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
	165578	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER ESTATES OF MUSCATINE	3440 MULBERRY AVENUE MUSCATINE, IA 52761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 9-10-17 The following deficiencies relate to the investigation of complaints 68440-C, 68800-C and 69616-C conducted 7/27/17 - 8/3/17. Complaints 69616-C, 68800-C 68440-C were substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow physician's orders for 1 of 3 sampled (Resident #5). The facility reported a census of 69 residents. Findings include: According to the Admission Record dated 8/1/17 Resident #5 had diagnoses of heart failure and anxiety. The Minimum Data Set (MDS) assessment dated 7/13/17 revealed Resident #5 experienced no cognitive impairments. The MDS revealed	F 281		

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

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 281	Continued From page 1	F 281		

Resident #5 required limited assistance of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene.

The Plan of Care dated _____revealed Resident #5 had the potential for compromised skin integrity. The Plan of Care directed the staff to monitor/document location, size, and treatment of the skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to primary care physician. Nurse Aide to report any areas of concern to Licensed Nurse.

The Progress Notes dated 7/19/17 at 6:26 p.m. revealed Resident #5 returned from the hospital at 1:30 p.m. Staff completed dressing changes twice to the right lower extremity.

The facsimile dated 7/24/17 revealed a communication to physician. The staff informed the physician Resident #5 readmitted on 7/19/17 with no treatment orders to the open blister on right shin. The physician ordered triple antibiotic ointment to the blister daily and cover with a band aid until healed.

The July 2017 Treatment Administration Record (TAR) revealed the order dated 7/24/17 that directed staff to apply triple antibiotic ointment to the blister on the right lower extremity and change daily. The record revealed omissions (no initials to indicate the staff completed the treatment) 7/28, 7/29, 7/30 and 7/31.

During an interview on 8/1/17 at 12:06 p.m., Resident #5 reported he/she changed the dressing to the right lower extremity because the staff didn't do it. Resident #5 removed the telfa

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F 281	Continued From page 2 covering the area which revealed the blister had healed. In an interview on 8/3/17 at 3:37 p.m., the Director of Nurses (DON) reported the facility's expectation that staff should contact the physician for a treatment if the admitting orders do not contain one. The DON reported the staff failed to document the treatment was completed for Resident #5 on 7/28, 7/29, 7/30 and 7/31, because if the staff didn't document it, it wasn't done. The Nursing Admission Checklist and Validation sheet received 8/3/17 directed the staff to receive the orders and enter in Point Click Care. The sheet directed the staff to ensure diet orders, thickened liquids, supplements, routine lab orders, allergies, diagnosis, standard orders, therapy orders, blood sugars including parameters, treatment orders, wound care and ancillary orders as appropriate are obtained and unclear orders are clarified right away.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that	F 309		

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F 309	Continued From page 3 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to manage bowel movements and offer interventions according to facility bowel intervention policy for 2 of 4 sampled (Resident #1 and #3). The facility reported a census of 69 residents. Findings include: 1. According to the Admission Record dated 7/28/17 Resident #1 had diagnoses of traumatic subdural hemorrhage, hemiplegia, aphasia and dysarthria. The Minimum Data Set (MDS) assessment dated	F 309		

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F 309	Continued From page 4 7/3/17 revealed Resident #1 required extensive assist of two staff with bed mobility, transfers and toilet use, was frequently incontinent of bladder but always continent of bowel. The Plan of Care initiated 5/10/17 directed the staff to assist Resident #1 to the restroom every morning, afternoon, at bedtime and as needed. The care plan also revealed the resident wore a brief and directed staff to complete perineal cares with incontinent episodes. Review of the bowel records from 7/1/17 to 7/31/17 revealed Resident #1 had no documented bowel movement from 7/16 to 7/20 and from 7/24 to 7/28. The July 2017 Medication Administration Record revealed Resident #1 received Senna-Gen 8.6 milligrams (mg) by mouth every day. Resident #1 refused the medication 50% of the time. Resident #1 received Docusate Sodium liquid 10 milliliters two times a day. Resident #1 refused the medication over 50% of the time. An interview on 8/2/17 at 12:43 p.m. with the Director of Nurses (DON) revealed staff failed to document they offered any bowel protocol interventions when Resident #1 had not had a bowel movement over 3 days in July. The DON reported she planned to update the bowel protocol policy and educate the nurse aides on proper documenting and the nurses on implementing interventions and proper documentation. 2. According to the Admission Record dated 7/28/17, Resident #3 had diagnoses of cerebral infarct, hemiplegia, anxiety, and heart disease.	F 309		

