PRINTED: 06/10/2019 FORM APPROVED OMB NO. 0938-0391

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING  |   |                     | (X3) DATE SURVEY<br>COMPLETED                             |  |            |
|--------------------------|---|---|---------------------|---|--|------------|
|                          |   | 165352  | B. WING             |   |  | C          |
|                          | ROVIDER OR SUPPLIER   | 10332   |                     | STREET ADDRESS, CIT<br>2405 21ST STREET<br>EMMETSBURG, IA |  | 04/01/2019 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CO  | DER'S PLAN OF CORRECTION<br>DRRECTIVE ACTION SHOULD B<br>FERENCED TO THE APPROPRI<br>DEFICIENCY) | DATE       |
| F 000                    | INITIAL COMMENTS  | 3   | F 0                 | 00  |  |            |
|                          | Amended 6/10/2019   | following an IDR.   |                     |   |  |            |
|                          | Correction date   |   |                     |   |  |            |
|                          |   | omplaint 80498-C completed following deficiencies. as not substantiated.  |                     |   |  |            |
|                          | See Code of Federal<br>483, Subpart B-C.  | Regulations (42CFR) Part  |                     |   |  |            |
| F 580<br>SS=J            | •   | njury/Decline/Room, etc.)<br>4)(i)-(iv)(15)   | F 5                 | 30  |  |            |
|                          | consult with the residence consistent with his or representative(s) who (A) An accident involves and injury and he physician intervention (B) A significant charmental, or psychosodeterioration in health status in either life-the clinical complications (C) A need to alter to a need to discontinue treatment due to advolve commence a new for (D) A decision to transident from the fact §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section all pertinent informatics. | nediately inform the resident; lent's physician; and notify, her authority, the resident en there isving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or s); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or nsfer or discharge the |                     |   |  |            |
| LABORATORY I             | <br>DIRECTOR'S OR PROVIDER/   | SUPPLIER REPRESENTATIVE'S SIGNATU   | RE                  |   | TITLE  | (X6) DATE  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

04/08/2019

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|--------------------|---|--|-------------------------------|----------------------------|
|                          |  | 165352   | B. WING            |   |  |                               | 01/ <b>2019</b>            |
|                          | ROVIDER OR SUPPLIER  |  |                    | 2                                       | TREET ADDRESS, CITY, STATE, ZIP CODE<br>405 21ST STREET<br>EMMETSBURG, IA 50536                              | 1 04/                         | 01/2013                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 580                    | resident and the resident when there iswhen there is- (A) A change in room as specified in §483. (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must be update the address (uphone number of the representative(s). §483.10(g)(15) Admission to a composite di §483.5) must discloss its physical configural locations that comprispart, and must specifications that comprise the specification of the residence of the property of the specifications of t | also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph of the cord and periodically mailing and email) and resident osite distinct part. A facility estinct part (as defined in the in its admission agreement tion, including the various see the composite distinct by the policies that apply to en its different locations on its different locations is not met as evidenced itew and staff interview the diately inform the resident; ent's physician; and notify, her authority, the resident en there is- a significant of the physical, mental, or that is, a deterioration in ychosocial status in either | F                  | 580                                     |  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED   |                        |
|--|--|---|---------------------|---|------------------------|
|  |  | 165352  | B. WING             |   | C<br><b>04/01/2019</b> |
|  | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2405 21ST STREET<br>EMMETSBURG, IA 50536                               | 1 04/01/2010           |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETION        |
| F 580  | Findings include:  1. A Minimum Data S reference date of 11/with a brief interview score of "12" (moder. The resident required bed mobility, transfer room and personal h required extensive st dressing and bathing range of motion limita extremities on one si was occasionally incresident had left hip a from 10/23/18.  Bowel records identif following loose stools 12/2/18 loose diarrhed 12/4/18 4 bowel mov stools 12/5/19 4 bowel mov with loose stools 12/6/19 loose stools 12/6/19 loose stools 12/6/19 resident times daily. The nigh was up to the toilet a resident self transfer time. Staff encourage transfer. Staff prepar | set (MDS) with assessment 21/18, assessed Resident #3 for mental status (BIMS) at ecognitive impairment). If limited staff assistance with s, ambulation in and out of ygiene. The resident aff assistance with toileting, and the toileting of the body. The resident portions of the upper and lower de of the body. The resident continent of bowel. The and left humerus fractures are ments, 3 of them loose the ements, at least 3 of them 2 times and loose stools up to 6 to f the entry, the resident and incontinent 7 times. The red so she could make it in the dather esident review and advise. | F 580               |   |                        |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE<br>A. BUILDING _ | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |  |
|--|---|--|--------------------------------|---|----------------------------|--|
|  |   | 165352   | B. WING                        |   | C<br>04/01/2019            |  |
|  | ROVIDER OR SUPPLIER   |  | 2                              | TREET ADDRESS, CITY, STATE, ZIP CODE<br>405 21ST STREET<br>EMMETSBURG, IA 50536                                     | 1 04/01/2010               |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETION              |  |
| F 580  | physician acknowled "patient hospitalized" when the surveyor querician response, stated the physician 12/6/18 and address (12/15/18). She state renotified the physician received from the 12 DON stated if a common back in 24 hours physician.  On 3/18/19 at 12:48 12/6/18 communicating progress note that the physician office. Since expected her colleage through the cracks, a from anyone, they shall stated if she work and received the facing the resident, she work studies. She stated is colleagues may have more than one way to stated when the resident's appetite door fever. On 12/8/18 loose stools, the facing stated delay of notifical resident. The faster than reversed, the be | 8 progress note identified the ged it on 12/15/18 and wrote . On 3/18/18 at 11:22 a.m. Justioned the delay in the the director of nursing (DON) was out of the country on ed it the day she came back and no one from the facility an when no response was 16/18 communication. The munication to the physician is staff typically calls the p.m. the physician stated the on to the physician was a e facility hand carried to the eshe was gone, she use to address it. Since it fell and the facility didn't hear would have called the clinic. The all have worked on 12/6/18 lity communication regarding all have ordered stool he cant speak for what her end done due to their being to handle the situation. She dent had 2 loose stools, the aught the issue was resolving spect a call then unless the excreased of if she had pain when the resident had 10 ity should have called. She cation did not help the he etiology is determined the terent outcome if they | F 580                          |   |                            |  |

