STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 9/18/19 The following deficiencies resulted from investigation of complaint #84060-C and #84888-C. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, staff interview, facility record review, and facility policy review, the facility failed to provide bathing assistance at least weekly and/or per resident preference for 4 of 10 residents reviewed for bathing (Resident #2, #4, #6, #9, #10). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/26/19 for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 11. A score of 11 indicated moderate cognitive impairment. The MDS revealed the resident required the extensive physical assistance of 2 persons for transfers and of 1 person for personal hygiene, bathing. The MDS recorded the resident experienced episodes of bowel incontinence	F 677		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 677	Continued From page 1 always. The MDS documented diagnoses that included hip fracture and neurogenic bladder. The care plan focus area revised 7/9/19 identified a need for assistance in dressing, grooming, bathing, and pericare. The care plan informed staff the resident frequently refuse to change clothes and bathe despite encouragement. According to the Evening Shift Baths Schedule updated 1/25/19, the resident should have received offers to bathe on Sundays and Wednesdays. The resident should have been offered baths on the following dates in July and August 2019: 7/3, 7/7, 7/10 7/14, 7/17, 7/21, 7/24, 7/28, 7/31, 8/4, 8/7, 8/11, 8/14, 8/18, 8/21, 8/25. The Follow Up Question Report for Bathing revealed Resident #2 received assistance with bathing on the following days 7/1/19 thru 8/28/19: 7/7, 7/31, 8/4, 8/11, 8/17, 8/18, 8/25. The Bath Sheets provided additional documentation for bathing activity: 7/7 refused; 7/17 bed bath; 7/28 refused as wanted a female aide to provide bath; 7/31 bed bath; 8/11 bed bath; 8/18 bed bath; 8/27 bed bath. The clinical record lacked documentation of attempts to encourage the resident to bathe or refusals to bathe, other than noted above, on 7/3, 7/10, 7/14, 7/21, 7/24, 8/7, 8/14, and 8/21. 2. The MDS assessment dated 7/6/19 for Resident #4 identified a BIMS score of 08 which indicated severe cognitive impairment with signs	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 677	Continued From page 2 of inattention and altered level of consciousness present continuously. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, personal hygiene, and transfers did not occur during the 7 day look-back period. The MDS revealed the resident totally dependent upon staff for bathing. The MDS recorded the resident experienced episodes of bladder and bowel incontinence always. The MDS documented diagnosis that included non-Alzheimer's dementia and respiratory failure. The care plan focus area revised 2/19/19 directed staff to provide assistance of 1 person for dressing, grooming, and bathing. According to the Day Shift Baths Schedule updated 1/25/19, the resident should have received offers to bathe on Tuesdays and Fridays. The resident should have been offered baths on the following dates in July and August 2019: 7/2, 7/5, 7/9, 7/12, 7/16, 7/19, 7/23, 7/26, 7/30, 8/2, 8/6, 8/9, 8/13, 8/16, 8/20, 8/23, 8/27. The Follow Up Question Report for Bathing revealed Resident #4 received assistance with bathing on the following days 7/1/19 thru 8/28/18: 7/9, 7/25, 8/6, 8/11, 8/12, 8/13, 8/22, 8/27. The Bath Sheets provided additional documentation for bathing activity: 7/16 bed bath; 7/30 bed bath; 8/20 bed bath; 8/27 bed bath. The clinical record lacked documentation of attempts to encourage the resident to bathe or refusals to bathe, other than noted above, on 7/2, 7/5, 7/12, 7/19, 7/23, 7/26, 8/2, 8/9, 8/16.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 677	Continued From page 3	F 677		

3. The MDS assessment dated 7/3/19 for Resident #6 identified a BIMS score of 15 with signs of fluctuating inattention. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, transfers, and bathing. The MDS recorded the resident experienced occasional episodes of bladder and bowel incontinence. The MDS documented diagnosis that included chronic obstructive pulmonary disease (COPD).

The care plan focus area revised 2/6/19 directed staff to provide assistance of 1 person for dressing, grooming at times, and bathing.

According to the Evening Shift Baths Schedule updated 1/25/19, the resident should have received offers to bathe on Mondays and Thursdays. The resident should have been offered baths on the following dates in July and August 2019: 7/1, 7/4, 7/8, 7/11, 7/15, 7/18, 7/22, 7/25, 7/29, 8/1, 8/5, 8/8, 8/12, 8/15, 8/19, 8/22, 8/26.

The Follow Up Question Report for Bathing revealed Resident #6 received assistance with bathing on the following days 7/1/19 thru 8/28/18: 8/1, 8/26.

The Bath Sheets provided additional documentation for bathing activity: 7/11 shower; 7/29 shower; 8/12 shower; 8/18 whirlpool, 8/19 whirlpool.

The clinical record lacked documentation of attempts to encourage the resident to bathe or refusals to bathe, other than noted above, on 7/1, 7/4, 7/8, 7/15, 7/18, 7/22, 7/25, 8/5, 8/8, 8/15,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 677	Continued From page 4 8/22. On 8/27/19 at 11:40 a.m. Resident #6 reported he hated it when it took a week to get his bath. Resident #6 identified shortage of staff as part of the reason he didn't get a bath. Resident #6 felt the facility should be able to tell him when he gets a bath. Resident #6 said he was supposed to get baths on Monday/Thursdays and thought he had missed his Thursday bath the week prior. On 8/29/19 at 9:50 a.m. the Administrator voiced she wanted to highlight Resident #6's behaviors and felt his behaviors should be taken in to account when reviewing the resident's reports of not getting bathed 2 times a week. 4. The MDS assessment dated 8/6/19 for Resident #9 identified a BIMS score of 13 without signs/symptoms of delirium. A score of 13 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, personal hygiene, 2 persons for transfers, and and totally dependent upon 1 person for bathing. The MDS recorded the resident experienced occasional episodes of bladder incontinence and frequent episodes of bowel incontinence. The MDS documented diagnosis that included heart failure and non-Alzheimer's disease. The care plan focus area revised 8/1/19 directed staff to provide assistance of 1 person for dressing, grooming, and bathing. According to the Day Shift Baths Schedule updated 1/25/19, the resident should receive offers to bathe on Mondays and Thursdays.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 677	Continued From page 5 Staff should have offered baths on the following dates in July and August 2019: 7/1, 7/4, 7/8, 7/11, 7/15, 7/18, 7/22, 7/25, 7/29, 8/1, 8/5, 8/8, 8/12, 8/15, 8/19, 8/22, 8/26. The Follow Up Question Report for Bathing revealed Resident #9 received assistance with bathing on the following days 7/1/19 thru 8/28/18: 7/4, 7/11, 7/29, 8/1, 8/5, 8/8, 8/15, 8/18, 8/22, 8/27. The Bath Sheets provided additional documentation for bathing activity: 7/18 shower; 8/9 shower; 8/15 shower, 8/18 shower. The clinical record lacked documentation of attempts to encourage the resident to bathe or refusals to bathe, other than noted above, on 7/1, 7/8, 7/15, 7/22, 7/25. On 8/28/19 at 2:25 p.m. Resident #9 reported she should get a bath 2 times a week. She told staff she wanted it 2 times a week, but the staff tell her they do not have the time. On 8/28/19 at 4:00 p.m. the Administrator stated she didn't think Resident #9's account of not getting bathed was correct. 5. The MDS assessment dated 8/13/19 for Resident #10 identified identified a BIMS score of 14 without signs/symptoms of delirium. A score of 14 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 2 persons for bed mobility, bathing, and totally dependent upon 2 persons for transfers. The MDS recorded the resident experienced episodes of bladder and bowel	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 677	Continued From page 6	F 677		

incontinence always. The MDS documented diagnosis that included heart failure and morbid obesity.

