needs	F 657	Hiawatha Care Center will continue to prov plans that meet the following; (i) Developed days after completion of the comprehensive assessment. (ii) Prepared by an interdiscipli that includes but is not limited to(A) The attending physician. (B) A registered nurse with responsibility for resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services (E) To the extent practicable, the participatithe resident and the resident's representative and explanation must be included in a reside medical record if the participation of the resident resident representative is determined to practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals disciplines as determined by the resident's or as requested by the resident. (iii)Reviewed and revised by the interdiscipl team after each assessment, including both comprehensive and quarterly review assess Compliance shall be maintained by the QAG periodically reviewing the care plans to assirequirements are being met.	I within 7 a nary team, r the a staff. on of ve(s). ent's ident ned in needs iinary a the sments. &A team	4/15/2019	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1)	COMPLETED	
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F 657	by: Based on record reinterview the facility care plans for 2 of 2 #184). The facility residents. Findings include: 1. The Minimum Da 1/24/19 revealed Reparaplegia. Resider impairments. The M required extensives mobility, dressing and The Admission Nurs 10/18/18 revealed Resident #1 stool and required or The Nurse's Notes of revealed Resident #1 days, had a distension received magnesium staff notified the phy Resident #1 transpoon The discharge summ Resident #1 admitted abdominal pain and radiology (x-ray) replarge colonic stool be colon and difficult to	T is not met as evidenced view, observation and failed to revise the plan of 4 sampled (Resident #1 and eported a census of 105 ta Set assessment dated sident #1 had a diagnosis of at #1 had severe cognitive IDS documented Resident #1 taff assistance with bed ad personal hygiene. ing Assessment completed esident #1 unable to hold ccasional laxatives or enema. lated 12/18/18 at 12:06 p.m. 1 had no bowel movement for ded and firm abdomen, a citrate this morning and the sician. At 6:27 p.m., rted to the hospital. hary dated 12/24/18 revealed d to the hospital with distension and vomiting. The ort showed a moderate to urden (stool stuck in the	F 65		

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F 657	J (Registered Nurse) history of constipation her milk of magnesia reported she did not udid not know who upod J reported she would identified as a probler. During an interview or Resident #1's family n#1 had a hospitalization constipation. Resider and did not have a bothe physician ordered Dulcolax suppositories. During an interview or R (Licensed Practical completed the admiss 2018 she documented laxatives. Staff R report address the bowel issifamiliar with the care per 2. The Minimum Data dated 3/4/19 revealed had diagnoses of halluresident #184 had set The MDS dated 3/4/19 required limited assist mobility, dressing, tolke hygiene. The MDS re	in 3/12/19 at 2:49 p.m., Staff reported Resident #1 had a a for which the nurses gave and Dulcolax. Staff Jupdate the care plans and lated the care plans. Staff expect constipation to be in on the care plan. In 3/12/19 at 2:24 p.m., member reported Resident on in December 2018 for at #1 lived at another facility wel movement for 8 days. If a stool softener daily and is every 3 days. In 3/13/19 at 9:54 a.m., Staff Nurse) reported when she ion assessment in October If Resident #1 required arted the care plan should use. Staff R was not olan process. Set (MDS) assessment Resident #184 ucinations and diabetes. Evere cognitive impairments. For revealed Resident #184 ance of 1 staff for bed et use and personal evealed Resident #184 significant risk of getting to a	F 6	57			
	The Progress Note da	ted 3/1/19 at 4:17 p.m.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED		
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F 657	The Progress Note of revealed Resident #1 door open and staff of an alarm on it and it was a revealed Resident #1 wandering in the hall. Observation on 3/12/Staff K outside the fatracks in the snow frow wheelchair. Staff K restaff found Resident is The Progress Notes or revealed the staff four unattended wearing gown (open in the batankles. A 2/26/19 care plan of hallucinations. Care plan entries, daresident had the poted directed staff to answand to walk outside at monitor and check the wanderguard daily. A 3/7/19 care plan entries and the staff outside at monitor and check the wanderguard daily.	ated 3/3/19 11:45 p.m. 84 attempted to push the explained to him the door had was very cold outside. dated 3/4/19 3:00 a.m. 84 up and down tonight and visiting with the staff. 19 at 5:20 a.m., revealed cility. Staff K pointed out om Resident #184's eported this is where the #184 unattended. dated 3/4/19 5:20 a.m. nd Resident #184 outside 1 slipper sock, a hospital ck), and had brief around his entry stated the resident had ver door alarms per protocol and walk around corners, e roam alert weekly and	F	957			

