PRINTED: 07/16/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. BUILDING ______ B. WING ______	06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 7/20/18 The following deficiencies result from the facility's annual health survey. Investigation of facility-reported incidents # 76179-I and # 76240-I did not result in deficiency. Complaints # 76174-C and # 76652-C were not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Amended 7/16/18 by JM, RN	F 000	Please accept the attached Word Document as the facility's Plan of Corrections and Credible Allegation of Compliance.	07/20/2018
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and interviews, the facility failed to carry out	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald Strome	Administrator	07/16/2018

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.

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interventions and/or timely assessments to prevent and/or treat pressure ulcers for three of six residents reviewed with pressure ulcers or at a high risk for pressure ulcers (Residents #8, #40, and #41). The facility reported a census of 48 residents.

Findings:

1. The MDS (Minimum Data Set) assessment tool, dated 3/14/18, for Resident #8 listed diagnoses that included heart failure, incontinence, and mild cognitive impairment. The MDS recorded she required the assistance of one staff with personal hygiene, walking, bed mobility, transfers, dressing, toilet use and bathing. The resident had the risk for developing pressure ulcers but had no unhealed ulcers at the time of the assessment. The MDS listed the resident's BIMS (Brief Interview for Mental Status) score as nine out of 15, indicating moderately impaired cognition.

The Braden Scale for Predicting Pressure Sore Risk, dated 3/18/18, listed the resident's score as 14, indicating a moderate risk for pressure sore development.

An observation on 6/6/18 at 9:44 a.m. revealed the resident had a dark red/brownish area on the bottom of her left heel. The DON (Director of Nursing) measured the area as 0.6 cm (centimeters) x 1.4 cm(length x width). The resident's feet were floated on pillows and the DON removed her soft boots prior to measuring the area and re-applied the boots when finished.

The care plan, revised 2/24/17, instructed Resident #8 had the potential for pressure ulcer

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development related to impaired bed mobility and toilet use and a history of Stage 2 pressure ulcers (ulcers with partial thickness loss of skin) on the right buttocks. The care plan directed staff to turn and reposition the resident and utilize a pressure reducing mattress but did not include direction for staff to float the resident's heels or apply boots.

The resident's Wound/Skin Healing Records documented an unstageable pressure ulcer of the left heel and defined the stage of "unstageable" as known but not stageable due to non-removable dressing/device, due to coverage of wound bed by slough and/or eschar or as suspected deep tissue injury in evolution. The record listed the onset date as 5/29/18 with the measurement of 2 cm x 2.5 cm.

The resident's Wound/Skin Healing Records documented a Stage 1 pressure ulcer of the right heel and defined Stage 1 as intact skin with non-blanchable redness of a localized area usually over a bony prominence, darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. The record listed the onset date as 5/29/18 with the measurement of 3 cm x 3 cm and the ulcer as healed on 6/4/18.

A Progress Note entry, dated 5/29/18 at 12:10 p.m., recorded Resident #8 had unstageable pressure ulcers and directed staff to utilize moon boots (soft boots) on both feet at all times except when walking or showering.

The facility lacked any documentation of flotation of the resident's heels or application of soft boots prior to the date of the pressure ulcer developing on 5/29/18.

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F 686	Continued From page 3 During an interview on 6/6/18 at 10:50 a.m., Staff E CNA (Certified Nursing Assistant) stated she discovered the resident's heel ulcer last Monday. She stated at this point the facility began floating the resident's heels and applying soft boots. During an interview on 6/6/18 at 12:11 p.m., Staff B CNA stated after Resident #8 acquired heel ulcers, the facility initiated the interventions of floating the resident's heels and applying boots. During an interview on 6/6/18 at 1:21 p.m., the DON stated prior to Resident #8's development of heel ulcers, the staff did not assist Resident #8 to float her heels. She stated floating her heels was one factor which helped the ulcer improve since the date of development. 2. The MDS assessment tool, dated 5/9/18, listed diagnoses for Resident #41 that included heart failure, Alzheimer's disease, Non-Alzheimer's dementia, chronic kidney disease, atril fibrillation (an irregular heart rhythm), chronic venous insufficiency and hallucinations. The MDS recorded she required the assistance of one staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing. The assessment recorded the resident as at risk for the development of pressure ulcers and she had one unhealed Stage 2 pressure ulcer. The MDS listed the resident's BIMS score as 6 out of 15, indicating severely impaired cognition. The Braden Scale for Predicting Pressure Sore Risk, dated 5/14/18, listed the resident's score as 16, indicating a mild risk for pressure ulcer development.	F 686		

