STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING KCon 6/21/11 B. WING	C 06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE LIVING CENTER	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 6/17/11 Complaints #33717-C, 33565-C, and 33618-C, and a facility mandatory report #33507-M were investigated 04/07/11 to 05/09/1 and resulted in the following deficiencies. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure a resident with an identified with a medication allergy did not receive that medication for 1 of 9 residents reviewed (Resident #6). The facility reported a census of 96. Findings include. According to the Minimum Data Set (MDS) assessment, dated 03/24/11, Resident #5 scored 13 on the Brief Interview for Mental status, indicating no cognitive impairment. The MDS assessment documented the resident had diagnosis that included hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes, hyperlipidemia, arthritis, polyneuropathy and kidney disease. The Resident Admission Form dated 03/17/11 at 3:40 p.m. identified Resident #6 with allergies to	F 281	See attached	

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

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 6/20/11 VT summons

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

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F 281	Continued From page 1 Bactrim (Sulfatrimethoxazole and Trimethoprim). The Physician's Order Sheet dated 03/17/11 documented Resident #6 allergic to sulfa antibiotics. The Nurse's Notes dated 03/25/11 at 9:00 a.m. documented earlier in the shift staff contacted the physician because Resident #6 had an elevated temperature, lethargy, and urinary analysis results showed a urinary tract infection. The facility received orders for Bactrim DS 2 times a day for 1 week. Staff planned to call the physician with the culture results when receive and started the initial dose of the antibiotic. The Medication Administration Record (MAR) dated 03/17/11 to 03/31/11 listed Resident #6 allergic to sulfa antibiotics. About 1 inch above the listed allergy, the MAR contained a hand written entry dated 03/25/11 for Bactrim DS 1, 2 times a day for 1 week. The MAR documented Resident #6 received a dose on 03/25/11. A Paramedic report dated 03/25/11 documented Resident #6 as allergic to sulfa antibiotics. During an interview on 04/21/11 at 12:42 p.m. Staff C Registered Nurse (RN) stated when she gave Resident #6 the Bactrim she looked at the label on the chart that read no known allergies, and the transfer sheet. When asked about the allergies listed on the medication sheet, Staff C stated she didn't know she looked in the other 2 places. During an interview with staff at the pharmacy listed on Resident #6's MAR, a staff person	F 281		

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F 281	Continued From page 2 stated they had Resident #6 with an allergy to Bactrim. The staff person stated a notation contained the allergy. The pharmacy staff stated they called the facility and confirmed the allergy with Staff D Registered Nurse (RN). During an interview on 04/21/11 at 1:39 p.m. Staff E, RN stated when she did the admission with Resident #6, his/her family member identified his/her allergy to Bactrim. During an interview on 04/25/11 at 1:21 p.m. Resident #6's family member stated Resident #6 was allergic to Bactrim. Resident #6's family member stated he took it one time and it did not sit well with him/her, so they prescribed something else. Resident #6's family member stated he/she may have been the person who let the facility know about the allergy. The family member could not remember the exact reaction to the medication, but it was not life threatening. During an interview on 04/26/11 at 3:20 p.m. the Director of Nursing (DON) and Staff E, RN, Resident Care Coordinator (RCC) stated they were unable to find a signed physician's order for the Bactrim. Both agreed they should have checked the allergy before administering.	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309		

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F 309	Continued From page 3	F 309		

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide nursing provisions with timely assessment for one of nine residents reviewed (Resident #6) with an onset of changes in physical condition. The facility reported a census of 96.

Findings Include:

According to the Minimum Data Set (MDS) assessment, dated 03/24/11, Resident #6 scored 13 on the Brief Interview for Mental status, indicating no cognitive impairment. The MDS assessment documented the resident had diagnoses that included hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes, hyperlipidemia, arthritis, polyneuropathy and kidney disease.

A Bladder Assessment Form dated 03/17/11 documented Resident #6 continent of bladder.

