STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: 4/1/2020 The following deficiencies relate to the facility's annual health survey completed 3/9-12/2020. Deficiencies that resulted from the investigation of Complaints- #88853-C, #89276-C, and Self Report incidents #89277-I and #89164-I, ending 2/18/2020 were corrected. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/23/2020

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 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to facilitate resident self determination by getting cognitively impaired residents up before 6 a.m. when residents did not request it for 4 of 4 residents observed. (Resident #59, Resident #36, Resident #34, and Resident #46). The facility reported a census of 73 Residents. Findings include: Observation revealed on 3/10/20 @ 5:34 AM, Resident #59, Resident #36, Resident #34, and Resident #46, asleep in their wheelchairs in the common area lounge on the south side of the building. The Minimum Data Set (MDS) assessment dated 2/10/20 for Resident #59 documented a Brief Interview of Mental Status (BIMS) of 8 which indicates moderate cognitive impairment. The MDS also indicated the resident required extensive assist with bed mobility, transfers, and dressing. The MDS assessment dated 1/20/20 for Resident #36 documented a BIMS of 11 which indicates moderate cognitive impairment. The MDS also documented the resident required extensive assist with bed mobility, transfers, and dressing.	F 561		

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F 561	Continued From page 2 The MDS assessment dated 1/13/20 for Resident #34 documented a BIMS of 4 which indicates severe cognitive impairment. The MDS also documented the resident required extensive assist with bed mobility, transfers, and dressing. The MDS assessment dated 2/3/20 for Resident #46 documented a BIMS of 11 which indicates moderate cognitive impairment. The MDS also documented the resident required extensive assist with bed mobility, transfers, and dressing. On 3/10/2020 at 5:34 a.m. Staff H, Certified Nurse Aide (CNA), stated she received instruction to get 3 residents up on 3 hallways (9 residents' total). She revealed they start to get Resident's up at 4:30 AM, and bring them out to the common lounge area around 4:45 AM, where they sit and sleep in their wheelchairs. Staff H informed the surveyor that last year when state was in the building the facility instructed staff not to get people up before 6:00 AM. She stated she felt sorry for the residents. Staff H revealed Resident #59 and Resident#36 never request to get up early. Observation showed at 3/12/20 @ 9:03 AM, Resident #59, Resident #36, Resident #34, Resident #46 asleep in the common lounge area on the south side of the building in wheelchairs. On 3/12/20 at 9:22 AM, Resident #46 stated he does not like to get up early, and does not request to get up before 6:00 AM. He reported he would like to get up at 7:30 AM because he does not get enough sleep. The facility Resident Rights Policy with an origination date of 4/1/2008 identified residents	F 561		

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F 561	Continued From page 3 with the right to choose activites, schedules and health care consistent with his/her interestes, assessments and plan of care. On 3/12/2020 at 9:18 AM Director of Nursing (DON) stated staff should not get residents up before 6:00 AM, unless the resident requests to get up or the resident is awake, then the CNA's can offer to get the resident up.	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 583		

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F 583	Continued From page 4 provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure personal privacy during cares for 1 of 4 residents reviewed (Resident #8). The facility reported a census of 73 residents. Findings include: According to the Minimum Data Set (MDS) assessment, dated 12/16/19, Resident #8 scored 8 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The resident depended on staff for toilet use, and required extensive assistance with personal hygiene. The resident had an indwelling urinary catheter, and diagnoses included urinary tract infection and neurogenic bladder. The current care plan revised 2/12/20 identified the resident readmitted with an indwelling catheter. The interventions included to administer antibiotic as ordered, encourage fluids, and catheter care. During an observation on 3/10/20 at 9:14 a.m. Staff B Certified Nursing Assistant (CNA) and Staff C CNA provided care with Staff A Registered Nurse (RN) Clinical Manager observing. Staff C performed peri care, but did not clean down the catheter tubing.	F 583		

