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 11/27/2013	10/24/2013

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 000	INITIAL COMMENTS Correction date 11/14/13 The following deficiencies relate to the facility's annual health survey. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 248 SS=E	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 the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review staff interview, the facility failed to ensure staff assessed residents' activity interests and maintained quarterly activity progress notes for 9 of 23 residents reviewed (Residents #4, #6, #7, #8, #10, #12, #14, #16 and #18). The facility reported a census of 112 residents. Findings included: 1. According to the Resident Care Plan dated 5/2/13, Resident #7 entered the facility on 4/12/13. Review of the resident's record revealed no admission Activity assessment of his/her preferences and interests or any subsequent assessment of the resident's participation or	F 248		

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

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F 248	Continued From page 1	F 248		

satisfaction with activity programs.

During interview on 10/24/13 at 9:03 a.m. the Activity Director stated they had not been done but she had done late entry documentation after being asked about it the previous day.

2. According to the 10/13 Treatment Administration Record, Resident #14 entered the facility on 10/20/11.

Resident #14's record lacked any assessment of the resident's activity participation or satisfaction with activity programs since 4/19/13.

During interview on 10/22/13 at 12:52 p.m. the Activity Director stated no progress notes could be found for the resident since April 2013.

3. According to the Admission record dated 5/29/13, Resident #18 had an original admission date of 4/4/08.

Resident #18's clinical record lacked any assessment of the resident's activity participation or satisfaction with activity programs for 5 months from 4/19/13 until 9/19/13.

4. Resident #4's chart review on 10/21/13 revealed no Activity Progress Notes between 2/9/13 and 7/6/13. Further review revealed no Activity Progress Notes since 7/6/13.

During interview on 10/22/13 at 12:50 P.M., the facility Activity Director (AD) reported she started the job of AD in July, 2013 and she continued to learn her job. She reported she did not know of the need to write quarterly progress notes. During the same interview the AD presented

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Activity Progress Notes for 7/16/13 and 10/8/13. The AD stated she wrote Resident #4's Activity Progress Notes dated 7/16/13 and 10/8/13 on 10/22/13.

5. Resident #6's chart review on 10/22/13 revealed no Activity Progress Notes between 10/22/12 and 6/20/13. Further review revealed no current Activity Progress Notes on the Resident's chart.

During interview on 10/22/13 at 12:50 P.M., the AD presented an Activity Progress Note for 9/13/13 and stated she wrote the Activity Progress Note dated 9/13/13 on 10/22/13.

During interview on 10/22/13 at 2:55 P.M., the facility Administrator reported she met with the AD last week and informed her she needed to catch up on the Activity Progress Notes. The Administrator confirmed the Activity Progress Notes as not being done in a timely manner and stated late Activity Progress Notes needed to have a late entry date.

6. The MDS (Minimum Data Set) assessment tool dated 10/4/13 documented Resident #8 with short term memory impairment, moderately impaired cognitive skills for daily decision making, and diagnoses included Alzheimer's Disease.

Review of the resident's Activity Progress Notes revealed notes dated 4/15/13 and 6/27/13. During interview 10/23/13 at 2:00 p.m., Staff E4 (an Activity Assistant), stated she wrote the progress note dated 6/27/13 sometime during the week of 10/5/13. Staff E4 stated the Activity Director gave her predated Activity Progress Notes to complete for Residents #8, #10, #12, and #16.

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7. The MDS assessment tool dated 9/4/13 documented Resident #10 with short and long term memory impairment, moderately impaired cognitive skills for daily decision making, and diagnoses included Alzheimer's Disease.

Review of the resident's Activity Progress Notes revealed notes written 3/11/13, 6/5/13, and 9/12/13. During interview 10/23/13 at 2:00 p.m., Staff E4 stated she wrote the progress note dated 9/12/13 sometime during the week of 10/5/13.

8. The MDS assessment tool dated 10/1/13 documented Resident #12 with short and long term memory impairment, moderately impaired cognitive skills for daily decision making, and diagnoses included Alzheimer's Disease.

Review of the resident's Activity Progress Notes revealed notes written 4/23/13, 6/4/13, and 7/25/13. During interview 10/23/13 at 2:00 p.m., Staff E4 stated she wrote the progress note dated 7/25/13 sometime during the week of 10/5/13.

9. The MDS assessment tool dated 9/7/13 documented Resident #16 with short term memory impairment, moderately impaired cognitive skills for daily decision making, and diagnoses included Alzheimer's Disease.

