STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165432	A. BUILDING _____ B. WING _____	C 01/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIVING SENIOR CAMPUS	2421 LUTHERAN DRIVE MUSCATINE, IA 52761

(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 AMENDED 2/10/17 Correction Date: 2/16/17 The following deficiencies result from the investigation of Intakes #64531-M, #64553-A, #64566-A, and #64542-I and Complaints #64498-C, #64430-C. Complaints #62406-C, #64345-C, #64343-C and #64344-C and Incidents #64532-I, #63778-I, and #64542-I were also investigated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		

2/10/17 Trans

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 2/9/16

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.

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F 000	INITIAL COMMENTS Correction Date: _____ The following deficiencies result from the investigation of Intakes #64531-M, #64553-A, #64566-A, #64553-I and #64542-I and Complaints #64498-C, #64430-C. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Armstrong Adm | TITLE: Administrator | (X6) DATE: 2-9-17

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F 157	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to notify the physician when staff did not administer an anti-coagulant medication (slows blood clotting to help to prevent blood clots) to Resident #10 as ordered. The resident sample consisted of 17 residents and the facility census was 137 residents. Findings include: The admission Minimum Data Set (MDS) assessment for Resident #10 with the reference date of 9/21/16, identified the resident with severely impaired cognition. The resident	F 157	F157 R#10 has been discharged from facility as of 11-3-16. All resident records receiving Coumadin were audited for accuracy in orders, administration and orders following INRs. All residents who receive Coumadin are at risk. Staff D was educated upon finding error on the importance of correct timely transcription of orders on 9/28/16. Facility nurses were educated by 2-9-17 by Interim DON on the importance of monitoring Coumadin orders and response to INRs. Coumadin orders, INRs, administration and notification of physician regarding Coumadin/INRs will be monitored daily x 4 weeks; weekly x 2 months with findings reported monthly to facility QAPI Committee with follow-up to Committee recommendations. Date Certain February 16, 2017.	

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F 157	Continued From page 2 required limited assist of one staff member for activities of daily living. Diagnoses for the resident included atrial fibrillation (abnormal heart rhythm), coronary artery disease, diabetes mellitus, Non-Alzheimer's Dementia, and cardiomyopathy. According to the MDS, the resident received anti-coagulant medication daily. An initial care plan for the resident dated 9/14/16 through 10/10/16, utilized while receiving skilled level of care, did not address the resident's anti-coagulation therapy. When the resident was transferred to long term care on 10/10/16 a new care plan was initiated. This care plan also did not address the focus problem of anti-coagulation therapy. Record review of the resident's admission physician orders revealed the resident was to receive Coumadin 2.5 milligrams (mg) on Sunday (S), Monday (M), Tues (T), Thursday (Th) Friday (F), and Saturday (Sa) by mouth once daily. On Wednesday (W) the resident was to receive 5 mg by mouth. Later that day, based on the results of a PT/INR laboratory test the order was changed to hold the Coumadin that day, Wednesday 9/16/16, and reduce the dosage to 1.25 mg on Sa, M, and W, with 2.5 mg ordered for S and T. Staff was to repeat the PT/INR on 9/22/16. The Protime (PT) and International Normalization Ratio (INR) blood tests measure the effect of the anticoagulant on clotting time to ensure that the medication is increasing the resident's clotting time to a therapeutic level. The optimal INR range for therapeutic results of Coumadin is 2.5 to 3.5 as documented on the resident's admission instructions from the admitting hospital to the facility.	F 157		

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F 157	Continued From page 3 An incident report dated 9/28/16 revealed on 9/22/16, a nurse called the physician's office with results of the day's INR of 1.9. The physician changed the Coumadin to 2.5 mg every day. The incident reported the nurse who took the order, Staff D, Registered Nurse (RN), neglected to write the order and enter it into the computer. When Staff D returned to work on 9/26/16 she realized she did not enter the order on 9/22/16 so she entered it on 9/26/16. The next INR was to be obtained on 9/28/16 and this order was sent to lab. Review of Resident #10's Medication Administration Record (MAR) revealed the resident did not receive any Coumadin on 9/22, 9/23, 9/24, and 9/25. The dosage was started again on 9/26/16. Review of a laboratory test result revealed the INR on 9/28/16 was 1.1, below therapeutic level which can result in the formation of a blood clot in the body. During an interview on 12/21/16 at 2:30 PM with Staff A, RN and TC manager (skilled care), she stated she received a call from the physician's office on 9/28/16 and she was asked to check on the resident's Coumadin administration as the level had dropped down and the physician did not know why. Staff A reviewed the record and realized the resident had missed four days of Coumadin administration due to Staff D's error. She reported this back to the physician who reordered an INR for 10/3/16 and ordered the Coumadin to remain at 2.5 mg daily. Staff A stated nursing staff enters a stop date for Coumadin when a new order for INR is entered. She stated the nurse who entered the order for	F 157		

