STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING _____ B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

(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 VLK 4/20/18	INITIAL COMMENTS Correction date 4/19/18 The following deficiencies result from the facility's annual health survey and investigation of complaints # 74058-C and # 74592-C and of facility-reported incident # 74521-I. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	F 000 This plan of correction constitutes our credible Allegation of Compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550	F 550 The facility will transport and interact with residents in a dignified manner. 1. Resident #4 has been transported and interacted with residents in a dignified manner. 2. All residents will have interactions with staff that provide for dignity to be maintained. 3. Staff were in-serviced on this policy on 3/22/18 4. Social Service Designee will complete routine audits on dignity. Results of the audit will be discussed at QAPI for 6 months. 5. Completion date 3/22/2018	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: mlmartin — TITLE: Administrator — (X6) DATE: 4202018

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 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to transport to interact with a resident in the shower in a dignified manner (Resident #4) out of 36 residents reviewed. The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/1/18 for Resident #4 identified a Brief Interview for Mental Status (BIMS) score of 7 indicating severely impaired cognition. The resident experienced signs/symptoms of fluctuating inattention and disorganized thinking, hallucinations and delusions with daily verbal behavioral symptoms directed toward others. The MDS revealed the resident required the physical help in part of bathing activity from 2 persons. The MDS documented diagnoses that included Non-Alzheimer's dementia, anxiety disorder, psychotic disorder, disruptive mood dysregulation disorder and borderline personality	F 550		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 550	Continued From page 2 disorder. The care plan focus area revised 12/7/17 identified the resident had the potential for behaviors such as name calling and cursing generally directed at staff who attempted to care for her. The care plan interventions revised 3/5/18 directed staff to allow the resident time to regroup her thoughts when frustrated, approach the resident from the front when wanting to communicate with her, allow the resident to verbalize concerns/frustrations, give the resident a chance to communicate her thoughts, if the resident inappropriate and will not communicate effectively, try to reapproach at a later time and explain to the resident you are going to leave the room and why, this occasionally calms the resident and redirects behaviors. Observation on 3/6/18 at 11:05 a.m. revealed Resident #4 screaming in the shower room on the 200 Hall. Resident #4 cursed repeatedly stating f*** you many times over and stating f***ing b****. The surveyor knocked on the door and observed the Administrator and another staff member in the shower room with Resident #4, who sat in a shower chair with caster wheels. Resident #4 said she did not refuse a shower 3 times already, the staff were lying to her. Resident #4 began to cry and yelled why would anyone want to take a shower in this disgusting bathroom with a broken, rusty, nasty drain. The Administrator responded the other shower room was getting assist grab bars installed in it. Resident #4 again cursed and called the Administrator names and a liar. The Administrator responded 'really (resident's name), if you want to go there we will go there', in a sharp argumentative tone. Staff assisted the resident to	F 550		

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	166497	A. BUILDING _____ B. WING _____	03/21/2018

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F 550	Continued From page 3 transport via shower chair back to her room on the 500 hall and shut the door. In an interview on 3/06/18 at 3:50 p.m., the Director of Nursing (DON) stated staff should not argue with Resident # 4 when she had behaviors. The DON acknowledged arguing back with the resident would be considered a dignity issue.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561	F 561 The facility will honor residents' requests for bathing. 1. Resident #112 no longer resides at the facility. 2. All residents' requests for bathing will be honored. 3. Shower aide was in-serviced on this policy on 3/22/2018. 4. Social Services Designee will complete routine audits on self-determination. Results of th audit will be discussed at QAPI for 6 months. 5. Completion date 3/22/2018	

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F 561	Continued From page 4 facility. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview and staff interview, the facility failed to honor a resident's request for bathing for 1 of 36 residents reviewed (Resident #112). The facility reported a census of 61 residents. Findings include: The Minimum Data Set (MDS) assessment dated 3/7/18 documented Resident #112 had diagnoses that included high blood pressure, shingles, a hernia, back pain and a history of urinary tract infections. The MDS documented the resident scored a 10 out of 15 on The Brief Interview for Mental Status indicating moderate cognitive impairment. Resident #112 required the assistance of two with bed mobility, transfers, walking, bathing and toilet use and the assistance of one with personal hygiene. The MDS documented the resident had pain almost constantly, disturbed the resident's sleep, and limited day to day activities. During observation on 3/5/18 at 2:00 p.m., the resident's call light came on. During interview at the time, Resident #112 stated today the staff made her take a shower. The resident stated she had too much pain and did not want to take a shower. The shower aide told the resident she needed to take the shower at that time. During interview on 3/5/18 at 2:15 p.m. the shower aide stated she had just started as the shower aide and she told the resident she needed to take a shower at that time so the shower aid would not get behind.	F 561		

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F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(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 §483.10(g)(17)(i)(A) and (B) of this section. §483.10(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 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	F 582	F 582 The facility will provide the required notices when skilled nursing services are no longer covered 1. Notices for Residents 25, 40, and 62 cannot be provided as the dates are in the past. 2. All residents who have orders for skilled nursing services will be provided the required notice when skilled nursing services are no longer covered. 3. Staff were in-serviced on this policy on 3/26/2018 4. Director of Nursing and/or designee will complete routine audits on required notice. Results of the audit will be discussed at QAPI for 6 months. 5. Completion date 3/26/2018	

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F 582	Continued From page 6 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 facility record review and staff interview, the facility failed to provide three of three residents residents reviewed the required notices (form 1055 or similar mandatory denial notice) when skilled nursing services were deemed no longer covered (Residents #25, #40 & #262). The facility reported a census of 61. Findings include: 1. A review of medicare billing information for Resident # 25, revealed the resident received skilled services from 9/3/17 to 9/19/17 and 10/24/17 to 12/12/17. Record review revealed no mandatory denial notice had been provided to or signed by the resident or residents representative, with an opportunity to request a demand bill on both occasions when services were deemed no longer covered by medicare. 2. A review of medicare billing information for Resident # 40, revealed the resident received skilled services from 10/27/17 until 11/10/17. Record review revealed no mandatory denial	F 582		

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F 582	Continued From page 7 notice had been provided to or signed by the resident or residents representative, with an opportunity to request a demand bill when services were deemed no longer covered by medicare. 3. A review of medicare billing information for Resident # 262, revealed the resident received skilled services from 8/7/17 until 10/12/17. Record review revealed no mandatory denial notice had been provided to or signed by the resident or residents representative, with an opportunity to request a demand bill when services were deemed no longer covered by medicare. On 3/6/18 at 10:00 a.m., the Director of Nursing confirmed the facility failed to complete a mandatory denial notice, form 1055 or similar form for the three residents selected for review and the nurse who had been responsible for the task no longer worked at the facility.	F 582		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 610	F 610 The facility will investigate an allegation of abuse and separate a staff member from a resident after receiving an allegation of abuse to ensure the resident's protection. The facility will investigate an allegation of abuse and separate a staff member from a resident after receiving an allegation of abuse ensure the resident's protection. 1. Resident #28 has been assessed under the abuse policy. 2. All residents fall under our abuse reporting policy. 3. Staff were in-serviced on this policy at different times from 3/8/2018 through 3/9/2018. 4. Administrator and/or designee will complete routine audits. Results of the audit will be discussed at QAPI for 6 months. 5. Completion date 3/9/2018	

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F 610	Continued From page 8 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, observation, staff interview, facility record review and facility policy review, the facility failed to investigate an allegation of abuse and separate a staff member from a resident after receiving an allegation of abuse to ensure the resident's protection for one of 36 residents reviewed (Resident #28). The facility reported a census of 61 residents. Findings include: The Minimum Data Set (MDS) assessment dated 1/19/18 for Resident #28 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact memory and cognition. The MDS documented the resident displayed no behaviors during the 7 day assessment reference period. The resident required the assistance of one person for transfers. The MDS documented diagnoses that included depression, history of falling, abnormal posture, generalized muscle weakness and difficulty in walking. The Skin Conditions of the MDS documented the resident had no skin problems at the time of the assessment. The care plan focus area revised 11/24/17 identified a potential for injury/impaired physical mobility related to weakness, chronic arthritic type pain, osteoporosis, history of falls, resident impulsive at times and gets up unattended. The	F 610		

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F 610	Continued From page 9 care plan directed staff to provide transfers with assist of 1 to and from bed, wheelchair, toilet, walker for transfers prn (as needed), and wheelchair for any mobility outside the resident's room. The care plan informed the resident could mobilize her wheelchair using the rails in the halls and her feet and staff to assist with wheelchair propulsion prn. The intervention revised 1/19/18 instructed staff to not let the resident return to the room unattended and to go to her room to make sure the resident's needs met to prevent self transfers. In an interview on 3/6/18 at 3:00 p.m. Resident # 28 stated her only concern a 2 p.m. to 10 p.m. shift nurse picked on her and hurt her arm the day before. Resident #28 showed a bruise approximately the size of 1/2 a dollar bill, deep purple color on her posterior left forearm. Resident # 28 reported the nurse jerked her arm. Resident #28 stated a nurse hurt her left forearm a night or 2 ago; the nurse assisted her in her room and then jerked her arm hard. Resident # 28 said she commented 'you hurt me' and the nurse said 'no I didn't'. Resident #28 said she grabbed her arm hard twice and that made the bruise really purple. Resident #28 said she thought the time of day on the 2 p.m. to 10 p.m. shift was around 6 p.m. Resident #28 stated she was mad at herself that she could not remember the nurse's name, she thought the nurse had dark hair pulled back and was taller. Resident #28 said the nurse worked at the facility a lot and stated she would be able to pick her out if she saw her, she just didn't know her name. Resident #28 said the nurse picked on her and she didn't know why because she's never done anything wrong.	F 610		