The care plan focus area revised 2/6/19 directed staff to provide extensive assistance of 1 person for dressing, grooming and bathing.

According to the Day Shift Baths Schedule updated 1/25/19, the resident should have received offers to bathe on Mondays, Wednesdays, and Fridays. The resident should have been offered baths on the following dates in July and August 2019: 7/1, 7/3, 7/5, 7/8, 7/10, 7/12, 7/15, 7/17, 7/19, 7/22, 7/24, 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/9, 8/12, 8/14, 8/16, 8/19, 8/21, 8/23, 8/26, 8/28.

The Follow Up Question Report for Bathing revealed Resident #10 received assistance with bathing on the following days 7/1/19 thru 8/28/18: 7/3, 7/8 bed bath, 7/22, 7/29, 7/31, 8/2 bed bath, 8/5, 8/7 bed bath, 8/9, 8/14, 8/16 bed bath, 8/19 bed bath, 8/21, 8/28 bed bath.

The Bath Sheets provided additional documentation for bathing activity: 7/12 bed bath; 8/7 bed bath; 8/19 bed bath, 8/21 shower.

The clinical record lacked documentation of attempts to encourage the resident to bathe or refusals to bathe, other than noted above, on 7/1, 7/5, 7/10, 7/15, 7/17, 7/19, 7/24, 7/26, 8/12, 8/23, 8/26.

On 8/28/19 at 2:30 p.m. Resident #10 stated she would get bathed if staff had a bath sling. Resident #10 reported the last 2 scheduled baths she had to have a bed bath as no sling available

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 677	Continued From page 7 and she should get 3 baths a week per doctor order. On 8/28/19 at 4:00 p.m. the Administrator stated she didn't think Resident #10's account of not having slings for bathing correct. Additional Interviews: On 8/27/19 at 3:19 p.m., the Director of Nursing, (DON), reported the facility policy stated baths only needed to be provided once a week. The DON responded that staff documented bathing in the computer and also staff filled out a bathing sheet. On 8/28/19 at 9:55 a.m., the DON stated she rolled out education about documentation of baths in the electronic clinical record. The DON reported she reviewed her plan with the Administrator. The DON stated she took over the DON position 7/17/19 but the former DON did bath sheet documentation as well. On 8/28/19 at 5:00 p.m., Staff A, Certified Nurse Aide (CNA), provided copies of bath schedules for rooms. Staff A reported each room scheduled for baths 2 times per week. On 8/28/19 at 5:05 p.m., the DON confirmed staff are to offer residents 2 baths per week but the facility policy states only 1 bath per week is required. The DON identified the bath sheets as the most up to date schedule as of the interview. The DON stated she would be in the process of revamping the schedule as it still had C hall on it, but no residents resided on C Hall any longer. The facility policies revised 3/1/14 titled Bath in Whirlpool and Bath in Shower, both included the	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 677	Continued From page 8 following documentation: Policy - To provide the resident the opportunity to bathe at least weekly and/or as per resident's request or as needed.	F 677		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, family, resident, staff and hospice interviews, the facility failed to ensure a resident who demonstrated a need for dining assistance received assistance to eat and failed to provide/document administration of a nutritional intervention to one resident (Resident #4), who experienced a significant weight loss of 18.22% in	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 9 a 6 month period out of 4 residents reviewed for weight loss. The facility reported a census of 74 residents. Findings include: The Minimum Data Set (MDS) assessment dated 6/3/19 for Resident #4 identified a Brief Interview for Mental Status (BIMS) score of 08 which indicated severe cognitive impairment with signs of inattention and altered level of consciousness present continuously. The MDS revealed the resident required extensive physical assistance of 1 person for bed mobility, dressing, eating, toilet use and personal hygiene. The MDS recorded the resident did not transfer or ambulate during the 7 day look-back period. The MDS revealed the resident as totally dependent upon staff for bathing. The MDS documented diagnoses that included: non-Alzheimer's dementia, respiratory failure, and abnormal weight loss. The MDS recorded the resident's height as 60 inches and weight as 86.0 lbs (pounds). The resident experienced weight loss not prescribed by a physician of 5% or more in the last month or 10% or more in the last 6 months. The MDS revealed the resident received hospice level of care. Care Plan: A care plan focus area revised 2/19/19 identified the resident needed assistance with transfers, bed mobility, and non-ambulatory. A care plan focus area revised 12/20/18 identified the resident at risk for weight loss due to diagnosis of a progressive cognitive disease. On 3/18/19 the care plan informed staff the resident ate in her room the majority of the time and could feed herself at the time, however she	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 10	F 692		

had a poor appetite. On 3/28/19, the care plan directed staff to give the resident supplements as ordered. On 6/10/19 the care plan informed staff the resident to receive a magic cup (nutritional supplement) with meals. On 8/15/19 the care plan informed staff a hospice aide came intermittently per family request as the resident required much encouragement. On 8/22/19 (during the investigation) the care plan directed staff to ensure the bed in an upright position during meals, meals to be set up with all packaging open, and frequent checks by staff to offer encouragement and assistance when needed.

The Weights and Vitals Summary report printed 8/27/19 included the following weight measurements:
a. 12/5/18 - 105.0 lbs
b. 1/3/19 - 119.2 lbs (the report documented on 2/6/19 the value struck out as re-weigh)
c. 1/31/19 - 108.1 lbs
d. 2/13/19 - 107.6 lbs
e. 3/5/19 - 119.9 lbs (the report documented on 5/21/19 the value struck out as incorrect documentation)
f. 4/11/19 - 99.0 lbs
g. 5/16/19 - 101.4 lbs
h. 6/1/19 - 88.0 lbs
i. 6/5/19 - 90.0 lbs
j. 7/8/19 - 85.9 lbs
k. 8/13/19 - 88.0 lbs

