PRINTED: 03/24/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		TE SURVEY MPLETED
		165161	B. WING	·		03	R 3 /01/2017
	PROVIDER OR SUPPLIER	COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	rs	{F 0	00)			
	revisit of the facility	encies relate to the first s annual health survey complaints #66009-C				Y	
	The complaints wer	re substantiated.					
{F 309} SS=G	Part 483, Subpart E	PROVIDE CARE/SERVICES	{F 30	09}			
	applies to all care a residents. Each res facility must provide services to attain or practicable physical well-being, consiste	e Indamental principle that Ind services provided to facility Isident must receive and the Ithe necessary care and Ithe maintain the highest Ithe mental, and psychosocial Int with the resident's Ithe essment and plan of care.					
	applies to all treatm facility residents. Ba assessment of a res that residents receiv accordance with pro practice, the compre	fundamental principle that ent and care provided to used on the comprehensive sident, the facility must ensure the treatment and care in ofessional standards of ehensive person-centered esidents' choices, including					
	(k) Pain Manageme The facility must en	nt. sure that pain management is					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SNZW12

Facility ID: IA0429

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION 3		E SURVEY IPLETED
		165161	B. WING	i			R
NAMEOF	PROVIDER OR SUPPLIER	103101	1		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	01/2017
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TOUCHS	TONE HEALTHCARE	COMMUNITY			SIOUX CITY, IA 51104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	consistent with profithe comprehensive and the residents' g (I) Dialysis. The factoresidents who requiservices, consistent of practice, the compared care plan, and the repreferences. This REQUIREMENT by: Based on clinical residents reviewed assessment and time residents reviewed assessment and time residents reviewed assessment and time resident #8 had a from the facility and a diagnost Resident #8's family condition and requestaff noted Resident well, with difficulty so the resident's clinical documentation or as change of condition transferred to the hose sepsis related to UT hypernatremia likely Resident #11 return following hospitalizative resident developed required return to the facility reported a certain septiment of the facility reported a certain septiment in the facility reported a certain septiment of the facility reported a certain septiment for the facility reported facility reported for the facility reported facility	ts who require such services, essional standards of practice, person-centered care plan, loals and preferences. cility must ensure that re dialysis receive such with professional standards aprehensive person-centered	{F 30	29)			
	i. According to the	withinfulli Data Set (MDS)					

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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
TOUCHS	TONE HEALTHCARE	COMMUNITY		1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 309}	assessment dated 2 on the Brief Intervindicating severe or impairment. Reside of one staff membe diagnoses included Parkinson's disease Resident #8's had a included: a. A Department of Services final report of Resident #8 had greforming units (CFU) urine. The report docurrent antibiotics. b. A Department of Services report colle Resident #8 had greforming units (CFU) urine. The report docurrent antibiotics. b. A Department of Services report colle Resident #8 had greform negative physician ordered a (an antibiotic) 500 m for 10 days. c. A Department of Services report colle report date of 9/20/greater than 100,00 coli in their urine. A Resident #8 receive mg 2 times a day from The resident's Careidentified that Reside with eating and had intake of food and fit to assist the resider to record meal intake	11/18/16, Resident #8 scored riew for Mental Status (BIMS) ognitive and memory nt #8 required the assistance in order to eat. Resident #8's Non-Alzheimer's dementia, and urinary retention. In history of UTIs, which of Pathology and Clinical Lab twith a collected dated of status dated 7/1/16 showed eater than 100,000 colony of aerococcus urinae in the ocumented to continue the of Pathology and Clinical Lab eater than 100,000 CFU per expected on 7/23/16 showed eater than 100,000 CFU per expected in their urine. The dministration of Cephalexin and (milligrams) 2 times a day of Pathology and Clinical Lab eater on 9/17/16 with a final fin	{F 30	9}		