| AND BLAN OF CORRECTION IDENTIFICATION NUMBER: |  | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |  |                        |  |
|---|--|---|---|--|------------------------|--|
|   |  | 165352  | B. WING   |  | C<br><b>04/01/2019</b> |  |
|   | ROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 2405 21ST STREET EMMETSBURG, IA 50536 |  | 04/01/2013             |  |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION          |  |
| F 580   | director of nursing) stakes printed communications that physicians day this is done variethe clinic, they will drommunication notes.  On 3/19/19 at 10:23 became aware of the communication shee after the physician rebefore the first of the reviewed with her off to check her communifacility when she is go 12/15/18 and the first yesterday after the same date at 11:27 at the one that keeps trommunications retudidn't know what hap communication note knew. She stated she progress notes if thir doctor. There's been procedure for tracking and there has been in A progress note date revealed the resident saying she needed the felt warm to the touck 97.9 degrees, pulse pressure 112/55 and resident was very we say the sa | m. the ADON (assistant tated every day the facility inication for physicians to the se finished communication is have reviewed. The time of es. If a resident is going to rop off and pick up at that time.  a.m. the DON stated they is sat that time.  a.m. the physician is to returned sometime exturned on 12/15/18 and is year. The physician is to that other providers need inication notes from the one. She did this between it of the year and again urveyor questioned it. On the a.m. the DON stated she is ack of physician irrning timely. She stated she opened with Resident # 3's on 12/6/18. She wishes she is keeps track through ags come back from the no change in their g physician communication | F 580   |  |                        |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING |   |  | (X3) DATE SURVEY COMPLETED |  |                 |
|---|---|--|----------------------------|--|-----------------|
|   |   | 165352   | B. WING                    |  | C<br>04/01/2019 |
|   | ROVIDER OR SUPPLIER   |  |                            | STREET ADDRESS, CITY, STATE, ZIP CODE 2405 21ST STREET EMMETSBURG, IA 50536                            | 1 04/01/2013    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION |
| F 580   | hands. The resident cramps. Staff called I the resident transport. An ED (emergency d 12/9/18 revealed the and dehydrated. The very dry. The resident The resident's blood following: BUN (blood creatinine 1.87 high, 2.6 low, chloride 118 BUN/creatinine ratio cell) 18.8 high. The difficle (c.difficle) diarr Hospital discharge didentified the residen include: c. difficle colkidney injury. The disc. difficle colitis curre (antibiotic) and IV fladiarrhea slowly improved. The report be admitted to skilled and IV antibiotics. Ho family will arrive on 1 | I on the dorsal aspect of both complained of severe belly ER (emergency room) and ted to the hospital.  epartment) final report dated resident presented weak resident's oral mucosa was at's skin turgor was "tenting". Ilaboratory work revealed the durea nitrogen) 63 high, sodium 146 high, potassium critical high, CO2 15 low, 33.7 high, WBC (white blood liagnosis was clostridium rihea.  coumentation dated 12/12/18 tt's admission diagnoses to itis, acute diarrhea and acute scharge diagnoses included: ntly on oral vancomycin gyl (antimicrobial), acute oving and acute kidney injury revealed the resident would I care for continued IV fluids ospice is considered and 2/14/18 to discuss it. | F 58                       |  |                 |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING |                     |   | (           | X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|---|-------------|------------------------------|--|
|   |  |  | A. BOILDII          |   |             | С                            |  |
|   |  | 165352   | B. WING _           |   |             | 04/01/2019                   |  |
|   | ROVIDER OR SUPPLIER BURG CARE CENTER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>2405 21ST STREET<br>EMMETSBURG, IA 50536    | E           |                              |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE |                              |  |
| F 580   | 12/4/18 9:44 a.m. 25 12/4/18 1:04 p.m. 12 12/4/18 6:05 p.m. ze 12/5/18 9:45 a.m. 25 12/5/18 7:04 p.m. 5 12/5/18 7:04 p.m. ze 12/6/18 9:25 a.m. 12 12/6/18 12:38 p.m. 1 12/6/18 7 p.m. 12% 12/7/18 9:26 a.m. 12 12/7/18 9:26 a.m. 12 12/7/18 6:13 p.m. 30 12/8/18 12:07 p.m. 2 12/8/18 1:01 p.m. 50 12/8/18 7 p.m. zero A death certificate file resident expired on 1 medical cause of deafollowing: Immediate cause of deafollowing: Immedia | % % % % % % % % % % % 2% % \$  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$  \$                  | F                   | 580   |             |                              |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIF  | PLE CONSTRUCTION  G | (X3) DATE SURVEY<br>COMPLETED   |                      |
|---|---|--|---------------------|---|----------------------|
|   |   | 165352   | B. WING             |   | 04/01/2019           |
|   | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2405 21ST STREET<br>EMMETSBURG, IA 50536             | •                    |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLETION |
| F 580   | Continued From pag  |  | F 58                | 80  |                      |
|   | then fax the progres review and pending   | create a progress note and is note to the physician for any new orders. the charge a return within 24 hours if   |                     |   |                      |
|   | call to the provider,<br>will be made directly<br>nurse asking for the<br>physician of the cha<br>nurse then will eithe   | in condition requiring a phone no fax will be sent but a call to the clinic by the charge provider and will inform the nge in condition. The charge r obtain orders by the nonitor condition or provide  |                     |   |                      |
|   | p.m. until 8:30 of the close of clinic until Nopening procedure of non-immediate fax reports be faxed to the emedoctor. They will result for condition warrants are to bypass the fasaid provider on corrections. | nday through Friday from 5 e next morning, or Friday after Monday morning of clinic will be as follows: Any not requiring a phone call will regency for notification to the pond in 24 hours.  s immediate phone call they a and call immediately out to adition and await orders. The en make a progress note |                     |   |                      |
|   | stating that a phone orders if any were of the facility will bypa (emergency room) rephysician to take the speak with the physic wait unless the Ecode blue or other experience.                                  | call has been made and what  |                     |   |                      |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '              | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|--------------------|--|--|-------------------------------|----------------------------|
|   |  | 165352  | B. WING            |  |  | l                             | 01/ <b>2019</b>            |