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F 610	Continued From page 10 In a follow-up interview on 3/6/18 at 3:30 p.m., Resident # 28 showed a bruise on her left forearm and another on her left wrist. Resident # 28 said the areas hurt before. Resident # 28 stated the nurse hurt the area twice in one evening. Resident # 28 described the nurse as dark hair with medium build, not skinny and not fat with hair pulled back. Resident #28 stated the nurse grabbed her am, swung her around in the lobby, and it happened just once. Resident #28 said the nurse hollered and scolded her that she needed to wait for helpers to help down her aisle. Resident #28 reported her room at the end of the 200 Hall. Resident #28 clarified it did not happen in her room and not where the residents ate, but where the TV and chairs were by the nursing station. Resident #28 stated she started to go back to her room when the nurse grabbed her and pulled her back telling her she needed to wait until 6 helpers came, but no one on 200 hall. Resident #28 said when she asked why she couldn't go down (the hall) the nurse said, you wait here. Resident #28 commented she thought the nurse had glasses and she thought it was a nurse, not a CNA (Certified Nurse Aide). Resident #28 said she couldn't recall the nurse's clothes or anything else that would be identifying information. Resident #28 said the nurse worked a lot of evenings. Resident #28 said there were a lot of other people around the nurses desk looking when it happened, all nurses. Resident #28 clarified the time frame since the incident to be at least one or 2 days. Resident #28 stated when she saw the nurse behind the desk she shuddered because before the incident the nurse yelled at her. Resident #28 reiterated the nurse grabbed her twice at the same time so that was why the area appeared so purple.	F 610		

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F 610	Continued From page 11	F 610		

In an interview 3/7/18 at 7:00 a.m., Staff B, LPN (Licensed Practical Nurse) described Resident #28 as a sweetheart and she was familiar with her care. Staff B stated she first became aware Resident #28 had a bruise on her arm on the previous Friday, 3/2/18. Staff B reported she worked an overnight, Friday into Saturday morning (3/3/18). Staff B stated she was in Resident #10's room when she heard screaming. Staff B reported it occurred during rounds, she did not recall which rounds, but thought it happened in the middle of the night. Staff B stated she heard Resident #28 scream and she went to Resident #28's room. Staff B reported Staff D, CNA (certified nursing assistant), from agency staffing, was in the room with Resident #28. Staff B responded it was not the first time Staff D had worked with her but usually Staff D worked in the back of the building on the 400 hall. Staff B stated Resident #28 said, she hurt me, she hurt me. Staff B reported she stepped in and took over for Staff D and got Resident #28 into the bathroom. Staff B said Resident #28 showed her arm but there was no bruise there; she did not see anything. Staff B stated she went into the resident's room later and the area appeared a little red; Staff B did not know if the area was red because the resident rubbed it or if it was a bruise. Staff B reported the resident had just said, she hurt me and pointed to the arm. Staff B stated she did not tell anyone about the incident and Staff D did not go back in Resident #28's room. Staff B stated Staff D said she did not do anything to the resident and she did not recall anything else being said by Resident #28 or Staff D. Staff B stated Saturday morning, she saw a red mark develop. Staff B reported only she and Staff D worked up front on that night, no one else would have been there. Staff B clarified she did

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F 610	Continued From page 12	F 610		

not tell Staff D she could not go back into Resident #28's room but she did not think that Staff D went back in there.

The Progress Notes dated 3/6/18 at 4:41 p.m. documented a Social Service Note. The note recorded the resident reported to state surveyor in the building that a nurse grabbed her arm and bruised it. The note documented the Director of Nursing (DON) interviewed the resident and the resident stated a nurse grabbed her arm a couple of weeks ago. The entry documented the resident did not know the nurses name and verified it was a couple of days prior in the front lobby, a nurse grabbed her arm to turn her wheel chair around, and asked her to wait until someone could help her transfer in her room.

The Progress Notes dated 3/6/2018 at 4:46 p.m. documented staff notified the resident's son of the bruise on the resident's arm.

The facility abuse policy and procedures titled Abuse Prevention, Identification, Investigation, and Reporting Policy revised 4/1/17 included the following information:

Initial/Immediate Protection During Facility Investigation - Upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2)

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F 610	Continued From page 13 segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents.	F 610		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656	F 656 The facility will develop and update a comprehensive care plan to monitor side effects for psychotropic medications for residents 61, 37, and 3. 1. Residents 61, 37, and 3 will all have updated comprehensive care plans to monitor side effects for psychotropic medications. 2. All residents on psychotropic medications will have a comprehensive care plan to monitor side effects. 3. Staff were in-serviced on this policy on 3/26/2018 4. Director of Nursing and/or designee will complete routine audit/s on care plans. Results of th audit will be discussed at QAPI for 6 months. 5. Completion date 4/19/2018	

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F 656	Continued From page 14 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observation, the facility failed to develop and update a comprehensive care plan to monitor side effects for psychotropic medications for three residents (#61, #37 and #3) and regarding a resident's dental needs (#49) of 36 total residents reviewed. The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/22/18 identified Resident # 61 had a Brief Interview for Mental Status (BIMS) score of 2 out of 15, which indicated severely impaired memory and cognition. The MDS identified the resident had diagnosis of Non-Alzheimer's dementia, muscle weakness, difficulty walking and depression. Resident #61 required the assistance of two staff for transfers and the assistance of one staff locomotion on and off the	F 656		

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F 656	Continued From page 15 unit and during walking. The MDS revealed the resident received an antidepressant medication daily during the previous 7 day look back period. The care plan revised on 2/27/18 documented the resident took an antidepressant medication. The interventions instructed to administer the medication as ordered, monitor ASE (acute side effects) and report concerns to her doctor as needed. The care plan also identified the resident had a self-care deficit and required assistance with activities of daily living. The care plan lacked identified potential side effects related to the medications. The Order Review Report dated 3/1-3/31/18, included an order for donepezil 10 mg orally (PO) every evening (q p.m.) and lexapro 20 mg PO every morning (q a.m.) for major depressive disorder. During an interview on 3/08/18 at 12:24 PM, the Director of Nursing (DON) reported she expected care plans to be reviewed and updated at least quarterly and as needed when changes occurred. 2. The MDS assessment dated 2/1/18 documented Resident #37 had diagnoses of depression, cerebrovascular accident (CVA, or a stroke), anemia, diabetes, weakness and difficulty in walking. The assessment documented the resident received antidepressant and hypnotic medications during the previous 7 days in the look back period. The Order review report revealed a physician's order for escitalopram (an antidepressant) 10 mg q a.m. for major depression beginning on 8/2/17.	F 656		

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F 656	Continued From page 16 The care plan dated 1/18/17 lacked documentation the resident received an antidepressant or hypnotic medication and had no plan that identified goals, interventions and potential side effects related to the administration of escitalopram. 3. The MDS assessment dated 12/1/17 recorded Resident # 3 had diagnoses of Alzheimer's disease, dementia, chronic pain and anxiety disorder. The MDS documented the resident had severely impaired cognitive skills for daily decision making. The MDS revealed the resident received an antipsychotic, antianxiety and antidepressant medications during the previous 7 days in the look back period. The order review report dated 3/1-3/28/18, revealed a physician's order for clonazepam 1 mg PO q a.m., doxepin 25 mg PO q d and escitalopram 10 mg PO q a.m. for anxiety and quetiapine 75 mg PO q HS for Alzheimer's dementia. The resident's care plan date of 9/4/14 recorded the resident had dementia, impaired communication skills, anxiety and used psychotropic medication related to disease process and behaviors. The care plan interventions instructed staff to administer medications as ordered daily, monitor changes in mood, behavior, and communication, monitor any adverse reactions or ineffectiveness of medications, and report problems to the physician. The care plan lacked documentation the resident received an antidepressant medication and had no listing of potential side effects related to the administration of clonazepam, doxepin, escitalopram or quetiapine.	F 656		

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4. The MDS assessment dated 2/19/18 for Resident #49 identified a BIMS score of 15 without signs or symptoms of delirium. The MDS documented diagnoses that included cancer, malnutrition and vitamin D deficiency. The MDS recorded the resident had no oral/dental issues and the box for no natural teeth/edentulous had been left blank.

The care plan focus area revised on 3/6/18 identified altered nutrition related to a diagnosis of depression. One intervention directed staff to serve a regular diet with ground meat. The care plan did not address the resident's oral status.

The Progress Note dated 12/27/17 at 3:32 p.m. recorded the resident entered the facility. She had both upper and lower dentures but did not have the dentures in and the resident received a regular diet. The Progress Notes dated 1/2/18 at 4:04 p.m. documented a nutrition/dietary note. The Registered Dietician (RD) documented the resident reported she had trouble chewing some foods as she did not have her dentures. The RD wrote its unclear whether the dentures were available and she recommended investigating.

The Progress Note dated 2/26/18 at 2:57 p.m. documented a nutrition/dietary note. The note recorded by the RD documented the resident re-admitted to the facility 2/12/18 after a fall. The RD documented the resident reported she chose a softer diet as she still did not have her dentures, the resident reported the dentures didn't fit properly and the resident would like to see a dentist.