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F 157	Continued From page 4 the 9/22/16 INR would have placed a stop on the Coumadin for that day anticipating a new Coumadin order. She stated this is why the Coumadin dosage was stopped completely on 9/22/22. Staff A stated she would have expected the nurse to contact the physician on 9/26/16 when she realized her mistake and the resident had missed four days of Coumadin administration. She would also expect medication errors would be reported immediately to herself or the Director of Nurses. Staff A stated Staff D was disciplined and all staff re-educated on physician orders and anti-coagulant administration. Staff A stated the resident did not suffer any effects of missing the Coumadin doses but did agree the INR level dropped in relation to the missed doses and if the physician had been notified on 9/26 a new order might have been placed and the INR might not have dropped so significantly on 9/28/16.	F 157	F281 R#11 was discharged from facility on 11-7-16. All residents are at risk. Facility nurses were educated by 2-9-17 by Interim DON on the importance of interventions being delivered according to physician orders with adherence to quality clinical protocol.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to follow physician orders for Resident #11 when the order for the application of TED (compression stockings) Hose was not followed as ordered. The resident sample consisted of 17 residents and the facility	F 281	5 random TARs will be monitored weekly x 3 months to assure interventions are in accordance with physician orders. Residents with orders for application of TED hose will be monitored for correct application and removal times. Findings will be reported monthly to facility QAPI Committee with follow-up to Committee recommendations Date Certain February 16, 1017.	

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F 281	Continued From page 5 census was 137 residents. Findings include: The admission Minimum Data Set (MDS) assessment with reference date of 10/26/11, identified Resident #11 with a brief interview for mental status (BIMS) score of 14 indicating intact cognition. The resident was admitted to the facility for skilled care after hip replacement surgery. Diagnoses for the resident included recent hip fracture and chronic stasis ulcers on his/her right lower extremity. According to the MDS, the resident needed extensive assist from one staff member for ambulation and activities of daily living. The Initial Care Plan for Resident #11 did not address the resident's need for TED hose (supportive elastic stockings typically used for compression of the lower extremities after surgery to prevent edema). Record review of physician admission orders dated 10/26/16 revealed the resident was to have TED hose placed post-surgical on his/her lower extremities each morning and taken off each night. Record review of Resident #11's Treatment Administration Record (TAR) for October and November 2016 noted staff was to apply the hose at 8:00 AM (0800 military time) and remove at 7:59 AM (0759 military time). Nursing documented the following on the TAR. The following documentation was noted: 10/27/16- hose applied at 8:00 AM by nursing staff (Staff C). The documentation for removal was " 9 " which indicates " other see nursing	F 281		

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F 281	Continued From page 6 notes " . 10/28/16- hose applied at 8:00 AM by nursing staff. The documentation for removal was " 9 " 10/29/16- hose applied at 8:00 AM by nursing staff. The documentation for removal was " 9 " . 10/30/16- the documentation for placement and removal was " 9 " . 11/1/16- the documentation for placement and removal was " 9 " . 11/2/16- the documentation for placement and removal was " 9 " . 11/3/16- the documentation for placement and removal was " 9 " . 11/4/16- the documentation for placement and removal was " 9 " . 11/5/16- hose applied at 8:00 AM by nursing staff and removed by staff at 7:59 AM. 11/6/16- hose applied at 8:00 AM by nursing staff and removed by staff at 7:59 AM. During an interview on 12/22/16 at 11:30 AM with Staff C, Registered Nurse (RN), she stated she applied the hose on Resident #11's left lower leg only at 8:00 AM because the resident had weeping venous stat[sis ulcers on the right leg and a dressing and the TED hose would get soiled if placed on the right leg. The RN stated she wrapped the lower right leg and dressing with Kerlix (gauze dressing) to add compression to the right leg. She stated the " 9 " s on the TAR meant documentation was to be made in the nursing notes as to why the " 9 " was documented. She stated the instructions on the TAR should have been to remove the TED Hose at 7:59 PM (1959 military time) and must have been a computer glitch. She agreed the order should have been clarified. She stated her initials were documented that she removed the TED Hose at 7:59 AM however she stated the hose	F 281		

