Citation Number	er:			Date: August	: 31, 2017	
Facility Name:			Survey [Survey Dates:		
Touchstone Healthcare Community			July 31,	2017, August 1-	15, 2017.	
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56.12	481—56.12(135C) Class I violation as a result of multiple lesser violations. The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.	Ι	\$5000.00 Held in Suspension	Upon Receipt
58.24(1) and	481—58.24(135C) Dietary. 58.24(1) Organization of dietetic services. The facility shall meet the needs of the residents and provide the services listed in this standard. If a service is contracted out, the contractor shall meet the same standard. A written agreement shall be formulated between the facility and the contractor and shall convey to the department the right to inspect the food service facilities of the contractor. (III)			
58.24 (1)a	<i>a.</i> There shall be written policies and procedures for dietetic services that include staffing, nutrition, menu planning, therapeutic diets, preparation, food service, ordering, receiving, storage, sanitation, and staff hygiene. The policies and procedures shall be made available for use by dietetic services. (III)			
58.24(3)a	481—58.24(135C) Dietary.			

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 as planned. Onsite observation revealed no bread or snacks available for residents. Several staff reported the facility was running out of food the last few weeks; and similarly residents and family members reported the facility was running out of food. Onsite observation showed the Director of Housekeeping (with no dietary training) preparing meal service. Staff interviews revealed the facility failed to order and receive food and according to the planned dietary menu; the facility failed to procure menu items in advance and failed to have a dietitian approve substitutions for the planned menu. The facility identified a census of 90 residents. Findings include: 1. During the group interview on 8/2/17 at 1:15 p.m., 7 out of the 7 residents in attendance complained this month the facility had cook and management troubles. The group reported times in the month they did not have food because the food not ordered. The group explained on Saturday 7/29/17 the facility had Pizza Ranch deliver pizza and chicken since the facility did not have the food for lunch. 2. During an observation of meal service on 8/1/17 at 		
12:40 p.m., the facility ran out of carrots during the meal service with 20 residents still left to have lunch served.		Page 3 of

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3. During an observation on 8/1/17 at 1:10 p.m. the Dietician checked the freezer to see if the facility had the food for the next day's meal. The facility did not have the meat balls listed on the menu for 8/2/17.		
4. The Resident Council minutes from 2/17/17 documented under the Dietary section: the food did not taste good; suggested a cook/dietitian make the menu on the corporate level; and wanted the facility to get away from canned fruit as the desert.		
The Resident Council minutes from July 2017 documented under the Minutes section: residents discussed with the Administrator issues in the kitchen without a kitchen manager such as the food not being as good; use of pre-packaged food; and the Administrator explained she would be helping with food ordering and making sure things ran smoothly in the kitchen. Under the Dietary section the minutes documented: dietary stinks; the food lousy, not taste good; food is cold; portions getting smaller, especially on room trays; and [residents] not always being served when requests room trays.		
 5. The consultant Registered Dietician (RD) review for 5/2/17 included the following documentation: Meal Observation: Point 2. Menu not posted on white board in the dining room. Point 3. Please do not order the fish served today. 		
 ······································		Page 4 of

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The fish needed to be fried to look appealing; it did not look appealing and it did not taste very good. Point 4. Chicken fried steak overcooked and very tuff. Point 6. Use correct scoop sizes - reviewed with the cook proper scoop sizes and how to check the menu to ensure proper scoop sizes are used. The RD review for 5/11/17 documented please check into when going to get the spring/summer menus as they need to be started ASAP (as soon as possible). The RD review for 6/22/17 included the following documentation: a. Use correct scoop sizes at meals. Steam cart did not use correct scoop sizes for the mashed potatoes. They used a #12 scoop (1/3 cup) instead of a #8 (1/2 cup) b. Make sure all diet orders match diet cards. There are a few residents with diabetic and low fat/low cholesterol diet orders that need to followed; the MD (doctor) did not want them on a general diet. c. Small portion diet orders needed to be followed. d. A resident complained of waiting too long in the		
(doctor) did not want them on a general diet. c. Small portion diet orders needed to be followed.		
The RD review for 7/25/17 included the following documentation: a. The eggs at breakfast looked horrible, they were		Page 5 o

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	 gray. Staff needed to cook scrambled eggs on the stove top and stop using the steamer to cook eggs. b. No dessert served at lunch. The RD asked the dietary aid to get the residents a brownie left from the cook out and pudding for pureed diets. c. The RD asked the staff what week of the menu cycle they were "ON" and the cook could not even tell her. The RD asked the cook how he knew what to cook and she [RD] got just excuses that they didn't have everything on hand to follow the menus. d. Follow the menu as written!! 		
	6. In an interview on 7/31/17 at 6:00 p.m., Staff I, Dietary Aide, stated the facility ran out of food for the last 2 weeks. Staff I commented they did not have dry foods. Staff I showed the dry storage racks barren and the snack rack empty. Staff I stated waiting on the truck for deliveries and she did not think there was a set delivery date. Staff I said the truck comes whenever the main person orders. Staff I showed the freezer and stated the freezer should be filled up but appeared empty.		
	Observation on 7/31/17 at 6:01 p.m. revealed the food contents of the kitchen inventoried by 2 surveyors in the dry storage, walk-in cooler, and walk-in freezer, with no bread or snacks found on the shelves.		
	In an interview on 7/31/17 at 6:40 p.m., Staff L, Cook, stated he worked for the facility previously for 2 years, took about a month off, and that day he's second day		Page 6 of

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back. Staff L reported he did not have enough of the correct food for the meal the day before; and he ran out of the food he made. Staff L stated he was not able to serve the menu items, they ran out of bread, and toast to be served everyday. Staff L reported staff went to the store the day before to buy bread. Staff L stated he heard Saturday 7/29/17 staff ordered pizza because there was no Cook on Saturday and he had no idea how they got things served.		
In an interview on 7/31/17 at 6:50 p.m., Staff MM, Dietary Aide, stated she had worked for the facility for 5 months. Staff MM said they had been running out of food like bread, snacks, and juices. Staff MM reported the Administrator had told them not to order snacks anymore but she did not know the reason why. Staff MM stated the residents were not happy for about 2 to 3 weeks; since Staff Aa, previous Dietary Manager, left. Staff MM reported Staff PP, Dietary Cook, did not show 7/31/17 so they called in Staff L. Staff MM stated substitutes not getting made for lunch or suppers. Staff MM reported tater tots not available for that night's meal so they substituted Spanish rice. Observation revealed the meal board in the dining room listed dinner as tilapia, yellow squash, Spanish rice, strawberry cake, and substitute chicken salad croissant.		
The facility's Spring/Summer Week 2 Day 2 menu, signed by the Consultant Dietitian on 7/11/17, identified the following items to be served for dinner on		

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Facility Administrator

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Monday 7/31/17:		
a. cornflake fish		
b. tater tots		
c. yellow squash with red peppers		
d. dinner roll or bread, margarine		
e. fresh fruit		
f. milk		
g. alternative - egg salad on a croissant		
h. alternative - marinated cucumber & onion salad		
In an interview on 7/31/17 at 7:05 p.m., the		
Administrator reported Staff PP called in on Saturday		
7/29/17, but Staff NN, Dietary Aide (although the		
Administrator referred to as a cook), did not get the		
message in the kitchen. The Administrator stated Staff		
JJ, Receptionist/Administrative Assistant, came in later		
in the morning at approximately 8:00 a.m., and Staff		
OO, Dietary Cook, came in at 11:00 a.m. The		
Administrator stated 4 dietary aides also in the kitchen		
on 7/29/17. The Administrator said breakfast went		
okay but the menu items for lunch were not prepped.		
The Administrator reported they made mash potatoes		
and gravy for the puree at lunch and the staff ordered		
pizza for the other residents. The Administrator		
reported the facility had no dietary manager employed		
at the time. The Administrator stated the facility		
ordered food 2 times per week; order Mondays for		
delivery Tuesdays and order Thursday for delivery		
Fridays from US Foods. The Administrator stated		
bread and milk separately ordered and not certain on		
the vendors or when the bread and milk delivered.		

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The Administrator commented she thought the vendor		
for bread might be Earthgrains. The Administrator		
stated 2 cooks, Staff OO and Staff PP, came in to		
assist her with ordering the food items.		
The facility's Spring/Summer Week 1 menu identified		
the following items to be served for lunch on Saturday		
7/29/17:		
a. herbed turkey		
b. poultry gravy		
c. sage bread dressing		
d. squash medley		
e. dinner roll or bread, margarine		
f. chocolate brownie		
g. milk/beverage of choice		
h. alternative - tilapia with lemon butter		
i. alternative - wild blend rice		
j. alternative - creamy coleslaw		
In an interview on 8/1/17 at 6:45 a.m., Staff N, Dietary		
Aide, stated she worked for the facility for 3 weeks.		
Staff N reported they had bread and eggs the past		
couple of days only but not able to serve other stuff.		
Staff N stated she thought food deliveries came on		
Tuesdays and Fridays but no groceries had arrived yet		
that day (which was a Tuesday). Staff N stated she		1
did not think the groceries would come.		
Observation on 8/1/17 at 6:47 a.m. revealed Staff QQ,		
Director of Housekeeping, worked in the kitchen		
cooking bacon and sausage. Staff QQ stated the cook		
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did not answer her phone and did not come. Staff QQ stated she was not cross trained in dietary department. Staff QQ reported she started breakfast and bread available because management bought it last night. Staff QQ stated the kitchen had issues since December 2016. At 6:50 a.m., Staff M, Dietary Aide, arrived. Staff QQ left the kitchen stating left because surveyor on site and Staff JJ, Receptionist/Administrative Assistant was coming.		
Staff M responded Staff JJ can't cook. Staff RR, Dietary Cook, arrived at 7:15 a.m. Staff RR stated the facility fired the previous Dietary Manager (Staff Aa) about a month ago and they had no food the last 3 weeks. Staff RR reported no manager came to the kitchen and that included the Administrator. Staff RR		
stated the last Saturday (7/29/17) she had been the one there. Staff RR stated the facility ordered pizza. Staff RR said she prepared cheese pizza, mashed potatoes, and vegetables for residents on puree diets. In an interview on 8/1/17 at 7:20 a.m., Staff JJ stated		
she was trained in dietary and worked in dietary a couple times a month. Staff JJ entered the dry storage to put on a hairnet. Staff JJ stated the empty shelves should contain snacks and pop. Staff JJ said she thought food delivered Tuesdays around 9:00 a.m. and Friday around 1:00 p.m. Staff JJ commented she did not think the food getting ordered and she made a		
huge list which she gave to the dietician. At the time of the interview, the bread rack contained 6 loaves of white bread and 5 loaves of wheat bread [with a		Page 10 of

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census of 90 residents].	
In an interview on 8/1/17 at 7:25 a.m., the	
Administrator stated Staff Aa on a 60 day PIP	
(Performance Improvement Plan) for recurring issues.	
The Administrator reported she fired Staff Aa on 7/8/17	
and actively sought a manager. The Administrator	
stated she changed the position to a senior, salaried	
position and had awarded Staff PP a step up with	
responsibility for ordering. The Administrator clarified	
Staff PP not the manager as she did not know much	
about dietary. The Administrator stated she did the	
ordering with Staff PP but there were times not enough	
food ordered. The Administrator reported the previous	
night she bought bread and sausage because Staff L	
did not think they had enough sausage. The	
Administrator stated Staff PP did not come today to do	
the order. The Administrator stated the kitchen	
needed solid leadership. The Administrator stated she	
planned on Staff JJ for breakfast today. The	
Administrator stated normally, the facility did not get a	
delivery on Tuesday so food would come on	
Wednesday. The Administrator reported the consultant	
RD would be coming to see what food the facility had	
on hand and what to make. The Administrator stated	
the kitchen staff made a lot of drama in the kitchen that	
past 2 weeks. The Administrator commented the issue	
on 7/29/17 that staff did not take items out of the	
freezer versus not having items. The Administrator	
stated Staff JJ trained for the pureed process so she	
pureed pizza that day. The Administrator reported the	
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weekend circumstances beyond her control. The		
Administrator reported she had received grievances		
from care conferences about food quality, pre-made		
foods like meatloaf, and not attempting to follow the		
menus. The Administrator stated she reviewed in QA		
(Quality Assurance meeting) monthly. The		
Administrator commented she wanted to clarify Staff		
Aa's PIP about sanitation, food quality, attendance,		
ordering issues, but not for lack of food. The		
Administrator stated she had gone into the kitchen.		
The Administrator stated she initiated a pre-production		
meeting with Staff JJ to ensure each day food there.		
The Administrator said yesterday a late morning so		
she started the meetings after breakfast on 7/31/17 to		
ensure the lunch and dinner items available for that		
day. The Administrator reported she had access to a		
sister facility but she did not know if they had the same		
order schedule. The Administrator stated she may be		
able to get food delivered from the sister facility.		
In an interview on 8/1/17 at 8:30 a.m., the consultant		
RD stated sometimes the facility had food but not have		
the food on the menu.		
In an interview on 8/1/17 at 9:07 a.m., Staff D, Certified		
Nurse Aide (CNA), stated lately the residents		
complained of running out of food and snacks.		
In an interview on 8/1/17 at 9:10 a.m., Staff K, CNA,		
stated she heard residents complained of no bread or		
eggs; Staff K said it had been like that for a week.		