The 3/5/19 struck out value(119.9 pounds) compared to the 4/11/19 value (99 pounds) showed a 17.43% weight loss over a 1 month period.
The 2/13/19 value (107.6 pounds) to the 4/11/19 value (99 pounds) showed a 7.99% weight loss over a 2 month period disregarding the struck out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 11 value from 3/5/19. The 5/16/19 value (101.4 pounds) compared to the 6/1/19 value (88 pounds) showed a 13.21% weight loss over a 2 week period. The 6/5/19 value (90 pounds) compared to the 7/8/19 value (85.9 pounds) showed a 4.56% weight loss over a 1 month period. The 2/13/19 value 107.6 pounds) compared to the 8/13/19 value (88 pounds) showed a total 18.22% weight loss over a 6 month period. The physician's verbal order dated 2/19/19 identified an active order for Ensure (nutritional supplement) 3 times a day related to abnormal weight loss. The Hospice Physician's Plan of Care dated 2/28/18 documented a terminal diagnosis of COPD. The plan of care identified the resident as completely dependent for all activities of daily living. The resident did not even have enough energy to chew food. The Registered Dietician (RD) documented an assessment in the Progress Notes on 3/25/19 at 3:50 p.m. The RD identified the resident with significant weight gain times 30 days and 90 days. (This was incorrect) She identified the resident's diet as appropriate for the resident's medical condition and intakes inadequate to meet the resident's estimated needs. The resident received protein powder with Ensure started within the last month in addition. The dietician identified that with the new order for Ensure, the resident would not need the additional protein powder. The dietician sent a facsimile (fax) to the physician to request discontinuation of the protein powder.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 12 On 3/25/19 the RD wrote a fax informing the physician the resident experienced a significant weight gain of 11% in 30 days and 14% in 90 days with a current weight of 119.9 lbs (Body Mass Index) of 23. The RD identified an order for Ensure TID (3 times a day) in place as well as protein powder mixed with ice cream daily. The RD identified the supplementation as excessive and requested discontinuation of the protein powder and ice cream. The physician "okayed" the discontinuation. (The RD based her findings on the 3/5/19 inaccurate weight of 119.9 pounds with no reweight requested.) The RD documented an assessment in the Progress Notes on 4/29/19 at 5:09 p.m.. The RD wrote the resident with significant weight loss. She identified the resident's diet as appropriate for the resident's medical condition. She identified the resident with poor intakes. She wrote the Ensure TID resulted in meeting/exceeding the resident's estimated nutrient needs. The resident continued to lose weight despite this. She identified the resident on hospice with diagnosis of abnormal weight loss. The dietician expected that the resident was adequately nourished and malnutrition was not the cause of the weight loss. The dietician made no further recommendations at that time. On 4/29/19 the RD wrote a fax informing the physician the resident experienced a significant weight loss of 22% in 60 days and 13% in 90 days with a current weight of 93.7 lbs and BMI (Body Mass Index) of 18. The RD documented the intake of meals and supplements exceeded nutrient needs. The physician responded to	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 13	F 692		

increase house supplement. The facility sent a fax to clarify and inform the physician the resident currently received Ensure 240 ml (milliliters) TID and how would the physician like to increase the supplement. The physician responded with no new orders.

A Hospice Clinical Progress Note dated 5/10/19, documented by the resident's hospice case manager Registered Nurse (RN), identified a new order for magic cup with meals TID and to also keep the Ensure order.

A late entry Progress Note dated 5/10/19 at 11:00 a.m. documented the hospice nurse saw the resident and magic cup added to meal times, TID.

The Medication Review Report dated 6/4/19 lacked documentation of an order to give magic cup with meals TID.

The June 2019 Medication Administration Record (MAR) lacked documentation of administration of magic cup TID.

The RD documented an assessment in the Progress Notes on 6/10/19 at 4:30 p.m. that identified the resident with significant weight loss. The RD identified the diet as appropriate for the resident's medical condition but the resident had poor intakes. With intakes of Ensure TID, the resident met her estimated nutrient needs. However, the resident continued to lose weight. The RD identified that, given hospice level of care, weight loss was not unexpected. The facility notified the physician of weight loss and the physician declined further orders/interventions. Hospice services then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 14 requested magic cup. The resident received a high amount of supplementation and given the resident's condition and expectation of decline, the RD made no further recommendations at that time. An Order Summary Report dated 7/25/19 lacked documentation of an order to give magic cup with meals TID. The July 2019 MAR lacked documentation of administration of magic cup TID. The Medication Review Report dated 8/7/19 recorded an active order for magic cup with meals started 7/16/19. The August MAR documented an order for Magic cup with meals for poor appetite started 8/16/19 with scheduled administration times of 8:00 a.m., 12:00 p.m., and 1:00 p.m. 8/16/19 thru 8/20/19 then changed to times of 8:00 a.m., 12:00 p.m., and 6:00 p.m. 8/21/19 thru 8/28/19. The MAR contained no information to indicate the resident received magic cup with meals 8/1/19 thru 8/15/19. Review of the August 1-26, 2019 MAR revealed the resident did not take the Ensure or just took 25% 52 out of 78 opportunities. There was no evidence the dietician attempted to provide food likes to the resident such as breakfast items or more ice cream items. A Physician Visit dated 7/25/19 documented orders for the resident to sit up for meals, assistance to be offered with eating and provide a general diet with no pureed food per family/patient preferences. The resident's weight	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 15 was 85.9 lbs. The care plan conference signature sheet signed by the resident's daughter on 7/25/19 included a photocopied post it note that recorded the daughter wanted the resident up more and did not think staff assisted/fed the resident like she needed. The care plan continued to identify the resident as able to feed herself and lacked a revision to reflect the family's desire and the doctor's order for the resident to receive assistance with dining. The RD documented an assessment in the Progress Notes on 8/16/19 at 10:42 p.m.. The RD identified the resident with significant weight loss overall, however with weight gain in past 30 days. She wrote the resident's diet was appropriate for the resident's medical condition. The RD expected the intake of meals and supplements met the resident's estimated nutrient needs. The RD documented that given hospice level of care, weight loss was not unexpected. The facility notified the physician of weight loss and the physician declined further orders/interventions. The RD had no further recommendations at that time and directed staff to continue the current plan of care. The Follow Up Question Report for Eating recorded the residents ability to self perform eating from 7/29/19 thru 8/27/19. The report documented the resident required extensive physical assistance and/or totally dependent upon 1 staff for eating on: 7/29, 7/31, 8/2, 8/3, 8/4, 8/5, 8/6, 8/7, 8/9, 8/11, 8/12, 8/13, 8/14, 8/17, 8/19, 8/21, 8/22, 8/23, 8/24, 8/25, 8/26. The report documented only once during that time period the resident independent with set up help only with	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 16 eating; 8/9. The facility provided list on 8/21/19 titled Residents who need physical assistance with eating. The list did not contain Resident #4's name. The facility provided a list on 8/22/19 titled Residents who need supervision with eating. The list did not contain Resident #4's name. The email correspondence dated 8/22/19 at 2:16 p.m., written by the resident's hospice RN case manager, included the following documentation: Hospice aide feeds the resident 5 times a week per family request. The patient does not have much appetite and nothing tastes good to her. She is on pureed food but also can have pleasure food per family request. Aides are there to advocate food choices, set up, and encourage and assist with feeding. She is able to feed self but daughter wanted her to eat more and gain weight. She is up 3 lbs this month due to change to pureed diet and aides going above and beyond helping with meal choices. Patient started wanting something and when the food got there she changed her mind and the aide gets another choice. Hospice meets with TLC (unknown) every 3rd Tuesday of each month to go over hospice patients and the concerns we have with each patient. Observation on 8/20/19 at 3:45 p.m. revealed Resident #4 laid in bed with head of bed raised to 45 degrees (also known as semi-fowler position which is lying in the supine position on the bed at an angle of 30 to 45 degrees). The resident appeared alert with eyes open and TV on in the room. Blankets covered the resident's lower body and the resident appeared thin in stature. At 6:28 p.m. Resident #4 laid in bed with oxygen	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 17 on via nasal cannula and concentrator. At 6:42 p.m. Staff B, CNA, took a room meal tray to Resident #4's room and then came back out of the room. At 6:44 p.m. observation revealed Resident #4's food tray with pureed food on a bedside table over the resident as she laid in semi-fowlers position in bed. The drink cup remained covered with a lid. Resident #4 scoffed when asked if the staff helped her to dine and stated she'd just as soon have the surveyor help her. At 6:47 p.m. Staff B went back down the hall to 5th room on the right with a food tray then back out. No staff entered Resident #4's room to assist with dining. At 6:56 p.m. the Administrator appeared on the hall and then left the hall. Resident #4 rested with eyes closed, food untouched and lid still on the drink. No staff entered the room to provide dining assistance. At 6:58 p.m. Staff B on appeared on the hall to collect trays. At 7:08 p.m. Staff B entered Resident #4's room and attempted to assist the resident to take a bite. The resident took a bite, then said no and pushed/waved the CNA away. At 7:09 p.m. Staff B exited the room with tray and said Resident #4 refused and wouldn't eat. Staff B responded it was not possible to meet everyone's needs with only 1 CNA assigned to a hall as everyone needed help. Staff B said he tried his best because they were human beings but it was sad. Staff B acknowledged he had to pass meal trays then go see if the residents needed assistance to eat as he picked up the food trays. Staff B stated sometimes it's okay by himself but really not possible. On 8/21/19 at 5:30 p.m., Staff C, CNA/Scheduler,	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 18	F 692		