Review of the Resident's Activity Progress Notes revealed notes written 9/27/12, 2/23/13, 5/21/13, and 8/22/13. During interview 10/23/13 at 2:00 p.m., Staff E4 stated she wrote the progress note dated 8/22/13 sometime during the week of 10/5/13.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET F 281

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F 281 SS=D	Continued From page 4 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 interview, the facility failed to follow physician's for a dressing change for 1 of 20 current residents reviewed (Resident #2). The facility reported a census of 112 residents. Findings included: According to a Physician's Orders form dated 10/8/13, Resident #2's diagnoses included diabetes mellitus, hemiplegia, decubitus ulcers on the bilateral ischium, lower extremity ulcers and chronic pain. Review of a Medical Care Practitioner Progress Note dated 5/7/13 revealed Resident #2 would undergo debridement of [his/her] left heel ulcer in preparation for the first Apligraf treatment. The resident would then have the Apligraf applied to keep the dressing dry and intact for the following week... (Note: Apligraf is created from cells found in healthy human skin and has the appearance of real skin). Review of a Physician Dperative/Procedure Report dated 5/7/13 included documentation in regards to the Apligraf treatment being applied to Resident #2's heel on 5/7/13. Review of a Physician consultation form dated 5/7/13 revealed a Medical Care Practitioner	F 281		

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instructed facility staff to discontinue all previous orders and refer to discharge instructions for new orders in regards to the resident's left heel.

Review of Wound Clinic Instructions (discharge instructions) dated 5/7/13 contained orders to maintain Resident #2's dressing to his/her left heel and use an Allevyn (soft foam) dressing to the resident's right heel.

Review of a Medical Practitioner Progress Note dated 5/14/13 documented the Resident #2 had diabetes and had approval for Apligraf to apply to [his/her] left posterior heel, which was applied on the last visit. The orders for the nursing home were to keep the dressing dry and intact and discontinue all previous dressing orders. However, when the patient arrived today, the wound had a different dressing in place. Verification with the nursing home is that the Apligraf was removed 2 days after [his/her] last wound care visit and they reverted back to using the old dressing change orders which effectively wiped out the benefits of having the Apligraf applied.

Review of a Physician consultation form date 5/14/13, revealed a Medical Care Practitioner wrote a message in large letters addressed to facility staff. The message instructed staff to follow wound care instructions. The Medical Care Practitioner documented the advanced Apligraf placed last exam (5/7/13) and removed by facility staff "... was a 2 -3 week treatment at high dollar value...".

During interview on 10/23/13 at 2:10 P.M., Staff H, Registered Nurse (RN), Resident Care Coordinator, stated Staff O1 removed Resident

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F 281	Continued From page 6 #2's at the facility 2 days after the Apligraf application, rather than leaving the Apligraf dressing on until seen in the wound clinic on 5/14/13. Staff H stated Staff O1 removed the dressing in error. Staff H stated there had been some confusion with the order. Chart review revealed no staff attempted to contact the Medical Care Practitioner for clarification of the order for the resident's left heel. During interview on 10/23/13 at 2:35 P.M., Staff O1, RN, reported he followed the instructions on Resident #2's TAR (Treatment Administration Record) for the dressings on the resident's heels. Review of Resident #2's 5/2013 TAR revealed an entry with a start date of 3/21/13 for Allevyn dressings to both heels. Further review of the TAR revealed the entry as not discontinued on the TAR until 5/15/13, rather than 5/7/13 as ordered by the Medical Care Practitioner. Review of the TAR revealed another entry, with a start date of 5/7/13, for Allevyn heel dressing to be applied to the Resident's right heel every day. In Summary, Resident #2's TAR revealed 2 conflicting entries in regards to the Allevyn dressing entry to both heels. Facility staff failed to discontinue the entry for Allevyn dressings to both heels as ordered by the Medicare Care Practitioner on 5/7/13 until 5/15/13.	F 281		
F 309 SS=D	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	F 309		

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F 309	Continued From page 7 and plan of care.	F 309		

This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review and staff interview, the facility failed to assess skin impairment for 1 of 20 current residents reviewed (Resident # 6). The facility reported a census of 112 residents.

Findings included:

According to Physician's Orders dated 10/8/13, Resident #6's diagnoses included diabetes mellitus, chronic renal disease, iron deficiency anemia and history of a foot wound.

A Minimum Data Set (MDS) assessment dated 9/3/13 documented Resident #6 required extensive assistance from staff with bed mobility and total dependence on staff with toilet use and personal hygiene. The same MDS identified the resident as frequently incontinent of bowel. The MDS documented the resident had no ulcers or other skin conditions at the time of the assessment.

Review of Braden Scale form dated 9/3/13, identified Resident #6 at moderate risk for the development of pressure sores.

A care plan with an initial date of 7/11/12 documented the resident as at risk for skin breakdown due to his/her need for assistance with bed mobility and incontinence of bowel and bladder. The care plan included an intervention for staff to monitor the resident's skin during

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F 309	Continued From page 8	F 309		

baths, cares and treatments.

Observation on 10/23/13 at 8:15 A.M., revealed Staff K2, Certified Nurse Aid (CNA) and Staff S, CNA performed morning perineal cares for Resident #6, with Staff Z4, Registered Nurse (RN) also present in the room. Staff K2 and Staff S rolled the resident to his/her right side and removed the resident's brief. Ongoing observation revealed a black scabbed area on the resident's left buttock.