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In an interview on 8/1/17 at 10:20 a.m., Staff OO	
stated he was starting to cook lunch at that time. Staff OO said he should unthaw the beef patties but due to time constraints, he would cook from frozen.	
The facility's Spring/Summer Week 2 Day 3 menu identified the following items to be served for lunch on Tuesday 8/1/17:	
a. beef pepper steak with gravyb. ricec. parslied carrots	
d. dinner roll or bread, margarinee. banana puddingf. milk/beverage of choice	
 g. alternative - baked thyme chicken h. alternative - roasted red skin potatoes i. alternative - greens 	
The facility's Spring/Summer Week 2 Day 3 menu identified the following items to be served for dinner on Tuesday 8/1/17:	
a. BBQ pork rib patty on a bunb. crinkle cut fries	
c. red supreme cabbaged. chilled peaches	
e. milk/beverage of choicef. alternative - hamburger on a bun	
g. alternative - battered corn nuggetsh. alternative - lettuce tomato onion & pickle	

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facility would go buy hamburger buns for the fish	
sandwich. The RD reported they also did not have all	
the food items needed for Wednesday, 8/2/17. The	
RD stated they were missing the Swedish meatballs	
and 1 bag of soup. The RD stated she would take a	
look at what had been ordered to come on 8/2/17,	
compare it to the menu, and go from there.	
bompare it to the mend, and go nom there.	
The delivery invoice dated 8/1/17, for the order date of	
7/31/17, failed to contain orders/deliveries for bread,	
peaches, BBQ pork rib patty, red cabbage, hamburger	
buns, asparagus cuts, Swedish meatballs, Italian soup,	
or mandarin oranges. The delivery invoice	
documented receipt of 13 foods on 8/1/17: a. banana pudding mix	
b. snack chips	
c. mild cheddar cheese	
d. ground beef	
e. coleslaw mix	
f. beef chuck ground	
g. red potatoes	
h. eggs	
i. frozen beef patty	
j. chicken breast	
k. sausage, pork links	
I. loin pork chops	
m. potato, french fries	
Observation on 8/1/17 at 5:40 p.m. revealed Staff OO	
finishing cooking hamburgers for the supper meal;	
some of the hamburger fresh and some made from	
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frozen beef patty, (the same patty served at lunch). At	
6:00 p.m. the steam cart held a small pan of fish, corn	
nuggets, green bean mix, fries, and spinach. The	
main kitchen cart did not contain fish or broccoli as	
substituted by the RD but rather all hamburger patties	
and spinach. At 6:10 p.m. meal service started and	
Staff OO stated he cooked spinach instead of broccoli	
because quicker to cook and he had short notice.	
The facility's Spring/Summer Week 2 Day 4 menu	
identified the following items to be served for lunch on	
Wednesday 8/2/17:	
a. crispy baked chicken	
b. baked sweet potato	
c. asparagus cuts	
d. dinner roll or bread, margarine	
e. pineapple upside down cake	
f. milk/beverage of choice	
g. alternative - Swedish meatballs	
h. alternative - noodles	
i. alternative - roasted zucchini	
The facility's Spring/Summer Week 2 Day 4 many	
The facility's Spring/Summer Week 2 Day 4 menu	
identified the following items to be served for dinner on	
Wednesday 8/2/17:	
a. Italian wedding soup	
b. saltine crackers	
c. ham salad sandwich	
d. broccoli salad	
e. mandarin orange gelatin	
f. milk/beverage of choice	
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g. alternative - egg and hashbrown casserole		
h. alternative - sausage links		
i. alternative - tomato wedges		
j. alternative - muffin/margarine		
Observation on 8/2/17 at 8:37 a.m. revealed the dry		
storage room contained items obtained from a delivery		
or the store:		
a. 1 box of Cheetos with 90 - 1 oz bags of Cheetos		
b. 14 cans of 15 oz mandarin oranges - Hy-Vee brand		
c. 2 - 6 lb 5 oz cans of asparagus cuts (previously		
inventoried on 7/31/17)		
In an interview on 8/2/17 at 9:00 a.m. Staff L reported		
he needed 3 to 4 cans of asparagus cuts for lunch.		
Staff L stated Staff UU, Dietary Manager (from a sister		
facility), brought a 3rd can that day. The RD stated		
she had been unaware the Cheetos and banana		
pudding delivered on 8/1/17. The RD reported the		
main delivery truck should arrive sometime between		
9:00 a.m. and 11:00 a.m. that day.		
In an interview on 8/2/17 at 10:00 a.m. the		
Administrator reported Monday's order for Tuesday		
delivery not entered in time. The Administrator stated		
she did a late bulk order and told US Foods told her it		
did not come; but they did send 10 warehouse items		
available on another truck received 8/1/17. The		
Administrator again stated the facilities normal delivery		
days Tuesdays and Fridays. The Administrator stated		
she would have Staff UU's help that week and the		
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next. The Administrator commented she had been afraid they did not have enough meatballs for that day's lunch so she went to the store the day before to				
day's lunch so she went to the store the day before to				
day s functi so she went to the store the day before to				
purchase foods after the RD left for the day. The				
Administrator stated she would need to clarify which				
day the next truck would come for delivery as they				
were ordering food at that time. The Administrator				
unclear if truck would come Thursday or Friday and				
acknowledged not aware about only having 3 cans of				
asparagus cuts available for that day's lunch or the				
Administrator stated she would have to check if the				
asparagus ordered Monday and coming on the truck				
substitutions.				
Observation on 8/2/17 at 12:18 p.m. revealed the first				
commented the steam cart should leave the kitchen at				
12:15 p.m. but they had to wait on meatballs. Staff L				
stated the residents used to fill out menus but don't				
now and he believed it lead to a lot more food waste				
because staff did not know how much to prepare. At				
	Administrator stated she would need to clarify which day the next truck would come for delivery as they were ordering food at that time. The Administrator unclear if truck would come Thursday or Friday and unclear when the next deadline for ordering food was; either 3:00 p.m. 8/2/17 or 8/3/17. The Administrator acknowledged not aware about only having 3 cans of asparagus cuts available for that day's lunch or the cook saying it took 3 to 4 cans for a meal. The Administrator stated she would have to check if the asparagus ordered Monday and coming on the truck that day; she commented but there's enough viable substitutions. Observation on 8/2/17 at 12:18 p.m. revealed the first plate served in the main dining room. At 12:25 p.m., all menu items available per the menu. The chicken baked but not crusted. At 12:35 p.m. Staff L commented the steam cart should leave the kitchen at 12:15 p.m. but they had to wait on meatballs. Staff L stated the residents used to fill out menus but don't now and he believed it lead to a lot more food waste	Administrator stated she would need to clarify which day the next truck would come for delivery as they were ordering food at that time. The Administrator unclear if truck would come Thursday or Friday and unclear when the next deadline for ordering food was; either 3:00 p.m. 8/2/17 or 8/3/17. The Administrator acknowledged not aware about only having 3 cans of asparagus cuts available for that day's lunch or the cook saying it took 3 to 4 cans for a meal. The Administrator stated she would have to check if the asparagus ordered Monday and coming on the truck that day; she commented but there's enough viable substitutions. Observation on 8/2/17 at 12:18 p.m. revealed the first plate served in the main dining room. At 12:25 p.m., all menu items available per the menu. The chicken baked but not crusted. At 12:35 p.m. Staff L commented the steam cart should leave the kitchen at 12:15 p.m. but they had to wait on meatballs. Staff L stated the residents used to fill out menus but don't now and he believed it lead to a lot more food waste because staff did not know how much to prepare. At 12:50 p.m. staff delivered the first room trays on Northside. At 12:55 p.m. Staff OO informed staff out of milk cartons as waiting on the milk truck but residents	Administrator stated she would need to clarify which day the next truck would come for delivery as they were ordering food at that time. The Administrator unclear if truck would come Thursday or Friday and unclear when the next deadline for ordering food was; either 3:00 p.m. 8/2/17 or 8/3/17. The Administrator acknowledged not aware about only having 3 cans of asparagus cuts available for that day's lunch or the cook saying it took 3 to 4 cans for a meal. The Administrator stated she would have to check if the asparagus ordered Monday and coming on the truck that day; she commented but there's enough viable substitutions. Observation on 8/2/17 at 12:18 p.m. revealed the first plate served in the main dining room. At 12:25 p.m., all menu items available per the menu. The chicken baked but not crusted. At 12:35 p.m. Staff L commented the steam cart should leave the kitchen at 12:15 p.m. but they had to wait on meatballs. Staff L stated the residents used to fill out menus but don't now and he believed it lead to a lot more food waste because staff did not know how much to prepare. At 12:50 p.m. staff delivered the first room trays on Northside. At 12:55 p.m. Staff OO informed staff out of milk cartons as waiting on the milk truck but residents	Administrator stated she would need to clarify which day the next truck would come for delivery as they were ordering food at that time. The Administrator unclear if truck would come Thursday or Friday and unclear when the next deadline for ordering food was; either 3:00 p.m. 8/2/17 or 8/3/17. The Administrator acknowledged not aware about only having 3 cans of asparagus cuts available for that day's lunch or the cook saying it took 3 to 4 cans for a meal. The Administrator stated she would have to check if the asparagus ordered Monday and coming on the truck that day; she commented but there's enough viable substitutions. Observation on 8/2/17 at 12:18 p.m. revealed the first plate served in the main dining room. At 12:25 p.m., all menu items available per the menu. The chicken baked but not crusted. At 12:35 p.m. Staff L commented the steam cart should leave the kitchen at 12:15 p.m. but they had to wait on meatballs. Staff L stated the residents used to fill out menus but don't now and he believed it lead to a lot more food waste because staff did not know how much to prepare. At 12:50 p.m. staff delivered the first room trays on Northside. At 12:55 p.m. Staff OO informed staff out of milk cartons as waiting on the milk truck but residents

