**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREQX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR USC IDENTIFYING INFORMATION)</th>
<th>ID PREQX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>DATE COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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<td></td>
<td>The following deficiencies relate to the facility's annual health survey and the investigation of facility reported incidents #45369, #45035, #45125 &amp; #45472. (See Code of Federal Regulations 42 CFR Part 483, Subpart B-C)</td>
<td></td>
<td>F000 Please accept this as the facility's credible allegation of compliance as of November 6, 2013.</td>
<td></td>
</tr>
<tr>
<td>F 242</td>
<td>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</td>
<td>F 242</td>
<td>Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. With respect to resident #25, #7, #6 and #19 and any similarly situated resident, the facility is ensuring residents are able to make decisions about his/her life in the facility. Medications that were scheduled for 5:00 am have been moved to a different time. Staff Q, M, J and B as</td>
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**LABORATORY DIRECTOR(S) OR PROVIDER/SUPPLIER REPRESENTATIVE(S) SIGNATURE**

**DATE**

11/6/13

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 disclosed 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continue program participation.
F 242 Continued From page 1

Review of the Minimum Data Set (MDS) Assessment Tool dated 7/2/13 revealed Resident #26 to score a 15 out of 15 on the Brief Interview for Mental Status (BIMS). The score indicated the resident cognitively intact.

The resident’s Care Plan last updated 9/3/13 directed the Nursing staff to work towards reasonable outcomes - include the resident in decision making as able. Administer medications as ordered per the doctor for esophageal reflux disorder and osteoporosis and monitor for side effects/complications with medication use and report to the doctor as needed. Also provide the resident a Gastrointestinal (GI) consult if ordered by the doctor.

Review of the Medication Administration Record Sheets (MARS) for July 2013, August 2013 and September 2013 and the POS for August 2013 dated 8/26/13, revealed Resident #26 had 3 medications scheduled for 5:00 a.m. in the morning. A medication for the esophageal reflux disorder entitled omeprazole 20 milligram (mg) capsule by mouth daily, a medication for hypothyroidism entitled levothyroxine 50 microgram tablet by mouth daily and a medication for the osteoporosis entitled fosamax 70 mg tablet by mouth every Wednesday.

During observations on 9/17/13 at 5:10 a.m., this surveyor noted when walking down the Station 1 A-Hall the hallway dark and rooms dark and observed Staff Q, Licensed Practical Nurse (LPN) down Station 1 B-Hall with a medication cart and walked out of a resident’s room. Staff Q walked up B Hall and entered the A-Hall area to attend to a resident there. Staff Q continued on with med
<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LTC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(K5) COMPLETION DATE</th>
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<tr>
<td>F 242</td>
<td></td>
<td>Continued From page 2 pass checking to see if residents awake for early morning medications. Staff Q observed from 5:10 a.m. till 6:15 a.m. and did not return down the Station 1 B-Hall nor Station 1 A-Hall during that time.</td>
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<td>F 242</td>
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<td>During review of the September 2013 MAR for Resident #25 in the Station 1 B-Hall on 9/17/13 at 6:05 a.m., indicated Staff Q administered the omeprazole and levothyroxine medications scheduled for 5:00 a.m. to the resident by initiating the medication as given. This medication given prior the surveyor's observations of Staff Q from 5:10 a.m. until 6:15 a.m..&lt;br&gt;&lt;br&gt;During an interview on 9/18/13 at 1:22 p.m., Resident #25 indicated not liking get woke up at 5:00 a.m. for medications. Resident #25 reported the nurse woke up the resident around 5:00 a.m. this morning (9/18/13) for medications and would prefer to not be woken up at that time when doesn't sleep good at night. Resident #25 able to identify given the famotidine medicine and the Nurse told the resident needed to sit up in bed for at least 15 minutes after taking the medication. Resident #25 reported thought &quot;to hell with that&quot; and wasn't going to sit up for 15 minutes at 5:00 a.m. in the morning and laid back down. When asked if talked to any staff about not liking to be up for early morning medications, Resident #25 reported not knowing had a choice about that. The resident reported not wanting to be woke up at 5:00 a.m. for pills and would prefer to take them at a different time.</td>
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2. Resident's #7 Physician's Order Statement (POS) dated 8/18/13 documented the resident with diagnoses that included
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<td>F 242</td>
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- Hypertension, atrial fibrillation and glaucoma.