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	PROVIDER OR SUPPLIER	COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	1 007	01/2017
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{F 309}	of UTIs. Review of the reside documentation of R A Progress Note da documented Reside from his/her spouse spouse visited multi A Weights and Vital documented Reside 1/9/17. The Progress Notes documented Reside swallow medication. physician at 11:20 a and the family mem documenting nurse not swallowed well a family stated he/she s/he believed Residemember wanted the The nurse requested and culture and sen and awaited a call be the physician's office member requested soon as possible, te on for at least a week Resident #8 had a Usend Resident #8 to Resident #8 left the p.m. The Progress Notes	ent's clinical showed no esident #8's fluid intake. ted 12/2/16 at 4:27 p.m. ent #8 had excellent support e and family. Resident #8's	{F 3·	09}			
	family member cam	e in and questioned how					

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	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 800 INDIAN HILLS DRIVE BIOUX CITY, IA 51104	007	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	Resident #8 could be member stated the would make Resided could and let him/he stated Resident #8 dehydration that his The family member to care for people or did not know? The ER recorded daresident arrived at 2 voiced that nursing resident fluids; family resident fluids; family resident fluids; family resident's mucosa (very dry. The ER refollowing abnormal cell count of 17.69 (level of 158 (elevated); a Blood 78 (very elevated), a elevated). The phy resident had the act related to a UTI and According to LabTes electrolytes (like sof function studies (like often present with decompanied Resid apparently over the declined, been more and was not eating.	be so sick. The family ER doctor told them they ent #8 as comfortable as they er die. The family member had such a bad UTI and /her body was shutting down. asked how a place supposed ould let this happen and they ated 1/20/17 documented the l:26 p.m. Family members home staff did not give the ly members do it. The mucous membranes) were eport documented the laboratory findings: a white normal 5 to 10); a sodium ed); a chloride level of 116 Urea Nitrogen (BUN) level of a Creatinine level of 256 (very rsician documented the ive diagnosis of sepsis I dehydration. ets Online, elevation of dium and chloride) and kidney e BUN and Creatinine) are	{F 3	09}			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION		E SURVEY IPLETED
		165161	B. WING			1	R 01/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	0112011
тоисня	STONE HEALTHCARE	COMMUNITY			1800 INDIAN HILLS DRIVE BIOUX CITY, IA 51104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	membranes. Hospi with minimal urine of the catheter tubing. #8 had been very codays, and had similar behat 156# (30# less the facility on 1/9/17). Feelight of the catheter tubing at 156# (30# less the facility on 1/9/17). Feelight of the catheter than the facility on 1/9/17). Feelight of the catheter than the facility on 1/9/17). Feelight of the catheter than the facility on 1/9/17). Feelight of the catheter than the facility of the	tal staff inserted a catheter butput with thick sediment in The family stated Resident onfused over the past couple ar episodes in the past with a aviors. Resident #8 weighed an the last weight at the Resident #8 appeared tic (ill health with all thinness), and sickly. oses included: ary to acute cystitis with a not of 17.69. The urine ocyte esterase with moderate oteria. Resident #8 started on and received 2 liters of and hospital staff planned to dration. The mean (elevated sodium level) ation as he/she did not eat or previous week. Opathy, secondary likely to the kidney injury, likely ration. On 2/28/17 at 12:10 p.m. Staff is sistant (CNA) stated to been him/herself that whole ent to the hospital. The ean appetite and pushed y. Resident #8 slept in their	{F 3	29}			

