STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE VISTA HOME, INC.	1109 NORMAL STREET WOODBINE, IA 51579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 5-30-19 The following deficiencies are a result of the facility's annual health survey and investigation of facility reported incident #82325-I, which was substantiated.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to refer a resident to the appropriate state-designated authority for a Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination who was identified with a newly evident mental disorder for one of six residents reviewed	F 644		

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

[redacted]

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F 644	Continued From page 1 (Resident #37). The facility reported a census of 56 residents. Findings include: The Minimum Data Set (MDS) assessment dated 3/6/19, included diagnoses of psychotic disorder, unspecified dementia with behavioral disturbances, and non-alzheimer's dementia. Review of PASARR Negative Level I Screen dated 5/4/17, documented no major mental illnesses. Review of PASARR Negative Level I Screen dated 6/21/17, documented no major mental illnesses. Review of Medication Administration Record (MAR) dated April 2019, documented resident received Risperdal 0.125mg two times a day related to Psychotic Disorder with delusions. During an interview with the Director of Nursing (DON) on 4/24/19 at 10:31 AM, the DON confirmed the resident was not referred for a Level II PASARR evaluation and determination with a new diagnosis of psychotic disorder. The DON stated her expectation would be for a referral for a Level II PASARR to be completed for a resident with a newly evident mental disorder and significant change in status.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		

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F 657	Continued From page 2 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and resident and staff interviews, the facility failed to update the care plan for 1 of 16 residents reviewed (Resident # 40). The facility reported a census of 56 residents. Findings include; According to the Minimum Data Set (MDS) assessment tool dated 3/6/19, Resident #40 had diagnoses of diabetes mellitus, dementia and cerebral vascular accident (stroke). The MDS	F 657		

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F 657	Continued From page 3 documented the resident scored 14 on the Brief Interview for Mental Status (BIMS), which meant the resident displayed no impairment in cognitive status. The MDS also documented the resident was dependent on staff for bed mobility and transfers and had an unhealed pressure ulcer. Observation on 4/23/19 at 3:13 p.m. revealed Resident # 40 had an unstageable pressure area on her left outer ankle. Observation of Staff A performed the treatment to the pressure area was done at this time. The facility matrix provided on 4/24/19 revealed Resident #40 had an unstageable, facility acquired pressure ulcer. However, the facility failed to revise the resident's care plan to identify the pressure area on the left outer ankle. During an interview on 4/24/19 at 12:49 p.m., the MDS Nurse confirmed she completed Resident #40's care plan and verified the care plan failed to document the pressure ulcer. When asked, the MDS agreed pressure ulcers are typically listed on the care plan. During an interview with the Director of Nursing on 4/24/19 at 1:05 p.m. she verified the pressure ulcer should be listed on the care plan.	F 657		
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		

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F 730	Continued From page 4 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of employee files and staff interview, the facility failed to ensure Certified Nursing Assistants (CNAs) completed twelve hours of in-service training on an annual basis for one of four CNAs employed by the facility for greater than one year. The facility reported a census of 56 residents. Findings included: A document titled Employee In-Service Education Attendance Record dated 2018, revealed the facility hired Staff E, CNA on 4/5/17 and the staff person had completed only two in-service training hours during 2018. During an interview with the Director of Nursing (DON) on 4/25/19 at 9:20 AM, the DON confirmed Staff E completed two in-service training hours during 2018, although the requirement mandates twelve hours of in-service training per year.	F 730		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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F 758	Continued From page 5 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 758		

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F 758	Continued From page 6	F 758		

facility failed to assure as needed psychotropic medication had a stop date of 14 days from the physician order date or provide the rationale to maintain the order longer than 14 days for 1 of 5 residents reviewed (Resident #4). The facility reported a census of 56 residents.

Findings include:

According to the Minimum Data Set (MDS) assessment dated 4/3/19, the resident scored 7 on the Brief Interview for Mental Status (BIMS), which identified the resident displayed severely impaired cognition. The MDS listed diagnoses of Alzheimer's disease, cerebrovascular accident, non-Alzheimer's dementia, depression and mood disorder due to known physiological condition with depressive features.

The facility diagnosis report showed mood disorder due to known physiological condition with depressive features, unspecified sequelae of unspecified cerebrovascular disease, Alzheimer's disease, cerebral infarction, other recurrent depressive disorders, and unspecified dementia without behavioral disturbance.

The Medication Administration Record (MAR) for March 2019 showed an order for Lorazepam (anti-anxiety medication) 0.5 mg as needed for insomnia and anxiety, with an order date of 3/12/19 and administration on March 12th, 15th, 27th, 30th and 31st.

The MAR for April 2019 showed an order for Lorazepam 0.5 mg as needed for insomnia and anxiety with an order date of 3/12/19 and administration on April 2nd and 8th.