|   | ROVIDER OR SUPPLIER  |   |                    | 2                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1405 21ST STREET<br>EMMETSBURG, IA 50536                            |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 609<br>SS=D                                       | absence the chain of assistant DON, QA (cand administrator will check mark and initial that the fax was looked. The charge nurses we the nurses notes reflected follow up.  Reporting of Alleged CFR(s): 483.12(c)(1) (square)  §483.12(c) In responsing the following abuse, negligible mistreatment, including source and misapproare reported immedia hours after the allegates that cause the allegates and do not residue administrator of the second control of the second cause the administrator of the second cause the second cause the administrator of the second cause the second cause the administrator of the second cause the second cause the administrator of the second cause the second c | ary to first check. In her command is as follows, quality assurance) nurse, be responsible to place a I with date and time to note ed at.  ill be making an entry into ecting noting if the order and Violations (4)  se to allegations of abuse, or mistreatment, the facility |                    | 609                                    |  |                               |                            |
|   | for jurisdiction in long<br>accordance with State<br>procedures.<br>§483.12(c)(4) Report   | ces where state law provides -term care facilities) in e law through established the results of all administrator or his or her   |                    |  |  |                               |                            |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTI<br>A. BUILDIN  | PLE CONSTRUCTION  G   | , ,     | OATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|---|---|---------|----------------------------|
|                          |  | 165352   | B. WING _   |   |         | C<br><b>04/01/2019</b>     |
|                          | OVIDER OR SUPPLIER   | 1  | STREET ADDRESS, CITY, STATE, ZIP CODE 2405 21ST STREET EMMETSBURG, IA 50536 |   | ·       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCE   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 609                    |  | tative and to other officials in   | F6  | 09  |         |                            |
|                          | Survey Agency, with incident, and if the a appropriate corrective. This REQUIREMEN by:  Based on record reversed facility failed to ensure involving abuse, negomistreatment, includ source and misapprowere reported immediate hours after the allegate that cause the allegate in serious bodily injurify the events that cause involve abuse and dinjury, to the administ other officials (included Agency and adult prolaw provides for jurist facilities) in accordant established proceduralleged violations were alleged violations were alleged violations were alleged violations were stablished proceduralleged violations were alleged violations were allegedly known Resident #8 leaving failed to report the infracility census was a serious findings include:  1. A Minimum Data Street and moderately imparts and includes and moderately imparts and moderately | te law, including to the State in 5 working days of the lleged violation is verified to action must be taken. This not met as evidenced view and staff interview the re that all alleged violations elect, exploitation or ing injuries of unknown opriation of resident property, diately, but not later than 2 fation is made, if the events ation involve abuse or result rry, or not later than 24 hours use the allegation do not onot result in serious bodily strator of the facility and to ling to the State Survey of the State Survey of the State Iaw through reshave evidence that all ere thoroughly investigated for ff B LPN (licensed practical wingly left a heating pad on 3 burn areas. The facility incident to the State agency, thirty-nine (39) residents.  Set (MDS) with assessment /19/18 assessed Resident #8 erm memory impairments aired decision making ability. In the staff assistance with |   |   |         |                            |

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|  |   | 165352   | B. WING _            |  |                            | C<br>04/01/2019            |  |
|  | ROVIDER OR SUPPLIER   | 1  |                      | STREET ADDRESS, CITY, STATE, ZIP CODI 2405 21ST STREET EMMETSBURG, IA 50536              |                            |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |  |
| F 609  | resident had daily in was occasionally income A 12/2018 treatment identified an order "a area QID (four times needed every 6 hou Nursing progress not a.m. identified the reeyes closed. The reeverbal or physical st Nursing progress not a.m. and documents (DON) revealed she room. When the DO CNAs repositioned to observed redness to blisters.  Nursing progress not a.m. identified "incidated (CNA) called Sto the resident's room report a heating pad overnight which caublisters beginning. Staff administered in possible related pair burn areas on the measuring 1.5 centiling area. | g. The resident had ded: stroke and arthritis. The dicators of pain. The resident continent of urine.  administration record (TAR) apply heat pack to affected a day) for 20 minutes as rs as needed for pain".  tes. dated 12/19/18 at 10:24 esident as resting in bed with sident did not respond to | F 6                  | 09   |                            |                            |  |
|  |   | arding the burns documented ed 12/21/19 at 9:11 a.m.   |                      |  |                            |                            |  |

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|   | ROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 2405 21ST STREET EMMETSBURG, IA 50536 |  | , 0.00.20.0     |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION   |  |
| F 609   | pink line to the botto. There were 3 blister 1.1 cm. by 1.2 cm. s scabbed area. The c yesterday was TAO dressing twice a day identified the areas. Nursing progress not p.m. revealed the restant line of the state of the com. Staff Interviews:  On 3/20/19 at 2:25 prot recall who the C room. She didn't knot heating pad was set removed it before she stated she was not in nurse at shift changusing the heating pad called another CNA resident and found to resident right next to the resident right next to the resident right next to the resident to state of the resident was on her skin and stated the resident voculdn't turn herself hands and could not the could not could not staff B LPN | s. There was a tiny fading om of the resident's back. s. 1 cm. by 0.5 cm. fluid filled, cabbed area, 1.2 by 1.3 cm. current treatment received (triple antibiotic ointment) with a until healed. The DON were healing.  Stes dated 12/21/18 at 1:41 sident expired.  D.m. Staff C RN stated she did NA was that called her to the low what temperature the low. She stated the CNAs the got to the room. Staff C informed by the off going ereport that the resident was red.  p.m. Staff D CNA stated she in to help her turn the he heating pad on the lower skin under her back. It was completely red. She is eput it on the resident and the staff most likely didn't turn have noticed the heating pad and ther skin was red. Staff D was not really responsive and the resident could move her | F 60'   | 9  |                 |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | TIPLE CONSTRUCTION  NG   |                  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|---------------------|--|------------------|-------------------------------|--|
|   |  | 165352  | B. WING             |  |                  | C                             |  |
