PRINTED: 08/09/2022 FORM APPROVED OMB NO. 0938-0391

F 000 INITIAL Correct The foll investig #10584 27, 202 Complation of the following and the followin						(X3) DATE SURVEY COMPLETED	
F 000 INITIAL Correct The foll investig #10584 27, 202 Complate C		165161	B. WING			C 07/27/2022	
F 000 INITIAL Correct The foll investig #10584 27, 202 Complate C	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07	12112022	
F 000 INITIAL Correct The foll investig #10584 #10549 27, 202 Complete Comple	JK 3011 LILK			1800 INDIAN HILLS DRIVE			
F 000 INITIAL Correct The foll investig #10549 27, 202 Complation Complation of the following formula formul	ALTHCARE COI	MMUNITY		SIOUX CITY, IA 51104			
Correct The foll investig #10584 #10549 27, 202 Complete Complete Complete Finding	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
See the Part 48	gation of comp 12-C, and facili 99-M conducte 22. aint #104776-C aint #105842-C gs for facility re- sent to the facilite cover.	ncies relate to the laints #104776-C, ity reported incident d on July 20, 2022 to July C was not substantiated. C was not substantiated. ported incident #105499-M lity at a later date under a eral Regulations (42CFR)	F 000 PLAN OF CORRECTION Touchstone Healthcare Community denies any federal or state regulations. According plan of correction does not constitute an a agreement by the provider to the accuracy alleged or conclusions set forth in the state deficiencies. The plan of corrections is preand/or executed solely because it is require provisions of federal and state law. Compare provided for procedural processing purcorrelation with the most recently comples accomplished corrective action and do not chronologically to the date the facility may in compliance with the requirements of part or that corrective action was necessary. F 600 1. In continuing compliance with		ngly, this admission or ey of the facts atement of repared ired by the pletion dates aurposes and ated or ot correspond aintains it is participation,		
§483.12 Exploita The res neglect and exp include corpora any phy treat the §483.12 physica involun	2 Freedom from ation sident has the at, misappropria ploitation as des but is not limital punishment, ysical or chemite resident's medical The facilitation (a) The facilitation (a) (b) Not use all abuse, corportary seclusion	e verbal, mental, sexual, or		Healthcare Community corrected the dethe DON suspending the alleged staff mr. 7/12/2022. Staff A, Staff D, the DON, a were educated by the Administrator on the process for reporting abuse, includir obligation as mandatory reporters. The ensured resident #1, #2, and all like resifree from abuse and neglect until the factor 7/21/2022. 2. To correct the deficiency and to ensure problem does not recur, an all-staff educinitiated by the Administrator on 7/12/2 process for reporting any suspected or we resident abuse. The facility closed on 7/3. This deficiency was mitigated when to closed on 7/21/2022.	ficiency by ember on and the SSD 7/12/2022 on g their acility dents were illity closed re the action was 022 on the itnessed 21/2022.		

