STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E277	A. BUILDING _____ B. WING _____	09/01/2021

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STORY COUNTY HOSPITAL LTC	630 SOUTH SIXTH STREET NEVADA, IA 50201

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F 000	INITIAL COMMENTS Correction Date: 9-15-21 A recertification health survey and investigation of Complaint 97393-C was completed 8/24/2021 to 9/1/2021 and resulted in the following deficiencies. Complaint #97393-C was not substantiated. (See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced	F 606		

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

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

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F 606	Continued From page 1 by: Based on personnel and policy review and staff interview, the facility failed to request a Department of Human Services (DHS) evaluation for misdemeanor convictions, with a finding of guilty by a court of law, for 2 of 5 employees reviewed. The facility reported a census of 50 residents. Findings include: 1. Employee records documented a start date of 03/10/20 for Staff B, cook. Staff B's SING (Single Contact License and Background Check) dated 02/26/20 revealed the need for further research for criminal history. An undated Criminal History Record Check Request Form was submitted to the DCI (Department of Criminal Investigations) The results dated 03/02/2020 documented 4 arrests and convictions including 1st and 2nd OWI and 2 convictions of Possession of Controlled Substances. There was no documentation of a DHS submission for review and determination of eligibility for hire. 2. Employee records documented a start date of 01/30/20 for Staff C, LPN (licensed practical nurse). Staff C's SING report dated 01/22/20 revealed the need for further research for criminal history. Staff C signed a Record Check Evaluation request dated 01/28/19. The Associate Administrator stated HR informed her the 1/28/19 date was a typo and reflected the Record Check Evaluation request for the date of hire of 01/30/20. An Iowa Record Check Result dated 01/27/20 documented a Misdemeanor conviction of Criminal Mischief 5th Degree.	F 606		

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F 606	Continued From page 2 There was no documentation of a DHS submission for review and determination of eligibility for hire. 3. On 09/01/21 at 11:50 AM the associate Administrator stated Human Resources (HR) could not provide any documentation of the the DHS findings from the record check evaluation requests for Staff B and Staff C. She stated the prior HR director was terminated and the new HR director in place since March 2021 and stated the current practices are to receive the DHS findings and determination before hiring an employee. The Associate Administrator stated she expected the HR department to complete all required background checks and clearances prior to hire. 4. The facility policy titled Background Checks, effective 12/01/17 directed the facility to conduct background checks in order to determine if individuals should not be granted employment. It instructed that DHS would evaluate and determine the employee's eligibility for continued employment.	F 606		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		

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F 656	Continued From page 3 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to develop a care plan to address pain medication, goals and interventions for 1 out of 18 sampled residents reviewed for comprehensive care plans (Resident #25). The facility reported a census of 50 residents.	F 656		

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F 656	Continued From page 4 Findings include: The Minimum Data Set (MDS) assessment dated 7/19/21 for Resident #25 showed the Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment. The MDS documented diagnosis that included: pain in the left knee, idiopathic peripheral autonomic neuropathy (nerve damage that interferes with the functioning of the peripheral nervous system, causing pain), hemiplegia following cerebral infarct (brain damage or spinal cord injury that causes half of the body to be paralyzed, causing pain and stiffness). The MDS dated 7/19/21 revealed Resident #25 received pain medication 7 out of 7 days during the review period. An Order Summary Report dated 8/26/21 revealed the following orders signed by the physician: a. Baclofen (muscle relaxant for pain caused by muscle stiffness and tightness). Give one tablet by mouth three times a day with a start date of 1/14/21. b. Gabapentin (used to treat nerve pain) 600 mg. Give one tablet by mouth three times a day with a start date of 1/14/19. c. Hydrocodone-Acetaminophen Tablet (used for pain) 5/325 mg. Give one tablet by mouth every 8 hours as needed for pain and fever with a start date of 1/14/21. d. Tylenol Capsule 325 mg. Give 2 capsules by mouth every 8 hours as needed for pain, fever/ e. Tylenol Tablet 325 mg. Give 650 mg by mouth at bedtime for shoulder pain, chronic pain related to pain to the left knee and age related	F 656		

