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 _____	09/13/2012

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 The following deficiencies are the result of the facility's annual health survey conducted 9/10-9/13/2012. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C. Correction date 10/4/12	F 000		
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on facility record review, the facility failed to assure they had enough money in the surety bond to protect the facility's residents monies if misappropriated. The facility had a census of 93. Findings include: 1. The review of the facility's surety bond dated 2/7/12 revealed the facility had been insured for $10,000 to cover the residents trust fund. The review of the totals of the trust fund as of 9/10/12 included $10,518.21. The sum of the monies in the trust fund on 7/31/12 totaled $11,684.91.	F 161	See attached	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	F 248		

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 10/9/12 VS

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 _____	09/13/2012

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 248	Continued From page 1	F 248		

the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on clinical and facility record review and staff interview, the facility failed to develop a comprehensive activity program to meet the needs, interests, physical, mental and psychosocial well-being for 3 of 16 current residents sampled (Residents #5, #6, and #7). The facility reported a census of 93 residents.

Findings include:

1. The facility diagnosis detail report dated 8/24/12 identified Resident #5 with diagnoses of anxiety, urinary retention, altered mental status, delusional disorder, dementia, depressive disorder, and chronic airway obstruction.

The activities progress note dated 9/5/12 documented a quarterly assessment. The resident continued to reside on the memory care unit of the home, propelled him/herself in the wheelchair and would like to walk more. Staff planned to continue to invite Resident #5 to activities including going outside and dog pet therapy.

The August 2012 activity calendar identified the resident participated in the following activities:
a. One day of ball toss.
b. One to one visit twice.
c. Guest three days.
d. Outside one day.
e. Snack one day.

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 _____	09/13/2012

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 248	Continued From page 2	F 248		

f. Cards one day.

The July 2012 activity calendar identified the resident participated in the following activities:
a. Guest three days.
b. One to one visit six days.
c. Social two days.

The resident went outside only once in 2 months, even though staff documented this as a goal. The resident received no pet therapy visits during July or August. The activity progress notes and documentation lacked individualized activity goals, methods of measurement for activity completed, and one to one topics with measurable outcomes.

2. The Minimum Data Set (MDS) Assessment Tool dated 9/11/12 identified Resident #6 with diagnoses of Alzheimer's disease, heart failure and insomnia.

The activities progress note dated 5/21/12 documented an admission note. The resident admitted into the memory care unit, did not communicate much other than a few words and had gotten physically aggressive with both family and staff. The resident had a T.V. but did not engage in it. The resident did not verbalize any preference for activities or really anything else.

The clinical record lack a quarterly progress note for the month of August 2012.

The August 2012 activity calendar identified the resident participated in the following activities:
a. One day of ball toss.
b. One to one visit once.

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 _____	09/13/2012

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 248	Continued From page 3	F 248		

c. Guest two days.
d. Ring toss six days.
e. Snack two days.
f. Social hour two days.
g. Movie one day.

The July 2012 activity calendar identified the resident participated in the following activities:
a. Ball toss three days.
b. Movie one day.
c. Social one day.
d. Puzzle one day.

The activity progress notes and documentation lacked individualized activity goals, methods of measurement for activity completed, and one to one topics with measurable outcomes.

3. The MDS Assessment Tool dated 7/15/12 identified Resident #7 with diagnoses of Non-Alzheimer's disease, hypertension, and thyroid disease.

The activities progress note dated 8/8/12 documented an admission note. The resident moved to the secured memory care unit shortly after arriving at the facility. He/she is confused and not oriented to time and place. He/she wanders, self ambulating in his/her wheelchair. The resident participated in some group activities but he/she did not hold attention very long and/or wandered.

The activity progress notes and documentation lacked individualized activity goals, methods of measurement for activity completed and one to one topics with measurable outcomes.

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 _____	09/13/2012

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 248	Continued From page 4 During an interview on 9/13/12 at 10:05 a.m. the Activity Director reported that they are working on individualized activities. She reported that the memory loss unit does not have an activity calendar specified for those residents. She reported that some residents that live on the memory care unit come off the unit for other activities.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, as staff interview, the facility failed to develop comprehensive care plans for 1 of 16 residents	F 279		

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 _____	09/13/2012

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 279	Continued From page 5	F 279		

sampled (Resident #5). The facility reported a census of 93 residents.

