STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166482	A. BUILDING _____ B. WING _____	C 01/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED PRESBYTERIAN HOME	1203 EAST WASHINGTON STREET WASHINGTON, IA 52353

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F 000	INITIAL COMMENTS Correction date: February 10, 2020 The following deficiencies relate to investigation of complaints #85975, #85990, and #86217. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580	F 580 Notify of Changes Without waiving the foregoing statement, the facility states that with respect to notifying of changes of a newly developed wound. Resident #2's wound is now healed. The physician and resident representative of resident #2 were notified of the residents newly developed wound on 08/17/2019. An audit was completed on 02/4/2020 on all other similarly situated residents and was concluded that all other resident physicians and resident representatives were notified of newly developed wounds and skin sheets were initiated. Education was provided to Staff K individually and all nurses on the importance of notifying the physician and responsible party when a newly developed wound is identified as well as initiating a weekly skin sheet on 02/06/2020. Admission Packet updated to remove family preference of when to be contacted for skin and wound issues as of 2/4/2020. Social worker educated that this was removed and that facility is to contact family for all skin concerns.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erin Drahota	CEO/Administrator	2/10/20

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.

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F 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify the Physician and Resident Representative of a newly developed wound for 1 of 4 sampled (Resident #2). The facility reported a census of 53. Findings include: According to the Minimum Data Set (MDS) assessment dated of 12/4/19, Resident #2 had short and long term memory deficits and a severely impaired decision making. Resident #2 required extensive assistance with ambulation, transfers, dressing, toilet use and personal hygiene needs. Resident #2 had diagnoses of dementia, hypertension and coronary artery disease.	F 580	DON/Designee will complete periodic audits to ensure the physician and responsible party are notified when a newly developed wound is identified and weekly skin sheets are initiated. Ongoing Audit findings will be brought to the quarterly QAPI meetings. Ongoing	

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F 580	Continued From page 2 According to a Progress Note dated 8/16/19 at 5:28 a.m., a Nurse Aide reported Resident #2 had a small open area on her bottom to Staff K (Registered Nurse). The Progress Notes failed to reflect the staff notified Resident #2's Physician or Representative. During an interview on 1/14/20 at 4:00 p.m., the Director of Nursing (DON) stated when the staff notice skin breakdown they assess the area, obtain measurements and initiate a skin sheet. Then the nurse contacts the Physician for treatment orders and notifies the family. The DON verified the staff failed to contact the Physician and family and failed to complete a skin sheet for weekly monitoring.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609	F 609 Reporting of Alleged Changes Without waiving the foregoing statement, the facility states that with respect to having operationalize policies and procedures for identifying, reporting, and investigating injuries of unknown origin. With regards to resident #2, an investigation was initiated on 08/18/2019. Staff J was re-educated on reporting abuse allegation guidelines on 02/5/2020. All staff were re-educated on reporting abuse allegations guidelines on 02/6/2020. DON and DNS were re-educated on reporting abuse allegation guidelines, investigation process, and injury of unknown origin reporting on 01/28/2020. The policy on identifying, reporting, and investigating injuries of unknown origin was reviewed on 02/4/2020.	

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F 609	Continued From page 3 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to operationalize policies and procedures for identifying, reporting and investigating injuries of unknown origin for 1 of 4 sampled (Resident #2). The facility reported a census of 53. Findings include: According to the Minimum Data Set (MDS) assessment dated 12/4/19, Resident #2 had short and long term memory deficits and a severe cognitive impairments. Resident #2 required extensive assistance with ambulation, transfers, dressing, toilet use and personal hygiene needs. Resident #2 had diagnoses of dementia, hypertension and coronary artery disease. During an interview on 1/14/20 at 1:29 p.m., Staff J (Nurse Aide) stated she worked the day shift on 8/17/19. Staff J noticed Resident #2 had a large bruise on the left temporal area when she assisted Resident #2 out of bed. Staff J meant to report it right away, but got busy. That afternoon, Resident #2's daughter visited and asked about the bruise. Staff J stated she informed the Director of Health Services of the bruise.	F 609	DON/designee will complete periodic audits to ensure injury of unknown origin investigations are completed and reporting occurs timely. Ongoing Audit findings will be brought to the quarterly QAPI meetings. Ongoing	

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F 609	Continued From page 4 During an interview on 1/14/20 at 9:20 a.m., the Director of Health Services (DHS) stated Resident #2's family member pointed out the bruise on Saturday afternoon (8/17/19) around 2:00 p.m. The family member asked how it happened. The DHS initiated an investigation and interviewed caregivers responsible for Resident #2's cares that weekend. The DHS stated no one seemed to know when it first appeared or of it's origin. Staff K (Nurse Aide) stated it was not there when she worked the afternoon shift on 8/16/19, but was there at 2:00 p.m. on 8/17/19. The DHS stated the aides she spoke with thought it most likely happened during a hoyer transfer as Resident #2 will sometimes grab a hold of the straps. The DHS stated it most likely occurred during a hoyer transfer, however no one owned up to it. The DHS stated hoyer lift re-education was provided to her staff. The DHS stated she did not feel the bruise was related to abuse, so she didn't report it to the Department of Inspections and Appeals. The DHS was unable to find her notes related to her investigation and had no written statements from staff.	F 609		
F 684 SS=G	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	F 684	F 684 Quality of Care Without waiving the foregoing statement, the facility states that with respect to quality of care with lack of a comprehensive assessment and timely intervention following a fall. Resident #1 was sent to the hospital for evaluation and treatment on 9/14/2019. All similarly situated residents who have had falls have had a comprehensive assessment and timely interventions have been put into place. 02/4/2020.	

