DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530956	A. BUILDING: _____ B. WING _____	C 02/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINICON PLACE	**1615 BRECA RIDGE DRIVE ANAMOSA, IA 52205**

(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) COMPLETE DATE
R 000	Initial Comments The following deficiencies were cited during the investigation of Complaint #88248-C.	R 000		
R 726	481-57.19(3)a Drugs 481-57.19(135C) Drugs 57.19(3) Drug administration-authorized personnel. a. A properly trained person shall be charged with the responsibility of administering medications as ordered by a primary care provider. (II, III) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review staff failed to follow primary care provider orders for 1 of 6 residents observed during a medication pass (Resident # 1). Findings include: A review of Resident # 1's record revealed a primary care provider order dated 1/29/20 to crush all medications and administer in food. A review of the medication administration record revealed the verbiage: "ok to crush meds in food." On 2/6/20 at 12:27 PM, Staff A was observed administering medications to Resident #1. Staff A attempted 6 different times until Resident #1 finally ingested the medications. None of the meds administered were crushed in food. The resident swallowed the medications whole. On 2/17/20 at 2:00 PM, the Executive Director	R 726		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530956	A. BUILDING: _____ B. WING _____	C 02/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINICON PLACE	**1615 BRECA RIDGE DRIVE ANAMOSA, IA 52205**

(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) COMPLETE DATE
R 726	Continued From page 1 confirmed the above findings.	R 726		
R 830	481-57.22(3)a Orientation and Service Plan 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) a. The service plan shall include measurable goals and objectives and the specific service(s) to be provided to achieve the goals. Each goal shall include the date of initiation and anticipated duration of service(s). Any restriction of rights shall be included in the service plan. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure service plans addressed assessed needs by including measurable goals, objectives and specific services provided for 3 of 4 residents reviewed (Residents #1, #2, and #4) Findings include: 1. A review of incident reports and facility first responder reports for Resident #1 revealed the following significant aggressive incidents:	R 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530956	A. BUILDING: _____ B. WING _____	C 02/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINICON PLACE	1615 BRECA RIDGE DRIVE ANAMOSA, IA 52205

(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) COMPLETE DATE
R 830	Continued From page 2	R 830		

a.) 12/16/19 - Resident #1 was resistant and aggressive during staff assistance with changing incontinent clothing.
b.) 12/19/19 - Resident #1 was resistant and aggressive during staff assistance with changing incontinent clothing.
c.) 12/20/20 - Resident #1 was upset and agitated when husband ended his visit and hit staff in the back 3 times as well as grabbed at staff's neck and punched.
d.) 1/29/20 - Resident #1 was very aggressive with staff when trying to change her clothing after incontinence. Staff was bit.
e.) 2/4/20 - Resident #1 was agitated during staff assistance with soiled clothing. Staff was punched in the back.

On 2/11/20 at 10:30 AM, Staff B stated she felt Resident #1 was difficult to work with and always required two staff to complete personal cares. On 2/11/20 at 9:55 AM, Staff C stated Resident #1 was almost always agitated and combative during incontinence cares. Staff C stated they always needed two staff to complete cares. On 2/6/20 at 12:50, Staff A stated Resident #1 was always very combative during morning incontinent cares.

A review of Resident #1's most recent service plan dated 1/13/20 revealed the following:
a.) Resident #1 is very resistant to whirlpool baths and it takes a lot of work getting her to agree to it.
b.) Resident #1 is very resistant to allowing staff to assist her in changing incontinent clothing. Her goal is not to have skin breakdown.
c.) Resident #1 is very resistant to allowing staff to assist her in changing her clothing.
d.) Resident #1 does not always like to take her medications. Different staff get her to take her medications in different ways.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530956	A. BUILDING: _____ B. WING _____	C 02/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINICON PLACE	1615 BRECA RIDGE DRIVE ANAMOSA, IA 52205

(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) COMPLETE DATE
R 830	Continued From page 3 e.) Resident #1 does not like assistance with her activities of daily living. Resident #1 will yell, punch and scratch. The service plan information was generalized and did not include measurable goals to address the assessed needs of resistance and aggression, objectives to decrease the behaviors or directives to staff on what to do when these behaviors occurred. 2. A review of incident reports for Resident #2 revealed the following falls: a.) 12/1/19 - Fell and received a skin tear b.) 12/3/19 - Fell and was found laying in own urine c.) 1/22/20 - Slid to floor from bed d.) 1/26/20 - Fell on his way to the restroom e.) 1/26/20 - Fell a 2nd time on same day Resident #2's service plan dated 12/13/19 indicated she had falls but failed to include a measurable goal including objectives or services provided. The plan did not include what the resident could or should do to prevent falls and what role the staff had in keeping the resident from falling. 3. A review of Resident #4's behavior log revealed he had aggressive behaviors toward staff on 10/14/19, 10/16/19 (3 times), 10/22/19 (twice), 1/9/20, 1/21/20, and 2/6/20 (twice). Resident #4's service plan dated 1/13/20 only addressed the behavior of elopement. The plan did not include a measurable goal for aggression towards others, objectives to decrease the behaviors or directives to staff on what to do when these behaviors occurred.	R 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530956	A. BUILDING: _____ B. WING _____	C 02/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINICON PLACE	**1615 BRECA RIDGE DRIVE ANAMOSA, IA 52205**

(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) COMPLETE DATE
R 830	Continued From page 4 4. On 2/17/20 at 2:00 PM, the Executive Director confirmed the above findings.	R 830		
R 916	481-57.25(1) Dignity Preserved 481-57.25(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (I, II) 57.25(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (I, II) This REQUIREMENT is not met as evidenced by: Based on observation and interview facility staff failed to display dignity and respect toward 1 of 6 residents reviewed during a medication pass (Resident #1). Findings include: Resident #1 had an order dated 1/29/20 for all medications to be crushed. During a medication pass observation on 2/6/20 at 12:27 AM, Staff A attempted to administer Resident #1's medications without success as the resident was agitated and showed signs of refusal. Staff A attempted to give them in a cup and on a spoon. Eventually, on the sixth attempt, Staff A placed the whole tablets on Resident # 1's plate next to her food and convinced her to take them one at a time. The medications were never crushed.	R 916		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	530956	A. BUILDING: _____ B. WING _____	C 02/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINICON PLACE	1615 BRECA RIDGE DRIVE ANAMOSA, IA 52205

(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) COMPLETE DATE
R 916	Continued From page 5 After the medication pass observation was completed at 12:50 PM, Staff A stated normally staff took the resident to her room to administer meds. If the resident resisted, a staff held her hands down and the medication aide put the pills into her mouth. This was often the only way the resident would take her medications. The facility had the following policies on file: a.) "General Guidelines for Resident Care: Staff will be trained on implementing and supporting the principles of choice, dignity, privacy, independence, individuality and a home-like setting, during new employee training and on an ongoing basis." b.) "Medication Administration: The six rights of medication and treatments administration will be observed every time a medication is administered - right resident, right medications, right dose, right form and route, right time, right documentation. In addition to these sex rights, the resident always has the right to refuse medication." c.) "Restraints and Bed Rail Use: Physical restraints are any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the resident that restricts freedom of movement." On 2/11/20 at 11:10 AM, the Executive Director confirmed the above and stated she had already spoken with the staff to discontinue this type of technique, as they could not force a resident to take his/her medications.	R 916		