DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165307 | A. BUILDING _____ B. WING _____ | 07/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COUNTRY VIEW | 1410 WEST DUNKERTON ROAD WATERLOO, IA 50703 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>Correction date 8-24-17<br><br>VBK 8/25/17 The following deficiencies relate to the facility's annual health survey and investigation of incident #69280 & #68138. (See code of federal regulations (42CFR) Part 483, Subpart B-C) Facility reported incident #69279 was not substantiated. | F 000 | Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by this provider #165307 of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared solely because of provisions of federal and state law requires it. Country View will continue to operate and provide services in compliance with all federal, state and local laws, regulations and codes, and with professional standards and principles to provide services within this facility. This is Country View's credible allegation of compliance with the identified F246, F314, F323, F329 tags. | |
| F 246 SS=D | 483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:<br><br>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical record review, resident and staff interview, the facility failed to ensure a call light was accessible for one of nineteen residents reviewed. The facility census was 106 residents.<br>(Resident # 10)<br><br>Findings include;<br><br>1. The Minimum data set (MDS) assessment dated 7/6/17, documented Resident #10 had diagnoses that included Parkinson's disease and required total assistance with activities of daily living. | F 246 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis Coleman | TITLE: Administrator | (X6) DATE: 8-25-17 | 08/16/2017

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 246 | Continued From page 1<br>Plan of care with an original date of 11/1/16 documented a problem of visual impairment secondary to glaucoma, bilateral eye as evidenced by senior vision and interventions that included:<br><br>a. Orientation to arrangement of furniture in room to increase awareness of environment.<br><br>b. Arrange furniture in residents room as desired and maintain clutter free environment to increase ability to move around without injury.<br><br>c. Keep bed in lowest position.<br><br>d. Explain procedures and care before performing.<br><br>e. Announce self when entering Residents area.<br><br>f. Assist with care as needed.<br><br>g. Provide large print materials.<br><br>h. Encourage independence to ability and praise efforts.<br><br>On 7/24/17 at 11:00 a.m., the resident laid in bed with no call light with in reach. Observation revealed the call light on the floor underneath the bed towards the wall.<br><br>On 7/24/17 at 3:00 p.m., the resident laid in bed with no call light with in reach. Observation revealed the call light at the end of the bed on frame.<br><br>During interview on 7/24/17 at 3:05 p.m., Staff A, | F 246 | **(F246)** Please accept this as provider #165307 credible allegation of compliance. It is the policy of the facility to assure to provide accommodation of all residents needs and preferences. Staff was initially educated on August 8, 2017 that all residents must be provided with all adaptive devices including but not limited to call lights. Follow-up education was provided again on August 23 & 24, 2017. The RN Supervisors will monitor call-light placement with random daily rounds during tour of duty. Correction and re-education will be provided to individual staff as necessary. Results will be provided to the Director of Clinical Services and/or her designee. The provider will monitor this deficient practice for a period of 6 months through the Quality Assurance Committee. | 8-24-17 |

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| F 246 | Continued From page 2<br>certified nurse aide, CNA came into the room attached the call light to the top of the resident bed spread and stated the resident was able to use his/her call light. The resident stated they could now push the button when needing something.<br><br>During interview on 7/24/17 at 3:05 p.m., the resident stated staff laid him/her down at 1:45 p.m. and no call light was attached to the bed spread.<br><br>On 7/25/17 at 10:41 a.m., the resident laid in bed with no call light with in reach. Observation revealed the call light on the floor between the wall and bed. Resident stated the housekeeper came in and placed a blanket on them and the call light fell on the floor and staff failed to attach it to the fleece blanket. | F 246 | | |
| F 314 SS=G | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(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 | F 314 | | |