provided a list of residents he thought required dining assistance by hall. The list included 1 resident on Ginger Grove hall and approximately 10 other resident names that included Resident #4. The surveyor asked the Director of Nursing (DON) to copy the half sheet of paper to a full sheet. At that time, the DON stated Staff C was not supposed to give the surveyor the list. Staff C was supposed to write the list then give it to a manager who to confirm those residents actually required dining assistance for feeding. The DON stated they would verify the list as accurate then give the surveyor a list of residents who required dining assistance.

On 8/21/19 at 5:42 p.m., the Administrator brought information to the surveyor. At that time, the Administrator commented she asked Staff C to write down off the top of his head which residents required feeding assist then give the list to the nurse consultant so she could verify the information prior to giving it to the surveyor. The Administrator stated after the consultant verified the information correct then she would give it back to the surveyor.

On 8/21/19 at 5:48 p.m. the DON returned with a list and identified that list as much better. The list, titled "residents who need physical assistance with eating", included 8 resident names; the list did not include Resident #4.

On 8/21/19 at 6:32 p.m., Staff D, CNA, reported Resident #4 refused a supper tray.

On 8/22/19 at 11:00 p.m., the Dietary Manager stated dietary staff passed out supplements but nursing staff is responsible for recording intakes of those supplements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 19 On 8/22/19 at 11:20 a.m., Staff E, LPN, identified the resident's magic cup documentation as located on the MAR. Staff E reported on her shift Resident #4 refused the meal but could feed herself. Staff E stated if Resident #4 said no to a meal, she would will leave and recheck in 5 minutes. Staff E reported the resident had chewing issues and went back/forth on diet. Staff E commented when the resident wanted to feed herself she could but identified that as rare. If the resident needed it then staff fed the resident. Staff E stated she thought they started assisting the resident with feeding due to weight loss. In response to the question if resident needed direct supervision with dining given the care plan listed the resident as able to feed self, Staff E responded she could change the care plan from independent if she needed to if the the care plan identified the resident as independent. On 8/22/19 at 11:55 a.m., the DON stated the facility used care plans to determine which residents needed supervision and/or assistance with dining and used care plans to meet resident needs. The DON acknowledged Resident #4 as not on the list of residents who need supervision with eating. The DON said Resident #4 ate independently and did not need help or supervision. On 8/22/19 at 12:58 p.m., the resident's daughter reported the Social Worker said she'd find out where the resident's food tray was at approximately 30 minutes earlier. Observation on 8/22/19 at 1:13 p.m. revealed the resident's daughter at the bedside . The daughter reported the resident couldn't see to eat and	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 20	F 692		

hospice fed the resident 5 times a week. She stated the resident couldn't eat by herself. At 1:14 p.m. the Social Worker returned with a meal tray and asked the daughter if she wanted her to leave it, then left. The daughter identified that staff did not assist the resident to sit up in bed for the meal. At 1:17 p.m. the daughter asked Resident #4 if she could try to sit herself up and take bites. Resident #4 raised her head then dropped it quickly back to the pillow. The resident was unable to take a bite of food. The magic cup supplement was not opened on the food tray. Resident #4 said she didn't know if she could try to eat or not. The daughter obtained the controls for the bed from it's placement under the mattress and stuck on the bed frame. The daughter reported Resident #4 had macular degeneration and couldn't see what the food was on the tray. The daughter raised the bed up to 80 degrees and encouraged the resident to try a bite of food. The resident took a bite. Resident #4 accepted a few more bites then tried to pick up the cup of applesauce with her right hand. The daughter asked the resident what she was trying to do to which the resident stated she was trying to take a drink. The daughter informed the resident the juice was located by her left hand. Resident #4 said she preferred to use her right hand. The daughter assisted the resident to hold the drink with 2 hands with hand over hand assistance. The daughter asked the resident to try to lift the water mug with straw. The resident struggled as her whole arm shook and the daughter said Resident #4's mouth always appeared dry and cracked. The daughter reported she was told in the beginning that the facility won't help assist the resident to dine unless she went to the dining room. The daughter gave the resident coffee that her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 21	F 692		

husband had to go get and poured it into a small cup. The daughter prevented the resident from spilling several times then the resident took a drink herself. The daughter opened the magic cup and the resident ate it readily with daughter providing the bites. The daughter reported she informed the facility what the resident liked to eat food items such as breakfast foods. The daughter stated no doctor ever said the resident's weight loss was unavoidable. The daughter commented she lived far enough away she couldn't be there to assist dining all the time. Resident #4 ate 100% of the magic cup.

On 8/22/19 at 1:54 p.m. Staff F, CNA, and Staff E, LPN, assisted Resident #4 to use the bedside commode. Resident #4 needed assistance from Staff E to maintain a sitting position, otherwise the resident fell back.

On 8/22/19 at 2:25 p.m., Staff F reported Resident #4 no longer had strength to get up so normally so just went to the bathroom in the bed due to difficulties with sitting. Staff F reported it was difficult to serve room trays and then need to help put other residents get changed or put in bed. Staff F stated she just encouraged Resident #4 to eat, stayed awhile, tried to joke around, and thought the Kardex (care plan) just listed to encourage the resident to eat as the resident was listed to eat on her own. Staff F stated she did not know if the resident could put the bed up on her own, but staff needed to assist with food tray setup and putting the bed up.

On 8/22/19 at 3:14 p.m., the Administrator reported she took the meal tray to the resident approximately 2 weekends previous and saw the resident sit on the edge of the bed and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 22	F 692		

resident could eat/drink on her own. The Administrator stated she also saw the resident refuse meals and knew it was her right to do so. The Administrator stated she realized the resident's performance could fluctuate. The Administrator commented aides have to have critical thinking to tell the nurse when seeing different things for the day. The Administrator reported they talked about feeding assistance on the Tuesday before the surveyor came. The DON reported the resident made a gain lately doing better with the puree foods, tolerating better, and making gains with the magic cup. The DON stated staff should document magic cup intakes on the MAR and the RD brought it to her attention they were not entered on the MAR. Following that staff placed it onto the MAR.