The Social Service admission progress notes dated 3/17/11 documented the resident had been admitted to skilled care at the facility following a short hospital stay. The form documented the resident with diagnosis of gout and left foot non healing ulcer.
The documentation revealed the resident had been living at home prior to his/her admission and the aim was to return home with the resident's family supporting this goal.

The PRN Pain Log documented Resident #6

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F 309	Continued From page 4 complained of leg pain from 03/18/11 through 03/23/11 at 5 to 7. On 03/24/11 at 12:30 a.m. and again on 03/24/11 at 7:35 a.m. Resident #6 complained of back pain at 10. A Pain Screen form showed a numerical scale of 0 indicating a smiley face and 10 a sad, crying face. The Nurse's Notes dated 03/24/11 at 9:15 a.m. documented Resident #6 complained of lower back pain. Staff noted a strong urine odor in the room. Resident #6 demonstrated incontinence of urine during the 10-6 shift. Staff encouraged fluids, contacted the physician for a possible urine specimen, received an order for a urine analysis (UA) for culture and sensitivity, and informed the family. Resident #6's lungs sounded clear. Resident #6 made no complaints of foot pain, but stated having back pain at 10. Resident #6 received pain medication. Resident #6 fed him/herself breakfast in bed with an appetite at 100%. His/her temperature registered at 98.6, pulse at 74, respirations at 20, and blood pressure of 126/76. At 10:00 p.m. Resident #6 had large diarrhea. Staff noted medicating the resident twice and since taking Immodium on or around 4:00 p.m. Resident #6 had no further episodes of diarrhea. His/her temperature registered at 97.3, pulse at 88, respirations at 20, and blood pressure of 130/82. The document revealed Resident #6 did not appear as jovial as seen on other days. The nurse suspected dehydration and persuaded the resident to drink plenty of fluids. Resident #6 did not eat supper. The Resident Care Coordinator (RCC) and nurse agreed they would monitor and probably contact the physician 03/25/11 if the	F 309		

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F 309	Continued From page 5 resident did not regain his/her usual strength. Resident #6 could speak, but staff noted lethargy. His/her lung sounds were clear to auscultation, bowel sounds with hyperactivity, and skin warm, pale and dry. Staff informed a family member about Resident #6's status and agreed with the plan to seek physician intervention if his/her current status did not improve. Resident #6 went to bed at 10:00 p.m. The clinical record lacked any assessment of Resident #6 throughout the night shift. The Nutritional Assessment dated 03/22/11 documented Resident #6's estimated fluid needs at 2,200 cubic centimeters (cc's) per day. The clinical record lacked any indication of Resident #6's fluid intakes. The Food/Fluid Intake log contained no entries. The Nurse's Notes dated 03/25/11 at 9:00 a.m. documented earlier in the shift staff contacted the physician because Resident #6 had an elevated temperature, lethargy, and the UA results showed a urinary tract infection. The facility received orders for Bactrim DS 2 times a day for 1 week. Staff planned to call the physician with the culture results when received and they started the initial dose of the antibiotic. Fluids were encouraged and cranberry juice given. Staff contacted the family with the new orders. Resident #6 had a temperature of 99.6 degrees, a pulse of 116, respirations of 20, and blood pressure of 150/52. Resident #6 needed assistance with eating. Staff contacted the physician's office with a condition update and received orders to transfer Resident #6 to the hospital. The RCC notified the family.	F 309		