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F 656	Continued From page 5 osteoporosis. f. Assess pain every shift using the 1-10 pain scale or the Wong Baker Faces pain scale three times a day per policy with a start date of 5/7/21. The care plan last revised on 7/22/21 lacked any documentation pertaining to the residents usage, goals, and interventions related to pain. On 08/31/21 at 12:20 PM, Associate Administrator, Director of Nursing (DON) and Assistant DON, confirmed the care plan should contain information regarding pain medications, goals and interventions. On 09/01/2021 at 10:01 AM, Associate Administrator stated they developed a process to track medications for care plans and staff is currently working to update the care plans using this process.	F 656		
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 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).	F 657		

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F 657	Continued From page 6 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 record review and staff interview the facility failed to update the resident's care plan with a new diagnosis and medication for two (Resident #26 and Resident #27) of 18 residents reviewed. The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #26 dated 7/19/21, included diagnoses of Mild Cognitive Impairment, Rheumatic Aortic Stenosis with insufficiency (narrowing of the heart valve), Atrioventricular Block, Second Degree (the electrical signal that controls the heartbeat is partially or completely blocked and the heart can't pump blood effectively). The MDS documented the resident received an antidepressant and had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment for decision-making. Resident #26's Order Summary Report dated 6/28/21, contained a physician's order, dated 5/10/21, for Prozac 20 milligrams (mg), give 1	F 657		

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F 657	Continued From page 7 capsule by mouth one time a day for depression. Resident #26's care plan, with last review date of 7/23/21, lacked documentation of diagnosis of depression and antidepressant medication. 2. The MDS assessment for Resident #27 dated 7/19/21, included diagnoses of cancer, Coronary Artery Disease, and visual hallucinations. The MDS documented the resident received an antidepressant and had a BIMS score of 11, indicating moderate cognitive impairment for decision-making. Resident #27's Order Summary Report dated 6/28/21, contained a physician's order dated 12/3/20, to start 12/5/20 Celexa (antidepressant)10 mg, give 1 tablet by mouth one time a day for depression. Resident #27's care plan with last review date of 7/23/21, lacked documentation of new diagnosis of depression and antidepressant medication. 3. On 8/31/21 at 11:05 AM, the Associate Administrator stated she expected staff to update care plans with new antidepressant medication orders.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		

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F 686	Continued From page 8 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to follow the physician ordered treatment to a Stage II pressure ulcer for one (Resident #26) of three residents reviewed. The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #26 dated 7/19/21, included diagnoses of Mild Cognitive Impairment, Rheumatic Aortic Stenosis with insufficiency (narrowing of the heart valve), Atrioventricular Block, Second Degree (the electrical signal that controls the heartbeat is partially or completely blocked and the heart can't pump blood effectively). The MDS documented the resident needed extensive assist of 1 staff for transfers, dressing, toilet use and personal hygiene, with extensive assist of 2 staff for bed mobility. The MDS documented the resident with an unhealed pressure ulcer and at risk of developing pressure ulcers. A Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment for decision-making. The State Operations Manual identified a Stage II pressure sore as: Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed	F 686		

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F 686	Continued From page 9 dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Resident's skin evaluation dated 3/11/2021 documented: Skin Issue: Pressure Ulcer / Injury. Skin Issue Location: left lateral foot Pressure Ulcer / Injury Stage: Stage II - Partial thickness skin loss. Length: .8 Width: 1 Depth: 1 millimeter (mm) Wound Bed: Necrotic. Wound Exudate: None. Peri Wound Condition: WNL (within normal limits). Dressing Saturation: None. No wound odor. No tunneling. No undermining. Tissue: Painful. Physician's progress note for resident, dated 3/11/21, documented lower extremity ulcer located on left lateral foot. Physician's progress note for resident, dated 8/26/21, documented lower extremity ulcer located on left lateral foot. A physician's order dated 8/26/21, directed staff to: clean all areas with wound wash. Left foot: Puracol (collagen dressing to promote natural healing while absorbing the wound drainage) to lateral foot wound, 4X4 gauze, abdominal pad (ABD), kerlix (dressing wrap), coban (sticky dressing wrap to hold dressing in place).	F 686		