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F 684	Continued From page 5 by: Based on record review and staff interviews, the facility failed to provide comprehensive assessments and intervene in a timely manner following a fall for 1 of 4 sampled (Resident #1). The lack of assessment delayed the treatment of Resident #1's arm and pubic fractures. The facility reported census of 53. Findings include: According to the Minimum Data Set (MDS) assessment dated 6/12/19, Resident #1 had moderate cognitive impairments. Resident #1 required limited assistance supervision with ambulation, limited assistance with transfers and extensive assistance with dressing, toilet use and personal hygiene needs. Resident #1had diagnoses of dementia and hypertension. The Care Plan revealed Resident #1 ambulated independently with a walker and independently used the bathroom. According to the Fall/Injury Monitor - Suspected Head Injury sheet dated 9/13/19 at 10:05 p.m. the staff heard Resident #1 yelling out, "Oh, I fell, I fell". Staff A (Licensed Practical Nurse) documented on the sheet. Resident #1 complained of right elbow pain, although flailing her arm about. Resident #1 complained of right hip pain, but able to move right leg without expressing pain or yelling out. Resident #1 assisted to stand with assistance of three staff to her bed. The sheet revealed noted no pain, injury, bruising or impaired mobility related to the fall. The sheet revealed follow up neurological checks at 11:10 p.m., 12:10 a.m., 1:10 a.m. and 2:10 a.m. The neurological checks noted no	F 684	F 684 Quality of Care Fall Policy was reviewed and updated by DON and DNS both on 9/15/19 and on 2/4/2020. Staff member H is no longer employed. Staff A was re-educated regarding fall policy on 9/15/2019. All nursing staff re-educated on 9/26/2019. Nurses Meeting on 9/16/19 nurses were re-educated regarding the fall policy. Nurses were educated again on 2/6/20 regarding the fall policy. DON/designee will complete fall audits to ensure a comprehensive assessment and timely intervention has been completed. Ongoing Audit findings will be brought to the quarterly QAPI meetings. Ongoing	

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F 684	Continued From page 6 change in condition and range of motion as before. During an interview on 1/13/20 at 4:22 p.m., Staff H (Nurse Aide) stated around 10:05 p.m. on 9/13/19 she heard Resident #1 scream for help from across the hall. Staff H summoned Staff A (Licensed Practical Nurse) who assessed Resident #1. Three staff lifted Resident #1 off the floor and placed her in bed. Resident #1 screamed out, but Staff H did not know whether it was her anxiety or pain related. During an interview on 1/9/20 at 5:00 p.m., Staff I (Nurse Aide) stated she worked 9/13/19 on the evening shift. Staff I passed by Resident #1's room and observed Resident #1 on the floor with Staff A and Staff H present. Staff I reported Resident #1 did not seem to be in pain and moved her legs. However, Resident #1 could not move her arm. The three staff picked Resident #1 up and placed her in a chair. Resident #1 could not bear weight. Staff I could not recall if Resident #1 had pain or not. During an interview on 1/14/20 at 11:40 a.m. Staff A (Licensed Practical Nurse) reported she assessed Resident #1 and she was fine, kicking her legs and moving her arms. Resident #1 stated she had no more than the usual amount of pain. Staff A stated they lifted Resident #1 to her feet and she ambulated back to bed using her walker. Staff A stated she never noticed anything unusual and Resident #1 was not yelling out in pain. Staff A stated she completed additional assessments per protocol and did not notice any abnormalities. Staff A stated Resident #1 was able to move her legs and arms "as before" which meant as she could prior to her fall. Resident #1	F 684		

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F 684	Continued From page 7	F 684		

squeezed Staff A's hands, but noted her arms are normally stiff anyway and have limited movement. Staff A denied the overnight aide reported Resident #1 had pain or of anything unusual.

During an interview on 1/13/20 at 11:25 a.m., Staff B (Nurse Aide) stated she worked overnight on 9/13/19. The evening aide reported to Staff B that Resident #1 had a fall earlier, Staff A responded and Staff A later reported everything was fine. Staff B stated she cared for Resident #1 that night and every time she was in the room providing cares Resident #1 moaned in pain. Staff B reported to Staff A that Resident #1 had pain, but Staff A stated Resident #1 was fine.