On 8/26/19 at 10:25 a.m., a 2nd daughter reported Resident #4 couldn't see the food and felt her mom needed assistance to eat. The 2nd daughter stated the facility wouldn't feed the resident unless she went to the dining room but they wouldn't get the resident out of bed. The 2nd daughter reported she asked the Administrator why not assist her mother to eat and was told the resident needed to eat in the dining room. The 2nd daughter reported Resident #4 needed assistance to dine for at least the past 2 months. The 2nd daughter stated Resident #4 couldn't work the remote for the bed to put up and down and commented she saw the controls for the bed tucked between the mattress and the bed frame.

Observation on 8/27/19 at 7:48 a.m. revealed Resident #4 laid in bed on her back with head of bed raised to approximately 30 degrees and the foot of the bed elevated which raised the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 23 resident's knees. The remote for the bed to control the adjustments laid on the floor, out of the resident's reach. Resident #4 laid in bed with eyes closed. On 8/27/19 at 11:30 a.m. , the Dietary Manager responded she wasn't very familiar with the tracking system for magic cup intake so couldn't provide when Resident #4's magic cup was entered on to meal tracker ticket system. The Dietary Manager said the nurses entered the magic cup into their computer software then someone communicated over to other software called meal tracker. The dietary staff then printed a meal ticket and knew to serve magic cup, also known as tasty treat. On 8/27/19 at 11:45 a.m., the DON said magic cup intake tracking needed clarification with nurses. The DON stated the nurses thought the dietary department put the magic cup on the meal card from communication forms they gave them, then dietary staff put the magic cup on the meal tray. The DON said the nurses thought they didn't have to put magic cup on the MAR or track intakes. The DON stated it was after May 2019 when she clarified the expectation for the MAR to contain the magic cup order but she didn't know exact dates. The DON stated the RD brought it to her attention that the magic cup was not being tracked for who gave it and they needed to establish a system. Observation on 8/27/19 at 1:07 p.m. revealed Resident #4 laid in bed with eyes closed, food tray over the bed, food uncovered, and spoon in magic cup. There were no staff present in the room and the head of bed appeared raised 45 degrees. The control for the bed laid under the	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 24	F 692		

mattress, between the mattress and the bed frame, not reachable. Resident #4 aroused easily and denied she could sit up per self. Resident #4 nodded head yes when asked if she wanted the ice cream/magic cup on her food tray.
At 1:15 p.m., Staff E directed Staff F to assist Resident #4 to eat.
At 1:16 p.m. Staff E asked Resident #4 if she was ready to eat and the resident agreed to a bite of magic cup. Staff E raised the head of the bed up to an upright position. Resident #4 accepted bite of magic cup ice cream then regular food, took drinks of water, all with total assist. Resident #4 ate 100% of the magic cup with no resistance.

On 8/28/19 at 10:46 a.m., the RD stated she always looked at the intakes and added together 25 to 75% of intakes so the resident's intake must totaled 973 calories or greater. The RD identified the Ensure supplement as packed with nutrients so that was why she did not recommend the restart of protein plus powder. The RD stated she attended a risk meeting every week where they talked about resident intakes. The RD said she recalled talking about Resident #4 but not recall when. The RD recalled a fax from the doctor not wanting to start anything else for supplement as the resident received hospice care. The RD did not recall a discussion of the resident eating with assist or not. The RD commented knowing Resident #4 and the scenario, she didn't think the magic cup hospice recommended was necessary due to counting the percentage of meal intakes the resident refused every day, not eating, no appetite, and the magic cup supplement would not change the outcome. The RD reported the magic cup was less than 300 calories and 9 grams of protein per container. The RD responded the number of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 25 magic cups the resident would need to eat to get calories if she only ate magic cups would be about 5 a day. The RD said the Ensure supplement provided more nutrients per ounce than the magic cup and she knew the resident only took 2 to 3 bites of food. The RD responded she never personally observed the resident eating and the care plan listed the resident just needed set up help. The RD said the information she received was the resident refused to eat. The RD recalled there was a conversation about no real tracking of the intakes of magic cup on 8/16/19. On 8/28/19 at 11:45 a.m., the Administrator and the DON acknowledged they invited everyone to come out to dining room for therapeutic eating but if residents wanted to eat in their rooms, then they do that. The Administrator stated they had in the past encouraged residents to come to the dining room as they had 30 room trays to serve. On 8/28/19 at 12:20 p.m., Resident #4's hospice RN case manager said the hospice aide came 5 times a week doing hands on assist with the resident. The hospice nurse stated the resident could feed self but preferred for someone to feed her. The hospice nurse reported the resident's daughter requested they feed the resident but a lot of times the resident refused or the resident requested food but refused once it came. The hospice nurse said the resident stated she ate more because her daughter wanted her too. The hospice nurse reported ice cream was definitely a go to for Resident #4. The hospice nurse stated assistance was provided as the resident had no strength to eat or drink which was common with COPD. The hospice nurse stated they switched supplements as the resident's taste changed. The resident used to like chocolate but day to day not	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 692	Continued From page 26 know what appealed to her. The hospice nurse responded she knew the hospice aide would give the magic cup but not know if it was on request or not. On 8/29/19 at 8:05 a.m., the physician reported the resident had no problem eating with the daughter's help the last time she visited. The physician reported it was her suspicion that with additional help from the facility, the resident should have eaten better and not lost as much weight. The physician reported the resident's COPD and other problems certainly contributed to weight loss, however, not being able to sit up with daughter there to help, she would have thought the facility may have done better.	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 27 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, clinical and facility record review, resident, family and staff interviews, the facility failed provide a sufficient number of nursing personnel to meet the needs of each resident in a timely manner for dining assistance, bathing assistance, and timely response to call lights, for 5 of 17 residents reviewed for sufficient staffing (Resident #4, #6, #7, #8 #10). The facility reported a census of 74 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/3/19 for Resident #4 identified a Brief Interview for Mental Status (BIMS) score of 08 which indicated severe cognitive impairment with signs of inattention and altered level of consciousness present continuously. The MDS revealed the resident required extensive physical assistance of 1 person for bed mobility, dressing, eating, toilet use and personal hygiene. The MDS recorded the resident did not transfer or ambulate during the 7 day look-back period. The MDS revealed the resident as totally dependent upon staff for bathing. The MDS documented diagnoses that included: non-Alzheimer's dementia, respiratory failure, and abnormal weight loss. The MDS recorded the resident's height as 60 inches and weight as 86.0 lbs	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 28	F 725		

(pounds). The resident experienced weight loss not prescribed by a physician of 5% or more in the last month or 10% or more in the last 6 months. The MDS revealed the resident received hospice level of care.

Care Plan:
A care plan focus area revised 2/19/19 identified the resident needed assistance with transfers, bed mobility, and non-ambulatory. A care plan focus area revised 12/20/18 identified the resident at risk for weight loss due to diagnosis of a progressive cognitive disease. On 8/22/19 (during the investigation) the care plan directed staff to ensure the bed in an upright position during meals, meals to be set up with all packaging open, and frequent checks by staff to offer encouragement and assistance when needed.

A Physician Visit dated 7/25/19 documented orders for the resident to sit up for meals, assistance to be offered with eating and provide a general diet with no pureed food per family/patient preferences. The resident's weight was 85.9 lbs.