|   | ROVIDER OR SUPPLIER  | 100002  |                     | STREET ADDRESS, CITY, STATE, Z 2405 21ST STREET EMMETSBURG, IA 50536 |                  | 4/01/2019                     |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | CROSS-REFERENCED   | ACTION SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 609   | all night because it she placed it over the bed pad. Staff B to resident that night a previous nights. She the details of the conher statement that 3/22/19 at 12:05 p. that was emailed to statement from 12/2 On 3/20/19 at 1:59 resident could not nonly "flail". The resionly verbalization with the same date at 3 was no policy for uspacks. She stated in warm/hot pack that if they wanted to.  On 3/22/19 at 10 a placed the heating slightly under the lewould not fall off the resident could wight. She assume heating pad and stap.m. or 9 p.m. She or 12:30 a.m.  A major injury deter at 9:30 a.m. inform resident had redne the back due to "hot identified the "heating alleviate pain. The | resident's back and left it on wasn't on the skin. She said he resident's pajamas and the ld her she placed it on the and had done so on other restated she couldn't recall all proversation but it should be in she wrote that morning. On m. Staff E typed a statement of the surveyor saying her 21/18 was not available.  p.m. the DON stated the reposition herself. She could ident wouldn't have a clue. Her was moaning or groaning. On p.m. the DON stated there is sing heating pads or warm/hot if the physician ordered a staff could use a heating pad in the pad next to the resident and restaff thip so the heating pad rebed. She placed it there so warm her hands through the dono one would move the lated she placed it about 8:30 last checked on it at midnight remination form dated 12/21/18 red the physician that the last to the back and 3 blisters to but pack". The form further ring pack" was used to help resident was Hospice and not The physician responded on | F                   | 609  |                  |                               |  |

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '              |         | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|--------------------|---------|---|-------------------------------|----------------------------|
|                          |   | 165352  | B. WING            | B. WING |   | C<br>04/01/2019               |                            |
| NAME OF PR               | ROVIDER OR SUPPLIER   |   | 1                  | s       | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 04/                         | 01/2019                    |
| EMMETSE                  | BURG CARE CENTER  |   |                    | 2       | 405 21ST STREET<br>MMETSBURG, IA 50536  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| F 609                    | injuries as NOT a major on 3/21/19 at 11:34 at the physician returned identified that it was mot think of reporting. Policy:  Facility policy defined adult" as meaning the food, shelter. clothing mental health care or maintain the depender mental health. The poor staff member shall person in charge or the agent who shall then 24 hours or the next to notification. Investigate/Prevent/CCFR(s): 483.12(c)(2)-\$483.12(c) In responsing lect, exploitation, must:  §483.12(c)(2) Have eviolations are thorough \$483.12(c)(3) Preventing lect, exploitation, investigation is in progression. | in p.m. and identified the for injury.  I.m. the Administrator stated the major injury form and the amount injury. She did for possible abuse.  "neglect of a dependent of deprivation of the minimum, supervision, physical or other care necessary to ent adult's life or physical or olicy revealed the employee immediately notify the ne person's designated notify the department within ousiness day of such correct Alleged Violation (4)  se to allegations of abuse, or mistreatment, the facility vidence that all alleged hly investigated.  It further potential abuse, or mistreatment while the gress. |                    | 609     |   |                               |                            |
|                          |   | ative and to other officials in   |                    |         |   |                               |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION   |                                   | ATE SURVEY<br>OMPLETED     |
|--------------------------|---|--|-------------------------|---|-----------------------------------|----------------------------|
|                          |   | 165352   | B. WING _               |   |                                   | C<br><b>04/01/2019</b>     |
|                          | ROVIDER OR SUPPLIER   |  |                         | STREET ADDRESS, CITY, STATE, ZIP ( 2405 21ST STREET  EMMETSBURG, IA 50536       |                                   | 04/01/2019                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF<br>( (EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 610                    | accordance with Sta Survey Agency, with incident, and if the a appropriate corrective. This REQUIREMEN by: Based on record residents. Staff B LF allegedly knowingly #8 leaving 3 burn and thirty-nine (39) residents. A Minimum Data Serference date of 10 with short and long the and moderately impart and moderately impart he resident require bed mobility and extending and toileting diagnoses that inclures identified an order "a area QID (four times needed every 6 hour Nursing progress no a.m. identified the ree eyes closed. The resverbal or physical sti | te law, including to the State in 5 working days of the lleged violation is verified re action must be taken. T is not met as evidenced view and staff interview the evidence that all alleged oughly investigated for 1 of 3 et (licensed practical nurse) left a heating pad on Resident reas. Facility census was ents.  Set (MDS) with assessment /19/18 assessed Resident #8 rem memory impairments read decision making ability. In dimited staff assistance with resident had ded: stroke and arthritis. The dicators of pain. The resident reontinent of urine.  The administration record (TAR) reply heat pack to affected a day) for 20 minutes as re as needed for pain".  The sident did not respond to | F 6                     | 510   |                                   |                            |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,   | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|---|---|-------------------------------|--|
|                          |   | 165352  | B. WING   |   | C<br>04/01/2019               |  |
|                          | ROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP CODE 2405 21ST STREET EMMETSBURG, IA 50536 |   | ,                             |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | D BE COMPLETION               |  |
| F 610                    | (DON) revealed she room. When the DOI CNAs repositioned the observed redness to blisters.  Nursing progress not a.m. identified "incide aide (CNA) called St to the resident's roor report a heating pad overnight which caus blisters beginning. S Staff administered m possible related pain burn areas on the mi measuring 1.5 centin cm. by 1.2 cm. and were red and intact.  A follow up note regably the DON and date identified no redness pink line to the botton There were 3 blisters 1.1 cm. by 1.2 cm. so scabbed area. The coyesterday was TAO of dressing twice a day identified the areas where the control of | was called to the resident's N entered the room, the ne resident and the DON the resident's back with 3  tes dated 12/20/18 at 10:30 test report". A certified nurse aff C RN (registered nurse) in during morning care to left under the resident sed redness with possible taff removed the heating pad. orphine (narcotic) for . Staff C documented 3 small d left back and left iliac crest neters (cm.) by 0.5 cm., 1.1 1.2 cm. by 1.3 cm. The areas arding the burns documented and 12/21/19 at 9:11 a.m. at the resident's back. Staff C m. by 0.5 cm. fluid filled, cabbed area, 1.2 by 1.3 cm. urrent treatment received (triple antibiotic ointment) with until healed. The DON were healing. | F 61  |   |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---------------------|---|-------------------------------|--|