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A care plan entry, revised 5/16/18, documented she had a history of Stage 2 buttock pressure ulcers due to impaired bed mobility and the resident required a pressure reducing device in her wheelchair. The care plan lacked information related to a pressure reducing device for the recliner.

Observations at the following times revealed the resident sitting in the recliner in her room with an incontinent pad under her and no cushion present in the recliner:
a. 6/4/18 at 10:03 a.m., 11:29 a.m. and 12:05 p.m.
b. 6/5/18 at 6:18 a.m., 7:30 a.m., 8:00 a.m., 9:15 a.m., 9:52 a.m., 10:51 a.m. and 11:20 a.m.
c. 6/6/18 at 7:32 a.m.

During an observation on 6/5/18 at 8:00 a.m., Staff B CNA cleansed both the resident's buttocks. The area was red and when Staff B cleansed the area the resident stated "ouch".

An observation on 6/6/18 at 9:43 a.m. revealed both of the resident's buttocks as red. The DON palpated the areas to check for blanching and the resident stated "ouch".

The Wound/Skin Healing Records recorded the resident had a Stage 2 pressure ulcer on the right buttock with an onset date of 5/7/18 and a measurement of 0.2 cm x 0.5 cm. A Progress Notes entry dated 5/16/18 listed the right buttock pressure area as resolved.

A Social Services Note, dated 5/23/18, documented the resident refused a recliner cushion. The record lacked any further

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F 686	Continued From page 5 documentation of resident refusals of a cushion or any documentation of staff attempts to encourage a different type of cushion to relieve pressure while Resident #8 sat in her recliner. The facility's Pressure Sore Skin Assessments policy, reviewed 1/27/12, instructed staff would ensure residents entering the facility without pressure sores would not develop pressure sores unless the individual's clinical condition demonstrated it was unavoidable. During an interview on 6/6/18 at 10:50 a.m., Staff E CNA stated the resident never slept in bed, always in the recliner. She stated she had never seen a cushion in the recliner and thought the resident had an open area on the buttocks previously. During an interview on 6/6/18 at 12:11 p.m., Staff B CNA stated the resident always slept in the recliner and she had never seen a cushion in the recliner. During an interview on 6/6/18 at 1:29 p.m., the DON stated the resident was at risk for the redevelopment of pressure ulcers in the buttock area. 3. Resident #40's MDS assessment dated 5/9/18 documented he had diagnoses that included cancer, anemia, heart failure, renal insufficiency (poor kidney function), malnutrition and adult failure to thrive. The assessment documented a BIMS score of 12 out of 15, indicating moderate cognitive impairment. Resident #40 required the assistance of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene and experienced frequent incontinence of bladder and bowel. The assessment	F 686		

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F 686	Continued From page 6 documented he had one Stage 2 pressure ulcer with the onset date of 5/9/18 and the risk of developing further pressure ulcers. The resident's Care Plan, updated 2/27/18, identified the resident with the problem of a history of unstageable pressure ulcer on his sacrum and potential for pressure ulcer development Interventions included: Administer medications and treatments as ordered and evaluate for effectiveness Requires extensive assistance of one to reposition in bed Non-compliant with requests to reposition at times, re-direct, re-attempt and educate on benefits of repositioning Requires Liquid Cell 2 ounces twice daily to promote wound healing Pressure reducing devices on bed, chair and recliner. Ortho boots on in bed Follow facility protocols to prevent skin breakdown Monitor/record/report any changes in skin status to hospice Provide thorough peri cares after each incontinent episode Utilize incontinent products and barrier creams Weekly skin documentation measurement of each skin breakdown to include length, width, depth, type of tissue and exudate. Review of physician orders revealed orders to clean the wound daily, apply calcium alginate to wound bed, cover with bordered foam every day shift and give Liquid cell supplement 2 ounces by mouth twice daily (BID) A review of nurse's notes revealed the following	F 686		

