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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD. BETTENDORF, IA 52722

(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 10/17/17 The following information relates to the investigation of #69624-I, #70255-C, #70712-I and 70491-M. Facility report #69624-I was not substantiated, Complaint #70255-C was substantiated, facility report #70712-I was substantiated and investigation of facility report #70491-M will be submitted for determination. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000		
F 226 SS=D	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 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,	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelley Katzenberger — TITLE: Administrator — (X6) DATE: 10/13/17

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.

10/16/17

Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Executive Director, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency.

Compliance Date Set: 10/5/2017

F 226 Develop/Implement Abuse/Neglect, ETC Policies

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents were identified as being affected by this deficient practice.

After identification of the concern Staff G and H have not been scheduled to work at the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

All facility and agency employees will have evidence of Iowa criminal record check, licensure check and dependent adult abuse/child abuse registry checks on file prior to the first date of work or orientation to the facility.

All new staff personnel files will be audited by HR prior to general floor orientation to ensure the Iowa criminal record check, licensure check and dependent adult abuse/child abuse registry checks are on file prior to the first date of work or orientation to the facility.

Administrator will review HR audit to ensure completeness prior to new staff first date of work or orientation to the facility.

How will the facility monitor its corrective actions:

HR will present results of audits to QAPI for review for 2 months.

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Compliance Date Set: 10/17/17

F281 Services Provided Meet Professional Standards

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

All orders for Residents #3, 4, 7 and 9 were clarified with their respective providers and staff education performed related to following physician orders and documentation of such.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

The facility has ensured adequate staffing to provide timely treatments daily as ordered, including a designated "treatment nurse" 5 days per week.

All nursing staff has been educated related to following of all physicians orders and documentation requirements of the same every shift.

DON/Designee will complete random weekly audits to ensure compliance.

How will the facility monitor its corrective actions:

The results of audits as above will be reviewed in QAPI for 2 months.

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F312 ADL Care provided for Dependent Residents

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

Resident #5 bathing services have been provided twice weekly.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

Random weekly audits of all resident bathing services by DON/Designee to ensure provision of services will be completed.

How will the facility monitor its corrective actions:

The results of audits as above will be reviewed in QAPI for 2 months.

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Compliance Date Set: 10/5/17

F314 Treatment/Services to Prevent/Heal Pressure Sores

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

Resident #2, 5 & 6 have received provider visits and new orders/order changes as needed to promote healing of wounds and have had weekly wound measurements documented in the clinical record.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

The facility has ensured adequate staffing to provide timely completion of treatments daily as ordered and following of all physician orders with documentation of the same every shift.

All nursing staff has been educated related to thorough assessment of skin with documentation and intervention for any areas of concern upon admission as well as following of all physician orders and documentation of the same every shift including follow up appointment scheduling.

In addition to the above interventions effective 10/16/17 the facility will have a designated "treatment nurse" 5 days per week. The treatment nurse will be responsible for weekly measurement and documentation of the condition of all wounds and reporting to/obtaining orders from the provider as needed.

DON/Designee will complete random weekly audits to ensure compliance

How will the facility monitor its corrective actions:

The results of audits as above will be reviewed in QAPI for 2 months.

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Compliance Date Set: 10/5/17

F353 Sufficient 24 hour nursing staff per care plans

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

For Residents #1 & 2, as well as all others, the facility has ensured adequate staff to provide timely completion of treatments and answering of call lights daily.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

Administrator/Designee will conduct random weekly schedule/staffing audits to ensure appropriate number of staff are available to meet resident needs.

How will the facility monitor its corrective actions:

The results of audits as above will be reviewed in QAPI for 2 months.

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Compliance Date Set: 10/5/17

F354 Waiver-RN 8 Hrs 7 days/wk, Full-time DON

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

Administrator/Designee completed audits of all nursing schedules for the month and ensured 8 consecutive hours of RN coverage was scheduled daily.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

Administrator/Designee will conduct random weekly schedule/staffing audits to ensure ongoing compliance as above.

How will the facility monitor its corrective actions:

The results of audits as above will be reviewed in QAPI for 2 months.

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F431 Drug records, label/store drugs & biologicals

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

Residents #8 & 9 as well as all others have had all medications reviewed and accounted for with documentation ongoing.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

DON/Designee have educated nursing staff responsible for medication administration on medication storage and documentation requirements and appropriate procedures for change of shift reconciliation of the same.

In addition to the above, on 10/18/17 the pharmacy RN consultant will provide an additional training at the facility for nursing staff responsible for medication administration.

DON/Designee will conduct random audits to ensure all doses of medications are documented/accounted for by nursing staff per documentation every shift.

How will the facility monitor its corrective actions:

The results of audits as above will be reviewed in QAPI for 2 months.

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F499 Employ qualified FT/PT/Consult Professionals

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

No residents were identified as affected by the deficient practice.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents have the potential to be affected by this deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

Licensure verification will be obtained/completed by HR prior to completion of hiring/general orientation for all new facility staff and all agency staff.

All new and agency staff personnel files will be audited by HR prior to general floor orientation to ensure completion.

Administrator will review HR audit to ensure completeness prior to new staff first date of work or orientation to the facility.

How will the facility monitor its corrective actions:

The results of audits as above will be reviewed in QAPI for 2 months.

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L 190 General Policies

How the corrective action will be accomplished for those residents found to have been affected by the deficient practices:

Staff I with a hire date of 7/27/17 had the TB test and physical completed on 9/8/17.

All staff will have a physical and TB test prior to starting work at the facility.

No residents had a negative outcome because of this deficient practice.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

The facility recognizes that all residents could be affected by the deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not reoccur:

All new staff personnel files will be audited by HR prior to general floor orientation to ensure the physical and TB test are completed.

How will the facility monitor its corrective actions:

HR will present results of audits to QAPI for review for 2 months.

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F 226	Continued From page 1 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 a staffing agency record, staff interviews and review of policy and procedures, the facility failed to verify a staffing agency had obtained criminal background and dependent adult abuse checks prior to allowing temporary agency personnel to work in the facility. Concerns identified for 2 of 7 files reviewed. The facility reported a census of 60 residents. Findings include: 1. According to the Staffing Agency sheet, Staff F (Licensed Practical Nurse) had a hire date of 6/29/17. The Single Contact License & Background Check dated 6/30/17 revealed the agency completed a Criminal History Background check. The results revealed a further search required. The Record Check Evaluation sheet dated 7/26/17 revealed Staff F "MAY WORK". The Staff Agency time sheets revealed Staff F worked 12 hour shifts at the facility before the agency became aware the staff person could work (7/26/17). Staff F worked on 7/4/17, 7/8/17, 7/9/17, 7/12/17, 7/13/17, 7/14/17, 7/15/17 and	F 226		