Findings include:

1. The facility diagnosis detail report dated 8/24/12 identified Resident #5 with diagnoses of anxiety, urinary retention, altered mental status, delusional disorder, dementia, depressive disorder, and chronic airway obstruction.

The Minimum Data Set (MDS) Assessment Tool dated 8/21/12 identified Resident #5 with weight loss of 5 percent or more in the past month or 10 percent in the past 6 months. The document identified the weight loss as not prescribed (or planned) by the physician. The assessment also documented the resident received antianxiety medications for 2 of 7 days of the assessment period and antidepressent medications for 7 of 7 days of the assessment.

The Medication Administration Record (MAR) for September 2012 identified the following psychotropic medications administered:
a. Zoloft (anti-depressant) 25 mg every day.
b. Ativan (anti-anxiety medication) 0.5 mg 1 - 2 tablets by mouth as needed.

The care plan dated 8/30/12 lacked interventions for Resident #5's altered nutritional status, psychotropic medications and depression, anxiety and/or an altered mood state.

During an interview on 09/12/12 at 4:45 p.m. Staff C, Resident Care Coordinator, reported the care plans were a work in progress with identification in all care related areas.

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 _____	09/13/2012

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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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:
Based on clinical record review and staff interview, the facility failed to perform a complete assessment following administration of a new medication for 1 of 16 current residents reviewed (Resident #7). The facility reported a census of 93 residents.

Findings include:

1. The Minimum Data Set (MDS) Assessment Tool dated 7/15/12 identified Resident #7 with diagnoses of non-Alzheimer's dementia and thyroid disorder.
The assessment documented the resident had fluctuating inattention and disorganized thinking during the assessment period. The assessment did not document the presence of behavioral symptoms.

Nurse's notes dated 7/11/12 at 1:30 a.m. documented staff gave the resident Tylenol 650 milligrams for low grade fever of 99.1 degrees Fahrenheit. Staff documented Resident #7 as warm to the touch. At 3:00 a.m. staff noted him/her crying, wanting to call dad and upset

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 _____	09/13/2012

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 309	Continued From page 7	F 309		

about having alarms on. At 5:00 a.m. resident continued anxious behavior and refused to lay down. The resident stated the feeling of being held here and wanting to leave. The facility received a phone call from the local sheriff's department, stating a resident had called them. Staff spoke with resident and confirmed s/he called the police so they can come pick him/her up. Staff attempted to redirect the resident with little effect and faxed doctor for prn (as needed) Ativan (anti-anxiety medication) order.

A physician order dated 7/11/12 documented Lorazepam (Ativan) 0.5 milligrams 1 tablet 3 times daily.

The nurse's notes dated 7/12 through 7/14/12 lacked follow up documentation for positive or negative effects and side effects for administration of a new medication Ativan 0.5 milligrams 3 times a day.

During an interview on 9/12/12 at 4:45 p.m. Staff C, Resident Care Coordinator, confirmed the lack of follow up documentation.

F 371 SS=F 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY — F 371

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

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 _____	09/13/2012

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 371	Continued From page 8	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation, facility record review and staff interview, the Dietary Department failed to maintain clean storage for food items, sanitizable cooking pans and proper food temperatures on the salad bar. The facility identified a census of 93 current residents.

Findings include:
1. An observation on 9/10/12 at 11:10 AM, during the initial tour of the Dietary Department, with the FSS (Food Service Supervisor) revealed the following concerns:

a. 18 packages of Hamburger buns stored on the floor in the dry storage room
Industrial floor mixer with dried on food debris near the surface of the beater attachment
b. 10 full sheet pans with black brown grease build-up on the cooking surface

2. Observation on 9/11/12 at 12:25 PM, during the serving of the noon meal revealed a self serve salad bar in the main dining room. Staff A, Cook, measured the temperature of the following items which revealed:

a. Potato salad at 45.9 degrees Fahrenheit
b. Cottage cheese at 45.3 degrees Fahrenheit
c. Shredded cheese at 43.7 degrees Fahrenheit
d. Chicken chunks at 45 degrees Fahrenheit
e. Coleslaw at 44.6 degrees Fahrenheit
f. Milk at 46.9 degrees Fahrenheit.