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		165161	B. WING			C 07/27/2022	
	ROVIDER OR SUPPLIER	MMUNITY	•	18	REET ADDRESS, CITY, STATE, ZIP CODE 00 INDIAN HILLS DRIVE OUX CITY, IA 51104		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	procedure review ald facility staff failed to reviewed remained for that were imposed for convenience for white of abuse (Resident # facility reported a certainly reported a cer	cord review, policy and any with staff interviews, the ensure 2 of 5 residents are from physical restraints or purposes of discipline or ch could potential be a form and Resident #2). The ensus of 11 residents. Immum Data Set (MDS) (27/22, documented a Brief Status (BIMS) score of 0, gonitive impairment. The MDS 1 had delusions, verbal six days, but less than daily, ymptoms not directed toward are days in the lookback antified that Resident #1 unce for all activities of daily k, he had impaired functional motion on upper, and lower ides. Resident #1's raumatic brain injury, anxiety, MDS documented that	F	600			

Event ID: XG3511

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		165161	B. WING _			07/2	27/2022	
	ROVIDER OR SUPPLIER	MMUNITY		STREET ADDRESS, CITY, STATE, 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE	
F 600	Service Director notif Credentialing Directo situations of potential management. The So that nothing happene that they should have Department of Inspector of North Programment of North Programment of Inspector of Ins	documentation dated tely 11:45 a.m. the Social ied the Admissions and r of three previously notified abuse that got reported to ocial Service Director felt d about them and still felt been reported to the lowactions and Appeals (DIA). m. the SSD reported that of the situation regarding 22, at approximately 5:52 nessaged the SSD via a text edded to talk with Staff A, nber that kept tying up eported that statement to g (DON), on 6/23/22. The strator at that time told the take care of it. The SSD saiding more about that incident situation was taken care of. mately 3:28 p.m. Staff D a stating that a coworker	F	600				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		165161	B. WING _			C 07/27/2022
	ROVIDER OR SUPPLIER	DMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODI 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	E	***************************************
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 600	skin areas at that tir got reported to her of the time. The SSD of C, CNA, about when Resident #1, that he C turned Resident # the gown tied around it secured in the back received reports that with a hospital gown Resident #1 and Resident	in. They didn't observe any me. The SSD said that it also on 7/9/22, but she didn't know got a text message from Staff in she did morning rounds on a wore two briefs. When Staff it onto his back she noticed it of his body. The SSD it this happened for months in being used to tie up it is ident involving Resident #1. In on 7/20/22 at 3:45 p.m., the ursing (DON) verified that she in dent involving Resident #1 with being tied around the written education in estaff that allegedly applied round the resident bottom and it is the the staff to work at the facility after the 2 and the staff member with the two residents that were in the two residents. Detail Reporting, documented in the mother allegation was the two residents. 7/20/22 1:10 p.m., the Interimed he expected all staff to in of potential abuse and that we up with investigating and	F6			

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		165161	B. WING		C 07/27/2022	
	ROVIDER OR SUPPLIER	MMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		N
F 604 SS=D	that the prior manage provide the facility we Policy/Procedure on investigate any type: The Resident Rights 12/17, documented to ensure that the rigrecognized and respass the medical staff. a. Expect reasonables services within our cand applicable law ab. Considerate and applicable law ab. Consideration of psycand safety needs. Right to be Free from CFR(s): 483.10(e)(1) §483.10(e) Respect The resident has a right and dignity, including §483.10(e)(1) The riphysical or chemical purposes of discipling required to treat the consistent with §483.12 The resident has the neglect, misappropriand exploitation as coincludes but is not lire corporal punishments.	ce Manager (BOM) stated ement company failed to ith an Abuse how to identify, report, and so of abuse. policy/procedure dated that a mechanism is in place that of the resident will be ected by the facility as well. The policy further directed: e responses to requests for apacity, our stated mission and regulation respectful care, including chosocial, spiritual, cultural, an Physical Restraints, 483.12(a)(2) and Dignity. ght to be free from any restraints imposed for e or convenience, and not resident's medical symptoms, 1.12(a)(2). Tright to be free from abuse, ation of resident property, lefined in this subpart. This mited to freedom from the incoluntary seclusion and nical restraint not required to	F 60	1. In continuing compliance with F 604 Right to be Free from Physical Restrain Touchstone Healthcare Community corrected deficiency by the DON suspending the alleges member on 7/12/2022. Staff A, Staff B, and the were educated by the Administrator on 7/12/2012 the process for reporting any suspected or with abuse to include the use of physical restraints. Facility ensured restraints were not utilized on resident #1, #2, and all like residents until the closed on 7/21/2022. 2. To correct the deficiency and to ensure the problem does not recur, an all-staff education initiated by the Administrator on 7/12/2022 or right for all resident to be free from use of resonant to the free from use of resonant to the free from the facility closed on 7/21/2022. 3. This deficiency was mitigated when the facility closed on 7/21/2022.	d staff ne DON, 1022 on ness The facility was n the traints.	