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F 226	Continued From page 2 7/16/17. 2. According to the Staffing Agency Staff G (Licensed Practical Nurse) had a hire date of 6/27/17. The Single Contact License & Background Check sheet dated 6/27/17 revealed the agency failed to complete a Dependent Adult Abuse Registry Check. The Staffing Agency time sheets revealed Staff G worked 12 hours shifts at the facility on 6/28/17, 6/29/17, 6/30/17, 7/1/17 and 7/2/17. The policy and procedures titled The Abuse and Neglect Prevention (dated April 2017) identified the facility shall screen all potential employees for a history of abuse, neglect, exploitation, misappropriation of property, or mistreatment of residents. This will be accomplished through the following (including maintaining documentation of such results): 1) The facility will conduct an Iowa Criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 58.11(3). 2) The facility will make reasonable attempts to request and obtain information from previous employers and/or current employers that may be indicative of a history of abuse, neglect or mistreatment. On 9/12/17 at 11:37 a.m. and 11:47 a.m. Staff H (Human Resource Director) was interviewed and	F 226		

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F 226	Continued From page 3 reported in the past, the Nursing Department verified the Criminal Checks and Dependent Adult Abuse Checks on the agency staff prior to working in the facility. Staff H verified the facility did not verify the Criminal Background Check on Staff F and the Dependent Adult Abuse Registry Check on Staff F and Staff G. Staff H stated effective immediately the Human Resource Department planned to verify the Criminal Background and Dependent Adult Abuse checks on all current and future agency staff. On 9/13/17 at 2:10 p.m. the Administrator was interviewed and stated the facility planned to verify the criminal background checks, dependent abuse checks and the license checks on all prior, current and future agency staff. The Administrator reported the Human Resource Department will keep the required information on file.	F 226		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to follow physician's orders for four of five sampled. Concerns identified for Resident #3, #4, #7 and #9. The facility reported a census of 60 residents.	F 281		

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F 281	Continued From page 4 Findings include: 1. According to the Admission Record dated 8/23/17 Resident #3 had diagnoses of cardiopulmonary disease, kidney failure, osteoarthritis and candidiasis (fungal infection). The Minimum Data Set (MDS) assessment dated 8/4/17 revealed Resident #3 had moderate cognitive impairments and required limited assistance of one staff with transfers, dressing and toilet use. The Plan of Care dated 9/7/17 revealed Resident #3 had history of excoriations under the breasts and abdominal folds and directed the staff to complete treatments as ordered. The Order Details sheet dated 7/10/17 revealed an order to apply Nystatin Powder under breasts and abdominal folds twice a day and as needed for redness. The July 2017 Treatment Administration Record had omissions once a day on 7/11, 7/14, 7/16, 7/17, 7/21, 7/23 and 7/28. The sheet revealed omissions (twice a day) on 7/22. The August 2017 Treatment Administration Record had omissions on 8/1, 8/2, 8/3, 8/4, 8/8, 8/10, 8/14, 8/18, 8/20, 8/21, 8/22 and 8/23. 2. According to the Admission Record dated 8/23/17 Resident #4 had diagnoses of peripheral vascular disease and anxiety. The MDS assessment dated 6/21/17 revealed Resident #4 had moderately impaired decision making and required extensive assistance of one	F 281		

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F 281	Continued From page 5 staff with bed mobility, eating, toilet use and personal hygiene. The Plan of Care updated 7/3/17 revealed Resident #4 had a skin tear to the left lower leg and directed the staff to measure the wound weekly, antibiotics for 10 days, offer pain medication prior to wound treatment, wound clinic appointments as ordered and treatments as ordered. The July 2017 Treatment Administration Record revealed an order dated 7/12/17 for Xeroform gauze daily to left lower extremity wound, cover with gauze and secure with tape. The treatment administration record had omissions of wound treatments on 7/14, 7/20, 7/21 and 7/27. The August 2017 Treatment Administration Record revealed an order dated 7/22/17 for staff to cleanse the left lower extremity with normal saline, pat dry, apply Xeroform, cover with gauze and tape into place as ordered by wound clinic. The record had omissions of the ordered dressing changes on 8/2, 8/5, and 8/10. 3. The Admission Record dated 8/29/17 revealed Resident #7 had diagnoses of chronic obstructive pulmonary disease, chronic pain and cerebral infarct. The MDS assessment dated 8/4/17 revealed Resident #7 without cognitive impairments. The MDS revealed Resident #7 required extensive assistance of one staff with bed mobility, dressing, toilet use and personal hygiene. The MDS revealed Resident #7 had a surgical wound. The Plan of Care dated 5/8/17 revealed Resident	F 281		

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F 281	Continued From page 6 #7 developed a wound on the right posterior heel from a cast and directed the staff to provide wound clinic appointments, observe for pain and medicate as ordered, wear cam boot (walking boot) as ordered and complete treatments as ordered. The July 2017 Treatment Administration Record revealed an order dated 6/22/17 to cleanse right posterior heel with normal saline, pat dry, apply moisturizing lotion (Amlactin 12%) to dry areas of feet, apply moistened hydrofera blue dressing (cut to size) to wound and cover with secure dressing once a day. The record revealed omissions of the wound treatments on 7/4, 7/6, 7/7/, 7/8, 7/19, 7/23 and 7/24. The August 2017 Treatment Administration Record had omissions of the wound treatments on 8/2, 8/4, 8/8, 8/24, 8/25 and 8/26. An interview on 8/27/17 at 4:47 p.m. Resident #7 reported the treatments were not done on 8/25 or 8/26. Resident #7 reported the staff last completed the wound treatment this morning (8/27/17) and prior to that on 8/23/17. Resident #7 reported the wound treatments should be completed daily. 4. According to the Admission Record dated 9/7/17 Resident #9 had diagnoses of chronic obstructive pulmonary disease, carpal tunnel syndrome, spondylosis with myelopathy in the lumbar region and low back pain. The MDS assessment dated 7/21/17 revealed Resident #9 without cognitive impairments. The MDS revealed Resident #9 is independent with bed mobility, transfers, eating and personal	F 281		

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F 281	Continued From page 7 hygiene. Review of a physician's order dated 5/4/17 revealed Resident #9 had an order for Tramadol 50 milligrams, 2 tablets by mouth four times a day. The July 2017 Medication Administration Record revealed an order for Tramadol 50 milligrams by mouth four times a day (9:00 a.m., 12:00 p.m., 5:00 p.m. and 9:00 p.m.). The sheet revealed an "R" (refused medication) recorded on 7/2/17 for the 5:00 p.m. dose and omissions on July 17 and 29 at 9:00 p.m. An interview on 9/8/17 at 11:10 a.m. Staff B-Nurse reported she asked Resident #9 if he/she refused the 5:00 p.m. dose of Tramadol on 7/2/17, the resident reported he/she did not refuse, the staff never offered it. Staff B reported Staff J-LPN did not always administer the 4:00 p.m. and 5:00 p.m. medications and would pass the task to the oncoming nurse at 6:00 p.m. An interview on 9/8/17 at 1:30 p.m. Staff J reported Resident #9 did not refuse medications especially the Tramadol. Staff J reported she did not document "R" on the medication record. Staff J reported Staff G-LPN documented the "R". Staff J reported she worked 6:00 a.m. to 6:00 p.m. full time and reported the nurse working 6:00 a.m. to 6:00 p.m. is responsible for passing the medications at 5:00 p.m. Staff J reported when the facility staffs one nurse and two medications aide the 5:00 p.m. medication task is passed on to the nurse working 6:00 p.m. to 6:00 a.m.	F 281		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