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F 657	Continued From pag	je 9	Ff	657		·		
,	from 3/1/19 when the exit-seeking behavior resident eloped from During an interview of	nented to prevent elopement e resident first displayed ors and 3/4/19 when the						
F 677 SS=D	standard regulations planning.	dard regulations as their facility policy on care ning. Care Provided for Dependent Residents		677	cares for all dependent residents. Proper inc	continence ident	4/15/2019	
West of the second seco	out activities of daily services to maintain of personal and oral hygonis REQUIREMENT by: Based on record revinterviews the facility incontinence care for	T is not met as evidenced		The state of the s	residents. Compliance shall be maintained by QA&A committee conducting periodic review assure proper ADL care is being provided.	ov the		
	Findings include:				ı			
	dated 12/1/2018 reve diagnosis of dementia Resident #11 had sev The MDS dated 12/1/ required extensive as	verely impaired cognition. /18 revealed Resident #11 ssistance with toilet use and staff for personal hygiene. ed the staff to assist	A Constant					

NAME OF PROVIDER OR SUPPLIER HIAWATHA CARE CENTER CASH CARE CASH CASH		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAWATHA CARE CENTER AGS NORTH 15TH AVENUE			165537	B. WING		<u> </u>	03/	14/2019
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 677 Continued From page 10 During observation on 03/11/19 at 01:05 p.m., Staff D (Certifled Nursing Assistant) assisted Resident #11 to the toilet. Staff D applied gloves and removed Resident #11 solided parts and elean brief on Resident #11. Resident #11 to that to the bathroom. Resident #11 spants had a soiled area. Staff D falled to provide incontinence care. Staff D applied glove described had been brief on Resident #11. Resident #11 to falled to perform incontinence care. Staff D applied gloves and removed Resident #11 soiled parts and placed clean brief on Resident #11. Staff D falled to perform incontinence care. Staff D confirmed Resident #1. Staff D falled to perform incontinence care. Staff D confirmed Resident #1. Staff D applied gloves and removed. During an interview on 03/11/19 at 01:37 p.m., Staff E (Nurse Alde) reported when performing incontinence care should be comploted with each swipe. Staff E reported incontinence care should be comploted with each incontinence care should be comploted with each incontinence care when the resident is changed or toileted, regardloss of whether the resident goes to the bathroom. Staff F reported all areas that touch brief touch are cleaned including the abdomen,				•	405	NORTH 15TH AVENUE		
During observation on 03/11/19 at 01:05 p.m., Staff D (Certified Nursing Assistant) assisted Resident #11 to the toilet. Staff D applied gloves and removed Resident #11's soiled brief. Staff D wiped Resident #11's buttocks with toilet paper from front to back and then applied a clean brief. Staff D failed to provide incontinence care. Staff D failed to change gloves before putting a clean brief on Resident #11. Resident #11 walked out of the bathroom. Resident #11 spants had a soiled area. Staff D assisted Resident #11 back to the toilet. Staff D applied gloves and removed Resident #11's soiled pants and placed clean pants on Resident #11. Staff D failed to perform incontinence care. Staff D confirmed Resident #11's brief was soiled when it was removed. During an interview on 03/11/19 at 01:37 p.m., Staff E (Nurse Aide) reported when performing incontinence care she wipes in a front to back motion and changes the washcloth or wipe with each swipe. Staff E reported incontinence care should be completed with each incontinent episode. During an interview on 03/12/19 10:56 a.m., Staff F (Assistant Director of Nursing) reported an expectation of staff to perform incontinence care when the resident is changed or toileted, regardloss of whether the resident goes to the bathroom. Staff F reported all areas that touch brief touch are cleansed including the abdomen,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
