STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
10/31	155161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Correction Date 10-26-06 The following deficiencies related to a revisit to complaint #8689-C and investigation of Complaint # 9147-C. Investigation of facility-reported incident # 9204-I was not substantiated. (See Code of Federal Regulations (42CFR) part 483, Subpart B-C)	{F 000}	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because provisions of State and Federal law require it.	

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

Karen E Mineer — Administrator — 10-23-06

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

Accepted 10/31/06 Tonka Vanmeter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Relates to Complaint # 9147-C. Based on staff interview and clinical record review of 8 in-house residents and 3 closed records, the	F 157	The facility will continue to ensure physician notification when a resident has a potential for requiring a physician's intervention. Resident #6 no longer resides in the facility. All licensed personnel will be re-educated regarding filling out resident information completely, and timely notification of physician. The director of nursing or designee will monitor documentation and physician notification for 4 weeks. Ongoing monitoring will then become part of the facilities quarterly QA process.	10-26-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157	Continued From page 2 facility failed with 1 closed record to ensure physician notification when the resident had a potential for requiring a physician's intervention. (Resident #6) The facility identified a census of 100 residents. Findings include: 1. Resident #6 had, according to the minimum data set assessment (MDS) dated 8/26/06, diagnoses which included diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease and surgical wound. The MDS indicated the resident with no memory problems and some difficulty in decision-making in new situations only. The MDS revealed the resident required extensive assistant with transfers, toileting and personal hygiene and limited assistance with dressing and to walk. It did indicate bedfast all or most of the time. The resident assessment-data collection form/initial care plan revealed admission 8/23/06 at 6 p.m. This assessment/care plan failed to include diagnoses or the information of the resident gall bladder surgery on 8/17/06. The assessment revealed surgical staples and left buttock open area. A Fax sent to the physician on 8/23/06 indicated resident had a superficial open area, approximately .25 centimeters to left buttock and asked "how do you want to treat?" Also, the resident's groin and abdominal skin fold are opened raw and moist. This Fax, sent to the physician, had the wrong resident last name; therefore the physician failed to receive the information about the open area; therefore no	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157	Continued From page 3 treatment provided. Nurse's notes dated 8/24/06 at 4 p.m. revealed at 3:30 p.m. staff transferred the resident to another room in the facility. It documented at 3 p.m. the resident had a large emesis and loose stools. The resident then said he/she felt better. The note at 10 p.m. by Staff G documented the resident complained of frequent emesis off and on. The note contained no evidence of physician notification. Interview with Staff G on 10/2/06 at 2:15 p.m. revealed she knew the resident had surgery but not sure what kind. She said the resident had no emesis for her, when she got report staff said the resident had emesis and she charted from the prior shift. She said, "guess I need to chart better". On 8/25/06 at 6:30 a.m. the nurse's notes revealed the resident complained nausea and emesis throughout the shift with emesis light brown, approximately 30 cubic centimeters and complains of general discomfort. The notes dated 8/25/06 at 1:40 p.m. documented staff contacted the resident's physician who ordered Phenergan (an antinausea medication), a stat Complete Blood Count laboratory test and Prevacid solutabs (an anti acid medication). The physicians telephone order sheet revealed the orders to be given at 10 a.m. At 5:35 p.m., the nurses notes documented the physician called and requested the 2 laboratory sheets to be re-faxed. The physician, at that time, ordered Levaquin 500 milligrams, daily for 10 days. Review of the medication records revealed the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157	Continued From page 4 Prevacid solutab and Levaquin not administered to the resident as ordered and no explanation of why or physician notification of medication not administered. The nurse's notes entry dated 8/25/06 at 9:20 p.m. indicated family here off and on throughout shift and the resident consuming only clear liquids and ice chips; the resident had 3 small, clear emesis. The resident oxygen saturation measured 91 percent at 4 p.m. with oxygen on at 2 liters and oxygen saturations ranging from 89 - 94 percent. The resident had labored breathing and "dry heaves". Lung sounds were clear; however staff failed to listen to the resident's bowel sounds and or measure vital signs since 7:15 a.m. There failed to be evidence of physician notification of the need for oxygen. The medication administration record revealed Phenergan suppository administered at 3 p.m. and 7 p.m.; however, the nurse's notes failed to indicate the need to administer this medication. During interview on 10/11/06 at 1:15 p.m., the resident's physician stated that he didn't realize the resident had started vomiting the afternoon of 8/24/06. He stated that it would have been appropriate to notify him at that time, as he would have ordered the Phenergan suppositories earlier.