STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 1-30-20 The following deficiencies relate to the facility's annual health survey and investigation of facility reported incident 86330-I Facility reported incident 86330-I was substantiated See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Amended 1/31/20	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure Resident #51 took his medications when staff dispensed them. During a resident interview, the resident's medication was in resident had his pills in a paper medication cup, sitting on top of coffee mug. The facility reported a census of 54 residents. Findings include: Observation on 01/12/20 at 10:27 AM revealed Resident #51 had pills in a paper medication cup sitting on the lid of his cup. The medication cup contained two white capsules.	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/29/2020

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
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 554	Continued From page 1	F 554		

According to a quarterly Minimum Data Set (MDS) with a reference date of 12/26/19, Resident #51 had a Brief Interview for Mental Status (BIMS) score of 9, indicating the resident experienced moderate cognitive impairment. The MDS documented the resident had diagnoses of dementia and dysphagia.

Review of Resident #51's care plan with a revision date of 1/4/2020 revealed he had a history of self-neglect and required staff assistance with his activities of daily living (ADL). The care plan documented he had impaired cognitive function due to his dementia and a history of not taking his diabetic medications while at home.

Review of Resident #51's Order Summary Report dated 1/8/19 revealed he received the following medications in the morning:

-Crestor 10 milligrams (mg)
-Invokana 300mg
-Januvia 100mg
-Lisinopril 5mg
-Multivitamin
-Oxybutynin 5mg
-Proscar 5mg
-Metformin 1000mg
-Namenda 10mg

Review of Resident #51's record revealed it lacked a self-administration of medications assessment.

During a staff interview on 01/14/20 at 3:53 PM, the Director of Nursing (DON) stated staff are not to leave the pills in a resident's room; they should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 554	Continued From page 2 stay with them and ensure they take their medications. During a staff interview on 01/15/20 at 9:03 AM Staff H Licensed Practical Nurse (LPN) reported she would not leave medications in a room for a resident to take, although she did state Resident #51 was "really good" about taking his medications while staff stayed in the room.	F 554		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 636	Continued From page 3 (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the correct comprehensive Resident Assessment Instrument (RAI) specified by CMS for 1 of 16 residents reviewed (Resident # 11). The facility failed to complete a discharge with anticipation to return	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 636	Continued From page 4 Minimum Data Set (MDS) for Resident #11 when she was hospitalized for a right hip fracture. The facility reported a census of 54 residents Findings include: According to an entry MDS with a reference date of 10/7/19 revealed Resident #11 reentered the facility from an acute hospitalization. Record review of Resident #11's MDS tab in her Electronic Health Record (EHR) revealed it lacked a discharge with anticipation to return MDS after she was sent to the Emergency Room (ER) and was later admitted to the hospital for 5 days. Review of Resident #11's EHR revealed the following: -10/1/2019 1:37 PM: received a call from the Emergency Room (ER) and Resident #11 had non-displaced right fibular neck fracture and was transferred to another hospital for possible surgical repair. -10/7/19 Resident #11 returned to the facility During a staff interview on 01/14/20 at 3:55 PM the MDS coordinator stated a discharge with return anticipated MDS should have been completed when Resident #11 admitted to the hospital.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 641	Continued From page 5 resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to document Resident #33's Level II Pre-Admission Screening and Record Review (PASRR) on her comprehensive Minimum Data Set (MDS) assessment tool as required for 1 of 16 residents reviewed (Resident #33). The facility reported a census of 54 residents. Findings include: According to an annual MDS with a reference date of 11/28/19, revealed the facility marked "no" to the question: is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The MDS listed the following diagnoses: anxiety, depression, and bipolar. Review of Resident #33's care plan with a revision date of 10/22/19 revealed it contained the specialized services the PASRR recommended. Review of Resident #33's Electronic Health Record (EHR) revealed a PASRR Notice of Nursing Facility Approval dated 10/14/19. During a staff interview on 01/14/20 at 3:58 PM the MDS coordinator stated she would correct the MDS so it would reflect the Level II PASRR approval.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 6 § 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 observations, record review, and resident and staff interviews, the facility failed to provide treatment in accordance with professional standards of practice and the comprehensive care plan for 2 of 16 residents reviewed. (#31 and #53) The facility reported a census of 54 residents. Findings include: 1) The quarterly Minimum Data Set dated 11/28/19 documented Resident #31 scored 15/15 for the Brief Interview of Mental Status (intact cognition) and required extensive assist of one person for dressing. The Face Sheet for Resident #31 documented medical diagnoses that included hypertension, chronic kidney disease, atherosclerotic heart disease, and diabetes mellitus. The Physician Order dated 11/13/18 documented an order for Ted hose. The Care Plan documented the resident needed assistance and contained an intervention dated 11/13/18 that directed staff to assist resident with his Ted hose.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 7 The Task Complete form dated 1/14/20 documented the Ted hose were applied in the afternoon for several days, but directed the staff to apply them in the morning. On 1/12/20 at 11:10 AM, observation revealed the resident's Ted hose hung next to his sink and both of his feet were edematous (swollen). The resident stated he wore compression socks (Ted hose) daily but staff had not come to put them on yet. On 1/13/20 at 10:27 AM observation revealed the resident's Ted hose hung next to his sink and not on his feet or legs. On 1/13/20 at 12:52 PM observed Resident #31 at lunch wearing gripper socks only, while his Ted hung next to his sink. In an interview with the Director of Nursing (DON) on 1/15/20 at 09:00 AM, she stated she expected staff to put the resident's Ted hose on first thing in the morning and to remove them at bedtime. 2) The Admission Minimum Data Set dated 1/7/2020 documented Resident #53 scored 6/15 (severe cognitive impairment) on her Brief Interview of Mental Status. The Face Sheet listed medical diagnosis that included hypertension, dementia, and need for assistance with personal care. The Progress Note dated 12/31/19 at 2:29 PM documented the resident continued to have 2+ edema to both lower extremities. Staff notified the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 8 physician and received an order for TED hose. The Progress Note dated 12/31/19 at 3:53 PM documented staff received an order for TED hose. The Task Complete form dated 1/14/20 documented the Ted hose were applied in the afternoon on several days, but directed the staff to apply them in the morning. During an observation on 1/12/20 at 11:38 AM, the resident's Ted hose were clean and dry and hung next to her sink. The resident stated that she was supposed to have her Ted hose on, but the staff forget to put them on every morning. On 1/13/20 at 10:50 AM, observation revealed the resident's Ted hose hung next to her sink and not on resident's feet. In an observation on 1/13/20 at 1:54 PM, a staff member applied the resident's Ted hose in the dining room while she waited for bingo to start. Interviewed the Director of Nursing on 01/15/20 at 09:00 AM and she stated that she expected staff to put the resident's Ted hose on first thing in the morning and to remove them at bedtime.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 9	F 686		

pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcers and ensure the resident does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 of 2 residents reviewed (Resident #50). On 12/17/19, Resident #50 admitted to the facility with diagnoses that included a femur fracture, malnutrition, and malignant neoplasm of the esophagus. Upon admission, the resident had three open areas on her buttock. Although the facility assessed the resident as at high risk for pressure ulcers and identified the resident had multiple risk factors, the facility failed to implement additional interventions in an attempt to address the resident's risk of developing pressure ulcers until the resident developed one on 12/28/19. The facility reported a census of 54 residents.

Findings include:

Review of the Braden Scale completed upon admission to the facility on 12/17/19 revealed Resident #50 scored 15. A score of 15 indicated the resident was at risk for pressure related skin breakdown.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 10 The admission Minimum Data Set (MDS) dated 12/24/19 documented Resident #50 required extensive assist of 2 staff for bed mobility. The MDS also documented the resident did not have a pressure ulcer. The resident's Face Sheet documented medical diagnoses that included right femur fracture, malnutrition, difficulty walking, weakness, dysphagia (swallowing difficulties), and malignant neoplasm of the esophagus. The Progress Notes contained an Admit/Re-Admit Note documented 12/17/19 at 10:59 a.m. The noted contained an area to address skin condition that had been completed as follows: Skin/Wound (left blank) Pressure Injury: No Non-Pressure Wound: Yes Skin Temperature: Warm Dry Skin Color: Normal A Progress Note dated 12/17/19 at 11:15 a.m. documented the facility received report from a nurse at the hospital. The nurse stated the resident had moderate swelling in both lower extremities and 2 open areas on her buttocks that appeared to be from shearing (Shearing wounds occur when forces moving in opposite directions are applied to tissues in the body. This can occur when the skin is stuck to a surface, such as a bed, while gravity forces the body downward on the bed. https://study.com/academy/lesson/shearing-friction-wounds-definitions-treatments.html)	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 11	F 686		

A Progress Note dated 12/18/19 by the dietician documented the resident experienced weight loss, triggered for malnutrition, and had been receiving medpass (a nutritional supplement) 2 ounces four times per day.