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approached Staff OO asking what was available for		
lunch. The resident stated he/she asked Staff L for		
pancakes but Staff L looked around and no pancake		
mix available. At 1:40 p.m. Staff OO stated he finished		
service as the last 3 trays were residents attending		
Resident Council who he would serve them when they		
got done with their meeting.		
got dono mini dice inge		
In an interview on 8/2/17 at 2:30 p.m., the		
Administrator stated no delivery truck would be coming		
that day. The Administrator stated US Foods arranged		
a special truck to come Thursday 8/3/17 which would		
have all items ordered Monday 7/31/17 plus food items		
ordering that day. The Administrator acknowledged		
the facility needed to get the order finished because it		
was due by 3:00 p.m. The Administrator said not		
aware out of pancakes and surveyor informed her		
pancakes on the menu for Friday morning. The		
Administrator confirmed no truck coming Friday 8/4/17		
now so she needed to order food all the way thru		
Tuesday 8/8/17 of the next week.		
In an interview on 8/2/17 at 3:05 p.m., the Director of		
Operations (DOO) reported the facilities contractor for		
housekeeping would be supplying the facility with a		
Certified Dietary Manager (CDM) on 8/7/17. The DOO		
stated the plan going forward would include Staff UU		
continuing to do the facilities ordering. The DOO said		
the facility had his approval to go to the store for any		
items not received on an order. The DOO stated they		
 needed to make sure staff utilized the right portion		Page 19 c

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sizes. The DOO said Staff UU put together inservices for the dietary staff. The DOO reported the facility realized the last Director of Dietary (Staff Aa) worked with HR (human resources) with a PIP but had to let her go. The DOO stated the internal person planned for the position not available so some transitions being worked thru. The DOO said the facility between a rock and hard place. The DOO stated they talked about going thru the menu on a daily basis, line by line, to ensure they had the food items. In an interview on 8/3/17 at 8:30 a.m., the DOO reported bread and milk ordered and received from US Foods. The DOO stated the corporate policy to use US Foods for all food and US Foods procures the food from all the vendors for delivery thru US Foods truck. At 8:45 a.m., the Administrator informed the DOO and surveyor Staff Aa got off track from corporate policy and ordered milk from Dean Foods. The Administrator stated since Staff Aa left on 7/8/17, Staff PP and Staff OO would have ordered the milk. The Administrator said the last milk ordered on 7/27/17 from Dean Foods. When questioned if she personally looked at milk for orders prior to Staff UU assisting, the Administrator responded no, Staff PP and Staff OO would have been responsible to ensure milk ordered. The Administrator, the DOO, and surveyor went to Staff UU in the kitchen to confirm if she ordered milk. Staff UU stated she did not order milk because staff told her a truck comes with it. The Administrator	
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 milk. At that time, Staff Bb, Dietary Manager (from a different sister facility), observed bringing in food for the facility. Observation of the cooler on 8/3/17 at 9:00 a.m. revealed 9 - one gallon 2% milks, no cartons (pints) of milk, no chocolate milk, and no skim milk. In an interview on 8/3/17 at 9:30 a.m., the Administrator verified the US Food truck expected to deliver between 1:00 p.m. to 2:00 p.m. that day. The Administrator confirmed the milk truck from Dean Foods came every Thursday. The Administrator stated she learned the milk guy checks their stock and automatically brings them back up to a certain level each week; 200 - 1/2 pints chocolate milk, 36 gallons 2% milk, and 600 half pints of skim milk. The Administrator stated the milk truck en route making deliveries on the south side of the city and should be at the facility around lunch time. The Administrator confirmed she had not been aware the facility had a recurring order every Thursday. In an interview on 8/10/17, the contracted Dietary Manager confirmed he served all menu items as 	
Manager confirmed he served all menu items as written on the menu from 8/7/17 thru 8/10/17. The Dietary Manager stated the facility had all the food	
items except the ravioli with cheese on the menu for	
8/7/17 dinner. The Dietary Manager reported the facility went to the store on the morning of 8/7/17 to	
purchase the ravioli.	Page 21 of 8 2

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The facility's Spring/Summer Week 3 Day 2 menu identified cheese ravioli casserole to be served for dinner on Monday 8/7/17.		
7. The Minimum Data Set (MDS) assessment dated 6/23/17 for Resident #14 identified a Brief Interview for Mental Status (BIMS) score of 09. A score of 9 indicated moderate cognitive impairment.		
In an interview on 8/8/17 at 8:15 a.m., Resident #14 sat in the dining room almost finished with breakfast. Resident #14 reported the food did not taste good. Resident #14 said the facility had been running out of food and they did not have snacks. Resident #14 stated the previous week awful even waiting for butter. Resident #14 commented the facility serves things for breakfast that were not normal breakfast items like sandwiches.		
8. In a family interview on 8/7/17 at 3:25 p.m., a family member for Resident #3 stated the facility had issues with running out of food. The family member reported the resident ate in his/her room. The family member reported the resident once received a pureed diet tray and he/she had to correct staff to give a regular food tray.		
9. The MDS assessment dated 5/18/17 for Resident #20 identified a BIMS score of 15. A score of 15 indicated intact cognition.		Page 22 of 8 2

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In an interview on 8/14/17 at 2:25 p.m., Resident #2 reported the facility had plenty of food that day and week, but the facility had been running out of food. Resident #20 stated 1 day he/she received lima bea and spinach 2 times. Resident #20 commented he/she could not have pork and the facility did not always have an alternative for him/her.	
10. The facility's Week 3 menu, signed by the Consultant Dietitian on 7/11/17, identified a pureed serving of dinner roll, as part of the planned menu for the pureed texture diet, at the noon meal on 8/8/17.	
Observation on 8/8/17, from 10:10 a.m. to 1:00 p.m. revealed Staff L, Cook, assigned to puree the food items needed for the noon meal. Staff L pureed the meat, potato and vegetable, but did prepare pureed dinner rolls nor did Staff L add dinner rolls/bread to items pureed.	
Review of a document titled "Diet Listing", dated 7/31/17, revealed the 6 observed residents identifier to be on a pureed texture diet.	ed
Observation on 8/8/17, from 12:05 p.m. to 1:00 p.m. during noon meal service revealed a pureed bread item not served to the 6 of 6 observed residents on pureed diet.	
During an interview on 8/8/17, at 1:05 p.m., Staff L	Page 23 of

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acknowledged he did not puree a bread item or add bread to pureed meat and/or vegetables at the noon meal . He reported he did not routinely puree bread and only added it to products that needed it to help with improved texture. During an interview on 8/8/17, at 1:35 p.m., the Consultant Dietitian confirmed the expectation for the bread items, identified on the menu, to be pureed and prefers the addition to meat/vegetable to help with a cohesive texture, rather than pureeing by itself.		
Review of a policy titled "Pureed Foods", revealed residents will receive pureed foods in accordance with the prescribed diet order all food is pureed per the procedure attached/posted "		
Review of documents titled "Pureed Vegetable/Starch Procedure" and "Pureed Meat Procedure", posted in the kitchen, identified the addition of 1/2 piece of buttered bread or 1/2 dinner roll for each portion of vegetable and meat pureed. FACILITY RESPONSE:		

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58.28(3)e	481- 58.28(3) Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)	I	\$2000.00 Held in Suspension	Upon Receipt
	DESCRIPTION:			
	Based on clinical record review, family interview, staff interview, and facility policy review, the facility failed to provide adequate supervision during rounds and shift change leading to a resident being unaccounted for 1 resident out of 20 total residents reviewed for adequate nursing supervision (Resident #3). The facility failed to complete rounds in a manner to check on all residents whereabouts on 7/14/17 when Resident #3 not in the building or on the premises when shift change occurred at 10:00 p.m. The facility remained unaware until the resident's family member reported to the facility at 12:10 a.m. on 7/15/17 the resident being treated at the hospital Emergency Room. The facility reported a census of 90 residents. Findings include:			
	1. The Minimum Data Set (MDS) assessment dated 7/20/17 for Resident #3 identified the resident admitted on 7/13/17 with a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, transfers, dressing, and toilet use. The MDS			

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revealed the resident independent with locomotion on/off the unit and the resident utilized the use of a walker and wheelchair. The MDS documented diagnoses that included diabetes, traumatic amputation of right great toe, history of diabetic foot ulcer, and cellulitis (inflammation of cells). The care plan focus areas revised on 7/13/17 identified the resident: with a wound and infection in his/her right lower extremity post amputation; at risk for skin impairment related to decreased mobility and medical diagnosis; needed assistance with ADLs (Activities of Daily Living) related to weight bearing status, de- conditioning, safety and decline in health; and at risk for falls due to need for ADL assistance. The care plan directed staff to: use a wheelchair for mobility as the resident not ambulatory; assist bed mobility with 1 staff, dressing 1 to 2 staff, toileting 2 staff with use of a gaitbelt; and encourage the resident to use the call light and request assistance for any needs that required transfer or to reach unsafely. The Progress Notes dated 7/13/17 at 7:43 p.m. documented the resident admitted at 4:10 p.m. with pain in the right foot. The Progress Notes dated 7/13/17 at 10:00 p.m. documented a skilled status note. The entry		
documented a skilled status note. The entry documented the resident skilled for PT/OT (physical & occupational therapy) related to transmetatarsal amputation, (surgical procedure to remove the forefoot		Page 28 of

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epair, more extreme than a toe amputation), (right lower extremity) osteomyelitis (infection ne). The entry recorded the resident rated	
A, Licensed Practical Nurse (LPN),	
PN, on 7/14/17, who worked the 2nd shift as	
n., reflected Staff H signed off the pain g on the MAR at 5:29 p.m. The audit Staff H documented she administered	
cation signed off at 5:31 p.m. cations signed off at 9:15 p.m.	
cation signed off at 9:17 p.m. cation signed off at 9:19 p.m.	
ly member on 7/15/17 at 12:10 a.m., recorded / member took the resident on 7/14/17 at 9:00	Page 2
	where the tissues in a patient's foot injured epair, more extreme than a toe amputation), (right lower extremity) osteomyelitis (infection ne). The entry recorded the resident rated ain a 6 out of 10. ress Notes dated 7/14/17 at 4:20 p.m., written A, Licensed Practical Nurse (LPN), ted a skilled status note. ress Notes lacked any documentation by .PN, on 7/14/17, who worked the 2nd shift as #3's charge nurse. ication Admin Audit Report, dated 8/10/17 at n., reflected Staff H signed off the pain g on the MAR at 5:29 p.m. The audit Staff H documented she administered ons to the resident on 7/14/17 at the following ications signed off at 5:30 p.m. cations signed off at 9:15 p.m. cations signed off at 9:15 p.m. cation signed off at 9:17 p.m. cation signed off at 9:19 p.m.

