STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 10/1/17 The following deficiencies are the result of the facility's annual health survey. Investigation of facility-reported incidents # 69130-I and # 70474-I and complaint # 69636-C did not result in deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/18/2017

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

POC accepted 9/28/17 VSummers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1	F 156		

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email),	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 3 and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 4 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 5 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to adequately inform 1 of 3 residents reviewed of their appeal rights following discharge from skilled services (Resident #12). The facility reported a census of 30 residents. Findings include:	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 6 A facility-provided list entitled Skilled Residents indicated that Resident #12 received Medicare Skilled Services 5/13/17 to 6/9/17 and remained in the facility after that. The facility could provide no documentation of the resident's or representative's option to appeal discharge from skilled services or receipt of the notice that the skilled services were ending. During an interview with the social worker designee and Staff B, Director of Clinical Services on 8/29/17 at 10:40 AM, they confirmed they could not locate any paperwork to verify the resident received notice of the services ending or a choice of whether to appeal the discharge from skilled services.	F 156		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 7 requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure all staff have received an abuse and criminal back ground history check from the Iowa Department of Public Safety (Administrator). Five personnel files were reviewed and the facility reported a census of 30 residents. Findings include: 1. Personnel record review for the facility's new hires since last survey revealed the Administrator's date of hire as 4/24/17. A review of the employee's file revealed a criminal background check dated 5/23/17, 29 days after the Administrator's hire date. An interview on 8/29/17 at 9:30 a.m. with the Director of Clinical Services identified the corporate office failed to do a criminal background check prior to hiring When staff noticed the background check had not been completed, the corporate office completed the	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8 background check on 5/23/2017. A review of the facility's Abuse Prevention Plan, revision date 2/2017, revealed: III. Components of abuse prevention plan; procedure: A. Screening: 2. For all potential employees and contracted workings: (1) After a conditional offer BUT before an employee starts working, facility must obtain criminal background checks from the Department of Public Safety and abuse checks from the Department of Human Services.	F 226		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and review of policy and procedures, the facility failed to prevent the development of a pressure sore and failed to adequately follow the facility policy and procedures and assess the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 pressure sore weekly for 1 of 1 resident reviewed with a pressure sore (Resident #3). The facility reported a census of 90 residents. Findings include: Resident #3 had a MDS (Minimum Data Set) assessment with a reference dated of 6/28/17. The MDS identified the resident had diagnosis including, anemia (low red blood count), hypertension (elevated blood pressure), diabetes mellitus, non-Alzheimer's disease, anxiety disorder, depression, history of falling, dysphasia (partial or complete ability to communicate due to brain injury) and generalized muscle weakness. The resident scored 1 on the BIMS (Brief Interview for Mental Status) test. A score of 1 identified severely impaired cognition. The MDS identified the resident required extensive assistance of 2 or more staff members for bed mobility, dressing, toilet use and personal hygiene. The resident did not walk in the room or corridor. The assessment documented the resident had 1 unstageable deep tissue injury. The MDS identified the resident did not have a turning and repositioning program. A MDS dated 2/3/17 documented no unhealed pressure ulcers. A Braden Scale Assessment for Predicting the risk for Pressure Sore development, dated 1/4/17 identified a score of 16. A score of 16 represented the resident at risk for the development of pressure sores. The Care Plan identified a focus area related to skin breakdown on 2/10/15 and revised on 8/12/17. The approaches identified an air	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10	F 314		

mattress overlay on the bed and a pressure reducing cushion in the wheel chair as implemented on 2/10/15 and revised on 8/26/17. Additional interventions included: On 8/16/17 the staff were directed to keep the Prevalon boots (cushioned boots to suspend heel) on feet for pressure relief and to provide incontinence care and report any open or red skin areas to the nurse.

The Care Plan identified a focus area on 2/10/15 and revised on 3/31/17 for the risk for pain. The interventions included and directed staff to assist the resident with repositioning (no frequency identified).

Review of an Initial Weekly Wound Documentation Form identified the following:

On 5/10/17, the right heel blister measured 3.5 centimeters (cm) by 2 cm. The form documented the nurse notified the physician on this date. The form documented the wound treatment was to float the heels. A Treatment Administration Record (TAR) dated 5/1/17-5/31/17 identified a skin prep treatment to the right heel initiated on 5/11/17 twice daily.