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F 686	Continued From page 7 entries: a. 5/3/18 at 6:43 a.m. - Discontinue collagen powder & wound gel. Clean the coccyx wound, cover it with calcium aliginate & a bordered foam dressing daily b. 5/8/18 at 1:25 p.m. - Give 4 ounces of supplement twice daily and continue Liquid cell 2 oz BID to promote wound healing. The notes and the electronic medical record contained no documentation on 5/9/18 of measurements of the pressure ulcer identified on 5/9/18. Review of wound/skin healing record identified resident with a Stage 2 pressure ulcer with an onset date 5/9/18 on the left buttock: a. 5/16/18 - First measurement documented with a length (L) of 0.7 cm, a width (W) of 0.6 cm and a depth (D) of 0.1 cm. The wound showed no exudate or odor, the wound bed had epithelial tissue the surrounding skin appeared normal. The clinical record had no documentation to show staff notified the dietary department, family or physician. b. 5/23/18 - Measurements of a L of 0.7 cm, a W of 0.5 cm and D of 0.1 cm with no change in the appearance of the wound. c. 5/30/18 - Measurements of a L of 3.5 cm, a W of 2.5 cm and D of 0.1 cm with no change in surrounding skin and tissue During an observation of wound care on 6/5/18 at 9:54 a.m., Staff D, LPN provided the resident's ordered treatment. The wound appeared to have healthy tissue and had no odor or redness to the surrounding skin. During an interview on 6/5/18 8:24 a.m. the DON reported there should have been documentation	F 686		

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F 686	Continued From page 8 of measurements and the assessment of the wound on 5/9/18. In an interview on 6/6/18 at 1:04 p.m. Staff D, LPN reported the resident's pressure ulcer may have been caused by shearing which lead to the ulcer healing, opening, healing and opening again. The resident's nutritional status had also been altered; sometimes he refuses to eat and he drinks the supplements about 80% of the time. He also reported assessments of the wound should include the appearance and measurements. During an interview on 6/7/18 at 9:37 a.m., the DON reported she could not locate documentation of an assessment or measurements of the wound when first identified on 5/9/18. The facility's Pressure Sore Skin Assessments policy, reviewed 1/27/12, instructed staff to assess any new pressure sore as soon as discovered. Include all pertinent information on pressure sore form, as well as in nurse's notes, location of open area, stage, measurement in centimeters of width and depth surrounding skin conditions and any drainage should be described.	F 686		
F 690 SS=D	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 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.	F 690		

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F 690	Continued From page 9 §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, and staff interview, the facility failed to ensure a catheter anchor in place for one sampled resident who required an indwelling urinary catheter (Resident #33). The facility reported a census of 48 residents. Findings include: 1. Resident #33's Minimum Data Set (MDS) assessment date 4/11/18 documented diagnoses	F 690	Past noncompliance: no plan of correction required.	