Resident #6's chart review on 10/23/13 lacked any assessment or documentation of any skin issue on his/her buttocks.

During interview on 10/22/13 at 3:00 P.M., Staff Z4 confirmed the presence of a black scab on the resident's left buttock. Staff Z4 stated she expected staff to assess an area such as the black scab on the resident's buttocks at first site. Staff Z4 stated staff did not assess the area on Resident #6's buttocks. Staff Z4 instructed the nurse on duty on 10/22/13 to assess the resident's black scab on his/her buttock and initiated a skin assessment sheet.

Review of a Skin Condition Report dated 10/22/13 revealed staff measured the black scab on Resident #6's buttocks as 2.6 centimeters (cm) in length and 0.8 cm in width.

During interview on 10/23/13 at 4:30 P.M., Staff S2, RN, confirmed he reviewed Resident #6's recent bath sheets and staff did not document any skin issues on the resident's buttocks.

During interview on 10/23/13 at 7:50 A.M., the facility Director of Nursing (DON) stated she

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F 309	Continued From page 9 expected Bath Aids to complete body audits during residents baths and expects CNAs to complete body audits during cares and report any skin issues to a charge nurse.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews with staff and resident the facility failed to provide planned restorative interventions for 1 of 20 current residents reviewed (Resident #14). The facility reported a census of 112 residents. Findings included: According to the Minimum Data Set (MDS) assessment dated 10/2/13, Resident #14 had diagnoses that included malnutrition, cardiac murmurs and ruptured abdominal aneurysm. The assessment documented the resident had a BIMS (brief interview for mental status) score of 12, indicating moderately impaired cognition. The assessment documented Resident #14 required limited assistance with transfers and did not walk during the assessment period. On entrance to the facility staff identified Resident	F 318		

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#14 as able to give reliable information on interview.

The resident's record documented the resident received Medicare Skilled services for Physical Therapy and Occupational Therapy from 8/24/13 through 10/1/13. Staff documented on the resident's Treatment Administration Record they resumed a restorative program with Resident #14 on 10/2/13 which included ambulation with contact guard assistance (CGA) 50 feet with a front wheeled walker and NuStep exercises for 10 minutes 3 to 5 times weekly

Documentation on the TAR revealed staff provided ambulation assistance only 4 times from 10/2/13 through 10/22/13. Staff provided the Nustep exercise only 3 times from 10/2/13 through 10/22/13.

During interview on 10/22/13 at 8:33 a.m., Staff Z3, Restorative Aide stated she asked the resident to do the restorative program daily, but sometimes the resident refused. The resident's record lacked any documentation of refusals. Review of the records of other facility residents revealed Staff Z3 documented refusals and often made a detailed note about why the resident had refused to participate. Staff Z3 confirmed she had documented refusals for other residents.

During interview on 10/23/13 at 1:31 p.m. the resident stated he/she went to the Restorative Therapy room daily to be weighed but usually got assistance with the exercise program 1 to 2 times a week. When asked if he/she ever declined to participate the resident stated only if he/she had an appointment out of the facility at the time staff offered the exercises.

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F 323 SS=E	483.25(h) FREE OF ACCIDENT 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, staff interview and facility policy review, the facility failed to adequately secure medications from residents, unauthorized staff and visitors. The facility reported a census of 112 residents.

Findings included:

1. Initial tour of the facility on Monday 10/21/13 at 10:15 A.M., revealed an unsecured north side medication/supply room with an approximate 5 foot entry way (no door). Further observation revealed 2 Sterilite totes sat on a countertop. Both Sterilite totes contained many empty medication blister packs and many medication blister packs with medications in the cards. (Note: medication blister packs are used to dispense residents daily medications). Ongoing observation revealed a stack of medication blister packs sat on a different countertop in the unsecured medication room.

On 10/21/13 at 10:45 A.M., upon return to the north medication room, further observation revealed both of the Sterilite totes and the stack of medication blister packs were no longer seen.