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		165161	B. WING	i		1	R 01/2017
	PROVIDER OR SUPPLIER	COMMUNITY		18	TREET ADDRESS, CITY, STATE, ZIP CODE 800 INDIAN HILLS DRIVE IOUX CITY, IA 51104	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	Residents #8's fam UTI prior to the day hospital, and the re Resident #8 could resident #8 mot recall anyone resident #8. She could not know the resident #8. She could not know the resident #8. She could not could not know the resident #8 could not could not know the resident #8 hours appetite had do for his/her normal fluin 1/18/17 for the Could gave Resident #8 hours wallow them. day. Staff C worried day before hospitalis During an interview H CNA (who worked Resident #8 did not super tired and not tray and s/he did not was hard to arouse way. The resident I drinking well. Staff Resident #8 vital sig Staff H did not recal	nat nurse she reported to. ily member thought s/he had a the resident went to the sident declined. Staff B stated not swallow the day before spital; the resident had dry speared very pale. on 2/28/17 at 3:13 p.m. Staff (RN) (who worked 1/19/17 d she did not usually work D recall anything because she sidents well enough. She did sporting anything to her about did not know what she would to know Resident #8. on 2/28/17 at 4:20 p.m. Staff ion Aid (CMA) stated Resident ecreased and he/she took half sids. Staff C stated he came thristmas party, a staff member is/her pills and he/she would Resident #8 seemed tired that d about Resident #8, but the zation, s/he seemed OK. on 2/28/17 at 4:30 p.m. Staff d 1/19/17 evening shift) stated want to eat or drink, was talking. They sent him/her a set eat or drink. Resident #8 and had been getting that had not been eating or H stated she checked gns and they were normal. Il who the nurse was. Staff H is spouse expressed concern	{F 3	09}			

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NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01,2017
тоисня	TONE HEALTHCARE	COMMUNITY	•		1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	A Licensed Practica 1/20/17, she worked 4 years. She stated swallow pills. She as Staff B told Staff A to that for a few days, and she didn't know Resident #8's spous concerned about he Resident #8's spous had been (going on doctor's office and swallow, had lethard been a week. The dreturned the call whishowed up very upsoffice again and said was dying. The doc non-emergent trans Resident #8 looked was dehydrated. Streported (Resident #8 staff C but no one rethe charge nurse (of day before. She said would have assessed skin, urine, etc. Staff looked dehydrated bethe doctor's office. Staff C but no one rethe charge nurse (of day before. She said would have assessed skin, urine, etc. Staff looked dehydrated bethe doctor's office. Staff C but no one rethe charge nurse (of day before. Staff C but	on 3/1/17 at 11:43 a.m. Staff I Nurse (LPN) stated on I D hall for the first time in 3 to I Resident #8 could not esked Staff B about it and hat Resident #8 had been like She asked the unit manager the normal for Resident #8. See called about 8:00 a.m. whe/she was doing. See then showed up and said it is a week. Staff A called the said Resident #8 could not another family member et. Staff A called the doctor's office had not en another family member et. Staff A called the doctor's office said okay for fer to the ER. Staff A said rough and she thought s/he aff B told Staff A she had f8's condition) many times to exported to Staff A, who was in C hall) covering D hall the diff staff had reported she ed the resident's vital signs, aff A thought Resident #8 but she did not report that to Staff A felt like she had a live been taken care of a day	{F 3	09)			
	week until 1/20/17, a hospital. She move	after Resident #8 went to the d from the A hall to the D hall and did not get report.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION			E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	ODE .	<u> </u>	V 112-11
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{F 309}	idea what had hap member was very be in that condition that evening and to very ill. Staff D sate eat well she would and symptoms of mucous membrand a family member would call the document of the physical that it is a second to the hospital. The would assess urine, push fluids a buring an interview Resident #8's spot the nurse she thout to the hospital. The would interview Resident #8's spot the nurse she thout to the hospital. The would interview Resident #8's spot the nurse she thout to the hospital. The would interview Resident #8's spot the nurse she thout to the hospital. The would interview Resident #8's spot the nurse she thout to the hospital. The would interview Resident #8's spot to the hospital. The would interview Resident #8's spot to the hospital. The would interview Resident #8's spot to the hospital. The would interview Resident #8's spot to the hospital. The would interview Resident #8's spot to the hospital. The would interview Resident #8's spot to the hospital. The would interview Resident #8's spot to the hospital. The would interview Resident #8's spot to the hospital would would interview Resident #8's spot to the hospital would interview	B's family came in, she had no opened. Resident #8's family upset about how he/she could n. Staff D called the hospital hey told her Resident #8 was id if a resident did not drink or I check urine, check for signs dehydration (like skin and es) and notify the physician. If wanted a resident seen she tor right away. W on 3/1/17 at 7:53 a.m. Staff E sident's family wanted a ne physician or in the ER she sician. She would also assess otify the physician of the	{F 30	09}			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION 3	COM	E SURVEY IPLETED
		165161	B. WING	. i		1	R 01/2017
	PROVIDER OR SUPPLIER			٠	STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	1 03/	01/201/
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	Resident #8's spout 1/20/17 about 10 a. worsened. The spot had contacted the puthere had been not the physician. The not have time right family member arrivithe nurse's office an physician. The staff office said family the The spouse stated Resident #8's condition took 30 to 45 minute. Resident #8 to the ER told the family was totally dehydrate. During an interview. Nurse Consultant stand they had not include been declining for dephysical and stated patient two liters of for dehydration. She staff to assess and or drink well and had the facility's Interact (potential for) docur resident at risk for or decreased oral intal on others for fluids at the path directed the signs. If they did not to assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental st genitourinary, and stated patient would be assess mental stated be assess mental stated patient would be assess mental stated b	e physician in the a.m. se returned to the facility on m. and could tell s/he had buse asked the nurse if she physician and the nurse said ning in report about notifying nurse told the spouse she did then, she was busy. Another wed around 11:00 a.m. went to and stayed until they called the f who called the physician's bought Resident #8 was dying, no one did any assessment of tion. The spouse stated it es to get someone to take ER per van. The physician in ity Resident #8 had a UTI and	{F 3	09}			