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F 312	Continued From page 8 (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide bathing services for 1 of 4 sampled. Concerns identified for Resident #5. The facility reported a census of 60. Findings include: 1. According to the Admission Record dated 8/30/17 Resident #5 had diagnoses which included quadriplegia, pressure ulcers, seborrheic dermatitis and anxiety. The Minimum Data Set assessment dated 7/21/17 revealed Resident #5 had no cognitive impairments. Resident #5 required extensive assistance of two staff with bed mobility, dressing and personal hygiene. Review of the Care Plan dated 1/17/17 indicated the resident requires assistance with Activities of Daily Living but failed to provide staff with the resident's bathing preferences or procedures to bath the resident. Review of the August 2017 Skin Monitoring: Comprehensive CNA Shower Review sheets Resident #5 received a shower on 8/2, 8/5, 8/12, 8/20, and 8/26 and 8/30. An interview on 8/25/17 at 9:15 a.m. Resident #5 reported the last shower he/she received was on Sunday (8/20). Resident #5 reported he/she is	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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F 312	Continued From page 9 assigned Sunday and Wednesday for showers. Resident #5 reported he/she was not offered a shower on Wednesday (8/23). An interview on 8/31/17 at 9:32 a.m. the Director of Nurses reported an expectation of the staff to offer a shower twice a week or as the resident requests. The Director of Nurses reported he/she did not find documentation of showers for 8/10, 8/17 and 8/23/17.	F 312		
F 314 SS=J	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 record review, observations and interviews, the facility failed to prevent the development of pressure ulcers and failed to promote healing of the pressure ulcers for 3 of 4 residents reviewed with pressure ulcers (Residents #2, #5, #6). Resident #2 had a cast	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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F 314	Continued From page 10 applied for a fractured ankle on 6/5/17. The orthopedist wanted the resident seen in 3 weeks and no appointment had been made and the family notified the facility and the orthopedist saw the resident 10 weeks after the cast applications which identified 2 avoidable pressure sores (top of foot and heel). Upon admission, the resident had pressure ulcers behind the right knee. The open areas were not addressed. The facility reported a census of 60 residents. Findings include: 1. According to the Admission Record dated 8/23/17, Resident #2 had an admission date into the facility on 6/5/17. The record identified the resident had diagnoses including stroke, diabetes, obesity, anxiety and heart disease. Resident #2 had a MDS (Minimum Data) assessment with a reference date of 6/20/17 revealed Resident #2 had no cognitive impairments. Resident #2 had total dependence of staff for bed mobility, dressing, toilet use and personal hygiene. The MDS identified the resident to be at risk for the development of pressure ulcers and had 2 Stage II pressure ulcers. The MDS identified a Stage II as the following: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. May also present as an intact or open/ruptured blister. The MDS identified the following Stages of pressure ulcers: A Stage I is an observable, pressure-related alteration of intact skin, whose indicators as	F 314		

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F 314	Continued From page 11 compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: Skin temperature, Tissue consistency, Sensation, and or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues. A Stage II is described as a partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. May also present as an intact or open/ruptured blister. A Stage III is described as a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present, but does not obscure the depth of tissue loss. May include undermining or tunneling. A Stage IV is described as full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The Care Plan directed the staff to assess circulation, motion, sensation and temperature every shift until cast removed, provide pain medication as ordered, hospice care, inspect feet daily for open areas, sores, blisters, edema and redness, apply alternating air mattress to bed and ensure inflation control is correct, unable to assist with positioning in bed, staff to assist with turning and positioning, weekly head to toe assessment by licensed nurse, review skin risk via Braden scale, clinical observation/assessment, avoid friction and shearing when repositioning, use two staff for repositioning, use lift sheet, bed should be flat as possible while lifting and monitor skin	F 314		

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	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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F 314	Continued From page 12 with all cares and report changes to nurse. The orthopedic visit note dated 6/5/17 indicated Resident #2 had a mildly displaced bimalleolar (ankle) fracture and a cast applied to the right lower extremity. The note revealed a plan to follow up in 2-4 weeks. The Admission Orders dated 6/5/17 failed to contain orders for weight bearing status and care of the casted right lower extremity. The Orthopedic visit note dated 8/15/17 revealed Resident #2 had a visit 10 weeks post displaced bimalleolar right ankle fracture. The note had documentation that at the last visit, the nurse from the skilled nursing facility that Resident #2 stays, did not stop at the front desk and make a follow up appointment. The distal fibular and medial malleolus fracture healed. The cast was removed and Resident #2 had wounds on the right foot from the cast. The note indicated the physician assistant (PA) documented he would need to keep a close eye on the wounds and placed a non-stick dressing on the wounds before applying the boot. The PA ordered Cephalexin (antibiotic) and the resident should follow up in 10-14 days with the physician (orthopedist). The Hospice Clinical Notes dated 8/15/17 indicated the resident's responsible party called and reported he/she called the orthopedic clinic and the clinic reported Resident #2 should have been seen three weeks ago for a follow up. The responsible party made an appointment. The Hospice staff talked to the facility nurse on Friday, the computer was down and the facility nurse could check when the appointment was scheduled.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 13 The Progress Notes dated 8/15/17 at 2:22 p.m. revealed the staff received a new order from the orthopedic clinic for Cephalexin 500 milligrams by mouth every six hours for 14 days. The Progress Noted dated 8/18/17 at 7:12 p.m. revealed Resident #2 had the cast removed from the right foot on 8/15/17. Resident #2 had two necrotic areas from the cast. An oral antibiotic ordered. However, no treatment ordered. The nurse notified Hospice to look at the wound. The Initial Wound Assessment dated 8/18/17 identified the right heel had an unstageable area that measured 4.0 centimeters (cm) (length) by 3.0 cm (width). The Initial Wound Assessment dated 8/18/17 revealed the top of the right foot had an unstageable area that measured 9.0 cm (length) by 4.8 cm (width). The physician's order dated 8/18/17 revealed an order to cleanse the top of the right foot and heel with normal saline, pat dry, apply hydrogel, cover with a 4 X [by] (gauze) and wrap with Kerlix (roll of gauze type material) once a day. The Advanced Registered Nurse Practitioner (ARNP) visit note dated 8/20/17 at 3:33 p.m. identified Resident #2 had a medical device associated pressure injury. The right dorsal foot ulcer measured 8.0 centimeters (cm) by 5.4 cm. The note indicated the right heel ulcer measured 3.9 cm by 4.3 cm. and unable to stage both areas due to the amount of eschar (dead tissue that is generally black and hard) obscuring the wound bed. The nurse practitioner changed the treatment to cleanse both wounds with normal	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 14	F 314		

saline, pat dry, paint with betadine, allow to air dry, apply Telpha, secure with Kerlix and tape every day and as needed.

Observation on 8/24/17 at 4:50 p.m. identified a dressing to Resident #2's right foot dated 8/23 and the initials "CO".

Observation on 8/25/17 at 5:52 a.m. identified a dressing to Resident #2's right foot dated 8/23 and the initials "CO".

Observation on 8/25/17 at 9:35 a.m. identified Staff B changed the dressing to Resident #2's right foot. Resident #2 reported the dressing was not changed on 8/24/17.