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F 323	Continued From page 12 During the same observation, Staff Q3, Registered Nurse (RN), reported she and Staff K5, Licensed Practical Nurse (LPN), moved the 2 Sterilite totes with medications to a supply room with a key pad entry and placed the stack of medication blister packs in a locked medication cart. Staff Q3 stated she and Staff K5 moved the medications after noting the surveyor in the north medication room on 10/21/13 at 10:15 A.M. Staff Q3 reported Residents' medication blister packs are collected by a night nurse on a Thursday night from a locked medication cart, placed in a tote and generally picked up by a pharmacy employee on Friday. Staff Q3 confirmed she noted the 2 Sterilite totes with medications and the stack of medication blister packs in the unsecured medication room during her work shift on the evening of Saturday 10/19/13, thought to herself the medications needed to be locked up, but failed to do so herself. Staff Q3 confirmed the totes with medications and the stack of medication blister packs more than likely sat unsecured in the north medication room from Friday 10/18/13 - 10/21/13. Staff Q3 confirmed all medications needed to be in a locked room, cupboard or medication cart. During the same ongoing observation on 10/21/13 at 10:45 A.M., Staff Q3 opened a locked medication cart, confirmed the stack of medication blister packs in the unsecured medication room belonged to Resident #26 and obtained the same medication blister packs to the surveyor. Observation of Resident #26's medication blister packs revealed the following medications: Aspirin 8 milligrams (mg) - 14 tablets (tabs) Carvedilol 12.5 mg - 29 tabs Folic Acid 1 mg - 14 tabs	F 323		

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Dialyvite 100 mg - 14 tabs
Omega 3 1000 mg - 14 tabs
Atorvastatin 80 mg - 29 tabs
Midodrine HCL 10 mg - 6 tabs
Vitamin B12 1000 micrograms (mcg) - 1 tab
Ergocalciferol 1.25 mg - 2 tabs
Escitalopram 20 mg - 1 tab
Warfarin 1 mg - 15 tabs
Warfarin 6 mg - 15 tabs
Amitiza 24 mcg - 1 tab

During the same ongoing observation, Staff Q3 opened a key pad lock storage room next to the north medication room. Staff Q3 identified the 2 Sterilite totes with medication blister packs in the storage room as the same Sterilite totes that sat unsecured in the north medication room on 10/21/13 at 10:15 A.M. Ongoing observation of the medication blister packs revealed the following medications:

a. Resident #2:
Omeprazole 20 mg - 1 tab

b. Resident # 6:
Carvedilol 3.125 mg - 6 tabs

c. Resident #7:
Renvela 80 mg - 26 tabs

d. Resident #15:
Vesicare 10 mg - 14 tabs

e. Resident #24:
Nexium 40 mg - 4 tabs
Levothyroxine 0.008 mcg - 4 tabs
Citalopram 10 mg - 4 tabs
Buspirone HCL 10 mg - tabs

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f. Resident # 25
Gabapentin 100 mg - 7 tabs
Sucralfate 1 gram - 13 tabs
Cymbalta 60 mg - 2 tabs
Amlodipine Besylate 10 mg - 3 tabs

g. Resident # 27:
Pantoprazole 40 mg - 13 tabs
Phenytoin 100 mg - 28 tabs
Potassium Chloride 10 MEQ - 54 tabs
Senna S - 39 tabs
Sertraline HCL - 100 mg - 14 tabs
Prochlorperazine 5 mg - 13 tabs
Prochlorperazine 10 mg - 17 tabs
Dexamethasone 4 mg - 67 tabs
Lasix 40 mg - 19.5 tabs
Gabapentin 300 mg - 27 tabs
Gabapentin 600 mg - 14 tabs
Haldol 1 mg - 28 tabs
Lasix 20 mg - 13 tabs
Pantoprazole Sodium 40 mg - 1 tab
Loperimide 2 mg - 14 tabs
Ibuprofen 600 mg - 14 tabs
Acetaminophen 325 mg - 28 tabs

During observation and recording of the medications in the blister packs in the storage room, 1 laundry staff member entered the storage room with the use of the key pad entry, and placed laundry articles on a linen cart in the storage room.

During interview on 10/21/13 at 12:45 P.M., Staff S2, RN-Resident Care Coordinator (RCC) confirmed all staff employed in the facility had access to the storage room with the 2 Sterilte totes and medications due to a key pad entrance rather than a lock and key.

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During telephone interview on 10/21/13 at 1:25 P.M., a facility Pharmacist confirmed Resident # 26's medication blister packs as delivered on the evening of 10/17/13. The Pharmacist confirmed all medications in the facility needed to be behind a locked door or cupboard.

During interview on 10/22/13 at 6:45 A.M., Staff K5 stated that any medications in a Sterilite tote needed to be locked up in a supply room on the south end of the facility. Staff K5 reported only nurses had a key and access to the supply room on the south side.

During interview on 10/22/13 at 6:50 A.M., Staff K1, RN, confirmed she signed for and placed Resident #26's medications on a countertop in the unsecured north medication room on the evening of 10/17/13. Staff K1 stated she left the totes with medications in blister packs on the floor of the same north side medication room on the night of 10/17/13. Staff K1 stated she always leaves the totes with medications in blister packs in totes on the floor of the unsecured north medication room for pick up by pharmacy staff the next day.

During interview on 10/22/13 at 10:10 A.M., Staff I3, RN stated she noted the totes of medication blister packs in the unsecured north medication during her work hours on 10/19/13 and 10/20/13. Staff I3 reported the totes with medications as always kept in the unsecured north medication room.