Review of the policy titled, Guidelines for Food Temperatures dated 2009 revealed direction in

STATEMENT OF DEFICIENCIES AND PLAN DF CDRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CDNSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	09/13/2012

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 371	Continued From page 9 part that ...Cold food should be held at or below 41 degrees F. During an interview on 9/11/12 at 12:25 PM, Staff A, cook acknowledged the salad bar and milk temperatures measured high and added salad bar temperatures are not measured. During an interview on 9/11/12 at 1:00 PM, the Consultant Dietitian and Food Service Supervisor stated that dietary staff failed to measure salad bar temperatures.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	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 _____	09/13/2012

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 441	Continued From page 10	F 441		

from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, the facility failed to ensure linen remained free of potential spread of infection within the facility. The facility reported census of 93 residents.

Findings include:

1. During environmental tour on 7/12/12 at 1:38 a.m. revealed two fans in the clean side of the laundry room in operation.. Observation revealed a large industrial size machine on and blowing air toward the clean side of the laundry. The fan contained heavy amounts of dust on the blades, front part of fan cover, and also the back of the fan cover. Strings of dust hung from the front cover.

A second fan, a Lasko, fan was in operation and blew air onto the clean side of the laundry room. The fan contained a heavy amount of dust and debris on the blades and heavily coated on the fan covers. Observation revealed hung from the

STATEMENT OF DEFICIENCIES AND PLAN DF CDRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	09/13/2012

NAME OF PRDVIDER 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 CDRRECTIVE ACTION SHOULD BE CRDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 cDver of the fan.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and cDmfDrtable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, the Dietary Department failed to maintain a clean and sanitary environment. The facility identified a census of 93 current residents. Findings include: An observation on 9/10/12 at 11:10 AM, during the initial tour of the Dietary Department, with the FSS (Food Service Supervisor) revealed the following concerns: a. The industrial floor mixer with dried on food debris near the surface of the beater attachment; b. The oven hood's removable vents contained a moderate amount of black brown greasy lint debris; c. The convection oven front and edge meeting door contained a large amount of black brown grease build-up.	F 465		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CDRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	09/13/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT DF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 12 accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on review of facility records and staff interview, the facility failed to ensure that all staff completed the Adult Abuse Mandatory Training within 6 months of hire as required by state regulations for 1 of 8 staff members reviewed (Staff B). The facility identified a census of 93. Findings include: Review of the Employee Contact List for all new employee since the last annual survey revealed Staff B, CNA (certified nursing assistant) with a hire date of 10/31/11. Review of Staff B's employee file revealed she did not have a certificate of completion for Mandatory Adult Abuse Training within 6 months of her date of hire as required. Interview with the Administrator on 9/11/12 at 2:30 PM revealed she became aware of the lack of the Mandatory Adult Abuse Training when she pulled the records for the survey and reviewed them prior to giving them for review.	F 492		

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.

F 167—Surety Bond

Correct Deficiency as they relate to the individual

Resident funds deposited with the facility are secured with a surety bond of $20,000.

Protect Residents in Similar Situations

Resident funds deposited with the facility are secured with a surety bond of $20,000.

Systems we will alter to assure the problem does not recur

The surety bond amount was increased from $10,000 to $20,000.

Plan to monitor performance to make sure that solutions are permanent

Monthly, the business office manager, or designee, will provide a resident trust fund balance to the administrator. The administrator, or designee, will ensure that the balance amount is less than the amount in the surety bond.

Date of Correction: 10/4/12

F 248—Activities

Correct Deficiency as they relate to the individual

A comprehensive activity program that meets the needs of Residents 5, 6, and 7 is developed.

Protect Residents in Similar Situations

A comprehensive activity program that meets the needs of all residents is developed.

Systems we will alter to assure the problem does not recur

A ½ time activity person was hired devoted solely to the residents in the Memory Care neighborhood. She will develop daily activities specific for individuals in the Memory Neighborhood. An Activity Calender is developed for individuals in the Memory Neighborhood. A separate activity calendar is developed for the rest of the home. The 2 full time activity coordinators will devote time to the rest of the home. They are to develop personal care plans to meet the activity needs of the rest of the residents in the home.