Observation on 8/27/17 at 4:56 p.m. identified a dressing to Resident #2's right foot dated 8/27 at 1:15 p.m. Resident #2 reported the treatment as not completed on 8/26/17.
Review of the August 2017 Treatment Administration Record for Resident #2's right heel and top of the right foot revealed omissions on 8/24/17 and 8/26/17.

A phone interview on 8/27/17 at 6:10 p.m. Staff C (Assistant Director of Nurses) reported she worked as a charge nurse on West Hall on 6/26/17, the Director of Nurses worked North Hall and an Agency Nurse worked East. Staff C reported the Agency Nurse had Resident #2's treatment.

An interview on 8/24/17 at 10:02 a.m. Staff B reported he/she noticed Resident #2 had the right foot wrapped in Kerlix after Resident #2 returned from the orthopedic clinic on 8/15/17. Staff B asked Staff D (Agency Nurse) if Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 15	F 314		

#2 returned with treatment orders. Staff D reported Resident #2 had orders. Staff B reported he/she worked the floor on 8/18/17 and removed a dressing from the right foot and noted the two necrotic areas. Staff B reported she noted there was not an order for a treatment. Staff B reported she completed an assessment and requested a treatment from the physician.

An interview on 9/1/17 at 9:44 a.m. Staff D (Agency Nurse) reported she did not recall Resident #2 returning from the orthopedic appointment. Staff D reported she worked 8/16 and completed Resident #2's calf treatment. Staff D noticed Resident #2's right foot had two eschar areas. Staff D checked the treatment record and noticed there was not a treatment to the areas. Staff D told the Assistant Director of Nurses that there was not a treatment ordered. Staff D reported the main reason treatments are not getting done is due to a lack of nursing staff. Staff D stated she reports to the next shift any treatments that he/she didn't get done. Staff D reported at times the next shift cannot get the treatments done either.

An interview on 8/31/17 at 2:41 p.m. Staff A (Hospice Nurse) reported he/she went to the orthopedic appointment with Resident #2 on 6/5/17. Staff A reported she arranged emergency placement for Resident #2 as he/she could not return home. Staff A reported Resident #2 had family at the appointment. Staff A was not aware of a follow up appointment for Resident #2. Staff A reported the family had Resident #2's paperwork from the appointment.

An interview on 8/31/17 at 2:11 p.m. Staff C (Charge Nurse) reported she completed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

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F 314	Continued From page 16 admission paperwork for Resident #2. Staff C did not recall Hospice staff assisting Resident #2 with the admission process. Staff C did not recall if Resident #2 needed to follow up with the orthopedic clinic. An interview on 8/31/17 at 11:33 a.m. Resident #2 reported he asked the staff 5 to 6 times when he needed to go back to the orthopedic clinic. Resident #2 reported his heel started to hurt 5 to 6 weeks after the cast was put on. Resident #2 reported he told the staff that his heel hurt. Resident #2 reported the heel hurt worse than the ankle. Resident #2 described the pain as a stabbing pain. An interview on 9/1/17 at 1:35 p.m. Resident #2's responsible party reported she asked the staff when Resident #2 had a follow up appointment and the staff did not seem to know. The responsible party called the orthopedic clinic on 8/14/17. The responsible party explained the cast was on 10 weeks and it was way too long. An appointment was set up for the next day. The responsible party reported she was at the orthopedic appointment on 6/5/17 and did to receive any paperwork from the clinic with a follow up appointment time. An interview on 9/8/17 at 10:48 a.m. the ARNP reported she saw Resident #2's wounds and then the facility had a wound management company look at the wounds. The ARNP reported the nursing staff did not always get the treatments completed as ordered. The ARNP reported she looked at Resident #2's wounds. The ARNP reported the dressing as several days old according to the date on the dressing.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

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F 314	Continued From page 17 An interview on 9/6/17 at 4:55 p.m. the Orthopedic Specialist reported he treated Resident #2 on 6/5/17. The Specialist reported Resident #2's extensive medical history placed the resident at high risk. That being the case, the specialist planned to follow up in 2 to 4 weeks. The Specialist reported at the 2 to 4 week point he/she removes the cast and inspects the skin, obtains an x-ray and then decides the treatment plan. The Specialist reported wounds can develop after one week. The Specialist reported if wounds are identified the treatment can be changed to an immobilizing device, internal fixation, apply a cast with a window, add additional padding to the cast or consult cardiology for a work up. The Specialist reported Resident #2 should have been seen three times in the 10 weeks. The Specialist reported that had Resident #3 been seen at the 2 to 4 week point he/she could have intervened faster. The Specialist reported the wounds are extensive and Resident #2 has an 80% chance of amputation. Pressure Areas on the posterior right knee (behind knee). The Care Plan identified Resident #2 was admitted to the facility with a wound to the right leg. The Plan of Care directed the staff to provide treatments as ordered and complete a weekly assessment. The Admit/Readmit Screener dated 6/5/17 revealed Resident #2 had the following areas on the back of the right knee: a) A Stage II blister that measured 4.0 centimeters (length) by 4.0 centimeters (width).	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

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F 314	Continued From page 18 b) A Stage II pressure area that measured 2.0 centimeters (length) by 2.0 centimeters (width). The Progress Notes dated 6/5/17 at 4:30 p.m. revealed Resident #2 admitted with hospice. Resident #2 had a right lower extremity casted from the knee down. Resident #5 had a pedal pulse and exposed toes appeared cyanotic. The hospice staff reported Resident #2 had 2 pressure ulcers covered with an island dressing. The Hospice Admission Orders dated 6/5/17, did not contain a treatment order for the two pressure areas. An interview on 8/31/17 at 2:41 p.m. Staff A (Hospice Nurse) reported he/she went to the orthopedic appointment with Resident #2 on 6/5/17. Staff A reported she arranged emergency placement for Resident #2 as he/she could not return home. Staff A reported Resident #2 had family at the appointment. Staff A reported he/she went to the facility and prepared the admission orders. Staff A waited at the facility for the specialized air bed to be delivered and set up. Staff A reported after Resident #2 transferred to bed he/she completed an assessment and noted Resident #2 had an area on the calf and an area on the thigh. Staff A reported she either wrote a telephone order or gave the nurse a verbal order for Duoderm (a thin hydrocolloid dressing). The Order Summary Report dated 8/30/17 revealed the following orders to the right lower extremity: a) On 6/8/17, two orders to cleanse the right dorsal knee and with normal saline or wound wash, apply Hydrogel to the wound bed and cover with a dressing daily.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

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F 314	Continued From page 19 b) On 6/9/17, two orders to apply Duoderm to the right lower extremity and change every three days and as needed. c) On 6/13/17, an order to apply Santyl Ointment (debriding medication) 250 unit/gram to the right lower leg. d) On 6/15/17, two orders to cleanse the right posterior leg with foam/wound cleaner, apply a thick layer of Santyl ointment to the eschar wound bed and wrap with Kerlix. Review of the Treatment Administration Record for June 2017 revealed the staff first completed the treatment as ordered to the two areas on 6/17/17. Review of the Treatment Administration Record for July 2017 revealed omission in Resident #2's treatment on 7/4, 7/7, 7/8, 7/14, 7/19, 7/20, 7/21 and 7/24. Review of the Treatment Administration Record for August 2017 revealed omissions in Resident #2's treatment on 8/2, 8/5, and 8/6. During an interview on 8/31/17 at 2:55 p.m. the Director of Nurses (DON) reported the Treatment Record for Resident #2 is very confusing. The DON reported the staff did not sign the treatment out as completed from 6/5/17 to 6/16/17. The DON planned to in-service the staff on entering orders in the computer and selecting a treatment time. Resident #2's Weekly Wound Assessment sheets for right knee -posterior [back of knee] 1) revealed the following:	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