stated staff should change gloves when soiled, after removing a soiled brief and before applying creams or new brief.	F 677	During observation or Staff D (Certified Nurs Resident #11 to the to and removed Resider wiped Resident #11's from front to back and Staff D failed to provid D failed to change globiled to change globiled on Resident #11 the bathroom. Reside area. Staff D applied Resident #11's soiled pants on Resident #1 incontinence care. Staff E (Nurse Aide) incontinence care should be completed episode. During an interview of Staff E (Nurse Aide) incontinence care should be completed episode. During an interview of F (Assistant Director of expectation of staff to when the resident is of regardless of whether bathroom. Staff F reported touch are cleans inner thigh, pubis, but stated staff should chafter removing a soile	in 03/11/19 at 01:05 p.m., sing Assistant) assisted of the solid property of the applied gloves at #11's soiled brief. Staff D buttocks with toilet paper I then applied a clean brief. The incontinence care. Staff oves before putting a clean at Resident #11 walked out of the first pants had a soiled at Resident #11 back to the gloves and removed pants and placed clean and placed clean and placed clean and the first pants had a soiled by the gloves and removed pants and placed clean and placed clean and placed clean and the first pants had a soiled by the gloves and removed. In 03/11/19 at 01:37 p.m., the ported when performing the wipes in a front to back the washcloth or wipe with the ported incontinence care with each incontinent the of Nursing) reported an perform incontinence care thanged or toileted, the resident goes to the corted all areas that touch the discluding the abdomen, tocks and the hips. Staff Fange gloves when soiled,	F	577			

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F 677	Continued From page	ı 11	F	677			
	dated 12/8/18 revealed diagnosis of dementia Resident #17 had seven The MDS dated 12/8/10 totally dependent on silving. The MDS reveal incontinent of bowel and The Care Plan identification and change every few monitor for signs and sirelay this verbally and monitor daily for signs and some of the complete a glove chance of the complete a glove chance of the complete and placing and Resident #17. Observation on 3/11/15 Staff C (Nurse Aide) per Resident #17 had bow incontinence. Staff C peares and failed to complete on the complete and placing and seven which will be suffered to complete and failed to complete and	a. The MDS revealed vere cognitive impairments. 18 revealed Resident #17 staff for all activities of daily aled Resident #17 always and bladder. ed Resident #17 had a frected the staff to check a hours and as needed, symptoms as is unable to skin breakdown. 9 at 1:56 p.m., revealed and Staff B (Nurse Aide) care. The Director of cares. Resident #17 had continence. Staff B failed to a clean brief on the staff on the staff on the staff on the staff on Resident #17. 9 at 5:27 a.m., revealed erform incontinence cares. The dean brief on the staff on the staff on Resident #17. 13/12/19 10:55 a.m., Staff F Nurses) reported when					
	the staff to change glov	care, she would expect ves before starting cares, after the resident had a		-			

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	ROVIDER OR SUPPLIER A CARE CENTER			4	STREET ADDRESS, CITY, STATE, ZIP CODE 105 NORTH 15TH AVENUE HIAWATHA, IA 52233		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE,	(X5) COMPLETION DATE
F 677	During an interview of (Nurse Aide) repoincontinence she woremove her gloves, snew gloves on before the new brief. During an interview of H (Nurse Aide) repoincontinence she woremove her gloves, snew gloves on before the new brief. During an interview of (Nurse Aide) reportincontinence the star gloves, cleanse the wash hands and put applying any new oil of the new gloves of the new brief. During an interview of (Nurse Aide) reportincontinence the star gloves, cleanse the wash hands and put applying any new oil of the new gloves before the star resident, remove gloves before the star wash hands and apply new gloves before the star wash hands and apply new gloves of staff to the resident of staff to the province of staff to the resident of staff to the province of staff to the resident of staff to the province of staff to the resident of staff to the province of the province o	d before applying any barrier incontinent brief. on 3/12/19 at 2:05 p.m., Staff rted if the resident had bowel build cleanse the resident, sanitize her hands and put on the applying any ointment or on 3/12/19 at 2:14 p.m., Staff rted if the resident had bowel build cleanse the resident, sanitize her hands and put on the applying any ointment or on 3/12/19 at 2:24 p.m., Staff red if the resident had bowel for the new brief. on 3/12/19 at 2:49 p.m., Staff (a) reported after bowel for the new brief. on 3/12/19 at 2:49 p.m., Staff (a) reported after bowel for the new brief. on 3/12/19 at 2:49 p.m., Staff (a) reported after bowel for the new brief. on 3/12/19 at 2:49 p.m., Staff (a) reported after bowel for the new brief. on 3/12/19 at 2:49 p.m., Staff (a) reported after bowel for the new brief. on 3/12/19 at 2:49 p.m., Staff (a) reported after bowel for the new brief. on 3/12/19 at 9:54 a.m., Staff (a) reported bowel for the new brief.	F	677			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		DENTIFICATION NUMBER:	A. BUILD		UNSTRUCTION	COMPLETED	
		165537	B. WING				03/14/2019