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F 583	Continued From page 5 During an observation on 3/11/20 at 11:50 a.m. Staff D CNA and Staff E did cares with Staff A observing. Staff pulled the blankets down exposing the residents groin/perineal area. The window curtain remained open. Staff D obtained a graduate and placed it on a paper towel on the floor. She opened an alcohol wipe, and the catheter bag drain spout, then cleaned the spout, and emptied the catheter into the graduate. When empty, Staff D cleaned the spout with another alcohol wipe and replaced the spout. She took the graduate to the bathroom and emptied in the toilet and rinsed the graduate. She then went to the sink and washed her hands before going to provide care to the resident. The resident remained exposed throughout this with the curtain open. Staff D performed perineal care in the front including the catheter tubing. Staff rolled the resident to her left. The resident had soft bowel movement on the pad. Staff D wiped the resident from the back to the front, and Staff E cued her to wipe front to back. Staff A closed the window curtain. During an interview on 3/11/20 at 1:49 p.m. Staff A stated it was not necessary to have the resident exposed all that time and they should have pulled the curtain before exposing the resident.	F 583		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

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F 657	Continued From page 6 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to updated the care plan for 1 of 18 residents reviewed (Resident #23). The facility reported a census of 73 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 1/6/20, Resident #23 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included heart failure and chronic lung disease. The current care plan with a goal target date of	F 657		

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F 657	Continued From page 7 4/8/20 identified the resident had difficulty with shortness of breath (SOB) at times, especially and night because of chronic obstructive pulmonary disease (COPD) revised 07/05/2018. The interventions included oxygen at 1 liter per nasal cannula PRN to keep O2 saturations >90%, may titrate up to 3 liters. Notify the physician for increased SOB or sats below 90% on 3 liters (initiated 2/6/19). The resident's current orders dated and signed by the physician 2/13/20 included Oxygen (O2) at 2 liters via nasal cannula as needed (PRN) to keep saturations greater than 90% (initiated 10/7/2019). During an observation on 3/9/20 at 3:07 p.m. the resident had the O2 on at 3 liters with the cannula pointing to her forehead. During an observation on 3/10/20 at 9:35 a.m. and 3:41 p.m. the resident had O2 at 3 liters per nasal cannula. During an interview on 3/11/20 at 8:40 a.m. the Director of Nursing (DON) stated the resident's current (O2) order at 2 liters. She said the care plan did not get updated.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		

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F 689	Continued From page 8 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to assure smoking policies were followed to prevent accidents for 2 of 2 residents who smoked (Resident #27 and #12). The facility reported a census of 73 residents with 10 residents who smoked. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 1/13/20, Resident #27 scored 7 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included unspecified intellectual disabilities. The current Care Plan initiated 5/25/18 identified the resident chose to smoke cigarettes. The interventions included the resident would only smoke in designated areas, and staff would perform smoking evaluations per facility protocol. The facility Smoking Assessment dated 3/5/20 indicated the resident had no cognitive loss and continued to smoke safely, utilize a lighter and comply with the facility smoking policy. During an observation on 3/11/20 at 12:50 p.m. the resident smoked outside unsupervised. The resident sat in the chair to the left of a (covered) receptacle. When finished smoking, the resident dropped the cigarette butt on the cement behind the receptacle. The area contained no ashtray to extinguish or place the butt in lieu of the covered receptacle.	F 689		

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F 689	Continued From page 9	F 689		

2. During an observation on 3/11/20 at 11:45 a.m. Resident # 12 went outside in his electric wheelchair to the smoking area unsupervised. The area contained no ashtrays, only a small red covered receptacle with a foot mechanism to open it. The area had many cigarette butts on the ground on the cemented area and in an area around a tree with no cement. There were no signs posting the smoking area and no signs regarding oxygen.

During an interview on 3/11/20 at 12:20 Staff A Registered Nurse (RN) Clinical Coordinator stated she did the smoking assessments and the the resident deemed independent with smoking. She said residents would extinguish cigarette butts in the receptacle. She did not know if the resident would be able to open the receptacle. She confirmed there was no ashtray only a trash receptacle.

During an interview on 3/11/20 at 1:15 p.m. at 12:30 p.m. the resident stated he could not open the receptacle to dispose of his cigarette. He said he would either wait for someone who could open it or throw it on the ground.

During an observation and interview on 3/12/20 at 8:18 a.m. the Administrator confirmed they had no posting of the smoking area, they had no signs related to not using oxygen, and they had no ashtray for residents to use who could not manipulate the covered can.