A Progress Note dated 12/18/19 at 3:53 p.m. documented:

Skin/Wound
Pressure Injury: No
Non-Pressure Wound: No
Skin Temperature: Warm Dry
Skin Color: Pale

A Progress Note dated 12/19/19 at 12:30 p.m. documented:

Skin/Wound
Pressure Injury: No
Non-Pressure Wound: Yes, right hip incision healing well with no signs and symptoms of infection
Skin Temperature: Warm Dry
Skin Color: Normal

A Progress Note dated 12/21/19 at 9:44 a.m. documented:

Skin/Wound
Pressure Injury: No
Non-Pressure Wound: No
Skin Temperature: Warm Dry
Skin Color: Normal

A Progress Note dated 12/22/19 at 3:24 p.m. documented:

Skin/Wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 12	F 686		

Pressure Injury: No
Non-Pressure Wound: No
Skin Temperature: Warm Dry
Skin Color: Pale

A Progress Note dated 12/24/19 at 1:21 a.m. documented resident lying in bed at this time, rolled to apply Sensi to bottom, does not roll easily, and total assist of 1 staff. Incontinent of urine, briefs worn.

Skin/Wound
Pressure Injury: Yes Coccyx
Non-Pressure Wound: No
Skin Temperature: Warm Dry
Skin Color: Pale

A Progress Note dated 12/24/19 at 11:15 a.m. documented:

Skin/Wound
Pressure Injury: No
Non-Pressure Wound: No
Skin Temperature: Cool Dry
Skin Color: Normal

A Progress Note dated 12/25/19 at 12:01 p.m. documented:

Skin/Wound
Pressure Injury: No
Non-Pressure Wound: No
Skin Temperature: Warm Dry
Skin Color: Normal

A Progress Note dated 12/26/19 at 11:18 a.m. documented:

Skin/Wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 13 Pressure Injury: No Non-Pressure Wound: Yes, coccyx with 3 open areas. Sensi applied Skin Temperature: Warm Dry Skin Color: Normal A Progress Note dated 12/26/19 at 7:39 p.m. documented the resident transferred with assist of 2 staff and was incontinent of bowel and bladder. Staff applied cream to coccyx. The Progress Notes contained an Administration Note dated 12/27/19 at 10:03 p.m. documented the resident complained of coccyx pain and requested pain pill. The nurse administered 1 tablet of Oxycodone-Acetaminophen Tablet 5-325 MG. A Progress Note dated 12/27/19 at 12:53 a.m. documented: Skin/Wound Pressure Injury: Yes, coccyx. Unstageable due to slough. Coversite applied. Non-Pressure Wound: No Skin Temperature: Warm Dry Skin Color: Pale A Progress Note dated 12/28/19 at 11:48 a.m. documented slough noted in sore on coccyx when staff applied Sensi to the resident's buttock. Sores present upon admission, but coccyx deteriorated. Staff assisted the resident to lay in bed as much as possible and repositioning the resident on her sides to keep pressure off area. Coversite applied. The Pressure Injury Evaluation form dated 12/28/19 documented the resident had a	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 14 pressure injury to her coccyx (tailbone) which measured 2.4 cm long by 1.9 cm wide. The ulcer was unstageable due to loose, yellow/tan slough, with surrounding tissue red and inflamed. The resident rated the resident's pain in her sacrum (a shield shaped, bony structure between the last vertebrae and the tailbone) at 5 on a scale of 0-10. A Progress Note dated 12/29/19 at 11:52 p.m. documented: Skin/Wound Pressure Injury: No Non-Pressure Wound: No Skin Temperature: Warm Dry Skin Color: Normal The Progress Notes contained a Care Plan Conference Summary dated 12/30/19 at 10:30 a.m. which documented the resident required assist of two staff with all cares and experienced both bowel and bladder incontinence. The note also documented Certified Nursing Assistant (CNA) stated they are assisting the resident to lay in bed to assist in healing the sore on her buttocks. A progress note dated 12/30/19 at 1:20 p.m. documented when the resident admitted to the facility, she had 3 superficial areas on her coccyx from shearing in the hospital that measured 2.5 x 7 cm and Sensi initiated. On 12/25/19, area measured 7 x 7 cm with areas joined with slough in center that measured 2.4 x 1.9 cm with treatment changed to Coversite. Staff attempting to encourage the resident to stay off her back although that is her most comfortable position.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 15 A progress note dated 1/3/20 at 12:23 p.m. documented staff spoke with the resident's family regarding weight loss, decline in therapy, wound worsening, and discussed hospice. Labs drawn on 12/31/19 documented a hemoglobin (a red protein responsible for transporting oxygen in the blood) of 10.2, a hematocrit (the proportion, by volume, of the blood that consists of red blood cells expressed as a percentage) of 32.3 and an albumin level of 2.2. Albumin, the main protein produced in the liver, has numerous functions in the body, the most important of which is maintaining intravascular colloid osmotic pressure (COP). COP helps fluid stay within the vasculature instead of leaking into tissue. https://www.vetfolio.com/learn/article/the-role-of-albumin-and-fluids-in-the-body Low albumin levels can be seen in inflammation, shock, and malnutrition. https://labtestsonline.org/tests/albumin The Pressure Injury Evaluation form dated 1/2/20 documented the coccyx pressure injury had deteriorated, had odor after irrigation, and the surrounding tissue was red and inflamed. It measured 2.5 cm length by 2.5 cm width. The MDS dated 1/5/20 documented the resident had one unstageable pressure ulcer. The Care Plan for Resident #50 lacked documentation of any pressure relieving devices in place to prevent skin breakdown. The Care Plan was not updated with the pressure ulcer until	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 16 12/30/19. The Pressure Injury Evaluation form dated 1/8/20 documented the coccyx pressure injury had deteriorated, had odor after irrigation, had hard black eschar present and measured 3 cm length by 2.8 cm width by 2.2 cm depth. The resident rated the sacrum pain at 5 on a scale of 0-10. The Weight Record for the resident recorded an admit weight of 129.3 pounds on 12/17/19 and 114.6 pounds on 1/10/2020. A Care Communications Sheet dated 12/25/19 contained an undated, handwritten note that directed staff to assist Resident #50 out of bed last and back to bed first: lay on sides. The facility policy Assessments - Residents at Risk dated January 2015 documented its purpose was to identify residents at risk that need prevention interventions and the specific factors placing them at risk. The policy directed staff, in part: - Address Risk Factors and preventative measures upon admission to include non-compliance and diagnoses. - Document use of protective measures according to policy - Identify problem: include diagnosis, pre-existing conditions, nutrition, and past history of ulcers. - Provide information to assure staff are aware of preventative measures. In an interview on 01/14/20 at 11:34 AM, the Director of Nursing (DON) reported the facility implemented interventions implemented to prevent the development of pressure ulcers. She	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 686	Continued From page 17 reported they used a positioning wedge and also put an air mattress in place when they noticed the breakdown. She stated the chart contained documentation regarding those interventions. In a subsequent interview on 01/14/20 at 01:32 PM, the DON stated the air mattress was ordered on 1/6/20 and delivered on 1/7/20. She also stated the facility policy directed staff to complete a Braden Scale (a tool used to gauge pressure ulcer risk in residents) upon admission and then weekly for the first 4 weeks. She also stated reported if the resident is at risk interventions, staff are to put interventions in place to prevent (skin) breakdown. The DON reported the resident had some areas of the shearing on admission, but they didn't expect it to get so bad so quickly because the resident had a good rehab potential and was expected to go home soon. She added that she sent a fax to the physician asking if the pressure ulcer was unavoidable and the physician responded it was likely due to malnutrition.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility guideline and procedure review, the facility failed to provide an	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 689	Continued From page 18 environment free from accident hazards for 2 of 2 residents reviewed (Resident #11 & #29). Resident #11 exhibited severe cognitive impairment and required assist of one staff for surface-to-surface transfers and ambulation (walking). On 10/1/19, staff heard a yell and a moan from the resident's room and found the resident on the floor. The resident had sustained a skin tear and her right leg appeared externally rotated and shortened. Staff called an ambulance via 911 to take the resident to the Emergency Room (ER) for evaluation. X-rays taken at the hospital revealed Resident #11 sustained a non-displaced right fibular neck (hip) fracture. During the fall investigation, facility staff discovered a housekeeper had mopped the floor in the resident's room while the resident sat in her recliner and left the floor wet. When the resident attempted to transfer herself from the recliner, she slipped on the wet floor and fell. The facility also failed to place Resident #29's fall mat next to her bed while she was in it in an attempt to avoid injury as directed on the care plan. The facility reported a census of 54 residents. Findings include: According to the annual Minimum Data Set (MDS) assessment tool dated 8/29/19, Resident #11 had diagnoses that included renal failure, dementia, and pain. The MDS documented the resident displayed severe cognitive impairment. The MDS also documented Resident #11 required limited assist of one staff for transfers and ambulation in her room, and required extensive assistance of 2 staff for toilet use. According to the significant change MDS dated 10/22/19, Resident #11 had diagnoses that	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 689	Continued From page 19	F 689		