Minimum Data Set (MDS) assessment dated 8/12/13 documented the resident had a cognitive score of 1 out of 15 meaning the resident had severe impairment related to making daily decisions. The resident required extensive assistance of 2 staff persons for transfers, bed mobility, dressing, toilet use, and had limited range of motion to one lower extremity.

Resident #075 Care Plan did not address the resident requesting early morning care or early medication administration.

The Medication Administration Record (MAR) dated September 2013 directed staff per Physician's order to administer a pain medication (Loratadine 5/500 milligrams) 4 times a day at 6:00 a.m., 10:00 a.m., 3:00 p.m. and 7:00 p.m.

Observation on 9/12/13 at 5:00 a.m., revealed Staff M, Registered Nurse, touched the resident to wake him up and give a scheduled pain medication (due in another hour). Staff M stated what the medication was and what it was for and the resident replied "I am fine." The resident then asked for the time with Staff M answering 5:10 a.m. In which the resident replied "oh, Lordy"

3. Resident's #19 Face Sheet dated 7/15/13 documented the resident with diagnoses that included late effect of cerebrovascular accident (CVA) including aphasia, dysphasia and hemiplegia.

Minimum Data Set (MDS) assessment dated 7/22/13 documented the resident had short and long term memory loss and severely impaired
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID Prefix Tag</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 242</td>
<td>Continued From page 4 related to making daily decisions. The resident required extensive assistance of 2 staff persons for transfers, bed mobility, dressing, and toilet use. Resident #19's Care Plan dated 7/17/13 did not address the resident requesting early morning cares or early medication administration. The care plan did document the resident was elert but unable to verbalize most of their thoughts and needs related to the stroke and aphasia. The care plan noted intervention that included to ask questions with a &quot;yes&quot; or &quot;no&quot; answer as needed. The Medication Administration Record (MAR) dated September 2013 directed staff per Physician's order of a thyroid medication (levithroxine 100 micrograms) every day before breakfast. Staff initialed the medication given at 5:00 a.m. Breakfast at the resident's dining room is at 6:00 a.m. On a Pharmacy Consulting Notes to nursing form dated 07/01/13 documented a suggestion for the resident to change the Lavorthyroxine medication from 5 a.m. to 6:00 a.m., noting there was no clinical reason to give the medication that early based on the current medication regimen. During an interview on 9/18/13 at 1:00 p.m., the resident stated the staff does administer the medication in the early morning and noted not liking to be woke up that early. During an interview on 9/18/13 at 1:15 a.m., Staff J, Certified Nurses Aide, stated the resident knows w</td>
<td>F 242</td>
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Continued From page 5

4. Resident #6's Face Sheet dated 3/14/12 documented the resident with diagnoses that included paralysis agitans (Parkinson's disease), anemia, mental disorder, and hypertension.

Minimum Data Set (MDS) assessment dated 8/29/13 documented the resident had a cognitive score of 7 out of 15 meaning the resident had severe impairment related to making daily decisions. The resident required extensive assistance of 2 staff persons for transfers, bed mobility, dressing, toilet use, did not walk in the hallway, used a wheelchair and had limited range of motion to one upper extremity.

The Medication Administration Record (MAR) dated September 2013 directed staff per Physician's order of a thyroid medication (levothyroxine 100 micrograms) every day before breakfast. Staff initiated the medication given at 5:00 a.m. Breakfast at the resident's dining room is at 8:00 a.m.

The Medication Administration Record (MAR) dated July and August 2013 directed staff per Physician's order of a thyroid medication (levothyroxine 100 micrograms) every day before breakfast. Staff initiated the medication given at 5:00 a.m. for those months.

Resident #6's Care Plan dated 9/5/13 identified the problem of self-care deficit related to diagnoses of Parkinson's disease and dementia required assistance with bed mobility, dressing, bathing, toileting, and set up for feeding. The resident's care plan does not address the resident's request to get up early for care or for medication.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Provider/Supplier/Clinic Identification Number: 165310</th>
<th>Multiple Construction</th>
<th>Date Survey Completed: 10/08/2013</th>
</tr>
</thead>
</table>