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the rest. The report reflected a print date in the top		
right hand corner of 7/15/17.		
The Progress Notes dated 7/15/17 at 2:09 a.m., written		
by Staff AA, Registered Nurse (RN). Staff AA wrote		
the resident's family member approached her at		
approximately midnight and stated he/she picking up		
the resident's belongings. Staff AA wrote the family		
member stated at 9:00 p.m. he/she took the resident to		
the hospital without informing staff because concerned		
about the resident's dressing changes and not getting		
pain medication routinely. Staff AA wrote the family		
member reported the ER (emergency room) said they		
would probably admit the resident and he/she wouldn't		
be back. Staff AA recorded she had the family		
member sign for taking personal belongings. Staff AA		
wrote she received call from the ER doctor stating they		
had changed the resident's dressing and everything		
looked fine. Staff AA recorded the doctor reported		
they gave the resident pain medication and would be		
sending him/her back. Staff AA documented she told		
the doctor the family member had just picked up		
personal belongings and stated hospital admitting the		
resident and he/she wouldn't be back. Staff AA		
recorded the doctor stated there wasn't a need to		
admit and he would attempt to get the family member		
to bring the resident back to facility. Staff AA		
documented the doctor asked if the resident on the		
skilled unit and she told him yes. The entry		
documented at approximately 1:30 a.m. the resident		
 returned to the facility accompanied by the family		

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member. Staff AA documented she contacted the DON (Director of Nursing) and informed her of the situation.	
The Emergency Department (ED) Discharge Summary, documented on 7/15/17 at 1:06 a.m., recorded a DOS (Date of Service) of 7/14/17 at 9:25 p.m. for Resident #3. The Summary recorded the resident departed the ER on 7/15/17 at 1:06 a.m.	
In a family interview on 8/7/17 at 3:25 p.m., Resident #3's family member confirmed the resident admitted on 7/13/17. The family member stated on 7/14/17 the resident told him/her he/she had asked for quite some time for pain pills. The family member reported when he/she came into the facility no one at the nursing station so he/she grabbed the resident from the smoking area to take him/her to the ER. The family member said he/she concerned about infection as the resident already had infection in the bone, the resident diabetic, and he/she did not want the resident to have their foot amputated. The family member reported the smoking area had no supervision while the resident smoked. The family member reported the overnight shift did not know the resident gone. The family member reported the overnight shift nurse said the evening shift nurse, Staff H, reported to her everyone in the building. The family member stated he/she left with the resident around 9:00 p.m. to 9:30 p.m. The family member reported the coen allowed	
to smoke alone. The family member stated no one	age 31 of 8 2

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called while they were gone.			
called while they were gone. In a follow-up family interview on 8/9/17 at 3:45 p.m., Resident #3's family member recalled he/she returned to the facility from the ER on 7/14/17 to get Resident #3's clothing. The family member stated he/she didn't take everything but thought the resident would be admitted to the hospital. The family member reported he/she returned to the facility for clothes after 3rd shift on duty, around midnight to 12:30 a.m. The family member did not think or recall signing anything for the belongings. The family member clarified that at 9:00 p.m. he/she looked for staff on the Northside, the nurses' desk, no one in the office, and he/she assumed staff with other residents. The family member stated she looked around for about 5 minutes then left with the resident. The family member reported the resident could stand, pivot, and transfer by his/herself, but did need help in the bathroom. The family member stated he/she did not sign out in a book.			
In an interview on 8/7/17 at 4:15 p.m., the Administrator stated she was aware of a night when Resident #3 out of the building without staff knowledge. The Administrator said she looked into the fact the resident's family member worked for the facility in the past but she could find no record of the employment. The Administrator stated the family member must have worked for agency staffing. The Administrator stated she believed the family member			Page 32 of

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must have appareted employment on had terms	1	
must have separated employment on bad terms		
because she talked to the family member at length		
before about many concerns.		
In an interview on 8/8/17 at 11:30 a.m., Staff H stated		
she worked for the facility for 6 weeks. Staff H		
acknowledged slightly familiar with Resident #3's		
cares. Staff H reported skilled nursing assessments		
done once a shift on the 1st and 2nd shifts but not on		
3rd shift, that would be redundant. Staff H responded		
if she did not make a skilled status note that day she		
probably worked short staffed.		
Staff H reported on 7/14/17 she worked on the		
Northside for the 1st time and recalled having 3 extra		
hours of charting. Staff H stated Northside fast paced,		
a lot to take on, and it took adjustment to work that		
side. Staff H said Southside not as critical as the		
Northside which had more frequent specific needs.		
Staff H commented she had been a little overwhelmed.		
Staff H said the resident spent time roaming with		
family and outside smoking. Staff H stated the		
resident could be hard to track down. Staff H		
responded she did not know the resident went out to		
the ER on 7/14/17, but unsure if she knew that or not,		
because it happened 3 weeks prior. Staff H continued		
stating she worked with the resident 3 times, did not		
recall that night, and did not understand how the mix		
up happened because the resident had to sign out at		
the front. Staff H then asked if the surveyor saying the		
resident left that night without her knowing. When told		
yes, Staff H responded the resident's family member		

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	-	
quite an advocate when wants to be. Staff H stated she guaranteed the family member didn't tell her then stated a 2nd time she knew the family member didn't tell her. Staff H commented, "see this is what I mean about the resident being hard to find." Staff H reported residents who smoked tended to wander and she could not see someone if they smoked out front. Staff H stated, unfortunately, the family member didn't say		
anything to anyone. Staff H stated the more she talked the clearer the issue became to her. Staff H stated up until a little bit ago, they staffed just 1 nurse and 1 med aide on Northside; now they staff 2 nurses.		
In an interview on 8/8/17 at 12:28 p.m., Staff AA stated she worked overnights 1 day a week on Fridays and acknowledged familiar with Resident #3's cares. Staff AA recalled working on the overnight of 7/14/17 going into the morning of 7/15/17. Staff AA reported she did not know the resident was not there. Staff AA stated the nurse before her did not tell her the resident		
was gone. Staff AA said Resident #3's family member came after midnight sometime taking all belongings out. Staff AA stated the family member left then she received a call from the ER saying the resident ready to return to the facility. Staff AA said she informed the doctor the family member picked up all stuff and the doctor told		
her then maybe you'll see him/her maybe you won't. Staff AA reported the family member then came back to the building to say the resident couldn't stay at the hospital and asked permission to bring the resident		Page 34 of a

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sure stay back Adm calle she resid Staf not t did r	k. Staff AA stated she told the family member e. Staff AA commented the family member only ved approximately 10 minutes once the resident k, but he/she said they wanted to speak to the ninistrator about the situation. Staff AA stated she ed the DON to report the event. Staff AA clarified did not know if the shift before her knew the dent went to the ER but she did not know either. if AA stated the family member told her he/she did tell anyone; he/she so mad the dressing change not get done and the resident did not get pain pills, she just took the resident.		
(Cer Res on 7	n interview on 8/8/17 at 2:30 p.m., Staff CC, CNA rtified Nurse Aide), stated he did not recall sident #3. Staff CC said he did not recall working 7/14/17 or recall knowing about the resident leaving the hospital.		
state build 10:0 Res resid fami repo	n interview on 8/8/17 at 2:45 p.m., Staff DD, CNA, ed she worked overnights on both sides of the ding. Staff DD recalled she worked 1 night at 00 p.m. and someone said throughout the shift, sident #3 not there. Staff DD stated no one said the dent gone. Staff DD said she knew the resident's ily member spoke to the nurse that night. Staff DD orted she did not know the resident gone until the ily member brought him/her back.		
	n interview on 8/8/17 at 2:52 p.m., Staff G, CNA, ed she worked the 2:00 p.m. to 10:00 p.m. shift for		Page 35 of 8

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In an interview on 8/8/17 at 3:48 p.m., Staff FF, CNA, stated she did not work Northside and not familiar with
In an interview on 8/8/17 at 3:45 p.m., Staff W, CNA, responded not familiar with Resident #3. Staff W reported not aware the resident left the building on 7/14/17.
In an interview on 8/8/17 at 3:35 p.m., Staff O, CNA, stated she did not work Northside and not familiar with Resident #3. Staff O reported not aware the resident gone on 7/14/17.
In an interview on 8/8/17 at 3:10 p.m., Staff K, CNA, stated she did not usually work on Northside. Staff K reported not aware of anytime Resident #3 went to the ER or of being told the resident gone 7/14/17.
In an interview on 8/8/17 at 3:05 p.m., Staff EE, CNA, stated she worked at the facility since December and usually picked up in activities. Staff EE responded a little bit familiar with Resident #3. Staff EE reported she had no knowledge of the resident going to the hospital on 7/14/17.
2 months. Staff G responded familiar with Resident #3 only after a description of the resident given to Staff G. Staff G stated she remembered the resident always seem to go smoke. Staff G reported not aware the resident left the facility to the hospital ever. Staff G stated she did not recall the night of 7/14/17.

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Resident #3. Staff FF reported not aware the resident left the building 7/14/17.]
In an interview on 8/8/17 at 4:00 p.m., Staff GG, CNA, stated she worked the 2nd shift, always on the Southside, and not familiar with Resident #3. Staff GG reported not aware the resident left the building 7/14/17 and no one told her either.		
In an interview on 8/8/17 at 4:15 p.m., Staff Q, CMA (Certified Medication Aide), stated she worked all shifts on Southside. Staff Q reported not familiar with Resident #3 and not aware the resident left the facility on 7/14/17.		
In an interview on 8/8/17 at 4:45 p.m., Staff F, CNA, responded familiar with Resident #3. Staff F reported not aware the resident left the building on 7/14/17 and no one told her.		
In an interview on 8/81/7 at 4:55 p.m., Staff X, LPN, responded not familiar with Resident #3. Staff X reported not aware the resident left the building 7/14/17 and stated she did not work that side.		
In an interview on 8/8/17 at 5:05 p.m., Staff HH, LPN, responded took care of Resident #3 a couple of times. Staff HH reported not aware the resident left the building 7/14/17.		
In an interview on 8/9/17 at 10:00 a.m., Staff II, CNA	Page 37 c	ļ

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and Staff C, CNA, stated they did report at the end of the shift by doing rounds going room to room to look at residents. Both Staff II and Staff C worked the Northside at the time of the interview. In an interview on 8/9/17 at 10:05 a.m., Staff X stated nurses did not go down the halls for reports at the end of shift. Staff X said nurses have paper but the aides should go room to room. Staff X worked the Northside at the time of the interview. In an interview on 8/9/17 at 10:08 a.m., the DON stated she expected residents to be checked on by the CNA's every 2 hours with eyes on the residents. The DON stated the CNA's complete physical rounds at the end of the shifts by making sure they know where the residents are at. The DON stated the nurses sit to do verbal report nurse to nurse. The Administrator commented she expected residents who were alert and orientated to sign out and let the nurse know if leaving. The Administrator stated Resident #3 and their family member did not do that. The DON stated she staffed Northside 6:00 a.m. to 2:00 p.m. shift with 1 nurse, 1 CMA, 2 CNA's, and a float depending on census on. The DON stated she staffed Northside 2:00 p.m. to 10:00 p.m. shift with 1 nurse, may not get a CMA, and 2 CNA's. The DON stated she staffed Northside 10:00 p.m. to 6:00 a.m. shift with 1 nurse and 1 CNA.		
On 8/9/17 at 11:23 a.m. a follow-up interview		Daga 29 of

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the nurse to nurse reports were not documented.	
In an interview on 8/9/17 at 4:30 p.m., the DON stated the sign out book usually accessible to resident by the	
nursing station, but she could only find an old book.	
On 8/10/17 at 9:55 a.m., a follow-up interview conducted with Staff AA to ask if she had been aware	
Resident #3 admitted Thursday 7/13/17 as she only	
worked on Fridays. Staff AA stated she did not think she knew. Staff AA reported when Resident #3's	
family member approached her that night she told the family member she did not know who Resident #3	
was. Staff AA stated she knew Staff H her did not	
know the resident out of the building because the family member told her he/she did not tell Staff H.	
Staff AA responded if Staff H had told her the resident had untreated pain, she would have assessed the	
resident right away. Staff AA concluded the interview	
by stating again she did not know Resident #3 had been admitted.	
On 8/10/17 at 10:00 a.m., Staff KK approached the	
surveyor and stated "if the thing with Resident #3 being out of the facility going to be a big issue then,	
the facility wanted to submit additional information and	
do their own investigation." Staff KK stated the facility had a different timeframe of the resident being gone	
without staff knowledge 2 1/2 hours rather than 3 hours	
the surveyor portrayed; 9:00 p.m. to 12:00 p.m. Staff KK refused a meeting with the surveyor to discuss her	
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information/investigation and stated the facility wasn't	
ready to present any information.	
The Resident/Patient Rounding policy & procedure	
effective June 2014, documented the following:	
Policy	
Rounding will be completed at the beginning and end	
of each shift, and more often as needed, to observe	
and discuss direct care and services of the	
residents/patients provided.	
Purpose	
Nursing staff will complete walking rounds to ensure a	
safe and comfortable environment for the	
residents/patients who reside at the facility. These	
rounds should review/note the following (not all	
inclusive):	
Safety: environment is safe	
a. no fall risks (liquid on floor, cord not in hazardous	
positions, etc.)	
b. individual fall interventions are in place, if needed	
c. adequate lighting and room uncluttered	
Adaptive equipment and support items present, if	
ordered/needed per care plan	
Call light in place - personal items within reach for	
resident	
Appearance of resident (e.g. clean and comfortable)	
Privacy and dignity	
Change in resident condition	
Ensure resident's care needs met	
Note and correct any issues and report to the charge	
nurse/supervisor.	
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135C.44 Treble fines for repeated violations. The penalties authorized by section 135C.36 shall be trebled for a second or subsequent class I or class II violation occurring within any twelve-month period if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor. [C77, 79, 81, §135C.44]481—56.6 (135C) Treble and double fines.	II	\$1,500.00 (treble fine \$500.00 x 3) Held in Suspension	Upon Receipt
56.6(1) <i>Treble fines for repeated violations.</i> The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.			
481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: 58.19(2) <i>Medication and treatment.</i> <i>j.</i> Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)			
	 The penalties authorized by section 135C.36 shall be trebled for a second or subsequent class I or class II violation occurring within any twelve-month period if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor. [C77, 79, 81, §135C.44]481—56.6 (135C) Treble and double fines. 56.6(1) <i>Treble fines for repeated violations</i>. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor. 481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: 58.19(2) <i>Medication and treatment.</i> j. Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in 	 The penalties authorized by section 135C.36 shall be trebled for a second or subsequent class I or class II violation occurring within any twelve-month period if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor. [C77, 79, 81, §135C.44]481—56.6 (135C) Treble and double fines. 56.6(1) <i>Treble fines for repeated violations</i>. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor. 481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: 58.19(2) <i>Medication and treatment.</i> <i>j</i>. Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in 	The penalties authorized by section 135C.36 shall be trebled for a second or subsequent class I or class II violation occurring within any twelve-month period if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.(treble fine \$500.00 x 3) Held in Suspension[C77, 79, 81, §135C.44]481—56.6 (135C) Treble and double fines.56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12- month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: 58.19(2) Medication and treatment. j. Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in