included renal failure, dementia, and pain. The MDS documented the resident displayed severe cognitive impairment for daily decision making. The MDS also documented Resident #11 as totally dependent on 2 staff for transfers and locomotion, and extensive assistance of two staff for toilet use.

The care plan with a revision date of 11/13/19 documented Resident #11 as at risk for falls due to weakness and poor safety awareness and noted she used to get up and walk without assistance. The care plan also documented the resident had an unwitnessed fall in her room and sustained a right hip fracture. The care plan instructed staff to attach her call light to a blanket on her lap when she was in her room (initiated on 10/1/19), encourage her to use her call light for assistance (initiated on 1/5/19), provide a safe environment without clutter (initiated on 01/05/2019), ensure she had appropriate footwear (initiated on 01/05/2019), and implement an electric hi/low bed (initiated on 1/15/19).

Review of Resident #11's Electronic Health Record (EHR) revealed the following progress notes:

-10/1/2019 at 11:15 AM: staff heard a yell and a moan from Resident #11's room. When staff arrived, they found her on the floor with her back to the bed, sitting on her buttock. Staff noted a skin tear to her right elbow; hypafix applied. The resident then grabbed her right hip and stated, "I think I hurt myself worse than I thought." The record documented her right leg as shortened and externally rotated. Staff called the resident's daughter and physician, left messages for both, and then dialed 911.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 689	Continued From page 20 -10/1/2019 12:46 PM: Resident had been incontinent and stated to staff "it's my own fault." Staff noted the floor was wet at the time of the fall. -10/1/2019 1:37 PM: the Emergency Room (ER) called to report Resident #11 had sustained a non-displaced right fibular neck fracture and was transferred to another hospital for possible surgical repair. -10/4/2019 3:29 PM the hospital called and reported Resident #11 had transferred out of the Intensive Care Unit (ICU) today, was doing well, and planned to return Monday. -10/7/19 Resident #11 returned to the facility Record review revealed a hospital History and Physical (H&P) for Resident #11 dated 10/1/19. The H & P documented a pelvis x-ray that showed a non-displaced right femoral neck fracture. Record review revealed an operative report dated 10/2/19 that revealed Resident #11 underwent a right hip hemiarthroplasty (surgical procedure that involved replacing half of the hip joint). Review of the facility's five minute meeting for employees dated 10/2/19 revealed staff educated regarding mopping resident room floors. During the education, the facility directed staff not to mop the floor in a resident's room with an ambulatory resident in the room. The facility directed staff to return later after the resident left the room to ensure the resident's safety to keep them from slipping and falling. The facility also directed staff	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 689	Continued From page 21	F 689		

to thoroughly ring out the mops when mopping floors to prevent leaving a large amount of water on the floor while it dried. Staff were instructed to consider the resident's cognitive level as many of the residents had some form of cognitive decline or dementia, which could hinder their judgment. Resident's might potentially attempt to transfer themselves, which could result in a fall. The facility directed if staff questioned if they should mop the floor of a resident's room, they should stop and speak to their supervisor for clarification. Meeting documentation showed Staff C attended the meeting and signed in.

Review of the facility's Environmental Guidelines and Protocols, March 2013 Edition revealed no information about resident safety when mopping resident room floors.

An observation on 01/14/2020 at 9:03 AM revealed Staff E Certified Nursing Assistant (CNA) and Staff F CNA had transferred Resident #11 from her wheelchair to her bed using a Hoyer lift.