On 3/6/18 at 10:40 a.m. observation revealed

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F 656	Continued From page 18 Resident # 49 as edentulous (without teeth). Resident # 49 reported she would really rather have her dentures but she left them at home. Resident # 49 said she had lost weight at home and the dentures did not fit well. Resident # 49 reported she had told the quite a few staff nurses about wanting dentures.	F 656		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and resident, physician and staff interviews, the facility failed to properly assess and intervene after significant condition changes for 2 of 36 residents reviewed (Residents #6 and #49). The facility reported a census of 61 residents. Findings include: 1. The MDS (minimum data set) assessment dated 12/8/17 listed depression, dementia, Parkinson's disease, psychotic disorder and cognitive communication deficit as Resident #6's diagnoses. The MDS also noted his cognitive skills for daily decision making as severely impaired. According to the MDS, Resident #6	F 684	F 684 The facility will properly assess and intervene after significant condition changes for residents. 1. Residents 6 no longer resides at this facility. Resident 49 has been assessed after significant condition changes. 2. All residents fall under our significant condition change policy. 3. Staff were in-serviced on this policy on 3/22/2018. 4. Administrator and/or designee will complete routine audits on change of condition. Results of the audit will be discussed at QAPI for 6 months. 5. Completion date 3/22/2018	

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F 684	Continued From page 19 required extensive assistance of one for most ADLs (activities of daily living). The 12/7/17 care plan documented that Resident #6 had ADL deficits related to severe dementia and very poor cognition. The Care Plan instructed staff to help him be safe in his environment and provide one to one supervision whenever necessary. The care plan also instructed staff to assess his behaviors for a decline and report the changes to the doctor. The care plan also noted Resident #6's risk for skin breakdown related to incontinence and sitting or lying for periods of time. The care plan directed staff to follow the facility protocol for skin issues, report them to the doctor as needed. The 12/14/17 addition to the Care Plan instructed staff to assist him with incontinence cares. A 12/21/17 revision instructed staff to anticipate the resident's needs. A Nursing Note dated 3/8/18 at 9:40 p.m. noted that Resident #6 slept most of the shift. The nurse documented that Resident #6 refused to eat or take medication. An untitled document (24 hour report) dated 3/9/18 of recorded information obtained during a shift to be relayed to the following shift noted that the day shift could not get Resident #6 to take his medication and the evening shift noted to push (encourage) fluids. A Nursing Note dated 3/9/18 at 8:30 p.m. noted that fluids had been encouraged but taken poorly on day two of follow up related to antibiotics. An untitled document dated 3/10/18 of recorded information obtained during a shift to be relayed to the following shift noted that Resident #6 was	F 684		

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F 684	Continued From page 20 "OK" on the overnight shift, on antibiotic follow up on the day shift and refused supper and medication on the evening shift. A Nursing Note dated 3/11/18 at 2:27 p.m. and authored by Staff G, LPN, revealed that Resident #6 would not eat, take medication and was lethargic. The nurse also documented she faxed the doctor because Resident #6 had loose stools, very red skin and she requested if the doctor wanted a follow up UA (urinalysis) since the resident just completed a round of antibiotics for a UTI (urinary tract infection). A Physician Fax Order Request dated 3/11/18 notified that Resident #6 continued acting lethargic after just completing a round of antibiotics for a UTI. The nurse also noted that Resident #6 had loose stools, very red skin and she could not get him to take medication. The document noted the physician ordered a follow up UA (urinalysis) and lab tests the on 3/12/18 when he responded to the request. An untitled document dated 3/12/18 of recorded information obtained during a shift to be relayed to the following shift noted that Resident #6 was "OK" on the overnight shift, but hospitalized during the day shift and evening shift. After requesting the 3/8/18 and 3/11/18 24 hour reports, the current DON (Director of Nursing) stated she could not find those documents. A Nursing Note dated 3/12/18 at 10:31 a.m. and authored by the current DON revealed that Resident #6 was lethargic and unable to verbally respond to commands. The nurse also documented that Resident #6's mucus	F 684		

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membranes were dry, his lips were cracked and bleeding, orbital (eye) sockets were sunken and he had poor skin turgor (can be associated to dehydration). The nurse noted that she obtained orders to have Resident #6 sent to the ER by ambulance.

Nurse's Notes from Hospital noted that Resident #6 arrived in ER on 3/12/18 at 11:05 a.m. with diagnoses of altered mental status and acute kidney failure.

The presentation dated 3/12/18 at 11:31 a.m. noted the presenting complaint as decreased LOC (level of consciousness) for 2 days, altered mental status, finished course of antibiotics for UTI last Wednesday and decreased oral intake. The ER assessment documented that Resident #6 appeared emaciated, malnourished and described his behaviors as listless, somewhat obtunded (lethargic) and only responded to stimulus.

The ER physician's 3/12/18 exam report at 11:55 a.m. revealed a hard mass of the lower right and left abdomen and extreme distention (swollen and/or stretched) per nursing report on arrival. The doctor noted special observations as the resident being markedly cachectic with a superficial pressure sore on the right hip.

The Patient Care Notes dated 3/12/18 at 1:01 p.m. and authored by an RN noted that Resident #6 finished antibiotics for UTI on Wednesday, had lowered LOC, mental status change and decreased output. The nurse noted they catheterized the resident in ER with significant dark urine output with moderate sediment present. The nurse documented Resident #6's

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eyes would not focus and he only responded to painful stimuli. The resident appeared very emaciated. While turning the resident, the nurse noted her observation of his rectum being dilated to the size of a half dollar with stool visible. The nurse documented that a small amount of very firm stool had been digitally removed before cleaning the resident's buttocks. The nurse also noted multiple areas of redness on the bony prominences. They admitted Resident #6 to the medical surgical floor at 1:49 p.m.

The Patient Care Notes on 3/12/18 at 4:19 p.m. noted that Resident #6 met admission criteria as a sepsis (potentially life threatening complication of an infection) patient with significant mental status changes, severe dehydration and evidence of acute kidney failure.

The Patient Care Notes on 3/12/18 at 7:30 p.m. noted Resident #6 lying in bed unresponsive to stimuli with a mass to the left abdomen about the size of a fist.

The Patient Care Notes on 3/12/18 at 11:00 p.m. noted that Resident #6 had an extra large dark brown formed bowel movement.

The Patient Report dated 3/12/18 of the results of an imaging test of the abdomen confirmed they saw a large about of stool in the colon and determined the correlation for fecal impaction.

The Patient Care Notes on 3/13/18 at 7:16 a.m. noted Resident #6 had an episode of an extra/extra large soft/hard bowel movement.

The Patient Care Notes on 3/13/18 at 7:20 a.m. noted Resident #6 had been incontinent of a

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F 684	Continued From page 23 large amount of dark stool. The Patient Care Notes on 3/13/18 at 8:45 a.m. noted Resident #6 had been incontinent of a large amount of stool. The Patient Care Notes on 3/13/18 at 9:09 a.m. noted Resident #6 had been incontinent of large loose with hard bowel movement. The Patient Care Notes on 3/13/18 at 10:45 a.m. noted Resident #6 had been incontinent of large amount of dark stool. The Patient Care Notes on 3/13/18 at 11;02 a.m. noted Resident #6 had been incontinent of extra large soft bowel movement. The Patient Care Notes on 3/14/18 at 7:45 a.m. noted that Resident #6 's mouth, tongue and roof of his mouth were dry and bleeding. The Patient Care Notes on 3/14/18 at 9:45 a.m. noted the doctor discussed the treatment of C diff with the family. The family agreed to NG (naso gastric (through nose into stomach)) tube placement for administration of oral antibiotics. The Patient Care Notes on 3/18/18 at 3:17 a.m. documented they pronounced Resident #6 dead. An Employee Warning/Discharge Notice dated 3/14/18 documented that the previous DON had been terminated for negligence or carelessness, poor and/or disrespectful interpersonal communication skills and abandoning or failing to perform her job responsibilities. The documentation referred to the DON's failure to document a change in Resident #6's condition	F 684		

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F 684	Continued From page 24 during the evening shift on 3/10/18 and also noted the DON had been suspended on 3/12/18 pending the outcome of an investigation. The document also referred to a 3/13/18 email correspondence provided by the Administrator about a conversation she had with Resident #6's family. The Administrator documented that Resident #6's son complained that his father's abdomen was distended; which was relieved once he expelled 1100 ml of urine when hospital staff catheterized the resident after being admitted on 3/12/18. The email also noted that the resident's son wanted to know why nobody noted the distention and took preventative measures. Resident #6's son also complained about the "lack of medication administration" since Thursday, extreme dehydration and that a fax had been sent to the doctor's office. An Employee Warning/Discharge Notice dated 3/16/18 documented that Staff G, LPN received a written warning for abandoning or failing to perform her job responsibilities. According to the document, Staff G failed to document the change in Resident #6's condition on the 3/10/18 day shift. The document also noted the LPN was being reprimanded for faxing the change of condition to the doctor on 3/11/18 over the weekend when the doctor's office was closed. A statement written by Staff A on the second page of the document noted that she spoke to Resident #6's family on 3/10/18 about monitoring the resident's behaviors and changes in status. The LPN wrote that she relayed information about Resident #6's change in status to the previous DON at shift change and asked her to assess the resident. A Nursing Note dated 3/18/18 at 6:08 a.m. noted	F 684		

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QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

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that Resident #6's son notified them that his father died at 4:00 a.m. at the hospital.