	ROVIDER OR SUPPLIER A CARE CENTER			405	EET ADDRESS, CITY, STATE, ZIP CODE NORTH 15TH AVENUE WATHA, IA 52233	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	applying a new brief a 3. The Minimum Data revealed Resident #44 dementia. Resident # impairments. The MDS dated 1/12/required assistance of mobility, transfers, toil hygiene. The MDS reincontinent of bowel a Continuous observationa.m. to 1:27 p.m., revenuelchair in West Dimoved to lounge area #48 attended an exercitant from the television. and took Resident #48 rested in wheelchair. back to West Dining a After the meal Residet back to his room. Resprovide cares. The starepositioning and incomand 27 minutes. Observation on 3/11/1 Staff T (Nurse Aide) procession on 3/11/1 Staff T (Nurse Aide) procession. Staff T wiped the side to side. The Care Plan dated 4 assist resident with toil	apply new gloves before nd ointment. Set (MDS) dated 1/12/19 3 had a diagnosis of 48 had severe cognitive 19 revealed Resident #48 5 one to two staff with bed et use, and personal vealed Resident #48 always and bladder. 20 on on 3/11/19 from 8:00 ealed resident #48 sitting in ning area. Resident #48 after breakfast. Resident ise activity and then sat Resident #48's wife arrived to his room. Resident #48 Resident #48 was assisted rea for the noon meal. In the #48's wife pushed him ident #48 waited for staff to affed failed to provide ntinent cares for 5 hours 19 at 1:27 p.m., revealed ovided perineal cares for wiped the anterior perineal front with a disposable to posterior perineal from 1/10/18 directed staff to	F	677			

STATEMENT OF DE AND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		165537	B. WING_		03/	14/2019
NAME OF PROVID	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 NORTH 15TH AVENUE HIAWATHA, IA 52233		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
repche The bed goe Re number the channot repber bef Du Dir exptoil and The resulunto version of the shine of	eck on him around en provide inconting. d. Staff T reported es to breakfast. Aft sident #48 to an acres station or assist front lounge. Staff ance she will lay him to both a sident she does not fore lunch. In an interview 3/ sector of Nursing (Dectation for the state and after meals	coutine for Resident #48 is to 6:00 a.m. during rounds. ence cares and assist out of at 8:00 a.m. Resident #48 ier breakfast, Staff T assists stivity, leaves him at the ists him to the television in f T reported if she gets the m down in the morning. If fown after lunch. Staff T is always time to get to him end to provide routine and change residents before at bedtime and as needed. The end at expectation of staff ack when performing ent Care policy revealed all incontinence care every levening cares and as ontinent episode. ards/Supervision/Devices (2)	F 6			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		165537	B. WING			03/14/2019		
	ROVIDER OR SUPPLIER A CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 NORTH 15TH AVENUE HIAWATHA, IA 52233	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	by: Based on record revirinterview the facility fasupervision to prevent identified at risk for elean immediate jeopard safety. Resident #184 wandering and exited knowledge and was for The facility reported a Findings: 1. The MDS (Minimur dated 3/4/19 revealed diagnosis of dementia disturbance and halluch had severe cognitive in The MDS dated 3/4/19 required extensive asstransfers and walking. Resident #184 wander 7-day look back period significant risk of gettin dangerous place. The Care Plan dated 2/4/184 had hallucination allow to share prior exfarm photos, medicate and social service staf support if inappropriate.	is not met as evidenced ew, observation, and illed to provide adequate t elopement for 1 of 10 opement which resulted in y to residents health and t has a history of the building without staff ound outside in the snow. census of 105 residents. In Data Set) assessment Resident #184 had with behavioral cinations. Resident #184 mpairments. In revealed Resident #184 sistance of 1 staff for The MDS documented and for 1-3 days during the the Resident #184 had the to a potentially In Resident #184 had the to a potentially	F 689	Past compliance: no plan of corequired.	correction			

	(vi)		(X2) MUL A. BUILDI			(X3) DATE SURVEY COMPLETED		
		165537	B. WING				03/14/2019	
	ROVIDER OR SUPPLIER A CARE CENTER			405	EET ADDRESS, CITY, STATE, ZIP CODE NORTH 15TH AVENUE WATHA, IA 52233			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE	
F 689	Continued From page The Progress Notes of revealed Resident #1 door open and staff edoor had an alarm on outside. The Progress Notes of revealed Resident #1 wandering in the hall. The Progress Note of revealed at 5:00 a.m. room and the staff set The staff exited the frest #184 outside next to right end of the building slipper sock and a howard back. Resident #184 around his ankles. The staff exited the frest #184 around his ankles. The staff exited the frest #184 around his ankles. The staff exited the frest #184 around his ankles. The staff exited the frest #184 around his ankles. The staff exited the frest #184 around his ankles. The staff exited had a frest #184 and the staff exited had a frest #184 an	dated A 3/3/19 11:45 p.m. 84 attempted to push the xplained to the resident the rit and it was very cold dated 3/4/19 3:00 a.m. 84 up and down "tonight", and visiting with staff. ated 3/4/19 5:20 a.m. Resident #184 not in his arched the southwest hall. ont door and found Resident the second window on the ng. Resident #184 had on 1 spital gown open in the had his incontinent brief he staff placed a jacket on alled for assistance. superficial scratch to the		689	DEFICIENCY)			