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F 309	Continued From page 5 The MDS assessment dated 6/16/17 revealed Resident #3 had no cognitive impairments and required extensive assistance of one staff with bed mobility and toilet use. The MDS documented Resident #3 had bowel and bladder continence. The Plan of Care dated initiated 6/1/17 directed the staff to provide assistance of two staff and a gait belt for transfers, place call light in reach to alert staff of needs/wants. The care plan revealed the resident was occasionally incontinent, used incontinent products and directed to assist with changing as needed. Review of the June 2017 Bowel Movement Report revealed Resident #3 had no documented bowel movement from 6/3 to 6/9 and from 6/22 to 6/29. Review of the July 2017 Bowel Movement Report revealed Resident #3 had no documented bowel movement from 7/4 to 7/18 and from 7/19 to 7/26. The Medication Administration Record for June and July 2017 revealed Resident #3 received Senna S 8.6-50 milligrams by mouth every day. Resident #3 had as needed orders for Lactulose (liquid) and Bisacodyl (suppository) for constipation. According to the record Resident #3 had no as needed medication documented as given in June or July. During an interview on 8/1/17 at 3:00 p.m., Resident #3 reported he/she had a bowel movement 4 to 5 days ago. Resident #3 reported the staff do not offer a laxative and then	F 309		

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F 309	Continued From page 6 reported he/she has refused. Resident #3 reported he has a bowel movement every 5 days. Resident #3 denied difficulty passing the stool. An interview on 8/1/17 at 2:18 p.m. the DON reported Resident #3 has a bowel movement every 3 to 5 days. Resident #3 asks for a suppository when he/she needs it. The staff offer laxatives and Resident #3 refuses them. The DON reported the staff documented on refusal on 7/12/17. The DON reported the staff do not follow the bowel protocol and planned to educate the staff. The Bowel Intervention Policy received on 8/1/17 directed the staff to initiate the bowel protocol after three days without a bowel movement. The protocol directed to start with the most non-invasive intervention ordered first. This may include Milk of Magnesia, Bisacodyl tablets or prune juice. The second shift nurse will place the residents on the bowel intervention log, leave it posted in the charting room, and begin the first intervention. Residents who do not have a result from the first intervention will receive a suppository from third shift nurse at 6:00 a.m. Then, starting on day four residents must be tracked on the bowel intervention log as well. If the resident does not have results from the suppository intervention, the physician must be called for further instructions. If the resident does not have a current order for an as needed medication for bowel intervention, one must be written from the standing orders.	F 309		
F 353 SS=G	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services	F 353		

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F 353	Continued From page 7 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and	F 353		

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F 353	Continued From page 8 described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to have adequate staff in order to promptly respond to activated resident call lights which resulted in Residents #1, #3 experienced bladder incontinence and Resident #5 had ongoing chest pain. Resident #1 felt disgusted and embarassed due to the incontinent episode and Resident #5 felt scared becasue staff did not respond to the call light when he/she had chest pain. The sample consisted of 5 residents and the facility reported a census of 69 residents. Findings include: 1. Resident #1 had a Minimum Data Set (MDS) assessment with a reference date of 7/3/17. The MDS indicated Resident #1 had diagnoses of traumatic subdural (bleeding on the brain) hemorrhage, stroke, depression, anxiety and hemiplegia (paralysis of arm and leg) The Roster Sample Matrix document, provided by the facility on 7/28/17, identified Resident #1 as able to be interviewed. The MDS indicated Resident #1 required extensive assistance of two staff for bed mobility, transfers and toilet use. Resident #1 had frequent bladder incontinence. The current Care Plan initiated a problem with the resident at risk for falls due to gait and balance problems. The approaches directed the staff to	F 353		

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F 353	Continued From page 9 be sure the resident's call light is within reach and encourage the resident to use the call light for assistance as needed. The approach directed the staff that the resident needed prompt response to all requests for assistance. Observation of Resident #1's room identified a Therapy Communication -Teaching - Training sheet, attached to the wall. The sheet dated 7/6/17 directed the staff to transfer/ambulate Resident #1 with assistance of one staff and a platform rolling walker. On 8/1/17 at 3:45 p.m. Resident #1 was interviewed and reported 2 weeks ago he/she asked the staff for assistance to go to the restroom. Resident #1 stated a staff person told him/her they would be back and then didn't return for almost an hour. Resident #1 stated she/he had an accident (urinated) in his/her pants. Resident #1 reported he/she felt a feeling of disgust and embarrassment and had to walk down the hallway with wet pants. Resident #1 stated she/he is in the common area most of the day and even sleeps in the common area. On 8/3/17 at 10:40 a.m. Staff B reported Resident #1 tells the staff when he/she needs to use the restroom. Staff B reported the residents may have to wait over 15 minutes for assistance if one of the staff is on break. 2. Resident #3 had a MDS assessment with a reference date of 6/16/17. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 13. A score of 13 represented no cognitive problems. The MDS identified the resident had diagnoses of diabetes, aphasia (inability to speak), hemiplegia (paralysis	F 353		