When asked for their protocol they used prior to Resident #6's 3/12/18 hospitalization, the current DON submitted a document titled Change of Condition-Resident Physician/GNP Notification. According to the document, the attending physician/NP (nurse practitioner) physician/NP on call should be notified of all changes in resident's condition or health status seven days a week between the hours of 8:00 a.m. and 10:00 p.m. The policy also directed that any change in condition, health status or incident should be reported to the attending physician or physician on call between 10:00 p.m. and 8:00 a.m. for acute symptoms that include significant changes in mental or psychosocial status or other conditions that are deemed necessary.

The Policy and Procedure for the Prevention and Treatment of Skin Breakdown revealed the facility's policy as properly identifying and assessing residents whose clinical conditions increase the risk for impaired skin integrity, to implement preventative measures and to provide appropriate treatment according to the industry standards of care. According to their procedure, skin will be observed daily during cares and concerns should be reported to the nurse immediately. The nurse should notify the physician to obtain orders, but the wound care protocol should be initiated for new skin issues until orders are received.

An interview on 3/19/18 at 3:05 p.m. with Staff G revealed that Resident #6 had not taken his medication for her on 3/10/18 before Staff L, CNA reported Resident #6 acting lethargic at about

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lunch time. Staff G said she found him in bed when she went to assess him. Staff G said he typically would get up for lunch, but the aids kept him in bed that day because he had not been feeling well. The LPN said Resident #6 seemed abnormally lethargic, but that was about the extent of her assessment at that time. Staff G said the aids also told her Resident #6 had been having loose stools, but she did not see them. The LPN said Resident #6's bottom was quite red around his coccyx, but she attributed that to loose stools. Staff G said she told them to apply barrier cream after incontinence cares and to leave the area open to air whenever possible. The LPN said the previous DON relieved her of duty at about 7:30 p.m. on Saturday 3/10/18; at which time Staff G said she asked the DON to go check on Resident #6. Staff G said she also wanted an RN's opinion. The LPN said she told the DON that Staff L told her Resident #6 had been acting different and that he spit out his medication. The LPN said she checked Resident #6's vital signs on 3/10/18 and 3/11/18. The LPN said they were supposed to be in the computer, but she might have documented them on the 24 hour sheet instead. Staff G said she sent a fax to notify the doctor on 3/11/18.

An interview on 3/20/18 at 8:05 a.m. with the Administrator revealed that she learned on Monday 3/12/18 that Resident #6's condition changed over the weekend. The Administrator said they pre-emotively educated staff on 3/14/18 because they were not following their protocol.

An interview on 3/20/18 at 9:30 a.m. with Staff L revealed that she worked with Resident #6 on 3/10/18 and 3/11/18. Staff L said she and Staff M, CNA got him up on Saturday (3/10/18) morning

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and noticed him being weaker than usual. Staff L said he typically would be on the edge of his bed ready to get up, but not that day. The CNA said he responded to them when they asked him how questions, but he seemed lethargic. Staff L said he barely had the energy to participate in getting dressed like he normally would. The CNA said that although Resident #6 did not always want breakfast, they could usually get him to eat something. Staff L said they could not get him to eat anything that morning, which she also considered to be abnormal for him. The CNA said his family visited before lunch and had been asking if he had any medication changes because of being so sluggish. They referred the family to his nurse; Staff G. The CNA heard Staff G tell them Resident #6 just finished a round of antibiotics for a UTI, but she had not noticed any other medication changes. Staff L said she had been off for a couple of days, but nobody told her anything about a change in his condition when she returned that day. Staff L said she wondered why he still acted like that if he just finished an antibiotic. Staff L said she told Staff G how she noticed Resident #6 had not been acting like himself, and asked why in light of the fact that he just finished his antibiotics. According to Staff L, Staff G told her she would fax the Dr. to see what he thought. Staff L expressed concern that Staff G had not been taking the matter as seriously as she should have. The CNA said Resident #6 had a relatively normal BM on Saturday. The CNA said despite their efforts to get him to eat something, he still refused to take a drink or a bite of anything at lunch time. Staff L said they laid him down after lunch. Staff L said she saw the previous DON when she reported to work at 2:00 p.m. and told her how Resident #6 had been acting. Staff L said she told the DON that special

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attention should be shown to repositioning him and checking up on him frequently. Staff L said she and Staff M were the only CNAs up front on Sunday 3/11/18 and Staff G was the nurse. Staff L said the previous DON worked all night too, so she saw her on Sunday morning also. Staff L said she did not hear anything about Resident #6 in shift report, nor did the DON say anything about him. Staff L said Resident #6 would not respond to them when they went in to help him about 8:00 a.m. Staff L said she noticed a strong urine smell when she entered the room. Staff L said it looked as if he was in the same position they left him in at 1:00 p.m. on the day before. The CNA said Resident #6's brief, the pad under him and the bedding was saturated in urine and dark brown watery feces that smelled awful when they pulled the covers back. Staff L said she identified a purplish red oval shaped area on his right hip bone that measured approximately 2" x 3" that she did not see the day before. The CNA said Staff M went and got Staff G after they got Resident #6 cleaned up and repositioned. Staff L said Staff G returned and commented about it being "ridiculous that he hadn't been touched since the day before." Staff L said Staff G once again did not seem to be taking his condition quite as seriously as she should have. Staff L said she believed Resident #6 should have been sent to the ER to be evaluated instead of just ignoring him without doing anything while he declined. Staff L said she asked Staff G throughout the day if they should get him up or leave him lying in bed. Staff L said Staff G said leaving him lying in bed was fine. Staff L said she reported his condition and that he had not improved to Staff G every two hours after she repositioned him. Staff L said she also reported his condition to the oncoming aids and told them

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to reposition him frequently. Staff L said she found that they had repositioned him and kept him clean when she saw Resident #6 on Monday morning about 7:00 a.m. Staff L said although he was not unconscious, he "was completely out of it" on Monday morning. After checking on Resident #6, Staff L said she reported his condition to the current DON. Staff L said she and the current DON entered his room and saw the spot on his hip. Staff L said the sore was still about the same size and color. Staff L said she told the DON how the weekend went, but the DON primarily focused on getting Resident #6 sent out; which happened within a half an hour.

An interview on 3/20/18 at 11:15 a.m. with Staff M revealed that she worked 6:00 a.m. to 2:00 p.m. on 3/10/18 and 3/11/18. According to Staff M, nobody told her anything about a change in Resident #6 at shift report on Saturday 3/10/18. Staff M said she and Staff L got Resident #6 up about 7:50 a.m. The CNA said he had been incontinent with what appeared to be a normal bowel movement for him. Staff M said she had not noticed any skin issues on his buttocks or anywhere else. Staff M said he seemed tired. According to the CNA, they got him up for breakfast and he might have eaten about 25% and had a few drinks of white milk and juice. Staff M said Resident #6 loved coffee, but he did not drink it that morning. Staff M said he did not eat any lunch despite their efforts prompting him to eat. Staff M said they laid him down after lunch about 12:45 p.m. or 1:00 p.m. and she did not see him any more during her shift. Staff M said she told Staff G that he had not been eating and was more tired than usual. Staff M said she reported off to the oncoming shift. Staff M said when she checked on him first thing Sunday

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F 684	Continued From page 30 (3/11/18) he was in the same spot they left him in on Saturday. Staff M said he only had a tee shirt and a soiled brief on. Staff M said his urine seemed much darker than the day before and his brief, pad and sheets were soaked in urine and dark brown runny feces. The CNA said she saw a purplish red pressure sore about 2" x 3" on his hip (unsure of which side) which she did not see the day before. Staff M said she went straight from his room after helping him and told Staff G about the sore and how it looked like he had not been moved from the day before. Staff M said they later asked Staff G if she looked at it and she told them she had. Staff M said Resident #6 stayed in his bed for the rest of the day. The CNA said they went in there every 2 hours to reposition him and offer him something to drink; which he declined the fluids. Staff M said she and/or Staff L had been in and out of his room at least 6 times during their shift. An interview on 3/20/18 at 12:25 p.m. with the ER doctor revealed he attended to Resident #6 when he arrived in ER on 3/12/18. The doctor recalled that Resident #6 had dementia, Parkinson's disease and was markedly cachectic (wasting with loss of weight and muscle mass) with all his bony prominences observed and redness over his hips. The physician said he remembered that Resident #6 had a diminished level of consciousness and would not interact or track with stimuli in the ER. Although the doctor said he did not know what Resident #6's baseline was, he had only a minimal reaction to a sternal rub (aggressive rubbing on the breast bone). The physician said Resident #6 had a fecal impaction (large hard mass of stool that gets stuck in the colon or rectum and cannot be pushed out), which could be caused by lack of mobility,	F 684		