During interview on 10/22/13 at 9:45 A.M., the facility Director of Nursing (DON) stated she expected nurses to lock up all totes with medications in a south supply room under lock

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F 323	Continued From page 16 and key. The DON stated Resident #26's medications needed to be under lock after delivery. A facility Nursing News Letter dated 4/20/12 advised facility nurses to ensure all medications be kept behind a locked cabinet or door. A facility Pharmacy Policy and Procedure for disposal of medications (effective date of 6/1/07), included a policy for medications awaiting disposal or return to the pharmacy, as to be kept in a locked secure area designated for that purpose, until destroyed or picked up by the pharmacy.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review and resident and staff interviews, the facility failed to assure indications for use, assessment of possible causes or alternative interventions for one resident with a prn (as needed) hypnotic medication (Resident #14). The facility reported a census of 112 residents.

Findings included:

According to the Minimum Data Set (MDS) assessment dated 10/2/13, Resident #14 had diagnoses that included malnutrition, cardiac murmurs and ruptured abdominal aneurysm. The assessment documented the resident had a BIMS (brief interview for mental status) score of 12, indicating moderately impaired cognition. The assessment documented Resident #14 felt tired or with little energy on 12 - 14 days of the 14-day assessment. The assessment did not document problems with trouble falling or staying asleep.

On admission to the facility staff identified Resident #14 as able to give reliable information on interview.

The resident's record included a 1/9/12 physician's order for Restoril (a hypnotic/sleep medication) 15 mg (milligram) every bedtime and Restoril 15 mg. as needed. A 7/17/13 physician's order directed staff to decrease the Restoril

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(Temazepam) tD 15 mg. at bedtime as needed.

Staff documented on the Medication Administration RecDrd (MAR) the resident received the sleeping pill 25 of 30 days in September 2013 and 18 times during the 22 days from 10/1 - 10/22/13.

The resident's 9/2/13 Physician's PrDgress note documented a diagnosis of insomnia. The resident's Care Plan identified the resident at risk for falling and noted the resident received medications for depression and insomnia, but lacked any interventions to help the resident sleep.

During interview on 10/23/13 at 10:29 a.m. when asked why the resident's Care Plan had nD interventions for insomnia Staff V, Licensed Practical Nurse, Resident Care Coordinator, stated that after someone had been on a psychoactive medication a lDng time they didn't care plan it because they just knew it worked.

During additional interview on 10/23/13 at 1:41 p.m. Staff V stated no documentatiDn of assessment of causes of insomnia, alternative interventions planned or attempted cDuld be found in the resident's record. Additionally, the chart contained no documentation the resident experienced insDmnia or difficulty sleeping.

During interview on 1/23/13 at 1:31 p.m. the resident stated his/her roommate sometimes fell out of bed. Staff came in and turned on lights, all Df which awakened the resident. The resident stated he/she never took a sleeping pill prior to cDming to the facility and no one had talked to him/her about why s/he had trouble sleeping.

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F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	F 363		

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:
Based on facility record review, observation and staff interview, the facility failed to follow the menu as written for 5 of 5 residents who received pureed diets. The facility identified a census of 112 current residents.

Findings include:

1. Review of the menu titled Wednesday dinner revealed the following should be served to residents with puree diets:
a. 1 serving of puree hushpuppy fish filets,
b. 1 serving of puree malibu blend vegetables (1 serving = 4 ounces).

Observation on 102313 at 11:55 AM revealed Staff A1, Chef prepared the puree diets for the noon meal. He identified 5 residents with puree diets but he planned to puree 8 4-ounce servings. He placed 8 4-ounce vegetable servings into the robot coup and added 2 slices bread and an unmeasured amount of vegetable water. Staff A1 poured the puree mixture into the steam table pan, but did not measure the total volume of pureed food. He identified the serving size as 1/4 cup. Staff A1 then added 16 pieces of fish (2 pieces per serving) into the robot coup and added

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an unmeasured amount of milk. He placed the puree fish into the steam table pan, but did not measure the total volume of food before doing so. He identified the serving size as 2/5 cup. Observation of the remaining puree food at the end of meal service revealed that approximately 9 1/4 cup servings of vegetables remained and approximately 6 2/5 cup servings of fish remained.

2. Review of the menu titled Wednesday supper revealed the following to be served to residents who received puree diets:
a. 1 serving of quiche,
b. 1 serving sausage link (1 serving = 2 sausage links),
c. 1 serving puree cinnamon roll.

The alternate menu directed to serve:
a. 1 serving ham sandwich. (identified change to turkey),
b. #8 scoop 1/2 cup coleslaw (identified changed to mashed potatoes).