During an interview on 1/14/20 at 12:59 p.m., Staff C (Licensed Practical Nurse) reported she worked from 6:00 a.m. to 10:00 p.m. on 9/14/19. At 6:00 a.m., the nurse reported Resident #1 had a fall and hit her right arm. Staff C assessed Resident #1 and Resident #1 could move her arms and legs freely without any indication of pain. Resident #1 did not want to get out of bed and Staff C instructed the Aides to allow Resident #1 to stay in bed. Staff C stated she passed Resident #1's medications and did not notice anything unusual. Staff C primarily focused on Resident #1's right side, as told in report. Resident #1 remained in bed through lunch and took her noon pills without incident. Staff C stated no one reported to her anything unusual. Resident #1 could move her arm and legs and squeeze her fingers upon request. Staff C admitted she did not do any passive range of motion on Resident #1's arms and legs.

According to a Fall Follow-up report dated 9/14/19 at 11:00 a.m., Staff C documented

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F 684	Continued From page 8 Resident #1 had no injury, impaired mobility and normal range of motion. Resident #1 denied pain and reported she did not feel well, sick at her stomach, and wanted to stay in bed. During an interview on 1/13/20 at 11:40 a.m., Staff D (Nurse Aide) stated she worked the day shift on 9/14/19. Staff D reported Resident #1 had pain all day and screamed out when moved. Resident #1 complained of left arm pain. Staff D stated she told the Staff C (Nurse) a couple of times that day and Staff C told her not to get Resident #1 up. Resident #1 stated, "I'm going to die, I'm going to die". Staff D stated the nurse checked on her, but really did not do anything. During an interview on 1/9/20 at 4:36 p.m., Staff E (Nurse Aide) stated she worked the day shift on 9/14/19 with Staff D. Staff E stated Staff D informed her that Resident #1 refused to get up and complained of pain. Staff E instructed Staff D to report her observations to Staff C (Nurse) and get a room tray. After breakfast, Staff D assisted Resident #1. Staff E heard Resident #1 yelling. Staff E entered Resident #1's room and observed Resident #1 sitting at the edge of the bed vomiting. Resident #1 stated she hurt. Staff C (Nurse) entered the room and Staff E left. Staff C later stated, Resident #1 was yelling because she did not have her medications or food yet. Staff E stated later when she checked on Resident #1, she screamed out when touched. Staff E reported this to Staff C (Nurse). Staff E stated later Staff D and Staff F provided cares and Resident #1 still had pain. Staff E reported Resident #1 did not get out of bed that day, which was unusual.	F 684		

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F 684	Continued From page 9	F 684		

The Progress Notes dated 9/14/19 at 5:40 p.m., Staff C documented a Nurse Aide reported Resident #1 had pain and not want to eat her soup. Resident #1 complained she felt sick. Resident #1 had pain with range of motion to her lower extremities. Resident #1 voiced discomfort when the left hip and thigh palpated. Resident #1 assisted to sit on the edge of the bed. Resident #1 held on with both hands while changing position. Resident #1 stated she hurt and did not want to get up. When asked where she hurt, Resident #1 responded her head and then pointed at her stomach and left side.

Review of the September 2019 Medication Record sheets revealed Resident #1 had an order for Tylenol 650 milligrams every 4 hours for general discomfort as needed. The sheets revealed Resident #1 had no Tylenol administered on 9/13/19 or 9/14/19.

During an interview on 1/13/20 at 2:45 p.m., Staff F (Nurse Aide) stated she worked from 10:00 a.m. to 10:00 p.m. on 9/14/19. At 1:00 p.m., she assisted Staff D with Resident #1. Resident #1 yelled and screamed in pain when moved. Staff F stated she attempted to tell Staff D (Nurse) but Staff D responded Resident #1 exaggerates. Staff F observed Resident #1 was anxious, would not get out of bed, and she knew something was wrong. Staff F stated she checked on Resident #1 about every hour. At 5:00 p.m., Staff F entered Resident #1's room. Staff F removed the pajamas, Resident #1 had on all day. When Staff F removed the long sleeved pajama top, Resident #1 cried out in pain. Staff F noticed Resident #1's left arm had swelling and a huge bruise. Staff F stated she knew it was broken and had never seen anything like it. Staff F stated she left the

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F 684	Continued From page 10 room and had Staff G (Nurse) assessed Resident #1. Resident #1 transferred to the Emergency Department. During an interview on 1/13/20 at 11:05 a.m., Staff G (Licensed Practical Nurse) stated he worked the evening shift on 9/14/19. At 7:40 p.m., the staff informed Staff F that Resident #1 had an injury. Staff G assessed Resident #1 immediately and noticed a large bruise on her left elbow, swelling in her left arm, pain with movement of the left arm, and diminished range of motion in left leg. Staff G had knowledge of the fall the evening before, but to that point, had not been involved with her care. Staff G stated he suspected an injury right away, contacted the physician, and had her transported to the hospital. The Radiology Consultation Report dated 9/14/19 revealed Resident #1 had a displaced fracture of the left ulna and displaced fractures of the left superior and inferior pubic rami.	F 684	This plan of correction constitutes my credible allegation of compliance. All deficiencies and/ or materials needed to meet code have been completed as of February 10, 2020.	