STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 12-31-19 Investigation of complaint #87045-C completed November 15 - December 11, 2019 resulted in the following deficiencies. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	This plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and physician interview, the facility failed to complete timely resident assessments and interventions for 1 of 4 residents reviewed who required wound care and/or such assessments, (Resident #3). The facility identified a census of 40 residents. Findings include: During an interview on 11/19/19 at 3:10 p.m. the Director of Nursing (DON) confirmed the facilities policy and procedure and/or expectation with a resident's change of condition, which included wound care/skin issues, required staff to have thoroughly assessed the condition change for up	F 684	F 684 1. Resident #3 no longer resides at the facility. 2. The DON or Designee will complete an audit of skin assessment for current residents by 12/26/2019. DON or Designee will complete an audit to verify interventions are provided as ordered by 12/31/2019. 3. The DON or Designee will provide education by 12/26/2019 to Licensed Nursing Staff on requirements and expectations of skin assessments and providing interventions as ordered. 4. The DON or Designee will audit 5 times per week for 4 weeks and 3 times per week for 8 weeks to verify skin assessments continue to be completed as required. The DON or designee will audit 5 times per week for 4 weeks and 3 times a week for 8 weeks to verify treatments continue to be provided as ordered by the physician. The results of these audits will be reported to the QAPI committee monthly for 3 months, for review and recommendations. The Director of Nursing is responsible for monitoring and follow up. Date of compliance:	12-31-19

1.2.2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Giovanna — TITLE: DON — (X6) DATE: 1/2/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 684	Continued From page 1 to 72 hours. A Skin Care & Wound Management form dated 6/2015 documented the components of the skin care and wound management program included but not limited to the following: a. Existing wounds monitored daily. b. Weekly monitored resident/patient skin status. A Minimum Data Set (MDS) assessment form dated 8/9/19 indicated Resident #3 had diagnoses of atrial fibrillation (AF), hypertension (HTN), diabetes mellitus (DM), osteoarthritic right knee and morbid obesity. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact), required extensive assistance of 2 staff with bed mobility, transfers and toilet use, extensive assistance of 1 staff member with locomotion on and off the unit, dressing and limited assistance of 1 staff with ambulation in room and personal hygiene. The resident was at risk for pressure ulcers however no other skin issues were addressed. A Care Plan with a Focus area revised 8/9/19, documented the resident had an abrasion and scabbed areas to her right lower leg and at risk for alteration in skin integrity related to morbid obesity, decreased mobility, Type II DM and urinary incontinence. Interventions included the following: a. Pad the wheel chair leg rests. (dated 8/9/19) b. CNA's to check skin daily with cares and the nurse to have completed head to toe skin checks weekly. (8/9/19) c. Provided the resident with a reclining chair as to not sit in her wheelchair all day. (8/9/19) d. Encouraged good nutrition and hydration.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 684	Continued From page 2 (8/9/19) e. Linens maintained clean, dry and wrinkle free as possible and cleaned weekly and as needed. (8/9/19) f. The resident's skin kept clean and dry. (8/9/19) g. Pressure reduced mattress on the bed and cushion in the chair. (8/9/19) A Progress Note entry dated 8/9/19 at 10:14 a.m. included the following documentation: a. Weekly skin assessment completed. The resident had a scabbed area and abrasion to the right and left lower legs. The left lower leg area measured 4.0 centimeters (cm) by (x) 1.0 cm and the right lower leg area measured 1.0 cm x 1.3 cm scabbed area. The resident denied pain. Areas left open to air (OTA) with no drainage noted. No increased warmth, redness or swelling noted to the areas. The resident stated she bumped them on her wheel chair leg/rests/pedals. The staff padded the wheel chair leg/rests and pedals. The