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F 686	Continued From page 10 Observation showed on 8/30/21 at 9:34 AM, Staff A, Licensed Practical Nurse (LPN) washed hands, donned gloves, and on left foot cleansed 3 toes and lateral wound with wound wash. Staff A, LPN doffed gloves, washed hands, donned new gloves, and applied Betadine, 2 X 2 gauze, and tube gauze on the 3 toe wounds. Staff A, LPN applied Betadine and ABD pad to left lateral foot wound and wrapped with kerlix and coban. Staff A, LPN removed gloves and washed hands. Staff A, LPN failed to apply Puracol to left lateral foot ulcer as ordered. On 9/01/21 at 1:59 PM, the Director of Nursing identified the left lateral wound as a pressure ulcer. On 9/01/21 at 12:25 PM, the Associate Administrator stated she expected staff to follow physicians orders.	F 686		
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. §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	F 690		

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F 690	Continued From page 11 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, staff interview, and record and policy review the facility failed to provide appropriate incontinence care for one (Resident #24) of three residents reviewed. The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) for Resident #24, dated 7/12/21, included diagnoses of Alzheimer's disease, Diabetes, and stroke. The MDS identified the resident was total dependence on two staff for bed mobility, transfers, dressing, and toilet use. The MDS identified the resident as always incontinent of urine and bowel. The MDS identified the resident as rarely/never understood and no BIMS (Brief Interview for Mental Status)	F 690		

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F 690	Continued From page 12 test performed, indicating severe cognitive impairment. Observation showed on 8/25/21 at 9:07 AM, Staff D, Certified Nurse's Aide (CNA) and Staff E, CNA apply hand sanitizer and gloves. With resident lying in bed, Staff D, CNA and Staff E, CNA lowered resident's pants, brief, and acknowledged brief was wet. Staff D, CNA wiped between the perineal area and right leg/thigh with a wipe, then wiped between the perineal area and left leg/thigh with the same wipe and same side of the wipe. Staff D, CNA used a new wipe for each swipe to cleanse the middle perineal area, right hip, and both buttocks. Staff D, CNA failed to cleanse the left hip. Staff E, CNA applied new brief while Staff D, CNA removed gloves, applied hand sanitizer, and donned new gloves. Staff D and Staff E, CNA pulled up resident's pants, transferred resident to wheelchair, doffed gloves, and washed hands. Review of facility policy titled "Perineal Care", dated 11/30/17, documented: a. Separate labia and wash with peri wash/soap and water from front to back toward rectum. Use a new section of the washcloth for each stroke, repeating strokes until the area is clean. b. Wash the outer labia and inner thighs the same way, with front to back strokes using a clean washcloth. The policy did not direct staff to wash the hips. On 8/31/21 at 11:05 AM, the Associate Administrator stated she expected staff to use 1 swipe with each wipe and to cleanse the hips with incontinent care.	F 690		

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, facility staff failed to store drugs in accordance with currently accepted professional practices, in one of two medication (med) carts (Hall 200). The facility reported a census of 50 residents. Findings include: 1. Observation on 08/30/21 at 08:05 AM revealed an outdated stock supply of acetaminophen	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E277	A. BUILDING _____ B. WING _____	09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORY COUNTY HOSPITAL LTC	630 SOUTH SIXTH STREET NEVADA, IA 50201

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F 761	Continued From page 14 (Tylenol). The bottle contained an open date of 10/19/20 written with black marker. The manufacturer's labeled expiration date was stamped as 06/20/21. The bottle was labeled by the manufacturer as having 1000 tablets packaged. Approximately 50 tablets remained in the bottle when observed. On 08/30/21 at 08:07 AM, Staff A confirmed the stock bottle of acetaminophen contained an expiration date of 06/20/21 and should be removed from the cart. Staff A then stepped to the phone on the wall next to the med cart and called the pharmacy to request a replacement bottle. Staff A then placed the expired bottle in the medication room on Hall 200 for disposal. On 08/30/21 at 08:42 AM the DON (Director of Nursing) stated it is "common nursing knowledge" to check for expiration dates. On 08/30/21 at 09:01 AM, the Associate Administrator reported there is no facility policy addressing the inspection of medications for outdates. She stated it is "best nursing practice" to monitor outdates and discard medications as indicated.	F 761		

Story County Medical Center - Senior Care
Facility Annual Survey - 2021
Plan of Correction

F 000

This plan of correction constitutes Story County Medical Center-Senior Care's written compliance for the deficiencies cited. Submission of the plan of correction is not an admission that the deficiencies exist or were cited correctly. This plan of correction is submitted to meet State and Federal regulations.