	body temperature wa on 3/4/19 at 5:25 a.m During an interview o K (Licensed Practical the alarm sound, wer	s 96.3 degrees Fahrenheit						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED				
		165537	B. WING			03/14/2019	
	ROVIDER OR SUPPLIER A CARE CENTER		•	STREET ADDRESS, CITY, S 405 NORTH 15TH AVENU HIAWATHA, IA 52233		30,11,2010	_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		ı
F 689	the window, did not salarm and went back 10 to 15 minutes late if she knew Resident reported they searche outside wearing a hos around his ankles. Restaff he was fixing the stated called for assis Resident #184 indoor assessment. Staff K education regarding chire. Staff K stated sl not have silenced the completed a perimete she received training Assistant Director of N was a plan to implement aff receive the same During an interview of Staff P (Nurse Aide) nat the Nurse's Station 10:00 p.m. Staff K Lic (LPN) assisted Reside a.m. Later, during rounds. Staff P to calling out for help be in their room. Staff P to calling out for help be in their room. Staff P fin went to check Resider Resident #184's room rooms and could not for noticed the Velcro strip outside the staff in the control of the policy of the velcro strip outside the velcro	ee anything, silenced the to her work. Staff K reported or Staff P (Nurse Aide) asked #184's location. Staff K ed and found Resident #184 spital gown and had a brief esident #184 informed the eair conditioner. Staff K estance. The staff assisted and completed an reported she did not receive loor alarm protocol upon the did not know she should alarm and should have or check. Staff K reported after this elopement. The Nursing told Staff K there ent a training checklist so all	F	89			

= · · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	ULTIPLE CONSTRUCTION			COMPLETED		
		165537	B. WING			03	3/14/2019		
	ROVIDER OR SUPPLIER A CARE CENTER				DRESS, CITY, STATE, ZIP CODE 15TH AVENUE A, IA 52233				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 689	184. Staff K acknow alarm, looking outsid Staff P reported she #184 outside. Staff F was found outside st. Resident #184 had o had brief around the Resident # 184 state the staff to assist him Staff P reported 10 to time she heard the al Resident # 184 was \$ Staff P stated Reside touch and his body to K. Staff P reported F wander device place exiting. Staff P reported F reported F wander device place exiting. Staff P reported F wander device place exiting. Staff P reported F r	he location of Resident # ledged clearing the door e, and not seeing anyone. went to look for Resident Preported Resident #184	F	689					
l	back and forth in the	hall, wandering into other booked out the window a lot.							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED		
	165537	B. WING	***************************************	03/1	4/2019	
			STREET ADDRESS, CITY, STATE, ZIP CODE 405 NORTH 15TH AVENUE HIAWATHA, IA 52233	, , ,		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE	
During an interview of (Nurse Aide) stated delusions and talked lake". Staff O report staff should go outsing an interview of (Assistant Director elopement she went with Staff K. She stawas paperwork on hireported a plan to imhires that included all elopement was the fi	on 3/12/19 at 6:27 a.m., Staff and Resident #184 had all about the "farm across the led when an alarm sounded de to look around. on 3/12/19 at 8:48 a.m., Staff of Nurses) stated after the over the door alarm protocol ated she did not know if there are for Staff K. Staff K plement a checklist for new arms. Staff F reported this arest time she knew of	F 68				
Administrator stated Resident #184 elope if a resident was an a have a wanderguard he spoke to Staff K. Staff K should have I completed a head co stated he did not thin the doors prior to the During an interview of DON (Director of Nursounded, she would the cause and stated door and looked out. have documentation regarding door alarm they would go over the She stated the facility.	he received a phone call that d. The Administrator stated elopement risk, they would. The Administrator reported The Administrator reported eft the alarm sounding and runt. The Administrator k the resident tried to get out elopement. In 3/12/19 at 9:58 a.m., the rsing) stated if an alarm not silence it until she knew she would have opened the She stated they did not Staff K signed upon hire s but stated moving forward ne policy with all new hires.					