Observation on 10/23/13 at 4:05 PM revealed Staff Z1, Cook prepared the puree items for the evening meal. Staff Z1 stated she planned to prepare 6 servings of the sandwich. Staff Z1 added 18 slices of turkey and 6 slices of bread and then added an unmeasured amount of milk. Staff Z1 placed the puree food items in a steamer pan, but did not measure the total volume of the food before doing so. She stated each resident would receive a #16 scoop (1/4 cup) per serving. Staff Z1 then prepared the quiche and pureed 8 slices of quiche with an unmeasured amount of milk; she failed to measure the total volume. She identified serving size as 1/4 cup per resident. Observation at the end of the meal service

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F 363	Continued From page 21 revealed 3 residents received the puree sandwich and approximately 4 1/4 cup servings remained after service. Two residents received puree quiche and approximately 8 1/4 cup servings remained after service. Observation revealed residents also received 2/5 cup of mashed potatoes, but did not receive puree sausage or puree cinnamon roll. The undated Pureed Diet Portion Sizes/Scoops form directed staff to do the following: a. To use chart, find the number of persons that you are pureeing food for along the left hand column of the table, then find the total cups pureed food that you prepared along the top row. Follow both the row and column to where they meet and you will find the correct scoop to portion the pureed food item.	F 363		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff and resident interview, the facility failed to always ensure palatability of food service by serving food at appropriate food temperatures. The facility identified a census of 112 current residents. Findings include:	F 364		

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1. Observation on 10/23/13 at 12:00 PM revealed Staff B4 Cook served the noon meal. Staff B4 did not test the temperature of the ground sausage and served the ground sausage to residents. The surveyor then asked Staff A1, Cook to test the temperature. The temperature measured at 122 degrees Fahrenheit and he then placed the meat in the steamer. The temperature then reached 172 degrees prior to serving to the remaining residents.

2. Resident #7's 10/8/13 Minimum Data Set (MDS) assessment documented the resident had no impairment of cognitive function.

During interview on 10/23/13 at 10:12 a.m. the resident stated sometimes he/she ate in the dining room and sometimes he/she had a room tray. The resident stated the food on the room trays had been cold most of the time.

3. Resident #9's 10/8/13 MDS assessment documented the resident had no impairment of cognitive function.

During interview on 10/23/13 at 9:46 a.m. Resident #9 stated he/she took his/her meals in their room. The resident stated s/he often received cold food on the room trays. On 10/23/13 at 12:44 p.m. staff served the resident their noon meal. The resident tasted the food and stated it was warm that day, but usually the food had been cold.

4. On entrance to the facility, staff identified Resident #14 as able to give reliable information on interview. During interview on 10/23/13 at 1:31 p.m. the resident stated he/she had received

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F 364	Continued From page 23 room trays at times when not feeling well. The resident stated the food on the meal trays had usually been cold. 5. On entrance to the facility staff identified Resident #28 as able to give reliable information on interview. During observation on 10/23/13 at 12:33 p.m. the resident sat in his/her room eating food from a tray. When asked if the food had been served warm the resident stated it had been hot that day but usually had not been warm. During observation and interview on 10/23/13 at 12:28 p.m. Staff F5, dietary staff delivered meal trays to residents on an uninsulated cart. The food had been covered, but the plates had no insulation. Staff F5 stated staff had been directed to only deliver 4 trays at a time so some trays didn't get cold while others were being served. She stated sometimes delivered 5 or 6 trays at a time. She stated it depended on what was ready. 6. During a facility group interview on 10/23/13 at 10:30 A.M., 3 of 6 residents in attendance reported food at meal times as cold approximately 3 days a week. One resident stated he/she brought this to the facility's attention during a Resident Council Meeting. The same resident reported the temperature of the food improved for a short while, but the food as now cold again.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		

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F 371	Continued From page 24 (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility policy review, the facility failed to always ensure food prepared, stored and served under sanitary conditions. The facility identified a census of 112 current residents.

Findings include:

1. Initial tour on 10/21/13 at 10:15 AM revealed the following:
a. One bag of cheddar cheese open with no date of opening,
b. 9 pieces of undated chicken breasts in a plastic container,
c. A 1/2 full plastic container of tuna salad with no marked date of preparation,
d. An undated plastic container with macaroni salad covered with plastic wrap,
e. The ice machine contained a large amount of white build-up on the left side and front of the hinged opening and visible dust on the vents located on the right and left sides.

2. Observation on 10/23/13 at 12:00 PM revealed Staff S1, Dietary Aid assisted with service of the noon meal. He had a beard on the chin area approximately 3/4 inch in length and served food without covering the beard.

During an interview with the Administrator on

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F 371	Continued From page 25 10/22/13 at 4:00 PM she stated that staff cleaned the ice machine every month.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 26	F 431		

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and policy and procedure, the facility failed to date 5 injectable vials of medications and 1 injectable vial of Aplisol when opened to prevent usage after the expiration date. The facility reported a census of 112 residents.