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F 281	Continued From page 7 came off at bedtime and she did not remove the hose in the morning. She stated routine policy was to place on at 8:00 AM and remove at 8:00 PM. During an interview on 12/22/16 at 11:45 AM with Staff A, RN/TC manager (skilled care unit manager), she agreed the TED Hose instructions on the TAR for Resident #11 were confusing and inaccurate. The instructions should have read to remove at 7:59 PM (or 8:00 PM). She stated the nursing staff should have clarified the instructions with her. She also stated if a nurse documents " 9 " on a TAR there should be an explanation documented in the nursing notes.	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to properly identify services required, planned interventions and personalize a care plan for one of three residents identified on anti-coagulant medications (an anti-coagulant medication slows the process of blood clotting and thus helps to prevent the formation of blood clots). Resident #10 received anti-coagulant medications and interventions were not implemented on the care plan. The	F 282	F282 R#10 was discharged from facility on 11-3-16. All care plans of residents receiving Coumadin were audited to assure anticoagulation care planning present. All residents receiving Coumadin are at risk. Facility nurses were educated by 2-9-17 by Interim DON on the need for anticoagulation care planning. Care planning of Coumadin will be audited on all newly admitted residents receiving x 3 months with findings reported monthly to facility QAPI Committee with follow-up to Committee recommendations. Date Certain February 16, 2017.	

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F 282	Continued From page 8 facility census was 137 residents. Findings include: 1. The admission Minimum Data Set (MDS) assessment for Resident #10, with reference date of 9/21/16, identified the resident with severely impaired cognition. The resident required limited assist of one staff member for activities of daily living. Resident diagnoses included atrial fibrillation (abnormal heart rhythm), coronary artery disease, diabetes mellitus, Non-Alzheimer's Dementia, and cardiomyopathy. The MDS revealed the resident received an anti-coagulant medication daily. An initial care plan for the resident dated 9/14/16 through 10/10/16, utilized while on skilled level of care, did not address the resident 's anti-coagulation therapy. When the resident was transferred to the long term care on 10/10/16 a new more detailed care plan was initiated. This care plan also did not address the focus problem of anti-coagulation therapy. Clinical record review of the resident's physician orders and lab orders revealed the resident's Coumadin therapeutic blood levels were unstable as evidenced by dose changes by the physician and frequent INR tests. During an interview on 12/21/16 at 2:30 PM with Staff E, Care Plan nurse, she stated the skilled residents are given a one page care plan which directs staff in the care of the residents for activities of daily living. Special instructions are added to the one page care plan as indicated. This is procedure because the skilled residents generally are short term stays. She does the	F 282		

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F 282	Continued From page 9 problem oriented more detailed care plans for all residents on the long term care unit. She has a specific focus problem with interventions for monitoring residents on anti-coagulant therapy and includes specific interventions the staff need to monitor the residents for such as excessive bleeding and heightened fall monitoring. She does not know why the specific focus problem on anti-coagulant therapy with interventions did not appear on Resident #10's care plan when he/she transferred to long term care. During an interview on 12/21/16 at 2:30 PM with Staff A, RN and TC manager (skilled care), she stated staff utilized a " Quick Look " one page care plan for the residents on the skilled unit. The Quick Look care plan notes staff instructions for resident ambulation, transfers, diet type, and activities of daily living. The care plans do not typically note anti-coagulant therapy or interventions to monitor residents on anti-coagulant medications. She stated her nurses are familiar with which residents are on Coumadin and alert to signs of excessive bleeding. She has policies for Warfarin (Coumadin) administration and protocols regarding INR lab tests for staff 's information available on the unit. She stated she would discuss implementing onto the skilled residents' care plans the more detailed care plans for anti-coagulant therapy which currently are in place for long term care residents. She does not know why the specific focus problem on anti-coagulant therapy with interventions did not appear on Resident #10's care plan when he/she transferred to long term care.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 10 (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility did not provide three residents (#10, #11 and #15) with two weekly baths per facility policy. The resident sample was 17 residents. The facility census was 137 residents. Findings include: 1. The Minimum Data Set (MDS) dated 11/3/16 indicated Resident #10 required limited assist from one staff member for bathing. The plan of care with target date of 12/22/16, instructed staff to assist the resident with bathing. Review of the Certified Nurse's Aide (CNA) electronic documentation of showers revealed from 9/14/16 through 10/10/16 the resident received assistance with one shower. The resident was transferred to long term care and hand documented shower sheets revealed the resident received four showers from 10/10/16 through 11/3/16. 2. The admission MDS dated 10/26/16 indicated Resident #11 required extensive assist from one staff member for bathing. The Initial Care Plan for Resident #11 noted the resident was to receive two showers a week from staff.	F 312	F312 R#10, #11, and #15 have been discharged from facility since survey. Interviews with facility staff indicate that baths/showers were being completed, however documentation of baths/showers was omitted at times. Agency CNAs do not have access to document baths/showers via POC. A paper bath/shower record has been developed/CNA staff were educated on form, and is being used by staff to document resident bathing. All residents are at risk of not receiving bathing as scheduled. CNAs (including agency CNAs) were educated one on one by Interim DON on the need to document residents' bath/showers via POC or via paper bathing form if CNA does not have POC access. Documentation of bathing of all residents will be monitored weekly x 3 months; findings will be reported monthly to facility QAPI Committee with follow-up to Committee recommendations Date Certain February 16, 2017.	