3. According to the Minimum Data Set (MDS) assessment dated 12/17/19 for Resident #12 documented the resident with a Brief Interview of Mental Status (BIMS) at 15 which indicates no

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F 689	Continued From page 10 cognitive impairment. The MDS also indicated diagnoses of Pneumonia, Diabetes Mellitus (DM), and Hemiplegia (paralysis of one side of the body). The MDS documented the Resident required supervision with locomotion on and off unit and extensive assist with eating. The resident's most recent smoking assessment dated 3/5/20 at 3:33 AM, and a lock date of 3/11/20 at 4:52 PM revealed the resident with very limited mobility to right arm, and limited mobility to left arm and identified the resident to require assistive devices to smoke, which included a cigarette extender. Review of the resident's current care plan identified the resident would ask others to light cigarettes and that he would use a cigarette extender. Observation showed on 3/11/20 at 2:15 PM the resident with a pack of cigarettes and a lighter in his purse. On 3/11/20 at 2:15 PM, the resident stated he had a whole carton of cigarettes in his dresser. He also stated he did not know what a cigarette extender is or that he should use one.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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F 690	Continued From page 11 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide catheter care in a manner to prevent infection for 2 of 3 residents reviewed (Resident #8 and Resident #23). The facility reported a census of 73 residents. Findings include: 1. According to the Minimum Data Set (MDS)	F 690		

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F 690	Continued From page 12 assessment, dated 12/16/19, Resident #8 scored 8 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The resident depended on staff for toilet use, and required extensive assistance with personal hygiene. The resident had an indwelling urinary catheter, and diagnoses included urinary tract infection (UTI) and neurogenic bladder. The current care plan revised 2/12/20 identified the resident readmitted with an indwelling catheter. The interventions included: administer antibiotic as ordered, encourage fluids, and catheter care. During an observation on 3/10/20 at 9:14 a.m. Staff B Certified Nursing Assistant (CNA) and Staff C CNA provided care with Staff A Registered Nurse (RN) Clinical Manager observing. Staff C performed peri care, but did not clean down the catheter tubing. During an observation on 3/11/20 at 11:50 a.m. Staff D CNA and Staff E did cares with Staff A observing. Staff D emptied the resident's catheter bag. Staff D performed perineal care in the front including the catheter tubing. Staff rolled the resident to her left. The resident had soft bowel movement on the pad. Staff D wiped the resident from the back to the front, and Staff E cued her to wipe front to back. During an interview on 3/11/20 at 1:49 p.m. Staff A stated staff should definitely wipe front to back. During an interview on 3/11/20 at 1:52 Staff E confirmed Staff D wiped the resident back to front and cued her to go front to back.	F 690		

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F 690	Continued From page 13 The facility Perineal Care policy revised 3/1/14 included washing from the urethral area toward the rectum. 2. According to the MDS assessment, dated 1/6/20, Resident #23 scored 14 on the BIMS indicating no cognitive impairment. The resident required extensive assistance for toilet use and personal hygiene. The resident had an indwelling urinary catheter, and diagnoses included urinary tract infection and neurogenic bladder. The current Care Plan revised 3/11/20 identified the resident had a a history of UTI's (urinary tract infection) and an indwelling urinary catheter. The interventions included: catheter care every shift, monitor for signs and symptoms of infection per standards of practice and notify the doctor as needed. The February 2020 Medication Administration Record (MAR) showed the resident received Cephalexin (antibiotic) Capsule 500 milligrams (MG) by mouth two times a day for UTI for 7 days starting 1/31/20. During an observation on 3/9/20 at 3:08 p.m. the catheter bag hung from the bed frame in a dignity bag. During an observation on 3/10/20 at 8:44 a.m. Staff B and Staff C performed care with Staff A observing. During the transfer from the wheel chair to the bed, staff laid the dignity bag containing the catheter bag on the floor. The catheter tubing laid on the floor. During observation on 3/10/20 at 3:44 and 4:45	F 690		

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	165161	A. BUILDING _____ B. WING _____	03/12/2020

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F 690	Continued From page 14 p.m., the resident laid in the low bed with the catheter tubing on the floor. During an interview on 3/11/20 at 1:49 p.m., Staff A stated the catheter bag and tubing should not lay on the floor.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assure resident's received care consistent with professional standards of practice for 2 of 2 residents with oxygen (O2) (Resident #8 and Resident #45). The facility reported a census of 73 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 1/6/20, Resident #23 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included: heart failure and chronic lung disease. The current care plan with a goal target date of 4/8/20 identified the resident had difficulty with	F 695		

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F 695	Continued From page 15	F 695		

shortness of breath (SOB) at times, especially at night because of chronic obstructive pulmonary disease (COPD), revised 07/05/2018. The interventions included Oxygen at 1 liter per nasal cannula as needed (PRN) to keep O2 saturations (sats) >90%, may titrate up to 3 liters. Notify the physician for increased SOB or sats below 90% on 3 liters (initiated 2/6/19).