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NAME OF E	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE		
TOUCHS	TONE HEALTHCARE	COMMUNITY			BIOUX CITY, IA 51104		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	Continued From pa	ge 10	{F 30	09}			
		ge, not eating or drinking at all it. If noted notify the	•				
	p.m. documented R 12/22/16. Resident oriented to person,	ting dated 12/22/16 at 1:43 Resident #11 admitted on #11 presented as alert and place, time and situation. red assistance with transfers					
	documented Reside constant sharp lower of 10. The resident hypoactive (slow) on the left, with tendern #11 had been restled lung sounds showed diminished. Reside	s dated 12/27/16 at 4:31 a.m. ent #11 complained of er abdominal pain rating 8 out 's bowel sounds were in the right side and absent on ness on palpation. Resident #ss all night. Resident #11's d slight crackles and were ent #11 requested to return to called the paramedics for					
	documentation until the Progress Notes complained of fluid s/he had shortness not urinating since to the physician for ord Resident #11 comp urinate, and his/her with fluid. Resident sputum and the nur him/her back to the	acked any additional 1/5/17 at 11:47 p.m. when documented Resident #11 buildup. Resident #11 stated of breath and complained of being there. The nurse called ders. On 1/6/17 at 1:58 a.m. lained of the inability to legs and abdomen were filling #11 coughed up blood tinged se received orders to transfer hospital. At 4:37 a.m. the spital and Resident #11					
	A History and Physi	cal dated 1/6/17 documented					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{F 309}	Resident #11 had of the previous morning Resident #11 press (coughing blood), a retention. A bladde had greater than 8 their bladder. The facility failed to Resident #11 on his on 1/5/17. During an interview Nurse Consultant a Resident #11 had resident #10 on the resident with the confirmal factor of his/her condition complaints on the reconsultant expected.	discharged from the hospital ing (1/5/17) to the facility. ented with hemoptysis shortness of breath and urinary er scan showed Resident #11 50 cubic centimeters of urine in perform any assessment of s/her return from the hospital or on 3/1/17 at 11:00 a.m. the stated she had to check on insfer information due to the tion in the clinical record. Teturned from the hospital on	{F 30)9}		
	facility failed to pro- and timely interven reviewed (Resident had a history of Uri diagnosis of urinary family had concern requested he/she b Resident #8 not ea difficulty swallowing through the week.	eview and staff interview, the vide adequate assessment tion for 2 of 11 residents t #8 and #11). Resident #8 nary tract infection (UTI) and a y retention. Resident #8's s with his/her condition and be seen. Facility staff noted ting or drinking well, with g. Staff indicated this went on The clinical record lacked any Resident #8's change of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		165161	B. WING	,			R /01/2017
	PROVIDER OR SUPPLIER	COMMUNITY		STREET ADDRESS, CITY, STATE, ZIF 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTIVE ACTI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 309}	Resident #8's cond transferred to the h sepsis related to ur acute kidney injury related to dehydrati. The facility reported: 1) According to the assessment, dated 2 on the Brief Intensindicating severe co. #8 required extensistivity daily living (ADL's) hygiene and toilet us included non-Alzhe disease, and urinar. Resident #8's histo (UTI) included: a. A Department of Services final report Resident #8 had gr forming unit (CFU) urine. The report discurrent antibiotics. b. A Department of Services collected of 7/27/16 showed	Facility failed to assess lition. On 1/20/17 Resident #8 cospital where he/she had inary tract infection (UTI) and and hypernatremia likely ion. It is a census of 86 residents. Minimum Data Set (MDS) 11/18/16, Resident #8 scored view for Mental Status (BIMS) ognitive impairment. Resident ive assistance with activities of including eating, personal ise. Resident #8's diagnoses imer's dementia, Parkinson's	{F 30				
	500 mg 2 times a d c. A Department of Services collected 9 of 9/20/16 showed	took Cephalexin (antibiotic) ay for 10 days. of Pathology and Clinical Lab 9/17/16 with a final report date Resident #8 had greater than nl of escherichia coli in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL [*] A. BUILDI		(X3) DATE SURVEY COMPLETED		
		165161	B. WING			R	
		100101	D. WING.			03/	01/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TOUCHS	TONE HEALTHCARE	COMMUNITY			800 INDIAN HILLS DRIVE		
1000110	TONE HEREIHORINE			S	IOUX CITY, IA 51104		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL	PREFIX	Κ	(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE
TAG	REGULATURY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	XIATE	1 2702
{F 309}	Continued From pa	ugo 12	(E 30	101			
fr anal	,		{F 30	19}			
		Record showed Resident #8		İ			
		acrobid (antibiotic) 100 mg 2					
	times a day for 10 o	lays.					