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F 312	Continued From page 11 Review of the CNA electronic documentation of showers revealed during the resident's skilled rehab stay from 10/26 - 11/7/16, Resident #11 received two showers. 3. The MDS dated 10/10/16 indicated Resident #15 required extensive assist from one staff member for bathing. The Initial Care Plan for Resident #15 noted the resident was to receive two showers a week from staff. Review of the CNA electronic documentation of showers revealed during the resident's skilled rehab stay of 10/17/16 - 10/29/16, Resident #15 did not receive assistance with bathing. During an interview on 12/22/16 at 1:40 PM with Staff B, CNA, she stated the residents are divided into three groups for bathing. Each CNA is assigned a group to assist with baths and checks the list to see who is to receive a bath that day. The assigned CNA is responsible for providing assistance with bathing and documenting the bath. Staff B stated she generally has time to complete her bathing duties on her shift. If a resident initially refuses then she will re-approach the resident later to offer the bath. She stated during routine morning cares most residents get " washed up well " including under arms and hygiene cleansing. During an interview on 12/22/16 at 2:00 PM with Staff A, Registered Nurse, she stated she did not know why there was no documentation of bathing for Resident #15. She stated facility policy was to provide two baths a week and as needed. She	F 312		

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F 312	Continued From page 12 stated she thought the CNAs were forgetting to document assistance with bathing.	F 312		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews and review of facility policy and procedures, the facility failed to provide adequate supervision and ensure a resident remained free from accident hazards (Resident #1). Resident #1 received an ice pack filled with hot water from	F 323	F323 R#1 has been discharged from facility on 11-30-16. All residents are at risk. Following this incident, immediate education on safe use of hot packs was given to Staff F. Event was reported to the Iowa DIA. The medical director was notified on 12/1/16. An Ad Hoc QAPI Committee meeting was held on 12/1/16 where nursing leadership and executive director developed and implemented a plan that educated all nursing staff on the safe application of hot packs. Staff F remains on suspension pending Iowa DIA's investigation decision. All staff were educated on safety in application of hot packs by 12-14-16. All newly hired staff, including agency staff, files will be audited for the documented receipt of safety education as it pertains to the use of hot packs x 3 months; orientation form has been revised to include education on safety in the use of hot packs. The use of hot packs within the facility will be closely monitored x 3 months. Date Certain February 16, 2017.	

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F 323	Continued From page 13 a coffee maker. The ice bag with hot water burst and burned the resident. The policy and procedure directed the staff to not apply this type of pack to the skin of residents. The sample consisted of 22 residents and the facility reported a census of 139 residents. Findings include: 1. Resident #1 had a MDS (Minimum data set) assessment with a reference date of 11/30/16. The MDS identified the resident had diagnoses including hypertension, anxiety disorder, depression, encounter for orthopedic aftercare, spinal stenosis, and lumbar radiculopathy. The MDS documented the resident had no long or short term memory problem or an impairment of cognitive skills for daily decision making. The MDS identified Resident #1 as requiring extensive assistance of two staff member for bed mobility, transfer, and toilet use, and limited assist of two staff members for ambulation, and dressing. The MDS documented the resident with an admission date of 11/28/16 to the facility. The Care Plan dated 11/28/2016, identified the resident had recent back surgery. The Care Plan directed staff that the resident required assist of one staff member for dressing, transfers, ambulation, repositioning, bed mobility, and staff are to monitor for sign and symptoms of back pain, use pain scale as applicable. The Care Plan identified the resident as alert and orientated to person, time and place. The Incident Report dated 11/30/16 at 7:15 p.m. indicated a Certified Nurse Aide (CNA) notified	F 323		

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F 323	Continued From page 14 the nurse that Resident #1 requested something for bladder spasms other than pain medication. The nurse went to the resident ' s room to ask what the resident wanted. Resident #1 requested a hot bottle for the lower pelvic area. The nurse told the resident the facility did not have water bottles. The resident told the nurse "They have been using bags like in the hospital and putting hot water from the coffee machine in it " . The nurse picked up bag that the resident acknowledged had been used. The nurse did what the resident requested and checked the bag for leaks and held it upside down to make sure it did not leak. The nurse then laid the bag on the resident ' s lower pelvic area below the abdominal fold. The nurse turned away and the resident grabbed the bag and the bag burst open. The nurse quickly grabbed cold washcloths from the bathroom and applied them to the resident ' s burned areas. The nurse than assisted the resident to the bed and had the resident lie on the non-affected side and continued to apply cold washcloths to the affected areas. The resident had pain so the nurse rushed to get pain medication and then called 911 to send the resident to the emergency room for treatment. Review of the Progress Notes, Nurses Notes, dated 11/30/16 at 8:57 p.m. identified at around 7:15 p.m. a CNA notified Staff F, Registered Nurse (RN) that Resident #1 requested something for bladder spasms other than a pain medication. Staff F went to the resident ' s room to ask the resident what they wanted. The resident told Staff F he/she wanted a hot water bottle for the lower pelvic area. Staff F told the resident the facility does not have hot water bottles and the resident responded " They have been using bags like this in the hospital and	F 323		