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 281} SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Relates to revisit of complaint #8689-C and investigation to complaint #9147-C: Based on staff interview and clinical record review of 8 in-house residents and 3 closed records, the facility failed with 1 of the closed records to always follow physician orders for medications and ensure the physician signed resident admission orders. (Resident #6) The facility identified a census of 100 residents. Findings include: 1. Resident #6 had, according to the minimum data set assessment (MDS) dated 8/26/06, diagnoses which included diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease and surgical wound. The MDS indicated the resident with no memory problems and some difficulty in decision-making with new situations only. The assessment revealed the resident as oriented to the season, room location, staff names and placement in a nursing home. The assessment documented the resident as without behavioral or mood symptoms. The MDS revealed the resident required extensive assistant with transfers, toileting and personal hygiene and limited assistance with dressing and to walk. It did indicate bedfast all or most of the time. On 9/29/06 at 2:30 p.m., the admission orders dated 8/23/06 did not contain a physician	{F 281}	The facility will continue to follow physician orders for medications and ensure that the physician's signs the resident admission orders. Licensed nurses will be re-educated regarding physician's signed orders. The director of nursing or designee will monitor new physician's orders for 4 weeks to ensure orders are followed. Ongoing monitoring will then become part of the facility's quarterly QA process.	9/15/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 281}	Continued From page 6 signature. The orders included aspirin 81 milligrams daily, cardizem cd, 240 milligrams daily, spironolactone 25 milligrams daily, potassium chloride 10 milligrams, 2 times a day, prazosin HCL 4 milligrams daily, lasix 40 milligrams daily, zoloft 50 milligrams daily, theophylline 300 milligrams 2 times a day and Lortab 5/500 milligrams every 6 hours as needed. The nurses' notes dated 8/25/06 at 1:40 p.m., revealed resident had a coffee ground emesis at 6:45 a.m. and the physician called and advised of problem. The notes revealed the physician ordered phenergan suppository for nausea control, also an immediate complete blood count (CBC) from the hospital laboratory. Results from the CBC returned at 10:20 a.m. and physician notified and gave orders to draw another CBC on 8/26/06 and call with the results. The documentation revealed the physician also gave orders for Phenergan suppository 25 milligrams rectally every 4 hours, as needed, for nausea and vomiting and Prevacid solutab 30 milligrams, 2 times a day for 7 days, then daily. The notes revealed the resident had no further nausea and vomiting after the suppository given at 7:15 a.m. and could take their daily medications, a few at a time. Nurse's notes dated 8/25/06 at 5:35 p.m., revealed the physician called and requested the 2 laboratory sheets to be refaced. The physician, at that time, ordered Levaquin 500 milligrams, daily for 10 days. Review of the resident's 8/06 medication records revealed the Prevacid solutab and Levaquin not administered as ordered on 8/25 and no	{F 281}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 281}	Continued From page 7 explanation of why or physician notification of the medication not administered. The MAR also recorded no administration of the Phenergan suppository every 4 hours, as needed since 7 p.m. During interview on 10/2/06 at 2:20 p.m., the facility Director of Nurses said the facility had oral Levaquin in the emergency box. On 8/26/06 at 1:10 a.m., the nurse's notes documented at 11 p.m. the resident had a moderate coffee ground emesis, appeared disorientated, threw a cell phone, a watch and a glass of water to the floor. The notes revealed the resident constantly removes his/her oxygen. At 11:30 p.m., the resident's daughter visited and sat with resident. Their daughter stated, "he/she knew who I was earlier today, what has happened?" The notes revealed the resident transferred to the hospital at 1:05 a.m..	{F 281}		
{F 309} SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Relates to revisit of complaint #8689-C and investigation of complaint #9147-C:	{F 309}	The facility will continue to ensure timely professional assessment, physician notification and follow up charting. Licensed nurses will be re-educated on through assessments, intervention and physician notification. The director of nursing or designee will monitor Resident's conditions and documentation for 4 weeks. Ongoing monitoring will then become part of the facilities quarterly QA process.	