During a staff interview on 1/13/2020 at 9:22 AM, Staff A Licensed Practical Nurse (LPN) stated she was in the Director of Nursing's (DON) office when she heard Resident #11 yell. When Staff A arrived in Resident #11's room she stated Resident #11 sat on the floor with her back against the bed. An assessment revealed a skin tear. Staff B Certified Nursing Assistant (CNA) entered Resident #11's room to assist. Staff A stated Resident #11 then complained of hip pain. Staff A stated the resident had been incontinent of bowel and possibly bladder and she believed the resident had tried to walk to the bathroom at the time of the fall. Staff A stated Resident #11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 689	Continued From page 22 required the assistance of 1 staff with a gait belt and walker prior to her fall, although on occasion, Resident #11 would get up on her own to go to the bathroom. Staff A stated she did not notice if the floor was wet or if there was a wet floor sign at the resident's doorway, but did see Resident #11 wore non-skid socks on at the time of the fall. During an interview on 1/13/2020 at 9:46 AM, Staff B stated she heard a crash from Resident #11's room and went to see what had happened. When she arrived, she found Resident #11 on the floor kind of facing the door with her back against the bed, and she then yelled for help. When asked if she noticed Resident #11's floor was wet or if there had been a wet floor sign placed outside the door, she stated yes, because the housekeeper had just finished mopping. Staff B reported Resident #11 wore gripper socks. Staff B stated prior to the fall, Resident #11 required limited staff assistance, a gait belt and her walker for ambulation, toilet use, and walking to and from meals. When asked, Staff B reported she did not remember if the wet floor sign had been placed in the doorway, but did remember Staff C, Housekeeper in the hall with her cleaning cart. Staff B added Resident #11 had been known to get up on her own without using the call light. During a staff interview on 1/13/2020 at 9:53 AM Staff C, Housekeeping stated Resident #11 was in her recliner when she entered her room to clean. She also stated she mopped the resident's floor because that was what she was taught to do upon hire in April 2019. Staff C reported as she left Resident #11's room, she reminded her to use her call light if she needed help, and also told the resident she had just mopped her floor. Staff C stated she had placed the wet floor sign next to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 689	Continued From page 23 the doorway. After Staff C left the resident's room, she heard her fall, and returned to the room. When asked she had been directed to mop a resident's room if the resident was non-ambulatory and in bed, she stated she had not been given specifics. Staff C stated she was trained right away (after Resident #11's fall) not to mop a resident's floor if the resident was in the room, and said she felt horrible after it happened. When asked during an interview on 1/13/2020 at 11:30 AM if the facility had guidelines for new housekeeping staff to follow with regard to when it was safe to mop the floor in a resident's room, the Administrator stated they did not have specific guidelines. He added it should be common knowledge to not mop a resident's room floor with the resident in the room. During a staff interview on 1/13/2020 at 11:58 AM, Staff D, Housekeeping Supervisor, stated the day of the fall she noticed Staff C had just finished sweeping, dusting, mopping, and cleaning the bathroom in Resident #11's room. Staff D reported she did train Staff C regarding the Environmental Guidelines and Protocols, which included housekeeping staff were allowed to spot mop if they noticed it needed it if a resident was in the room. She clarified when staff spot mop, they mop a small area, place the wet floor sign over the area, and wait for the spot to dry. Staff D also reported if a resident is wheelchair bound, housekeeping staff could mop the resident's rooms. Staff D stated Resident #11 was able to get up and down by herself and staff should not have mopped her room while she was in there because the resident had dementia. She added she did not think about not mopping a room with the resident was in it because she	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 689	Continued From page 24 forgot Resident #11 had dementia. Staff D reported after the resident fell, the facility immediately educated housekeeping staff to not mop a resident's room with a resident present. Staff D stated when she arrived at Resident #11's room after the fall, the floor was noticeably wet, as if staff had not wrung out the mop head. When asked during a staff interview on 01/15/20 at 9:03 AM if an ambulatory resident was in their room and their floor needed to be mopped how she would proceed, Staff G Housekeeping Aide stated she would wait until the resident left the room. 2) The quarterly MDS dated 11/21/19 documented Resident #29 required extensive assist of 2 staff for bed mobility and transfers. The MDS also documented she had two falls with injury since the last assessment and she was unable to complete the Brief Interview for Mental Status. The Face Sheet for Resident #29 documented diagnoses that included vascular dementia and repeated falls. The Safe Bed Environment Evaluation dated 11/21/19 documented the resident with a landing mat next to the bed. The Care Plan with revision date of 1/20/20 documented the resident as at risk for falls and with multiple falls in the last year. The Care Plan directed staff to provide a high/low bed, keep walker in reach at all times, place a landing mat next to the bed. Observation on 1/12/20 at 10:00 AM revealed the resident lay in bed with a half rail up on both sides	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 689	Continued From page 25 of the bed. The fall mat lay completely under the bed. During an observation on 1/13/19 at 2:30 PM the resident yelled for help. Upon entering the room, observation revealed the resident attempted to transfer herself out of bed. She sat up, leaned on her right elbow, and had placed her legs over the side of the bed. Staff were alerted and they attended to her needs. On 1/14/20 at 8:24 AM, staff entered the resident's room to assist her to bed. After staff left the room, observation revealed the resident lay in bed with the top half of the mat fall mat under the bed and the walker in the closet. Observation on 1/14/20 at 10:42 AM and 11:08 AM revealed the walker remained in the closet. The resident lay in bed and the top half of the fall mat remained under her bed. A nurse aide went in during the observation to freshen the resident's ice water, but did not adjust the mat. Observation on 1/14/20 at 2:28 PM revealed the resident rested in bed after lunch with the fall mat under her bed and the walker in the closet. In an interview on 01/15/20 at 8:55 AM, the DON stated that she expected the staff to follow the care plan to ensure all fall interventions were in place.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 758	Continued From page 26 processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 758	Continued From page 27 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to discontinue Resident #8's as needed (PRN) Ativan (antianxiety) order after 14 days. The order was started on 12/19/19 and remains a current order that has not been used since it was ordered. The facility reported a census of 54 residents. Findings include: According to a quarterly Minimum Data Set (MDS) with a reference date of 10/17/19, Resident #8 had a Brief Interview of Mental Status score (BIMS) of 3, indicating severe cognitive impairment. The MDS listed anxiety as a diagnosis. The MDS indicated he did not receive an antianxiety medication during the 7 day review period. Review of Resident #8's care plan with a revision date of 11/11/19 revealed he is at risk for side effects from antianxiety medication use and he has an as needed (PRN) Ativan order for increased anxiety. PRN order Review of Resident #8's December 2019 Medication Administration Record (MAR) reviewed he did not receive his PRN order of Ativan 0.5mg during the initial order dates of 12/4/19-12/19/19. The review also revealed he	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165193	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNLAP SPECIALTY CARE	1403 HARRISON ROAD DUNLAP, IA 51529