	ROVIDER OR SUPPLIER A CARE CENTER SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY	F CORRECTION IDENTIFICATION NUMBER: 165537 ROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER A CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 During an interview on 3/12/19 at 6:27 a.m., Staff O (Nurse Aide) stated Resident #184 had delusions and talked about the "farm across the lake". Staff O reported when an alarm sounded staff should go outside to look around. During an interview on 3/12/19 at 8:48 a.m., Staff F (Assistant Director of Nurses) stated after the elopement she went over the door alarm protocol with Staff K. She stated she did not know if there was paperwork on hire for Staff K. Staff K reported a plan to implement a checklist for new hires that included alarms. Staff F reported this elopement was the first time she knew of Resident #184 exit seeking. During an interview on 3/12/19 at 9:37 a.m., the Administrator stated he received a phone call that Resident #184 eloped. The Administrator reported he spoke to Staff K. Staff Staff R should have left the alarm sounding and completed a head count. The Administrator stated he did not think the resident tried to get out the doors prior to the elopement. During an interview on 3/12/19 at 9:58 a.m., the DON (Director of Nursing) stated if an alarm sounded, she would not silence it until she knew the cause and stated she would have opened the door and looked out. She stated moving forward they would goo over the policy with all new hires. She stated the facility implemented a wanderguard for the	ROYIDER OR SUPPLIER A CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH LOPENCIENCY MIST BE PRECEDED BY FULL (REGULATORY OR I.SC IDENTIFYING INFORMATION) Continued From page 19 During an interview on 3/12/19 at 6:27 a.m., Staff O (Nurse Aide) stated Resident #184 had delusions and talked about the "farm across the lake". Staff O reported when an alarm sounded staff should go outside to look around. During an interview on 3/12/19 at 8:48 a.m., Staff F (Assistant Director of Nurses) stated after the elopement she went over the door alarm protocol with Staff K. She stated she did not know if there was papenwork on hire for Staff K, Staff K reported a plan to implement a checklist for new hires that included alarms. Staff F reported this elopement she she knew of Resident #184 exit seeking. During an interview on 3/12/19 at 9:37 a.m., the Administrator stated he received a phone call that Resident #184 eloped. The Administrator reported have a wanderguard. The Administrator reported Staff K should have left the alarm sounding and completed a head count. The Administrator stated he did not think the resident tried to get out the doors prior to the elopement. During an interview on 3/12/19 at 9:58 a.m., the DON (Director of Nursing) stated if an alarm sounded, she would have opened the door and looked out. She stated they did not have a countentation Staff K signed upon hire regarding door alarms but stated moving forward they would go over the policy with all new hires. She stated the facility implemented a wanderguard for the resident after the elopement	TOMOTER OR SUPPLIER A CARE CENTER SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 19 During an interview on 3/12/19 at 6:27 a.m., Staff Olluring an interview on 3/12/19 at 8:48 a.m., Staff F (Assistant Director of Nurses) stated after the elopement he went over the door alarm protocol with Staff K. Staff F or Staff K. Staff K. Staff K. Staff K. Staff K. Staff K. Staff C appended a plan to implement a checkles for new hires that included alarms. Staff F popted this elopement was en elopement risk, they would have a wanderguard. The Administrator reported he spoke to Staff K. The Administrator reported he spoke to Staff K. The Administrator reported he abad count. The Administrator reported the doors prior to the olopement. During an interview on 3/12/19 at 9:37 a.m., the Administrator stated if a resident was an elopement risk, they would have a wanderguard. The Administrator reported he spoke to Staff K. The Administrator reported he abad count. The Administrator reported the doors prior to the olopement. During an interview on 3/12/19 at 9:38 a.m., the DON (Director of Nursing) stated if an alarm sounded, she would not silence it until she knew the cause and stated she would have opened the door and looked out. She stated they did not have documentation Staff K signed upon hire regarding door alarms but stated moving forward they would go over the policy with all new hires. She stated the facility implemented a wanderguard for the resident after the eloppement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		165537	B. WING		0	3/14/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 NORTH 15TH AVENUE HIAWATHA, IA 52233			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	she was not aware the behavior prior to the Care plan entries, day resident had the potential of the control of the Care plan entries, day and to walk outside a monitor and check the wanderguard daily. A 3/7/19 care plan enter wandered out the fact monitor the resident's building. The undated Door Allidentify which door a and check for a resident fact this might requoutside and check for surrounding area. The undated New Act Elopement Decision resident had a history doors to the outside, were going to leave, wanderguard to the wanderguard to the wanderguard to the variations. The Door Alarm and Training Conducted a completed staff training. The facility abated the in-service training receipement policies. the IJ prior to the staff to answer the staff training to the staff training the policies.	get out the door. She stated he resident had exit seeking elopement. Inted 3/4/19, stated the ential for wandering and wer door alarms per protocol and walk around corners, he roam alert weekly and he roam alert weekly a	F6	89			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING ___ 165537 B. WING 03/14/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 405 NORTH 15TH AVENUE **HIAWATHA CARE CENTER** HIAWATHA, IA 52233 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 689 Continued From page 21 F 689 situation was identified an IJ past non-compliance.