Event ID: XG3511

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165161	B. WING _			C 07/27/2022		
	ROVIDER OR SUPPLIER	MMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104				
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 604	Continued From pag	e 5	F6	04				
		e that the resident is free						
	purposes of disciplin	mical restraints imposed for e or convenience and that eat the resident's medical e use of restraints is						
	alternative for the lea	must use the least restrictive ast amount of time and e-evaluation of the need for						
	This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews,							
	indicate medical sym need for a restraint;	e review the facility failed to nptoms that indicated the failed to complete consent the responsible parties that						
	provide education of to document dates a	the risks and benefits; failed nd times of restraint usage eviewed. The facility reported						
	a census of 11. (Res	idents # 1, and Resident #2).						
	1. Resident #1's Min	imum Data Set (MDS)						
	Interview for Mental indicating severe cog	/27/22, documented a Brief Status (BIMS) score of 0, gnitive impairment. The MDS						
	behaviors for four to and other behavior s	1 had delusions, verbal six days, but less than daily, ymptoms not directed toward be days in the lookback						
	period. The MDS ide required staff assista	entified that Resident #1 ance for all activities of daily						
		k, he had impaired functional motion on upper, and lower sides. Resident #1's						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	OMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		···
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 604	and depression. Th Resident #1 did not The Medication Rev 6/14/22, documente such as: itching, pic (agitation), hitting, it kicking, spitting, cus stealing, delusions, aggression, and ref The cancelled Care documented include a. Resident #1 som head. He likes to do safe and secure. b. Please offer Resi disruptive, this help c. Staff to observe f d. Resident #1 enjo room, sometimes h music. e. Resident #1 enjo daily basis, during o common area. f. Resident #1 has o lower extremities. g. Please provide R and support when h and demanding. Me timely manner. Resident #1's Care related to the use o Resident #1's clinic consent form signed	traumatic brain injury, anxiety, e MDS documented that use restraints. view Report signed on ed to monitor for behaviors sking at skin, restlessness increase in complaints, biting, ssing, racial slurs, elopement, hallucinations, psychosis, using care. Plan dated 7/19/22, ed the following interventions: etimes puts a blanket over his or that as it makes him feel ident #1 coffee if he becomes is calm him down. Or symptoms of confusion ys listening to the radio in his eruses his television for a care, or when he is in the contractures to his upper and desident #1 with reassurance he becomes upset, impatient, eet Resident #1's needs in a	F 6	04		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		165161	B. WING _			C 07/27/2022
	ROVIDER OR SUPPLIER ONE HEALTHCARE CO	MMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	2. Resident #2's MD documented a BIMS revealed Resident #2 all activities of daily I impaired functional li on upper, and lower Resident #2's diagnodisorder and unspect The MDS document use restraints. The cancelled Care I the following interver a. Resident #2 is incomposed by the following interver a. Resident #2 is incomposed by the following interver a. Resident #2 is incomposed by the following interver a. Resident #2 is incomposed by the following interver a. Resident #2 is incomposed by the following interver as the following interverse as the following intervers	I record lacked a physician's straint. S assessment dated 7/5/22, score of 0. The MDS 2 required staff assistance for iving, did not walk, and had imitation of range of motion extremities on both sides. Sees included a seizure ified intellectual disabilities. The ed that Resident #2 didn't Plan dated 7/20/22, included nations: ontinent of bladder and range approximately every eded. Staff to provide Int #2 having behaviors such asse provide privacy, and lay ricares and handwashing as bating.	F6	504		
	consent form signed party for the use of a benefits and risks ha	by the resident's responsible restraint that described the d been completed. I record lacked a physician's				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
	165161	B. WING _			C 07/27/2022	
	DMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	l	<u> </u>	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE	
The Restraints, Physical restraint and limited bed. During an interview Director of Nursing of the restraint and limited bed. During an interview During an interview A, Certified that a hospite each of the resident move and reposition.	e physical restraint guidelines sident attains and maintains ticable well-being in an obibits the use of restraints for ience and limits physical reumstances in which the all symptoms that warrant the the definition of a restraint limited to: Velcro to hold a sheet, fabric, that a residents movement is sints shall not be used to limit the convenience of staff ide (CNA), confirmed and ital gown tied in a knot behind is knees was considered a the residents movement in on 7/21/22 at 9:30 a.m., the confirmed and verified that is debehind the residents' knees id a physical restraint due to a themselves independently. on 7/26/22 at 3:12 p.m., Staff and verified that a hospital around each of the residents' movement of them and id a restraint.					