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[ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 2560C, IAB 6/8/16, effective 7/13/16]	
DESCRIPTION:	
Based on clinical record review, hospital record review, family interview, and staff interview, the facility failed to complete ongoing assessments of a resident's pain by a qualified nurse and failed to provide pain medications after indicators of pain presented for 1 out of 15 current residents reviewed (Resident #3). The facility continually ignored the resident's request for pain medication over a minimum period of 8 hours who had a recent amputation of the forefoot and failed to provide a daily dressing change to the surgical site. The facility failures lead to Resident #3 seeking treatment at the hospital. The facility reported a census of 90 residents.	
Findings include:	
1. The Minimum Data Set (MDS) dated 7/20/17 for Resident #3 identified the resident admitted on 7/13/17 with a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 1 person for bed mobility, transfers, dressing, and toilet use. The MDS revealed the resident independent with locomotion on/off the unit and the resident utilized the use of a walker and wheelchair. The MDS documented diagnoses that	

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included dispetes traumatic amputation of right graat	
included diabetes, traumatic amputation of right great	
toe, history of diabetic foot ulcer, and cellulitis	
(inflammation of cells). The MDS recorded the	
resident received scheduled and PRN (as needed)	
pain medications for pain management. The MDS	
documented the resident experienced pain frequently	
rating the worst pain in the previous 5 days a 6 on a	
scale of 10 (with 0 indicating no pain and 10 the worst	
pain imaginable). The MDS recorded the presence of	
surgical wounds with the surgical wound care. The	
MDS documented the resident received IV	
(intravenous) medications.	
The care plan focus areas revised on 7/13/17 identified	
the resident with a wound and infection in his/her right	
lower extremity post amputation and at risk for skin	
impairment related to decreased mobility and medical	
diagnosis. The care plan directed staff to: educate the	
resident/family/staff regarding preventative measures	
to contain the infection; give all meds and IV therapy	
as ordered; and assess the resident's skin with any	
dressing changes, bathing, dressing/undressing, and	
update the resident's physician as needed.	
update the resident's physician as heeded.	
The Dismissal/Interagency Instruction Sheet dated	
7/13/17 at 12:00 p.m. directed the following Discharge	
Instructions Medication Orders for Resident #3:	
a. Norco 5/325 (narcotic pain pill with 5 milligrams (mg)	
hydrocodone and 325 mg of Tylenol); take 1 tab by	
mouth every 4 hours as needed for pain	
b. Change dressing to right lower extremity (RLE) daily	Page 46 of 8

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with adaptic (non-adhering gauze), gauze, Kling (absorbent gauze roll), and lightly wrap ACE bandage		
The Progress Notes dated 7/13/17 at 6:20 p.m., written by Staff E, Unit Manager/Registered Nurse (RN), documented a general note. Staff E wrote she pulled 2 tabs of Norco 5/325 from the e-box per pharmacy Code #WC02IA15Y. The note did not indicate what Staff E did with the narcotic pain pills.		
The Progress Notes dated 7/13/17 at 7:43 p.m. documented the resident admitted at 4:10 p.m. with pain in the right foot. The note recorded an incision at the amputation site of the toes of right foot with sutures intact, top of foot sore area, and boot on right foot. The entry did not indicate that any pain medication given to the resident.		
The Initial Nursing Evaluation and Vitals dated 7/13/17 at 7:47 p.m., documented a resident assessment. The assessment did not assess pain and did not indicate that any pain medication given to the resident.		
The Pain Assessment dated 7/13/17 at 8:07 p.m. documented: A. Pain Presence - pain or hurting at any time in the last 5 days Answer: Yes B. Pain Frequency - how much time experienced pain		
or hurting over the last 5 days Answer: Almost constantly		Page 47 of

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D. Pain Intensity - numeric rating scale 00-10		
Answer: 8		
E. Indicators of Pain or Possible Pain		
Answer: vocal complaints of pain		
F. Frequency of Indicator of Pain or Possible Pain		
Answer: Indicators of pain for 3 to 4 days		
G. Pain Management		
1a. Describe treatment, any side effects and		
effectiveness		
Answer: Hospitalized		
2a. Describe administration patterns, any side effects		
and effectiveness		
Answer: Effective, brings pain to a 5 -6 which is		
tolerable		
RN Analysis of Pain and Plan		
Answer: Patient has pain that is controlled.		
The assessment did not indicate that any pain		
medication given to the resident.		
The Comprehensive Evaluation of Skin Inspection and		
Risk Factors, dated 7/13/17 at 7:57 p.m., documented		
a skin assessment. The assessment recorded a		
surgical incision on the right toes measured 15.2		
centimeters (cm) length by 0.1 cm width by 0.1 cm		
depth. The assessment did not assess pain and did		
not indicate that any pain medication given to the		
resident or that a dressing change completed.		
The Skilled Status Assessment dated 7/13/17 at 10:00		
p.m. documented:		
A. Neuro Checks		Page 48 of a

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Citation Numb	er:			Date: Augus	t 31, 2017
Facility Name:			Survey I		
Touchstone He	ealthcare Community		July 31,	2017, August 1·	15, 2017.
Facility Addres 1800 Indian Hil Sioux City, IA					
		HL			
Rule or				Fine Amount	Correction
Code	Natur	e of Violation	Class		date
Section					

used a effects Answe Questi	ion 6 - Please enter pain level, pain interventions and if effective Describe treatment, any side and effectiveness er: Resident rates pain 6 out of 10 ion 8 - Does patient have any surgical wounds?	
medica	er: No ssessment did not indicate that any pain ation given to the resident or that a dressing e completed.	
docum docum occupa amputa in case beyond and RI entry ro of 10.	rogress Notes dated 7/13/17 at 10:00 p.m. hented a skilled status note. The entry hented the resident skilled for PT/OT (physical & ational therapy) related to transmetatarsal ation, (surgical procedure to remove the forefoot es where the tissues in a patient's foot injured d repair, more extreme than a toe amputation), LE osteomyelitis (infection of the bone). The ecorded the resident rated his/her pain a 6 out The entry did not indicate that any pain ation given to the resident.	
p.m. de (LPN): A. Neu Questi used a effects Answe	killed Status Assessment dated 7/14/17 at 4:20 ocumented by Staff A, Licensed Practical Nurse uro Checks on 6 - Please enter pain level, pain interventions and if effective Describe treatment, any side and effectiveness er: 10 prn given with relief obtained on 8 - Does patient have any surgical wounds?	

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Facility Administrator

Citation Numb 6631	er:			Date: August	31, 2017
Facility Name: Touchstone He	ealthcare Community		Survey I July 31,	Dates: 2017, August 1-	15, 2017.
Facility Addres 1800 Indian Hil Sioux City, IA					
		HL			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date

Answer: yes Question 8a - if yes, describe what type, and treatment, any redness, drainage, or pain Answer: Right transmetatarsal amputation, change dressing to RLE daily with adaptic, gauze, Kling, and lightly wrapped ACE bandage. The assessment did not indicate that a dressing change actually completed just listed type. The Progress Notes dated 7/14/17 at 4:20 p.m., written by Staff A documented a skilled status note. The entry documented a 10 prn given with relief obtained. The note recorded the resident oriented to person, place, and time. The note documented a surgical wound present with right transmetatarsal amputation, change dressing to RLE daily with adaptic, gauze, Kling, and lightly wrap with ACE bandage. The Controlled Medication Utilization Records for Resident #3 documented no Norco signed out on 7/13/17. The record documented 1 Norco signed out on 7/14/17 at AM. The July 2017 Medication Administration Record (MAR) documented Norco not given on 7/13/17 and only given once on 7/14/17 at 10:26 a.m. by Staff Cc, Certified Medication Aide (CMA). The July 2017 Treatment Administration Record (TAR) documented the dressing change scheduled to be completed on the 6 to 2 shift. The TAR reflected a		1.	I I	
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Citation Numb 6631	er:			Date: August	31, 2017
Facility Name: Touchstone He	ealthcare Community		Survey I July 31,	Dates: 2017, August 1-	15, 2017.
Facility Addres 1800 Indian Hil Sioux City, IA					
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blank space on 7/14/17 which indicated the treatment not completed.		
The July 2017 MAR reflected Staff H initialed a check for monitoring the resident's pain and the resident rated pain at a 10 level on 7/14/17.		
The Medication Admin Audit Report dated 8/10/17 at 12:59 p.m. recorded Staff H signed off the pain monitoring on 7/14/17 at 5:29 p.m.		
The Transfer/Discharge Report, signed by Resident #3's family member on 7/15/17 at 12:10 a.m., recorded the family member took the resident on 7/14/17 at 9:00 p.m. to the hospital, took stuff, and would be back for the rest. The report reflected a print date in the top right hand corner of 7/15/17.		
The next Progress Note occurred at 7/15/17 at 2:09 a.m., written by Staff AA, RN. Staff AA wrote the resident's family member approached her at approximately midnight and stated he/she picking up the resident's belongings. Staff AA wrote the family member stated at 9:00 p.m. he/she took the resident to the hospital without informing staff because concerned about the resident's dressing changes and not getting pain medication routinely. Staff AA documented the family member requested the names of staff who worked the evening shift. Staff AA wrote the family member reported the ER (emergency room) said they		
would probably admit the resident and he/she wouldn't		

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Facility Administrator

Date

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be back. Staff AA recorded she had the family member sign for taking personal belongings. Staff AA wrote she received call from the ER doctor stating they had changed the resident's dressing and everything looked fine. Staff AA recorded the doctor reported they gave the resident pain medication and would be sending him/her back. Staff AA documented she told the doctor the family member had just picked up personal belongings and stated hospital admitting the resident and he/she wouldn't be back. Staff AA recorded the doctor stated there wasn't a need to admit and he would attempt to get the family member to bring the resident back to facility. Staff AA documented the doctor asked if the resident on the skilled unit and she told him yes. The entry documented at approximately 1:30 a.m. the resident returned to the facility accompanied by the family member. Staff AA recorded the family member reported the dressing changed and the resident had received pain medication. Staff AA documented she gave the resident medication at 1:50 a.m., the resident went outdoors for cigarette, and the resident returned inside at 2:30 a.m. going to bed. Staff AA documented she contacted the DON (Director of Nursing) and informed her of the situation. The Emergency Department (ED) Discharge		
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Facility Administrator