Observation on 8/20/19 at 3:45 p.m. revealed Resident #4 laid in bed with head of bed raised to 45 degrees (also known as semi-fowler position which is lying in the supine position on the bed at an angle of 30 to 45 degrees). The resident appeared alert with eyes open and TV on in the room. Blankets covered the resident's lower body and the resident appeared thin in stature.
At 6:28 p.m. Resident #4 laid in bed with oxygen on via nasal cannula and concentrator.
At 6:42 p.m. Staff B, CNA, took a room meal tray to Resident #4's room and then came back out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 29 the room. At 6:44 p.m. observation revealed Resident #4's food tray with pureed food on a bedside table over the resident as she laid in semi-fowlers position in bed. The drink cup remained covered with a lid. Resident #4 scoffed when asked if the staff helped her to dine and stated she'd just as soon have the surveyor help her. At 6:47 p.m. Staff B went back down the hall to 5th room on the right with a food tray then back out. No staff entered Resident #4's room to assist with dining. At 6:56 p.m. the Administrator appeared on the hall and then left the hall. Resident #4 rested with eyes closed, food untouched and lid still on the drink. No staff entered the room to provide dining assistance. At 6:58 p.m. Staff B on appeared on the hall to collect trays. At 7:08 p.m. Staff B entered Resident #4's room and attempted to assist the resident to take a bite. The resident took a bite, then said no and pushed/waved the CNA away. At 7:09 p.m. Staff B exited the room with tray and said Resident #4 refused and wouldn't eat. Staff B responded it was not possible to meet everyone's needs with only 1 CNA assigned to a hall as everyone needed help. Staff B said he tried his best because they were human beings but it was sad. Staff B acknowledged he had to pass meal trays then go see if the residents needed assistance to eat as he picked up the food trays. Staff B stated sometimes it's okay by himself but really not possible. 2. The MDS assessment dated 7/3/19 for Resident #6 identified a BIMS score of 15 with signs of fluctuating inattention. The MDS revealed the resident required the extensive	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 30	F 725		

physical assistance of 1 person for bed mobility, transfers, and bathing. The MDS recorded the resident experienced occasional episodes of bladder and bowel incontinence. The MDS documented diagnosis that included chronic obstructive pulmonary disease (COPD).

The care plan focus area revised 2/6/19 directed staff to provide assistance of 1 person for dressing, grooming at times, and bathing.

According to the Evening Shift Baths Schedule updated 1/25/19, the resident should have received offers to bathe on Mondays and Thursdays. The resident should have been offered baths on the following dates in July and August 2019: 7/1, 7/4, 7/8, 7/11, 7/15, 7/18, 7/22, 7/25, 7/29, 8/1, 8/5, 8/8, 8/12, 8/15, 8/19, 8/22, 8/26.

The clinical record lacked documentation of attempts to encourage the resident to bathe or refusals to bathe on 7/1, 7/4, 7/8, 7/15, 7/18, 7/22, 7/25, 8/5, 8/8, 8/15, 8/22.

On 8/27/19 at 11:40 a.m. Resident #6 reported he hated it when it took a week to get his bath. Resident #6 stated he thought part of the reason he didn't get a bath was due to a facility staffing shortage. Resident #6 felt the facility should be able to tell him when he gets a bath. Resident #6 said he was supposed to get baths on Monday/Thursdays and thought he missed his Thursday bath the week prior. Resident #6 reported call light response time as sometimes longer than 15 minutes and alot of times taking longer that because of short staffing. Resident #6 said times and days varied with call light response. Resident #6 commented he didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 31 think management did a damn thing about being short staffed and alot of staff quit. On 8/29/19 at 9:50 a.m. the Administrator voiced she wanted to highlight Resident #6's behaviors and felt his behaviors should be taken in to account when reviewing the resident's reports of not getting bathed 2 times a week and call lights taking a long time. 3. The MDS assessment dated 7/30/19 for Resident #7 identified a BIMS score of 15 without signs/symptoms of delirium. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, personal hygiene and 2 persons for transfers, toilet use. The MDS recorded the resident experienced bladder incontinence always and frequent episodes of bowel incontinence. The MDS documented diagnoses that included: heart disease and lung disease. The care plan focus area revised 2/6/19 identified the resident needed extensive assist of 1 staff for dressing, grooming, bathing, and transfers with EZ stand (mechanical lift). On 8/28/19 at 1:30 p.m. Resident # 7 reported she thought staffing levels lousy (low). Resident #7 stated at times she waited 40 to 45 minutes for help. Resident #7 responded she used a clock on the wall to time the wait and the long wait time occurred approximately once a week. On 8/29/19 at 9:50 a.m. the Administrator voiced she wanted to highlight Resident #7's behaviors and felt her behaviors should be taken in to account when reviewing the resident's reports call lights taking a long time.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 32 4. The MDS assessment dated 6/12/19 for Resident #8 identified a BIMS score of 15 without signs/symptoms of delirium. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. The MDS recorded the resident experienced frequent episodes of bowel incontinence. The MDS documented diagnoses that included heart disease and chronic kidney disease. The care plan focus area revised 2/6/19 identified the resident required assistance with dressing, grooming, and bathing. On 8/28/19 at 1:50 p.m. Resident #8 reported sometimes call light response took 30 minutes to an hour. Resident #8 stated the aides are just busy and sometimes only 1 aide works on the hall making it harder and/or new staff don't know what's going on. 5. The MDS assessment dated 8/13/19 for Resident #10 identified identified a BIMS score of 14 without signs/symptoms of delirium. A score of 14 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 2 persons for bed mobility, bathing, and totally dependent upon 2 persons for transfers. The MDS recorded the resident experienced episodes of bladder and bowel incontinence always. The MDS documented diagnosis that included: heart failure and morbid obesity. The care plan focus area revised 2/6/19 directed staff to provide extensive assistance of 1 person	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 33 for dressing, grooming, and bathing. On 8/28/19 at 2:30 p.m. Resident #10 stated there was not enough staff. Resident #10 reported staff needed to help her with everything and call light response time took 20 minutes to 30 minutes. Resident #10 said she used a clock on the wall to time the wait, weekends were worse, and long call light waits occurred daily. Resident #10 stated a lot of times rather than activating her call light, she just waited to see staff then yelled for them as it was a faster way to get a response. Resident #10 said she felt staff failed to look up to see call light indicators. Additional observations and staff interviews: On 8/20/19 at 3:50 p.m., Staff I, Licensed Practical Nurse (LPN), observed on Bayberry hall and reported he had 2 CNA's assigned to the hall; Staff A, CNA, and Staff B, CNA. Staff I identified Staff A and Staff B as dedicated to the Bayberry hall. Staff I responded most times he felt they were staffed with enough CNA's with 2 assigned to Bayberry hall and 2 assigned to Aspenwood hall. On 8/20/19 at 3:55 p.m. observation showed Staff G, LPN, on Aspenwood hall. Staff G reported he worked for the facility for a year and a half with 2 CNA's assigned to Aspenwood hall. Staff G stated 2 CNA's were enough to meet the needs of resident's on Aspenwood hall. On 8/20/19 at 4:00 p.m., Staff E, LPN, reported she was only in the building to finish the charting from the dayshift. Staff E stated she primarily worked Aspenwood hall. Staff E responded she worked for the facility for almost a year. Staff E responded usually Aspenwood hall and Bayberry	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 34	F 725		

hall worked with 2 CNA's each, and Daisy Lane hall varied depending on census. Staff E said at the time of the interview, Daisy Lane hall staffed with 1 CNA and 1 care aide not certified, so they could only help with certain tasks. Staff E commented she felt 2 staff on Aspenwood hall and Bayberry hall and 1 on Daisy Lane hall "doable" to typically meet the needs of the residents. Staff E said she could only speak for the staffing on the 6 a.m. to 2 p.m. dayshift.