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F 684	Continued From page 31 dehydration and medication. The doctor said once they started to hydrate him with IV fluids he started having massive bowel movements; the resident had 3 or 4 solid bowel movements before it turned to diarrhea. The doctor said Resident #6 tested positive for c-diff (bacterial infection). The doctor said he had a total of 7 to 8 bowel movements; which included the diarrhea. The doctor would have expected staff to intervene sooner if they knew about his change of condition over the weekend. Although the doctor could not say that delayed intervention caused Resident #6's death, he would say that being seen sooner certainly could have been beneficial. An interview on 3/20/18 at 5:08 p.m. with Staff J, LPN revealed that the previous DON would have been responsible for Resident #6 on the 3/10/18 overnight shift, so she would not have received shift report about him. Staff J said she went into Resident #6's room with Staff K, CNA during their shift. The LPN said Staff K changed Resident #6 while she changed his roommate. An interview on 3/20/18 at 5:50 p.m. with Staff K, revealed that she worked the overnight shift on 3/10/18. According to Staff K, she did not remember what she heard in report about Resident #6 because that was her first night working at the facility. Staff K said she never had any training before that night; she just started working the floor. The CNA said she rounded on every resident 3 times because that is what they told her to do. According to Staff K, Resident #6 had been sleeping every time she went in there. Staff K said she checked Resident #6 every time she rounded, but she could not remember if the resident's brief was dry every time she went in there. Staff K said she remembered that she	F 684		

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changed him at least twice during the night. The CNA said she repositioned him every time she rounded on him that night. Staff K said she worked with the previous DON that night. Staff K said the DON never told her anything about the resident having a decline in his physical health. Staff K said the DON assisted her with every resident that she had anything to do with that night. The CNA considered her workload to be manageable and completed everything for her residents. Staff K could not recall if Resident #6 had a bowel movement during the night. The CNA said Resident #6 woke up lightly whenever she went in there to explain what she was going to do for him, but he did not said anything back to her. Staff K said she the DON gave shift report to the oncoming shift on Sunday morning. She said they walked down the hallway and talked outside of the resident's rooms so they did not wake them up again. Staff K said she did her last round between 5:00 a.m. and 6:00 a.m., but she could not remember if Resident #6 needed to be changed then.

An interview on 3/21/18 at 8:30 a.m. with the current DON revealed they have not found the 3/8/18 or 3/11/18 24 hour reports and nobody initiated any skin sheets for Resident #6.

A subsequent interview on 3/21/18 at 9:40 a.m. with the Administrator revealed that she knew Resident #6 had been sent to ER on Monday 3/12/18, but she did not know the magnitude of the situation until his family called on Wednesday at 4:30. The Administrator said the resident's son called about concerns that his father expelled about 1100 ml of urine when they catheterized him at the hospital. According to the Administrator, Resident #6's son expressed

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concern about staff not following up with the change in his father's condition over the weekend. The Administrator said the resident's son mentioned speaking with Staff G over the weekend, but he was kind of vague. The Administrator said she expected a full assessment to be done on each shift when a resident has a change of condition. The Administrator said she also expected them to document their findings completely and accurately and she considered anything less to be unacceptable.

2. The MDS assessment dated 1/3/18 for Resident #49 documented an admit date of 12/27/17. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15 without signs/symptoms of delirium. A score of 15 indicated intact cognition. The MDS revealed the resident required the limited physical assistance of 1 person for transfers, walking in room and corridor, dressing, and toilet use. The MDS documented diagnoses that included cancer, arthritis, other fracture, respiratory failure, uncomplicated opioid dependence, chronic pain syndrome, and chronic peripheral venous insufficiency. The MDS documented the resident fell and sustained an injury 2 or more times since admission to the facility.

The MDS assessment dated 2/5/18 for Resident #49 documented a discharge on 2/5/18 to the hospital with return anticipated. The MDS recorded the resident experienced 2 or more falls without injury since the previous MDS assessment.

The MDS assessment dated 2/19/18 for Resident #49 documented a readmission date of 2/12/18.

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F 684	Continued From page 34 The MDS identified a BIMS score of 15 without signs/symptoms of delirium. The MDS recorded the resident experienced 2 or more falls with injury since the previous assessment. The care plan focus area initiated 12/29/17 identified a high risk for falls related to poor safety awareness, did not comply with using call light for assist, did not use walker in room, musculoskeletal deformities related to remote history of fractures, and chronic pain and arthritic changes. The Progress Notes dated 2/4/18 at 3:22 a.m., documented by Staff C, recorded the resident on the floor, stated she tripped on oxygen tubing, and landed on her buttocks. The entry recorded the resident complained of pain to her buttocks and skin assessment showed thumbnail size red mark to butt cheek. Staff C wrote the resident's hips/ legs not sore to palpitation; Staff C and CNA (certified nurse aide) assisted the resident to her feet and into the wheelchair. The entry documented the resident then asked for a Hydro (narcotic pain pill) but it was too soon for another dose, the nurse offered Tramadol or Tylenol, the resident screamed, I want a f****** Hydro right now. Staff C wrote she again explained to the resident the pain pill ordered every 6 hrs and it was too soon for the nurse to provide that form of medication, and the resident told her to leave. Staff C wrote a few minutes later the resident had her call light on. The entry documented the resident had her head in chair with leg up and stated she could not put pressure on the leg and to give her a pain pill. Staff C wrote she again reminded the resident it was too early for hydro but that she could have Tramadol. Staff C documented the resident stated, then call the	F 684		

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F 684	Continued From page 35 f****** ambulance or I will. Staff C wrote she offered to again assess ROM (range of motion), the resident refused and said, I will stop if you go get me a pain pill. Staff C wrote she again explained that it was too early for the hydro that she had one 2 hours prior. Staff C documented the resident got agitated so she left the resident's room to get an ice pack and washcloth. Staff C recorded she knocked and entered the resident's room and the resident ambulated across the room with no signs and symptoms of pain, turned to face Staff C with a shocked look on her face, and Staff C asked the resident if leg was doing better after giving the resident the ice pack. Staff C documented the resident threw the ice pack onto the table and told Staff C to leave. Staff C documented she faxed the doctor and would inform the day shift to continue to monitor. The Physician Fax Order Request form dated 2/4/18 at 3:22 a.m., without a fax time stamp and documented by Staff C, recorded the following: Vital Signs, blood pressure 99/65, pulse 84, respirations 15, temperature 97.2. Nurse called to the resident's room and the resident stated she tripped over O2 (oxygen) cord and landed on butt. ROM (range of motion) WNL (within normal limits) small thumbnail size red mark to buttocks, no outward rotation of BLE (bilateral lower extremities) noted, no painful palpation to the hips, buttocks, arms, legs, noted. The resident asked the nurse for a Hydro, nurse explained too early for Hydro as the resident had 2 hours prior, resident could have Tramadol or Tylenol, the resident screamed profanities and told the nurse to call ambulance, they would give her one, the resident continued to be monitored, up walking without signs/symptoms of pain immediately in room, call light within reach. Under the orders	F 684		

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F 684	Continued From page 36 section of the fax, in a different handwriting and different ink, documented Send to ER, no signature. Under the signature of nurse receiving orders, Staff B signed and dated 2/13/18. The Progress Notes dated 2/5/18 at 3:10 p.m. documented at 9:30 a.m. staff called the nurse to the resident's room and the resident's left upper thigh swollen, hard, and discolored. The note recorded the resident sat on the floor next to her sink, chocolate milk spilled on her gown and down her legs. The entry documented Resident #49 stated she didn't know what happened; denied hitting her head; complained of no pain or discomfort; vitals taken and AROM to all extremities per normal. The entry documented staff assisted the resident up by 3 staff and assisted to her recliner. The note recorded the resident stated, I don't know what happened. The nurse notified the doctor and the resident sent to the Emergency Room (ER) at 10:30 a.m. The Physician Fax Order Request form dated 2/4/18 at 3:22 a.m., with a fax time stamp received 2/5/18 at 4:15 p.m., was a copy of the same information as the above fax dated 2/4/18 at 3:22 a.m. without a time stamp. However, this second fax did not contain Send to ER in the order section but rather the ARNP wrote noted - monitor per facility protocol. Under the signature of nurse receiving orders, Staff B signed and dated 2/6/18. The Physician Fax Order Request dated 2/5/18, with a sent fax time stamp of 11:11 a.m. and received time of 4:16 p.m., recorded x-rays of left hip and thigh. The ARNP wrote orders of: okay as above, update, due to extensive swelling, send pt (patient) to ED (Emergency Department).	F 684		

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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 684	Continued From page 37 Under the signature of nurse receiving orders, Staff B signed and dated 2/6/18. The Progress Notes dated 2/5/18 at 10:33 p.m., documented by Staff B, recorded a fax sent to the doctor regarding X-rays of left hip and thigh with a fax back stating due to extensive swelling send PT to ED. The Progress Notes dated 2/5/18 at 10:37 p.m., documented by Staff B, recorded a fax back from the doctor stating monitor per facility protocol. The Progress Notes dated 2/5/18 at 11:20 p.m., documented by Staff B, recorded received fax back from doctor states: noted NNO (no new orders); dated and signed. The Hospital Discharge Summary recorded an admit date of 2/5/18 and discharge of 2/12/18. The summary documented the resident Admission History of Present Illness and Hospital Course. The summary documented the patient with LLE (left lower extremity) pain following a fall 2 days prior and had pain with progressive swelling of the left thigh since then. The summary recorded the resident admitted for fall and LLE pain secondary to mechanical fall that occurred prior to arrival at the hospital after tripping on oxygen tubing at home. The summary documented the resident found to have a large hematoma on CT (cat scan), otherwise no acute injuries, and transfused with 2 units of packed red blood cells due to low hemoglobin levels (a protein in red blood cells that carries oxygen throughout the body). The summary included diagnoses of circumferential hematoma with extensive edema of LLE due to mechanical fall and acute blood loss anemia.	F 684		