|                          |  | 165352   | B. WING             |   | C<br><b>04/01/2019</b>        |  |
|                          | ROVIDER OR SUPPLIER BURG CARE CENTER   |  | 24                  | REET ADDRESS, CITY, STATE, ZIP CODE<br>05 21ST STREET<br>MMETSBURG, IA 50536                                      | ,                             |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETION                 |  |
| F 610                    | heating pad was seremoved it before stated she was not nurse at shift changusing the heating pad on 3/21/19 at 12:03 called another CNA resident and found resident right next to The resident's back stated the night nur didn't shut it off. The her or they would have on her skin and stated the resident couldn't turn herself hands and could not on 3/21/19 at 12:55 phoned Staff B informe heating pad on and wasn't on the skin. Staff B informe heating pad on and wasn't on the skin. Staff B informe heating pad on and wasn't on the skin. Staff B informe heating pad on so or stated she couldn't conversation but it sthat she wrote that p.m. Staff E typed at to the surveyor saying 12/21/18 was not at On 3/20/19 at 1:59 resident could not nonly "flail". The residently verbalization was not at the surveyor saying 12/21/18 was not at the surveyor s | ton. She stated the CNAs he got to the room. Staff C informed by the off going he report that the resident was ad.  8 p.m. Staff D CNA stated she in to help her turn the the heating pad on the other skin under her back. Was completely red. She see put it on the resident and the staff most likely didn't turn have noticed the heating pad of the resident could move her of the move her clothing.  6 p.m. Staff E LPN stated she if (night nurse) that morning doing her that she placed the left it on all night because it is said she placed it over has and the bed pad. Staff B it on the resident that night in other previous nights. She recall all the details of the should be in her statement morning. On 3/22/19 at 12:05 in statement that was emailed ing her statement from | F 610               |   |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G   | , ,       | COMPLETED                  |
|--------------------------|--|---|---------------------|---|-----------|----------------------------|
|                          |  | 165352  | B. WING             |   |           | C<br><b>04/01/2019</b>     |
|                          | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>2405 21ST STREET<br>EMMETSBURG, IA 50536  | E         | 04/01/2013                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 610                    | was no policy for usin packs. She stated if the warm/hot pack that sif they wanted to.  On 3/22/19 at 10 a.m placed the heating paslightly under the left would not fall off the the resident could wanight. She assumed heating pad and state p.m. or 9 p.m. She lad or 12:30 a.m.  A major injury determat 9:30 a.m. informed resident had redness the back due to "hot identified the "heating alleviate pain. The regetting out of bed. The same date at 1:4 injuries as NOT a material policy:  Facility policy identificallegation needed to including: interviewing the occurrence, interto the reporting of the interviewing other pewitnessed similar every behavior could have determine scope and | ing heating pads or warm/hot the physician ordered a staff could use a heating pad.  In. Staff B LPN stated she ad next to the resident and hip so the heating pad bed. She placed it there so arm her hands through the no one would move the ed she placed it about 8:30 ast checked on it at midnight hination form dated 12/21/18 at the physician that the sto the back and 3 blisters to pack". The form further g pack" was used to help esident was Hospice and not the physician responded on 5 p.m. and identified the agor injury.  Bed that every abuse be thoroughly investigated g all potential witnesses to view all potential witnesses to view all potential witnesses to occurrence and arsons who might have ents where the alleged occurred in order to a frequency. | F 6                 | 10  |           |                            |

|                          | OF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G   | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|---|----------------------------|
|                          |  | 165352  | B. WING             |   | C<br>04/01/2019            |
|                          | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 2405 21ST STREET EMMETSBURG, IA 50536                             | 1 04/01/2010               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLETION          |
| F 610                    | Continued From pag   | e 18  | F 61                | 10  |                            |
| F 656<br>SS=D            |  | Comprehensive Care Plan   | F 65                | 56  |                            |
|                          | implement a comprecare plan for each reresident rights set for §483.10(c)(3), that in objectives and timefin medical, nursing, and needs that are identificated assessment. The condescribe the followin (i) The services that or maintain the residing physical, mental, and required under §483 (ii) Any services that under §483.24, §483 provided due to the runder §483.10, inclustreatment under §48 (iii) Any specialized sere in the residing of the PASA rationale in the residing findings of the PASA rationale in the residing (iv) In consultation with resident's representation (A) The resident's profuture discharge. Facument of the resident's profuture discharge. Facument in the residing of the resident's profuture discharge. Facument in the resident's profuture discharge. | cility must develop and hensive person-centered sident, consistent with the rth at §483.10(c)(2) and icludes measurable ames to meet a resident's dimental and psychosocial fied in the comprehensive mprehensive care plan must grane to be furnished to attain ent's highest practicable dipsychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 6.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized as the nursing facility will final part of the resident record. It is medical record. It is the resident and the |                     |   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '              |        | ISTRUCTION  | (X3) DATE<br>COMP | SURVEY                     |
|--------------------------|--|---|--------------------|--------|---|-------------------|----------------------------|
|                          |  | 165352  | B. WING _          |        |   |                   | C<br>01/2019               |
|                          | ROVIDER OR SUPPLIER  |   |                    | 2405 2 | ET ADDRESS, CITY, STATE, ZIP CODE<br>21ST STREET<br>ETSBURG, IA 50536   | <u>,</u>          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | ×      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE                | (X5)<br>COMPLETION<br>DATE |