Findings included:

1. Observation of the B Hall medication cart 10/23/13 at 5:30 p.m., revealed an opened 300 unit Novolog Flex Pen (an insulin used for Resident #26 to control diabetes) with an open date of 7/30/13. Staff T3, RN (Registered Nurse) verified that approximately 50 to 60 units Novolog remained in the pen. The resident's 10/13 MAR (Medication Administration Record) revealed the resident received the Novolog on 15 days between 10/1/13 and 10/23/13.

2. Observation of the A Hall medication cart 10/23/13 at 5:40 p.m. revealed the following:

a. An opened partially used Byetta injectable pen (used to control diabetes) without any type of identification label and open date. Staff Z4, RN, verified the Byetta belonged to Resident #30 and lacked any type of label and open date. Review of the resident's 10/13 MAR revealed the resident received Byetta daily from 10/1/13 to 10/24/13.

b. Two opened partially used Lantus SoloStar Pens (an insulin used for Resident #31 to control diabetes) with pharmacy fill dates of 7/22/13 and lacked open dates. Staff Z4 verified the pens lacked open dates. Review of the resident's 10/13

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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 431	Continued From page 27	F 431		

MAR revealed the resident received Lantus SoloStar daily from 10/1/13 to 10/23/13.

c. One opened partially used Lantus SoloStar Pen for Resident #32 with a pharmacy fill date of 3/19/13 and lacked an open date. Staff Z4 verified the pen lacked an open date. Review of the resident's 10/13 MAR revealed the resident received the Lantus SoloStar Daily from 10/1/13 to 10/24/13.

3. Observation of the North medication room 10/23/13 at 5:55 p.m. revealed an opened almost full five milliliter bottle of Aplisol (used to test for tuberculosis) with an open date of 6/13/13 verified by Staff Z4.

During interview 10/24/13 at 9:00 a.m., Staff T3 stated she spoke to the facility pharmacy staff. Staff T3 stated the pharmacist confirmed staff needed to discard Novolog, Lantus SoloStar, and Byetta 28 days after the open date and discard Aplisol 30 days after the open date. The pharmacist stated the Byetta most likely delivered to the facility in a labeled box and the pharmacy planned to label the Byetta pens in the future.

The 2008 American Society of Consultant Pharmacists Med Pass information sheets provided by the facility, directed staff the expiration date for Byetta 30 days after opened and the expiration date for insulins 28 days after opened.

An undated Medications With Shortened Expiration Dates sheet directed staff medications used for tuberculin testing (Aplisol) expired 30 days after opened.

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 _____	10/24/2013

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F 431	Continued From page 28 A facility Policies and Procedures for Long-Term Care Procedure sheet directed all medications dispensed by the pharmacy needed to meet facility, state, and federal requirements and labels included the following: brand/generic name, strength of medication, quantity dispensed, expiration date, resident's name, specific directions for use, prescriber's name, date dispensed, name, address, telephone, facsimile, and DEA (Drug Enforcement Administration) number of pharmacy where medication dispensed, pharmacist's name, and prescription number. The procedure sheet directed the pharmacy to attach labels permanently to the outside of the prescription container.	F 431		
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 the facility failed to maintain a clean sanitary environment in the kitchen of the facility. The facility identified a census of 112 current residents. Findings include: 1. The initial dietary tour on 10/21/13 at 10:15 AM revealed the following: a. A sticky substance on the outside of the microwave, b. The dish room had standing water and debris	F 465		

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 _____	10/24/2013

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F 465	Continued From page 29 on the floor, c. Food trays stacked with large amount of water, d. The stand mixer contained a large amount of a powdered substance on the brace and grill covering, e. The outer counter had juice spills and dirt with clean resident drinking pictures sitting on top of the spills and dirt.	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 appeal this deficiency, the following is the facility's Plan of Correction.

F 248—Activities

Correct Deficiency as they relate to the individual
Activity assessments are completed on residents 4, 6, 7, 8, 10, 12, 14, 16, and 18.
Quarterly progress notes are completed on residents 4, 6, 7, 8, 10, 12, 14, 16, and 18.

Protect Residents in Similar Situations
Activity assessments are completed on all residents.
Quarterly progress notes are completed on all residents.

Systems we will alter to assure the problem does not recur
Activity director is educated on assessment and quarterly notes. The activity director will complete an Activity Assessment on every resident upon admission. The AD will complete a quarterly note in each resident's chart during resident care plan meetings.

Plan to monitor performance to make sure that solutions are permanent
Charts are audited by the nurse consultant 1 time a month. Residents without activity assessments or quarterly notes will be updated.

Date of Correction: 11/14/13

F281—Services Provided Meet Professional Standards

Correct Deficiency as they relate to the individual
Resident 2 provided with wound care according to physician's order.

Protect Residents in similar situations
All residents are provided with wound care according to physician's orders.

Systems we will alter to assure the problem does not recur
Within 24 hours of admission, the Resident Care Coordinator or designee will verify that orders are transcribed and updated.