On 8/20/19 at 4:05 p.m., Staff A reported at the time of the interview, they worked with only 1 CNA on Aspenwood hall and 1 CNA on Bayberry hall. Staff A said he was assigned to Bayberry hall and Staff F, CNA, to Aspenwood hall. Staff A stated he had just brought the concern up that day of his concern of not enough help. Staff A clarified Staff B as not in the building. When asked to confirm why Staff I reported Staff B worked Bayberry hall that day, Staff A responded Staff B did not arrive until 6:00 p.m. Staff A stated at 6:00 p.m. Staff B arrives and replaces Staff F on Aspenwood hall. Staff A identified 1 aide per hall not enough help to meet the needs of the residents. Staff A said with 1 aide they could only complete 50% of the showers assigned, they could get toileting needs met if they ran, and identified Bayberry hall as heavy acuity with 5 residents requiring the assistance of a hoyer (mechanical lift) to transfer. Staff A stated he asked for help and Staff I used to be an aide so he would help a lot. Staff A identified the work as very exhausting with just 1 aide. Staff A stated a resident on Bayberry Hall there used their call light frequently so staff could not possibly answer call lights within 15 minutes with 1 aide staffed. Staff A said at meal times, he has to stand to assist 6 residents to dine due to not enough help to assist with dining. Staff A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 35 identified the facility staffed like that since he started at the facility. He felt the facility was short staffed. Staff A stated he felt the management knew of the short staffing but did not think he told them exactly what staff could not get done such as feeding assistance. Staff A stated he felt by the next day, management would call in extra help with the surveyor in the building and said if the surveyor looked at the schedule, the surveyor would see he was not listed as he picked up the shift extra. On 8/20/19 at 4:10 p.m., Staff J, Registered Nurse (RN), stated if she worked the other side of the building she primarily worked Aspenwood hall. Staff J stated usually 1 CNA worked on each hall and that was enough but Aspenwood got a couple aides because it seemed busier with more transfer assistance needed. On 8/20/19 at 5:05 p.m., the surveyor requested the daily schedule assignments. The Administrator identified the daily schedule as a mess as several staff called in and they had to piece together coverage. The Administrator confirmed the correct coverage for Aspenwood hall and Bayberry as 1 CNA each. The Administrator stated Staff A covered Bayberry hall, Staff F worked the day shift so only worked until 6:00 p.m. on Aspenwood hall, then Staff B arrived to cover the 6:00 p.m. to 10 p.m. shift. The Administrator acknowledged the facility ideally wanted 2 staff assigned to both Aspenwood and Bayberry halls. The Daily Assignment Sheet showed Staff K, CNA, called in and Staff L, CNA, a No Call No Show (NCNS). Staff M scheduled at 4:00 p.m. and Staff N, CNA, 6:00 p.m. to 10 p.m. on the Bayberry hall. The Administrator identified Daisy Lane hall with 15	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 36	F 725		

residents and staffed with 1 nurse 1 aide that day. The Administrator identified staffing as always an issue but they did pretty good recently and did not use agency staffing. The Administrator stated staffing levels always depended upon resident acuity levels and census and the facility had many fluctuations in census in the previous week.

On 8/22/19 at 11:10 a.m., Staff S, CNA, identified good days and bad days with staffing levels. Staff S identified 1 CNA down each hall dayshift and evening shifts. Staff S reported it was not "doable". Residents did not receive the attnetion they needed. Staff could not complete baths and staff could not respond to call lights within the required 15 minutes. There was not always enough help with dining assistance. Staff S responded she thought the Administrator and the DON knew and said they worked on staffing. Staff S reported staffing as a concern for approximately 2 months. Staff S identified ideal staffing as Aspenwood and Bayberry halls working with 2 CNAs each and Daisy Lane hall 1 to 2 depending, and Ginger Grove hall 1 CNA. Staff S responded staffing of 1 to 2 aides on Daisy Lane hall depended based on staffing and said 2 residents on that hall required a hoyer assist transfer.

On 8/22/19 11:15 a.m. observation radio/walkie going off and activities saying they needed assistance asking where everyone was several calls made. The Administrator on the hall asked Staff S for the location of staff.