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F 323	Continued From page 15 putting hot water from the coffee machine in it ". Staff F picked up the bag that the resident acknowledged and that is what is being used. The nurse did what the resident requested and checked the bag for leaks and held it upside down to make sure it did not leak. Staff F then laid the bag on the resident ' s lower pelvic area, below the abdominal fold. Staff F turned away and the resident grabbed the bag and it burst open. Staff F quickly grabbed cold washcloths from the bathroom and applied them to the resident ' s burned areas. Staff F than assisted the resident to the bed and had the resident lie on the non-affected side and continued to apply cold washcloths to the affected areas. The resident in pain so Staff F rushed to get pain medication and then called 911 to send resident to emergency room for treatment. Staff F notified the resident ' s family of incident and resident being transported to the emergency room. An emergency transport report dated 11/30/16 indicated a call was received from the facility at 7:27 p.m. The call identified Resident #1 had signs and symptoms of second degree burns to the left lower quadrant, left lower back and upper groin area. The resident stated was burned by hot water used for bladder spasms. The resident reported the hot water was placed in a Ziploc type of bag with a commercial type of sleeve that goes over the bag. The resident voiced extreme pain. The facility nurse reported the resident had been at facility 2 to 3 days to recover from back surgery. The nurse reported using hot water from a commercial coffee maker into a bag to apply heat to the resident. The nurse stated she administered pain medication and the resident needed transported to the emergency room. Emergency transport personnel further	F 323		

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F 323	Continued From page 16 documented they found resident lying in bed on the right side wearing a hospital gown with second degree burns to the left lower quadrant, left upper pelvic/genital area, left upper thigh/buttock area, and left lower back buttock area. An emergency transport personnel was advised to bypass the local emergency room and transport to the nearest out of city burn unit. Review of Resident #1 hospital records with admission date of 12/1/16 and discharged on 12/14/16 revealed the resident was admitted with 7% of body burns to the abdomen and left thigh. This injury occurred on 11/30/16 around 7:00 p.m. when a heated water/bag broke and spilled hot water across back, lower abdomen and left thigh. The resident was admitted to the burn unit during the early morning of 12/1/16. Hospital course consisted of portions of the burns were full thickness and skin grafting performed on 12/9/16 and the grafts appeared to have good graft take. Resident was distressed about the circumstances of the burn and psych nursing visited throughout his/her stay. Resident did not to return to facility and choose another facility to be discharged to. Review of a facsimile sent from the facility to Resident #1 physician dated 12/1/16 indicated an incident happened last night with resident that resulted in burns to abdomen and upper thigh due to improper use of applying heat, using hot water in a disposable pack. Immediate education has been initiated with all nursing staff on proper use of heat packs and proper equipment. Review of the policy and procedures for Aqua K pad heating application, with a revision date of 4/2009, directed the staff to use with a physician ' s order in order to provide heat at a constant	F 323		

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F 323	Continued From page 17	F 323		

temperature for an extended period of time. The only heat treatment to be used by the Nursing Department is the Aqua K pad; other sources, such as hot water bottle, heating pad, or microwave hot, may not be used. Staff are to document in the Nurse ' s Notes the date, time, procedure, observations, and resident reactions. Staff are to sign off treatment on the treatment sheet.

Review of Resident #1 clinical record lacked a physician ' s order for using the heating device or any documentation of what staff used for the application and the reaction of the application.

On 12/16/16 at 3:15 p.m. Resident #1 was interviewed and stated she/he lived at home independently prior to going to the facility for rehabilitation following back surgery. Resident #1 stated he/she expected to receive therapy and return back home and back to his/her job. The resident stated he/she had bladder spasms at the hospital and they used warm washcloths that resulted in relief. The resident stated he/she came to the facility on 11/28/16 and on 11/29/16 he/she had bladder spasms and asked staff to get him/her a heating application for it. The resident stated the staff got a disposable ice bag from the facility and filled it with warm tap water one time and on another time staff filled half full with hot water from the coffee machine and ½ full with ice cubes. The resident stated the bag seemed to be a little hot but did not hurt him/her. The resident stated on the evening of 11/30/16, he/she asked staff to get him/her a warm application and told staff they have been using the disposable ice bags that were in his/her room. The resident stated a staff member took the bag from his/her room and filled it with hot water from