(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 20 a) On 6/5/17, the area measured 4.0 centimeters (cm) length by 4.0 cm (width). b) On 6/8/17, the area measured 0.4 (length) cm by 4.7 cm (width). c) On 6/14/17, the area measured 2.4 cm (length) by 4.7 cm (width). d) On 6/21/17, the area measured 4.2 cm (length) by 4.7 cm (width). e) On 6/13/17, the area measured 4.2. cm (length) by 4.7 cm (width). Resident #2's Weekly Wound Assessment sheets for the right knee posterior blister (Area 2) revealed the following: a) On 6/5/17, the area measured 2.0 centimeters (length) by 2.0 centimeters (width). b) On 6/8/17, the area measured 0.7 cm (length) by 1.0 cm (width). c) On 6/14/17, the area measured 1.7 cm (length) by 1.5 cm (width). d) On 6/21/17, the area measured 1.5 cm (length) by 2.3 cm (width). e) On 6/28/17, the area measured 0.5 cm (length) by 1.2 cm (width). The Progress Note dated 8/25/17 at 11:18 a.m. revealed the wound below Resident #2's right knee healed. The staff notified the physician and received a new order.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

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F 314	Continued From page 21 The Order Summary Report dated 8/31/17 revealed an order to apply Aquaphilic to legs and feet bilaterally once a day for dry skin and observe right upper leg to ensure are does not open again. An interview on 8/25/17 at 12:54 p.m. the Director of Nursing (DON) reported the facility did not currently have a wound nurse. The DON reported there is a lapse in weekly assessments. However, the DON was uncertain how long the assessments have not been done. The DON reported she could not locate any assessments for Resident #2 for July and August for the right calf wounds. 2. According to the Admission Record dated 8/30/17 Resident #5 had diagnoses of quadriplegia, history of pressure ulcers and hip pressure ulcer. The Minimum Data Set (MDS) assessment with a reference date of 7/21/17 revealed Resident #5 had no cognitive impairments. The MDS identified Resident #5 required extensive assistance of one staff person with bed mobility, dressing and personal hygiene. The MDS identified the resident at risk for the development of pressure sores and had 2 Stage III pressure sores 2 Staff IV pressure sores. The pressure ulcers were present upon admission or reentry to the facility. The MDS describes a description of the following wounds: Stage III pressure ulcer as a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be	F 314		

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	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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F 314	Continued From page 22 present but does not obscure the depth of tissue loss. May include tunneling or undermining of the wound. Stage IV pressure ulcer is full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often included undermining and tunneling. The Care Plan directed the staff to utilize an alternating air mattress to the bed, culture wounds as needed, encourage good nutrition to promote healing, pressure reducing cushion to wheelchair, Prevalon boots to bilateral lower extremities, nutritional supplement to help healing, trapeze to bed to assist mobility, treatment as ordered, turn and reposition frequently when in bed and wheelchair and wound clinic appointments when scheduled (every three weeks). Review of the Weekly Skin Assessment sheets identified the last facility assessment completed on 7/20/17 revealed the following: a) The Stage III wound to the left greater trochanter (hip bone) measured 1.0 centimeters (cm) (length) by 2.5 cm (width) by 3.4 cm (depth). b) The Stage III wound to the right greater trochanter measured 3.8 cm (length) by 2.5 cm (width) by 7.0 cm (depth). c) The Surgical Incision to the right gluteal fold measured 7.3 cm (length) by 5.4 cm (width) by 0.4 cm (depth). The Wound Clinic Multi Wound Chart details dated 8/24/17 identified the following:	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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F 314	Continued From page 23 a) The Stage IV Pressure Injury wound to the left trochanter measured 0.2 cm (length) by 0.4 cm (width) by 2.0 cm (depth). b) The Stage IV Pressure Injury wound to the right trochanter measured 0.5 cm (length) by 1.0 cm (width) 1.3 cm (depth). c) The Stage III Pressure Injury wound to the left proximal posterior thigh measured 3.5 cm (length) by 5.5 cm (width) by 1.6 cm (depth). The Treatment Administration Record sheet for July 2017 revealed an order to cleanse the left trochanter with normal saline or wound cleanser, pack with gauze soaked with normal saline and cover with an abdominal pad twice a day until healed. The sheet revealed omissions in the treatment one time on 7/2, 7/4, 7/7, 7/8, 7/10, 7/22, 7/23, 7/24 and 7/29. The Treatment Administration Record sheet for August 2017 revealed omissions in the left trochanter treatment once a day on 8/1, 8/3, 8/7, 8/15, 8/20, 8/21 and 8/23. The Treatment Administration Record sheet for July 2017 revealed an order to cleanse the right trochanter with normal saline, pack with gauze soaked with normal saline and cover with an abdominal pad twice a day until healed. The sheet revealed omissions in the treatment one time on 7/4, 7/7, 7/8, 7/10, 7/22, 7/23, 7/24 and 7/29. The Wound Clinic notes dated 7/13/17 revealed the wound clinic ordered to change the treatment to cleanse with normal saline, apply 0.125% Dakin's soaked gauze tucked into wound bed and cover with a secure dressing and MUST BE CHANGED TWICE DAILY!!!! The Treatment	F 314		

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F 314	Continued From page 24	F 314		

Record revealed the treatment first completed on 8/4/17. The Treatment Administration Record sheet for August 2017 revealed omissions in the right trochanter treatment twice a day on 8/1, 8/2 and 8/3, 8/5, 8/8, 8/13, 8/14, 8/19, 8/20 and 8/21 and once a day on 8/7, 8 /10, 8/11, 8/12, 8/15, 8/16, 8/17, 1/18 and 8/22.

The Treatment Administration Record sheet for July 2017 revealed an order to cleanse the left ischial wound with normal saline, pack with gauze soaked in normal saline and cover with an abdominal pad twice a day. The sheet revealed omissions once a day on 7/2, 7/4, 7/7, 7/8, 7/10, 7/22, 7/23, 7/24 and 7/29. The Treatment Administration Record for August 2017 revealed omissions in the left ischial wound treatment once a day on 8/3, 8/7, 8/13. 8/15, 8/20, 8/21 and 8/23.

An interview on 8/25/17 at 2:01 p.m. Resident #5 reported the staff rarely measure the wounds. Resident #5 reported the wound clinic measures the wounds every three weeks.

An interview on 8/25/17 at 9:15 a.m. Resident #5 reported he goes to the Wound Clinic every three weeks. Resident #5 told the Wound Clinic the treatments were not getting done as ordered. The physician wrote an order to complete the treatments twice a day. Resident #5 reported its better but the treatments are still not getting done every day.