Plan to monitor performance to make sure that solutions are permanent
A chart review is completed within 2 weeks of admission. During the chart review the Resident Care Coordinator or designee will verify that physician orders are followed.

Date of Correction: 11/14/13

F 309—Skin Assessments

Correct Deficiency as they relate to the individual
The skin of Resident 6 is assessed for skin impairment.

Protect Residents in Similar Situations
The skin of all residents is assessed for skin impairment.

Systems we will alter to assure the problem does not recur
Resident Care Coordinators will flag skin assessments to be completed daily and check that they are completed daily.

Plan to monitor performance to make sure that solutions are permanent
Skin sheets are audited during weekly skin and weight meeting.

Date of Correction: 11/14/13

F 318—Restorative

Correct Deficiency as they relate to the individual
Resident 14 is provided with planned restorative interventions.

Protect Residents in Similar Situations
All residents with restorative needs are provided with planned restorative interventions.

Systems we will alter to assure the problem does not recur
Education is provided to restorative nurse assistants on following restorative plans, documenting refusals, and requests for changing a plan when necessary.

Plan to monitor performance to make sure that solutions are permanent
RCCs will audit Restorative Logs weekly for accuracy.

Date of Correction: 11/14/13

F 323—Free of Accidents

Correct Deficiency as they relate to the individual
Discontinued medications are adequately secured from residents and unauthorized staff and visitors.

Protect Residents in Similar Situations
All medications are adequately secured from residents and unauthorized staff and visitors.

Systems we will alter to assure the problem does not recur
Education is provided to all nursing staff regarding the requirement of medication security.

Plan to monitor performance to make sure that solutions are permanent
The DON or designee will monitor storage and security of medications.

Date of Correction: 11/14/13

F 329—Free From Unnecessary Drugs

Correct Deficiency as they relate to the individual
An indication of use, assessment of possible causes or alternative interventions for use of a hypnotic is provided to Resident 14.

Protect Residents in Similar Situations
An indication of use, assessment of possible causes or alternative interventions for use of a hypnotic is provided to all residents.

Systems we will alter to assure the problem does not recur
Education is provided to all nursing staff regarding the requirement that at least 2 interventions will be in place prior to administering a PRN hypnotic, antipsychotic, or pain medication.

Plan to monitor performance to make sure that solutions are permanent
Quick MAR (eMar system) will not allow PRN's to be signed out without having two interventions being recorded in Quick MAR

Date of Correction: 11/14/13

F 363—Menus Followed

Correct Deficiency as they relate to the individual
Residents with pureed diets receive items from the menu as written.

Protect Residents in Similar Situations
All residents receive items from the menu as written.

Systems we will alter to assure the problem does not recur
Education is provided to all cooks regarding the procedure for puree menu preparation.

Plan to monitor performance to make sure that solutions are permanent
The registered dietician or designee will audit puree preparation weekly for one month.

Date of Correction: 11/14/13

F 364—Food temperature

Correct Deficiency as they relate to the individual
Residents 7, 9, 14, and 28 are served meals of proper temperature.

Protect Residents in Similar Situations
All residents are served meals of proper temperature.

Systems we will alter to assure the problem does not recur
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.

Date of Correction: 11/14/13

F 371—Sanitary Food, temps

Correct Deficiency as they relate to the individual
All food is dated and stored in appropriate containers. Staff S1 wears a beard cover. The ice machine is free of buildup and vents are clean.

Protect Residents in Similar Situations
All food is dated and stored in appropriate containers. All staff with facial hair wears a beard cover. The ice machine is free of buildup and vents are clean.

Systems we will alter to assure the problem does not recur
All dietary staff is educated on food storage, beard covers, and cleaning schedules.

Plan to monitor performance to make sure that solutions are permanent
The Dietary Manager will monitor food storage, beard covers needs, and cleaning schedule compliance daily.

Date of Correction: 11/14/13

F 431—Drug Records (Dates)

Correct Deficiency as they relate to the individual
The 5 injectable vials of medication and one vial of Aplisol are dated and labeled.

Protect Residents in Similar Situations
All medications and Aplisol are dated and labeled when opened.

Systems we will alter to assure the problem does not recur
Staff is educated on labeling and dating open medications and medication experation standards. At the end of each shift check that all insulin pens have resident labels and will sign off on check sheet accordingly.

Plan to monitor performance to make sure that solutions are permanent
Education nurse will review check sheet weekly and will discard all expired medications.

Date of Correction: 11/14/13

F 465—Sanitary Kitchen

Correct Deficiency as they relate to the individual
The outside of the microwave is clean. The dish room floor is clean. The industrial floor mixer is clean and free of debris. The counter is clean and drinking pitchers are stored on racks.

Protect Residents in Similar Situations
The outside of the microwave is clean. The dish room floor is clean. The industrial floor mixer is clean and free of debris. The counter is clean and drinking pitchers are stored on racks.

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. All staff are educated 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: 11/14/13