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F 690	Continued From page 10 that included neurogenic bladder, malnutrition and MRSA (an infection) identified elsewhere. It also identified the resident to be cognitively impaired with a BIMS (brief interview for mental status) score of 6 out of 15. The assessment identified the resident required assistance of one staff with toilet use, supervision with personal hygiene and an indwelling catheter. Resident #33 walked independently. The resident's care plan revised on 9/14/17 identified a focus of an indwelling catheter due to neurogenic bladder. The care plan instructed, in part, to monitor and document intake and output as per facility policy and to monitor and document pain/discomfort due to the catheter. Review of urine culture dated 4/9/18 revealed an infection of 100,000 CFU/ml of Proteus mirabilis The resident's physician ordered Ampicillin 500 milligrams three times daily for 7 days for Proteus urinary tract infection on 4/12/18. A review of the nurse's notes revealed the following entries: -- On 1/7/18 at 1:00 a.m. the resident appeared to have a small spot on his penis less than 1/2 centimeter, possibly rubbed area. -- On 1/7/18 at 7:40 a.m. staff noted leaking around the catheter. Staff discontinued the catheter and inserted a new catheter without difficulty. -- On 2/25/18 at 11:30 p.m. staff documented finding him sitting on a stool, holding onto his penis due to thinking the catheter was going to fall out. Once in bathroom, staff noted his penis as very swollen with a small amount of blood. Staff cleansed the area and replaced the catheter.	F 690		

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F 690	Continued From page 11 During an observation on 6/5/18 beginning at 7:12 a.m. Staff F and Staff G, CNAs (certified nursing assistants) used the correct technique to cleanse the resident after he had a bowel movement and then pulled up his incontinent briefs and pants. The resident's urinary (Foley) catheter was connected to large drainage bag without a catheter anchor in place. At 7:14 a.m. Staff G provided standby assistance while the resident walked using a cane and the resident sat in recliner. Staff G removed her gloves, washed hands and remained with Resident #33 as Staff F left the room to find a leg bag. At 7:17 a.m. Staff F placed plastic bags on floor underneath large drainage bag and performed used correct techniques to cleanse the spigot, drain the large bag. Staff F then pulled the catheter tubing from underneath the resident's scrotum; the tubing appeared taught and had no anchor to secure the catheter in place. Staff F disconnected the tubing from Foley catheter, wiped the end with alcohol then connected a leg bag to urinary catheter. At 7:26 a.m. Staff G left room to find straps for leg bag and she returned to room with straps for leg bag. Staff F removed her gloves and used alcohol hand sanitizer and attached straps to leg bag and secured to the resident's leg. Staff completed the care at 7:31 a.m. Neither aide applied a catheter anchor to the resident's thigh prior to leaving the resident's room. During an interview on 6/6/18 at 11:56 a.m., Staff A, CNA reported Foley catheters should be held in place with a sticker placed on the resident's thigh. In an interview on 6/6/18 at 12:05 p.m., Staff B,	F 690		

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F 690	Continued From page 12 CNA reported Foley catheters should be held in place with a butterfly sticker on the resident's thigh to keep the tubing from getting kinked. During an interview on 6/5/18 at 12:20 p.m., Staff C, CNA reported Foley catheters should be held in place with a butterfly strapholder that should be placed on the resident's thigh to keep the tubing from being pulled. In an interview on 6/6/18 at 1:04 p.m., Staff D, LPN (Licensed Practical Nurse) reported Foley catheters should be held in place with an adhesive that is placed by the port on the resident's thigh. On 6/6/18 at 2:02 p.m., the Director of Nursing (DON) reported Foley catheter should be secured by an anchor placed on the thigh. Observation at 2:10 p.m. with the DON revealed the resident did not have a catheter anchor in place and the DON verified this.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		

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	165549	A. BUILDING ______ B. WING ______	06/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	**THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501**

(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 725	Continued From page 13 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to answer call lights in a timely manner for 4 of 8 interviewable residents present in the group interview including 1 resident(Resident #20)of 5 also interviewed individually during the survey. The facility reported a census of 48 residents. Findings: 1. During the group interview on 6/4/18 at 1:15 p.m., 4 out of 8 interviewable residents stated they had to wait longer than 15 minutes for staff to respond to their call lights. All 4 stated they wore incontinence pads because they had had accidents waiting so long for staff to respond. Three residents stated they had to wait longer than 30 minutes for staff to respond. All utilized clocks or watches to time the lights. 2. Resident Council Minutes, dated 3/20/18, revealed residents had a concern of third shift call lights taking longer to answer.	F 725		

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F 725	Continued From page 14	F 725		

During an interview on 6/6/18 at 1:57 p.m., the DON(Director of Nursing) stated she expected staff to answer call lights within 15 minutes. She stated she did not believe the facility had a policy related to call lights.