facilities Progress Notes forms revealed the following entries related to the resident's skin issues: a. 8/10/19 - No assessment completed. b. 8/11/19 @ 2:27 a.m. - Scabs and abrasion remained, no drainage or signs and symptoms of an infection. Denied pain, would continue to monitor. The assessment failed to address the measurements of the affected areas. c. 8/11/19 at 2:14 p.m. - The resident continued with new skin areas. Areas intact, no complaints of pain. Would continue to monitor per facility protocol. The assessment failed to address the measurements of the affected areas. d. 8/12/19 at 2:25 a.m. - Scabbed area and	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 684	Continued From page 3 abrasion to the right and left lower leg remained. Scab intact and no drainage noted. No signs and symptoms of infection noted. Denied pain to areas. Left OTA. The assessment failed to address the measurements of the affected areas. e. 8/12/19 at 10:15 a.m. - The resident continued with scabbed areas to the right and left lower leg with no signs and symptoms of infection. No drainage present. Denied pain to the areas and caution encouraged. The assessment failed to address the measurements of the affected areas. f. 8/13/19 at 12:17 p.m. - Resident continued with scabbed areas to the right and left lower leg. Scab intact. No drainage, warmth, redness or swelling present. Resident complained of general pain. As needed Tylenol 650 mg given. Continued to monitor. The assessment failed to address the measurements of the affected areas. g. 8/16/19 at 1:02 p.m. - Weekly skin assessment completed. No new skin issues. (According to the Non-Pressure Weekly Skin Record form dated 8/16/19 at 1:03 p.m. the left anterior lower leg abrasion measured 3.5 cm x 1.0 cm with no depth and the right anterior lower leg scabbed area measured 1.0 cm x 0.2 cm with no depth.) h. 9/2/19 at 12:25 p.m. - Skin check done and noted that she had red/purple discoloration to the bilateral lower legs with dried and intact scabs present. i. 10/19/19 at 5:54 p.m. - The resident received an initial dose of Keflex 500 milligrams (mgs) related to a bilateral lower leg infection. Area noted to have an open area and 2 fluid filled blisters to the left leg and no open areas or blisters to the right leg. The resident complained of slight discomfort to the right leg but refused pain medication. Would continue to monitor. The facility failed to address the measurements of the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 684	Continued From page 4 open area and blisters. j. 10/20/19 at 1:23 p.m. - The resident continued on scheduled Keflex 500 mg related a bilateral lower leg infection. No ADRs (adverse reactions) observed. The resident stated it tasted terrible. No complaints of nausea or vomiting Denied pain at that time. Skin area to the left lower leg had 2 scabbed blisters that measured 1 cm x 1 cm (the upper) and 2.5 cm x 3 cm (the lower) One open area to the right lower extremity measured 3.0 cm x 2.0 cm. Cleansed the areas and placed a bandaide for cover. k. 10/21 thru 10/26 - The facility staff failed to assess and/or document on the condition of the resident's bilateral lower extremities. l. 10/27/19 at 3:31 a.m. - The resident continued on an antibiotic related to her bilateral lower extremity infection. No ADR's noted. Denied pain to the areas. The left area had been left OTA. Fluids encouraged. Would continue to monitor. The assessment failed to address the measurements of the affected areas and/or the color and condition of the bilateral lower extremities. m. 10/27/19 at 3:50 p.m. - Resident alert and oriented x 3. No shortness of breath. No complaints of pain related to her bilateral lower extremities. The resident continued on Keflex related to an infection of the bilateral lower extremities. No drainage, redness or odor noted at that time. Afibrile at 97.8 degrees Fahrenheit. The assessment failed to address the measurements of the affected areas. n. 10/28/19 at 6:07 p.m. - The resident continued on an antibiotic related to her bilateral lower extremity infection. No ADR's noted. Denied pain to the areas. The left area had been left OTA. Fluids encouraged. Would continue to monitor. The assessment failed to address the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 684	Continued From page 5 measurements of the affected areas and/or the color and condition of