The resident's current orders dated and signed by the physician 2/13/20 included Oxygen at 2 liters via nasal cannula PRN to keep saturations greater than 90% (initiated 10/7/2019).

An O2 Sats Summary documented the resident had an O2 sat of 90% on 3/1/20 at 10:03 p.m. No additional sats were documented and the entry lacked liters of O2 used.

During an observation on 3/9/20 at 3:07 p.m. the resident had the O2 on at 3 liters with the cannula pointing to her forehead.

During an observation on 3/10/20 at 9:35 a.m. and 3:41 p.m. the resident had O2 at 3 liters per nasal cannula.

During an interview on 3/11/20 at 8:40 a.m. the Director of Nursing (DON) stated the resident's current (O2) order at 2 liters per nasal cannula PRN. She said the care plan did not get updated. She said they did not document the resident's PRN use of the O2. She said if the resident used O2 they should document the O2 sats to keep above 90% per the order. She stated the last check she found on 3/1/20 at 90%.

The facility Oxygen Administration Record revised 3/1/14 directed to regulate the flow in accordance

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F 695	Continued From page 16 with the physician's orders. The policy directed documentation of the date, time, and method of administration, number of liters per minute, observations, and resident's reaction in the nurse's notes. 2. According to the Minimum Data Set (MDS) assessment for Resident #45 dated 2/3/20, indicated the resident had diagnoses of heart failure and Chronic Obstructive Pulmonary Disease (COPD). The MDS also documented the resident utilized oxygen therapy. A Treatment Administration Record (TAR) for the month of March 2020 showed an order for oxygen. The order directed staff to supply oxygen at 2-5 liters as needed by nasal cannula for when the resident is short of breath. The March 2020 TAR identified the resident received oxygen from March 1st to March 11th at 9:00 a.m., 12:00 p.m., and 6:00 p. m. The TAR did not indicate if the resident received the oxygen continuously or only given at specific times. The TAR lacked documentation of why staff administered the oxygen , a follow up assessment to show effectiveness, the number of liters the oxygen given, or the resident's oxygen saturation readings.	F 695		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national	F 803		

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F 803	Continued From page 17 guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed assure residents received the appropriate servings per the therapeutic menu. The facility reported a census of 73 residents. Findings include: The menu for Tuesday 3/10/20 noon meal included a 3 ounce serving of chicken breast and 1/2 cup of baked apples. Observation on 3/10/20 at 11:20 a.m. revealed Staff F (Cook) pureed seven 3-ounce cups of baked apples. Staff F ground seven 3-ounce servings of chicken.	F 803		

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F 803	Continued From page 18 Observation showed on 3/10/20 at 12:21 p.m. staff serving the noon meal. During the meal service, the staff switched serving scoops for the baked apples. Staff in the kitchen served 3 residents ground meat. Staff took the remaining ground meat to the serving cart for the room trays. Staff G served 3 additional residents ground meat. Staff G measured the remaining ground meat with 3-1/2 servings leftover (should have 1 serving remaining) At 1:20 p.m. the Dietary Manager did not know why they had so much remaining. The Area Dietary Manager stated they switched to a 1/2 cup (4 ounce) serving of the baked apples during the meal service because the therapeutic menu called for that portion. She confirmed the residents on a pureed diet only received the 3 ounce serving as well as those residents prior to changing the scoops. During an interview on 3/10/20 at 1:40 p.m. the Corporate Dietician stated if they ground 7 servings and served 6 there should only be 1 serving left.	F 803		
F 926 SS=E	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview the facility failed to implement smoking	F 926		

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F 926	Continued From page 19	F 926		

policies. The facility reported a census of 73 residents, and 10 residents who smoked.

Findings include:

A list of individuals who smoke included 10 residents, 5 identified as independent and 5 supervised.

Observation showed on 3/11/20 at 11:45 a.m., the smoking area without ashtrays and only a small red covered receptacle with a foot mechanism to open it. The area had many cigarette butts on the ground on the cemented area and in an area around a tree with no cement. There were no signs posting the smoking area and no signs regarding oxygen.