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F 323	Continued From page 18	F 323		

the coffee maker and the staff member handed it to him/her as he/she set in recliner in her/his room. The staff person told resident to not squeeze the bag. The resident stated the bag was too hot to handle and before he/she could say anything, the bag exploded onto his/her gown and underwear and went around to the back area.
The resident stated he/she had immediate severe pain, causing him/her to scream out and cry out in pain. The resident stated the staff member immediately applied cold wash clothes to the area of groin, abdomen, left thigh and back area and assister him/her to bed and had him/her lay on right side and continued to apply the wash clothes. Resident #1 stated the pain to be unbelievable. The resident stated the ambulance arrived and administered a IV (Intravenously) fluids and administered him/her pain medication two times and after the second time he/she received the pain medication he/she did get some relief. The resident stated he/she transferred to the closest burn unit and admitted. The resident stated he/she underwent daily baths and scrubbing of the burn area that were very painful and described the pain as unbelievable. The resident stated he/she required a skin graft on 12/9/16 to treat the burn areas; the skin graft was taken from the abdominal area. The resident continued to need pain medication every day and would wake up daily with nightmares of the burn incident. The resident stated he/she will have to return to the burn clinic frequently and continue with the baths and scrubbing treatment to his/her burn areas. The resident stated he/she did not feel the staff did this on purpose but did think the staff member appeared to be in a rush.

On 12/16/16 at 5:05 p.m. Staff G, Certified Nurse

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F 323	Continued From page 19 Aide (CNA) was interviewed and stated on 11/29/16 she was assigned to care for Resident #1. Staff G stated the resident asked her for hot wash clothes or a hot water bottle for bladder spasms. Staff G stated she went to the storage unit of the facility and retrieved a disposable ice pack bag and filled it half full of hot water from the coffee machine and half full of ice. Staff G stated the bag to be warm but not too hot to touch. Staff G reported she placed this bag onto the resident ' s skin of the lower abdomen and checked on resident 10 minutes later and the resident had removed the bag. Staff G stated prior to using and applying the bag, she asked Staff H, Registered Nurse (RN) if this would be alright. Staff G stated Staff H was shown the disposable ice bag and ok to use for the resident and make sure not to hot. Staff G stated she did this application for the resident 2 times during her second shift. Staff G stated another staff member attempted to heat water in the disposable ice pack bag in the microwave and the bag exploded in the microwave. Staff G stated she then went and got a second bag from the facility ' s storage supplies and filled ½ full with hot water from the coffee machine and ½ full of ice cubes on the second time she applied the heating application on 11/29/16. Staff G stated she had never used a disposable ice bag for heat before but have used them with ice. Staff G stated she has seen and used the Aqua-K heating application at the facility before. On 12/14/16 at 4:10 p.m. Staff H, Registered Nurse (RN) was interviewed and stated Staff G, CNA, asked her on 11/29/16 if she could get another heat pack for Resident #1. Staff H stated she told Staff G yes and to get it from supplies. Staff H stated she did not see the heat pack that	F 323		

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F 323	Continued From page 20 Staff G got from supplies or what she put in the bag. Staff H stated she did not realize it was a disposable ice bag that was being used. Staff H stated she did not know if resident had an order for heat application as she did not check and did not document the use of the heat bag being applied to the resident. Staff H stated she was in the resident ' s room before and after the application of the heating bag that was used twice on 11/29/16. Staff H stated the resident requested the heating pack for complaints of bladder spasms. Staff H stated she has never seen these disposable ice bags used for heating application. On 12/9/16 at 1:23 p.m. Staff I, CNA was interviewed and stated Resident #1 asked her for a hot water bottle during the day of 11/30/16. Staff I stated this is the first time the resident asked for that and the resident pointed to disposable ice bag on his/her bed side table. The resident informed her staff had used that to put hot water in it. Staff I stated she checked with Staff D, RN, and she said it would be ok to use the disposable ice bag and put hot water in it for the resident. Staff I stated she filled the plastic bag with warm water from the sink, checked for leaks, and handed it to the resident who placed the bag with sleeve on it to his/her pelvic area and said he/she reported having bladder spasms. Staff I stated she told Staff D that the resident had bladder spasms. Staff I stated she checked on the resident after a little while and removed the heat pack. The resident had no further complaints. On 12/9/16 at 2:26 p.m. Staff D, RN was interviewed and stated she and Staff I (CNA) were in the resident ' s room. The resident informed them the staff used a disposable ice pack for a hot pack with hot tap water. Staff D	F 323		