Develop/Implement	Abuse/Neglect Policies	F6	07			
	CONTENT ONE HEALTHCARE CO SUMMARY S (EACH DEFICIENT REGULATORY OF The Restraints, Physical policy dated 12/17: The purpose of these is to ensure each restraint usage to convent restraint and limited and the resident restraint and limited bed. During an interview of the hospital gown tied that it would be considered that it would move and reposition. During an interview of the resident restraint and limited bed. During an interview of the resident restraint and limited bed. During an interview of the resident restraint and limited bed. During an interview of the resident restraint and limited bed. During an interview of the resident restraint and limited bed.	TONE HEALTHCARE COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 The Restraints, Physical, General Guidelines policy dated 12/17: The purpose of these physical restraint guidelines is to ensure each resident attains and maintains his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits physical restraint usage to circumstances in which the resident has medical symptoms that warrant the use of restraints. Practices that meet the definition of a restraint include, but are not limited to: *tucking in or using Velcro to hold a sheet, fabric, or clothing tightly so that a residents movement is restricted *Physical restraints shall not be used to limit resident mobility for the convenience of staff During an interview on 7/20/22 at 1:15 p.m., Staff A, Certified Nurse Aide (CNA), confirmed and verified that a hospital gown tied in a knot behind each of the residents' knees was considered a restraint and limited the residents movement in	TOORTECTION 165161 B. WING	IDENTIFICATION NUMBER: 165161 REVING STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAGG	TOURIER OR SUPPLIER 165161 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRESTA TAG COntinued From page 8 The Restraints, Physical, General Guidelines policy dated 12/17: The purpose of these physical restraint guidelines is to ensure each resident attains and maintains his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits physical restraint the use of restraints. Practices that meet the definition of a restraint include, but are not limited to: Trucking in or using Velcro to hold a sheet, fabric, or clothing tightly so that a residents movement is restricted Physical restraints shall not be used to limit resident mobility for the convenience of staff During an interview on 7/20/22 at 1:15 p.m., Staff A, Certified Nurse Aide (CNA), confirmed and verified that a hospital gown tied behind the residents movement in bed. During an interview on 7/21/22 at 9:30 a.m., the Director of Nursing confirmed and verified that the hospital gown tied behind the residents knees would be considered a physical restraint due to the fact that it would limit the resident behind the resident since service and proposition themselves independently. During an interview on 7/26/22 at 3:12 p.m., Staff B, CNA, confirmed and verified that a hospital gown tied in a knot around each of the residents' knees restricted the movement of them and would be considered a restraint.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 165161 B WING 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1800 INDIAN HILLS DRIVE** TOUCHSTONE HEALTHCARE COMMUNITY SIOUX CITY, IA 51104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (FACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1. In continuing compliance with 7/21/2022 F 607 Develop/Implement Abuse/Neglect Policies, F 607 Continued From page 9 Touchstone Healthcare Community corrected the SS=D CFR(s): 483.12(b)(1)-(3) deficiency by the Administrator initiating an all staff education on 7/12/2022. §483.12(b) The facility must develop and implement written policies and procedures that: 2. To correct the deficiency and to ensure the problem does not recur, an all-staff education was initiated by the Administrator on 7/12/2022 on what §483.12(b)(1) Prohibit and prevent abuse, the expectation for identifying and reporting any neglect, and exploitation of residents and suspected or witnessed abuse would be from misappropriation of resident property, 7/12/2022 until the facility closes. The facility closed on 7/21/2022. §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and 3. This deficiency was mitigated when the facility closed on 7/21/2022. §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and the review of resident rights policy/procedure the facility failed to ensure the nursing/long term care facility had an abuse prevention policy that directly related to long term care regulations and included all key components related to abuse prevention. The facility reported a census of 11. Findings include: During an interview on 7/21/22 at 8:00 a.m., the facility Business Office Manager, confirmed and verified that the prior management group failed to provide the facility with an Abuse policy/procedure for prevention, identification and investigation and reporting the different types of abuse. The Resident Rights policy/procedure dated 12/17, documented that a mechanism is in place to ensure that the rights of the resident will be recognized and respected by the facility as well as the medical staff: The policy further directed: a. Expect reasonable responses to requests for