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Push (a syringe a medicine pushed into the IV line):	
a. ondansetron (anti-nausea medication) 4 mg at 10:27 p.m.	
b. hydromorphone (used to treat severe pain) 1 mg at	
10:27 p.m. c. hydromorphone (also known as Dilaudid) 0.5 mg at	
11:31 p.m.	
The Summary recorded the resident departed the ER on 7/15/17 at 1:06 a.m.	
The ED Adult Triage Form, documented on 7/14/17 at	
9:59 p.m., recorded at 9:54 p.m. Resident #3 complained of a pain score of 10 in the left leg	
described as constant, throbbing.	
The ER Progress Note Form, documented on 7/15/17	
at 1:03 a.m., recorded at 1:00 a.m. Resident #3 foot rewrapped with emulsion, 4 by 4's, Kling/ACE after	
additional dose of IV pain medication given.	
The ED Physician Notes Final Report, documented on	
7/15/17 at 1:23 a.m., included the following documentation recorded for Resident #3:	
History of Present Illness: Patient presented with right,	
foot pain; complained of sever right foot pain; family member upset because stated the dressing to the right	
foot not changed since arriving at the facility; also	
stated upset because facility not giving pain	
medication; the last dose of Norco sometime in the early morning; and Resident #3 stated the nurse told	
him/her his/her pain pills had run out.	Dogo 52 of

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Reexamination/Reevaluation: After 2 doses of		
Dilaudid patient's pain now under adequate control.		
Called the facility and had a conversation with a nurse		
named (Staff AA). She does tell me that they have		
orders for dressing changes to the right foot daily. She		
cannot tell me when they have not yet been done.		
They also have a prescription for Norco to be given to		
the patient scheduled for pain. She cannot tell me why		
the patient not provided with this earlier. She does		
however have a prescription and does not need any		
further orders. The doctor discussed the importance of		
following physician orders as directed. The doctor		
noted the dressing to right foot reapplied by RN.		
Impression and Plan:		
Diagnosis acute postoperative pain of right foot.		
In a family interview on 8/7/17 at 2:25 nm. Resident		
In a family interview on 8/7/17 at 3:25 p.m., Resident #3's family member expressed concern the resident		
did not receive pain medications the day of and after		
admit. The family member confirmed the resident		
admitted on $7/13/17$. The family member stated on $7/13/17$ and 3 stated if the resident received		
7/14/17 he/she asked 3 staff if the resident received		
pain medication but told the computer showed it had		
not been given. The family member said staff		
informed him/her the pain medication not scheduled to		
be given, only ordered as needed every 4 hours. The		
family member reported the 3 staff to be: Staff H,		
LPN; Staff CC, CNA (Certified Nurse Aide); and Staff		
G, CNA. The family member stated he/she did not		
 believe any staff took pain medication from an EKIT		Page 54 0

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(emergency medicine box containing certain backup medications in a facility) to give to the resident. The family member reported the day of admit, a staff nurse removed the resident's dressing and put it on the floor. The family member stated after the nurse did an assessment, she put the same dirty dressing back on the resident. The family member stated the nurse informed him/her the facility had not ordered new dressings yet. The family member commented the facility had been aware the resident would be admitting and they should have had the dressings ready. The family member stated on 7/14/17 the resident told him/her he/she had asked for quite some time for pain pills. The family member reported the resident requested he/she bring the resident's pain pills from		
home. The family member stated the nurse offered the resident a Tylenol. The family member reported when he/she came into the facility no one at the nursing station so he/she grabbed the resident from the smoking area to take him/her to the ER (Emergency Room). The family member stated at that time the resident's dressing bleeding through the ace wrap and into the boot. The family member said he/she concerned about infection as the resident already had infection in the bone, the resident diabetic, and he/she did not want the resident to have their foot amputated. The family member stated he/she left with the resident around 9:00 p.m. to 9:30 p.m. The family member reported the facility gave the resident a pain pill around 10:00 a.m. only on 7/14/17.		
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Facility Administrator

Date

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Facility Name: Touchstone Healthcare Community			Survey I July 31,	Dates: 2017, August 1-	15, 2017.
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In an interview on 8/8/17 at 11:00 a.m., Staff A, LPN,		
reported familiar with Resident #3's care. Staff A		
recalled the day of 7/14/17 she stayed over to get		
charting done. Staff A commented she did not like to		
do charting till the end of a shift. Staff A said med		
aides assist the nurses to administer pills and the med		
aides must let the nurses know if they give a pain pill		
because the nurse needed to do an assessment. Staff		
A reviewed her charting from that day and stated she		
wrote an end of day summary. Staff A said at the end		
of the shift she looked back at what the CNA's and		
med aides told her. Staff A stated the resident		
reported a pain level of 10 and a pain pill given at		
10:26 a.m. by Staff Cc. Staff A stated she never gave		
the resident any pills and the pain rating of a 10		
reflected the pain assessed at 10:26 a.m., not at 4:20		
p.m. when she actually completed charting.		
In an interview on 8/8/17 at 11:30 a.m., Staff H stated		
she worked for the facility for 6 weeks. Staff H		
acknowledged slightly familiar with Resident #3's		
cares. Staff H reported she recalled 1 instance when		
the resident's PRN hydrocodone (narcotic pain		
medication) did not come in from the pharmacy. Staff		
H stated the resident's pain pill PRN, but the resident		
expected the pills every 4 hours. Staff H commented		
the resident did not get pills automatically, only if		
he/she showed signs/symptoms of pain. Staff H stated		
she did not want to give the resident pain pills because		
she did not want to make the resident dependent on		
pills or drug the resident up. Staff H stated honestly,		

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the med aide assesses for pain and gives pain pills.				
would be redundant. Staff H responded if she did not				
make a skilled status note that day she probably				
worked short staffed. Staff H reported on 7/14/17 she				
worked on the Northside for the 1st time and recalled				
having 3 extra hours of charting. Staff H stated				
Northside fast paced, a lot to take on, and it took				
adjustment to work that side. Staff H said Southside				
not as critical as the Northside which had more				
frequent specific needs. Staff H reported at that time				
she did not prioritize when pills due but she did now.				
Staff H commented she had been a little overwhelmed.				
Staff H stated, honestly, the resident very angry when				
he/she arrived to the facility. Staff H said the resident				
felt he/she did not get things promised before				
admission and the resident wanted a pain pill				
whenever he/she wanted it. Staff H recalled the				
resident called for her because he/she did not want the				
med aide. Staff H stated she informed the resident				
his/her order for PRN only and the resident got upset				
H stated she then told the resident he/she could have				
Tylenol but unfortunately, the resident adamant he/she				
	Staff H said residents need to go to the person on the medication cart if they want pain pills because nurses are for phone calls and skilled assessments. Staff H reported skilled nursing assessments done once a shift on the 1st and 2nd shifts but not on 3rd shift, that would be redundant. Staff H responded if she did not make a skilled status note that day she probably worked short staffed. Staff H reported on 7/14/17 she worked on the Northside for the 1st time and recalled having 3 extra hours of charting. Staff H stated Northside fast paced, a lot to take on, and it took adjustment to work that side. Staff H said Southside not as critical as the Northside which had more frequent specific needs. Staff H reported at that time she did not prioritize when pills due but she did now. Staff H stated, honestly, the resident very angry when he/she arrived to the facility. Staff H said the resident felt he/she did not get things promised before admission and the resident wanted a pain pill whenever he/she wanted it. Staff H recalled the resident called for her because he/she did not want the med aide. Staff H stated she informed the resident his/her order for PRN only and the resident got upset saying he/she would bring their pills from home. Staff	Staff H said residents need to go to the person on the medication cart if they want pain pills because nurses are for phone calls and skilled assessments. Staff H reported skilled nursing assessments done once a shift on the 1st and 2nd shifts but not on 3rd shift, that would be redundant. Staff H responded if she did not make a skilled status note that day she probably worked short staffed. Staff H reported on 7/14/17 she worked on the Northside for the 1st time and recalled having 3 extra hours of charting. Staff H stated Northside fast paced, a lot to take on, and it took adjustment to work that side. 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that the resident hard to find at times. Staff H said the		
resident spent time roaming with family and outside		
smoking. Staff H stated the resident hard to track		
down, so if she did not sign the treatment then it was		
because the resident not available. When told the		
resident went to the ER on 7/14/17, Staff H responded		
she wondered if the resident just tried to get more pain		
pills. Staff H stated the more she talked in the		
interview the clearer the issue became to her. Staff H		
said she recalled the resident arrived with an abnormal		
number of pills; 3 of each med. Staff H recalled the		
last hydrocodone pill used and she had to await		
authorization from the pharmacy to open the EKIT for		
narcotics. Staff H commented pharmacy readily		
available at all hours, however, when she had 30		
residents who all needed something from her, calls		
from doctors, a resident already angry about not		
getting pain meds; it was not her problem the		
medication not scheduled to give routinely. Staff H		
stated she couldn't do everything simultaneously and		
she had to prioritize a resident's chest pain that		
needed to go to the hospital. Staff H stated the pain		
pill important also and she did the best she could, but		
the resident well enough to go out to smoke. Staff H		
said the priority of the resident with chest pain took a		
chunk of time and working on Northside there's no time		
for anything to go wrong. Staff H stated up until a little		
bit ago, they staffed just 1 nurse and 1 med aide on		
Northside; now they staff 2 nurses. Staff H reported		
she asked the resident to exercise patience because		
he/she did not show any signs of non-verbal pain.		
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Staff H stated again, she offered the resident Tylenol	
but he/she said no, they wanted a narcotic. Staff H	
said she did tell the resident he/she could not take the	
medicine from home. Staff H commented she felt the	
resident easily not pleased that day, bitter about meds	
not being in, and she was in a terrible situation with not	
enough staff.	
In an interview on 8/8/17 at 12:28 p.m., Staff AA, RN	
(Registered Nurse), stated she worked overnights 1	
day a week on Fridays and acknowledged familiar with	
Resident #3's cares. Staff AA recalled working on the	
overnight of 7/14/17 going into the morning of 7/15/17.	
Staff AA reported she did not know the resident not	
there. Staff AA stated the nurse before her did not tell	
her the resident gone. Staff AA said Resident #3's	
family member came after midnight sometime taking	
all belongings out; something to do with upset about a	
dressing change. Staff AA stated the family member	
left then she received a call from the ER saying the	
resident ready to return to the facility; the dressing off	
and they redressed the wound. Staff AA said she	
gave the resident a pain pill upon return to the facility.	
Staff AA clarified she did not know if the shift before	
her knew the resident went to the ER but she did not	
know. Staff AA stated the family member told her	
he/she did not tell anyone; he/she so mad the dressing	
change not done and no pain pill given, he/she just	
took the resident. Staff AA recalled pain pills available	
for the resident. Staff AA remembered 3 pain pills in	
an envelope from the EKIT. Staff AA said the	Page 59 of 8

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 pharmacy needed to hear an lowa approval number to give the okay to take so may out of stock. Staff AA stated she called the pharmacy and they reported a whole card, (contains pills packed to punch out of a bubble pack - usually a month's worth at a time), of medicine should be at the facility. Staff AA said, sure enough, she found 3 pills in an envelope and a whole card. Staff AA concluded, so we had the pain pills available to give. In an interview on 8/9/17 at 10:08 a.m., the DON, stated she addressed that CMA's could not assess for pain or effectiveness of pain pills in meetings the last 3 months. The DON stated the CMA's could give a pain pill after a nurse assessed the pain. The DON stated it would be out of the scope of practice for a CMA to assess pain. 	
On 8/9/17 at 11:23 a.m. a follow-up phone interview conducted with Staff H to ask why she signed out a narcotic on 7/19/17 at 1:00 a.m. but failed to document anywhere else that she gave the pain pill to the resident. Staff H stated she had no idea why she signed out a pill on the narcotic count sheet and said not going to own up to it. Staff H commented she guaranteed though, if she signed out a pill she gave it. Staff H stated she did not know why she did not document on the MAR or in the nurses notes, but she guaranteed she gave the pain pill to the resident if she signed it out.	