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| F 314 | Continued From page 3<br>from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical record review and staff interview, the facility failed to identify the risk factors to prevent a pressure area from developing for which resulted in the resident acquiring an avoidable pressure ulcer while at the facility for 1 of 3 residents reviewed with pressure ulcers (Resident #10). The facility reported a census of 106 residents.<br><br>Findings included:<br><br>1. The Minimum Data Set (MDS) assessment tool dated 7/6/17, for Resident #10, documented the resident with diagnoses which included heart failure, diabetes mellitus, Parkinson's Disease, and anxiety. The MDS documented the resident with a Brief Interview for Mental Status score of 0, which identified the resident cognitively impaired. The assessment revealed the resident requires total dependence for bed mobility (how resident moves to and from lying position, turns side to side and positions body while in bed or alternate sleep furniture), transfers, and personal hygiene. The MDS documented the resident with functional limitation in range of motion in both sides of lower extremity (hip, knee ankle, foot), and used a indwelling catheter. The assessment revealed the resident at risk for developing pressure ulcers and a pressure relieving devices were used.<br><br>The Braden Scale completed 7/6/17, identified the resident with no sensory impairment, rarely moist, chairfast, slightly limited with mobility, potential problem with friction/shear and also at risk with a terminal condition. The Braden Scale | F 314 | **(F314)** Please accept this as provider #165307 credible allegation of compliance. It is the policy of this provider to provide services to residents to prevent pressure ulcers. The resident Skin Alteration Program has been reviewed for consistency and continuity in application to meet current Standards of Practice and continued quality of care on August 2, 2017. Standards for pressure reduction floatation mattress and protective flotation device use have been incorporated into the program. A Low Air Loss mattress has been applied to the bed of resident #10. Registered Nurses on August 2, 2017 initially received training of skin conditions, including, pressure ulcer assessment, staging, documentation and the definition of the term "Un-stageable." Protocol for Pressure Ulcer Prevention for low, moderate and high risk pressure ulcer protocol | 8-18-17 |

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| F 314 | Continued From page 4<br>documented a score of 17, for which indicated moderate risk and to implement Pressure Ulcer Prevention Protocol 1.<br><br>The resident Care Plan with an original date of 4/21/17, identified a problem of at risk for developing pressure ulcers related to altered mobility related to end stage Parkinson's disease, cognitive impairment and fecal incontinence. Approaches directed staff to keep resident skin clean, dry and keep linens free of wrinkles. Staff would monitor the resident's skin integrity when providing care and with each shower/bath, turn and position frequently as resident allows. An alternating pressure reducing mattress and roho/mosaic chair cushion were used to ensure inflation standards are met.<br><br>A Non-Pressure Skin Condition Report dated 7/22/17, documented right buttock, 1.8 centimeter by 1.6 centimeter red area with a 0.6 centimeter by 0.5 centimeter open area inside.<br><br>A Non-Pressure Skin Condition Report dated 7/14/17, documented right exterior heel, 4.0 centimeters by 1.5 centimeters, bright red in surrounding skin color, no odor or drainage.<br><br>A Weekly Pressure Injury Record dated 7/15/17, documented a Stage 1, (intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury) 2.5 centimeter by 2.5 centimeters to right lateral heel with wound bed defined as dark edge-center, | F 314 | has been reviewed with professional nurses. Licensed Nurses received review of the skin alteration program beginning on August 8, 2017 with ongoing education, including Protocol for Pressure Ulcer Prevention for low, moderate and high risk pressure ulcer protocol. C.N.A.'s have received re-education on turning and repositioning, frequency and technique, including standards for linen use with pressure reduction mattress use, as well as guidelines for pressure ulcer prevention for low, moderate and high risk residents, this education is ongoing. This deficient practice shall be reviewed and monitored by the providers Quality Assurance Committee for a period of 6 months. | |

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| F 314 | Continued From page 5<br>white/soft, surrounding skin color as pink/intact. Response to treatment/comments documented to leave open to air and apply pressure reduction boots, and request Prevelon boots to be ordered. Preventive Measures/Progress: documented turn frequently, as resident tolerates, may use pillow pressure reduction boots, will request to order Prevelon boot on at all times.<br><br>A Weekly Pressure Injury Record dated 7/21/17, documented the right lateral heel as unstageable, (full-thickness skin and tissue loss in which the extent of tissue damage with in the ulcer cannot be confirmed because it is obscured by slough or eschar). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed) measures 2.5 centimeters by 2.5 centimeters, wound bed as calloused border from 9 to 3 o'clock, wound flush with per tissue. Response to treatment/comments: site beginning to callous, flush with surround skin, intact. Heel firm to palpation. Preventive Measures/Progress: turn frequently as resident allows, cushion boots, pressure reduction overlay mattress, up one hour before/after meals.<br><br>A Weekly Pressure Injury Record dated 7/26/17, documented the right later heel as unstageable, 1.0 centimeter by 0.5 centimeters, with the wound bed being intact callous, heel firm, color per race.<br><br>Interview on 7/25/17 at 1:30 p.m., Staff C (registered Nurse) stated the pressure ulcer to the right heel of the resident is a non-stageable pressure area acquired at the facility due to staff failing to reposition the resident from side to side; and the Prevalon boots been applied to the resident right heel on 7/24/17, which needed to be placed on the heel upon initial assessment. | F 314 | | |

