| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 165161 | A. BUILDING _____ B. WING 12K on 5/9/13 | C 04/19/2013 |

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| 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 |
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| F 000 | INITIAL COMMENTS<br><br>Correction Date 5/6/13<br><br>Facility-reported incidents # 43287-I and # 43028-I and complaint # 43353-C were investigated on 3/26 to 4/19/13 and resulted in the following deficiencies. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, clinical record review and staff interview, the facility failed to assure a resident with a catheter received appropriate care to minimize the chance for infection for 1 of 3 catheterized residents reviewed (Resident #7). The facility reported a census of 104.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) assessment dated 2/5/13, Resident #7 had diagnoses that included spinal stenosis. The | F 315 | | |

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

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| F 315 | Continued From page 1 | F 315 | | |

assessment documented the resident required extensive assistance with activities of daily living (ADLs) including toilet use and personal hygiene. The MDS documented Resident #2 had a urinary catheter.

The Resident Care Plan dated 6/7/12 listed Resident #7's diagnoses included a history of urinary tract infection and identified Resident #7 with urinary retention and an order for a catheter. Resident #7 could get infections from the catheter. The approaches included:
a. Please take care of the catheter as needed.
b. Please empty the catheter bag each shift and as needed.
c. Please watch for signs of infection.

During an observation on 4/17/13 at 2:38 p.m. Resident #7 sat in his/her recliner with the feet up. The catheter bag and tubing laid on the floor. At 3:37 p.m. observation revealed the catheter bag hooked to the footrest of the recliner with the bottom of the bag touching the floor.

During an observation on 4/18/13 at 7:56 a.m. Resident #7 sat in the wheelchair in his/her room. The catheter bag was off the floor, but the catheter tubing touched the floor.

During an observation on 4/19/13 at 10:00 a.m. Resident #7 sat in the recliner with the catheter bag hooked to the recliner pocket, but resting on the floor. The Administrator came to the room and confirmed the catheter bag rested on the floor. The Administrator stated the catheter bag and tubing should be kept off the floor to help prevent infection.

F 323 483.25(h) FREE OF ACCIDENT — F 323

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| F 323 SS=G | Continued From page 2<br>HAZARDS/SUPERVISION/DEVICES | F 323 | | |

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to direct nursing services to ensure Resident #2 received adequate supervision against hazard and failed to develop care plan directives to meet his/her safety needs. The facility reported a census of 104 residents with four residents review.

Findings include:

According to the Minimum Data Set (MDS) assessment, dated 1/08/13, Resident #2 demonstrated long and short term memory problems and moderately impaired skills for daily decision making. Resident #2 showed inattention, difficulty focusing attention (easily distracted, out of touch or difficulty following what was said), and disorganized thinking. Resident #2 required extensive assistance of one staff for activities of daily living (ADL's) including bed mobility, transfer, ambulation, dressing, and toilet use. Resident #2's balance during transition and walking identified he/she was not steady able to stabilize with assistance when moving from a seated to a standing position when walking; when

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| F 323 | Continued From page 3 | F 323 | | |

turning around; when moving on and off the toilet; and when adjusting to surface to surface transfer (transfer between bed and chair or wheelchair). Resident #2's diagnoses included non-Alzheimer's dementia, anxiety disorder and depression. Resident #2 had 1 fall without injury since the prior assessment.

A Fall Risk Assessment dated 1/03/13 scored Resident #2 at 16, with a score of 10 or above indicating high risk for potential falls.

The Resident Care Plan dated 7/01/10 identified Resident #2 with taking antidepressant medication and a history of falls. The approaches included:
a. Sensory alarm dated 12/06/10.
b. Hipsters dated 3/12/13.
c. Soft stuffed animal attached to call cord for ease of visualizing the cord dated 3/12/13.
A new Care Plan printed 3/28/13 identified Resident #2 had poor safety awareness related to a dementia diagnosis. The approaches included:
a. Resident #2 had alarms on for safety and to let staff know when he/she attempted to transfer or get up on his/her own. Sensory for bed and wheelchair, and floor alarm.
b. Please attach the call light to a stuffed animal to encourage him/her to use/see the call light.

The Nurse's Notes dated 3/08/13 at 4:00 p.m. documented staff found Resident #2 on the floor of his/her bedroom. Resident #2 stated he/she hit his/her head and his/her right hip hurt and transferred to the emergency room. At 9:05 p.m. the nurse called the hospital and Resident #2 admitted with a right hip fracture.

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| F 323 | Continued From page 4 | F 323 | | |

A History and Physical dated 03/08/13 documented Resident #2 exhibited decreased range of motion of the right hip, tenderness and bony tenderness.

Emergency Department notes dated 03/08/13 documented Resident #2 presented with a hip fracture. Resident #2 described the pain associated with the fall as severe and continuous.