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		165161	B. WING		C 07/27/2022
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F 607	and applicable law ar b. Considerate and re consideration of psyc and safety needs. The State Operations (1-4) revised 11/22/1	pacity, our stated mission and regulation espectful care, including hosocial, spiritual, cultural, Manual section 483.12(b) 7 instructed that the	F 60	7	
F 609	(1-4) revised 11/22/17 instructed that the regulation was written to provide protections for the health, welfare and rights of each resident residing in the facility. In order to provide these protections, the facility must develop written policies and procedures to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property. These written policies must include, but are not limited to, the following components: Screening; Training; Prevention; Identification; Investigation; Protection; and Reporting/response.		F 60	9 1. In continuing compliance with F 609 Reporting of Alleged Violations, Toucl	7/21/2022
SS=D	neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, negl mistreatment, includir source and misappro are reported immedia hours after the allega	se to allegations of abuse, or mistreatment, the facility that all alleged violations		Healthcare Community corrected the deficienthe Administrator initiating an all staff educat 7/12/2022 to ensure alleged abuse violations a reported for Resident #1, #2, and all like resident #2. To correct the deficiency and to ensure the problem does not recur, an all-staff education initiated by the Administrator on 7/12/2022 of the expectation for reporting any suspected or witnessed abuse would be from 7/12/2022 unifacility closes. The facility closed on 7/21/2022.	cy by ion on are lents. was n what til the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	OMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		ONZINZOZZ
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 609	the events that cause abuse and do not reter the administrator of officials (including to adult protective sent for jurisdiction in lor accordance with Staprocedures. §483.12(c)(4) Repositive stigations to the designated represe accordance with Stasurey Agency, with incident, and if the appropriate correction This REQUIREMENT by: Based on record refacility failed to reposite Department of It (Resident #1 and Reported a census of the Department of It (Resident #1 with a Bestatus (BIMS) score indicates severely in inattention, disorgand level of consciousned documented the resident required states and other directed toward other resident required states.	or, or not later than 24 hours if see the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides ageterm care facilities) in attel aw through established and the results of all administrator or his or her intative and to other officials in attel aw, including to the State hin 5 working days of the alleged violation is verified we action must be taken. It is not met as evidenced eview, staff interview, the first an allegation of abuse to inspections and Appeals. esident #2) The facility of 11 residents.	F 60	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDI		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		165161	B. WING			C 07/27/2022	
	ROVIDER OR SUPPLIER ONE HEALTHCARE CO	MMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	<u>_</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	and lower extremity revealed the resident Traumatic Brain Injurand no restraints used. 2. A Quarterly Minimassessment tool, data resident #2 with a BI to 7 indicates severe inattention, long term severely impaired for inattention and altered The MDS revealed the assistance for all act not walked and imparange of motion on u both sides. The MDS diagnoses included sunspecified Intellector restraints used. Review of facility incitat approximately 11: Director notified the second control of the second c	of range of motion on upper on both sides. The MDS t's diagnoses included ry, anxiety and depression ed. um Data Set (MDS) ded 7/5/22, documented MS score of 0. A score of 0 dy impaired cognition with a memory impairment, redecision making abilities, and level of consciousness. The resident required staff divities of daily living and had irred functional limitation of per and lower extremity on a revealed the resident's Seizure Disorder, and ual Disabilities and no	F 60	,			
	the past and now feed done about them and have been reported to During an interview 7 Administrator verified report any allegation staff needed to follow reporting to the proposition of the properties of the properties and the properties of the properties are always and the properties of the properties are always and the properties of the properties are always and the properties of the properties of the properties are always and the properties of the propert	7/20/22 1:10 p.m., the Interim d he expected all staff to of potential abuse and that v up with investigating and er authorities.					