A Smoking policy dated 4/1/08 indicated the facility allowed smoking. If the facility allowed smoking, the facility would designate posted areas for smoking. The designated smoking area would have "No Oxygen" signs, smoking blankets, fire extinguishers and approved cigarette receptacles.

During an observation and interview on 3/12/20 at 8:18 a.m. the Administrator confirmed they had no posting of the smoking area, they had no signs related to not using oxygen, and they had no ashtray for residents to use who could not manipulate the covered can.

Plan of Correction
Touchstone Healthcare Community
Survey Date – 3/12/2020
The Alleged Date of Substantial Compliance is 4/1/2020.

F561
Self-Determination
CFR(s): 483.10(f)(1)-(3)(8)

1. Residents #59 and #46 were interviewed to determine the time they would like to rise in the morning, and the representatives for residents #36 and #34 were contacted to determine the time the residents would like to rise; their plans of care were reviewed and updated to reflect their preference.
2. Current facility residents who are able to articulate their wants were interviewed to determine the time they would like to rise in the morning. The representatives of the residents who are not able to articulate their wants were contacted to determine the time the residents would like to rise in the morning. The plans of care were reviewed and updated to reflect their preference.
3. The Director of Nursing Services and Interdisciplinary Team were educated by the Administrator on the facility Resident Rights Policy. The Director of Nursing Services and/or designee will likewise educate facility staff on the facility Resident Rights Policy.
4. Residents who are able to be interviewed will be randomly interviewed weekly for 4 weeks, then randomly for 2 months thereafter, to ensure facility staff are getting them up in the morning based on their personal preference. Residents who are not able to be interviewed will be reviewed at care conferences with their representatives for 4 weeks, then randomly for 2 months, to ensure facility staff are getting them up in the morning based on their personal preference. Results will be presented to the quarterly Quality Assurance Committee for consideration.

F583
Privacy and Confidentiality
CFR(s): 483.10(h)(1)-(3)(i)(ii)

1. Resident #8 was assessed for negative outcomes related to allegedly failing to keep them covered and the privacy curtain pulled during personal care.
2. Current facility residents with indwelling catheters were assessed for potential negative outcomes.
3. The DON and Interdisciplinary Team were educated by the Administrator on the facility Privacy and Confidentiality Policy. The DON and/or designee will likewise educate facility licensed nursing staff and Certified Nurse Aides on the facility Privacy and Confidentiality Policy.
4. Current facility residents with indwelling catheters will have their care randomly audited for 4 weeks, then randomly for 2 months thereafter, to ensure that residents' right to personal privacy during care is respected. Results will be presented to the quarterly Quality Assurance Committee.

F657
Comprehensive Care Plans
CFR(s): 483.21(b)(2)(i)-(iii)

1. The plan of care for resident #23 was updated to accurately reflect their respiratory status, specifically their need for PRN (as needed) supplemental oxygen per physician's order.

2. The plans of care for current facility residents that require PRN (as needed) supplemental oxygen were reviewed and updated to accurately reflect their respiratory status, specifically their need for PRN (as needed) supplemental oxygen per physician's order.
3. The DON, MDS Nurse, and Interdisciplinary Team were educated by the Administrator on the facility Person-Centered Plan of Care - Comprehensive Policy.
4. Resident plans of care for those residents requiring PRN (as needed) supplemental oxygen will be randomly audited for 4 weeks, then randomly for 2 months thereafter, to ensure the plans of care timely and accurately reflect residents' PRN (as needed) supplemental oxygen requirements. Results will be presented to the quarterly Quality Assurance Committee.

F689

Accidents

CFR(s): 483.25(d)(1)(2)

1. Residents #27 and #12 were assessed using the Smoking Safety Assessment and their plans of care were reviewed and updated, as needed.
2. Current facility residents that smoke were assessed using the Smoking Safety Assessment and their plans of care were reviewed and updated, as needed.
3. On 3/12/2020, a drop-in cigarette butt receptacle was placed in the designated smoking area that residents can easily access and use. Appropriate signage identifying the area as the designated smoking area and prohibiting the use of oxygen in the area were hung. Effective 3/16/2020, the facility Smoking Policy was amended to eliminate unsupervised smoking for residents.
4. The DON and Interdisciplinary Team were educated by the Administrator on the facility Accommodation of Needs Policy. The Administrator and/or designee will likewise educate facility staff on the facility Accommodation of Needs Policy.
5. Residents who smoke will be randomly audited for 4 weeks, then randomly for 2 months thereafter, to ensure residents can easily access and use the new cigarette butt receptacle. The Designated Smoking Area will be randomly audited 4 weeks, then randomly for 2 months thereafter, to ensure the designated smoking area complies with applicable Federal, State, and local laws and regulations. Results will be presented to the quarterly Quality Assurance Committee.

