STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	C 03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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F 000	INITIAL COMMENTS Correction date 4/22/18 Complaints # 72544-C and # 73674-C were substantiated. Complaint # 72772-C was substantiated, unrelated to the original allegation. Investigation of facility-reported incident # 70601-I resulted in deficiency. Investigation of facility-reported incident # 71501-I did not result in deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
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	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/12/2018

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

POC accepted 4/25/18 KS

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F 550	Continued From page 1 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 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, staff interview and facility policy review, the facility failed to always treat residents with dignity and respect when providing activities of daily living for 1 of 6 current residents reviewed (Resident #1). The facility identified a census of 91 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 2/16/18, Resident #1 had diagnoses that included coronary artery disease, seizure disorder, encephalitis, osteoporosis and dementia. The MDS identified the resident had a BIMs (brief interview for mental status) score of 4 which indicated severe cognitive impairment.	F 550		

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F 550	Continued From page 2 According to the MDS the resident had behavioral symptoms which included physical behavioral symptoms directed toward others during 4 to 6 days of the 7-day assessment period. The MDS identified the resident the assistance of two for transfers and toilet use and the assistance of one with bed mobility, dressing and personal hygiene. The care plan dated 5/29/17 documented Resident #1 had the potential to demonstrate physical behaviors related to dementia. The care plan directed staff to intervene before agitation escalates, guide the resident away from the source of distress, engage calmly in conversation, if the resident's response is aggressive, staff should walk calmly away and approach later. Review of the Employee Payroll Form dated 8/6/17 revealed Staff C, CNA (certified nursing assistant) terminated employment due to violation of company policy that included verbal abuse. Review of the Facility Investigation dated 8/6/17 at approximately 1:50 PM, Staff C and Staff D transferred the resident to the toilet. When they transferred the resident, she attempted to bite Staff C on the upper arm. Staff D heard Staff C state 'don't you dare bite me or I will knock your teeth down your damn throat.' During an interview with Staff D, CNA (certified nursing assistant) on 3/15/18 at 9:45 AM she stated she assisted Staff C to transfer Resident #1 from the bed to the bathroom. The resident had dementia and became combative. The resident used the toilet and staff assisted her to stand with a gait belt. The resident went to bite Staff C and Staff C stated to the resident 'if you	F 550		

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F 550	Continued From page 3 bite me, I'll knock you teeth out'. They transferred of the resident to the wheelchair and Staff D reported the incident right away. During an interview with Staff C, CNA on 3/15/17 at 3:40 PM she stated she assisted the resident with Staff D. She stated Resident #1 tried to bite her and she told the resident she'd like to knock her teeth out. Staff C did not even know why she said; it slipped out of her mouth. Review of the form Titled Approach to Behavioral Problems dated 8/10/17 through 8/23/17 revealed the facility educated staff on caring for residents with behaviors. Review of the undated Policy and Procedure titled Resident's Rights-Iowa revealed direction that: a. Each resident has the right to a dignified existence, self-determination and communication with and access to persons and services inside and outside he facility.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interviews, the facility failed to assure staff bathed all residents according to their preference and maintained residents' personal grooming for 4 of 6 current residents sampled (Residents # 1, # 2, # 3 and # 5). The facility identified a census of 91.	F 677		

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F 677	Continued From page 4 Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/8/17 documented diagnoses that included Asperger's syndrome, seizure disorder and aphasia for Resident #3. The same MDS documented the resident required the assistance of two with toilet use and personal hygiene, the assistance of one with bathing and as incontinent of bladder and frequently incontinent of bowel. The resident's undated care plan problem identified an alteration in activities of daily living (ADL) function related to history of cerebrovascular accident (stroke). The care plan directed one staff to assist the resident with bathing and personal hygiene and staff should anticipate the resident's needs. The resident's Kardex contained in his electronic health record provided direction to certified nursing assistant (CNA) staff to bathe the resident every Sunday and Thursday. The same Kardex directed staff to provide nail care with bathing and PRN (as needed). Review of the resident's bathing record 1/16/18 through 3/15/18 revealed the following: 1/28-resident bathed; 2/1-NA; 2/4-resident bathed (7 days since last bath); 2/8-NA; 2/11-NA; 2/15-no bath; 2/21-resident bathed (17 days since last bath). Observation on 3/15/18 at 9:47 AM revealed Staff	F 677		