the bilateral lower extremities. o. 10/29/19 - No assessment completed An Interdisciplinary Recapitulation of Stay - version 2 form dated 10/30/19 at 11:17 a.m. documented the resident as discharged home with a blister on her anterior left lower leg that measured 1.5 cm x 1.2 cm with no depth and a blister on her anterior right lower leg that measured 1.5 cm x 1.5 cm with no depth. The resident's bilateral lower extremity skin infection had not been addressed. During an interview on 11/19/19 at 3:18 p.m., the DON confirmed the blistered areas listed above should have been measured and that the facility staff dropped the ball. During a Physician interview on 11/26/19 at 11:54 a.m., the resident's Physician indicated he felt the resident's blistered lower extremities resulted from her venous stasis issues and he felt the facility had done nothing incorrectly.	F 684		
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	F 725	F 725 1. DON interview resident #1,resident #4 and resident #5 on 12/26/19 related call light response times. Each resident voiced satisfaction at this time with improved call response times. Resident #2 no longer resides at the facility. 2.Call light response time was audited from 12/11/2019 through 12/26/2019 by DON on 12/26/2019 to ensure call lights are being answered in timely manner as required. Concerns were addressed at the time of the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 6 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 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 record review, resident group interview, staff interview and an Alarm Event Report the facility failed to ensure resident call lights and needs were answered/met in a timely manner (no longer than 15 minutes) for 4 of 4 residents reviewed, (Resident #1, #2, #4 and #5). The facility reported a census of 40 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form dated 9/13/19 indicated Resident #4 had diagnoses of diabetes mellitus (DM), fractured right patella, muscle weakness, non-pressure chronic left foot ulcer, difficulty walking, unsteadiness on her feet and fatigue. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (cognitively intact), required extensive assistance of staff with transfers and toilet use,	F 725	3. Education was provided to staff during staff in-service on 12/18/2019 by DON regarding the requirements and expectations to answer call lights within 15 minutes, on 12/26/19 DON reviewed In-service list and all staff who did not attend have been educated. 4. DON or designee will audit call light response times 5 times per week for 4 weeks and 3 times per week for 8 weeks to verify call light response time continues to be within 15 minutes as required, if identified to be over the 15 minutes DON will provide individualized staff coaching. The results of these audits will be reported to the QAPI committee monthly for 3 months, for review and recommendations. The DON is responsible for monitoring and follow up. Date of Compliance:	12-26-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 7 non-ambulatory and always continent of both bowel and bladder. A Care Plan with a focus area revised 6/26/19, indicated the resident had a potential for falls related to a right patella fracture, increased weakness, Stage 3 chronic kidney disease, hypertenion and type II DM and a focus area revised 6/27/19, related to a self care deficit. The approaches included the following: a. Maintain the call light within reach and instruct the resident to use it for assistance. (revised 11/13/18) b. Resident had been weight bearing as tolerated with a right knee immobilizer. (revised 6/27/19) c. The resident required limited assistance of 1 staff with toileting and transfers as needed. The resident had been independent in room with a front wheeled walker and the brace on. (revised 7/11/19) A Progress Notes entry dated 11/10/19 at 7:50 a.m. included the following documentation: CNA heard help from a resident's room. The CNA enered the room and found the resident as she sat on the floor beside the bed. The resident stated I got tired of waiting I have had my call light on for 45 minutes. I need to go to the bathroom. The resident denied having hit her head. The resident stated her sock slid and she slid down also. Denied hitting her head. Right leg knee immoblizer brace on the resident at the time of the slide. Vital signs