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F 309	Continued From page 6 At 9:30 a.m. the ambulance transferred the resident to the emergency room. The resident's family member rode along. At 1:00 p.m. the facility found out Resident #6 admitted to the hospital. A Paramedic report dated 03/25/11 documented they dispatched a medic for an emergent transfer of a patient who staff believed to be septic. The report noted Resident #6 as allergic to sulfa antibiotics. The report documented Resident #6 had warm skin and delayed capillary refill. An electrocardiogram showed sinus tachycardia. A History and Physical dated 03/25/11 documented Resident #6 was febrile on arrival to the emergency room and significantly hypotensive. They started Resident #6 on intravenous fluid boluses and Dopamine for pressure support. The report documented the resident started having some right-side back pain and it had been getting worse in the last couple of days, and he/she had some sweats, chills and felt a little dizzy. The physical examination revealed Resident #6's vital signs: temperature 101.4 degrees, pulse 106, respirations 20, and blood pressure initially 82/32. Resident #6 presented a little somnolent and had dry oral mucosa. The impression included: a. Sepsis. b. Probable right pyelonephritis (kidney infection). c. Urinary tract infection. d. Hyponatremia (low sodium). e. Hypokalemia (low potassium). f. Dehydration. The hospital records identified the resident had	F 309		

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F 309	Continued From page 7 the principal diagnose of severe sepsis syndrome, severe hypotension and respiratory failure. The hospital record identified the resident died on 4/8/11. The Nurse's Notes dated 03/30/11 at 5:00 p.m. documented a late entry for 03/24/11 at 10:00 p.m. The note documented staff assumed the shift from the evening nurse. He was informed if Resident #6's condition changed and he thought Resident #6 should go to the hospital, the family wanted that. He asked the evening shift nurse if Resident #6 had been that way, and they told him yes. So during the shift they checked on Resident #6 multiple times and he/she demonstrated confusion. Staff offered Resident #6 cares and fluids when checked on. The nurse did not see a change of condition with Resident #6 on the shift. The nurse reported off to the day shift and if Resident #6 needed to go to the hospital, to send him. Resident #6's status remained the same all shift, confused, but able to answer questions and receptive to fluids. Resident #6's status stayed the same for the nurse all shift. The late entry contained no vital sign measurement or physical assessment of the resident. During an interview on 04/21/11 at 12:42 p.m. Staff C, RN (registered nurse) stated Resident #6 drank well on 03/24/11. Staff C called the physician on 03/25/11 because the UA returned abnormal, and he/she had a low grade temperature. Staff C stated she did not take another set of vital signs before Resident #6 left in the ambulance. Staff C stated she received no report about Resident #6's condition the previous evening from the night nurse.	F 309		

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F 309	Continued From page 8 During an interview on 04/25/11 at 12:50 p.m. Resident #6's spouse stated he/she visited Resident #6 the day before the hospitalization. Resident #6's spouse stated the resident's back hurt and he/she did not eat or drink anything for lunch. Resident #6's spouse left around 3:30 p.m. and stated they did not call him/her that evening, and they could have called any time. During an interview on 04/25/11 at 1:21 p.m. Resident #6's family member stated she usually went to the facility in the evenings, but did not the evening of 03/24/11. The family member stated the nurse called him/her and said if Resident #6's condition did not change by the next day they would send him/her to the hospital for intravenous fluids. The family member stated he/she asked if she should go to the facility or call Resident #6's spouse, and the nurse stated it was not necessary. The family member stated if she had known Resident #6's condition he/she would have gone to the facility. On 05/09/11 at 8:42 a.m. the Physician's office manager stated the Physician was not aware of Resident #6's condition the evening before the hospitalization on 03/25/11. During an interview on 05/26/11 at 6:02 p.m. Staff N, Licensed Practical Nurse (LPN) stated on 03/24/11 he received report on Resident #6. The resident developed confusion either on the day or the evening shift. Staff were monitoring his/her condition, and were to send Resident #6 to the hospital if he/she had a significant change in condition. Staff N stated he was in Resident #6's room at least 2 times during the shift. He assisted with Resident #6's cares and spent a	F 309		