(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 758	Continued From page 28 did not receive the PRN Ativan order during the new order dates of 12/19/19-12/31/19. Review of Resident #8's January 2020 MAR reviewed he has not received his PRN order of Ativan for the first 14 days of the month. Review of nursing progress notes and behavioral notes review documentation related to anxious behaviors. Review of nursing progress notes revealed the following progress notes: 1/14/2020 at 12:06: a call was placed to Resident #8's physician was asked to return call related to his prn Ativan order and not being used. 1/14/2020 at 1:12 PM: received a call back from Resident #8's physician and received an order to discontinue his PRN Ativan due to non use. During a staff interview on 01/14/20 at 11:54 AM the Director of Nursing (DON) stated it ordered be he was falling a lot and becoming anxious. She stated initially when it was reviewed after the first 14 days, the doctor continued the order for 6 months because of his anxiety. When asked if the doctor should be updated on the resident not using the Ativan since it was ordered in December, she stated yes he should.	F 758		

Dunlap Specialty Care
1403 Harrison Rd
Dunlap, Iowa 51529

Dunlap Specialty Care Plan of Corrections
Annual Survey January 12, 2020—January 15, 2020

F000:
Please accept this plan of corrections as our facility's credible allegation of compliance. All deficiencies stated in the 2567 were corrected and in compliance as of 1-30-2020

F554: Resident Self Admin Meds Clinically Appropriate:
Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and/or state law.

This is my credible allegation of compliance of F554. This allegation does not constitute guilt but that the facility is in compliance to F554.

All nursing staff (RN, LPN, Med Aides) were educated on not leaving a resident's medications with them unsupervised. This staff was educated on not leaving medications in a resident's room or at the dining table. This staff was also educated on making sure residents take medication before signing off that the medication was given. This was provided to them through a 5-minute meeting form on 1-29-2020 during the facility's All-Staff and Clinical meeting. This staff was provided with a coaching tool reeducating them on not leaving medications in resident rooms or at the dining table without watching resident take the medication. This will be monitored by the DON, Nurse Manger, and the QA team through the QA process daily for the next two weeks at random medication administration times for next 2 weeks and will re-evaluate for future auditing. Problems will be addressed and corrected as they are observed.

F636: Comprehensive Assessments and Timing:
Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and/or state law.