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DESCRIPTION: Based on resident group interview, observation, clinical record review, resident interviews, staff interview, and Resident Council minutes, the facility failed to answer call lights or requests for assistance in a timely manner to meet the needs of residents for 7 out of 7 group residents and 4 of 15 current residents	
clinical record review, resident interviews, staff interview, and Resident Council minutes, the facility failed to answer call lights or requests for assistance in a timely manner to meet the needs of residents for 7	
reviewed (Residents #9, #1, #15 and #20). The facility reported a census of 90 residents.	
Findings included:	
1. During the group interview on 8/2/17 at 1:15 p.m., 7 out of the 7 residents complained of issues with the call lights getting answered. The group reported not uncommon to take up to an hour to answer the light during the day and 1 resident stated once it took 4 to 5 hours to answer the call light at night. The group reported they have clocks on the wall, so they are able to keep track of how long it takes to get help. They even explained that some do not always have the call light available to reach, they have to go up the hall to yell for help. The group felt as if the facility did not	

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have enough staff to assist them with their needs. The group reported they have 1 aide staffed on Daisy Lane Hall, 1 aide Cherry Blossom Hall, 1 aide Bayberry Hall, and 2 on Aspenwood Hall. The group stated they needed to have 2 aides on each hall.		
2. The Minimum Data Set (MDS) assessment dated 7/13/17 identified diagnoses for Resident #9 included cerebrovascular accident (CVA), anxiety disorder and depression. According to the MDS, the resident is dependent on staff for bed mobility, transfers, dressing, bathing and toilet use. The MDS indicated the resident has a Brief Interview for Mental Status (BIMS) score of 15, which indicates no cognitive impairment.		
Review of the care plan dated 1/10/17 for Resident #9 revealed a toileting focus with an intervention for extensive assistance of 2 staff in toileting. The resident's care plan revealed he/she could use the bed pan at time and used incontinent pads.		
An observation on 8/8/17 at 9:58 a.m. call light turned on in Resident #9's room. An interview with Resident #9 on 8/8/17 at 10:06 a.m. revealed the resident needed to use the bathroom. An observation on 8/8/17 at 10:19 a.m. revealed call light on until this time. Staff D, CNA entered Resident #9's room and turned off the call light and then left. An interview with Resident #9 on 8/8/17 at 10:19 a.m. revealed resident stated the aide (Staff D, CNA) said		

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-	he/she would have to wait awhile. Resident also talked about having to wait in the morning to get out of bed		
	because the lack of staff and sometimes not assisted		
	up until 10 a.m. Resident talked about waiting too long		
	sometimes that he/she wets self before the staff return.		
l l	An observation on 8/8/17 at 10:29 a.m. showed Staff		
[D taking stand up lift into room 8.		
	An interview on 8/8/17 at 10:30 a.m. with Staff E, Unit		
	Manager/Registered Nurse (RN), revealed		
	acknowledged she had spoken to Resident #9 and is		
a	aware of the need to use bathroom.		
	An observation on 8/8/17 at 10:34 a.m. revealed Staff		
	E and a Licensed Practical Nurse (LPN) entered		
	Resident #9's room with a mechanical lift and shut the		
	door.		
ļ	An interview on 8/9/17 at 12:08 p.m. with Resident #9		
	revealed he/she had trouble with the call light again		
	ast night; and stated his/her call light had been on		
	from 9 p.m. to 9:45 p.m. before anyone answered.		
	Resident asked how this made him/her feel as he/she		
	reported being incontinent of urine and he/she replied		
	being mad.		
	3. The MDS assessment dated 7/10/17 identified		
	diagnoses for Resident #1 included hemiplegia		
	(paralysis on one side) and postprocedural		
	cerebrovascular infarction following other surgery		
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(stroke following surgery). According to the MDS, the resident required the extensive assistance for bed mobility, transfer, dressing and toileting. The MDS indicated the resident had a BIMS score of 15, indicating no cognitive impairment.		
The care plan dated 7/7/17 revealed a goal for the resident to be clean and odor free. The care plan revealed Resident #1 needed assistance of one staff for toileting. Resident #1 used the toilet and occasionally the urinal.		
An interview with Resident #1 on 8/9/17 at 1:45 p.m. revealed resident stating that she/he is not getting to the bathroom when needs to go. Also stated there is only 1 staff working down this hall D, the aide had come to answer the call light and she/he was told to hold for a while, then the aide never returned. Resident indicated she/he had waited up to 3 hours for staff to answer the call light.		
4. The MDS assessment dated 2/3/17 recorded a discharge assessment for Resident #15. The MDS identified a BIMS score of 15. A score of 15 indicated intact cognition.		
The MDS assessment dated 8/2/17 identified the resident admitted again on 8/2/17.		
The care plan printed 8/14/17 identified the resident anticipated a short stay. The care plan did not contain		Page 66 of

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any focus areas identifying cognition issues. The care		
plan listed diagnoses that included obstructive sleep		
apnea and chronic respiratory failure with hypoxia (low		
oxygen levels). The care plan fall prevention focus		
area initiated 8/7/17 directed staff to keep a floor mat		
beside the resident's bed. The care plan directed staff		
to assist the resident with transfers, bed mobility, and		
ambulation with 1 person.		
The Progress Notes dated 8/7/17 at 12:55 a.m.		
documented the resident heard yelling and found lying		
on the floor beside his/her bed. The note recorded the		
resident stated he/she sat on the edge of his/her bed		
and must have fallen asleep. The entry documented		
the staff used a Hoyer (mechanical lift) and 2 people to		
assist the resident back to bed.		
assist the resident back to bed.		
The Progress Notes dated 8/7/17 at 3:15 a.m., written		
by Staff Y, RN, documented staff discovered the		
resident lying on the floor beside his/her bed. Staff Y		
documented the resident assisted back to bed with the		
use of a Hoyer and 2 person assist. Staff Y wrote a		
mattress placed on the floor beside the resident's bed		
and the resident assisted to lay down on it.		
The next Progress Notes dated 8/7/17 at 7:30 a.m.,		
written by the MDS Coordinator, documented		
communication done with the resident. The note		
recorded a visit with the resident related to falls		
overnight. The MDS Coordinator wrote he discussed		
the possibility of the resident moving to a room closer		
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	to the building center, the resident agreed.		
	The Weekly ID (Interdisciplinary) Team Fall Review Committee report dated 8/7/17 at 8:16 a.m. recorded the resident fell 8/7/17 at 12:55 a.m. and 3:15 a.m. The report documented both falls the resident fell beside the bed with the resident stating he/she sat on the edge of the bed and fell asleep. The report recorded under category Dementia - no diagnosis. The New Interventions section listed floor mat beside bed after first incident, then mattress on floor temporarily, changed rooms.		
	In an interview on 8/7/17 at 8:52 p.m., Resident #15 reported he/she fell two times the previous night. Resident #15 stated his/her legs hurt when he/she laid down so he/she sat on the edge of the bed. Resident #15 said he/she fell out of bed to the floor. Resident #15 stated the staff helped him/her back to bed. Resident #15 reported he/she then fell out of bed a second time. Resident #15 stated the staff assessed him/her but then told him/her they would be back as they had another resident to assist; but they did not come back. Resident #15 reported the second fall occurred at approximately 3:45 a.m. and he/she had a clock on the wall. Resident #15 stated the staff did not come back until the 6:00 a.m. to 2:00 p.m. shift arrived and helped him/her up at 7:00 a.m.		
	In an interview on 8/8/17 at 7:45 a.m., Resident #15 reported Staff E, Unit Manager/RN, asked him/her a lot		Page 68 of

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of questions about his/her conversation with the surveyor the night before. Resident #15 stated Staff E made him/her confused about how long he/she remained on the floor the other night. Resident #15 said the thing he/she couldn't figure out though, staff brought him/her something like a blanket to lay on and staff would not have done that if he hadn't been on the floor. In an interview on 8/14/17 at 4:13 p.m., Staff Y stated Resident #15 did have 2 falls out of bed on the overnight of Sunday 8/6/17 going into the morning of 8/7/17. Staff Y stated after the first fall from bed it took 2 staff to assist the resident back to bed and then she placed a fall mat beside the bed as an intervention. Staff Y reported the resident fell a second time around 3:30 a.m. and it took 3 staff to assist the resident up. Staff Y said she retrieved a mattress from the storage room and put it on the resident's floor for his/her safety. Staff Y stated she directed the resident to get onto the mattress, sitting on the edge of the bed and rolling him/herself onto the mattress. Staff Y stated she did not recall the resident saving he/she did not	
she did not recall the resident saying he/she did not want to get on the mattress. Staff Y stated the resident on the mattress from 4:00 a.m. until 7:00 a.m. Staff Y stated she passed on during report the resident requested at 5:30 a.m. to get up and the resident upse	
that he/she not helped up yet.5. The MDS assessment dated 5/18/17 for Resident #20 identified a BIMS score of 15. A score of 15	Page 69 of 8

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indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of		
1 person for toilet use.		
The care plan focus area revised on 12/8/16 identified the resident at a risk for falls due to history of CVA and the medications he/she took. The care plan intervention dated 11/29/16 informed staff the resident able to dress, groom, toilet self, and will occasionally ask for assistance.		
The Progress Notes dated 7/30/17 at 7:45 a.m. documented the resident reported he/she experienced a fall off the commode at 6:37 a.m., the resident activated the call bell at the time of the fall, and waited on the floor until 7:10 a.m. because no one answered the call bell.		
In an interview on 8/14/17 at 2:25 p.m., Resident #20 reported the facility did not have enough staff. Resident #20 stated he/she fell about 2 weeks prior. Resident #20 said he/she had to get self up because no one came. Resident #20 stated he/she scraped his/her knuckles getting self up and scabs observed on the resident's right hand. Resident #20 said he/she spent a half hour on the floor and it took a total of 1 hour and 7 minutes for him/her to get help.		
6. The Resident Council minutes from 2/17/17 documented under the Nursing section: the changes on Cherry Blossom Hall not working and stretched the		Page 70 o

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	thin; call lights still took a while to answer; and t off the call light without the needs being ed.	
documer getting s Cherry B	ident Council minutes from 3/17/17 nted under the Nursing section: resident ick of everyone being over stretched due to Blossom hall, tried to be patient; staff state they et the resident if they remembered and had	
documer 45 minut	ident Council minutes from 4/21/17 nted under the Nursing section: call lights took tes to answer and a resident unhooked from tand (mechanical lift) and left there to wait.	
documer answere 40 minut and bath section tl	ident Council minutes from 5/20/17 nted under the Nursing section: call lights not d in a timely manner; a resident sat for 30 to tes on the toilet hooked up to the EZ stand; is not getting done. Under the Activities he minutes documented: upset over activities nceled because no staff available to do them.	
documer took 30 r	ident Council minutes from June (2017) nted under the Nursing section it sometimes minutes to find an EZ stand and it took forever ights answered.	
	ident Council minutes from July 2017 nted under the Nursing section it took 45	Page 71 of