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F 677	Continued From page 5 B and F, CNAs (certified nursing assistants) transferred the resident from bed to shower chair. The resident had long fingernails that extended above the tips of his fingers on both hands and all nails had debris under them. Observation of the resident on 3/15/18 at 5:30 PM revealed the resident seated in the dining room. The nails on both hands remained uncut with debris under them as previously observed. Observation on 3/16/18 at 8:20 AM and 11:00 AM revealed the resident's fingernails remained uncut with debris under the nails. Observation at 2:00 PM revealed the resident's fingernails now trimmed and clean. 2. The MDS assessment dated 1/9/18 documented diagnoses that included Non-Alzheimer's dementia and other fracture for Resident #5. The assessment documented Resident #5 required the assistance of one with transfers, personal hygiene and bathing. An care plan dated 1/18/18 for Resident #5 documented the additional diagnosis of non-displaced fractures of the 1st and 2nd cervical vertebra (fractured neck). The care plan identified a self-care deficiency and directed the resident required one assist for bathing. The resident's electronic Kardex directed staff to bathe the resident on Wednesday and Fridays. Review of the resident bathing record from 1/2/18 (day of admission) through 3/16/18 revealed the following: 1/10/18-resident showered; 1/13/18-NA; 1/17-resident showered (6 days since last bath);	F 677		

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F 677	Continued From page 6 1/24-resident bathed; 1/26-resident refused; 1/31-resident bathed (6 days since last bath); 2/2-RN (bath not completed); 2/7-resident bathed (6 days since last bath); 2/16-resident refused bathing; 2/21-resident bathed (13 days since last bath); 2/28-resident refused bathing; 3/2-resident bathed (8 days since last bath); 3/3 through 3/16/18-no baths documented (13 days). During interview on 3/20/18 at 2:10 PM Staff A, CNA/CMA (certified medication aide) stated she is supposed to be the full time bath aide on Resident #5's hall, but is usually assigned as a float CMA. Staff A stated Resident #5 may refuse baths, but it often because of the way she approached by staff. She stated the resident worries about her cervical collar being off but she likes the whirlpool bath. 3. According to the MDS assessment dated 1/5/18, Resident #2 had diagnoses that included hip fracture, aphasia, dementia, depression osteoarthritis and cerebral infarct. The MDS identified the resident had a BIMs score of 3 which indicated severe cognitive impairment. According to the MDS, the resident required the assistance of one with bed mobility, transfers, personal hygiene, toilet use and bathing. The resident's care plan dated 2/13/17 documented a focus of ADL self care deficiency related to dementia. The care plan directed staff to bathe the resident 2 times a week and as needed and monitor skin condition with bath. Review of the Bath Look Back Report dated 1/1/18 through 3/16/18 revealed staff provided	F 677		

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F 677	Continued From page 7 only one bath for the following weeks: a. 1/28/18 through 2/3/18; b. 2/4/18 through 2/10/18; c. 2/11/18 through 2/17/18; d. 2/25/18 through 3/3/18; e. 3/4/18 through 3/10/18. 4. According to the MDS dated 2/2/18 Resident #6 had diagnoses that included heart failure, dementia, anxiety disorder and depression. The MDS identified the resident had a cognitive score of 4 which indicated severe cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing, eating and hygiene and required total dependence with bathing. The care plan (not dated) directed staff to provide bathing/hygiene with 2 assist for bathing. Check skin with bath. The care plan also directed to provide 2 assist with daily grooming and hygiene. Review of the Bath Look Back Report dated 1/1/18 through 3/16/18 revealed the facility provided only one bath for the following weeks: a. 12/31/17 through 1/6/18; b. 1/7/18 through 1/13/18; c. 1/14/18 through 1/20/18; d. 1/21/18 through 1/27/18; e. 2/4/18 through 3/3/18; f. 2/11/18 through 2/10/18 (no bath documented); g. 2/25/18 through 3/3/18 (no bath documented); h. 3/4/18 through 3/10/18. Observation on 9/14/18 at 4:30 PM revealed Resident #6 sat in the wheelchair in the TV lounge area. The resident had fingernails that appeared to be jagged (not smooth).	F 677		