		on 7/21/22 at 8:00 a.m., the ce Manager (BOM) stated					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		165161	B. WING			C 27/2022	
NAME OF PROVIDER OR SUPPLIER TOUCHSTONE HEALTHCARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 609	provide the facility wi	ement company failed to	F 609				
F 610 SS=D	During an interview of facility DON confirms of the allegation on 67/9/22 allegations. Investigate/Prevent/CCFR(s): 483.12(c)(2)	ring an interview on 7/21/22 at 9:10 a.m., the illity DON confirmed that DIA was not notified the allegation on 6/23/22 and also 7/7/22 and illegations. estigate/Prevent/Correct Alleged Violation R(s): 483.12(c)(2)-(4) 83.12(c) In response to allegations of abuse, glect, exploitation, or mistreatment, the facility		1. In continuing compliance with F 610 Investigate/Prevent/Correct Alleged Violation, Touchstone Healthcare Community corrected the deficiency by the Administrator initiating an all-staff education on 7/12/2022 to ensure alleged abuse violations are investigated for Resident #1, #2, and allike residents. 2. To correct the deficiency and to ensure the problem does not recur, an all-staff education was initiated by the Administrator on 7/12/2022 on what the expectation for investigating any suspected or witnessed abuse would be from 7/12/2022 until the facility closes. The facility closed on 7/21/2022.		7/21/2022	
	neglect, exploitation, must: §483.12(c)(2) Have eviolations are thorough \$483.12(c)(3) Preveneglect, exploitation,						
	designated represent accordance with Stat Survey Agency, withis incident, and if the all appropriate corrective. This REQUIREMENT by: Based on clinical recressident rights policy failed to investigate a abuse and prevent for	administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the leged violation is verified to e action must be taken. To is not met as evidenced toord reviews, staff interviews, and procedure, the facility an allegation of potential aurther potential abuse for 2 of (Resident #1 and Resident		3. This deficiency was mitigated when the factorial closed on 7/21/2022.	acility		

Event ID: XG3511

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		165161	B. WING		C 07/27/2022		
NAME OF PROVIDER OR SUPPLIER TOUCHSTONE HEALTHCARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104		0112112022	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	TION SHOULD BE COMPLETION DATE		
F 610	assessment dated 6/ Interview for Mental 3 indicating severe cog identified Resident # behaviors for four to and other behavior sy others for one to three period. The MDS ide required staff assistate living, he did not walk limitation of range of extremities on both sy diagnoses included to and depression. The Resident #1 didn't use 2. Resident #2's MDS documented a BIMS revealed Resident #2 all activities of daily liting impaired functional liting on upper, and lower of Resident #2's diagnored disorder and unspect The MDS documenter use restraints. The Facility Incident 7/12/22 at approximate	mum Data Set (MDS) 27/22, documented a Brief Status (BIMS) score of 0, gnitive impairment. The MDS 1 had delusions, verbal six days, but less than daily, ymptoms not directed toward e days in the lookback ntified that Resident #1 nce for all activities of daily k, he had impaired functional motion on upper, and lower ides. Resident #1's raumatic brain injury, anxiety, MDS documented that e restraints.	F 61				
	Credentialing Director situations of potentia management. The So	or of three previously notified I abuse that got reported to ocial Service Director felt about them and still felt					

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED	
165161	B. WING			C 07/27/2022
NAME OF PROVIDER OR SUPPLIER TOUCHSTONE HEALTHCARE COMMUNITY			E, ZIP CODE	ONZINZOZZ
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTI) CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIAT	(X5) COMPLETION DATE
been reported to the lowations and Appeals (DIA). In the SSD reported that the situation regarding 2, at approximately 5:52 essaged the SSD via a text ded to talk with Staff A, ber that kept tying up ported that statement to g (DON), on 6/23/22. The trator at that time told the ake care of it. The SSD saiding more about that incident tuation was taken care of ately 3:28 p.m. Staff D stating that a co-worker se she could hurt forted that she saw a gown bound Resident #1's knees. The edd to tell someone else. Of that the knot was tied so could not move his legs get the knot out. The SSD on in a stand up meeting to and the Regional Nurse for said that they would look that she went down to check on him and that the degional Nurse entered the mey found Resident #1 wet the Regional Nurse untied They didn't observe any. The SSD said that it also 7/9/22, but she didn't know a text message from Staff he did morning rounds on the two briefs. When Staff he did morning rounds on the two briefs. When Staff	F	510		