F690

Incontinence

CFR(s): 483.25(e)(1)-(3)

1. Residents #8 and #23 were assessed to ensure there were no negative outcomes related to allegedly providing improper catheter care.
2. Current facility residents with indwelling catheters were assessed for potential negative outcomes.
3. The DON and Interdisciplinary Team were educated by the Administrator on the facility Perineal Care , Catheter Management, and Foley Catheter – Care Policies. The DON and/or designee will likewise educate facility licensed nursing staff and Certified Nursing Assistants on facility Perineal Care , Catheter Management, and Foley Catheter – Care Policies.
4. Current residents with indwelling catheters will have catheter care randomly observed for 4 weeks, then randomly for 2 months thereafter, to ensure compliance with the facility Perineal Care, Catheter Management, and Foley Catheter – Care Policies. Results will be presented to the quarterly Quality Assurance Committee.

F695

Respiratory Care

CFR(s): 483.25(i)

1. The order and plans of care for residents #8 and #23 were reviewed and updated. The Treatment Administration Records (TARs) for residents #8 and #23 were updated requiring documentation for PRN (as needed) supplemental oxygen usage.
2. The orders and plans of care of current facility residents who receive supplemental oxygen were reviewed and updated, as needed. The Treatment Administration Records (TARs) for residents requiring supplemental oxygen were updated requiring documentation for PRN (as needed) supplemental oxygen usage.
3. The DON and Interdisciplinary Team were educated by the Administrator on the facility Oxygen Administration Policy. The DON and/or designee will likewise educate facility licensed nursing staff on the facility Oxygen Administration Policy.
4. The physicians' orders and plans of care for current facility residents who require supplemental oxygen will be randomly audited for four weeks, then randomly for 2 months thereafter, to ensure compliance with the facility Oxygen Administration Policy. Results will be presented to the quarterly Quality Assurance Committee.

F803

Menus and Nutritional Adequacy

CFR(s): 483.60(c)(1)-(7)

1. Current facility residents who receive mechanically altered texture diets were assessed to ensure there were no negative outcomes related to allegedly providing incorrect food portion sizes.
2. Current facility residents were assessed to ensure there were no negative outcomes related to allegedly providing incorrect food portion sizes.
3. The Food Service Director and Interdisciplinary Team were educated by the Administrator on the facility Menus and Nutritional Adequacy and Dining and Food Service Policies. The Food Service Director and/or designee will likewise educate facility dietary staff on the facility Menus and Nutritional Adequacy and Dining and Food Service Policies.
4. Food preparation for mechanically altered texture foods will be randomly observed for four weeks, then randomly for 2 months thereafter, to ensure dietary staff are properly following recipes. Residents with mechanically altered texture diets will have meals randomly audited for four weeks, then randomly for 2 months thereafter, to ensure proper food portion sizes are provided. Results will be presented to the quarterly Quality Assurance Committee.

F926

Smoking Policy

CFR(s): 483.90(i)(5)

1. On 3/12/2020, proper signage was placed at the designated smoking area in accordance with applicable Federal, State, and local laws and regulations. Specifically, signage indicating the location of the designated smoking area and signage prohibiting the use of oxygen in the area of the designated smoking area were placed in and around the designated smoking area.
2. Effective 3/16/2020, the facility Smoking Policy was amended to eliminate unsupervised smoking for residents.
3. Starting 3/20/2020, the Maintenance Director and Interdisciplinary Team were educated by the Administrator on the amended facility Smoking Policy. The Maintenance Director and/or designee will likewise educate facility staff on the amended facility Smoking Policy.

4. Residents who smoke will be randomly audited for 4 weeks, then randomly for 2 months thereafter, to ensure residents can easily access and use the new cigarette butt receptacle. The Designated Smoking Area will be randomly audited for 4 weeks, then randomly for 2 months thereafter, to ensure the designated smoking area complies with applicable Federal, State, and local laws and regulations. Results will be presented to the quarterly Quality Assurance Committee.