9/15/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 8 Based on staff interview, hospital history and physical and clinical record review for 8 in-house residents and 3 closed records, the facility failed with 1 of 3 closed records to ensure timely professional assessments, physician notification and with follow up charting with a resident with a change of condition. (Resident #6) The facility identified a census of 100 residents. Findings include: 1. Resident #6 had, according to the minimum data set (MDS) assessment dated 8/26/06, diagnoses which included diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease and surgical wound. The MDS indicated the resident with no memory problems and some difficulty in decision-making in new situations only. The MDS revealed the resident required extensive assistant with transfers, toileting and personal hygiene and limited assistance with dressing and to walk. It did indicate bedfast all or most of the time. The resident assessment-data collection form/initial care plan revealed admission 8/23/06 at 6 p.m. This assessment/care plan failed to include diagnoses or the information of the resident gall bladder surgery on 8/17/06. The assessment revealed surgical staples and a left buttock open area. The facility inquiry record dated 8/23/06 at 11 a.m. indicated the resident desired admission on 8/23/06. This inquiry documented recent gallbladder surgery, had fallen at home and required therapy to get stronger and return home.	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 9 The admission orders dated 8/23/06 included aspirin 81 milligrams daily, cardizem cd, 240 milligrams daily, spironolactone 25 milligrams daily, potassium chloride 10 milligrams, 2 times a day, prazosin HCL 4 milligrams daily, lasix 40 milligrams daily, zoloft 50 milligrams daily, theophylline 300 milligrams 2 times a day and Lortab 5/500 milligrams every 6 hours as needed. The admission nurse's notes dated 9:30 p.m. indicated the resident admitted at 9:30 p.m. The resident assessment had indicated admission at 6 p.m. The notes indicated the resident came non-emergency ambulance with spouse accompanying. Resident alert and able to understand. The nurse's notes revealed a vital sign assessment on 8/24/06 at 2:10 a.m. At 2 p.m., the notes indicated the resident alert and orientated times 3 and offered no complaints. The notes revealed 1 medication, Prazosin, not available and the physician notified. On 8/24/06 at 4 p.m., the nurse's notes revealed at 3:30 p.m. transferred the resident to another room. The note documented that at 3 p.m. the resident had a large emesis and loose stools, then said he/she felt better. At 4:15 p.m., staff documented a vital signs assessment with a temperature at 96.5 degrees Farenheit, blood pressure (BP) of 124/80, pulse of 74 and respirations of 18. The nurse's note at 10 p.m. (by Staff G) recorded the resident complained of frequent emesis off and on. The note contained no assessment of	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 10 bowel sounds or vital signs or evidence of physician notification. Interview with Staff G on 10/2/06 at 2:15 p.m. revealed she knew the resident had surgery but not sure what kind. She said the resident had no emesis for her and when she got report they said the resident had emesis and she guessed she charted from the prior shift. She said, "guess I need to chart better". A nurse's note dated 8/25/06 at 6:30 a.m. documented the resident complained of nausea and emesis throughout the shift with emesis light brown in color, approximately 30 cubic centimeters (cc) in amount and complained of general discomfort. The note contained no assessment of bowel sounds or vital signs or evidence of physician notification. The notes of 8/25/06 at 1:40 p.m. revealed the resident had a coffee-ground emesis at 6:45 a.m., the physician called and advised of problem. The notes revealed the physician ordered phenergan suppository for nausea control and an immediate complete blood count (CBC) from hospital laboratory. The notes documented the resident's temperature of 98.5 degrees F, BP 160/62, pulse at 112 and respirations at 26 at 7:15 a.m. and the administration of Phengan suppository. According to the physician telephone order of 8/25/06, the Phenergan suppository failed to be ordered until 10:30 a.m. The nurse's notes documented results from the CBC returned at 10:20 a.m. and staff notified the physician, who gave orders to draw another CBC on 8/26/06 and call the results. The	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 11 documentation revealed the physician also gave orders for Phenergan suppository 25 milligrams rectally every 4 hours, as needed, for nausea and vomiting and Prevacid solute 30 milligrams, 2 times a day for 7 days, then daily. The notes revealed the resident stopped nausea and vomiting after the suppository given at 7:15 a.m. and resident able to take daily medications, a few at a time. The nurse's notes entry dated 8/25/06 at 5:35 p.m., revealed the physician called and requested the 2 laboratory sheets to be re-faxed. The physician, at that time, ordered Levaquin 500 milligrams, daily for 10 days. The nurse's notes entry dated 8/25/06 at 9:20 p.m. indicated family at the facility off and on throughout shift and the resident consuming clear liquids only and ice chips. The resident had 3 small, clear emesis. Staff (E) measured an oxygen saturation at 91 percent at 4 p.m., oxygen on at 2 liters and oxygen saturations from 89 - 94 percent. The resident had labored breathing and "dry heaves". Lung sounds were assessed to be clear; however, staff failed to assess bowel sounds and failed to measure the resident's vital signs. There failed to be evidence of physician notification of the need for oxygen or an order for it's administration. During interview on 10/2/06 at 2:50 p.m., Staff E (Registered nurse or RN) stated on 8/25/06 the B-hall nurse (Staff E) told her the resident had been having coffee ground emesis. Staff E stated she knew the resident had some kind of surgery but "not sure what". Staff E stated she administered a Phenergan suppository to the	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 12	{F 309}		