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F 684	Continued From page 38 The Patient Discharge & Transfer form from the hospital dated 2/12/18 at 11:20 a.m. recorded Resident #49's Primary Discharge Diagnosis as anemia due to acute blood loss and Other Medical Diagnosis as left leg hematoma. The form documented report given to the facility 2/12/18 at 12:30 p.m. The clinical record reflected no Progress Notes entered for 2/12/18 when the resident returned from the hospital; no return assessment documented. In an interview on 3/6/18 at 10:45 a.m. Resident # 49 responded since living at the facility she had been to the hospital once due to the flu. Resident # 49 reported she could not recall the day of the week or the date, but one night she requested to go to the hospital for breathing problems and the over night nurse, 10 p.m. to 6 a.m. nurse, told her it would be too expensive to call an ambulance. Resident # 49 said when the day shift nurse arrived she thought the resident needed to go to the hospital and the day shift nurse called an ambulance. Resident # 49 reported she waited about 8 hours to be able to go to the hospital. Resident # 49 stated it bothered her, made her feel bad, and felt like the staff did not give a shit about her. Resident # 49 stated she was not a person to just run to the hospital; she felt she needed to go. Resident # 49 did not think the hospital found any broken bones and commented the hospital took X-rays but she thought they came back fine. Resident # 49 said she just had a good bruise on her left groin area that had puffed up. Interview on 3/7/18 at 6:15 a.m. Staff C stated	F 684		

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F 684	Continued From page 39 she worked 6 p.m. to 6 a.m. shifts at the facility, 3 to 5 days a week, and worked for the facility for 16 months. Staff C acknowledged familiar with Resident #49's care. Staff C stated usually Resident #49 very with it but had one behavior of putting self on the floor. Staff C reported Resident #49 had blown up a couple times. Staff C said Resident #49's behaviors really bad. Staff C responded 1 time Resident #49 had pain pill then said she wanted her to call an ambulance. Staff C reported she did not call an ambulance as there was not any reason to call. Staff C acknowledged Resident #49 had the right to go to the hospital but said when the resident calmed down, not need to go. Staff C stated whatever Resident #49 wanted at a given moment the resident would do anything and everything to get it. Staff C confirmed she wrote the 2/4/18 fax. Staff C responded she did not call the physician on 2/4/18 and confirmed she had never called the physician before 2/4/18. Staff C commented she talked to doctor thru fax only and the physician said they were well aware of the resident's behaviors. Staff C responded she didn't know the resident's pain acute, but back at that time, the resident put herself on floor and said she had pain but when Staff C saw the resident she did not limp. Staff C stated she was not aware the resident went to the hospital and not aware the resident had cellulitis at the time (2/4/18). Staff C reported the resident also fell the day she went to the hospital (2/5/18). Staff C stated she really liked the resident but she couldn't do more than allowed to do; only do what doctor ordered. Staff C confirmed she did tell Resident #49 she could not go to the hospital. Staff C said the fax 2/4/18 documenting send to ER she did not know who signed it. Staff C stated she would have told dayshift about the fax she wrote. Staff C stated	F 684		

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F 684	Continued From page 40 the last time she saw Resident #49 on 2/4/18 was around 5 a.m. and Resident #49 said she didn't need anything but Staff C said she still faxed out what happened that night. Interview on 3/7/18 at 7:00 a.m. Staff B stated she started working for the facility again in January 2018, fulltime 10 p.m. to 6 a.m. shift. Staff B acknowledged familiar with Resident #49. Staff B reported she did not remember seeing a fax 2/4/18 to send the resident to the ER. Staff B stated when the faxes came back she wrote a progress note and she would need to check to see if she wrote a progress note about the fax. Staff B confirmed she had signed and noted the 2/4/18 fax that documented send to ER on 2/13/18, but commented she did not recognize the fax and definitely did not recall the order to send to ER. Staff B reported she sometimes found stacks of faxes no one had done and spent hours at night processing. Staff B stated faxes a problem but all faxes caught up at the time of the interview. Staff B reported she had found some faxes from January that had not been done but nothing major ordered on those faxes. In an interview on 3/8/18 at 8:50 a.m., the Director of Nursing (DON) stated she needed to find out what hospital the resident had gone to in order to retrieve the hospital records from Resident #49's most recent hospital stay. The DON acknowledged she would expect staff to obtain hospital records upon a resident's return to the facility for continuity of care and said usually the nurses did get the records but she couldn't find any. The hospital records fax cover sheet documented a sent date and time of 3/8/18 at 10:04 a.m.	F 684		

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F 684	Continued From page 41 On 3/19/18, the facility abated the IJ when they provided an inservice to licensed and unlicensed nursing on providing complete assessments by using the S-bar (tool to communicate with physician) and Stop and Watch (tool for CNA's) These findings lowered the IJ from a "J" severity level to an "D" with ongoing monitoring to ensure facility staff is following adequate assessments.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remain as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to safely transport a resident in a wheelchair for one of 36 residents reviewed (Resident #23). The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 12/28/17 for Resident #23 identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. The MDS recorded the resident required the assistance of one person for locomotion on the unit and she used a wheelchair for mobility. The MDS documented diagnoses that included psychotic	F 689	F 689 The facility will safely transport residents in a wheelchair. 1. Resident 23 has had leg rests installed on her wheelchair. 2. Any resident in a wheelchair will be safely transported. 3. Staff were in-serviced on this policy on 3/22/2018. 4. Social Services designee will complete routine audits on dignity. Results of the audit will be discussed at QAPI for 6 months. 5. Completion date 3/22/2018	

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F 689	Continued From page 42 disorder and generalized muscle weakness. The care plan focus area revised 9/15/17 informed staff the resident often refused to wear socks and shoes and wanted to be barefoot. The intervention dated 1/2/18 informed staff Resident #23 used a wheelchair for mobility and staff generally had to propel the resident to get to meals and activities; the resident could propel herself using her feet but did not watch for other residents or obstacles; and the resident needed supervision in the common areas. Observation on 3/5/18 at 11:22 a.m. revealed Staff A, Certified Nurse Aide (CNA) pulled Resident # 23 backwards out of her room in a wheelchair with the resident's feet dragging the floor. Staff A then pushed the resident from her room to the dining room with her feet continuing to drag on the floor. Staff A stated the resident would not put her feet up and there was nothing they could do about it. Observation on 3/8/18 at 9:06 a.m. revealed the distance from room 206-A to Resident # 23's table measured approximately 309 feet. During interview on 3/8/18 at 9:12 a.m. the Administrator stated she expected staff to put residents' feet on foot pedals during transfers. The Administrator stated she corrected staff if she saw them pulling residents backwards.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		

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F 697	Continued From page 43	F 697		

consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation and resident and staff interviews, the facility failed to put interventions in place for pain management for one of 36 residents reviewed (Resident #112). The facility reported a census of 61 residents.

Findings include

The Minimum Data Set (MDS) assessment dated 3/7/18 documented Resident #112 had diagnoses that included high blood pressure, urinary tract infection (UTI) in the past 30 days, shingles, an umbilical hernia and back (spinal) pain. The MDS documented the resident scored 10 out of 15 on the Brief Interview for Mental Status test, indicating mild cognitive impairment. The MDS documented Resident #112 required the assistance of two with bed mobility, transfers, walking and toilet use and the assistance of one with dressing and personal hygiene. The assessment documented the resident had pain almost constantly; the pain disturbed the resident's sleep and limited her day to day activities.

The resident's care plan updated on 10/31/17 contained no focus area or interventions to assist the resident in pain management.

The Medical Progress Note dated 10/8/17 documented Resident #112 admitted to the hospital for chest wall pain and discharged on 10/12/17. The physician documented the resident admitted to the hospital with mental status

F 697

The facility will put interventions in place for pain management for residents.

1. Resident #112 no longer resides at the facility.
2. All residents with pain will have interventions put in place for pain management.
3. Staff were in-serviced on this policy on 3/22/2018.
4. Director of Nursing and/or designee will complete routine audits on pain management. Resi of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/22/2018

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F 697	Continued From page 44	F 697		

changes likely due to a UTI and she also had shingles develop which resulted in severe chest pain at times. The resident developed pneumonia, which resolved, and she discharged from the hospital to the facility. Upon discharge, the physician instructed staff to administer Neurontin (or Gabapentin, often used for nerve pain) 400 milligrams 3 times a day.

Observation on 3/5/18 beginning 11:45 a.m. revealed the resident's call light on and the resident screamed out. Staff ____, CNA (certified nursing assistant) entered the room to answer the resident's call light and Resident #112 stated she had a lot of pain. Staff ____ notified the Assistant Director of Nursing (ADON), who looked through resident's medication list and could not find an order for any pain medication. At 11:47 a.m. the Dietary Manager attempted to give the resident a room tray and the resident refused the lunch tray. The Dietary Manager stated when she tried to deliver the resident's lunch tray, the resident told her she had too much pain to eat and the pain shot down her legs.
At 12:45 p.m. the resident had her call light while crying and she asked for something for pain. At 1:55 p.m. the ADON and DON stated they sent a facsimile to the doctor but have not received an order from the physician. In reading the resident's chart, she did not know why the medication had not been given.

The resident's Order Review Report 2/1/18 through 3/31/18 lacked an order for any medications or interventions for pain.