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F 309	Continued From page 9 few minutes talking with him/her to assess mental status. Since they were concerned about dehydration, they made sure to offer him/her fluids at each round. Staff N saw him drink from his/her water pitcher 2 times. He did not know how much s/he consumed and they did not keep outputs. Staff N stated they were not very good with intakes and outputs (I & Os). Staff N stated Resident #6's status remained the same throughout the shift. He stated maybe he should have checked Resident #6's vital signs. When discussing Resident #6's vital signs taken by the day nurse showing an elevated temperature and tachycardia, Staff N admitted he would not know if Resident #6's vital signs changed on his shift without checking them. Staff N stated he definitely should have documented on his shift. A CNA did rounds every 2 hours and did not report any problems. When asked if there were other things he should have assessed with the resident's change of condition, Staff N could not think of anything right then, but stated they now have cards with information on what to document on. He did not know if they were there before. During an interview on 04/21/11 at 2:05 p.m. the Administrator stated the night shift nurse received disciplinary action regarding the lack of an assessment on Resident #6 the night shift of 03/24/11-03/25/11. The Administrator stated they expected a resident with a change of condition would be assessed.	F 309		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days	F 387		

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F 387	Continued From page 10 thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a resident saw the physician at least every 30 days for the first 90 days after admission for 1 of 2 residents reviewed (Resident #4) for physician visits. The facility reported a census of 96. Findings include: According to the Minimum Data Set (MDS) assessment dated 02/07/11, Resident #4 had diagnoses that included gastroesophageal reflux disease, dementia, Down's syndrome, epilepsy and legal blindness. The assessment documented the resident entered the facility on 02/01/11. A Physician's Telephone Order dated 02/03/11 directed the resident have a 60-day appointment at 1:40 p.m. on 04/19/11. The order directed the 30 and 90 day visits would be done by another physician on rounds. The Physician's Orders of 02/10/11 documented new admitted or re-admitted residents must be seen every 30 days for the 1st 90 days. The clinical record lacked record of a Physician visit in the first 30 days of Resident #4's	F 387		

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F 387	Continued From page 11 admission. The Nurse's Notes dated 04/06/11 at 2:45 p.m. documented the doctor's office called and needed to see Resident #4. The physician did not see Resident #4 on rounds when visiting a few weeks prior. They scheduled an appointment for 04/13/11. An Office Visit/Communication form dated 04/13/11 documented Resident #4 had not been seen since admission over 2 months ago. During an interview on 04/21/11 at 11:50 a.m. the Director of Nursing (DON) stated Resident #4 was supposed to be seen by the physician when she did rounds 03/15/11, but for some reason she wasn't on the list brought by the physician, and not seen. When the facility realized the resident had not been seen, they called the physician's office and made the next available appointment on 4/13/11, or 71 days after admission.	F 387		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public, related to pets	F 465		

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F 465	Continued From page 12	F 465		

in the facility. The facility identified a census of 96.

Findings include:

During an observation on 04/13/11 at 5:01 p.m. 3 dogs were noted in the facility: a large black (lab) dog, a small black (dachshund) dog, and a short, round dog (corgi, a staff member's dog). At 5:20 p.m. observation revealed the black lab walked into the dining room during the evening meal. A resident yelled at the dog to "Get outside" and the dog left.

During an interview on 04/20/11 at 6:25 p.m. Staff F Certified Nursing Assistant stated the dogs pee on the floor. Staff F stated they have to take care of the dogs when the residents need assistance.

During an interview on 04/20/11 at 6:35 p.m. Resident #10 stated a dog barks all the time and is all over, even in the dining room.

During an interview on 04/20/11 at 6:43 p.m. Resident #11 stated the little dog barks quite loud, goes to the toilet on the floor leaving urine and feces. The resident then called a family member who stated over the phone that big dog growled and nipped at his girls when they approached it.

During an interview on 04/21/11 at 6:52 p.m. Resident #13 stated the little dog goes on the floor all the time.

During an interview on 04/21/11 at 6:59 p.m. Resident #14 stated the dog barks loudly and s/he had seen dog urine and feces on the floor.