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 15 been reported to the lowa ions and Appeals (DIA). 1. the SSD reported that the situation regarding 2, at approximately 5:52 essaged the SSD via a text ded to talk with Staff A, ber that kept tying up ported that statement to g (DON), on 6/23/22. The trator at that time told the take care of it. The SSD said ng more about that incident truation was taken care of. ately 3:28 p.m. Staff D stating that a co-worker se she could hurt borted that she saw a gown bund Resident #1's knees. eded to tell someone else. Of that the knot was tied so could not move his legs get the knot out. The SSD on in a stand up meeting to and the Regional Nurse for said that they would look hat she went down to check on him and that the regional Nurse entered the mey found Resident #1 wet the Regional Nurse untied They didn't observe any The SSD said that it also 7/9/22, but she didn't know a text message from Staff	MUNITY TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 15 Deen reported to the lowa ions and Appeals (DIA). 16. the SSD reported that if the situation regarding 2, at approximately 5:52 Dessaged the SSD via a text ded to talk with Staff A, ber that kept tying up ported that statement to 10 (DON), on 6/23/22. The trator at that time told the ake care of it. The SSD said and more about that incident tuation was taken care of. ately 3:28 p.m. Staff D stating that a co-worker se she could hurt corted that she saw a gown bound Resident #1's knees. Deded to tell someone else. Detail the knot out. The SSD on in a stand up meeting to and the Regional Nurse for said that they would look nat she went down to check on him and that the degional Nurse entered the degional Nurse sentered the degional Nurse entered the degional Nur	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) The SSD reported that the situation regarding 2, at approximately 5:52 assaged the SSD via a text ded to talk with Staff A, beer that kept tying up ported that statement to 1 (DON), on 6/23/22. The trator at that time told the ake care of it. The SSD said ag more about that incident tuation was taken care of, ately 3:28 p.m. Staff D stating that a co-worker se she could hurt toorted that she saw a gown bund Resident #1's knees. eded to tell someone else. Of that the knot was tied so could not move his legs get the knot out. The SSD on in a stand up meeting to and the Regional Nurse for said that they would look and she went down to check on him and that the egional Nurse untied They didn't observe any The SSD said that it also 7/9/22, but she didn't know a text message from Staff he did morning rounds on ore two briefs. When Staff he did morning rounds on ore two briefs. When Staff	A. BUILDING B. WING

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		165161	B. WING _			C 07/27/2022	
NAME OF PROVIDER OR SUPPLIER TOUCHSTONE HEALTHCARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	the gown tied around it secured in the back received reports that with a hospital gown Resident #1 and Resident Resident Rights 12/17, documented: A mechanism is in plof the resident will be by the facility as well policy further directed. Expect reasonable services within our cand applicable law ab. Considerate and resident resident resident will be services within our cand applicable law ab. Considerate and resident resident and resident and resident resident and resident and resident and resident resident and resident resident and resident r	I his upper right arm and with of of his body. The SSD this happened for months being used to tie up sident #2. In 7/21/22 at 9:10 a.m., the DON) confirmed and verified omplete incident reports or do to the allegations of the the allegations of the Manager (BOM) stated dement company failed to the an Abuse how to identify, report, and is of abuse. In a company failed to the policy/procedure dated are to ensure that the rights are recognized and respected as the medical staff. The diese responses to requests for apacity, our stated mission	F 6	10			