3. Resident #20's Minimum Data Set (MDS) annual assessment completed 4/4/18 documented she had diagnoses that included atrial fibrillation (an abnormal heart rhythm), coronary artery disease and heart failure. It also identified the resident with a BIMS (brief interview for mental status) score of 10 out of 15 indicating moderate cognitive impairment. The resident required the assistance of one staff with most activities of daily living and she had occasional incontinence of bladder.

The resident's care plan, revised on 4/10/18, documented the following focus areas: self-care deficit, behavior, cardiovascular, impaired cognitive ability, potential oral problems due to dentures, potential fluid deficit related to diuretic use, fall risk, depressive disorder, pain, potential nutritional problem, potential for pressure ulcer and impaired visual function

During group interview, Resident #20 complained about staff taking too long to answer her call lights which can take as long as 2 hours to answer on the night shift.

During interview on 6/6/18 9:50 a.m. the DON stated the facility did not have the capability to print out reports from the call light system.

On 6/6/18 9:50 a.m., Resident #20 sat in wheelchair in her room, appeared comfortable, had a clock on wall visible from her bed. She

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F 725	Continued From page 15 reported she did has waited an average of 45 minutes to up to 2 hours to get her call light answered on the night shift and that she had lost control of her bladder, which made her feel like an idiot and made her feel like a 2 year old. It was absolutely embarrassing and should not happen. The resident stated she talked about the concern during care conferences and was told it would be taken care of, but it still happens. During an interview on 6/6/18 at 11:56 a.m., Staff A, CNA (certified nursing assistant) reported staff should answer call lights within 5 minutes, typically there are 2 nurses and 6 aides that work on first shift and they are short staffed at least once a week. In an interview on 6/6/18 at 12:05 p.m., Staff B, CNA reported staff should answer call lights within 5 minutes, typically there are 2 nurses and 6 aides that work on first shift and they are short staffed at least once every other week. However, there are staff to pick up the extra shifts. During an interview on 6/5/18 at 12:20 p.m., Staff C, CNA reported staff should answer call lights as quickly as possible. Typically there are 2 nurses and 6 aides working on the first shift. In an interview at 6/6/18 at 2:02 p.m., the DON reported she expected her staff to answer call lights within 15 minutes. That Resident #20 had complained that she had to wait for a while to get her call light answered during the night shift and she spoke to the staff about it. The DON also stated she completed an audit on the resident's call lights on night shift and found lights were answered within 15 minutes. At 3:02 p.m., the DON reported Resident #20 had dementia, which	F 725		

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F 725	Continued From page 16 she hides her very well. The DON did not 'buy into the fact' the resident's call light had not been answered for up to 2 hours. During an interview on 6/7/18 7:04 a.m., the Maintenance supervisor reported that he has worked at the facility for 17 years and has always started his day at 3:00 a.m. He stated never seeing a call light stay on for more than 15 minutes, however, he had no documentation to verify this.	F 725		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews with 7 of 8 residents interviewed in the group interview, clinical record	F 809		

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F 809	Continued From page 17	F 809		

Continued From page 17

review and observations of 3 meals served revealed residents did not receive their meals in a timely manner. The facility reported a census of 48 residents.

Findings include:

1. Observations of the breakfast meal on 6/5/18 revealed Residents #30, #34, #24, #27, and #10 at the breakfast table at 8:15 a.m. Staff served Resident #34 at 8:17 a.m. Staff served Residents #10 and #27 at 8:23 a.m. Staff served Residents #24 and #30 at 8:30 a.m.

Observations of the lunch meal on 6/5/18 revealed Residents #20, #24, #30, and #34 at the lunch table at 12:09 p.m. Staff served Residents #24, #20, and #30 at 12:32 p.m. Staff served Resident #34 at 12:36 p.m.