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minutes to an hour to get call lights answered, especially when they are short [staff].	
7. Additional Staff Interviews revealed:	
In an interview on 8/1/17 at 9:07 a.m., Staff D, CNA, stated she was the only aide for 2 halls. Staff D said she could not keep up with the call lights.	
In an interview on 8/1/17 at 9:10 a.m., Staff K, CNA, stated she did not feel there was enough staff. Staff K said the previous week she was the only aide for Aspenwood Hall which required 2 aides. Staff K reported Aspenwood Hall the heaviest because 4 residents used the Hoyer (a full mechanical lift) and 7 residents used the EZ stand (a stand up lift).	
In an interview on 8/7/17 at 8:23 p.m., Staff W, CNA, stated sometimes she felt there was not enough staff on the 2:00 p.m. to 10:00 p.m. shift to meet residents' needs.	
In an interview on 8/7/17 at 8:25 p.m., Staff Z, CNA, stated sometimes the weekends did not have enough staff on the 2:00 p.m. to 10:00 p.m. shift.	
In an interview on 8/7/17 at 8:28 p.m., Staff X, LPN, stated residents have complained at times about not having enough staff. Staff X commented they needed 2 aides on each hall, Aspenwood, Bayberry, and Daisy Lane which also covers Cherry Blossom. Staff X	

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stated that night they only had 1 aide each hall so		
could be a challenge to meet the residents' needs.		
In an interview on 8/8/17 at 12:28 p.m., Staff AA, RN,		
stated she worked overnights one day a week on		
Fridays. Staff AA responded she did not feel they had		
enough staff. Staff AA said the census ranged from 28		
to 36 residents and the facility staffed with 1 nurse and		
1 med aide. Staff AA commented between completing		
treatments, managing IV's (intravenous fluids) and		
assisting residents who required 2 people, it left the		
floor uncovered for supervision because there were		
residents who required 1:1 (one to one) supervision		
and others on 15 minute observation checks. Staff AA		
stated she reported concern to the DON. Staff AA said		
the DON responded they would staff 1 nurse and 2		
CNAs, but not staffed with 2 CNAs. Staff AA stated		
times 1 nurse in the building and she told the DON not		
safe. Staff A reported the DON responded she trusted		
Staff AA's judgement but felt Staff AA could do it as		
there weren't many pills (to pass) on the Southside.		
Staff AA stated this occurred in the springtime but an		
ongoing staffing issue since then. Staff AA		
commented the facility had a lot of residents with		
heavy care due to mental and physical issues. Staff		
AA reported they used to staff with agency (temporary		
help) but no longer did. Staff AA stated she did not		
feel the staffing getting any better. Staff AA		
commented she could talk to management till she's		
blue in the face but it wouldn't matter. Staff AA		
reported she had so many residents requesting pain		
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 pills and the call lights super busy, she forgot to give a resident a pain pill.		
In an interview on 8/8/17 at 2:45 p.m., Staff DD, CNA, stated she worked overnights on both sides of the building. Staff DD responded she did not feel there was enough staff as it could be overwhelming at times. Staff DD stated some residents needed 1:1 and other residents used their call lights constantly. Staff DD said it took time to get to the residents when only one nurse and one aide; but when the facility staff 2 aides, she could do it. Staff DD stated management is aware yet they cut out agency staffing.		
In an interview on 8/8/17 at 3:35 p.m., Staff O, CNA, stated worked 2:00 p.m. to 10:00 p.m. Staff O reported if everyone showed up, they staffed 2 aides per hall. Staff O stated Aspenwood Hall took longer because 4 residents used a Hoyer and 7 residents used the EZ stand. Staff O reported there were times they couldn't get call lights answered in 2 hours because they only had 1 aide on each hall. Staff O commented she didn't think management cared. Staff O reported when she worked overnights, times the on-call nurse did not answer the phone. Staff O reported the week before the overnight shift staffed with just a med aide on the Southside and nurses had a hard time.		
In an interview on 8/8/17 at 3:48 p.m., Staff FF, CNA, stated they needed to staff 2 aides on each hall at all		Page 74

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times.		
In an interview on 8/8/17 at 4:45 p.m., Staff F, CNA, responded she did not feel there was enough staff. Staff F stated the Northside 2nd shift needed 3 aides but staffed with 2 aides. Staff F commented management aware they need 3 aides.		
In an interview on 8/9/17 at 10:08 a.m., the DON stated she staffed Northside 6:00 a.m. to 2:00 p.m. shift with 1 nurse, 1 CMA, 2 CNA's, and a float depending on census on. The DON stated she staffed Northside 2:00 p.m. to 10:00 p.m. shift with 1 nurse, may not get a CMA, and 2 CNA's. The DON stated she staffed Northside 10:00 p.m. to 6:00 a.m. shift with 1 nurse and 1 CNA. In an interview on 8/15/17 at 9:30 a.m., Staff S, CNA, stated sometimes not enough staff to complete baths. Staff S commented at times she stayed over by herself		
just to complete baths because couldn't get them done due to staffing issues. FACILITY RESPONSE:		

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58.11(3)	481—58.11(135C) Personnel.	П	\$500.00	Upon
50.9(3) b	58.11(3) Employee criminal record checks, child			Receipt
And	abuse checks and dependent adult abuse checks			
50.9(3)c	and employment of individuals who have			
	committed a crime or have a founded abuse. The			
	facility shall comply with the requirements found			
	in lowa Code section 135C.33 as amended by 2013			
	Iowa Acts, Senate File 347, and rule 481—			
	50.9(135C) related to completion of criminal record			
	checks, child abuse checks, and dependent adult			
	abuse checks and to employment of individuals			
	who have committed a crime or have a founded			
	abuse. (I, II, III) [ARC 0903C, IAB 8/7/13, effective			
	9/11/13]			
	50.9(3) Requirements for employer prior to			
	employing an individual. Prior to employment of a			
	person in a facility, the facility shall request that			
	the department of public safety perform a criminal			
	history check and the department of human			
	services perform child and dependent adult abuse			
	record checks of the person in this state.			
	b. Conducting a background check. The facility			
	may access the single contact repository (SING)			
	to perform the required background check. If the			
	SING is used, the facility shall submit the person's			
	maiden name, if applicable, with the background			
	check request. If the SING is not used, the facility			
	must obtain a criminal history check from the			
	department of public safety and a check of the			
	child and dependent adult abuse registries from			

Facility Administrator

Date

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the department of human services. (I, II, III)	
AND	
50.9(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a facility, the facility shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. c. If a person being considered for employment has been convicted of a crime. If a person being considered for employment in a facility has been convicted of a crime under a law of any state, the department of public safety shall notify the facility that upon the request of the facility the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the facility. (I, II, III)	
DESCRIPTION: Based on personnel file review, policy review and staff interview, the facility failed to obtain timely criminal and abuse background checks prior to hire; and failed to secure an evaluation by the Department of Human Services (DHS) to determine whether or not the individual could work at the facility prior to hire. A concern was identified for 2 of 5 employee records selected for review (Staff F and Staff I). The facility identified a census of 90 residents.	Dogo 70 of

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	r		
Findings include:			
1. Review of the personnel file for Staff F, Certified Nurse Aide (CNA), identified a hire date of 5/10/17. The file contained a document titled "Single Contact License & Background Check (SING), dated 5/3/17, which identified the need for further research on criminal history. Review of a document titled "Iowa Record Check Request Form", dated 5/8/17, revealed a criminal offense. The file lacked the required clearance from the Department of Human Services (DHS) to work at the facility.			
During an interview on 8/9/17, at 9:30 a.m., the Human Resources Coordinator confirmed the results of Staff F's criminal background check required a DHS clearance to work in the facility and her personnel file lacked documented evidence of the clearance. During a follow-up interview on 8/9/17, at 10:15 a.m., reported she had faxed the required form to obtain the DHS clearance.			
Staff F's Timecard showed she worked from 5/10/17 to 7/7/17, including on 5/10/17, 5/11/17, 5/15/17.			
2. Review of the personnel file for Staff I, Dietary Aide, identified a hire date of 6/15/17. The file lacked a copy of a SING check and failed to include any other documented evidence of dependent adult abuse			Page 80 o
	 Review of the personnel file for Staff F, Certified Nurse Aide (CNA), identified a hire date of 5/10/17. The file contained a document titled "Single Contact License & Background Check (SING), dated 5/3/17, which identified the need for further research on criminal history. Review of a document titled "Iowa Record Check Request Form", dated 5/8/17, revealed a criminal offense. The file lacked the required clearance from the Department of Human Services (DHS) to work at the facility. During an interview on 8/9/17, at 9:30 a.m., the Human Resources Coordinator confirmed the results of Staff F's criminal background check required a DHS clearance to work in the facility and her personnel file lacked documented evidence of the clearance. During a follow-up interview on 8/9/17, at 10:15 a.m., reported she had faxed the required form to obtain the DHS clearance. Staff F's Timecard showed she worked from 5/10/17 to 7/7/17, including on 5/10/17, 5/11/17, 5/15/17. Review of the personnel file for Staff I, Dietary Aide, identified a hire date of 6/15/17. The file lacked a copy of a SING check and failed to include any other 	 Review of the personnel file for Staff F, Certified Nurse Aide (CNA), identified a hire date of 5/10/17. The file contained a document titled "Single Contact License & Background Check (SING), dated 5/3/17, which identified the need for further research on criminal history. Review of a document titled "Iowa Record Check Request Form", dated 5/8/17, revealed a criminal offense. The file lacked the required clearance from the Department of Human Services (DHS) to work at the facility. During an interview on 8/9/17, at 9:30 a.m., the Human Resources Coordinator confirmed the results of Staff F's criminal background check required a DHS clearance to work in the facility and her personnel file lacked documented evidence of the clearance. During a follow-up interview on 8/9/17, at 10:15 a.m., reported she had faxed the required form to obtain the DHS clearance. Staff F's Timecard showed she worked from 5/10/17 to 7/7/17, including on 5/10/17, 5/11/17, 5/15/17. Review of the personnel file for Staff I, Dietary Aide, identified a hire date of 6/15/17. The file lacked a copy of a SING check and failed to include any other 	 Review of the personnel file for Staff F, Certified Nurse Aide (CNA), identified a hire date of 5/10/17. The file contained a document titled "Single Contact License & Background Check (SING), dated 5/3/17, which identified the need for further research on criminal history. Review of a document titled "Iowa Record Check Request Form", dated 5/8/17, revealed a criminal offense. The file lacked the required clearance from the Department of Human Services (DHS) to work at the facility. During an interview on 8/9/17, at 9:30 a.m., the Human Resources Coordinator confirmed the results of Staff F's criminal background check required a DHS clearance to work in the facility and her personnel file lacked documented evidence of the clearance. During a follow-up interview on 8/9/17, at 10:15 a.m., reported she had faxed the required form to obtain the DHS clearance. Staff F's Timecard showed she worked from 5/10/17 to 7/7/17, including on 5/10/17, 5/11/17, 5/15/17. Review of the personnel file for Staff I, Dietary Aide, identified a hire date of 6/15/17. The file lacked a copy of a SING check and failed to include any other

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During an interview on 8/9/17, at 9:30 a.m., the Human Resources Coordinator confirmed the file lacked a SING check and reported she always does one and could look to see if it had been misfiled. During a follow-up interview on 8/9/17, at 10:15 a.m., the Human Resources Coordinator provided a copy of a SING check which identified a dependent adult abuse registry check but confirmed she had just completed the check earlier today.	
Staff I's Timecard showed she worked from 6/15/17 to 7/7/17, including on 6/15/17, 6/16/17, 6/19/17.	
Review of a facility policy titled "Abuse Prevention Plan", revised in June 2017, identified the facility will attempt to obtain information regarding a history of abuse, neglect or mistreatment of residents from appropriate licensing boards and registries, prior to a conditional offer of employment. In addition, the policy identified, after a conditional offer, but before an employee starts working, the facility must obtain criminal background checks from the Department of Public Safety and abuse checks from the Department of Human Services. FACILITY RESPONSE:	

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