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F 353	Continued From page 10 of arm and leg) and anxiety. The MDS indicated the resident had no urinary or bowel incontinence problems. The Care Plan directed the staff to provide assistance of two staff for transfers with a gait belt, place call light in reach and encourage use. On 8/1/17 at 3:00 p.m. Resident #3 was interviewed and reported he/she turned the call light on and waited up to 30 minutes every day for the last two weeks. Resident #3 stated he/she knows when needs to go [to the bathroom] and can make it there if the staff respond timely. Resident #3 stated he/she times the response on his/her wristwatch. An interview on 8/3/17 at 10:35 a.m. Staff A reported residents had accidents waiting for the staff to use the restroom. The residents reported to Staff A that they waited 20 minutes for the staff to respond to the call lights. (A reasonable person would not like to urinate in their personal clothing). 3. According to the Admission Record dated 8/1/17, Resident #5 had diagnoses of heart failure, anxiety and oxygen dependence. The MDS with a reference d ate of 7/13/17 indicated Resident #3 dated 7/13/17 identified Resident #5 required limited assistance of 1 staff person for transfers and toilet use. The MDS identified the resident had no cognitive problems and had a BIMS score of 15. The Care Plan directed the staff to keep the call light in reach, encourage to use it for assistance as needed and provide a prompt response to all	F 353		

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F 353	Continued From page 11 requests for assistance. The Progress Notes dated 7/23/17 at 10:04 p.m. indicated Resident #5 called 911 [emergency number] because of chest pain. The note indicated when medics arrived; Resident #5 stated the chest pain had gone away. On 8/1/17 at 12:06 p.m. Resident #5 was interviewed and stated he/she had chest pain and put the call light on [activated]. Resident #5 stated when the staff didn't respond after 30 minutes, he/she called 911. Resident #5 described the experience as scary. On 8/2/17 at 3:46 p.m. Staff D (licensed practical nurse) was interviewed and stated Staff E (Nurse) informed him/her someone called and reported Resident #5 called 911 and an ambulance was dispatched. Staff D went to Resident #5's room. Staff D did not recall if the call light was activated. Resident #5 reported the chest pain subsided. Staff D reported she was in Resident #5's room 15 minutes prior to this and administered medications to Resident #5. According to the Medication Administration Audit dated 7/23/17, staff signed out Resident #5's medications from 4:52 p.m. to 5:01 p.m. A phone interview on 5/2/17 at 4:10 p.m. identified the emergency services received Resident #5's call at 5:34 p.m. On 8/3/17 at 10:55 a.m. Staff C (certified nursing assistant) was interviewed and stated she reported the residents have complained about the staff's response to the call lights. Staff C stated she reported the residents had accidents in their	F 353		

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F 353	Continued From page 12 pants while waiting for the staff to respond. Staff C stated the longest wait is when one of the staff is on break. Staff C stated the staffing is based on the census. Staff C reported the 500/600 Hall had 3 nurse aides instead of 4 for about a month because of the census. Staff C stated it is hard to answer the lights within 15 minutes. Staff C reported the staff is spread too thin. The CNA Orientation checklist, received on 8/3/17, identified a goal to respond to call lights in 10 minutes. The checklist directed the staff to never shut the call light off unless able to meet the resident's needs at that time. If the resident is the assistance of two staff, leave the light on and go ask for help.	F 353		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law.

F 281

Date of compliance 9-10-2017

It is the practice of Premier Estates of Muscatine to ensure physician orders are followed.

#1- For resident #5 staff were educated on the importance of following physician orders for treatment 08/10/2017

#2- For all similar residents, an audit was conducted by the Director of Nursing to ensure physician orders were being followed and documented appropriately. Staff were educated on the importance of following physician orders for treatment on 09/10/2017.

#3- The Director of Nursing or designee will audit physician order compliance a minimum of 3 times weekly for the next 2 months and randomly thereafter. Any issues identified will be addressed.

#4- The Director of Nursing or designee will monitor progress toward this plan of correction and report to the QAPI committee for a minimum of 2 months to ensure ongoing compliance.

F309

Date of compliance 9-10-2017

It is the practice of Premier Estates of Muscatine to ensure residents receive necessary care and services to attain or maintain quality of life.

#1- For residents #1 and #3 an audit was conducted on 8/8/2017 to ensure if their bowel records showed irregularities, that interventions were in place or offered. Education was provided to staff regarding monitoring and intervention for bowel management on 08/10/2017.

#2- For all similar residents, an audit was conducted on 8/8/2017 to ensure appropriate interventions were in place. Education was provided to staff regarding monitoring and intervention for bowel management on 08/10/2017.

#3- The Director of Nursing or designee will audit bowel records and interventions a minimum of 3 times weekly for the next 2 months and randomly thereafter. Any concerns identified will be addressed.

#4- The Director of Nursing or designee will monitor progress toward this plan of correction and report to the QAPI committee for a minimum of 3 months to ensure ongoing compliance

F 353

Date of compliance 8-31-2017

It is the practice of Premier Estates of Muscatine to ensure sufficient 24-hour nursing staff.

#1- For the residents identified in the statement of deficiencies, education was provided to staff regarding timely call light response on 08/10/2017.

#2- For similar residents, education was provided to staff regarding timely call light response on 08/10/2017.

#3- The Administrator or designee will perform a minimum of 5 call light audits per week. Resident interviews will be conducted a minimum of 5 times per week to evaluate satisfaction with call-light response times. Any concerns identified will be addressed.

#4- The Administrator or designee will monitor progress toward this plan of correction and report to the QAPI committee for a minimum of 3 months to ensure ongoing compliance.