2. During the group interview on 6/4/18 at 1:15 p.m., 7 of 8 interviewable residents present stated meals were often served late. They stated this could be any meal but the evening meal was especially late. They stated the evening meal was supposed to start at 6:00 p.m. but they often did not eat until 6:30-6:45 p.m.

3. Resident Council Minutes, dated 3/20/18, recorded residents stated the evening meals ran late.

Resident Council Minutes, dated 4/24/18, documented the Dietary Manager would address the late supper issue.

During an interview on 6/6/18 at 1:57 p.m., the DON (Director of Nursing) acknowledged late meals were a problem.

F 809 Continued From page 18 F 809

A review of the undated facility policy titled: mealtimes revealed documentation that meal service begins at:
Breakfast 8:00 a.m.
Lunch 12:00 p.m.
Supper 6:00 p.m.

3. Resident #39's Minimum Data Set (MDS) assessment dated 5/9/18 documented diagnoses that included cancer, anemia, renal insufficiency and diabetes. It also identified the resident to be cognitively impaired with a BIMS (brief interview for mental status) score of 10 out of 15. The resident required supervision with eating.

A review of the care plan with the target date of 8/8/18 identified the resident with the focus area of potential fluid deficit related to diuretic use and staff instruction to invite the resident to activities that promote additional fluid intake; offer drinks during one to one visits and ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements. It also identified the resident with a focus of diabetes mellitus type 2 and directed staff to monitor/document/report compliance with diet and document any problems as needed.

Observation on 6/4/18 at 12:05 p.m. seated in the main dining room with one cup of coffee, one glass of water and condiments on table. At 12:25 p.m. she remained in main dining room, waiting to be served lunch and worked on crossword puzzle. Neither Resident #39 or her tablemate had received lunch. At 12:37 p.m. staff served a tuna sandwich with macaroni salad and brownie, one glass of water and one cup of coffee. The resident's lunch arrived 37 minutes after the

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F 809	Continued From page 19	F 809		

planned start of the meal.

Observation on 6/5/18 at 8:00 a.m. and 8:30 a.m. revealed Resident #39 seated in the main dining room waiting to be served breakfast. At 8:34 a.m. the staff served the resident breakfast, 34 minutes after the planned start of the meal.

4. Resident #42's MDS assessment dated 5/9/18 documented diagnoses that included cancer, atrial fibrillation (an abnormal heart rhythm) and heart failure. It also identified the resident to be cognitively impaired with a BIMS score of 8 out of 15. The resident required supervision with eating.

The resident's care plan, updated on 10/20/17, identified she had the potential of nutritional problems and directed staff to provide a mechanical soft diet as ordered, to monitor her intake and record the intake at each meal.

Observations on 6/4/18 at 12:08 p.m. and 12:36 p.m. revealed Resident #42 sat in the main dining room with one glass of water and condiments on the table. At 12:33 p.m., staff served the resident lunch and she fed herself independently. The resident received her food 33 minutes after the planned start of the meal.

An observation of the noon meal service on 6/5/18 revealed the first meal to be served at 12:06
p.m. and the last meal to be served at 12:42 p.m. with 9 resident meals served after 12:30 p.m.

During an interview on 6/6/18 at 11:56 a.m. Staff A, CNA (certified nursing assistant) reported the following mealtimes: breakfast is 8:00 a.m., lunch is at noon and supper at 6:00 p.m. She also

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VISTA WOODS CARE CENTER	**THREE PENNSYLVANIA PLACE** **OTTUMWA, IA 52501**