| F 656                    | entities, for this purpor (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on record rev facility failed to devel comprehensive person each resident, consist that included measur timeframes to meet a and mental and psyc identified in the comp of 7 residents. Facilit residents.  Findings include:  1. A Minimum Data S reference date of 1/1 with a brief interview score of "6" (severe or resident required limi mobility, transfers an resident required ext toileting and bathing supervision with amb Review of resident pr at 4:30 p.m. revealed for clostridium difficient Review of the resident | in the comprehensive care in accordance with the h in paragraph (c) of this  I is not met as evidenced liew and staff interview, the op and implement a concentered care plan for stent with the resident rights able objectives and resident's medical, nursing, hosocial needs that are orehensive assessment for 1 by census was thirty-nine (39)  Set (MDS) with assessment 1/19 assessed Resident #2 for mental status (BIMS) cognitive impairment). The ted staff assistance with bed d personal hygiene. The ensive staff assistance with the resident required culation in the resident room. | F                  | 556    |   |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ' '                |            | NSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|--|--|--------------------|------------|---|-------------------|----------------------------|
|                          |  |  | 7 11 201231        |            |   | (                 | С                          |
|                          |  | 165352   | B. WING            |            |   | 04/               | 01/2019                    |
|                          | ROVIDER OR SUPPLIER BURG CARE CENTER   |  |                    | 2405       | ET ADDRESS, CITY, STATE, ZIP CODE<br>21ST STREET<br>IETSBURG, IA 50536  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | x          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 656<br>F 684<br>SS=J   | she checked and did  | m. the Administrator stated  |                    | 656<br>684 |   |                   |                            |
|                          | applies to all treatment facility residents. Bas assessment of a resident residents received accordance with professional standard comprehensive personal stan | Indamental principle that and care provided to ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of mensive person-centered sidents' choices.  The is not met as evidenced accordance with as of practice, the encentered care plan, and a for 1 of 7 residents failed to assess Resident es. The resident was later lium difficle (c.difficle) and eath included: c.difficle.  The includ |                    |            |   |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|--|-------------------------------|--|
|                          |   | 165352   | B. WING             |  | C<br><b>04/01/2019</b>        |  |
|                          | ROVIDER OR SUPPLIER   |  | :                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2405 21ST STREET<br>EMMETSBURG, IA 50536                      |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION               |  |
| F 684                    | dressing and bathing range of motion limits extremities on one si was occasionally incoresident had left hip a from 10/23/18 and re 10/26/18.  Bowel records identification following loose stools 12/2/18 loose diarrhed 12/4/18 4 bowel mow stools 12/5/19 4 bowel mow with loose stools 12/6/19 loose stools 12/6/19 loose stools A progress note date revealed the resident times daily. The night was up to the toilet a resident self transfer time. Staff encourage transfer. Staff sent the resident's physication them. 12/7/18 loose stools 12/8/19 loose stools | aff assistance with toileting, i. The resident had functional ations of the upper and lower de of the body. The resident ontinent of bowel. The and left humerus fractures sturned to the facility  fied the resident with the series are ments, 3 of them with loose dements, at least 3 of them  2 times do 12/6/18 at 1:49 a.m. at had loose stools up to 6 at of the entry, the resident and incontinent 7 times. The red so she could make it in ead the resident not to self ais information to the clinic for an to review and advise at 12/9/18 at 5:51 a.m. at loudly called out for help. It is information to the clinic for an erest room. The resident not to side the rest room as were: grees, pulse 96, respirations at 12/55 and oxygen saturation as very weak and unable to | F 684               |  |                               |  |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | PLE CONSTRUCTION                                 |   | (X3) DATE<br>COMP | SURVEY<br>PLETED           |
|--------------------------|---|---|---------------------|--|---|-------------------|----------------------------|
|                          |   | 165352  | B. WING_            |  |   | 1                 | C<br><b>01/2019</b>        |
|                          | ROVIDER OR SUPPLIER   | 1000-   |                     | STREET ADDRESS,  2405 21ST STREET  EMMETSBURG, I |   | <u>  04/</u>      | 01/2019                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH  | OVIDER'S PLAN OF CORRECTION<br>CORRECTIVE ACTION SHOULD<br>REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                | (X5)<br>COMPLETION<br>DATE |
| F 684                    | dorsal aspect of both complained of severe ER (emergency room transported to the hound and ED (emergency do 12/9/18 revealed the and dehydrated. The very dry. The resident The resident's blood following: BUN (blood creatinine 1.87 high, 2.6 low, chloride 118 BUN/creatinine ratio cell) 18.8 high. The dodifficle (c.difficle) diar In comparison, on 10 laboratory work was: normal range of 7 to (normal), sodium 142 (normal), chloride 11: 107), CO2 24 (normal (normal), WBC 9.8 (r.d. Hospital discharge do identified the residen include: c. difficle colikidney injury. The disc. difficle colitis curre (antibiotic) and IV flag diarrhea slowly improimproved. The report be admitted to skilled | hands. The resident belly cramps. Staff called a) and the resident spital.  epartment) final report dated resident presented weak resident's oral mucosa was it's skin turgor was "tenting". Ilaboratory work revealed the druce anitrogen) 63 high, sodium 146 high, potassium critical high, CO2 15 low, 33.7 high, WBC (white blood iagnosis was clostridium rhea.  /30/18 the resident's blood BUN 23 (slightly above 20), creatinine 0.84 (normal), potassium 3.8 (normal), potassium 3.8 (normal), potassium 3.8 (normal) becumentation dated 12/12/18 (resident's admission diagnoses to itis, acute diarrhea and acute charge diagnoses included: intly on oral vancomycin gyl (antimicrobial), acute oving and acute kidney injury revealed the resident would care for continued IV fluids is spice is considered and | Fé                  | 84   |   |                   |                            |
|                          | Review of appetite re   | cords with percentages of d a decline in food intake:   |                     |  |   |                   |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                  |                    |     | CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED            |
|--------------------------|---|--|--------------------|-----|---|-------------------|----------------------------|
|                          |   |  | 750.25.            | _   |   | (                 | c                          |
|                          |   | 165352   | B. WING            |     |   | 04/               | 01/2019                    |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                    | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |                   |                            |
| FMMFTSF                  | BURG CARE CENTER  |  |                    | 2   | 405 21ST STREET   |                   |                            |