	The Care Plan revis	sed 7/5/16 identified Resident					
		nce with eating, with a goal to		- 1			
		ake of food and fluids. The					
		ed any documentation of					
	Resident #8's fluid i						
		ed any identification of					
	Resident #8's histor						
		•					
	A Progress Note da	ited 12/2/16 at 4:27 p.m.					
	documented Reside	ent #8 had excellent support				•	
	from his/her spouse	and family. Resident #8's					
	spouse visited mult	iple times a week.					
		s Summary documented					
	Resident #8 weighe	ed 186# on 1/9/17.					
	The Business Meter	- d-6-d 4/00/47 40:40 ·· ·-					
		s dated 1/20/17 12:42 p.m.					
		ent #8 physically unable to					
		. Staff called the physician at ated on the issue and the					
		ncern. Staff told the nurse				ľ	
		t swallowed well since the				ľ	
		ne the family stated he/she					
		ek and believed he/she had a					
j		nted the urine checked. The					
		order for a urine analysis and					
		ity per straight catheter. The		1			
		ould return the call. At 17:25		1		1	
	p.m. staff called the	physician's office again when					
		ber of Resident #8's				}	
	requested they get	him/her seen ASAP, telling the				,	
		on for at least a week. The					
		ident #8 had a UTI. Staff					
		send Resident #8 to the					
	emergency room (E	R). Resident #8 left the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		165161	B. WING						
	PROVIDER OR SUPPLIER	COMMUNITY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
{F 309}	facility at approximate The Progress Note documented Residin and questioned in an and questioned in a series in a provious week hels weak, had more concept in a catheter thick sediment in the stated Resident #8 to the previous week hels weak, had more concept in a catheter thick sediment in the stated Resident #8 the past couple day the past with a UTI Resident #8 weight at the far appeared dehydrate emaciation/abnorm Resident #8's diagonal and an another the provious week hels weight at the far appeared dehydrate emaciation/abnorm Resident #8's diagonal question in a sepsis second white blood cell courthe urine revealed moderate blood and provided in a sepsis second white blood cell courthe urine revealed moderate blood and provided in a sepsis second white blood cell courthe urine revealed moderate blood and provided in a sepsis second white blood cell courthe urine revealed moderate blood and provided in a sepsis second white blood cell courthe urine revealed moderate blood and provided in a second in a seco	ately 1:20 p.m. s dated 1/20/17 at 4:41 p.m. ent #8's family member came now his/her family member the family member stated the n they would make Resident as they could and let him/her mber stated Resident #8 had d dehydration that his/her body The family member asked sed to care for people could let ne questioned how they did not and Physical dated 1/20/17 ief complaint as altered weakness per reports from the ty staff. Family accompanied ER and apparently over the she had declined, been more infusion, and not eating. very dehydrated with cous membranes. They with minimal urine output with e catheter tubing. The family had been very confused over is, and had similar episodes in and similar behaviors. and at 156# (30# less than the cility on 1/9/17). Resident #8 ed, cachetic (ill health with al thinness), and sickly.	{F 3	09}					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165161	B. WING				R 01/2017
	PROVIDER OR SUPPLIER			S 1	STREET ADDRESS, CITY, STATE, ZIP CODE 800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	<u> 03/</u>	0112017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
{F 309}	likely due to dehydr drank well over the c. Acute encepha sepsis and UTI. d. Acute on chron secondary to dehyd During an interview I Certified Nursing A Resident #8 had no week that he/she w not have an appetite away. Resident #8 not unusual for him. During an interview B CNA stated Resid didn't drink, so he/s the whole week. St nurse about Reside but did not know who Residents #8's spouprior to the day he/she declined. St could not swallow the hospital. He/she appeared very pale. During an interview F Registered Nurse evening shift) stated hall, so she did not did not know the result recall anyone recall anyon	is fluid. Iremia (elevated sodium level) ation as he/she did not eat or previous week. Ilopathy, secondary likely to ic kidney injury, likely ration. on 2/28/17 at 12:10 p.m. Staff Assistant (CNA) stated to been him/herself that whole ent to the hospital. He/she did e and pushed food and fluids slept in his or her chair a lot, liker. on 2/28/17 at 2:19 p.m. Staff lent #8 did not eat well and he slept a lot, and it went on aff B stated she reported to a not #8 not eating or drinking, at nurse she reported to. Use thought he/she had a UTI she went to the hospital, and raff B stated Resident #8 ne day before he/she went to be had dry cracked lips and on 2/28/17 at 3:13 p.m. Staff (RN) (who worked 1/19/17 of she did not usually work D recall anything because she sidents well enough. She did porting anything to her about id not know what she would	{F 30)9}			