Plan to monitor performance to make sure that solutions are permanent

Activity director will complete quarterly audits on resident activity records to ensure that the needs of residents are met.

Date of Correction: 10/4/12

F 279-Care Plans

Correct Deficiency as they relate to the individual

A comprehensive care plan is developed for resident 5.

Protect Residents in Similar Situations

A comprehensive care plan is developed for all residents.

Systems we will alter to assure the problem does not recur

The care plan for resident 5 is updated to provide proper interventions for altered nutritional status, psychotropic medications and depression, anxiety, and altered mood state. Staff members who write care plans have been educated on care plan documentation and proper interventions on 9/26/12.

Plan to monitor performance to make sure that solutions are permanent

The Director of Nursing will perform monthly audits on 5 random resident care plans for 6 months.

Date of Correction: 10/4/12

F 309-Assessments

Correct Deficiency as they relate to the individual

A complete assessment is completed following administration of a new psychotropic medication for resident 7.

Protect Residents in Similar Situations

Weekly, x3 weeks following a new psychotropic medication, an assessment will be completed in regards to the resident's response to the new psychotropic medication.

Systems we will alter to assure the problem does not recur

Nursing staff members were educated on 9/28/12 regarding follow up documentation for positive or negative effects for administration of a new psychotropic medication.

Plan to monitor performance to make sure that solutions are permanent

DON or designee will audit documentation for effects of administration of a new psychotropic medication one time a week for 3 weeks and monthly for 6 months.

Date of Correction: 10/4/12

F 371—Sanitary Food, temps

Correct Deficiency as they relate to the individual

The storage room for food items is clean. The cooking pans are sanitizable. The food on the salad bar is of proper temperature.

Protect Residents in Similar Situations

The storage room for food items is clean. The cooking pans are sanitizable. The food on the salad bar is of proper temperature.

Systems we will alter to assure the problem does not recur

Hamburger bun packages are removed from the floor. Floor mixer is clean. Non-sanitizable pans have been replaced with sanitizable pans. A staff in-service was held 9/26/12 regarding food temps on the salad bar, storage of food, and maintenance of a clean food storage.

Plan to monitor performance to make sure that solutions are permanent

Dietary walk through by the Registered Dietician or designee to monitor food temperature tracking will occur weekly for 4 weeks. Weekly kitchen environmental audits will be performed to assure cleaning compliance.

Date of Correction: 10/4/12

F 441—Clean Linens

Correct Deficiency as they relate to the individual

Linen is free of potential spread of infection.

Protect Residents in Similar Situations

Linen is free of potential spread of infection.

Systems we will alter to assure the problem does not recur

The two fans in the laundry room are cleaned weekly. Staff members were educated on the cleaning schedule of the fans on 9/13/12.

Plan to monitor performance to make sure that solutions are permanent

A weekly environmental walk through by the Housekeeping Supervisor will ensure that the cleaning schedule is followed.

Date of Correction: 10/4/12

F 465—Sanitary Kitchen

Correct Deficiency as they relate to the individual

The industrial floor mixer is clean and free of debris. The oven hood's removable vents are free of grease and debris. The convection oven is free from grease build up.

Protect Residents in Similar Situations

The industrial floor mixer is clean and free of debris. The oven hood's removable vents are free of grease and debris. The convection oven is free from grease build up.

Systems we will alter to assure the problem does not recur

Daily monitoring of kitchen cleanliness will be performed by the cooks and dietary supervisor. A staff in-service was held 9/26/12 regarding cleaning lists that need to be followed.

Plan to monitor performance to make sure that solutions are permanent

Weekly kitchen environmental audits will be performed to assure cleaning compliance.

Date of Correction: 10/4/12

F 492—Abuse Training

Correct Deficiency as they relate to the individual
Staff B received Mandatory Adult Abuse Training on September 27, 2012.

Protect Residents in Similar Situations
All staff members have completed the Adult Abuse Mandatory training within 6 months of hire.

Systems we will alter to assure the problem does not recur
Education was provided to the Staff Education Coordinator on 9/12/12 regarding the state requirement.

Plan to monitor performance to make sure that solutions are permanent
Human resource assistant will print off a new employee list monthly and give to the education nurse. Education nurse will check that all have received proper training within 6 months of hire.

Date of Correction: 10/4/12