A Radiographic Report dated 03/08/13 documented Resident #2 had a right femoral neck sub-capital fracture.

A Major Injury Determination Form dated 3/09/13 at 9:30 a.m. documented Resident #2 attempted to stand independently, and had an unsteady gait and poor safety awareness. Resident #2 used a wheelchair for mobility, transferred and walked with assist of 1. He/she refused to walk most of the time. The physician responded after reviewing the circumstances, injury and prognosis of the patient, he believed the injury sustained a major injury.

An Operative Note dated 03/09/13 documented Resident #2 went to the operating room and under general anesthesia underwent percutaneous pin fixation.

A Physical Therapy Evaluation and Plan of treatment documented Resident #2 referred for physical therapy following open reduction and internal fixation (ORIF) to the right hip. Resident #2 fell with resultant right hip fracture and surgical repair with partial weight bearing status currently, with resultant decline in ADL's and mobility. Resident #2 nodded his/her head when asked if

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| F 323 | Continued From page 5 | F 323 | | |

he/she had pain, but unable to verbalize specifics regarding the pain.

A Fall Investigation dated 3/08/13 documented Resident #2 fell at 4:00 p.m. The report indicated Resident #2 had a fall alarm and it was on and working.

In a written statement dated 3/12/13 Staff B Certified Nursing Assistant (CNA) wrote at the beginning of the 2 p.m. to 10 p.m. shift she got her assignment sheet ready, then went to Resident #2's room and asked if he/she would like to go to the bathroom (around 2 p.m. to 2:20 p.m.). He/she said no, but Staff B asked if she could take him/her anyway. Resident #2 did not void, but he/she had a wet undergarment, so she changed it. Staff B put Resident #2 back in the chair and put the alarm back on. After toileting Resident #2 she went to check if all the orthos (blood pressures) had been done for the month, and wrote down ones that hadn't been. She started working on those. After getting the last orthos, she went to the kitchen nook around 3:50 p.m. to write it down. At that point, 5 minutes later Staff A Licensed Practical Nurse (LPN) came down with Resident #2 and said he/she had fallen and neuros done on him/her. Another staff member came on for the beginning of his shift, 4 to 10 p.m. She told him she did not know Resident #2 fell because she could not hear the alarm. She then went to clock out and go home.

During an interview on 4/16/13 at 1:50 p.m. Staff B Certified Nursing Assistant (CNA) stated she worked 6:00 a.m. to 4:00 p.m., on the unit 2:00 to 4:00 p.m. She said she and Staff A Licensed Practical Nurse (LPN) were on duty at that time.

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| F 323 | Continued From page 6 | F 323 | | |

She said she assisted Resident #2 at 2:00 p.m. to 2:20 p.m. from the toilet to the wheelchair. She could have sworn she put the alarm on. She wheeled Resident #2 in front of the television. She then went and did orthostatic blood pressure checks that had not been done. When she walked out of another resident's room she met Staff A with Resident #2. Staff A said Resident #2 was on the floor, and helped get him/herself up. She did vital signs and someone did neuros. She thought Resident #2's knee bothered him/her. Staff B said she didn't assist Resident #2 with cares after the 2 to 2:20 p.m. time. She did not hear an alarm but probably wouldn't have, because she was in the nook and a movie was playing. She said staff was good about making sure the alarm was on. She said Resident #2 didn't try to get up on his/her own very often. She couldn't be absolutely certain the alarm was on, but sure thought she would have.
On 4/18/13 at 5:05 p.m. Staff B stated she didn't know if Staff A checked the alarms before she toileted Resident #2, she didn't pay attention to what he did. She said Resident #2 sat in the wheelchair when she took him/her to the toilet. Staff B stated she was pretty sure the alarm was not on when she got Resident #2 out of the wheelchair. Staff B usually put the alarm on pause to remind her to turn it on. She said apparently it didn't happen that day.

In a written statement dated 3/12/13 Staff A wrote at 3:30 p.m. to 3:45 p.m. he got Resident #2's medications, entered his/her room and gave them. He asked Resident #2 if he/she needed anything, a drink, snack, toilet. Resident #2 said no. Staff A went back to giving meds. He got another resident's meds 4:00 to 4:15, went down

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the hall to give them and observed Resident #2 on the floor in his/her room with staff. Resident #2 said he/she tried to get up because his/her spouse was coming to get him/her. Resident #2 said he/she hit his/her head on the roommate ' s bed. Staff A completed a head to toe assessment, with full range of motion. Staff assisted Resident #2 to the chair with 2. The alarm was not on. He turned it on after Resident #2 returned to the chair. Staff A took Resident #2 to the medication station to observe. Resident #2 complained of pain in the right thigh. Staff A called the on-call doctor and sent Resident #2 to the emergency room. Staff A said the previous statement changed due to his attempt to protect the facilities interest. The alarm was not on. Unknown who should have turned it on.