PRINTED: 04/10/2019

PRIEFIX TAG STATE CONTROLLO BY THE PRECEDED BY FULL RECULTORY OR ISC IDENTIFYING INFORMATION) L1093 E8.12(1) Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge, 58.12(1) General admission policies. I. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under lowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report the lowa commission on Veterans Affairs as requested by the lowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the lowa commissions on veterans affairs. Where appropriate, the facility may also report euch information to the lowa department of furnan services. In the event that a resident is unable to assist the facility in obtaining the information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the lowa commission on veterans affairs within 30 days of the resident's admission. For residents resident's eligibility or potential eligibility to the lowa commission on veterans affairs within 30 days of the resident's admission. For residents resident's eligibility or potential collect and report the required information regarding the resident's eligibility or potential collect and report the required information regarding the resident's eligibility or potential collect and report the required information in the resident's eligibility or potential eligibility or potential eligibility to the lowa commission on veterans affairs within 30 days of the resident's eligibility or potential eli	STATEMEN	MENT OF INSPECTIC TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER HIAWATHA CARE CENTER HIAWATHA (A SD233 (X)) D SUMMARY STATEMENT OF DEFICIENCISES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG L1093 EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG L1093 EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG EACH DEFICIENCY TAG EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG EACH DEFICIENCY TO THE APPROPRIATE COMES APPERENCY EACH DEFICIENCY TO THE APPROPRIATE TAG TAG EACH DEFICIENCY PRIFICE TAG EACH TAPENCY EACH T			IA0102	B, WNG		03.	/14/2019
HIAWATHA CARE CENTER CA) D SIMMARY STATEMENT OF DEFICIENCIES CROSS-PEPERIOR SIMMARY STATEMENT OF DEFICIENCIES CROSS-PEPERIOR OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PERCEDED BUT FULL TAGE CROSS-PEPERIOR OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PERCEDED BUT FULL TAGE CROSS-PEPERIOR OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY) CROSS-PEPERIOR OF THE APPROPRIATE	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CA) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION SHOULD BE CACH LOGRACITY AND STATEMENT OF DEFICIENCIES PREPRY REGULATORY OR LSC IDENTIFYING INFORMATION) TAPE TAPE CROSS-REFERENCED TO THE APPROPRIATE CACH CORRECTIVE AND THE PREVIOUS CACH CORRECTIVE AND			405 NOR	TH 16TH AVEN	UE		
PREFIX TAG PREFIX TAG PROPERTIES PROPERTIES PROPERTIES PROPERTIES PROPERTIES PROPERTIES PROPERTIES	HIAWATH	A CARE CENTER	HIAWATH	4A, IA 52233			
58.12(1) General admission, transfer, and discharge. I. For all residents residing in a health care facility receiving relimbursement through the medical assistance program under lowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility for benefits through the Federal Department of Veterans Affairs as requested by the lowa commission on Veterans affairs. The facility shall collect and report the information or forms and by the procedures prescribed by the lowa commissions on veterans affairs. Where appropriate, the facility metabolity in the tall ity metabolity in the facility in the tall right in the facility shall collect and report the information or the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's admission. For residents residenty admission in veterans affairs within 30 days of the resident's admission. For residents resident in facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident's admission. For residents resident information information regarding the resident's admission. For residents resident information regarding the resident's admission. For resident's eligibility or potential eligibility or potential required information or regarding the resident's admission. For resident's eligibility or potential eligibility or potential required information regarding the resident's eligibility or potential required information regarding the resident's admission.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC GROSS-REFERENCED TO	TTON SHOULD BE THE APPROPRIATE	(X6) COMPLETE DATE