AND DUAN OF CORRECTION DENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	•	165161	B. WING	i	-	R 03/01/2017	
	PROVIDER OR SUPPLIER	COMMUNITY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	<u>, </u>	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 309}	During an interview C Certified Medicat #8's appetite had d of his/her normal fluin 1/18/17 for the C gave Resident #8's not swallow them. day. Staff C worried day before hospital During an interview H CNA (worked 1/1 Resident #8 did not super tired, and not tray and he did not super tired and hargetting that way. H drinking well. Staff Resident #8 vital sig Staff H did not recastated Resident #8' about his/her conditional During an interview A Licensed Practical 1/20/17 she worked years. She stated swallow pills. She asked the know the normal for spouse called about how he/she was do then showed up and week. Staff A called Resident #8 could response said it hoffice did not return	on 2/28/17 at 4:20 p.m. Staff ion Aid (CMA) stated Resident ecreased and he/she took half uids. Staff C stated he came hristmas party, a staff member his/her pills and he/she would Resident #8 seemed tired that d about Resident #8, but the ized he/she seemed OK. on 2/28/17 at 4:30 p.m. Staff 9/17 evening shift) stated want to eat or drink, was a talking. They sent him/her a leat or drink. Resident #8 was a d to arouse, and had been el/she had not been eating or H stated she checked gns and they were normal. Il who the nurse was. Staff H is spouse expressed concern	{F 3	09}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		165161	B. WING			R 03/01/2017		
	PROVIDER OR SUPPLIER	1.		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	1 03/	01/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 309}	Resident #8 was dy okay for non emerg said Resident #8 lodehydrated. Staff Ereported (Resident Staff C but no one of the charge nurse (oday before. She sai would have assessed skin, urine, etcOn #8 had been like the Resident #8 looked that to the doctor's a mess that should day or days before. During an interview D LPN stated she howek until 1/20/17, hospital. She move after the shift started When Resident #8's idea what had happ member was very ube in that condition. That evening and the very ill. Staff D said eat well she would cand symptoms of demucous membrane a family member was would call the doctor. During an interview LPN stated if a residerit seen by the would call the physical said the said said	and said the family felting. The doctor's office said ent transfer to the ER. Staff A oked tough and she thought a told her that she had #8's condition) many times to reported to Staff A, who was in C hall) covering D hall the dif Staff had reported she ed the resident's vital signs, 1/20/17 Staff C said Resident at for a week. Staff A thought dehydrated but did not report office. Staff A felt like she had have been taken care of a on 3/1/17 at 10:15 a.m. Staff ad not worked on D hall that after Resident #8 went to the did and did not get report. It is family came in, she had no ened. Resident #8's family pset about how he/she could Staff D called the hospital ey told her Resident #8 was if a resident did not drink or check urine, check for signs enydration (like skin and so, and notify the physician. If anted a resident seen she	{F 30	09}				