| LIVINETOL                | ONO DAIL OLIVIER  |  |                    | Е   | MMETSBURG, IA 50536   |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | X   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 684                    | Continued From page   | 23   | F                  | 684 |   |                   |                            |
|                          | 12/2/18 11:24 a.m. 25<br>12/2/18 12:38 p.m. 75  |  |                    |     |   |                   |                            |
|                          | 12/3/18 9:23 a.m. 129<br>12/3/18 1:11 p.m. refu<br>12/3/18 6:55 p.m. zer                          | used   |                    |     |   |                   |                            |
|                          | 12/4/18 9:44 a.m. 259<br>12/4/18 1:04 p.m. 129<br>12/4/18 6:05 p.m. zer                           | %  |                    |     |   |                   |                            |
|                          | 12/5/18 9:45 a.m. 259<br>12/5/18 12:44 p.m. 50<br>12/5/18 7:04 p.m. zer                           | )%   |                    |     |   |                   |                            |
|                          | 12/6/18 9:25 a.m. 129<br>12/6/18 12:38 p.m. 12<br>12/6/18 7 p.m. 12%                              |  |                    |     |   |                   |                            |
|                          | 12/7/18 9:26 a.m. 129<br>12/7/18 12:28 p.m. 12<br>12/7/18 6:13 p.m. 309                           | 2%   |                    |     |   |                   |                            |
|                          | 12/8/18 12:07 p.m. 25<br>12/8/18 1:01 p.m. 509<br>12/8/18 7 p.m. zero                             |  |                    |     |   |                   |                            |
|                          |   | otes and other computer<br>entify the facility assessed<br>tal signs:                  |                    |     |   |                   |                            |
|                          | for back pain. 12/3/18<br>returned from ER. The<br>Tramadol (narcotic) 5<br>hours as needed for p | 0 milligrams (mg.) every 12<br>pain and follow up in a week.<br>was done and normal. A |                    |     |   |                   |                            |

|  |  | ` IDENTIFICATION NUMBER:  |                     | ) MULTIPLE CONSTRUCTION BUILDING   |             | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---------------------|--|-------------|-------------------------------|--|
|  |  | 165352  | B. WING             |  |             | C                             |  |
| NAME OF PROVIDER OR SUPPLIER  EMMETSBURG CARE CENTER |  |   |                     | STREET ADDRESS, CITY, STATE, ZIP COD 2405 21ST STREET EMMETSBURG, IA 50536                 |             | 4/01/2019                     |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 684  | Continued From page  | e 24  | F 6                 | 34   |             |                               |  |
|  | 12/4/18 no document condition or assessm   | tation of the resident's<br>ent/vital signs   |                     |  |             |                               |  |
|  | 10:44 p.m. staff docu<br>transferred twice due<br>incontinent once. The<br>pain. No assessment<br>12/6/18 at 1:49 a.m. | dent due to loose stools. At mented the resident self to loose stools and was e resident denied stomach //vital signs   |                     |  |             |                               |  |
|  | entry, the resident was<br>incontinent 7 times. I<br>so she could make it<br>the resident not to se                    | The resident self transferred in time. Staff encouraged lf transfer. Staff prepared e physician regarding this.   |                     |  |             |                               |  |
|  | 12/7/18 No assessme  | ent/vital signs   |                     |  |             |                               |  |
|  | entry documented 12 resident went to the resident had loose st The resident denied signs were in normal                | ent/vital signs until a late 1/9/18 at 6:34 a.m. (after the nospital) The entry stated the cols and decreased appetite. coain. The resident's vital ranges, bowel sounds wes at times. No emesis. |                     |  |             |                               |  |
|  |  | ation until 12/9/18 at 5:51<br>nt transported to the ER.  |                     |  |             |                               |  |
|  | nurse aide) stated sh<br>had 7 bowel moveme  | o.m. Staff A CNA (certified e documented the resident ents on the bowel record on She informed the nurse.   |                     |  |             |                               |  |
|  | On 3/18/19 at 12:48  | o.m. the resident's physician   |                     |  |             |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | 1 ' '               | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---------------------|--|-------------------------------|--|
|  | 165352  | B. WING             |  | C<br><b>04/01/2019</b>        |  |
| NAME OF PROVIDER OR SUPPLIER  EMMETSBURG CARE CENTER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 2405 21ST STREET EMMETSBURG, IA 50536                                | 1 04/01/2019                  |  |
| PREFIX (EACH DEFIC   | RY STATEMENT OF DEFICIENCIES<br>CIENCY MUST BE PRECEDED BY FULL<br>Y OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETION             |  |
| signs and assess "vital signs norm because there we nurse thought wat thought wat the sident expired medical cause of following: Immediate cause Due to or as a condisease Due | should have conducted vital sment. She stated the late entry al" was not adequate on 12/8/18 as no way to know what the as normal.  e filed on 12/28/18 identified the on 12/16/18 at 6:22 p.m. The f death information identified the of death:cardiopulmonary arrest onsequence of: Alzheimer's onsequence of clostridium difficle and the immediate jeopardy on ation of the investigation by a following:  ducated regarding nursing intervention. An educational was held on 3/20/19 at 11 a.m. with the exception of 3. One was in the other 2 worked the night reeducated prior to working.  In agenda included scenarios on the interventions and follow up to be in condition on residents. The processes in regard to ange in condition and incident process for routing faxes to | F 684               |  |                               |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′               | LE CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |  |
|---|--|--|---------------------|---|----------------------------|--|
|   |  | 165352   | B. WING             |   | C<br>04/01/2019            |  |
| NAME OF PROVIDER OR SUPPLIER  EMMETSBURG CARE CENTER  |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  2405 21ST STREET  EMMETSBURG, IA 50536                                   | 1 040112010                |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | O BE COMPLETION            |  |
| F 684   | Continued From pag   |  | F 68                | 4   |                            |  |
| F 689<br>SS=G   | Free of Accident Haz   | cation with providers.<br>cards/Supervision/Devices<br>((2)  | F 68                | 9   |                            |  |