This is my credible allegation of compliance F636. This allegation does not constitute guilt but that the facility is in compliance to F636.

An action plan was created for an inaccurate MDS assessment related to a discharge MDS. In response to this, the MDS Coordinator will pull the discharge report monthly for review and accuracy. The IDT will perform daily monitoring in our QA meeting along with the help from the corporate office reimbursement analyst to run report and alert facility staff for missing assessment report. The MDS Coordinator was reeducated on accuracy on the MDS for discharges that an MDS will be completed on all residents that are discharged from the facility. The IDT team and the MDS Coordinator are responsible for the monitoring of this. The action plan was completed and implemented on 1-28-2020.

F641: Accuracy of Assessments:
Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and/or state law.

This is my credible allegation of compliance F641. This allegation does not constitute guilt but that the facility is in compliance to F641.

An action plan was created of the accuracy of the MDS for coding a Level 2 on the MDS. The MDS that was inaccurate was corrected and submitted on 1-14-2020 by the MDS Coordinator. The MDS Coordinator was approved for ASCEND access on 1-22-2020 and reviewed and verified all current level 2 residents' assessments were correct on 1-22-2020. On 1-22-2020 a list of all level 2 PASSR were provided to MDS nurse. On 1-24-2020 MDS nurse was provided 1:1 education for ASCEND evaluations. The MDS coordinator was reeducated on 1-27-2020 on the importance of MDS accuracy for level 2 PASSR and how they are correctly coded on the MDS for compliance.

F684: Quality of Care:
Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and/or state law.

This is my credible allegation of compliance F684. This allegation does not constitute guilt but that the facility is in compliance to F684

An action plan was created on 1-29-2020 on monitoring the documentation of TED hose application prior to being applied on the resident. The nurse manager will complete random audits on when TED hose are on and times of the documentation and compare and follow up with staff that documented for two weeks and then re-evaluate the need at a future time. Clinical

staff was provided education on proper documentation of TED hose at the All-Staff and Clinical meeting on 1-29-2020. Clinical staff signed a 5-minute form indicating the understanding of education and guidelines for compliance.

F686: Treatment/Svcs to Prevent/Heal Pressure Ulcer
Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and/or state law.

This is my credible allegation of compliance F686. This allegation does not constitute guilt but that the facility is in compliance to F686.

In reference to Resident #50 who acquired a pressure ulcer at the facility, the facility has implemented an action plan to ensure compliance with the standard of providing consistent care with professional standards of practice to prevent pressure ulcers. On 1-29-2020 all clinical staff was educated on making sure all interventions are in place to prevent pressure ulcers. In response, all pressure relieving devices will be monitored every shift for a month and then re-evaluated for the future. The charge nurse on every shift is responsible for ensuring compliance. This will be monitored by the QA team during QA everyday meeting to ensure follow through and compliance.

F689: Free of Accident Hazards/Supervision/Devices
Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and/or state law.

This is my credible allegation of compliance F689. This allegation does not constitute guilt but that the facility is in compliance to F689.

All-Staff were educated on overall safety for each department and throughout the facility to ensure safety of staff and residents. A 5 minute meeting form was signed by all staff and presented at the All-Staff and Clinical meeting on 1-29-2020. In response to F689 an action plan was created to ensure the safety of residents and to ensure all fall interventions are in place. All fall interventions and safety check on all rooms will be completed 2x's per shift for the next 30 days and re-evaluated at that time. This was implemented 1-29-2020. Reeducation was completed for housekeepers on 1-28-2020. This meeting consisted of the administrator, environmental supervisor, and housekeeping aides. The meeting consisted going through the

housekeeping policies and procedures again located in the facility's Environmental Policy and Procedure Manual.

F758: Free from Unnecessary Psychotropic Meds/PRN Use
Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and/or state law.

This is my credible allegation of compliance F758. This allegation does not constitute guilt but that the facility is in compliance to F758.

In response to F758 an action plan was implemented for PRN psychotropic medications to have a DR follow up to ensure compliance. The DON reviewed all PRN psychotropic medications for provider updates within the 14 days for a response if needed to continue use past the 14 days. The DON will be responsible for monitoring all new PRN psychotropic medications daily in the QA everyday meeting for stop dates. Staff was provided education at the All-Staff and Clinical meeting on 1-29-2020 on the need for the 14 day stop date with all new orders for PRN psychotropic medications. This was completed on 1-29-2020.

.