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 _____	C 06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE LIVING CENTER	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 465	Continued From page 13 During an interview on 04/26/11 at 8:10 a.m. Resident #15 stated s/he didn't have much interaction with the dogs. Resident #15 stated s/he did not like the barking all the time. Resident #15 stated the dogs run through the dining room while they eat, but s/he did not mind if they didn't come to the table. During a group interview on 04/26/11 at 10:42 a.m. with 7 residents the facility identified as interviewable, 5 residents stated the dogs' barking as a concern. One resident stated they bark at 5:00 a.m. Another resident stated s/he woke up real easy and heard the little dog bark. The group stated the dogs would sniff around the dining room, but staff tried to take them out. One resident stated seeing urine and feces on the floor in the rehabilitation room. Another resident stated seeing the little dog toilet on the floor multiple times and the big dog once. The residents denied an odor problem. During an interview on 04/21/11 at 2:20 p.m. Staff G, housekeeping leader stated Staff H did A hall. Staff G stated she heard once in awhile the dog urinated on the carpet. Staff G stated when she knew about it she immediately went to clean it up, using 256 cleaner. Staff G stated if feces is on the floor, she wiped it up, sprayed the area, and shampooed the area. Staff G was unsure what they did at night if the dogs toileted on the floor. Staff G stated the dogs toileted on A hall, the front hall and once in awhile on G hall. Staff G stated housekeeping staff had responsibility for taking the dogs out at 2:00 p.m. A Material Safety Data Sheet identified 256 as a	F 465		

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	165161	A. BUILDING _____ B. WING _____	C 06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE LIVING CENTER	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 465	Continued From page 14 disinfectant cleaner. During an interview on 04/21/11 at 2:34 p.m. Staff H stated she had cleaned up puddles of urine from the carpet and the vinyl floor and she sprayed and then shampooed the area. After shampooing, they had to get the dryer out. Staff H stated the previous day they found feces by the nurse's station. She didn't know how long it had been there; they found it when they came in to work. An Incident Report dated 04/18/11 at 1:00 p.m. documented a visitor tried to catch the little dog outside and the dog bit him/her, with no injury. During an interview on 04/21/11 at 8:28 a.m. the Administrator in training stated the facility had not had the dogs very long and they had all their shots (she provided vaccination certificates). The Administrator stated the little dachshund had recently been fixed and since then she had been barking more. They were kind of waiting to see what happened with that. Otherwise they had had no complaints about the dogs. The Administrator stated she was not aware the little dog had been toileting on the carpet in A hall. She stated they do have a plan in the care of the dogs, including housekeeping. She also stated they assigned a staff member to keep the dogs out of the dining room. During further interview on 04/26/11 at 12:05 p.m. the Administrator stated she did not know they needed Department approval for pets in the facility.	F 465		

F000
Preparation of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.

Subject to and without waiving the facility's right to formally or informally appeal this deficiency, the following is the facility's Plan of Correction.

F281-Allergy
483.20(k)(3)(i)
Correct Deficiency as they relate to the individual
Resident #6 died in hospital.

Protect Residents in Similar Situations
All residents will be assured of not receiving a medication that has been identified as an allergy. Allergies are double checked by two nurses upon admission.

Systems we will alter to assure the problem does not recur
Admissions nurse will check allergies and admission orders. Charge nurse will check all allergies and admission orders. RCC or DON designee will check allergies and admission orders.

Plan to monitor performance to make sure that solutions are permanent
All medication errors are monitored during daily QA.

Date of Correction: June 17, 2011

Mrd 6/16/11

F309-Assessments
483.25
Correct Deficiency as they relate to the individual
Resident #6 died in hospital.

Protect Residents in Similar Situations
All residents receive timely assessments which are documented in the resident chart.

Systems we will alter to assure the problem does not recur
On 5/18/11 all nursing staff were educated at an in-service regarding standards of practice for Assessments and Documentation. Professional materials are in place at each nurse's station that nurse's can refer to when documenting on resident's acute condition.

Plan to monitor performance to make sure that solutions are permanent
Daily charting audits will be completed on residents with a significant change in condition for one month. Random chart audits will be completed and monitored at daily QA.