AND DIAM OF CORDECTION INCOMPRED 1		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		165161	B. WING			R	
		100101	B. WING -			3/01/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
TOUCHS	TONE HEALTHCARE	COMMUNITY		1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF		(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLÉTION DATE	
{F 309}	Continued From pa	ge 18	{F 30	9}			
	Resident #8's physi not eat or drink well assess the resident member wanted a r	on 3/1/17 at 8:31 a.m. cian stated if a resident did she would expect staff to and report. If a family esident seen, she would call and they would get them					
	RN stated if a reside	on 3/1/17 at 9:12 a.m. Staff G ent did not eat or drink well, or orientation, check urine, ort to the physician.					
	Resident #8's spous the nurse she thoug to the hospital. The #8's spouse told the	on 3/1/17 at 9:25 a.m. se stated on 1/19/17 she told tht Resident #8 needed to go nurse asked why. Resident nurse he/she was ill, not tell. The nurse told Resident	•				
	#8's spouse she wo day nurse to call the Resident #8's spous and could tell he/she	uld leave a message for the physician in the a.m. se went the following morning a had worsened. The spouse he had contacted the		,			
	physician and the nonthing in report about the nurse told the stright then, she was arrived around 11:00 office and stayed un	urse said there had been but notifying the physician. pouse she did not have time busy. Another family member 0 a.m. went to the nurses till they called the physician.					
	family thought Resid spouse stated no or Resident #8's conditook 30 to 45 minute Resident #8 to the E	I the physician's office said dent #8 was dying. The ne did any assessment of tion. The spouse stated it es to get someone to take ER per van. The physician in ly Resident #8 had a UTI and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		165161	B. WING			R 03/01/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		00/01/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{F 309}	nurse consultant sta and they had not ind been declining for de and physical and sta a patient two liters of for dehydration. Sh staff to assess and or drink well and had The Interact Care Pfor) documented a crisk for dehydration intake over 48 hours fluids, and swallowing was checking vital sign functional status, ge Evaluate symptoms status change, not es	_	{F 30	9}			
	p.m. documented R 12/22/16. Resident oriented to person,	rting dated 12/22/16 at 1:43 esident #11 admitted #11 presented alert and place, time and situation. ed assistance with transfers					
	documented Reside constant sharp lower 10. The bowel sour right side, and abse	s dated 12/27/16 at 4:31 a.m. ent #11 complained of er abdominal pain at 8 out of ends were hypoactive on the ent on the left, with tenderness ent #11 had been restless all					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		70172011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
{F 309}	crackles and were requested to return the paramedics for room. The clinical record documentation until the Progress Notes complained of fluid he/she had shortne of not urinating sinc called the physiciar Resident #11 compurinate, and his/her with fluid Resident inged sputum and transfer him/her baa.m. the nurse called #11 admitted. A History an Physic Resident #11 had do the previous a.m. 1. #11 presented with breath and urinary is scan and Resident the bladder. The facility failed to Resident #11 on his During an interview	age 20 1's lung sounds had slight diminished. Resident #11 to the hospital. Staff called transfer to the emergency lacked any additional 1/5/17 at 11:47 p.m. when a documented Resident #11 build up. Resident #11 stated so of breath, and complained be being there. The nurse of for orders. At 1:58 a.m. lained of the inability to regs and abdomen were filling int #11 coughed up blood the nurse received orders to ock to the hospital. At 4:37 and the hospital and Resident when the hospital retention. They did a bladder #11 had greater than 850 cc in perform any assessment of solver return from the hospital. on 3/1/17 at 11:00 a.m. the tated she had to check on	{F 30	,				
	Resident #11's translack of documentati Resident #11 had re 1/5/17. She confirm	sfer information due to the on in the clinical record. eturned from the hospital on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	165161	B. WING		03/	01/2017	
NAME OF PROVIDER OR SUPPLI			STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
on the night shift expected staff to and status on re	on, until he/she had complaints The Nurse Consultant document a residents return, rurn from the hospital. NUTRITIVE VALUE/APPEAR, EFER TEMP	{F 30				
(d)(1) Food prep nutritive value, fl (d)(2) Food and and at a safe an This REQUIREM by: Based on obser group and staff i serve the reside temperature. The Findings include 1. During group 1:00 p.m. four of did not always group and staff C, Certified trays on G hall. At 8:50 a.m., Sta	Based on observation, dietary menu review, group and staff interview, the facility failed to serve the residents food at safe and appetizing temperature. The facility census was 86 residents Findings include: 1. During group interview conducted on 2/28/17 at 1:00 p.m. four of seven residents stated the food did not always get served hot. 2. During observation on 3/1/17 at 8:45 a.m., Staff C, Certified Medication Aide (CMA) passed trays on G hall. At 8:50 a.m., Staff K, Dietary Aide checked the temperature of the resident food items on the					