**Name of Provider or Supplier:** HERITAGE NURSING & REHAB CENTER  
**Street Address, City, State, Zip Code:** 200 CLIVE DRIVE SW  
**CEDAR RAPIDS, IA 52404**

| F 242 | Continued From page 6  
Observation on 9/17/13 at 4:45 a.m. revealed the resident in bed sleeping.  
Observation on 9/17/13 at 5:20 a.m. revealed Staff B, Certified nurse Aide, dressing the resident in bed. The resident had a fresh depends on, the Foley catheter was attached to a leg bag (not the overnight bag) and was pulling the resident's pants up and buckling the belt. Staff M, Registered Nurse, administered medication to the resident, who was awake. The staff person finished dressing the resident, applied the bed covering on top and left the room with the resident lying in bed fully dressed.  
Observation on 9/17/13 at 6:40 a.m., revealed the resident transferred to the wheelchair from the bed with 2 staff persons.  
During an interview on 9/17/13 at 6:50 a.m. Staff B stated the orders were to have the resident dressed, in the wheelchair and out at the dining room table before the end of the shift at 7:00 a.m.  
During an interview on 9/17/13 at 5:50 a.m. Staff Q indicated would not give medications at 5:00 a.m. if the resident not awake then Staff Q denied would wake residents to give them medications.  
During an interview on 9/17/13 at 6:00 a.m., Staff Q reported would give report to the 1st shift Nurse of those who did not get the early morning medications.  
During an interview on 9/17/13 at 6:15 a.m., Staff Q explained staff do rounds around 4:30 a.m. on the residents and if the resident awakened would start medications with those residents if had early

| F 242 |
continued from page 7

morning medications.

During an interview on 9/18/13 at 12:05 p.m., the Director of Nursing (DON) indicated no facility policy in place for medication administration times. The DON further indicated the residents to not be woke up for medications even if scheduled early morning. The DON reported a past employee scheduled the early morning medications at 5:00 a.m.

During an interview on 9/18/13 at 12:07 p.m., the Corporate Consultant Nurse stated personally would not like to be woke up at 5:00 a.m. for medications. The Consultant Nurse indicated that needed to be looked at and changed.

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:

Based on observation, clinical record review and staff interview, the facility failed to provide two of four residents (Resident #5 & #17) with proper positioning during meal time and failed to assist one resident (Resident #6) from the dining room table in a timely manner after requesting to leave. The facility census was 130 residents.
situated resident are being removed from the dining room in a timely manner.

Staff D, J and K as well as all other nursing staff were re-educated on 09/27/13 in regards to proper positioning and assisting residents out of the dining room. In addition, an audit was completed by an Occupational Therapist to review residents for proper positioning in wheelchairs. Residents were placed on therapy caseload as appropriate. D.O.N./designee will perform random audits to focus on positioning and residents receiving the necessary assistance.

Date of compliance: 11/08/13
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:

165312

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

10/08/2013

NAME OF PROVIDER OR SUPPLIER
HERITAGE NURSING & REHAB CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE
280 CLIVE DRIVE SW
CEDAR RAPIDS, IA 52404

(X4) DEFICIENCY
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-REFERENCE TO THE APPROPRIATE
DEFICIENCY)

COMPLETION DATE

F 246 Continued From page 9
resident dropping a lot of food onto their lap.

2. The Physician Order Statement (POS) dated
6/18/13, documented Resident's #17 had
diagnoses that included Alzheimer's disease,
diabetes mellitus, congestive heart failure,
peripheral vascular disease and respiratory
system disease.

The MOS assessment dated 9/10/13,
documented the resident had a cognitive score of
0, indicating severe impairment related to making
daily decisions.

The Care Plan dated 6/27/13, documented a
potential problem for alteration in nutrition related
to Alzheimer dementia, difficulty chewing and
swallowing which was managed by a
mechanically altered diet. The care plan
documented the resident required staff to feed
the resident with intervention that included to
monitor for signs of chewing or swallowing
problems and to assist with meals as needed.
On 4/17/13 the plan documented noisy cups with
meals per recommendation Occupational
Therapy/ family request

Observation on 9/17/13 at 12:30 p.m., revealed
the resident sitting in a high back wheelchair at
the dining room table with staff feeding the
resident. The resident was slouched down in the
wheelchair leaning to the right side. The resident
was seated on 1/2 of their buttocks and 1/2 on
their backside. The resident was not repositioned
to sit more upright while chewing and swallowing.