During an interview on 4/17/13 at 4:53 p.m. Staff A stated he worked 1/2 the shift in the unit. He passed medications. He asked Resident #2 if he/she needed anything and he/she didn't. He went down to give another resident medications and Resident #2 was on the floor. Staff A checked Resident #2 out head to toe. He worried about a concussion. He took Resident #2 out and he/she complained of his/her hip hurting. He got an order to send Resident #2 to the hospital. An older lady from the business office was with Resident #2 when he got there (after the fall). The alarm was not on. He said he did not do anything with the alarm. He did not get Resident #2 up. There is a flap between the cushions with on, off and pause. The alarm was turned off. Staff A said whoever took care of Resident #2 last should have turned it on. It functioned.

In a written statement dated 03/12/13, Staff C

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| F 323 | Continued From page 8 | F 323 | | |

Registered Nurse (RN) wrote she walked down the hall of the unit when she heard someone say help me. She looked in Resident #2's room and he/she sat on the floor beside his/her wheelchair. Staff C did not recall hearing any alarms go off. Resident #2 had 1 leg bent under the other. Staff C asked Resident #2 if he/she hurt. Resident #2 said he/she may have hit his/her head, but didn't think he/she hurt it. Staff C asked if Resident #2 could straighten his/her leg and he/she did with no assistance from Staff C, with no complaints of pain in the leg or hip area. Staff C stood behind Resident #2. Resident #2 supported with his/her back against Staff C's legs. Staff C put the call light on. Staff A responded and they lifted Resident #2 to the wheelchair. They did not have Resident #2 stand or bear weight. When asked, Resident #2 said he/she was looking for his/her spouse. Staff C did not witness the fall.

During an interview on 4/16/13 at 2:28 p.m. Staff C stated she was on the unit. She heard Resident #2, looked in his/her room and he/she sat on the floor. Resident #2 responded that he/she may have hit his/her head. Resident #2 put his/her leg out in front of him/her. Staff C put on the call light. The nurse came in and asked Resident #2 if he/she hurt. Staff C said she did not silence the alarm (she didn't hear an alarm). Staff C said the nurse assessed Resident #2 before they moved him/her. They boosted Resident #2 up in the chair. Resident #2 didn't really put any weight on his/her legs, he/she had the gait belt on.

During an observation on 4/17/13 at 8:29 a.m. Resident #2 laid in bed. The call light sat on the nightstand out of Resident #2's reach. At 9:08 a.m. Resident #2 laid in bed awake, ready to get

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| F 323 | Continued From page 9<br>up. The call light remained on the nightstand.<br><br>During an observation on 4/18/13 at 2:41 p.m. Resident #2 sat in the lounge in the wheelchair watching television. The alarm was in the off position. At 2:55 p.m. no staff were in the area. At 3:03 p.m. Staff D LPN verified Resident #2's alarm was off. Staff D said the alarm should be on.<br><br>A Termination Report dated 3/12/13 documented Staff A terminated for intentionally providing false information on the fall investigation form as well as verbally falsifying the situation when questioned. The employee admitted the falsification.<br><br>The Fall Protocol dated 3/17/13 directed if an alarm was placed on a resident, or on their equipment, the nurse added this to the resident's treatment record (TAR) to be checked for sounding properly each shift. | F 323 | | |

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 appeal this deficiency, the following is the facility's Plan of Correction.

## F315—483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

*Correct Deficiency as they relate to the individual*
Resident #7's catheter bag is off of the floor and in a dignity bag.

*Protect Residents in similar situations*
All catheter bags are off the floor and in dignity bags or in a leg bag.

*Systems we will alter to assure the prablem daes not recur*
On 4/19/13 nursing staff were educated on the requirement to keep catheters off the floor.

*Plan to monitor performance to make sure thot solutions are permanent*
The Director of Nursing or designee will complete random audits to ensure that catheter bags are not on the floor. This will occur 3 times a week for 3 weeks, followed by one time a week for 3 weeks, and monthly thereafter.

Date Corrected: 5/6/13

## F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

*Correct Deficiency as they relate to the individual*
Resident #2's alarm is turned on and working per the plan of care.

*Protect Residents in similar situations*
All resident alarms are turned on and working per the plan of care.

*Systems we will alter to ossure the problem daes nat recur*
On 4/19/13 nursing and therapy staff were educated on alarm checks. CNAs will check that alarms are on and working at shift change, which will be documented on the CNA flow sheet. Nurses and CMAs will check that alarms are turned on and working two times a shift. This will be documented on the TAR.

*Plan to monitor performance to moke sure that solutions are permonent*
The Director of Nursing or designee will complete audits to ensure that alarms are on and working. This will occur 3 times a week for 3 weeks, followed by one time a week for 3 weeks, and monthly thereafter.

Date Corrected: 5/6/13