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F 677	Continued From page 8 During an interview with the Director of Nursing on 3/21/18 at 8:40 AM she stated she is aware of bathing not completed per care plan for some of the residents. She identified staff document by using abbreviations of RN or NA at times. RN identified the resident not available. NA identified the resident not available for bathing due to the bath may have already been completed by another person (i.e. hospice or another shift).	F 677		
F 684 SS=E	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 reviews, staff interview and facility policy review, the facility failed to assure necessary treatment to maintain resident bowel function for three of six current residents reviewed (Residents #2, #3 and #4). The facility identified a census of 91. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/8/17 documented diagnoses that included Asperger's syndrome, seizure disorder and aphasia for Resident #3. The same MDS documented the resident required the assistance of two with toilet use and personal hygiene, the	F 684		

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F 684	Continued From page 9 assistance of one with bathing and as incontinent of bladder and frequently incontinent of bowel. An resident's undated care plan focus identified an alteration in activities of daily living (ADL) function related to history of cerebrovascular accident (stroke). The care plan instructed staff to provide perineal care and clothing management and they should anticipate the resident's needs. The Order Summary Report for Resident #3 dated 3/21/18 contained the following as needed (PRN) orders for resident bowel management: a. Milk of Magnesia (MOM) 30 milliliters (ml) by 1 time a day PRN beginning 6/16/17; b. bisacodyl suppository 1 time a day PRN beginning 6/16/17; c. glycolax powder 17 grams (gm) in 4-8 ounces of liquid 1 time a day PRN beginning 6/29/17; d. fleets enema rectally 1 times a day PRN for constipation beginning 6/16/17. Review of the residents bowel movement (BM) reports and Medication Administration Records (MAR's) from 12/1/17 through 3/20/18 revealed the following: a. On 12/25/17, he had 2 BMs (bowel movements). The resident had no BM 12/26 through 12/29 (4 days). Review of the December, 2017 MAR (Medication Administration Record) revealed no MOM, bisacodyl suppository, fleets enema or glycolax powder administered to promote BMs. Review of the resident's clinical record for 12/26 - 12/29/17 revealed no bowel assessment documented as directed by facility policy.	F 684		

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F 684	Continued From page 10 b. On 1/15/18, the resident had a BM and did not have another BM until 1/19/18 (4 days). Review of the January, 2018 MAR revealed no MOM, bisacodyl suppository, fleets enema or glycolax powder administered to promote BM's. Review of the resident's clinical record for 1/15-1/19/18 revealed no bowel assessment documented as directed by facility policy. c. On 3/6/18, the resident had a BM and had no other BMs until 3/11/18. The March, 2018 MAR documented staff administered a biscodyl suppository rectally at 6:10 AM on 3/10/18 (day 4) which was not effective. 2. According to the MDS assessment dated 1/5/18, Resident #2 had diagnoses that included hip fracture, aphasia, dementia, depression osteoarthritis and cerebral infarct. The MDS identified the resident had a BIMs score of 3 which indicated severe cognitive impairment. According to the MDS, the resident required the assistance of one with bed mobility, transfers, personal hygiene, toilet use and bathing. The care plan dated 2/13/17 directed staff to monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucination, dysphasia; nausea; vomiting; dizziness and falls. Review of the Order Summary Report dated 3/20/18 revealed the following orders: a. MOM 30 cc by moth as needed for constipation daily b. docusate sodium capsule 100 mg by mouth as	F 684		

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F 684	Continued From page 11 needed for bowel management for constipation daily. c. Bisacodyl suppository 10 mg 1 suppository rectally as needed for bowel management daily for constipation. d. Fleet enema 7/19 gm/mg insert 1 application rectally as needed for bowel management rectal daily for constipation. Review of the Bowel Movement report dated 12/1/17 through 3/16/18 revealed the following days the resident had no documented bowel movement: a. 12/3/17 through 12/6/17 (4 days) b. 1/23/18 through 1/26/18 (4 days) Review of the MAR dated 12/1/7 through 12/31/17 revealed staff administered bisacodyl suppositories on 12/6/17 (day 4) and 12/7/17. Review of the MAR dated 1/1/18 through 1/31/18 revealed bisacodyl suppository administered on 1/27/18 (day 5). 3. According to the MDS assessment dated 1/5/18, Resident #4 had diagnoses that included atrial fibrillation, coronary artery disease, heart failure, arthritis and hip fracture. The MDS identified the resident had a BIMs score of 11 which indicated moderate cognitive impairment. According to the MDS the resident required extensive assistance with bed mobility dressing, eating and toilet use and total dependence with transfers. The care plan identified the resident occasional incontinent of bowel. The care plan dated 1/6/18 directed staff to monitor/document for side effects of the resident's pain medication. Observe for	F 684		