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F 758	Continued From page 7 The chart contained no documentation present in the resident's chart to show physician rationale for the as needed Lorazepam order greater than 14 days. In an interview, Staff C, RN stated the facility had no documentation from the physician to show the rationale for keeping the resident's as needed Lorazepam longer than 14 days. Staff C RN reported awareness of the requirement that the as needed Lorazepam needed a stop date at 14 days unless the facility provided the physician's rationale for the order.	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to meet the professional standards of medication administration 1 of 16 residents reviewed (Resident #311). On 3/29/19, Staff D administered Resident #311 another resident's medication (an antipsychotic and an antidepressant) in addition to her own (a narcotic pain reliever). The result, the resident became unresponsive, staff called 911, and the ambulance took her to the emergency room (ER). The resident then admitted to the intensive care unit (ICU) for treatment. The facility reported a census of 56 residents. Findings include: According to the Minimum Data Set (MDS)	F 760		

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F 760	Continued From page 8	F 760		

assessment tool dated 4/19/19, Resident #311 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident displayed moderately impaired cognitive skills. The MDS documented the resident required extensive assist of two staff for bed mobility, transfers, ambulation (walking) in room/corridor, toilet use, and bathing. The resident remained independent with eating. The MDS listed diagnoses that included Alzheimer's disease, non-Alzheimer's dementia, depression, respiratory failure, and signs of accidental poisoning by other drug/meds/biological substance.

Resident #311's March 2019 medication administration record (MAR) directed staff to administer Tramadol (narcotic pain reliever) 100 mg by mouth at 8:00 PM. The MAR contained Staff D's initials, which verified Staff D gave the medication as ordered on 3/29/19.

Resident #3's March 2019 MAR directed staff to administer Seroquel 550 mg and Trazodone 200 mg by mouth at bedtime. The MAR contained Staff D's initials, which verified Staff D gave the medication as ordered on 3/29/19.

Review of Resident #311's progress notes dated 4/5/19 at 3:58 PM contained a late entry summary report of medication error. The note documented staff administered Resident #311 her scheduled Tramadol 100 mg, and then mistakenly administered Resident #311 another resident's (Resident #3) Seroquel (antipsychotic) 550 mg and Trazodone (antidepressant) 200 mg. The progress notes also revealed the critical access hospital (CAH) transferred the resident to a Level 3 Trauma Hospital where she admitted to ICU (intensive care unit) on a BIPAP (Bi-level positive

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F 760	Continued From page 9 airway pressure). The progress notes dated 3/29/19 at 10:50 PM documented the resident ingested Trazadone and Seroquel at approximately 8:15 PM. The nurse called the emergency room and the physician gave parameters to monitor vital signs every two hours and transport Resident #311 to the emergency room with blood pressure below 80/40 or pulse less than 40. The notes revealed at 9:00 PM, staff checked the resident who slept with periods of apnea (temporary cessation of breathing) per resident's usual, however, staff could not rouse her. The record failed to contain any information related to the resident's temperature, pulse, respirations, or blood pressure at or around the time of the medication error. A progress note dated 3/29/19 at 9:15 PM revealed the facility obtained an order to send Resident #311 to the emergency room for evaluation. At 9:17 PM, staff called 911 and resident transferred by ambulance to the ER at 9:30 PM. The Rose Vista Home Transfer Report documented the facility transferred the resident on 3/29/19 due to decreased breathing with periods of apnea and unresponsive episode after ingesting the wrong medications. The facility medication administration guidelines with an effective date of 6/1/07, directed staff to administer medications in accordance with written orders of the attending physician. The policy also directed staff to identify the residents receiving medications, and do not give medications supplied for one resident to another resident.	F 760		

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F 760	Continued From page 10 In an interview with Staff D RN on 4/23/19 at 12:11 PM, she stated on 3/29/19 she set up 8:00 PM medications for both Resident #3 and Resident #311, entered Resident #311's room, and administered Resident #311 her 8:00 PM medications. Staff D RN reported she then became distracted while in Resident #311's room and subsequently administered Resident #3's 8:00 PM medications to Resident #311. She acknowledged she knew how medications were supposed to be given and also knew never to take two residents' medications with her at the same time. She reported as soon as she gave the medications to the resident she knew she gave them to the wrong resident, but Resident #311 cold not spit them out because she had already swallowed them. Staff D also she reported she called the Emergency Room within minutes and received an order to stay with the resident. In an interview with Director of Nursing (DON) on 4/25/19 at 7:33 AM stated she expected staff that passed medications to follow the 5 rights of medication administration (a nursing professional standard) and follow the facility medication administration policy. The DON stated staff should prepare one resident's medications, administer those medications, then move to a second resident to set up and pass medications without preparing two resident's medications at the same time.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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	165357	A. BUILDING _____ B. WING _____	04/25/2019

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F 880	Continued From page 11 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 12 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure staff followed infection control practices for 1 of 16 residents reviewed (Resident #40). The facility identified a census of 56 current residents. Findings include: The Minimum data set (MDS) assessment dated 3/6/19, documented diagnoses for Resident #40 that included Diabetes Mellitus, dementia and stroke. The MDS also documented the resident scored 14 on the Brief Interview for Mental Status	F 880		

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F 880	Continued From page 13	F 880		

(BIMS). A score of 14 identified no cognitive impairment. Resident #40 was totally dependent on staff for bed mobility and transfer. MDS documented Resident #40 had an unhealed pressure ulcer.