On 8/22/19 at 11:40 a.m. the Administrator provided a copy of 8/22/19 daily assignments schedules. The Administrator acknowledged the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 37 posting reflected Staff T, CNA, called in so Aspenwood staffed with 1 CNA 6:30 a.m. to 10:00 a.m. then Staff F arrived at 10:30 a.m. to cover Aspenwood so the hall worked with only 1 CNA the entire day shift. Bayberry with 1 CNA, Staff W, 6:00 a.m. to 8:30 a.m. when Staff U, CNA, arrived until 2:00 p.m. Staff Q, care aide, was scheduled but couldn't perform personal cares. Daisy Lane worked with 1 CNA, Staff S, and 1 care aide, Staff R. On 8/22/19 at 11:50 a.m., Staff V, RN, responded it was very hard with 1 CNA and 1 nurse on a hall as the nurse. Working with 1 CNA required the nurse to help the CNA which put the nurse behind in nurse work. Staff V stated 1 CNA in the a.m. for Aspenwood hall and 1 for Bayberry hall was not okay. Staff V commented she thought the facility scheduled for full staff but people call in. On 8/22/19 at 12:00 p.m. Staff C, CNA/Scheduler, stated from 6:00 a.m. to 6:30 a.m., care assistant Staff R worked on Aspenwood only then noticed Staff T did not come in. Staff C said he moved Staff Z, CNA, over to Aspenwood hall at 6:30 a.m. to be there till 10:30 a.m. when Staff F came in. Staff C reported Staff W and Staff Q (care aide) worked on Bayberry until Staff U arrived at 8:30 a.m. Staff C identified that as the accurate schedule of staff for 8/22/19. Staff C identified 1 CNA working on Aspenwood/Bayberry halls as "doable" and the only time more help was needed was with transfers. Staff C identified staffing as "doable" with 1 aide working Aspenwood/Bayberry hall because between 2:00 p.m. and 6:00 p.m. it was not busy. They needed 2 staff after 6:00 p.m. Staff C acknowledged 1 aide on Aspenwood and 1 on Bayberry as not ideal with a census of 70.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 38 The ideal goal is to have 2 aides each hall dayshift and 2 on evening shift after 6:00 p.m. Observation on 8/27/19 at 10:55 a.m. revealed the call light on in a room B6. At 11:00 a.m. Staff U answered the light, turned off, and said she needed help and couldn't find Bayberry assigned CNAs, Staff W or Staff Y. At 11:02 when room B3's call light went on, Staff U reported to someone the resident wanted to get up. The call light reactivated in B6 and Staff U told the nurses the resident in room B6 had a blowout and she needed help to get him up. Staff U commented she was assigned to Aspenwood hall. Staff U started down the hall calling out for Staff Y and Staff W repeatedly, then stated, "well I can't get them all up". The room call light turned off. At 11:06 a.m. room B6 call light reactivated as well room B3 while Staff Y and Staff W worked in room B8. At 11:08 a.m. call light went back off for room B6 and staff exited room B8. Staff U called on the radio to see if she could go to break, someone radioed yes, we are in A3, indicating Staff F. At 11:11 a.m. call lights remained off. Review of the Daily Staffing Assignment Sheets revealed only 1 CNA scheduled on Aspenwood and 1 CNA Bayberry on the following days in July and August 2019, with average census of greater than 70 residents: The facility with hallways Aspenwood, Bayberry, Daisy Lane, and Ginger Grove that housed residents. With only 5 or fewer CNAs, the facility would be unable to staff 2 aides on Aspenwood and Bayberry halls. Review of the Daily Posting of hours revealed the following days with only 5 or fewer CNAs	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 39 scheduled for either the day shift 6:00 a.m. to 2:00 p.m. or evening shift 2:00 p.m. to 10:00 p.m. with a census of greater than 70 reported: May 2019 - 5/25/19, 75 residents, dayshift with 5 CNAs 40 hours June 2019 - 6/6, 6/15, 6/25, 6/26, 6/29, 6/30 - no posting information available for review. 6/11/19, blank for # residents, 5 CNAs 36 hours 6/28/19, 70 residents, day shift with 5 CNAs 36 hours July 2019 - 7/3, 7/4, 7/5, 7/9, 7/10, 7/11, 7/12, 7/13, 7/14, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21, 7/22, 7/23, 7/24, 7/25, 7/26, 7/27, 7/28, 7/29, 7/31 - no posting information available for review. 7/1/19, 70 residents, evening shift with 5 CNAs 32 hours 7/6/19, 72 residents, day shift with 4 CNAs 32 hours 7/7/19, 72 residents, day shift with 5 CNAs 40 hours 7/15/19, 71 residents, evening shift with 3 CNAs 24 hours However, appears the totals entered into the wrong spots as the overnight and dayshift reflect the numbers usually put in dayshift and evening shift respectively August 2019 - 8/4/19, 70 residents, day shift with 5 CNAs 36 hours, 1 care aides 8 hours 8/5/19, 70 residents, day shift with 5 CNAs 40 hours, 1 care aides 8 hours 8/5/19, 70 residents, evening shift with 5 CNAs 36 hours 8/6/19, 70 residents, day shift with 5 CNAs 32 hours, 2 care aides 16 hours 8/12/19, 71 residents, day shift with 5 CNAs 56	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 725	Continued From page 40 hours, 2 care aides blank on hours 8/13/19, 71 residents, day shift with 5 CNAs 40 hours, 2 care aides 16 hours 8/13/19, 71 residents, evening shift with 5 CNAs 32 hours 8/15/19, 72 residents, day shift with 5 CNAs 40 hours, 2 care aides 16 hours 8/17/19, 72 residents, evening shift with 4 CNAs 24 hours 8/20/19, 74 residents, day shift with 5 CNAs 40 hours, 2 care aides 16 hours	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 732	Continued From page 41 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post accurate nurse staffing data in a prominent location visible to residents and visitors as well as retain the posting information for 18 months. The facility reported a census of 74 residents. Findings include: Review of the Daily Staff Posting of hours revealed the following: June 2019 - 6/6, 6/15, 6/25, 6/26, 6/29, 6/30 - no posting information available for review. 6/11 incomplete with the line for number of residents left blank 6/12/19, 68 residents July 2019 - 7/3, 7/4, 7/5, 7/9, 7/10, 7/11, 7/12, 7/13, 7/14, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21, 7/22, 7/23, 7/24, 7/25, 7/26, 7/27, 7/28, 7/29, 7/31 - no posting information available for review. On 8/21/19 at 3:00 p.m., the Administrator identified some of the Daily Staff Postings not available for the month of July 2019. The	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 732	Continued From page 42 Administrator identified the night nurseas responsible for the completion of posting and they had turn over with the night nurse position. On 8/21/19 at 6:08 p.m. the Daily Staff Posting of hours for 8/21/19 contained no census number of residents. Observation on 8/22/19 at 12:34 p.m. revealed the Daily Staff Posting of hours by the front door outside of the dining room dated 8/21/9. At 2:07 p.m., observation revealed still no current posting available for 8/22/19. Observation on 8/27/19 at 7:45 a.m. revealed the Daily Staff Posting of hours dated 8/26/19 and no posting found for 8/27/19 to report the amount of staff in the building or the census number.	F 732		

F 677

Immediate corrective action:

Residents # 2, 4, 6, 9 and 10 are receiving bathing assistance per their documented preference.

Action as it applies to others:

Resident interviews were conducted with cognitively intact residents to assure bathing schedules are in accordance with resident preferences.

Non-interviewable residents are provided bathing assistance per facility protocol.

Nursing staff were provided education regarding bathing schedules and documentation.

Date of completion: 9/18/19

Recurrence will be prevented by:

Weekly audits of bathing documentation will be completed x 3 months to ensure bathing assistance is provided per bathing schedules and resident's documented preferences.

The results of these audits will be brought to QAPI for review and recommendation.

The correction will be monitored by:

DON/Designee

F 692

Immediate corrective action:

Resident #4 is now receiving dining assistance per the plan of care updated 8/22/19 and again 9/12/19 and 9/17/19.

Resident #4's nutritional supplement is recorded as of 8/16/19.

Action as it applies to others:

All residents were reviewed to ensure appropriate dining assistance is provided 9/14/19.

All residents who receive nutritional supplements were reviewed to ensure intake of the supplement is recorded 9/15/19.

Nursing staff were provided education regarding dining assistance and nutritional interventions beginning 9/11/19 to current. Any nursing staff that has not received this education prior to 9/18/19 will not work until education is received.

Date of completion: 9/10/19

Recurrence will be prevented by:

Weekly audits of dining assistance, nutritional supplement provision and documentation will be completed x 3 months.

The results of these audits will be brought to QAPI for review and recommendation.

The correction will be monitored by:

DON/Designee

F 725

Immediate corrective action:

Resident #4 is being provided dining assistance,

Resident #6 was interviewed to ensure bathing assistance is being provided per his preference

Resident # 6, 7, 8 & 10's call lights are being answered appropriately and needs met.

Action as it applies to others:

Nursing staff were provided education regarding responding to resident call lights, providing bathing assistance and providing dining assistance for resident.

Date of completion: 9/18/19

Recurrence will be prevented by:

Weekly audits of bathing and dining assistance as well as call light responses will be completed x 3 months to ensure resident needs are met.

The results of these audits will be brought to QAPI for review and recommendation.

The correction will be monitored by:

DON/Designee

F 732

Immediate Corrective Action:

Nurse staffing data is being posted in a visible location.

Action as it applies to others:

Overnight Nurses and CMAs were educated regarding posting the staffing data in a visible location.

Date of Completion: 9/18/19

Recurrence will be prevented by:

Weekly audits of staff posting will be completed x3 months to ensure proper posting.

The results of these audits will be brought to QAPI for review and recommendation.

The correction will be monitored by:

DON/Designee.