An interview on 8/30/17 at 1:19 p.m. the Wound Clinic registered nurse reported Resident #5's wounds all looked stable. The registered nurse reported a plan for flap surgery on Resident #5's left and right greater trochanter wounds as soon as clearance is obtained. The registered nurse

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	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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F 314	Continued From page 25 reported Resident #5 reported to the Wound Clinic that the facility was not completing the treatments to his wounds as ordered. The Wound Clinic physician wrote an order to complete the treatments twice a day with no exceptions. On 9/5/17 at 9:06 a.m. the Assistant Director of Nurses (ADON) was interviewed and stated there was a lapse in weekly wound assessments. The Assistant Director of Nurses reported assessments completed on 7/20/17. The Assistant Director of Nurses reported Resident #5 had assessments in progress dated 8/16/17. However, the 8/16/17 assessments were not completed. The ADON reported she is starting weekly assessments tomorrow and will be in charge of completing the assessments weekly. On 9/5/17 at 10:17 a.m. the ADON verified the right trochanter treatment ordered on 7/13/17 was not completed until 8/4/17. 3. Resident #6 had a MDS assessment with a reference date of 8/4/17. The MDS indicated Resident #6 had diagnoses of peripheral vascular disease, multidrug resistant organism, chronic pain and a buttock pressure ulcer. The MDS indicated Resident #6 had no cognitive impairments and required extensive assistance of one staff member for mobility, dressing, toilet use and personal hygiene. The Care Plan directed the staff to provide Wound Care Clinic services, administer medications and treatments as ordered, alternating air mattress, assess/record/monitor wound healing weekly, measure length, width	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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BETTENDORF HEALTH CARE CENTER	2730 CROW CREEK ROAD BETTENDORF, IA 52722

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F 314	Continued From page 26 depth, document status of wound perimeter, wound bed and healing progress, report improvements and declines to physician, educate resident/family/caregivers on causes of skin breakdown, including transfer/positioning requirements importance of taking care during ambulation and mobility good nutrition and frequent positioning, encourage to lay down after meals, prefers to sit in electric wheelchair most of the day, encourage to stop smoking to promote wound healing, extra protein at breakfast, follow facility policies/protocols for prevention/treatment of shin breakdown, monitor nutritional status, serve diet as ordered, monitor labs, resident refuses to turn and reposition in bed and wheelchair, often refuses to lay down after meals of off load buttocks. The Treatment Administration Record sheet for July 2017 revealed an order to cleanse the sacral wound with 0.125% Dakin's soaked gauze, apply z-guard to periwound, apply silver alginate to wound bed, cover with abdominal pad and secure with tape daily. The July 2017 Treatment Record sheet revealed omissions in the treatment on 7/4, 7/7, 7/8, 7/10, 7/14, 7/18, 7/21 and 7/23. The August 2017 Treatment Record sheet revealed omissions in the treatment on 8/5, 8/14, 8/15, 8/19 and 8/21. The Treatment Administration Record sheet for July 2017 revealed an order to cleanse the left ischial wound with 0.125% Dakin's soaked gauze, apply z-guard to periwound, apply silver alginate to wound bed, cover with abdominal pad and secure with tape every day and as needed. The July 2017 Treatment Administration Record sheet revealed omissions in the treatment on 7/4, 7/5, 7/6, 7/7, 7/8, 7/9, 7/10, 7/14, 7/18, 7/20, 7/21,	F 314		

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F 314	Continued From page 27 7/22, 7/23, 7/25, 7/26, 7/27 and 7/28. The August 2017 Treatment Administration Record sheet revealed omission in the treatment on 8/1, 8/5, 8/6, 8/8, 8/11, 8/11, 8/12, 8/13, 8/14, 8/15, 8/16, 8/17, 8/19, 8/20 and 8/21. The Wound Clinic Physician Order Details dated 8/23/17 revealed an order to arrange negative pressure wound therapy (wound vac) to the left ischial wound. The orders directed to use silver alginate and an abdominal pad secure with tape until the wound vac received. The Treatment Administration Record sheet for August 2017 revealed the staff administered the wound vac on 8/29/17. On 8/30/17 at 1:41 p.m. the Wound Clinic registered nurse was interviewed and reported Resident #6 currently at the Wound Clinic. The registered nurse reported the facility did not properly apply the wound vac to the left ischial. The registered nurse reported there was not enough sponge in the wound and the disc caused pressure and expanded the wound. The registered nurse reported the clinic planned to change the wound vac three times a week. The Wound Assessment Details (Wound Clinic Note) dated 8/30/17 indicated the clinic assessed the Stage IV left ischial wound. The wound measured 3.4 cm (length) by 2.5 cm (width) by 2.1 cm (depth). The Multi Wound Chart Details (Wound Clinic Note) dated 8/23/17 revealed the left ischial wound measured 2.2 cm (length) by 1.4 cm (width) by 2.1 cm depth. On 8/25/17 at 9:30 a.m. Resident #6 was	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 28	F 314		

interviewed and reported the nurses complete the treatment about four days a week. Resident #6 reported it to be sporadic.

On 9/4/17 at 1:40 p.m. the ADON was interviewed reported the facility had a lapse in the weekly wound assessments for Resident #6. The ADON reported the last weekly assessment completed on the sacral wound was 8/10/17 and the last assessment completed on the ischial wound was 8/17/17. The ADON planned to take over the weekly assessments. The ADON reported the DON assisted her to place the wound vac on Resident #6's ischial wound. The ADON reported they both have experience with wound vacs. The ADON reported the vac must have shifted after it was placed on Resident #6.

The Skin Management Guidelines Overview revised 7/2017 revealed residents who are at risk or with wounds and/or pressure injury and those at risk for skin compromise are identified, assessed and provided appropriate treatment to encourage healing and/or integrity. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes.

The Skin Management Guidelines Practice Guidelines revised on 7/2017 revealed residents admitted with skin impairments will have physician's order for treatment. Ongoing monitoring and continuous quality improvement will be achieved by the Interdisciplinary Team. Lower extremity Ulcers will be monitored closely during treatment to evaluate appropriateness of treatment regime.

Note: At the time of the complaint investigation, the complaint was coded at a "J" immediate and

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F 314	Continued From page 29 serious jeopardy. By September 1, 2017, the facility had implemented measures that adequately addressed the jeopardy and the grid placement was lowered to the "D" level. The Director of Nursing and Assistant Director of Nurse audited all residents with treatments. The Administrator hired a daily treatment nurse (licensed practical nurse) that started on 9/2/17 and 2 registered nurses. The staffing agency nurses were informed of residents needing treatments and instruction. As of the 9/13/17 exit conference, the facility continued to need to: Continue to ensure wounds are assessed and treatments performed per the physician's orders. Continue to ensure adequate staffing is available to perform treatments. Continue to monitor the facility Skin Management Practice Guidelines so residents admitted with skin impairments, have physician's order for treatment and receive continuous on-going monitoring.	F 314		
F 353 SS=G	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 30 at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident and staff interviews, the facility failed to provide sufficient nursing staff to provide nursing care to residents. The facility reported a census	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 31	F 353		

of 60 residents and staff and residents reported there was inadequate staff to perform treatments and respond to the activated call lights in a timely manner (within 15 minutes).

Findings include:

1. According to the Minimum Data Set (MDS) assessment with a reference date of 6/20/17, Resident #2 had diagnoses of stroke, anxiety and an ankle fracture. The MDS dated 6/20/17 revealed Resident #2 had no cognitive impairments. Resident #2 required total staff assistance with bed mobility, dressing, toilet use and personal hygiene.