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F 323	Continued From page 21 stated she Ok ' d this for Staff I to do for the resident. Staff D stated the resident did not have a physician order for this and the nursing assistants are not allowed to be applying heat application. Staff D stated she just returned from a long trip and she just listened to what Staff I told her about staff using the disposable ice bag and putting hot water in it. Staff D stated she should have first checked the physician ' s orders to verify which heating application ordered and not allow a CNA to apply any heating application. Staff D stated the resident did not have an order for any heating application. Staff D stated she did not document the use of this heating application, times it was used and the resident ' s response. Staff D stated she never used a disposable ice bag for heat application nor had she seen it used. Staff D stated the facility used an Aqua K pad [device] for heat application and she had used this before for residents. Staff D stated the resident reported having bladder spasms and requested the hot pack. Staff D indicated she went back to check on resident and resident had removed the heat pack and stated he/she got relief from it like she usually does. On 12/16/16 at 4:06 p.m. Staff F, RN was interviewed and stated on 11/30/16, she came into work at 2 p.m. and did a new admission until 6 p.m. after receiving report. Staff F stated she then went to the floor and was assigned to care for Resident #1. Staff F stated around 7 p.m. a CNA reported to her that the resident requested something other than pain medication for bladder spasms. Staff F stated she went to the resident ' s room and talked with the resident. The resident sat in a recliner chair and wore a gown and underwear. Staff F stated the resident voiced she/he wanted a hot water bottle for her bladder	F 323		

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(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 323	Continued From page 22	F 323		

spasms and informed Staff F the staff had used the disposable ice bag and obtaining hot water from the coffee maker machine. Staff F stated she took the ice bag to the coffee machine and filled it up half full of hot water, applied the sleeve to the bag and closed the two zip like plastic closures. Staff F stated she checked the bag for leaks. Staff F reported she then took the bag to the resident ' s room. The resident lifted up the gown and abdominal fold so Staff F could apply the heated bag to the area. Staff F stated she placed the bag with the opening of the bag towards the left side and used no towel between the bag and the skin, just the sleeve of the disposable ice pack. Staff F stated she started to walk away from the resident when she saw the resident moving, heard resident yell out and saw the hot water bag burst open. Staff F stated she immediately got cold wet wash clothes and applied them to the area of burns. Staff F stated she assisted resident to lay on the unaffected [right] side in bed, continued to apply cold wet wash clothes, and removed the wet grown. Staff F stated the resident cried and yelled out in pain. Staff F stated she called 911 and administered pain medication to the resident. Staff F stated the groin, thigh, abdomen area appeared red and the skin peeled. Staff F stated the ambulance arrived 10-15 minutes after the hot water bag broke, and transferred the resident to the emergency room. Staff F stated she did not check for an order for the resident to have a heat application. Staff F stated the resident told me what to do and I did what he/she wanted. Staff F stated she should have checked the physician orders before applying any type of heat application and to use the appropriate heating application, such as an Aqua k pad. Staff F stated she had used an Aqua K heating application in the facility after receiving

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	166432	A. BUILDING _____ B. WING _____	C 01/13/2017

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F 323	Continued From page 23 the physician order. Staff F stated she did not intentionally mean for this to happen but was just following the resident ' s instruction. Staff F stated there was a label on the sleeve of the bag but she did not pay attention to it. The label identified the bag as disposable and for ice. On 12/9/16 at 11:08 a.m. and on 12/13/16 at 1:44 p.m. the Director of Nursing (DON) was interviewed and stated she received a call from Staff F about the incident. The DON stated she immediately went to the hospital and upon her arrival, the resident laid on an ambulance stretcher and exiting the facility. Staff A stated she immediately began an investigation of events. Staff A stated the staff had used inappropriate heating application for Resident at least 24 hours before this. Staff A stated staff did not have an order for any heating application, did not document the use of inappropriate heating application, nor reported the resident ' s complaints of bladder spasms to the physician and the resident requesting heat to the area. The DON stated she immediately removed all disposable ice packs from central supply and the floor [supply closet]. Review of the facility coffee/water machine NG-300 specifications, identified hot water temperature of 180 degrees. The Disposable Ice Pack label identified it to be ready to fill, latex-free, and measured 7 inches by 10 inches. Note: At the time of the complaint investigation, the complaint was coded at a "J", immediate and	F 323		

