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 (KS) 8.9.2013	C 07/23/2013

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_____ Investigation of complaint # 44260-C and facility-reported incident # 44588-I resulted in deficiency. Investigation of facility-reported incident # 44174-I did not result in deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 323 SS=G	483.25(h) FREE DF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 implement services to ensure 2 of 2 residents received adequate supervision to prevent altercations between Resident #6 and Resident #7. Record review identified Resident #7's care plan directed staff to keep him/her out of Resident #6's room as result of a prior altercation that occurred on 6/16/13. Record review and staff interviews revealed on 7/7/13 Resident #7 had been combative during cares and walked into Resident #6's room and refused to leave. The nursing home staff left the	F 323		

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 8/9/13 NW minutes

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F 323	Continued From page 1	F 323		

combative resident (Resident #7) with Resident #6 for approximately 20 to 30 minutes until Resident #7 grabbed Resident #6's head and slammed it down to the ground causing facial injuries and nasal bones to fracture. The pocket care plans used by the nursing home staff lacked any directives to keep the two residents separated. The facility reported a census of 111 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 7/2/13, Resident #6 demonstrated long and short term memory problems and moderately impaired skills for daily decision making. Resident #6 required supervision with activities of daily living (ADL's) including transfer, ambulation and personal hygiene. Resident #6's diagnoses included non-Alzheimer's dementia, depression and a delusional disorder.

2. Resident #7' s MDS with an assessment reference date of 6/4/13 identified the resident had cognitive and memory impairments (both long term and short term memory). Resident #7 required two staff to physical assist with dressing him/her. Resident #7 had been diagnoses with Alzheimer' s disease.

The Nurse's Notes dated 6/16/13 at 7:15 p.m. documented Resident #6 had an altercation with Resident #7 in Resident #6's room. A CNA (certified nursing assistant) saw Resident #6 swatting/hitting the other resident who lay in the bed of Resident #6's roommate. Resident #6 was upset Resident #7 laid in his/her roommate's bed. The two residents were separated immediately,

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F 323	Continued From page 2	F 323		

and they would continue to keep them separated.

Resident #6 ' s Care Plan with a team conference date of 10/25/12 identified Resident #6 did not speak English, but communicated by gestures and head nods. Resident #6 understood some English words. The approaches included to communicate in a way Resident #6 could understand. The care plan identified Resident #6 liked his/her own space, and did not like people in his/her room, dated 6/16/13. The care plan directed staff to :
a. Please allow time for Resident #6 to understand what is communicated to him/her.
b. If you see someone going in Resident #6's room attempt to redirect, dated 6/16/13.
c. Resident #6 does not like anyone invading his/her space.
d. Resident #6 likes to sit away from others at mealtimes.
e. Communicate with Resident #6 with gestures he/she could understand.

Resident #6 ' s pocket care plan behavior interventions dated 6/12/13 and 7/2/13 noted Resident #6 was impulsive, preferred not to be near females, liked his/her own space, and did not like crowded areas. On the 7/2/13 pocket care card added the comment Resident #6 liked things just right, so if they changed something he/she may get agitated. The pocket care card lacked info about keeping Resident #6 and Resident #7 separated.

Resident #7's pocket care plan lacked any directives to keep Resident #7 out of Resident #6's room.
On 6/16/13 Resident #7's care plan had been updated with a directive to keep him/her out of

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F 323	Continued From page 3	F 323		

Resident #6's room.

A consultation note with Resident #7's physician dated 6/24/13 documented Resident #7 had behavioral disturbance and had been admitted to the nursing home since March of 2013. The note reported the nursing home had difficult controlling Resident #7's aggression during cares.

Resident #7's Nurse's Notes dated 6/18/13, 6/19/13, 6/25/13, 7/6/13 and on 7/7/13 at 1 a.m. documented Resident #7 wandered or walked into other residents rooms.

The Nurse's Notes dated 7/7/13 at 1:25 p.m. documented Resident #6 got into an altercation with Resident #7. Resident #7 sat in a recliner in Resident #6's room. The nurse explained to Resident #6 that Resident #7 just wanted to sit there and would not bother Resident #6. Resident #6 shook his/her head yes. About 15 minutes later the nurse and aides walked down the hall and observed Resident #6 shake his/her fist in the other resident's face [Resident #7]. Resident #7 grabbed Resident #6's arm and threw him/her to the floor. Staff escorted Resident #7 out of the room. Resident #6 had a laceration to his/her right eyebrow and the bridge of his/her nose. Resident #6 transferred to the emergency room per the facility van.

A hospital History and Physical dated 7/7/13 documented Resident #6 presented after an altercation with another resident. The report noted apparently Resident #6 ' s head was slammed down into the ground causing a laceration above the right eye and nasal trauma. History obtained from the resident and caregiver. The history was limited by a language barrier, and

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F 323	Continued From page 4	F 323		

an interpreter was used. A computerized tomography (CT scan) of the facial bones revealed a minimally displaced fracture of the nasal bones. Resident #6 had a running suture above the right eyebrow of a 2.5 centimeter laceration.

During an observation on 7/16/13 at 2:35 p.m. Resident #6 sat in his/her room on the side of the bed. At 4:12 p.m. Resident #6 sat in a chair in the dining room by the window and appeared to have a bruise under his/her right eye and an abrasion on the bridge of his/her nose.