Observation on 9/18/13 at 7:30 p.m., revealed the
resident sitting in a high back wheelchair at the
Continued From page 10

dining room table with staff feeding the resident. The resident was slumped down in the wheelchair, not sitting upright. The resident was sitting on 1/2 of their buttocks and 1/2 on their backside with the head tilted slightly backwards. The resident was not repositioned to sit more upright while eating the meal.

Observation on 9/10/13 at 11:30 a.m., revealed Staff J, CNA and Staff K, CNA transferring the resident in a mechanical lift from the bedside to the wheelchair with appropriate placement. When asked if the wheelchair was adjustable they said yes and adjusted the wheelchair so the resident was sitting more upright. At the noon meal the resident stayed in an upright position during the meal.

3. The Face Sheet dated 3/14/12, documented Resident #6 had diagnoses that included paralysis agitans (Parkinson’s disease), anemia, mental disorder and hypertension.

The MDS assessment dated 8/29/13, documented the resident had a cognitive score of 7 of 15, indicating the resident had severe impairment related to making daily decisions. The MDS assessment documented the resident required extensive assistance for transfers, bed mobility, dressing and toilet use.

The Care Plan dated 9/9/13, identified a problem of impaired mobility with potential for injury from falls related to the diagnoses of Parkinson’s disease, weakness, dementia, arthritis and severe degenerative disc disease. The resident was noted to have limited range of motion in left hand digits, bilateral upper extremity tremors. The care plan noted an intervention to use of a
Continued From page 11

| F246 high back/reclining wheelchair with anti-tipper device and to assist the resident with propulsion. |
| Observation on 9/17/13 at 9:00 a.m., revealed the resident had completed the breakfast meal and put their right hand up in the air over their head to get someone's attention. Staff were present assisting other residents at 9:22 a.m. and again at 9:30 a.m. The resident sat in the back of the large dining room. |
| Observation on 9/17/13 at 9:43 a.m., revealed the resident had waved their hand overhead and then placed their hand down on the table too over their hands on the table. |
| Observation on 9/17/13 at 9:45 a.m., revealed the resident had waved their right hand overhead and yelled out, "Hey!" as a staff person ambulated across the large dining room, 'Hey' as a staff person ambulated across the front of the dining room. |
| At 9:47 a.m., the resident waved their right hand and yelled out 'Hey ladies' as two staff walked by in the front of the dining room, who stopped and went to assist the resident. The resident was wheeled to their room 47 minutes after the meal was completed. |
| F252 483.15(i)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT |
| The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. |
| This REQUIREMENT is not met as evidenced...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
200 Clive Drive SW
Cedar Rapids, IA 52404

**NAME OF PROVIDER OR SUPPLIER**
Heritage Nursing & Rehab Center

<table>
<thead>
<tr>
<th>Summary Statement of Deficiencies</th>
<th>Providers Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</td>
<td>(Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</td>
</tr>
<tr>
<td>F 252 by: Continued from page 12</td>
<td>F 252 executed solely because it is required by the provisions of federal and/or state law.</td>
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<tr>
<td>Based on observation, resident and staff interviews, the facility failed to provide a clean, comfortable, and homelike environment for two residents. (Resident #14 &amp; 29) The facility census was 130 residents. Findings include:</td>
<td>In respect to resident #26 and #14 and any similarly situated resident, the facility is ensuring a clean, comfortable and homelike environment. The IV pole in resident #29's room has been replaced. Resident #14's room has been deep cleaned to include repair to the wallpaper and night stand.</td>
</tr>
<tr>
<td>1. On 9/15/13 at 10:00 a.m., observation revealed Resident #29 lying in bed and an Intravenous pole/stand with an empty feeding bag hanging near the resident's bed. The pole/stand revealed areas of white, tan and brown areas on the equipment in the room in need of cleaning.</td>
<td>Staff as well as all nursing staff re-educated on 09/27/13. Housekeeping staff were re-educated on proper room cleaning techniques on 10/24/13. Facility QA team will monitor routinely to ensure the facility is clean, comfortable and homelike.</td>
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<td>On 9/17/13 at 12:05 p.m., Staff I, licensed practical nurse, LPN completed medication administration to Resident #29 as the resident lay in bed. The pole/stand at the side of the resident remained soiled with excessive dried liquid spills present on the base of the stand. During interview on 9/18/13 at 7:00 a.m., a housekeeper stated the cleaning of resident equipment was nursing's responsibility.</td>
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<td>2. During observation on 9/16/13 at 2:30 p.m., while in Resident #14's room the wall behind the resident's recliner had numerous areas of torn and curled wallpaper; the base of the bedside stand was in need of cleaning and a three drawer stand next to the resident's bed had excessive matted wood areas. During interview on 9/18/13 at 7:00 a.m., the housekeeping supervisor revealed the areas as housekeeping's responsibility and there was no</td>
<td>Date of compliance: 11/08/13</td>
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F 252  Continued from page 13
  Cleaning schedules at present for the cleaning of
  resident's bedside tables in the facility.