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F 323	Continued From page 24 serious jeopardy. On 11/30/16 the Director of Nursing began in-services to all nursing staff about the application of heat or cold and the need for a current physician order per nursing policy. By 12/14/16, the entire nursing staff [per attendance record] had received the in-services and the jeopardy and grid placement was lowered to "D" level. As of the January 13, 2017 exit conference, the facility needed to : continue to monitor nursing staff to assure the facility policy and procedures for the use of hot and cold therapy/treatment are followed.	F 323	F333 R#10 was discharged from facility on 11-3-16. All records of residents receiving Coumadin were audited to assure accuracy of order transcription, appropriate addressing of INRs and accurate administration of Coumadin. QAPI Ad Hoc Committee met 2/3/17 and put into place monitoring of medication administration and transcription errors. All residents receiving medications are at risk for medication error. Staff D was educated upon finding error on accuracy and timeliness in transcription of physician orders. Nurses were educated by 2-9-17 by Interim DON on timely accuracy in receiving and transcription of physician orders and monitoring of labs to assure accuracy in medication administration. Coumadin orders, INRs, administration and notification of physician regarding Coumadin/INRs will be monitored daily x 4 weeks; weekly x 2 months with findings reported monthly to facility QAPI Committee with follow-up to Committee recommendations. Date Certain February 16, 2017.	
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to administer Coumadin (anti-coagulant medication to slow blood clotting to help prevent blood clots) to Resident #10 as ordered by the physician. The resident sample consisted of 17 residents and the facility census was 137 residents. Findings include: The admission Minimum Data Set (MDS) assessment for Resident #10 with the reference date of 9/21/16, identified the resident with a severely impaired cognitive status. The resident required limited assist of one staff member for activities of daily living. Diagnoses for the	F 333		

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F 333	Continued From page 25 resident included atrial fibrillation (abnormal heart rhythm), coronary artery disease, diabetes mellitus, Non-Alzheimer's Dementia, and cardiomyopathy. According to the MDS, the resident received an anti-coagulant medication daily. An initial care plan for the resident dated 9/14/16 through 10/10/16 (utilized while on skilled level of care) did not address the resident's anti-coagulation therapy. When the resident was transferred to the long term care on 10/10/16 a new care plan was initiated. This care plan also did not address the focus problem of anti-coagulation therapy. Record review of the resident's physician orders for admission revealed the resident was to receive Coumadin 2.5 milligrams (mg) on Sunday (S), Monday (M), Tues (T), Thursday (Th) Friday (F), and Saturday (Sa) by mouth once daily. On Wednesday (W) the resident was to receive 5 mg by mouth. Later that day, based on the results of a PT/INR laboratory test (4.4) reported that day the order was changed to hold the Coumadin that day (Wednesday 9/16/16) and reduce the dosage to 1.25 mg on Sa, M, and W with Coumadin 2.5 mg given on S and T. Staff was to repeat the PT/INR on 9/22/16. The Protime (PT) and International Normalization Ratio (INR) blood tests measure the effect of the anticoagulant on clotting time to ensure that the medication is increasing the resident's clotting time to a therapeutic level. The optimal INR range for therapeutic results of Coumadin as 2.5 to 3.5 as documented on the resident's admission instructions from the admitting hospital to the facility.	F 333		

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F 333	Continued From page 26 An incident report dated 9/28/16 revealed on 9/22/16, Staff D, Registered Nurse (RN), called the physician's office with results of the day's INR of 1.9. The physician changed the order and the Coumadin was for 2.5 mg every day. The incident report stated the nurse who took the order (Staff D) neglected to write the order and enter it into the computer. When Staff D returned to work on 9/26/16 she realized she did not enter the order on 9/22/16 so she entered it on 9/26/16. The physician ordered the next INR obtained on 9/28/16 and this order was sent to lab. Review of Resident #10's Medication Administration record (MAR) confirmed the resident did not receive any Coumadin on 9/22, 9/23, 9/24, and 9/25. The dosage was started again on 9/26. Review of a laboratory test result revealed the INR on 9/28/16 was 1.1, an INR below therapeutic level can result in the complications from the formation of a blood clot in the body. During an interview on 12/21/16 at 2:30 PM with Staff A, RN and TC manager (skilled care) she stated she received a call from the physician's office on 9/28/16. She was asked to check on the resident's Coumadin administration as the level had dropped down and the physician did not know why. Staff A reviewed the record and realized the resident had missed four days of Coumadin administration. She reported this to the physician who reordered an INR for 10/3/16 and ordered the Coumadin to remain at 2.5 mg daily. Staff A stated nursing staff enters a stop date for Coumadin when a new order for INR is entered and this is procedure. She stated the nurse who entered the order for the 9/22/16 INR	F 333		

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F 333	Continued From page 27 would have placed a stop on the Coumadin for 9/22/16 anticipating a new Coumadin order when the new INR results were known. Staff A stated this is why the Coumadin dosage was stopped completely on 9/22/22. Staff A stated Staff D was disciplined and all staff re-educated on physician orders and anti-coagulant administration. Staff A stated the resident did not suffer any effects of missing the Coumadin doses but did agree the INR level dropped in relation to the missed doses.	F 333		