TOP DE AN AR AGORDONIAN INC. INC. INC. INC. INC. INC. INC. INC			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		165161	B. WING_		R 03/01/2017	
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 364	stated the hot food	n 3/1/17 at 8:45 a.m., Staff C should have measured around ne milk should not be that	F 36	4		

			•	
		ı		

Touchstone Healthcare Community Plan of Correction

Date: 03/27/2017

F309 Provide Care/Services for Highest Well Being

Immediate corrective action:

R#8 and R#11 no longer reside at the facility

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Education has been provided to nurse aides on reporting change in condition including decrease in appetite, intake of fluids.

Education has been provided with licensed nurses on completion of assessment and documentation of assessment when resident experiences a change in condition. Licensed nurses were also educated on completion of assessment and documentation of assessment for all new admissions/readmissions.

Date of completion: 04/04/2017

Recurrence will be prevented by:

Daily monitoring of progress notes will be completed seven days a week to monitor for assessment/documentation completion. Report will be given to nurse managers by licensed nurses and nurse aides seven days a week, reporting any changes in condition, decreased intakes, etc.

The correction will be monitored by: Administrator/designee will complete audits three days a week for four weeks. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/designee

Touchstone Healthcare Community Plan of Correction

Date: 03/28/2017

F364 Nutritive Value/Appear, Palatable/Prefer Temp

Immediate corrective action:

Steam tables were utilized to set up room trays on units when staff available to pass trays immediately to residents.

Action as it applies to others:

All residents residing in the facility have the potential to be affected.

Dietary staff were educated on appropriate temperature ranges of hot and cold foods.

Date of completion: 04/04/2017

Recurrence will be prevented by:

Dietary Manager will utilize temperature log daily to log food temperatures prior to meal service/tray service.

The correction will be monitored by: Administrator/designee will complete audits three times weekly for four weeks to ensure compliance. The results of these audits will be brought to the Quality Conference Meeting for review.

The correction will be monitored by: Administrator/designee