A weekly wound documentation form dated 5/15/17 indicated the right heel measured 3.5 cm by 4 cm with a depth unable to determine. The form documented the facility facsimiled (faxed) an update to the physician.

A weekly wound documentation form dated 5/22/17 indicated the right heel measured 5.5 cm by 5.5 cm with a depth unable to determine. The form documented the facility faxed an update to the physician regarding an overall decline in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 condition of the heel. The May 2017 TAR reflected no new treatment orders. A weekly wound documentation form dated 5/30/17 identified the right heel measured 4 cm by 7 cm with the depth unable to be determined. The form documented a moderate amount of serosanguinous (clear/bloody) drainage. The form documented to start new treatment orders and have a wound nurse evaluate the next week. The June Medication Administration Record (MAR) documented that Vitamin C 500 milligrams (mg) daily and Zinc 220 mg daily for 14 days was initiated on 6/14/17 (nutritional supplements). Arginade (nutritional drink providing protein and calories)) 1 package initiated twice daily for 14 days on 6/13/17 for wound healing. The June 2017 TAR documented a new treatment initiated on 5/30/17, but administered first on 6/1/17 for skin prep to the wound edges, Calcium Alginate (medicated dressing) to fit wound bed, cover with absorptive dressing and secure with gauze and tape, change the dressing daily and as needed. The TAR identified discontinuation of the treatment on 6/21/17. The June 2017 TAR documented a new treatment initiated on 6/22/17 to cleanse the wound, apply hydrogel to wound, cover with absorptive dressing and secure with gauze daily. A weekly wound documentation form dated 6/6/17 revealed the right heel measured 6 cm by 6.8 cm with a depth unable to determine. The form documented a scant amount of serosanguinous drainage with instruction to continue with the current treatment.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 A weekly wound documentation form dated 6/12/17 revealed the right heel measured 5.5 cm by 4.5 cm with a depth unable to determine. The form documented no drainage. A weekly wound documentation form dated 6/19/17 revealed the right heel measured 3.5 cm by 6.5 cm with a depth unable to determine. The form documented no drainage and identified the skin beginning to peel and black eschar remained. A weekly wound documentation form dated 6/27/17 indicated the right heel measured 5.5 cm by 4.5 cm with a depth unable to determine. The form documented a moderate amount of serosanguinous drainage. The nurse's analysis documented the wound was difficult to visualize and there was bloody drainage with the dressing change. A weekly wound documentation form dated 7/3/17 indicated the right heel measured 2 cm by 0.5 cm with a depth unable to determine. The form documented a scant amount of serosanguinous drainage. The form documented that the wound improved. A weekly wound documentation form dated 7/18/17 (8 days later) revealed the right heel not measured. The form documented no drainage. A weekly wound documentation form dated 7/19/17 identified the right heel without measurements. The July 2017 TAR documented a treatment initiated on 7/20/17 for skin prep daily to the right heel and discontinued 7/30/17.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 13 On 7/9/17 the staff initiated a Weekly Wound Documentation Form for a left heel pressure wound with no measurements documented on this form. The form documented a wound treatment plan to cleanse, apply skin prep and cover with Optifoam Gentle border dressing, float heels as able and moon boots. A weekly wound documentation form dated 7/10/17 identified the right heel measured 2 cm by 0.5 cm with a depth unable to determine. The form documented a scant amount of serosanguinous drainage. A weekly wound documentation form dated 7/10/17 revealed the left heel measured 5 cm by 4 cm with a depth unable to determine. The form documented no drainage. A weekly wound documentation form dated 7/18/17 (8 days later) revealed the left heel measured 4 cm by 4 cm with a depth unable to determine. The form documented no drainage. Observation on 8/28/17 at 9:10 a.m. identified the resident in bed and measured the left heel. The left heel wound measured 4 cm by 3 cm with dark eschar present. The Director of Nursing applied skin prep to the area. The left inner buttock measured 1.5 by 2 cm and the right buttock measured 1 by .8 cm. The July 2017 TAR documented a treatment initiated on 7/12/17 for skin prep daily to the left heel and discontinued 7/20/17. On 7/24/17 the left heel measured 4.5 cm by 4 cm with a depth unable to determine. The form	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 documented no drainage. The July 2017 TAR documented a treatment initiated on 7/9/17 to cleanse the left heel, dry, apply skin prep to the affected area, let dry, and apply Optifoam Gentle border dressing every 3 days and as needed. The July TAR documented the staff administered the treatment on 7/10/17 and was discontinued on 7/11/17. The weekly wound form dated 8/8/17 (15 days later) the left heel measured 2 cm by 2.8 cm with a depth unable to determine. The form documented no drainage. On 8/21/17 (13 days later) identified the left heel measured 4 cm by 3 cm with a depth unable to determine. The form documented no drainage. On 8/28/17 the wound form identified the left heel as unstageable with 100 percent eschar and 4 cm by 3 cm. The August 2017 TAR documented a treatment initiated on 7/31/17 for skin prep daily to the both heels. The August 2017 TAR documented a treatment initiated on 8/6/17 from 8/22/17 to mix collagen powder with normal saline to a paste consistency and apply to the wound bed, cover with