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| F 314 | Continued From page 6<br>The blue bunny boots that were on the resident's heel when the area was found had no padding to keep the heels floated.<br><br>A prior MDS assessment reference dated 4/9/17, documented Resident #10 with a BIMS score of 0, requires extensive assistance with bed mobility, transfer, personal hygiene, has functional limitations on both sides of lower extremity. The MDS documented the resident at risk for developing pressure ulcers, and has one or more unhealed pressure ulcer at Stage 1 or higher. The MDS documented (1) Stage 2 ulcer present on 2/23/17, with the most severe tissue for any pressure ulcer being granulation tissue-pink or red tissue with shiny, moist, granular appearance, and pressure ulcer care and treatment.<br><br>The prior Care Plan with an effective date of 11/10/16, documented on 2/2/17 red spot on right buttock, 2/10/17, open area lower left buttock. Interventions include to apply air mattress to bed, call light with in reach, provide rest periods throughout the day. | F 314 | **(F323)** Please accept this as provider #165307 credible allegation of compliance. It is the policy of this provider to provide an environment that is both comfortable and safe. All stainless steel corner guards will be removed and replaced with composite corner guards with blunt edges for protection of the residents, completion date will be September 15, 2017. The corner guards on the two elevator cars will be replaced, the elevator contractor has been contacted with an estimated completion date of September 15, 2017. Nursing staff were initially educated and instructed on August 8, 2017 to immediately report suspected hazards to maintenance per the protocol currently in place. The training included process of protecting residents from | 9-15-17 |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use | F 323 | | |

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| F 323 | Continued From page 7<br>appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical record review and staff interview, the facility failed to ensure one of thirteen residents reviewed received adequate supervision to protect against hazards in the environment. The facility census was 106 residents. (Resident #4)<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated 6/1/17, documented Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition and required extensive assistance for transfers, toilet use, dressing, and bathing.<br><br>Observation on 7/24/17 at 9:15 a.m., revealed the third floor west side shower room with caution tape placed diagonally across the doorway, a sign placed on the door stated the shower room closed, and the door was locked with key pad access only. Staff C, Registered Nurse (RN) | F 323 | potential harmful circumstances, closing down areas of hazard until properly assessed, reporting hazards to the charge nurse, supervisory staff and process for emergency repair needs. The identified shower room remains out of service until the replacement of the corner guards is complete. The Maintenance Director and/or designee will conduct weekly audits of the corner guards to assure they are in good repair and safe for the residents of the facility. The provider will monitor this deficient practice for a period of 6 months through the Quality Assurance Committee. | |

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| F 323 | Continued From page 8 | F 323 | | |

stated shower room had been closed after the incident with Resident #4. The metal corner covering had been repaired, but had let loose again. Staff C confirmed the metal corner covering had pulled away from the wall which exposed a sharp edge on the date of the incident. Observation at the time revealed the shower room had a shiny silver metal corner wall protector with a gap visible, where the metal had pulled away from wall. The exposed edge was not rounded and felt sharp to the surveyor. Staff C stated the resident's foot got caught when staff turned the resident in the shower chair.

An Unusual Occurrence Report dated 7/5/17 at 10:15 p.m., initiated by Staff D, Licensed Practical Nurse (LPN) documented the resident was seated in a shower chair placed over the toilet. Staff D noted a moderate amount of blood on the floor and the resident's great toe with moon shaped tear measuring 2 centimeters (cm) by 1 cm. Staff reported while turning the resident the residents toe caught on metal corner plate and caused the skin to tear.

On 7/24/17 at 1:00 p.m., observation revealed numerous areas with a metal corner and wall protectors in place in resident care areas, specifically noted in hallways and entrance area to the elevators.

During interview on 7/24/17 at 3:35 p.m., the Physical Plant Manager and the Assistant Administrator stated the third floor west shower to remain closed until safe to use again and identified plan to replace metal wall protectors with a product that was not a safety hazard. They had already contacted the elevator company to replace metal wall protectors at entrance to

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| F 323 | Continued From page 9<br>elevator. | F 323 | | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(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;<br><br>(2) Residents who use psychotropic drugs receive | F 329 | **(F329)** Please accept this as provider #165307 credible allegation of compliance. It is the policy of this provider to assure that a resident drug regimen is free from unnecessary drugs. Nursing staff have been educated initially on August 8, 2017 and again on August 23& 24, 2017 on the standards of practice for prn psychotropic medication use including the need for non-pharmacological intervention prior to the administration of the prn psychotropic medication. All prn psychotropic will have non-pharmacological interventions documented on the behavior intervention sheet. | 8-24-17 |