|   | as free of accident h §483.25(d)(2)Each r supervision and assi accidents. This REQUIREMEN' by: Based on record rev facility failed to ensu environment remaine hazards as is possib received adequate s devices to prevent a Staff B LPN (license knowingly left a heat leaving 3 burn areas thirty-nine (39) reside Findings include:  1. A Minimum Data S reference date of 10, with short and long t and moderately impa The resident require bed mobility and exte dressing and toileting diagnoses that include | are that - esident environment remains azards as is possible; and esident receives adequate estance devices to prevent  T is not met as evidenced riew and staff interview the re that the resident le; and each resident lupervision and assistance ecidents for 1 of 3 residents. d practical nurse) allegedly ing pad on Resident #8 . Facility census was ents.  Set (MDS) with assessment ref (MDS) with assessment |                     |   |                            |  |

| , ,  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  IG   | (X3) DATE SURVEY COMPLETED        |                        |
|--|--|---|---------------------|--|-----------------------------------|------------------------|
|  |  | 165352  | B. WING _           |  |                                   | C<br><b>04/01/2019</b> |
| NAME OF PROVIDER OR SUPPLIER  EMMETSBURG CARE CENTER |  |   |                     | STREET ADDRESS, CITY, STATE, ZIP<br>2405 21ST STREET<br>EMMETSBURG, IA 50536 | CODE                              | 04/01/2013             |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN           | CTION SHOULD BE<br>THE APPROPRIAT | DATE                   |
| F 689  | identified an order "a area QID (four times needed every 6 hour Nursing progress not a.m. identified the reveyes closed. The resverbal or physical stir Nursing progress not a.m. and documente (DON) revealed she room. When the DON CNAs repositioned the observed redness to blisters.  Nursing progress not a.m. identified "incide aide (CNA) called St. to the resident's room report a heating pad overnight caused reception beginning. Staff remeating administered morphical related pain. Staff C areas on the mid left measuring 1.5 centing cm. by 1.2 cm. and were red and intact.  Hospice notes dated revealed the resident on the low back. Whe repositioned the resident of 3 burned areas on CNA stated the resident con the resident of the resident on the low back. Whe repositioned the resident on the low back the resident on the low back the resident on the low back. Whe repositioned the resident on the low back the resident of the low back the resident on the low back the low back the low back the l | administration record (TAR) pply heat pack to affected a day) for 20 minutes as s as needed for pain".  tes. dated 12/19/18 at 10:24 sident as resting in bed with ident did not respond to | F 6                 | 89   |                                   |                        |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  IG   |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|---|---|---|-------------------------------|----------------------------|
|   |  | 165352  | B. WING _   |   |                               | C<br><b>04/01/2019</b>     |
| NAME OF PROVIDER OR SUPPLIER  EMMETSBURG CARE CENTER  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2405 21ST STREET<br>EMMETSBURG, IA 50536 |   | 04/01/2013                    |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 689   | mid back that was p 0.5 cm. and 0.5 cm. burn blister areas or open. Nursing staff of and cover with telfa. responsive with murher back, the reside grimaces. Hospice responsive with morphine (narcotic).  A follow up note regulate by the DON and data identified no redness pink line to the botton of the point line to the line of the point line to the line of the point line of the line o | ent. There was one area in the turple in color and measured Skin intact. She had 2 small in the low back with blisters will apply antibiotic ointment. The resident was awake and inbling. When positioned on intifidgeted with facial equested nurse administer.  arding the burns documented ed 12/21/19 at 9:11 a.m. is. There was a tiny fading in of the resident's back. is. 1 cm. by 0.5 cm. fluid filled, incabbed area, 1.2 by 1.3 cm. current treatment received triple antibiotic ointment) with it with a until healed. The DON were healing.  Attention to the CNA was a room. She didn't know what thing pad was set on. She moved it before she got to the she was not informed by the nift change report that the | F6  | 89  |                               |                            |

|  |  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD  |                     | ULTIPLE CONSTRUCTION  |          | (X3) DATE SURVEY COMPLETED |  |
|--|--|---|---------------------|---|----------|----------------------------|--|
|  |  | 165352  | B. WING _           |   |          | C<br><b>04/01/2019</b>     |  |
| NAME OF PROVIDER OR SUPPLIER  EMMETSBURG CARE CENTER |  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2405 21ST STREET<br>EMMETSBURG, IA 50536                 | '        |                            |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 689  | The resident's back stated the night nurs didn't shut it off. The her or they would have son her skin and stated the resident of couldn't turn herself hands but could not turn herself hands but could not On 3/21/19 at 12:55 phoned Staff B Informed heating pad on and wasn't on the skin. Staff eresident's pajart told her she placed and had done so on stated she couldn't conversation but it sthat she wrote that rp.m. Staff E typed at to the surveyor sayin 12/21/18 was not as On 3/20/19 at 1:59 president could not reconly "flail". The resident could not reconly "grail". The resident could not reconly verbalization with exame date at 3 processes was no policy for us packs. She stated if warm/hot pack that if they wanted to.  On 3/20/19 at 3:06 processes were sident adjusted the resider and stated in the resident adjusted the resider and stated in the resider the resider and stated and stated in the resider and stated an | o her skin under her back.  Was completely red. She se put it on the resident and e staff most likely didn't turn ave noticed the heating pad d her skin was red. Staff D was not really responsive and f. The resident could move her move her clothing.  is p.m. Staff E LPN stated she d (night nurse) that morning d her that she placed the left it on all night because it she said she placed it over has and the bed pad. Staff B it on the resident that night other previous nights. She recall all the details of the should be in her statement morning. On 3/22/19 at 12:05 a statement that was emailed ng her statement from | F6                  | 89  |          |                            |  |

| 165352     B. WING  | C<br><b>04/01/2019</b>     |
|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE   | 04/01/2013                 |
| EMMETSBURG CARE CENTER  2405 21ST STREET  EMMETSBURG, IA 50536  |                            |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE |
| F 689 Continued From page 30 on the heat control of the heating pad. She assumed the nurse monitored the heating pad. She wasn't aware the nurse had not taken it off. Staff F didn't recall who the nurse was. She stated she never moved the heating pad. On 3/22/19 at 10 a.m. Staff B LPN stated she placed the heating pad next to the resident and slightly under the left hip so the heating pad would not fall off the bed. She placed it there so the resident could warm her hands through the night. She assumed no one would move the heating pad and stated she placed it about 8:30 p.m. or 9 p.m. She last checked on it at midnight or 12:30 a.m.  A major injury determination form dated 12/21/18 at 9:30 a.m. informed the physician that the resident had redness to the back and 3 blisters to the back due to "hot pack". The form further identified the "heating pack" was used to help alleviate pain. The resident was Hospice and not getting out of bed. The physician responded on the same date at 1:45 p.m. and identified the injuries as NOT a major injury. |                            |