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F 809	Continued From page 20 reported there were times where meals are late, that usually nursing staff usually pass the trays and the Social worker and Activity coordinator also help to pass trays. In an interview on 6/6/18 at 12:05 p.m. Staff B, CNA reported the following mealtimes: breakfast is 8:00 a.m., lunch is at noon and supper at 6:00 p.m. She also reported that nursing staff had the responsibility to pass trays to the residents. During an interview on 6/5/18 at 12:20 p.m. , Staff C, CNA reported the following mealtimes: breakfast is 8:00 a.m., lunch is at noon and supper at 6:00 p.m. and that the nurse aides usually pass the trays to the residents with the help of the social worker and activity coordinator during the week. In an interview on 6/6/18 at 1:04 p.m. Staff D, LPN (Licensed Practical Nurse) reported the following mealtimes: breakfast is 8:00 a.m., lunch is at noon and supper at 6:00 p.m. and that the nurse aides usually pass the trays to the residents with the help of the social worker and activity coordinator during the week. During an interview on 6/6/18 at 1:18 p.m., Staff H, cook reported the following mealtimes: breakfast is 8:00 a.m., lunch is at noon and supper at 6:00 p.m. and felt meals had usually been served on time In an interview on 6/6/18 at 1:23 p.m., Staff I, cook reported the following mealtimes: breakfast is 8:00 a.m., lunch is at noon and supper at 6:00 p.m. The nursing staff usually serve the meals which are sometimes late and she has to stop serving the meals when a special order comes in	F 809		

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

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F 809	Continued From page 21 for an item that had not already been prepared. Sometimes co-workers are not always helpful with those special orders, which the 9 a.m. to 2 p.m. person should do. During an interview on 6/6/18 at 1:43 p.m., Staff J, dietary aide/cook reported the following mealtimes breakfast is 8:00 a.m., lunch is at noon and supper at 6:00 p.m., that at times meals can be late if the nurse aides take an extra break or are late from break In an interview on 6/6/18 at 1:47 p.m., the Dietary Director reported the following mealtimes breakfast is 8:00 a.m., lunch is at noon and supper at 6:00 p.m., that at times meals can be late if the staff in the dining room aren't ready. Usually nursing staff serves the meals and will rotate between serving meals in the assisted dining room, then the main dining room, etc. The residents have complained it takes too long, usually at supper time. Dietary staff try to serve within 30 minutes. One of the residents had expressed that ½ hour was too long to wait. Nursing staff with the help of the Social worker, the rehab aide and Activities director will pass trays. Sometimes a resident will refuse what is served and request something different. Sometimes the dietary aides will not help out with the above and Staff I, cook will stop serving and prepare the special request. Other times she reported a problem that staff think they need more breaks.	F 809		

F000

The following Plan of Correction is the Facility's Written Credible Allegation of Compliance.
Completion Date: 07/20/2018

The preparation of the following plan of correction for the stated deficiencies does not constitute and should not be interpreted as an admission of nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction prepared was executed solely because provisions of State and Federal law required it.

F686 Treatment/Services to prevent/heal pressure ulcer

Residents receive care, consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable and that a resident with a pressure ulcer receives necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.

With respect to Resident #8, the wound was healed on 6/20/18. Moon (soft) boots were care planned upon finding the wounds on the heels and remain on the care plan to help prevent them from recurring. Nursing staff are to continue to monitor/document/and report any changes in skin condition.

With respect to Resident #41, the care plan progress notes reflect that a pressure relieving cushion is to be used in the recliner and wheelchair to help prevent pressure sores in the future. Resident agreeable at this time. In the event that the Resident refuses again, alternative cushions will be attempted and/or identification on the care plan of continued refusal.

In respect to Resident #40, Hospice services were provided to assist with end of life cares and Resident's Physician participated in treating the pressure ulcer and documented that due to the individual's clinical condition, the ulcer was unavoidable. The Resident has since passed away.

Other residents in similar situations are protected by inservicing nursing staff on pressure ulcer prevention, including monitoring skin conditions, reporting changes, positioning and positioning devices. The facility has assigned a new wound care nurse effective 6/7/18. All residents will be assessed upon admission, quarterly or upon condition change for the risk of pressure sores and the need for pressure relieving devices.