Observation on 4/23/19 at 3:13 p.m., revealed Staff A, had donned gloves and gathered supplies for the wound treatment before she entered the room. Staff A gathered supplies for the wound treatment and laid them directly on a portable table that she used for the treatment, which included scissors and opened bandage were placed on the table. Staff A did not wash her hands upon entrance to the room and had touched the nurse's desk and cabinets by the nurse's station with gloved hands. Staff A then removed the wound dressing that was on the left outer ankle, removed her gloves, donned new gloves, and did not sanitize or wash her hands. Staff A completed the wound treatment as ordered, removed her gloves and left Resident #40's room without washing her hands. She then walked across the hall and touched the linen closet handle.

When asked on 4/23/19 at 3:32 p.m., Staff A verified she did not wash her hands while providing the above dressing change for Resident #40.

During an interview with the Director of Nursing she stated that it would be an expectation for staff to wash their hands during a dressing change.

Record review of a document provided by the Director of Nursing, (Clinical Nursing Skills book, Perry, Potter, Ostendorf) revealed hand hygiene should be performed with dressing changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE VISTA HOME, INC.	1109 NORMAL STREET WOODBINE, IA 51579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Rose Vista Plan of Correction 5-30-19

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law.

The preparation of the following plan of corrections for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law require it.

F644

Level 1 PASRR for Resident 37 was resubmitted on 5/10/19. This triggered a Level 2. The Resident was Ruled Out of Level 2 population with Summary date of 5/16/19.

With respect to all other similarly situated residents, the DON will review diagnosis list of all residents for psychiatric-related diagnoses and compare to current PASRR. DON will resubmit any necessary updates by 6/6/2019.

Nursing staff will be trained to notify DON of newly added diagnoses.

Diagnoses will be verified with current PASRR to validate continued compliance. This will be completed quarterly at the time of the quarterly MDS assessment.

The DON will monitor for compliance on a monthly basis through the quality assurance process.

F657

Resident 40 care plan was updated to include unstageable pressure area on 4/24/19.

With respect to all other similarly situated residents, Care Plans of Residents with any pressure injuries were reviewed for any needed corrections.

Documentation for any new pressure injuries will include addition to care plan. This will be reviewed weekly by DON or designee.

F730

C.N.A. staff E has been reprimanded and has now completed past due in-service hours.

All C.N.A. employee files were audited for compliance and as of 6/6/19 all will be up to date.

New policy written for in-service including 30-day deadline to make up any in-service which were not attended face-to-face. Policy includes potential disciplinary action, removal from schedule, and possible dismissal.

DON or designee will monitor monthly for compliance.

F758

With respect to Resident #4, the Doctor was made aware of no recent use of psychotropic medication and the Order was discontinued.

With respect to all other similarly situated residents, medication lists were reviewed for out of compliance psychotropic medication orders. Medication usage was reviewed and Providers were updated. Order changes have been made and are compliant.

On 5/6/19, order template for Point Click Care was created for prn Lorazepam, Ativan, Xanax, Alprazolam, Haldol. These templates include an automatic 14 day duration. Nurses who enter orders were trained on use of template on 5/6/19 and again on 5/22/19.

DON or designee will monitor new order entry for compliance on a weekly basis. Consulting Pharmacist will monitor monthly for compliance.

F760

With respect to Resident #311,Staff 8 immediately recognized her error. After caring for the Resident, she notified DON. Staff 8 and DON reviewed medication administration procedure and methods to reduce risk of future errors. Discussion included factors that contributed to this error and methods to eliminate or reduce those factors.

With respect to all other similarly situated residents, Medication Administration Policy was reviewed. Every staff member who is responsible for medication administration received a copy of policy and verbal review of safe methods to set up and administer medication. Training included all Nurses, Med Aides, and Nursing Students who were assigned to Rose Vista at the time.

Spot checks of medication carts are being done to assure that no medications are being set up in advance of administration.

Medication administration policy to be reviewed with staff quarterly.

F880

With respect to Resident #40, Staff A was immediately retrained on wound treatment and hand hygiene, including appropriate gloving.

With respect to all other similarly situated residents, on 5/1/19, all nursing staff were retrained on proper wound treatment and associated infection control measures.

Posters for Staff training regarding hand hygiene were placed in staff bathrooms for incidental training. Verbal quizzing on the topic was included in staff in-service on 5/22/19.DON or designee will monitor would treatment for appropriate infection control measures weekly for 4 weeks, then intermittently after that.