resident, but could not recall if the Prevacid came from pharmacy or not. She said the physician called at 5:35 p.m. and he only received 1 laboratory sheet and therefore wanted both faxed to him. Staff E said the family mentioned the resident's breathing was funny, oxygen saturations measured at 91 percent at 4 p.m. and the resident's spouse worried. Staff E stated she completed an assessment but "just didn't chart it" and started oxygen per her nursing judgement.

The nurse's notes dated 8/26/06 at 1:10 a.m. revealed that at 11 p.m. the resident had a moderate coffee ground emesis, appeared disorientated, threw cell phone and watch and a glass of water to the floor. The notes revealed the resident constantly removing his/her oxygen. At 11:30 p.m., the resident's daughter visited and sat with resident. The daughter stated, "he/she knew who I was earlier today, what has happened?" The staff measured a BP of 140/76, pulse of 96, respirations of 22 and temperature of 97.8 degrees F. The nurse's notes revealed the family wanted the resident sent to the hospital. The facility staff paged the physician through the hospital at 12:30 a.m., 12:40 a.m. and at 12:45 a.m. the physician responded with an order to transport to the hospital.

Nurse's notes dated 8/26/06 at 9 a.m. documented per doctor's orders, facility staff conducted a gastrocult (for the presence of blood) on the resident's emesis. The test revealed the presence of blood, which staff relayed to the resident's physician.

The hospital history and physical dated 8/26/06 revealed the resident's chief complaint to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 13 vomiting. The note revealed the nursing facility staff called the physician yesterday and informed him of the resident's coffee ground emesis. The physician ordered a complete blood count which showed an elevated white blood cell count. The note documented, the physician started the resident on Phenergan suppositories and oral Prevacid and due to the elevated white blood count and it revealed the physician started the resident on Levaquin but apparently he/she had not had a dose yet. The physician's documented his impression as sepsis with leukocytosis, dehydration, chronic renal insufficiency, altered mental status due to sepsis, atrial fibrillation, diabetes mellitus, mild anemia, coronary artery disease, history of cerebrovascular accident, hypertension, congestive heart failure, chronic obstructive pulmonary disease and osteoarthritis. During interview on 9/29/06 at 8:45 a.m., the Director of Nurses said they met with the resident's family on 8/28/06 and staff were instructed to write what happened. During interview on 9/29/06 at 9:30 a.m. the facility Corporate Director of Quality Assurance said she and the consulting nurse had reviewed the resident's record and found lack of documentation. The facility started to inservice immediately. On 10/3/06 at 8:40 a.m., the facility administrator said the resident's family came in on 8/28/06 after lunch. She said they started yelling at her and she said they needed to have a meeting with nursing. The facility did a concern investigation form on 8/28/06 and called the nurses who had been working, to write statements.	{F 309}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 309}	Continued From page 14 The 2 nursing statements, written on yellow legal pads, started documentation on 8/25/06 at 3 p.m., which provided more information than contained in the resident's clinical record. On 10/2/06, the 2 nurses entered a late entry for 8/25/06 with the information from the yellow legal pads. The entry for 8/25/06 documented Staff E administered a Phenergan suppository with the resident's spouse present in the room. Staff E explained the medication may make the resident drowsy. The note documented Staff E completed an abdominal assessment with bowel sounds present, the placement of oxygen and conversation with the resident's physician regarding the oxygen and assessment findings. The note did not detail measurement of vital signs. Staff H documented reviewing a clear liquid diet with Staff E, assessing the resident's bowel sounds, pain status, skin turgor and color and laboratory findings with the physician.	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 441} SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Relates to first revisit to Complaint #8689-C: Based on clinical record review and observations, the facility staff failed with 4 of 5 treatments or dressing changes observed to use techniques to ensure the prevention of the spread of infections. The facility identified 12 resident with treatments or dressing changes, 8 of the 12 records were reviewed. Concerns with appropriate infection control technique were identified for 4 residents and 4 staff. (Residents #1, #3, #4 and #8) The facility identified a census of 100 residents. Findings include: 1. Resident #1 had, according to the minimum data set assessment dated 9/15/06, diagnoses which included diabetes mellitus and depression. The assessment documented the resident with rashes and skin desensitized to pain or pressure. According to the consultant/clinic use only sheet dated 8/29/06, the physician ordered Nivea cream to abdominal wounds 2 times a day.	{F 441}	The facility will continue to ensure that treatments for dressing changes are completed by using techniques that prevent the spread of infections. The infection control policy and procedure regarding administration of treatments were reviewed and revised. Licensed nursing staff will be re-educated on infection control issues while performing a treatment or dressing changes. The director of nursing or designee will randomly monitor nurses as they do treatments or dressing changes for 4 weeks. Ongoing monitoring will then become part the of the facility's quarterly quality assurance program	9/15/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 441}	Continued From page 16 During observation on 9/29/06 at 9:45 a.m., Staff A cleansed the resident's abdominal and back areas with gauze pad and water. Staff A lay the soiled gauze pad on the resident's bedspread. Staff A then laid the Nivea cream tube directly on the resident's bed. Staff A took the Nivea cream to the hallway and sat it on top of the universal treatment cart while she unlocked the cart and then placed the Nivea ointment tube inside the cart, in the resident's drawer. Staff placed the used gauze pads into the room trash container, but failed to empty the trash container. 2. Resident #3 had according to the MDS dated 8/4/06 diagnoses which included diabetes mellitus, cerebrovascular accident, wound infection with antibiotic resistant methicillin resistant staph. The assessment documented the resident with rashes, skin desensitized to pain or pressure and with a surgical wound. The physician's order dated 9/15/06 directed staff to keep steri strips on the left foot area, apply normal saline to sterile gauze and lightly clean area with gauze where toes had been removed, apply new Zeroform over the sutured Zeroform, apply sterile gauze and wrap with Kling daily and as needed. The order directed staff to wear sterile gloves. On 9/27/06 a fax, to the physician, documented, "clarification, do you want the staff to use sterile gloves during dressing changes of the resident's left foot post surgery? The physician responded, "yes". During observation on 9/28/06 at 3:15 p.m., Staff B proceeded to provide the resident with a dressing change to his/her left foot. Staff used	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1600 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 441}	Continued From page 17	{F 441}		

