

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 165170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2020
NAME OF PROVIDER OF SUPPLIER POLK CITY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1002 WEST WASHINGTON AVENUE POLK CITY, IA 50226	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0658 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review, staff interview, and policy review the facility failed to follow professional standards with regard to documentation on the Medication Administration Record [REDACTED]. The facility reported a census of 39 residents. Findings include: Record Review of July 2020, MAR, for Resident #1 revealed missing documentation of insulin administration and blood sugar readings for the dates of July 6 and July 8, 2020. During an interview on 7/22/20 at 12:18 PM, Staff A, Registered Nurse (RN), verified she was the nurse working with Resident #1 on July 6 and 8 of 2020. She reported she forgot to document the results on the MAR, although she had documented the blood sugar readings and insulin administration in her personal notebook. The RN then opened the notebook during the interview and pointed to the numbers. She added now she would make a late note in the resident's medical record and document the values at this time. During an interview with the Director of Nursing (DON), on 7/22/20 at 1:00 PM, she revealed she expected nursing staff to complete and review their documentation after each shift and prior to leaving for the day. The Insulin Administration policy, with a revision date of September 2014, instructed staff to document the resident's blood glucose result as ordered and the dose and concentration of the insulin given.		

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.