normal. Assistance of 2 staff members required to get the resident up into a sitting position in the wheel chair. Resident alert and oriented x 3. Resident assisted x 2 staff members to the bathroom. Resident with loose stools. Assistance required with her undergarmet. No bruising observed. Denied	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 8 pain at that time. Assistance x 1 with morning activities of daily living. An Alarm Event Report dated 11/8/19 thru 11/15/19, included the following call light event times for the bedside call light unless specified differently for Resident #4. a. 11/10/19 - from 7:03:11 a.m. until 8:30:26 a.m. - for a total of 1:27:15. (1 hour, 27 minutes and 15 seconds). b. 11/11 - 7:47:32 a.m. - 8:17:34 a.m. - 30.02 minutes. 4:26:30 p.m. - 4:46:31 p.m. - 20:01. 4:30:45 p.m. - 4:46:31 p.m. - 16:04 (bathroom call light) 7:08:29 p.m. - 7:29:38 p.m. - 21:09 (bathroom call light) 10:18:19 p.m. - 10:58:01 p.m. - 39.42 c. 11/13 - 7:11:53 a.m. - 7:51:23 a.m. - 39.30 d. 11/14 - 2:09:43 a.m. - 2:29:32 p.m. - 19:49 e. 11/15 - 8:33:42 a.m. - 8:49:03 a.m. - 15:21 During an interview on 11/15/19 at 1:00 p.m. the resident stated she thought the facility needed more help because on Sunday 11/10/19 she turned on her call light at approximately 6:50 a.m. and she timed the light as on for approximately 1 1/2 hours as she used her watch. After she waited so long she tried to get up herself and slid to the floor and was incontinent of stool which she had not appreciated. The resident also indicated on another occasion a CNA told her to just go in her pants at which time she refused to go in her pants. The resident stated if she had to wait a long period of time that it started to hurt down there. During an interview on 11/20/19 at 10:36 a.m.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 9 Staff A, Registered Nurse (RN) confirmed only 1 CNA was scheduled to work on that side of the building on 11/10/19 which left the facility short staffed. During an interview on 11/20/19 at 12:25 p.m., Staff B, Certified Nursing Assistant (CNA) confirmed she had been the only CNA scheduled on the West end of the building on 11/10/19. Staff B stated she felt the staff could not adequately care for the residents with only 3 CNA's on duty. During an interview on 11/20/19 at 10:43 a.m. the Director of Nursing (DON) confirmed the facility as short staffed on 11/10/19. 2. An Alarm Event Report dated 11/8/19 thru 11/15/19 included the following call light event times for Resident #1. a. 11/8/19 - 8:25:06 a.m. - 8:42:29 a.m. - 17:23 6:33:04 p.m. - 6:57:03 p.m. - 24:04 b. 11/9 - 6:59:33 a.m. - 7:14:47 a.m. - 15:14 12:22:43 p.m. - 12:43:25 p.m. - 20:42 9:20:18 p.m. - 9:40:21 p.m. - 20:03 c. 11/10 - 8:13:08 a.m. - 8:55:45 a.m. - 42:37 (bathroom call light) 9:17:40 a.m. - 9:44:18 a.m. - 26:38 5:03:44 p.m. - 5:19:39 p.m. - 15:55 d. 11/11 - 7:02:58 p.m. -7:28:07 p.m. - 25:09 e. 11/14 - 6:18:44 p.m. - 7:08:54 - 50:10 f. 11/15 - 8:17:58 a.m. - 8:48:14 a.m. - 30:16 (bathroom call light) 3:47:57 p.m. - 4:04:42 p.m. - 16:45 3. An Alarm Event Report dated 11/8/19 thru 11/15/19 included the following call light event times for Resident #2.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165248	A. BUILDING _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT ACRES CARE CENTER	309 RAILROAD STREET HULL, IA 51239

(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 10 a. 11/13/19 - 12:22:50 p.m. - 12:38:52 - 16:02 minutes. 4. An Alarm Event Report dated 11/8/19 thru 11/15/19 included the following call light event times for Resident #5. a. 11/11/19 - 7:13:49 a.m. - 7:30:09 a.m. - 16:20 5. During an interview on 11/20/19 at 11:25 a.m., Staff C, CNA confirmed she had been unable to answer resident call lights within 15 minutes like the day prior because she had been the only CNA scheduled on the West side of the building and she had 6 residents that required 2 staff assistance with cares. During an interview on 11/20/19 at 10:44 a.m., Staff D, CNA confirmed she had not always been able to answer resident call lights within 15 minutes. During an interview on 11/20/19 at 10:59 a.m., Staff E, CNA confirmed she had absolutly not been able to answer resident call lights within 15 minutes. The staff member indicated there had been times they left residents on the toilet for 20-30 minutes who were not a fall risk so the staff could assist other residents.	F 725		