F 606

It is the responsibility of Human Resources to conduct record check evaluations on Senior Care employees. During pre-employment, employee will be asked to provide consent for Story County Medical Center to conduct a record check. This consent will be documented by having the candidate complete and sign the State of Iowa Criminal History Record Check Request Form (DCI-77) and the Authorization for Release of Child and Dependent Adult Abuse Information form (470-3301). Record check will be conducted using the Iowa Single Contact Repository (SING).

If a record check returns with further evaluation required Story County Medical Center requires the candidate to complete the Record Check Evaluation form (470-2310) to provide additional information on any adverse discovery from the criminal and/or child and dependent adult abuse check.

Since April 2021 (when new HR Director started), the 470-2310 form is sent to the Department of Human Services (DHS) for evaluation and a candidate is not cleared for employment unless approval is received via a Notice of Decision from DHS. If approval is received, employee is cleared for employment and Notice of Decision is retained in the employee's personnel file in Human Resources. If DHS does not approve employment, candidate will be contacted by Human Resources and offer for employment at Story County Medical Center will be rescinded.

Education on 483.12(a) (3) and 483.12(a) (4) was provided to the HR director on 09/01/202

This will be monitored by the associate administrator, who will audit new employee hire files for background checks weekly x 2 weeks and periodically thereafter. Report will be made to the QAPI committee quarterly and more often as needed.

F 656

It is the MDS Coordinator's responsibility to ensure the care plan is accurate and updated. The care plan will be developed upon admission and reviewed quarterly and PRN with the interdisciplinary team, the resident, and/or resident representative to review medication and diagnosis changes. Audits will be completed weekly x2 and then quarterly by the DON and reviewed with the Medical Director at Senior Care QA meetings at least quarterly and more often if needed.

Resident #25 care plan was updated on 09/01/2021 to include appropriate diagnoses, pain medications, interventions, and goals. In addition, all residents' care plans were reviewed to ensure pain medications, interventions and goals are identified on the care plan.

F 657

It is the MDS Coordinator's responsibility to ensure the care plan is accurate and updated. The care plan will be developed upon admission and reviewed quarterly and PRN with the interdisciplinary team, the resident, and/or resident representative to review medication and diagnosis changes. Audits will be completed weekly x2 and then quarterly by the DON and reviewed with the Medical Director at Senior Care QA meetings at least quarterly and more often if needed.

Resident #26 and #27 care plans were updated on 09/01/2021 to include appropriate diagnoses, depression medications, interventions and goals. In addition, all resident's care plans were reviewed to ensure antidepressant medication, interventions and goals are identified on the care plan.

F 686

It is the charge nurse's responsibility to ensure the treatment orders are followed for Resident #26 and all residents with treatments. Education was completed with staff A and all nurses on 09/01/2021 regarding reviewing orders thoroughly prior to completing treatments. Audits will be completed weekly x2 and then quarterly by the DON or designee and reviewed with the Medical Director at Senior Care QA meetings at least quarterly and more often if needed.

F 690

For resident #24 and similarly situated residents, employees were trained on 09/01/2021 regarding incontinent care. It is the management team's responsibility to ensure that direct care employees are completing their skills testing timely. Audits will be completed quarterly by the DON or designee and reviewed with the Medical Director at Senior Care QA meetings at least quarterly and more often if needed.

F 761

Med carts and treatment carts were audited on 09/01/2021 to ensure all expired medications were removed. Education was completed with all nurses and med aides regarding removing outdated medications on 09/01/2021. Audits will be completed quarterly by the DON or designee to ensure all medication and treatment carts are in compliance. These audits will be shared with the Medical Director during our Senior Care QA meetings at least quarterly and more often if needed.