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| F 329 | Continued From page 10<br>gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility failed to document non-pharmacological interventions attempted prior to administering anti-anxiety medication for 2 of 7 residents reviewed. (Resident #9 & #10) The facility census was 106 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated 7/16/17, documented Resident #9 had diagnoses that included Non-Alzheimer's dementia, anxiety and depression and required extensive assistance with activities of daily living.<br><br>The care plan with an effective date of 6/28/17, identified a focus area of resident was currently prescribed medication with high risk side effects related to major depression and anxiety. Interventions include:<br><br>*Gradual dose reduction will be addressed as recommended by pharmacy.<br>*Monitor response to medication and report non-therapeutic response to prescribing physician as necessary.<br>*Prompt to attend and or engage in 1:1 activities that do not put resident at risk for falls.<br>*Provide quiet, calm environment if resident is agitated.<br><br>A Physician Orders dated 7/19/17, documented an order for Lorazepam (anti-anxiety medication) tablet 1 milligrams (mg), give 1 tablet by mouth as | F 329 | Prior to administration of prn psychotropic medications, the charge nurse will have the documentation reviewed by the RN Supervisory staff on duty or another LPN prior to administration. PRN psychotropic medication documentation will be monitored weekly by the Director of Clinical Services and/or her designee with individual education provided if necessary. This deficient practice will be monitored by the facility Quality Assurance Committee for a period of 6 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165307 | A. BUILDING _____ B. WING _____ | 07/27/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRY VIEW | 1410 WEST DUNKERTON ROAD WATERLOO, IA 50703 |

| (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 329 | Continued From page 11<br>needed for anxiety every 4 hours as needed for agitation.<br><br>The Medication Administration Record dated 7/1/17-7/31/17 documented staff administered the Lorazepam on 7/18/17 at 11:00 p.m.<br><br>The Medication Administration Record dated 5/1/17-5/31/17 documented staff administered the Lorazepam on 5/19/17 at 10:30 p.m.<br><br>The Medication Administration Record dated 4/1/17-4/30/17, documented staff administered the Lorazepam on 4/3/17 at midnight, 4/5/17 at 1:30 a.m., 4/12/17 at 10:30 p.m., 4/18/17 at 10:30 p.m., 4/19/17 at 10:15 p.m., 4/27/17 at 11:00 p.m. and on 4/29/17 at 2:40 a.m.<br><br>Nurse notes lacked documentation staff attempted non-pharmacological interventions to decrease the resident's anxiety, agitation or restlessness prior to administering the lorazepam.<br><br>During interview on 7/26/17 at 1:00 p.m., Staff C, Registered Nurse confirmed the progress notes lacked documentation on any non-pharmacological interventions attempted and stated the expectation of the nursing staff was to document non-homological interventions prior to administering the lorazepam.<br><br>2. The MDS assessment dated 7/6/17, documented Resident #10 had diagnoses that included Parkinson's disease, anxiety and Bipolar disorder and received an anti-anxiety medications in the last 7 days.<br><br>The care plan with an effective dated 4/12/17, | F 329 | | |

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| | 165307 | A. BUILDING _____ B. WING _____ | 07/27/2017 |

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| COUNTRY VIEW | 1410 WEST DUNKERTON ROAD WATERLOO, IA 50703 |

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|---|---|---|---|---|
| F 329 | Continued From page 12<br>identified that resident with cognitive loss, alteration in thought process related to diagnosis of Anxiety disorder, schizo-affective disorder, bipolar disorder, narcissistic personality disorder. Intervention include:<br><br>a. Task segmentation as needed. Use elevated voice tone related to hearing impairment.<br>b. Explain procedures and care before performing.<br>c. Provide simple, structured activities that help residents orientation, self directed activities, social involvement, for example, Provide enough time to communicate obtain feedback to ensure resident understanding. Use short phrases and questions which requires yes or no answers.<br>d. Face resident and make eye contact when speaking.<br>e. Reality orientation and validation as needed.<br>f. Provide cues, prompting and demonstration as needed.<br>g. Provide quiet, calm environment if resident is agitated.<br><br>A Physician Order dated 7/9/17, documented an order for Lorazepam (anti-anxiety medication) tablet 0.5 milligrams (mg), give 1 tablet by mouth or sublingual every hour as needed.<br><br>The Medication Administration Record dated 7/1/17-7/31/17 documented staff administered the Lorazepam on 7/9/17 & 7/15/17.<br><br>The Medication Administration Record dated 6/1/17-6/30/17, documented staff administered the Lorazepam on 6/17/17 at 11:20 a.m. and 6/17/17 at 6:30 p.m. | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 329 | Continued From page 13<br><br>The Medication Administration Record dated 4/1/17-4/30/17, documented staff administered the Lorazepam on 4/23/17.<br><br>Nurse notes lacked any non-pharmacological interventions to decrease the resident's anxiety, agitation or restlessness prior to administering the lorazepam. | F 329 | | |