Staff H documented the following regarding Resident #7 on 7/7/13: Staff H went to assist the resident with cares and he/she was very resistive, smacking and swatting at her hands. The resident went down the hall without pants on and she calmly asked the resident to return to their room to put his/her pants on. The resident started swatting and biting her hands when the nurse assisted. Resident #7 went into another resident's room [Resident #6] and sat in the recliner. The nurse was unable to get the resident out of the resident's room without being hit. A ½ (half) hour later the aide and the nurse walked by the resident's room and heard yelling "No, No." Staff ran into the room and Resident #6 was on the floor face down with blood noted. Staff called for back-up assistance to address the combative resident [Resident #7] out of the resident's room.

During an interview on 7/18/13 at 4:34 p.m. Staff H CNA stated Resident #7 had been aggressive toward staff. She put Resident #7's socks on, but he/she would not allow her to finish dressing him/her. Resident #7 went in the hall in a shirt and a brief. She asked Resident #7 to go back to

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F 323	Continued From page 5	F 323		

his/her room for clothes, and he/she grabbed Staff H's arm. Staff H told the nurse someone else needed to take over because Resident #7 would not cooperate. Resident #7 walked into Resident #6's room and sat in the recliner. The nurse took pants into Resident #6's room for Resident #7. Resident #6 was on the bed and Resident #7 in the recliner. She thought the altercation occurred about 20 minutes after Resident #7 sat in the recliner. Staff H did not see the altercation. Staff H said Resident #6 was very territorial. She did not know Resident #7 and #6 had an altercation in Resident #6's room a few weeks earlier. If she had known, Staff H said she would not have left them alone.

In a written statement dated 7/20/13 Staff H wrote the date of the incident with Resident #6 and #7 after breakfast, she personally walked by Resident #6's room twice and observed Resident #6 in bed awake and Resident #7 in the recliner with his/her eyes closed.

During an interview on 7/18/13 at 10:51 a.m. Staff I CNA stated she did not know Resident #6 and #7 had an altercation prior to 7/7/13. She said the spouse of Resident #6's roommate came and told someone Resident #7 sat in the roommate's recliner. Resident #7 had been combative with cares prior to that, hitting at staff. Later when she walked down the hall she saw Resident #6 try to hit Resident #7. Resident #7 grabbed Resident #6's arm and slammed him/her on the floor. They went in to help immediately. Staff I stated if she had known about the previous incident with Resident #6 and #7 she would not leave them alone in the room.

During an interview on 7/18/13 at 10:15 a.m. Staff

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F 323	Continued From page 6	F 323		

J Registered Nurse (RN) stated she worked on 7/7/13 when Resident #6 and Resident #7 had an altercation. She said resident #7 demonstrated combativeness with staff and went into Resident #6's room and sat in Resident #6's roommate's recliner. The roommate's family notified staff Resident #7 sat in the room. Staff attempted to get Resident #7 to leave but he/she would not. Resident #6 returned to his/her room and pointed at Resident #7. Staff J stated she explained to Resident #6 in English that Resident #7 just wanted to sit there, and Resident #6 shook his/her head yes. Staff J thought Resident #6 understood English. Staff J left Resident #6 and Resident #7 in the room without supervision. About 15 minutes later as they walked down the hall (Staff I a step in front of her) she saw Resident #7 had a hold of Resident #6's arm and threw him/her down. They intervened immediately. Staff J stated she was not aware Resident #6 and Resident #7 had an altercation a few weeks prior to the incident. She did not know until this interview it had also occurred in Resident #6's room. She did not know there were new interventions on Resident #6 and #7's care plans relating to the previous incident (6/16/13). Staff J stated if she knew about it she would not have left the 2 residents alone in the room.

On 7/23/13 at 12:21 p.m. Staff J stated she walked by the room 1 time after the 2 were in the room and then would have walked back again. Resident #6 laid in bed with his/her eyes open and Resident #7 in the chair with his/her eyes closed. She would have walked by with in the next couple of minutes after leaving Resident #6's room.

During an interview on 7/23/13 at 11:34 a.m. the

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F 323	Continued From page 7	F 323		

Resident Care Coordinator (RCC) stated she found out about the 6/16/13 altercation between Resident #6 and Resident #7 and she spoke to staff about keeping them separated. She told staff to pass this on. She updated the 2 residents' care plans. She thought the pocket care card already said to keep people out of Resident #6's space. She said Resident #7 had not started going in and out of other resident's rooms that much at the time. She said it did not get passed on long enough to assure everyone was aware of the first incident.

During an interview on 7/18/13 at 2:40 p.m. the Administrator stated the RCC put new interventions on the care plans after the first altercation. She also added to the pocket care cards, and all staff had the pocket care cards. When looking at the pocket care cards the Administrator identified would be in effect 7/7/13 she agreed the interventions were not as specific as the ones on the resident's individual care plans regarding the altercation on 6/16/13.

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.

F 323– Free of Accident/Hazards/Supervision/Devices
483.25(h)

Correct Deficiency as they relate to the individual
Resident #6 and Resident #7 receive adequate supervision. They are not alone unsupervised in a resident room.

Protect Residents in similar situations
Residents who have had an altercation resulting in a physical injury within the last 30 days are not alone unsupervised in a resident room.

Systems we will alter to assure the problem does not recur
Communication is provided to nursing staff of resident altercations that have occurred in the last 30 days via the Nursing Summary Sheet. To assure information has been received, nursing staff sign off each shift stating they have read this summary.

Plan to monitor performance to make sure that solutions are permanent
Signatures will be reviewed for completion at Daily QA meetings for 3 weeks, 2 times a week for 3 weeks, and monthly thereafter.

Date Corrected: 8/7/13