dressing and change daily and as needed. The weekly wound documentation form identified the following: A weekly wound documentation form dated 7/10/17 revealed the coccyx wound measured 4 cm by 3 cm with a depth unable to determine. The form documented a moderate amount of	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15 serosanguinous drainage. The July 2017 TAR documented a treatment initiated on 7/10/17 to cleanse the coccyx wound with wound cleanser, apply skin prep around the wound, apply Aquacel to the wound bed and cover with Optifoam Gentle border dressing daily and as needed. The TAR indicated the treatment order discontinued on 7/11/17. The July 2017 TAR documented a treatment initiated on 7/11/17 to apply Optifoam dressing to the coccyx every 3 days and as needed. The July TAR documented the staff administered no treatment from 7/11/17 7/10/17 until the treatment was discontinued on 7/21/17. A weekly wound documentation form dated 7/24/17 (14 days later) revealed the coccyx wound measured 4.5 cm by 2.5 cm with a depth unable to determine. The form documented a moderate amount of serosanguinous drainage. The form documented a wound nurse was scheduled to be here Wednesday (2 days later). A weekly wound documentation form dated 7/24/17 identified the coccyx wound measured 1 cm by 1 cm with a depth unable to determine. The form documented a moderate amount of serosanguinous drainage. The form documented a wound nurse was scheduled to be at the facility on Wednesday. The 8/28/17 weekly wound sheets identified the coccyx wound intact. The July 2017 TAR documented a treatment for Nystatin powder (antifungal topical powder) to the coccyx three times daily initiated on 7/2/17 for 3 weeks and discontinued on 7/28/17.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16 On 7/5/17, the staff initiated a Weekly Wound Documentation Form for a left buttock moisture associated skin wound measuring 3.0 cm by 1.0 cm. On 8/21/17 identified the Stage II inner left buttock wound measured 1.8 cm by 2 cm by 0.1 cm. The form documented a scant amount of serosanguinous drainage. On 8/28/17 identified the Stage II inner left buttock wound measured 1.5 cm by 2 cm by 0.1 cm. The form documented no drainage. On 8/21/17 the Stage II inner right buttock wound measured 1.2 cm by 1.2 cm by 0.1 cm. The form documented a scant amount of serosanguinous drainage. On 8/28/17 identified a Stage II inner right buttock wound measured 1 cm by 0.8 cm by 0.1 cm. The form documented no drainage. During an interview with the Director of Nursing (DON) on 8/28/17 at 2:45 PM, she stated the resident developed pressure ulcers here at the facility. She stated the resident was not wearing protective heel boots prior to the development but the staff did float the resident's heels. Review of a facility policy with a revision date of April 2016 entitled Skin Program instructed when a skin ulcer is identified; a comprehensive wound assessment will be completed. Reassess the wound at least weekly.	F 314		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 17 (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain clean and sanitized exterior and interior cabinets and drawers in the kitchen and around the handwashing sink. The facility identified a census of 46 residents. Findings include: 1. Observation during an initial kitchen tour on 8/27/17 at 9:35 AM revealed the following concerns: a. A sticky exterior of the wood cabinet doors; b. The inside surface of the drawers and bottom cabinet surfaces contained debris; c. A black greasy substance on the surface under the sink. During an interview at this time with Staff B, dietary aide, she stated that the black substance under the sink was grease from the griddle.	F 465		
F 499 SS=D	483.70(f)(1)(2) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS (f) Staff qualifications.	F 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 499	Continued From page 18 (1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. (2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on a review of personnel files and staff interviews, the facility failed to ensure current licenses for 2 of 5 files reviewed (the Administrator and Staff A). The facility identified a census of 30 residents. Findings include: 1. Review of a list of the facility's new hires since last survey revealed the Administrator's hire date as 4/24/17. A review of the employee's file revealed no verification of a current administrator's license prior to hire. An interview on 8/29/17 at 1:30 p.m. with the Business Office Consultant confirmed the Administrator's file lacked verification of a current Administrator's license prior to hire. The Business Office Consultant stated that staff verified the Administrator's license on 5/23/17 with the background check, or 29 days after hire. 2. Review of a list of the facility's new hires since last survey revealed Staff A, Registered Nurse's (RN) hire date as 7/17/17. A review of the employee's file revealed no verification of a current nursing license.	F 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE HEALTHCARE COMMUNITY	600 MORNINGSIDE AVENUE IDA GROVE, IA 51445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 499	Continued From page 19 An interview on 8/29/17 at 9:40 a.m. the Administrator confirmed he did not verify Staff A's nursing license prior to hire. The Administrator provided a license verification for Staff A's RN license, dated 8/28/17, or 42 days after hire. Review of the facility's Abuse Prevention Plan, revised 2/17, revealed: III. Components of abuse prevention plan; procedure: A. Screening: 1. Prior to conditional employment offer, the facility will attempt to obtain information regarding a history of abuse, neglect or mistreatment of resident from:...c. Appropriate licensing board.	F 499		