sterile gloves, as ordered. After staff removed the soiled dressing, the resident kept resting his/her foot on the metal bed cover protector. Staff B kept reminding the resident to move his/her foot from the metal bar. The metal bar failed to be a clean field.

3. Resident #4 had, according to the MDS assessment dated 8/21/06, diagnoses which included diabetes mellitus, cerebral vascular accident and antibiotic resistant infection. The assessment documented the resident with abrasions, bruises, rashes and skin desensitized to pain or pressure.

The physician order dated 9/25/06 directed staff to treat the right shin by cleansing with normal saline, dry, apply skin prep around the lesion and apply OpSite dressing.

During observation on 9/28/06 at 10:03 a.m., Staff C removed the OpSite from the 2 areas on the resident's right shin area. Staff C washed her hands, applied clean gloves and cleansed the areas with normal saline. Staff C then sat the saline bottle directly on the resident's floor. After she applied the OpSite dressing, Staff C picked the normal saline can from the floor and placed it on her clean towel area on the resident's bed. Staff removed the trash and then took the normal saline can from the towel area and placed it on top of the universal treatment cart in the hallway while unlocking the cart to place it in the resident's drawer. Staff C did not cleanse or sanitize the can prior to placing in on the treatment cart.

4. Resident #8 had, according to the hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	R-C 10/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIAN HILLS NURSING & REHAB C	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 441}	Continued From page 18 history and physical, diagnoses which included lymphoma and varicella zoster. The initial resident assessment-data collection form/initial care plan indicated the resident in contact isolation and with draining shingle areas. The form recorded an admission date of 9/8/06. On 9/22/06 the physician ordered staff to cleanse the open area on the resident's back with normal saline, apply antibiotic ointment and OpSite and check every shift and change as needed. During observation on 9/29/06 at 10:20 a.m., Staff D provided a towel for a clean field at the foot of the resident's bed by the resident's shoes which observations revealed to have debris in the crevices of the shoe soles. Staff lay the saline can of cleanser half on the towel and half on the resident's bedspread, near the soles of the shoes. Staff lay the plastic bag, for the tube of antibiotic ointment off the towel by the soles of the resident's shoes. After providing the treatment, Staff D placed the tube of ointment into the baggie and then placed the baggie and can of saline on top of the universal treatment cart while unlocking the cart. The facility's Clean Dressing Change procedure dated 3/00 directed staff to discard the bag containing dressings in an an infectious waste container, following universal precautions.	{F 441}		