On 3/5/18 at 2:00 p.m. the resident had the call light on. Resident #112 cried, grimaced and moaned. The resident stated she had so much

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F 697	Continued From page 45 pain and asked why it was taking so long to give her something for the pain. Resident #112 stated tearfully she could not stand the pain and had pain everywhere. Review of the resident's Order Review Report 3/1/18 through 3/31/18 documented an order dated 3/5/18 for Gabapentin. Staff received the order at 6:00 p.m. The Discharge Summary dated 2/26/18 documented Resident #112 went to the hospital from 2/21/18 to 2/26/18 with a urinary tract infection, mental status changes and dehydration. The discharge orders did not include any medication for pain. The Social Service Note dated 3/6/18 documented the resident stated the pain pills worked, she felt much better and slept so good.	F 697		
F 757 SS=J	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757	The facility will administer the correct dose of narcotic pain medication. 1. Resident #113 no longer resides at the facility. 2. Any resident with narcotic pain medication will receive the correct dose. 3. Staff were in-serviced on this policy 3/13/2018. 4. Director of Nursing and/or designee will complete routine audits on narcotic medication administration. Results of the audit will be discussed at QAPI for 6 months. 5. Completion date 3/13/2018	

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F 757	Continued From page 46 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician and staff interviews, the facility failed to administer the correct dose of a narcotic pain medication which resulted in overdose and subsequent hospitalization for one of 36 residents reviewed (Resident #113). The facility reported a census of 61 current residents. Findings include: The Admission Record documented that Resident #113 admitted to QHC Winterset North from an acute care hospital on 3/8/18 with dementia, major depressive disorder and syncope (fainting) with collapse listed as her diagnoses. The Interim Plan of Care dated 3/8/18 noted that Resident #113 depended on staff for personal hygiene and ADLs (activities of daily living), would be staying at the facility for long term care and noted that the resident's current medications would be found with the admission orders. The WCCN Medicine Passing Policy dated 8/31/15 noted their purpose as ensuring uniformity in the medication pass process and to therefore minimize medication errors that could harm residents. The policy also noted that all residents are entitled to receive safe and appropriate nursing care and are entitled to	F 757		

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F 757	Continued From page 47 receive care from a competent and knowledgeable nurse. The document instructed staff to keep the "5 rights" in mind when passing medication; the right resident, the right drug, the right dose, the right route and the right time. A prescription printed on 3/6/18 from University of Iowa Health Care noted that Resident #113 should receive 2.5 ml (milliliter) of a 2 mg/ml (milligram per milliliter) solution of morphine concentrate (narcotic pain medication (5 mg total)) by mouth three times a day. The March 2018 MAR (Medication Administration Record) documented that Staff F, LPN administered 2.5 ml (5 mg) of morphine to Resident #113 at 8:00 a.m. and 2:00 p.m. on 3/9/18. The MAR also revealed that Staff H, LPN administered 2.5 ml (5 mg) of morphine to Resident #113 at 9:00 p.m. on 3/9/18 and Staff G, LPN administered 2.5 ml (5 mg) of morphine to Resident #113 at 8:00 a.m. and 2:00 p.m. on 3/10/18. The Controlled Drug Administration Record revealed that Staff I, LPN received the delivery with Resident#113's morphine on 3/8/18 and started the Administration Record. Staff I documented that 2.5 ml/5 mg should be given to Resident #113 TID (three times a day). The record also noted that Staff F administered 2.5 ml (5 mg) of morphine to Resident #113 at 8:00 a.m. and 2:00 p.m. on 3/9/18. The document also revealed that Staff H administered 2.5 ml (5 mg) of morphine to Resident #113 at 9:30 p.m. on 3/9/18 and Staff G administered 2.5 ml (5 mg) of morphine to Resident #113 at 8:00 a.m. and 2:00 p.m. on 3/10/18.	F 757		

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F 757	Continued From page 48 A Medication Error Note dated 3/10/18 at 10:27 p.m. documented that Resident #113 received an incorrect dose of morphine. According to the DON (Director of Nursing), Resident #113 should receive 2.5 ml of a 2 mg/ml solution of morphine concentrate by mouth TID. The DON noted that the pharmacy sent a twenty mg/ml solution of morphine concentrate instead and the incorrect dose had been administered five times according to their documentation. A Nursing Note dated 3/10/18 at 11:37 p.m. noted that Resident #113 displayed lethargy (extreme sleepiness) and had jerking movements of both her upper and lower extremities. According to the DON, she checked the resident's medications and found an error. The DON documented that Resident #113 received more morphine than she had been prescribed because of an incorrect pharmacy label on the bottle of morphine. The DON called 911 after she obtained orders to have the resident sent to ER by ambulance. The History and Physical (H&P) Consultation dated 3/11/18 noted that information had to be obtained from Resident #113's daughter due to the resident's encephalopathy (brain disease, damage or malfunction). According to Resident #113's daughter, her mother had been prescribed morphine as a patient in a hospital in Iowa City. The daughter said her mother had been discharged from the hospital and admitted to the nursing home 3 days before, at which time she noticed her mother had become more lethargic with episodes of twitching. According to the document, Resident #113 had been receiving 50 mg of morphine TID instead of 5 mg TID due to a dosing error. According to the H&P, Resident #113 had respiratory depression and had been	F 757		

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	165497	A. BUILDING _____ B. WING _____	03/21/2018

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given Narcan (to counteract the effect of morphine); which improved her respiratory rate prior to arriving at the ER. The tox (test for toxicity) screen showed positive for morphine. The doctor wrote that Resident #113 was obtunded (a diminished level of consciousness), did not respond to a sternal rub (aggressively rubbing breast bone) with occasional episodes of eye opening and multiple episodes of generalized twitching. After calling poison control, the doctor noted Resident #113 would be admitted to ICU on a Narcan drip.

A Nursing Note dated 3/12/18 at 11:15 a.m. noted that they called the hospital for an update of Resident #113's health status. The nurse documented that the ICU (intensive care unit) nurse told her the resident was stable on a Narcan drip.

A picture provided by the facility of the box that contained the bottle of morphine revealed the pharmacy label dated 3/8/18. According to the label, Resident #113 should receive 2.5 ml (5 mg) of a 100 mg/5 ml solution of concentrated morphine by mouth three times a day.

A picture provided by the facility of the bottle of morphine revealed the pharmacy label. According to the label, Resident #113 should receive 2.5 ml (5 mg) of a 100 mg/5 ml solution of concentrated morphine by mouth three times a day.

An interview on 3/13/18 at 9:10 a.m. with Staff F revealed she administered the wrong dose of morphine to Resident #113. When asked, Staff F said precautions like having an RN double check narcotics with the nurse that accepts delivery might help prevent

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errors. Staff F said checking the pharmacy label with the manufacturer's label would also be a precautionary measure that could also help eliminate errors. Staff F said anyone administering medication should check the 5 Rs; the right name, the right medication, the right dose, the right route and the right time before giving it.

An interview on 3/13/18 at 10:40 a.m. with the ADON (Assistant Director of Nursing) revealed that the overdose could have been prevented if they double checked the order. The ADON said she expected the administering nurse to follow the 5 Rs; route, name, time, dose and medication.

An interview on 3/13/18 at 3:40 p.m. with Staff I revealed she received the morphine delivery and filled out the narcotic sheet. Staff I said nobody cosigned for the delivery or the narcotic sheet. Staff I said she did not administer the morphine to Resident #113 because the resident was sleeping comfortably after receiving large doses of Trazodone (hypnotic medication) and Tylenol. Staff I said 2 people should have checked Resident #113's admission orders and 2 people should have checked the delivery from the pharmacy. Staff I said the facility does not practice those kind of precautions. Staff I said that although she did not administer the morphine, she should have started the narcotic sheet out correctly to try and prevent anyone after her from making a medication error.

An interview on 3/13/18 at 4:15 p.m. with Staff G revealed that she administered incorrect doses of morphine to Resident #113. Staff G said the pharmacy sent the wrong concentration of

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F 757	Continued From page 51	F 757		

morphine solution and they labeled the box incorrectly. Staff G said she did not check the label closely enough to realize it was incorrect. Staff G said she did not suspect that anything was wrong, nor did she question it because she figured it had been checked when it came into the facility. The LPN said she did not know that the label said 100 mg/5 ml. The LPN said she read the label and compared it with the MAR. When asked what would have prevented the medication error, Staff G said she should have checked the concentration of the bottle's contents.