Observation on 8/23/17 at 11:26 a.m. revealed Resident #2 lying in bed with the call light activated. Resident #2 reported he/she had the call light on for 5 to 10 minutes. Resident #2 reported he had a bowel movement and needed changed. Resident #2 had a clock on the wall and reported he/she timed the response at times. Resident #2 reported it can take the staff up to 30 to 45 minutes to respond to the call light. Resident #2 reported sitting in his/her feces for an hour. At 11:44 a.m., Staff P answered the light. Resident #2 told Staff P he needed changed. Staff P left the call light on and left the room to find another staff to help provide cares. At 11:47 a.m., Staff P and Staff Q returned to the room to assist Resident #2.

2. According to the MDS assessment dated 7/21/17 Resident #1 had a diagnosis of stroke. The MDS dated 7/21/17 revealed Resident #1 had moderately impaired decision making. Resident #1 required total staff assistance with bed mobility, transfers, toilet use and personal

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F 353	Continued From page 32 hygiene. Observation on 8/23/17 at 3:45 p.m. revealed Resident #1 lying in bed with call light activated. Resident #2 yelling out "momma". At 3:50 p.m., call light still activated. Resident #1 yelling out "momma". At 3:57 p.m., Resident #1 with a hoarse voice asking for a drink of water; at 4:00 p.m., the call light still activated. Resident #1 yelling out "momma" and "water". At 4:03 p.m., Staff R responded to Resident #1. Staff R raised the head of the bed and assisted Resident #1 with a drink of water. 3. Observation on 8/25/17 at 6:30 a.m. revealed Staff S (Agency Nurse) assigned to North Hall, Staff T (Registered Nurse) assigned to West Hall and Staff U (Medication Aide) assigned to East Hall. Staff A reported he/she had North Hall. Staff S reported he/she was only assigned to North Hall and did not have insulin or treatments on East Hall. Staff U (Medication Aide) reported he/she could not do the treatments on East Hall. Staff T reported he/she had West Hall and the treatments and insulin for Room 1 - 8 on East Hall. An interview on 8/24/17 at 12:40 p.m. Staff E reported the facility does not have enough nurses. Staff E reported they are able to get some agency nurses. However, they cannot get the treatments completed with two nurses and a medication aide. When they have two nurses they have to take a hall and split another hall. Staff E reported the facility at one time staffed 3 nurses. 4. An interview on 8/24/17 at 9:54 a.m. Staff B reported the facility had a limited amount of	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 353	Continued From page 33 nurses. Staff B reported the facility had 3 charge nurses on the facility payroll. Staff B reported the Director of Nursing, Assistant Director of Nursing and the MDS Coordinator covered recent shifts. Staff B reported the Assistant Director of Nursing worked 7:00 a.m. to 11:45 p.m. as a charge nurse and had to call agency and beg for them to send someone to relieve her. Staff B reported it's not always possible to get the treatments completed as ordered with limited nurses. An interview on 8/25/17 at 6:06 a.m. Staff V (certified nursing assistant/certified medical assistant) reported the facility schedules one aide on each hall at times. Staff V reported the staff cannot get to the call lights in a timely manner and baths do not get completed. Staff V reported the residents complain that their treatments do not get done and they have their call light on for 20 to 30 minutes. The residents complain that they had to sit in their urine and feces because the staff do not respond. Staff V reported a very good nurse walked out because she had two halls and a medication aide on the other hall. The nurse couldn't do it anymore. An interview on 8/25/17 at 6:16 a.m. Staff W (certified nursing assistant) reported with the current staffing the staff cannot answer the call lights in a timely manner. Staff W reported the residents complain the call lights do not get answered for 20 to 30 minutes. Staff W reported working doubles and had 127 hours the last pay period. Staff W reported it is impossible to provide adequate care with the lack of staff. An interview on 8/29/17 at 1:40 p.m. Staff J (Registered Nurse) reported the facility decided to quit using medication aides. Staff J was	F 353		

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	165280	A. BUILDING _____ B. WING _____	C 09/14/2017

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F 353	Continued From page 34 scheduled with an agency nurse. Staff J pulled a medication aide off the floor to pass medications as two nurses could not do all the medications, treatments, insulin injections and charting. Staff J reported it is not physically possible to get everything done with the lack of nurses. Staff J reported the residents complain about treatments not getting completed. Staff J told the Director of Nursing that the treatments were not getting completed. On 8/29/17 the Director of Nursing (DON) reported she had to work as a charge nurse over the weekend with an Agency Nurse and the Assistant Director of Nursing. The DON reported she worked a 12 hour shift and had to pass treatments on to the next shift because she could not get them completed. The DON reported a plan to assign the treatments to the Assistant Director of Nurses (ADON) and herself this week and the weekend to ensure they are completed. The DON reported the facility planned to sign 13 week contracts with traveling nurses to ensure nursing coverage. On 9/1/17 at 12:07 p.m. the Administrator was interviewed and stated he just learned the Director of Nursing and Assistant Director of Nurses had leave through 9/4/17. The Administrator reported he planned to take over the scheduling for the nurses and stay in town through the holiday weekend to ensure nursing coverage. The Administrator reported the facility had a licensed nurse from a sister facility arriving 9/2/17 to do all the treatments over the weekend. The Administrator had a Director of Nursing from a sister facility was arriving 9/2/17 to provide Registered Nurse coverage.	F 353		

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F 353	Continued From page 35 The Written Statement dated 8/29/17 revealed the Administrator noted the facility did not have a call light policy. However, the facility expected the staff to answer the call lights within the 15 minute State of Iowa regulation. During an interview with a group of residents on 8/24/17 at 11:00 a.m., 1 of 4 residents voiced treatments are not done as ordered by the doctor. The resident stated if the order is for the treatment twice a day, then it is only done once. One of the 4 residents stated it usually takes staff 20 to 60 minutes to respond to a call light when he has to have a bowel movement or lay down in bed.	F 353		
F 354 SS=E	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The facility reported a census of 60.	F 354		

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F 354	Continued From page 36 Findings include: Review of facility time sheets and staffing agency time sheets from 8/20/17 to 9/2/17 (2 weeks) revealed the facility failed to have 8 hours of consecutive RN coverage on 8/21, 8/22, 8/23, 8/27 and 9/1/17. During an interview on 9/6/17 at 2:09 p.m. the Administrator reported Director of Nurse (Registered Nurse) was on vacation from 8/17/17 to 8/23/17 and on medical leave from 9/1/17 to 9/4/17. The Administrator reported the facility brought in a registered nurse from a sister facility to cover one of the weekends. The Administrator reported Human Resources could not provide additional documentation of registered nurse hours on 8/21, 8/22, 8/23, 8/27 and 9/1.	F 354		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed	F 431		

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F 431	Continued From page 37 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to maintain accurate records to account for controlled drugs for 2 of 4 residents	F 431		