58.12(1) General admission policies. I. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under lowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential fer eligibility for benefits through the Federal Department of Veterans Affairs as requested by the lowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the lowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the lowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the required information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's admission, For residents residing in the facility shall collect and report the required information regarding the resident's admission, For residents residing in the facility shall collect and report the required information regarding the resident's admission, For residents residing in the facility shall collect and report the required information regarding the resident's admission, For residents residing in the facility shall collect and report the required information regarding the resident's admission, For residents residing in the facility shall collect and report the required information regarding the resident's admission, For residents residing in the facility shall collect and report the required information regarding the resident administration of the facility shall collect and report the required information regarding the resident administration of the facility shall collect and report the required information regarding the resident administration of the resident and report the residen	L1093	58.12(1)l Admission,	transfer, and discharge	L1093	11		
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Administrator

4/11/2019

DEPART	MENT OF INSPECTION	NS AND APPEALS					
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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	R	GOMP	reteo	
		IA0192	B. WNG,		03/	14/2019	
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NAMEOFP	ROVIDER OR SUPPLIER		DDRESS, CITY, ST				
HIAWATH	A CARE CENTER		TH 15TH AVEN	UE			
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	Eligibility for 2 out of 1						
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-	CAUROR OF TOO LASIDAN	55.					
1	Findings include:						
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	During the review of re	cords for the residents					
	checked for eligibility for	or Veteran's Benefits it was	-				
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	reported to the lowa D	eparment of veterants ent residing in the facility					
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		3/13/19 at 9:02 a.m., the eported Social Services					
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	they give her the admir						
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INAME OF PROVIDER OR SUPPLIER HIAWATHA CARR CENTER STREET ADDRESS, CITY, SFATE, ZIP CODE 469 NORTH 14TH AVENUE HIAWATHA, IA 5233 PROMIDERS PLAN OF CORRECTION GRACH DEPOSISSON MUST BE PRESCRIBED BY PAIL RESULATORY OR LSC IDEN HIS THIS INFO SEASON BY PROMIDERS PLAN OF CORRECTION RESULATORY OR LSC IDEN HIS THIS INFO SEASON BY PAIL RESULATORY OR LSC IDEN HIS THIS INFO SEASON BY PAIL RESULATORY OR LSC IDEN HIS THIS INFO SEASON BY PAIL RESULATORY OR LSC IDEN HIS THIS INFO SEASON BY PAIL RESULATORY OR LSC IDEN HIS THIS INFO SEASON BY PAIL RESULATORY OR LSC IDEN HIS THIS INFO SEASON BY PAIL RESULATORY OR LSC IDEN HIS THIS INFO SEASON BY PAIL TAKE PRIETX TAKE PRIETX TAKE PRIETX TAKE PRIETX TAKE PRIETX TAKE PRIETX TAKE PROMIDERS PLAN OF CORRECTION PRICTION PRIETX TAKE PROMIDERS PLAN OF CORRECTION PRICTION PRICTION TAKE PROMIDERS PLAN OF CORRECTION PRICTION PRICTION TAKE PROMIDERS PLAN OF CORRECTION PROMIDERS PLAN OF CORRECTION PRICTION PRICTION TAKE PROMIDERS PLAN OF CORRECTION PROMIDERS PLAN OF CORRECTION PROMIDERS PLAN OF CORRECTION PRICTION PRICTION TAKE PRICTION PRICTION TAKE PROMIDERS PLAN OF CORRECTION PROMIDERS PLAN OF CORRECTION PRICTION PRICTION PRICTION PRICTION TAKE PROMIDERS PLAN OF CORRECTION PRICTION PROMIDERS PLAN OF CORRECTION PRICTION PROMIDERS PLAN OF CORRECTION PRICTION PROMIDERS PLAN OF CORRECTION PRICTION STATEMEN	MENT OF INSPECTION FOR CORRECTION	(X1) PROVIDER/GUPPLIER/GLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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