An interview on 3/14/18 at 10:20 a.m. with the resident's doctor revealed that the doctor that prescribed morphine for Resident #113 was her resident (under her supervision). According to the physician, the facility did not let her know they administered doses that exceeded the prescribed amount. A Social Worker interjected that they found out about the overdose when Resident #113's daughter contacted them asking for her mother's discharge summary. The doctor stated they faxed the orders to the facility well in advance of Resident #113 being discharged from the hospital. The doctor said she would have welcomed any questions the facility might have had about the dose and/or concentration and she would have liked the facility to notify her about the incident. Resident #113 had been doing great on the same dose as a patient under her care and believed Resident #11 would have continued doing well. The resident's hospitalization could probably have been avoided if they followed the order. The doctor said she considered the doses Resident #113 received as quite large and elderly residents' organ function become diminished. The doctor said "quite frankly, I'm shocked that she survived it." The physician said nurses where

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F 757	Continued From page 52 she works have to double check narcotics to avoid those types of errors and "that's why they take those precautions." An interview on 3/14//18 at 1:10 p.m. with Staff H revealed she administered the wrong dose of morphine to Resident #113. Staff H said she checked the order many times because what she read on the bottle compared with what she read on the order did not make sense. Before giving the morphine, Staff H said she questioned if they had been giving Resident #113 an incorrect dose. The RN said she should have consulted another nurse or called the pharmacy for clarification before giving it. Staff H said she hesitated so many times that she probably administered it a little bit late. When asked why she gave it despite not understanding the order, Staff H said she felt pressured to make a decision because the facility always pressures them to get their work done and get out of there. On 3/13/18, the facility abated the IJ when they provided a medication administration audit and provided education on controlled substances. These findings lowered the IJ from a "J" severity level to an "D" with ongoing monitoring to ensure facility staff is follow correct administration for controlled substance.	F 757		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		

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F 791	Continued From page 53 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, resident interview, and staff interview, the facility	F 791	F 791 The facility will arrange dental services in a timely manner for residents without teeth or dentures. 1. Resident 49 has seen Senior Dental services and has been fitted for dentures. 2. Any resident without teeth or dentures will have a referral initiated for their dental needs. 3. Staff were in-serviced on this policy on 3/26/2018. 4. Social Services designee will complete routine audits on dignity. Results of the audit will be discussed at QAPI for 6 months. 5. Completion date 3/26/2018	

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F 791	Continued From page 54 failed to arrange dental services in a timely manner for a resident without teeth or dentures for one of 35 sampled residents (Resident #49). The facility reported a census of 61 residents. Findings include: The MDS assessment dated 2/19/18 for Resident #49 identified a BIMS score of 15 without signs or symptoms of delirium. The MDS documented diagnoses that included cancer, malnutrition and vitamin D deficiency. The MDS recorded the resident had no oral/dental issues and the box for no natural teeth/edentulous had been left blank. The care plan focus area revised on 3/6/18 identified altered nutrition related to a diagnosis of depression. One intervention directed staff to serve a regular diet with ground meat. The care plan did not address the resident's oral status. The Progress Note dated 12/27/17 at 3:32 p.m. recorded the resident entered the facility. She had both upper and lower dentures but did not have the dentures in and the resident received a regular diet. The Progress Notes dated 1/2/18 at 4:04 p.m. documented a nutrition/dietary note. The Registered Dietician (RD) documented the resident reported she had trouble chewing some foods as she did not have her dentures. The RD wrote its unclear whether the dentures were available and she recommended investigating. The Progress Note dated 2/26/18 at 2:57 p.m. documented a nutrition/dietary note. The note recorded by the RD documented the resident re-admitted to the facility 2/12/18 after a fall. The RD documented the resident reported she chose a softer diet as she still did not have her dentures,	F 791		

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F 791	Continued From page 55 the resident reported the dentures didn't fit properly and the resident would like to see a dentist. On 3/6/18 at 10:40 a.m. observation revealed Resident # 49 as edentulous (without teeth). Resident # 49 stated the facility gave her a ground meat diet, but recently staff had just been cutting up the meat. Resident # 49 reported she wrote the facility a note to ask for all meat to be ground up and she hoped they did. Resident # 49 reported she would really rather have her dentures but she left them at home. Resident # 49 said she had lost weight at home and the dentures did not fit well. Resident # 49 said if a dentist were to come to the facility, she would want to have another pair of dentures made. Resident # 49 reported she had told the quite a few staff nurses about wanting dentures. The resident's Progress Notes lacked documentation of any follow up with a dental appointment. In an interview on 3/8/18 at 8:30 a.m., the Director of Nursing, (DON) stated the resident had been on the list to see the dentist on 1/23/18. The DON confirmed no visit notes were documented in the clinical record. The DON planned to contact the dentist to see if they examined the resident on 1/23/18 and if not, why not. The DON commented she thought the resident may not have qualified for another pair of dentures at that time. At 10:27 a.m. the DON stated Resident # 49 did see the dentist on 1/23/18 but the dentist had all the information for the resident payee and would be seeing her. The DON stated she informed the dentist office the facility could not get a hold of the resident's son.	F 791		

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F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on facility policy review and staff interview, the facility failed to implement an Antibiotic Stewardship Program. The facility reported a census of 61 residents. Findings include: Review of the facility's undated and untitled policy and procedure for Infection Control revealed no policies and procedures pertaining to an Antibiotic Stewardship Program that included antibiotic use protocols or a system to monitor antibiotic use. In an interview on 3/8/18 at 1:57 p.m. the Director of Nursing (DON) stated the facility did not have anything formally set up for the antibiotic stewardship program. The DON stated the facility did get a microbiology report from the pharmacy that the facility reviewed in the QA (Quality Assurance) meeting.	F 881	F 881 The facility will establish an Antibiotic Stewardship Program. 1. The facility has established an Antibiotic Stewardship Program. 2. All residents on antibiotics will be monitored with the antibiotic stewardship program. 3. Staff were in-serviced on this policy on 3/21/2018. 4. Administrator and/or designee will complete routine audits on antiobiotic stewardship. Resul of the audit will be discussed at QAPI for 6 months. 5. Completion date 3/21/2018	

F 000

This plan of correction constitutes our credible Allegation of Compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws.

F 550

The facility will transport and interact with residents in a dignified manner.

1. Resident #4 has been transported and interacted with residents in a dignified manner.
2. All residents will have interactions with staff that provide for dignity to be maintained.
3. Staff were in-serviced on this policy on 3/22/18
4. Social Service Designee will complete routine audits on dignity. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/22/2018

F 561

The facility will honor residents' requests for bathing.

1. Resident #112 no longer resides at the facility.
2. All residents' requests for bathing will be honored.
3. Shower aide was in-serviced on this policy on 3/22/2018.
4. Social Services Designee will complete routine audits on self-determination. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/22/2018

F 582

The facility will provide the required notices when skilled nursing services are no longer covered

1. Notices for Residents 25, 40, and 62 cannot be provided as the dates are in the past.
2. All residents who have orders for skilled nursing services will be provided the required notice when skilled nursing services are no longer covered.
3. Staff were in-serviced on this policy on 3/26/2018
4. Director of Nursing and/or designee will complete routine audits on required notice. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/26/2018

F 610

The facility will investigate an allegation of abuse and separate a staff member from a resident after receiving an allegation of abuse to ensure the resident's protection. The facility will investigate an allegation of abuse and separate a staff member from a resident after receiving an allegation of abuse to ensure the resident's protection.

1. Resident #28 has been assessed under the abuse policy.
2. All residents fall under our abuse reporting policy.
3. Staff were in-serviced on this policy at different times from 3/8/2018 through 3/9/2018.
4. Administrator and/or designee will complete routine audits. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/9/2018

F 656

The facility will develop and update a comprehensive care plan to monitor side effects for psychotropic medications for residents 61, 37, and 3.

1. Residents 61, 37, and 3 will all have updated comprehensive care plans to monitor side effects for psychotropic medications.
2. All residents on psychotropic medications will have a comprehensive care plan to monitor side effects.
3. Staff were in-serviced on this policy on 3/26/2018
4. Director of Nursing and/or designee will complete routine audit/s on care plans. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 4/19/2018

The facility will develop and update a comprehensive care plan for resident 49's dental needs.

1. Resident 49 has had dentures ordered.
2. All residents with dental needs will have their needs addressed promptly.
3. Staff were in-serviced on this policy on 3/26/2018.
4. Administrator and/or designee will complete routine audits on dental needs. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date: 4/17/2018

F 684

The facility will properly assess and intervene after significant condition changes for residents.

1. Residents 6 no longer resides at this facility. Resident 49 has been assessed after significant condition changes.

2. All residents fall under our significant condition change policy.
3. Staff were in-serviced on this policy on 3/22/2018.
4. Administrator and/or designee will complete routine audits on change of condition. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/22/2018

F 689

The facility will safely transport residents in a wheelchair.

1. Resident 23 has had leg rests installed on her wheelchair.
2. Any resident in a wheelchair will be safely transported.
3. Staff were in-serviced on this policy on 3/22/2018.
4. Social Services designee will complete routine audits on dignity. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/22/2018

F 697

The facility will put interventions in place for pain management for residents.

1. Resident #112 no longer resides at the facility.
2. All residents with pain will have interventions put in place for pain management.
3. Staff were in-serviced on this policy on 3/22/2018.
4. Director of Nursing and/or designee will complete routine audits on pain management. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/22/2018

F 757

The facility will administer the correct dose of narcotic pain medication.

1. Resident #113 no longer resides at the facility.
2. Any resident with narcotic pain medication will receive the correct dose.
3. Staff were in-serviced on this policy 3/13/2018.
4. Director of Nursing and/or designee will complete routine audits on narcotic medication administration. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/13/2018

F 791

The facility will arrange dental services in a timely manner for residents without teeth or dentures.

1. Resident 49 has seen Senior Dental services and has been fitted for dentures.
2. Any resident without teeth or dentures will have a referral initiated for their dental needs.
3. Staff were in-serviced on this policy on 3/26/2018.
4. Social Services designee will complete routine audits on dignity. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/26/2018

F 881

The facility will establish an Antibiotic Stewardship Program.

1. The facility has established an Antibiotic Stewardship Program.
2. All residents on antibiotics will be monitored with the antibiotic stewardship program.
3. Staff were in-serviced on this policy on 3/21/2018.
4. Administrator and/or designee will complete routine audits on antiobiotic stewardship. Results of the audit will be discussed at QAPI for 6 months.
5. Completion date 3/21/2018