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F 431	Continued From page 38 sampled. Concerns were identified for Resident #8 and #9. The facility reported a census of 60 residents. Findings include: 1. The Controlled Drug Record dated 8/28/17 to 9/4/17 revealed Resident #8 had a count sheet for Hydrocodone-Acetaminophen 7.5-325 milligrams. The physician order directed staff to give one tablet every six hours for pain. On 9/4/17 at 1:00 p.m., Staff L-LPN administered one tablet to the resident with 34 tablets remaining. At 2:00 p.m., Staff L and Staff M-CMA (certified medication aide) completed a narcotic count and corrected the count to 33 tablets. The staff failed account for one tablet. In an interview on 9/12/17 at 9:58 a.m. Staff M reported she completed a narcotic count at 6:00 a.m. with Staff N-LPN. Staff M reported at 6:00 a.m. Staff N questioned who she should do the narcotic count as Staff N and Staff F-LPN shared the same medication cart. Staff N obtained the keys from Staff F to do the count with Staff M. Staff M reported Staff N announced the count written on the narcotic log. Staff M reported she did not compare the actual amount of tablets with the narcotic count sheet. Staff M reported when she did the count at 2:00 p.m. that day the count was off one tablet. Staff M was certain she only administered one tablet to Resident #5. In an interview on 9/12/17 at 8:42 a.m. Staff N reported he worked the overnight shift with Staff F on 9/3/17 to 9/4/17. Staff N reported she shared the North Hall medication cart with Staff F that shift. Staff N reported they did not do a narcotic count each time they exchanged the keys.	F 431		

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F 431	Continued From page 39 2. The Order Entry dated 5/4/17 revealed Resident #9 had an order for Tramadol 50 milligrams, two tablets by mouth for times a day for pain. The Controlled Drug Record sheet dated 6/26/17 to 7/5/17 revealed an order for Tramadol 50 milligrams two tablets by mouth daily. The sheet revealed the following entries: a) On 7/1/17 at 9:00 p.m. , Staff G administered two tablets with 26 or 25 tablets remaining (writing not legible). b) On 7/2/17 at 9:00 a.m., Staff J administered two tablets with 24 tablets remaining. c) On 7/2/17 at noon, Staff J administered two tablets with 22 tablets remaining. d) On 7/2/17 at 9:15 p.m., Staff G administered two tablets and 20 tablets remained. The 20 had a line through it and 19 written beside it, changing the tablets remaining to 19. The Typed Statement dated 7/7/17 revealed the interim Director of Nurses interviewed Staff J-LPN about the discrepancy. Staff J reported she completed a count on 7/1/17 at 6:00 a.m. with Staff G-LPN. According to Staff J the count sheet revealed 26 tablets. However, Staff J noted 25 tablets in the medication card. Staff J told Staff G the numbers and Staff G responded "Oh wait a minute", Staff J looked up and witnessed Staff G making a note on the narcotic count sheet. Staff G told Staff J 25 tablets was the correct number. Staff J thought nothing else of it and just figured Staff G forgot to sign out a dose. The same day at 6:00 p.m., Staff G relieved Staff J and completed a narcotic count. When Staff J read the count number of 20 tablets on the narcotic sign out sheet, Staff G reported	F 431		

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F 431	Continued From page 40 an actual count of 19 tablets in the medication card. Staff J reported when she signed out Tramadol for Resident #9 during her shift she did not pay attention to the total she wrote down on the narcotic count sheet which was more than what was in the medication card. The In-Service records dated 7/6/17 and 7/24/17 revealed the staff received training on medication pass, narcotics, proper documentation, destruction, and the policy on controlled substances. The Controlled Medication Storage Policy directed the staff at shift change or when narcotic keys are surrendered, a physical inventory of all schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. The nursing care center may elect to count all controlled medications at shift change. Any discrepancy in controlled substance medication counts is reported to the Director of Nursing immediately. The Director of Nurses or designee investigates and makes every reasonable effort tot reconcile all reported discrepancies while the nurses remain on duty. The Agency Staff Orientation checklist effective 9/6/17 revealed orientation for agency nurses included the narcotic count procedure and signature sheets.	F 431		
F 499 SS=D	483.70(f)(1)(2) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS (f) Staff qualifications.	F 499		

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F 499	Continued From page 41 (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 record review and interviews the facility failed to ensure temporary agency personnel were licensed prior to allowing them to work at the facility for 2 of 7 personnel files reviewed. The facility reported a census of 60. Findings include: 1. The Staffing Agency sheet revealed Staff F (Licensed Practical Nurse) had a hire dated of 6/29/17. The Single Contact License & Background Check sheet for Staff F dated 6/30/17 revealed a Nursing License check result of "Not Found in Database". The Staff Agency time sheets revealed Staff F worked 12 hour shifts at the facility on 7/4/17, 7/8/17, 7/9/17, 7/12/17, 7/13/17, 7/14/17, 7/15/17 and 7/16/17. An interview on 9/12/17 at 11:37 a.m., Staff H (Human Resource Director) reported in the past the nursing department verified the qualifications of the agency staff. However, the facility could not provide documentation that the verification was completed on Staff F prior to allowing Staff F	F 499		

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F 499	Continued From page 42 to work at the facility. Staff H reported effective immediately the Human Resource Department planned to verify the qualifications of all agency staff currently working at the facility and any new agency staff prior to allowing them to work. The Iowa Board of Nursing License Verification sheet dated 9/13/17 revealed Staff F had an active nursing license. 2. The Staffing Agency sheet revealed Staff G (Licensed Practical Nurse) had a hire dated of 6/27/17. The Single Contact License & Background Check sheet dated 6/27/17 for Staff G revealed a Nursing License Check result of "RECORD NOT FOUND". The Staffing Agency time sheet revealed Staff G worked 12 hours shifts at the facility on 6/28/17, 6/29/17, 6/30/17, 7/1/17 and 7/2/17. An interview on 9/12/17 at 11:47 a.m., Staff H (Human Resource Director) reported the facility did not verify Staff G's credentials prior to allowing Staff G to work at the facility. The facility staffing agency checklist effective 9/8/17 directed the staff to verify licensure prior to allowing agency staff to work in the facility.	F 499		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0903	A. BUILDING: _____ B. WING _____	C 09/14/2017

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L 190	58.10(3)a General policies 481-58.10(135C) General policies. 58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements: a. Employees shall have a physical examination and tuberculin test before employment; (I, II,III) This Statute is not met as evidenced by: Based on record review and interviews the facility failed to complete a physical and a tuberculin test prior to hire for 1 of 5 personnel files reviewed. The facility reported a census of 60 residents. Findings include: The Employee List dated 9/5/17 revealed Staff I had a hire date of 7/27/17. Review of Staff I's personnel file failed to contain documentation of a physical and a tuberculin test prior to hire. Review of the Prehire Checklist for new employees directed the candidate to complete a tuberculin test prior to attending orientation and complete a Pre-Employment Physical. The Prehire Checklist stated new candidates must be free of any communicable diseases and mentally and physically able to perform the essential functions of the job. An interview on 9/13/17 at 3:30 p.m. Staff H (Human Resource) reported she checked Staff I's personnel file and did not find a Prehire Checklist. An interview on 9/13/17 at 2:06 p.m. the Administrator verified the physical and tuberculin skin test was not completed prior to hire for Staff	L 190		

DEPARTMENT OF INSPECTIONS AND APPEALS

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L 190	Continued From page 1 I.	L 190		