STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165381	A. BUILDING _____ B. WING _____	11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGOURNEY HEALTH CARE	900 SOUTH STONE STREET SIGOURNEY, IA 52591

(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 12-1-17 The following deficiencies were identified during the facility's annual survey and investigation of 71936-C conducted from 11/6/17 through 11/9/17. The complaint was not substantiated. See the Code of Federal Regulations (42CFR) Part 483, subpart B-C).	F 000		
F 156 SS=D	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) (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

11/17/2017

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.

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F 156	Continued From page 1 (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 as established under the Developmental	F 156		

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F 156	Continued From page 2 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), and telephone numbers of all pertinent State	F 156		

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F 156	Continued From page 3 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		

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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. (i) Where changes in coverage are made to items	F 156		

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F 156	Continued From page 5 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 provide 2 of 3 residents the required forms for Medicare Liability Notices and Beneficiary Appeals when skilled services had been exhausted or services no longer covered (Residents #2, #5). The facility reported a census of 30 residents.	F 156		

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F 156	Continued From page 6 Findings Include: 1. Record review for Resident # 2 indicated the resident received skilled services from 6/14/17 to 7/15/17. Continued review revealed the facility failed to provide the resident with the Generic Notice(Notice of Medicare Provider non coverage, CMS form # 10123. Further review indicated the facility had failed to provide the resident with the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN-CMS form 10055). 2. Record review for Resident # 5 indicated the resident received skilled services from 9/6/17 to 10/7/17. . Continued review revealed the facility failed to provide the resident with the Generic Notice (Notice of Medicare Provider non coverage, CMS form #10123. Further review indicated the facility had failed to provide the resident with the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN-CMS form 10055). During an interview on 11/7/17 at 11:15am, the Administrator acknowledged the lack of forms provided to residents of either form, #10123 nor #10055. Moving forward expectations are that liability notices will be explained by the MDS Coordinator who will begin duties on December 1st, 2017.	F 156		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that:	F 226		

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F 226	Continued From page 7 (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, 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 personnel file review, policy review and staff interview, the facility failed to obtain timely criminal and abuse background checks prior to hire for 1 of 5 new employee personnel records selected for review. The facility identified a census of 30 residents. Findings include:	F 226		

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F 226	Continued From page 8 Review of the personnel file for the Director of Nursing, Registered Nurse (RN), revealed a hire date of 6/28/17. The Single Contact License & Background Check showed the criminal/abuse background check had been completed on 7/13/17 after the employee's hire date. An interview on 11/8/17 at 12:35pm with the Business Office Manager acknowledged the Single Contact License and Background Check (SING) was done after the Director of Nursing was hired (6/28/17). Business Office Manager acknowledged that all employees SING are to be done prior to the first day of employment. Policy dated 6/21/17 stated under Employee Screening: 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.	F 226		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (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 clinical record review and staff interview, the facility failed to ensure that	F 281		

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F 281	Continued From page 9 physician order summaries are being obtained, followed and signed for 2 of 9 residents reviewed (Resident #2, #7). The facility reported a census of 30 residents. Findings include: 1. An Minimum Data Set (MDS) dated 10/15/17 for Resident #2 listed diagnoses of hip fracture, non-Alzheimer's dementia, nephritis, transient cerebral ischemic attack, conduction disorder and osteoporosis. Clinical record review revealed the last order summary was obtained on 5/8/17. A screenshot of Resident #2's computerized order review showed the next order review for 7/10/17 as 121 days overdue. 2. A Minimum Data Set dated on August 19, 2017 revealed the following diagnosis for Resident #7: epilepsy (seizure disorder), dementia, and hyperlipidemia. Record review of the resident's medication review report revealed a physician signature of May 11, 2017. A screen shot of the resident's computerized next order review date revealed that the orders were 121 days overdue. In an interview on 11/08/2017 at 1:30 p.m., the Director of Nursing (DON) confirmed the medication review reports had not been updated or reviewed for the amount of time indicated by the computerized screen shot.	F 281		
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 10 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520		

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F 520	Continued From page 11 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to have a physician in attendance at the QA (quality assurance) meeting at least quarterly. The facility reported a census of 30 residents. Findings include: The facility Administrator provided sign-in attendance sheets for the following dates that documented the attendees to the QA meetings: a. 10/27/16 b. 01/20/17 c. 04/20/17 d. 07/20/17 e. 08/24/17 f. 10/19/17 The sign-in sheets lacked documentation that indicated a physician attended the meetings on 1/20/17 and 4/20/17. During an interview on 11/6/17 at 4:00 p.m., the Administrator confirmed the QA meetings on 1/20/17 and 4/20/17 both lacked a medical director/physician present at the meetings.	F 520		

Sigourney Health Care

12/6/2017

POC 11/2017

Plan and/execution of this Plan or Correction does not constitute admission or agreement by this provider of the truth of deficiencies. The Plan of correction is prepared and/or executed solely because it is required by the provisions of "Federal and/or State Law.

F156 Notice of Rights, Rules, Services, charges

The facility does and will continue to inform residents of rights, rules, service, and charges.

Residents #2 & #5 have received proper notification of discontinuation of skilled services and their appeals Rights.

All residents have the potential to be affected in a similar manner.

Documents required for notification of discontinuation of skilled services have been implemented. Notifications are being logged and tracked to ensure compliance.

Staff responsible have been educated on the notification process.

Administrator/Designee will audit compliance weekly x4 then monthly x2 with results forwarded to the QAA Committee for further review and recommendations.

Responsible party: Administrator/Designee

Compliance date 12/1/17

F226 DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
The facility has in place and will continue to utilize policies and procedures to prohibit mistreatment, neglect, abuse of residents, and misappropriation of resident, and misappropriation of resident Property.

The staff who was out of compliance is no longer employed By Sigourney Health Care. An audit of the current files was conducted to ensure compliance. New hire documents required by regulation will be reviewed by the administrator/designee prior to hiring of employees.

A checklist will be used to ensure documents are completed per regulatory requirements.

The business office has been educated on the back ground check requirements.

The Business office Manager/Designee will audit compliance weekly x4, then

Monthly x2 with results forwarded to the QAA Committee for further review and recommendations.