Measures taken to ensure the problem does not recur includes the wound care nurse and D.O.N. monitoring all residents weekly for condition changes that may cause skin breakdown. A weekly IDT wounds form will be completed for residents identified and preventative equipment and interventions will be put in place and added to the resident's plan of care.

Performance shall be monitored by the QA&A committee quarterly to make sure solutions are permanent.

Completion Date 7/20/18

F690 Bowel/Bladder Incontinence, Catheter, UTI

The facility ensures that a resident who is continent of bladder and bowel receives services and assistance to maintain continence unless his or her clinical condition becomes such that the continence is not possible to maintain and receives appropriate treatment to prevent urinary tract infections.

With respect to Resident # 33, the care plan was updated to ensure that the catheter is secured every shift. The nurse who changed the catheter without securing it to the leg was provided additional individual instruction on securing the leg bag tubing. Checking to check foley patency and ensuring the catheter is secured every shift was added to a Treatment Administration Record.

Other residents in similar situations will be protected by inservicing Nurses and CNA's on securing catheters. Monitoring and reporting issues related to catheters in general.

Measures taken to ensure the problem does not recur by receiving catheter care during initial and annual competency evaluations of CNA's and Nurses. The Infection Control Preventionist will monitor any signs or trends of catheter use and/or infections monthly.

Performance shall be monitored by the QA&A committee quarterly.

Completion Date 7/20/18

F725 Sufficient Nursing Staff

The facility has sufficient nursing staff with appropriate competencies and skill to provide nursing and related services to assure resident safety or to maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The facility provides prompt response from qualified staff for the resident's use of the nurse call system;(Prompt response being considered as no longer than 15 minutes).

With respect to Resident #20, the Director of Nursing and administrator consulted with both the Resident and Resident's Representative regarding the stated concerns of the call light. The Resident's Representative believes additional training would be beneficial as there has been times it was thought the call-light was on but was not. Additional training was provided to the Resident on call-light usage and he/she agreed to report any further issues directly to the D.O.N. or Administrator. The Resident agreed and nursing staff instructed to monitor.

Other residents in similar situations are protected by reviewing a recently developed call-light policy with nursing staff beginning on 07/09/2018 including the timeliness of lights being answered within 15 minutes. An inservice was held on 06/07/018 regarding the same policy and response to call-lights. Resident council minutes will be reviewed with staff at monthly inservice meetings.

Measures taken to ensure the problem does not recur includes the Administrator, D.O.N., and other designees to randomly audit call-light response times. Audit findings will be brought to QAPI meetings. The facility D.O.N. and Administrator will monitor nursing staffing to maintain adequate levels to meet the residents' needs. The facility gave an annual wage increase on 06/22/2018 and has ongoing employment advertising to maintain and recruit staff.

Performance shall be monitored by the QA&A Committee quarterly to make sure solutions are permanent. Completion Date: 07/09/2018

F809 Frequency of Meals/Snacks at Bedtime

Each resident is provided three meals daily, at regular times comparable to normal meal times in the community. There is not more than 14 hours between a substantial evening meal and breakfast on the following day.

With respect to Resident #39 and #42 and other residents in similar situations, meal service begins at 8:00AM, 12:00PM and 6:00PM. Dietary staff, nursing staff and serving staff will be inserviced on the expectation of prompt serving and quickest possible delivery of meals at those times. Serving sequence to tables in the Main Dining Room will be rotated so that the same individuals are not always served first nor last. The cooks will prepare alternative menu items in advance for quick substitution. Reasonable special orders requested during the meal will be served last so that the majority of residents are served timely. Snacks are available 24 hours per day.

Measures taken to ensure the problem does not recur includes routine monitoring and audits of meal serving beginning and ending times by the Administrator, D.O.N., Dietary Manager or other designee(s), will request to be invited to Resident Group Meetings to help resolve any meal service concerns. Both the meal service time audits, resident council minutes, and the DSM will be part of QAPI meetings.

Performance shall be monitored quarterly by the QA&A Committee.

Completion Date 07/20/2018