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F 684	Continued From page 12 constipation; new onset or increased agitation, restlessness, confusion, hallucination, dysphasia; nausea; vomiting; dizziness and falls. Review of the Order Summary Report dated 1/2/18 revealed the following orders: a. Dulcolax suppository 1 suppository rectally every 24 hours as needed for constipation. b. Fleet naturals cleansing enema 1 applicator rectally every 24 hours as needed for constipation. c. MOM 400 mg/5 ml every 24 hours as needed for constipation. d. On 1/8/18, a new order for Miralax 1 packet every morning for bowel management. Review of the Bowel Movement Report Sheet dated 12/27/17 through 1/11/18 revealed the following: a. No bowel movement documented 12/29/17 through 12/30/17 and a small, loose bowel movement on 12/31/17. b. No bowel movement 1/1/18 through 1/4/18 and a medium, formed bowel movement on 1/5/18. c. No bowel movement 1/6/18 through 1/7/18 and a large formed bowel movement on 1/8/17. Review of the MAR dated 1/1/18 through 1/3/18 revealed the following: a. Dulcolax suppository administered on 1/7/18. b. Fleet naturals enema 1 applicator rectally every 24 hour as needed administered 1/8/18. c. Milk of Magnesia 30 ml by mouth every 24 hours as needed for constipation administered 1/4/18. d. Miralax 17 gm every 24 hours as needed for constipation administered on 1/1/18 and 1/8/18. During an interview with the Director of Nursing	F 684		

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RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

(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 13 on 3/21/18 at 1:15 PM she stated she expected staff to not count a small loose BM as an actual BM. She stated it is not written that way in the facility policy. She further stated the Charge nurse responsible to monitor on a daily basis. Review of the Policy and Procedure titled Bowel Protocol dated 9/29/11 directed staff to do the following: a. Each resident will have his/her bowel movements documented on a BM Record. The BM record will be reviewed daily by the Charge Nurse. b. If a Resident is noted to have had no bowel movement in 3 days, the Charge Nurse will follow procedure for interview and assessment of the Resident. c. The Charge Nurse will assess for any current orders to address constipation that the Resident may already have and will administer as ordered or contact the physician as necessary. d. New onset of symptoms/findings that vary from Resident's baseline should always be reported to Resident, Physician and Healthcare Power of Attorney. e. The Charge Nurse will ensure that residents on admission and those with new orders for narcotic pain medication are prescribed routine and/or as needed intervention orders for the prevention and management of constipation. Resident preference for interventions will be communicated in consultation with the practitioner or Physician.	F 684		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		

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F 690	Continued From page 14 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interviews and facility policy review, the facility failed to always provide assessment and intervention for a resident with low urine output and dark urine for one of two residents sampled with urinary catheters (Resident #4). The facility	F 690		

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F 690	Continued From page 15 identified a census of 91 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 1/5/18, Resident #4 had diagnoses that included atrial fibrillation, coronary artery disease, heart failure, high blood pressure, arthritis and hip fracture. The MDS identified the resident had a BIMs (brief interview for mental status) score of 11 which indicated moderate cognitive impairment. According to the MDS, the resident required the assistance of two with bed mobility, transfers, toilet use and bathing, The assessment documented Resident #4 required an indwelling catheter for urination. The resident's care plan focus area for self care deficiency, dated 1/3/18, instructed staff to provide Foley (urinary catheter) cares every shift and as needed. Under the catheter focus area, dated 1/10/18, the care plan directed to check the catheter tubing for kinks each shift and monitor for signs/symptoms of discomfort due to the catheter. The catheter interventions also instructed to monitor/record/report to the medical doctor signs/symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and/or change in eating patterns. The Order Summary Report dated 1/8/18 directed staff to monitor the resident's Foley catheter site every shift for signs and symptoms of injection. If infection noted, document and notify the physician.	F 690		