F 156 Notice of Rights, Rules, Services, Charges

Immediate corrective action:

Res #12 was given the proper documentation for non-coverage and appeal process.

Action as it applies to others:

All residents with these services have the potential to be effected.

Education was provided on documents that are to be provided to residents when coverage is ending.

Date of completion: 10/1/17

Recurrence will be prevented by:

Residents who require such notices will be audited weekly for x 30 days and brought to QAPI committee for review and recommendation.

The correction will be monitored by:

Administrator/Designee

F 226 Abuse Policies

Immediate corrective action:

The Administrator's SING check was obtained and is in the personnel file.

Action as it applies to others:

All personnel files were reviewed to ensure proper criminal & abuse background checks are documented.

Education was provided on performing SING checks prior to start date.

Date of completion: 9/18/17

Recurrence will be prevented by:

New hire personnel files will be audited weekly for proper SING checks x 30 days and brought to QAPI committee for review and recommendation.

The correction will be monitored by:

Administrator/Designee

F 314 Pressure Ulcer

Immediate corrective action:

Wound assessments are being completed for resident # 3 per policy.

Action as it applies to others:

The facility Skin Program was reviewed and remains current.

All residents with Pressure Ulcers' Skin assessments have been reviewed to assure they are current and accurate and new assessments completed if indicated.

Nursing staff were re-educated regarding following care planned interventions.

Date of completion: 9/18/17

Recurrence will be prevented by:

Weekly observations of care planned skin integrity interventions being in place will be completed x 30 days and brought to QAPI committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F 465 Environment

Immediate corrective action:

The exterior of the wood cabinet doors were cleaned.

The inside surface of the drawers and bottom of cabinets were cleaned.

The surface under the sink was cleaned.

Action as it applies to others:

The checklists for assigned cleaning duties was reviewed by Dietary Manager and are current and accurate.

Dietary Staff re-educated regarding scheduled cleaning of kitchen.

Date of completion: 10/1/17

Recurrence will be prevented by:

Weekly sanitation audits of kitchen will be completed weekly x 30 days and brought to QAPI Committee for review and recommendation.

The correction will be monitored by:

Administrator/Designee

F499 Licenses Verification

Immediate corrective action:

The Administrator's License check was completed and is in the personnel file.

Staff A's License check was completed and is in the personnel file.

Action as it applies to others:

All personnel files audited to ensure appropriate license verifications present.

HR Coordinator educated on importance of obtaining license verification prior to start date for licensed professionals, and place the evidence in personnel files.

Date of completion: 10/1/17

Recurrence will be prevented by:

New Hire personnel files will be audited weekly x 30 days to license verification prior to start date. The results of these audits will be brought to QAPI Committee for review and recommendation

The correction will be monitored by:

Administrator/Designee