Date of Correction: June 8, 2011

F387-Physician Visits
483.40(c)(1)-(2)
Correct Deficiency as they relate to the individual
Resident #4 was to be seen by the physician on 3/15/11. Resident #4 was seen by his/her physician on 4/19/11.

Protect Residents in Similar Situations
Residents are seen by a physician at least every 30 days for the first 90 days after admission. Upon admission the charge nurse determines physician visits required and places the resident's name on the physician visit schedule.

Systems we will alter to assure the problem does not recur
A list of resident names will be provided to the attending physician or physician representative when they arrive at the facility to complete rounds. The list will also be verified by the physician's office.

Plan to monitor performance to make sure that solutions are permanent
Nurse educator will assume monitoring of scheduled physician rounds.

Date of Correction: June 17, 2011

F465-Pets
483.70(h)
Correct Deficiency as they relate to the individual
Residents #10, #11, #13, #14, and #15 are provided with a safe, sanitary, and comfortable environment.

Protect Residents in Similar Situations
All residents are provided with a safe, sanitary and comfortable environment.

Systems we will alter to assure the problem does not recur
The small dog that was barking and experienced frequent toileting has been removed from the facility. The large dog will be taken out of the facility overnight so as not to interrupt the residents during sleeping hours. The facility received approval from the Department of Inspections and Appeals on 4/26/11 to have pets in the home.

Plan to monitor performance to make sure that solutions are permanent
Environmental issues will continue to be monitored during daily QA.

Date of Correction: June 17, 2011

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 165161	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/1/2011
NAME OF PROVIDER OR SUPPLIER **TOUCHSTONE LIVING CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **1800 INDIAN HILLS DRIVE SIOUX CITY, IA**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to maintain a complete record for 1 of 9 residents reviewed (Resident #6). The facility reported a census of 96.

Findings include:

According to the Minimum Data Set (MDS) assessment, dated 03/24/11, Resident #5 scored 13 on the Brief Interview for Mental status, indicating no cognitive impairment. The MDS assessment documented the resident had diagnosis that included hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes, hyperlipidemia, arthritis, polyneuropathy and kidney disease.

The Nurse's Notes dated 03/25/11 at 9:00 a.m. documented earlier in the shift, staff contacted the physician because Resident #6 had an elevated temperature, lethargy, and urinalysis results showed a urinary tract infection. The facility received orders for Bactrim DS 2 times a day for 1 week. Staff planned to call the physician with the culture results when received and they started the initial dose of antibiotic. Staff also encouraged fluids and gave cranberry juice. Staff contacted the resident's family with the new orders. Resident #6 had a temperature of 99.6 degrees, pulse of 116, respirations of 20, and blood pressure of 150/52. Resident #6 needed assistance with eating. Staff contacted the physician's office with a condition update and received orders to transfer Resident #6 to the hospital. The RCC notified the family. At 9:30 a.m. the ambulance transferred the resident to the emergency room. The resident's family member rode along. At 1:00 p.m. the facility found out Resident #6 admitted to the hospital.

A History and Physical dated 03/25/11 documented Resident #6 was febrile on arrival to to the emergency room and significantly hypotensive. They started Resident #6 on intravenous fluid boluses and medication for pressure support. The physical examination revealed Resident #6's vital signs measured a temperature of 101.4 degrees, a pulse at 106, respirations at 20 and an initial blood pressure of 82/32. Resident #6 presented a little somnolent and had dry oral mucosa. The impression included:

a. Sepsis.
b. Probable right pyelonephritis.
c. Urinary tract infection.
d. Hyponatremia.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 165161	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/1/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE LIVING CENTER	1800 INDIAN HILLS DRIVE SIOUX CITY, IA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	Continued From Page 1 e. Hypokalemia. f. Dehydration. The clinical record lacked a Transfer Form from the facility to the hospital. During an interview on 04/26/11 at 12:05 p.m. the Administrator stated they did not keep a copy of transfer forms when residents transferred to the hospital and they were unable to retrieve the transfer form from the hospital.