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F 690	Continued From page 16 Review of the Intake/Output record dated 12/27/17 through 1/11/18 revealed the resident had the following outputs from her urinary catheter: a. 1/10/18 at 4:24 AM - 120 cc (cubic centimeters); b. 1/10/18 at 1:27 PM - 75 cc; c. 1/10/18 at 9:09 PM - 50 cc; d. 1/11/18 at 3:40 AM - 60 cc; e. 1/11/18 at 4:15 AM - 300 cc; f. 1/11/18 at 11:19 AM - 100 cc. Review of the Skilled Note dated 1/11/18 at 1:36 AM revealed the resident had a Foley indwelling catheter patent and draining dark tea colored urine. Staff offered fluids offered and the resident took minute sips. The note also identified the resident seemed to want to do less and less; she just wanted to stay in bed. Review of the Progress Notes dated 1/11/18 at 7:52 AM revealed the resident presented with a change in condition in the morning of 1/10/18. The change in condition related to bleeding and staff reported the change in condition to the resident's physician at 8:10 AM. Staff notified the resident's family/healthcare agent on 1/11/18 at 8:15 AM. The Progress Note dated 1/11/18 at 2:11 PM recorded Resident #4 admitted to the hospital for acute kidney injury, rapid fibrillation and hematuria. The resident's record revealed no further assessment of urine output/catheter patency. Review of the Hospital Discharge Documents dated 1/16/18 revealed the resident had been lethargic for 2 days and sleeping most of the time	F 690		

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F 690	Continued From page 17	F 690		

and was noted to be very sweaty in her bed. She then developed some hematuria (blood in the urine) which was seen in her Foley catheter. She had continued complaints of pain and describes the pain as "all over". Emergency department evaluation included a Foley catheter exchange with findings of several large blood clots which once passed resulted in 1200 cc of urine drained from the bladder. She was also noted to be in atrial fibrillation with a resting ventricular rate 150's. She admitted with urinary tract infection with ceftriaxone (antibiotic), gross hematuria, urinary retention and atrial fibrillation. The hematuria cleared and the clinician suspected hematuria secondary to UTI (urinary tract infection) with gross overdistention of the resident's bladder.

During an interview with Staff A, CMA (certified medication assistant) on 3/20/18 at 1:20 PM, she stated remembered the resident had a small output of dark colored urine the day before she went to the hospital. She stated she told the nurse but could not remember which one. She stated she did not see any blood in the urine and the resident did not complain of pain.

During an interview with Staff G, CNA (certified nursing assistant) on 3/20/18 at 1:40 PM she stated Resident #4 had brown urine towards the end of her stay. She stated the resident had been going downhill but she did not recall the resident complaining of pain. She stated she did not tell the nurse about the brown urine because the regular CNAs on her hall would have told the nurse.

During an interview with Staff E, RN (registered nurse) on 3/20/18 at 2:00 PM she stated it had

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F 690	Continued From page 18	F 690		

not been reported to her that Resident #4 had the low outputs on 1/10/18; this was the first she'd heard of it. She further stated they would irrigate the resident's catheter or call the physician if there had been no order related to the concern.

During an interview with Staff H, LPN (licensed practical nurse) on 3/21/18 at 2:20 PM, she stated she clocked in at 4:00 AM on 1/11/18 and worked CNA duties. She completed rounds with the resident at approximately 4:00 PM and emptied approximately 200 to 300 cc of extremely dark and blood tinged urine. She asked the night nurse if she had seen the urine and she said yes and it had been that way due to the catheter had been changed out the other day. Staff H stated it had not been that color previously and she told the nurse she didn't think it was right. Staff H finished rounds and received nursing report and instructed the day CNAs to watch the resident closely. She went to the resident's room, assessed her and took her vital signs. The resident stated her belly hurt a little bit; she had hyperactive bowel sounds in the upper quadrants and normal bowel sounds in the lower . The resident also had approximately 400 cc of real red urine at that time. She called the physician and he gave an order to send the resident to the hospital. Approximately 5 to 6 hours later, a urologist called and reported the catheter had been empty when at the hospital and they put in a new catheter and returned a large amount of urine. Staff H further stated it had not been reported to her the resident had a low output the day before.

Review of the facility's Incontinence and Catheter Management policy dated 4/2017 revealed that a resident who is incontinent of bladder receives

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F 690	Continued From page 19 appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 690		

F550 Resident Rights/Exercise of Rights

Correct the deficiency as it relates to the individual

Education was provided immediately after the incident. The staff member no longer works here.

How we will act to protect residents in similar situations

All staff have been reeducated on abuse policy, dignity and speaking respectfully to residents.

Measures to be taken or systems to be altered to ensure that the problem does not recur

Random observations will be completed by nurse managers to ensure respectful and dignified treatment of residents

How to monitor performance to make sure solutions are permanent

Random observations will be completed by nurse managers to ensure respectful and dignified treatment of residents. Managers will monitor 5x's a week x 4 weeks, then 3 x's a week for 4 weeks, then 2x's a week x 4 weeks Results will be reviewed at QA.

Date of Correction: April 22, 2018

F677 ADL Care Provided for Dependent Residents (Bathing and nail care)

Correct the deficiency as it relates to the individual
Residents 1,2,3,5 and 6 have had their baths twice a week and have short, clean fingernails. Baths have been documented.

How we will act to protect residents in similar situations
Bathing records have been reviewed and residents have received their baths and they have been documented.

Measures to be taken or systems to be altered to ensure that the problem does not recur
Nursing staff have been reeducated on importance of documenting baths given. They have been educated on the fact that nail care should be performed during the bath, unless the resident is diabetic, in which case the charge nurse should cut nails. Staff have been reeducated on how to document when hospice or other non-facility caretaker gives bath. C NAs will complete showers/baths according to bathing schedules when there is no bath aide.

How to monitor performance to make sure solutions are permanent
Nurse Managers will review daily bath schedules for documentation of baths given. Nurse Managers will do audits of resident's fingernails to ensure they are cut/cleaned routinely and as needed. Managers will monitor 5x's a week x 4 weeks, then 3 x's a week for 4 weeks, then 2x's a week x 4 weeks. Results will be reviewed in QA committee.

Date of correction: April 22, 2018

It is the policy of Risen Son Christian Village to follow all federal, state and local guidelines, laws and statues. This plan of correction is not to be construed as an admission of deficient practice by the facility manager, employee, agents or other individuals. The response to the alleged insufficient practice cited in this statement does not constitute agreement with the insufficiency. The preparation, submission, and implementation of this plan of correction will serve as credible allegation of compliance.

F684 Quality of Care (BM monitoring):

Correct the deficiency as it relates to the individual
Resident #2 and #3 have had BM's at least every 3 days or have received medications as ordered, along with a bowel assessment if 3 days without a BM. Resident #4 has been discharged.

How we will act to protect residents in similar situations
An audit of residents BM documentation was completed and any residents going longer than 72 hours without a BM were offered or administered medications.

Measures to be taken or systems to be altered to ensure that the problem does not recur
Nursing staff will be re-educated on the BM policy including documentation in PCC. Laxative list will be utilized daily for nurses to audit/document those residents who have not had a BM for greater than 48 hours. PRN medications will be given as indicated and ordered. Nurse Managers will review the laxative list routinely and follow-up with nurses not following the protocol.

How to monitor performance to make sure solutions are permanent
Nurse Managers will review PCC at morning stand up to validate that residents are receiving timely interventions and follow up for no BM in 3 days. Nurses will review the BM logs from previous day. Managers will monitor 5x's a week x 4 weeks, then 3 x's a week for 4 weeks, then 2x's a week x 4 weeks. Results will be reviewed by QA committee.

Date of correction: April 22, 2018

F690 Bowel/Bladder Incontinence, Catheter, UTI

Correct the deficiency as it relates to the individual
The resident no longer resides in the facility

How we will act to protect residents in similar situations
All residents with catheters have been audited to ensure that there is documented output each shift.

Measures to be taken or systems to be altered to ensure that the problem does not recur

C NAs will document output in POC. The nurse will review the output at the end of the shift, as documented by the C NA. If the documented output is significantly less than the resident's normal, the nurse will do a bladder assessment and document that assessment.

How to monitor performance to make sure solutions are permanent
Nurse Managers will review the records of residents with catheters to ensure that outputs are recorded and are not significantly less than the resident's normal output. If significantly below normal, the nurse manager will audit to make sure a bladder assessment was completed. Managers will monitor 5x's a week x 4 weeks, then 3 x's a week for 4 weeks, then 2x's a week x 4 weeks. Results will be reviewed at QA.

Date of Correction: April 12, 2018