  During interview on 9/18/13 at 10:45 a.m.,
  Resident #14 revealed staff cleaned his/their room
  but every once in awhile they forget. Observation
  revealed the bed side table remained unmade.

F 281 483.20(k)(3) SERVICES PROVIDED MEET
SS-D  PROFESSIONAL STANDARDS

The services provided or arranged by the facility
must meet professional standards of quality.

This REQUIREMENT is not met as evidenced
by:
Based on observation, clinical record review and
staff interviews, the facility failed to follow
physician orders for two of twenty-one residents
reviewed. (Resident #5 & #12) The facility
census was 130 residents.

Findings Include:

1. The minimum data set (MDS) assessment
dated 9/18/13 documented Resident #12 had a
diagnosis of heart failure.

A physician order sheet (POS) dated and signed
by the physician on 8/29/13, revealed an order for
apply tubigrip on the resident’s lower legs daily, on
in morning and off at bedtime.

On 9/18/13 at 7:25 a.m., the resident was up in
the wheelchair without the benefit of tubigrip to
the left and right lower legs.
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<th>F 281</th>
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<tbody>
<tr>
<td></td>
<td>On 9/18/13 at 10:00 a.m., the resident was up in the wheelchair without the benefit of tubigrip to the left and right lower legs.</td>
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<tr>
<td></td>
<td>On 9/18/13 at 1:00 p.m., the resident was up in the wheelchair without the benefit of tubigrip to the left and right lower legs.</td>
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<td>During interview on 9/18/13 at 2:30 p.m., the Director of Nursing, DON revealed tubigrip was used to protect skin.</td>
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<td>2. The Face Sheet dated 6/11/13, documented Resident #5 had diagnoses that included Alzheimer’s disease, epilepsy, blindness and peripheral vascular disease.</td>
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<td>A history and physical dated 8/9/13, documented the resident had complaints of shortness of breath and difficulty breathing. The plan was for the resident to attempt to wean from oxygen that was restarted.</td>
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<td>A Physician’s Order Statement (POS) dated 8/18/13, directed staff to apply oxygen at 2 liters per minute per nasal cannula continuously.</td>
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<td>The Treatment Administration Record (TAR) dated September 2013, directed staff to administer oxygen at 2 liters per minute continuous and had staff initials to verify the order being completed.</td>
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<td>Observation on 3/15/13 at 10:10 a.m. and 12:20 p.m., revealed the resident sitting in the wheelchair wearing oxygen per nasal cannula at the 2 1/2 liters per minute.</td>
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<th>been marked to easily identify the number of liters ordered.</th>
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<td>D.O.N./designee will perform random audits ensuring physician’s orders are being followed.</td>
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<td>Date of compliance: 11/08/13</td>
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<td>F 312</td>
<td>493.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</td>
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<td>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal oral hygiene.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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F 312  by the provisions of federal and/or state law.

In respect to resident #4 and any similarly situated residents, incontinency and grooming procedures have been reviewed with staff G, C, D, and F as well as all nursing staff re-educated on 09/27/13.

D.O.N./designee will perform random audits focusing on incontinency and grooming. Facility QA team will monitor grooming routinely.

Date of compliance: 11/08/13
F 312 Continued From page 17

2. The Physician Orders Sheet (POS) signed 8/23/13 identified Resident #7 had diagnoses that included hypertension (high blood pressure), atrial fibrillation (irregular heart beat) and glaucoma.

The Minimum Data Set (MDS) assessment dated 8/12/13, identified the resident required extensive assistance with bed mobility, transfer, dressing, hygiene and toilet use.

The Care Plan last updated 9/17/13, directed staff to provide care and comfort measures per doctor order since on Hospice. Monitor the resident for signs/symptoms of discomfort provide the resident with Beauty/Barber shop as desired, provide nail care routinely and as needed, offer choice of bath, shower or whirlpool routinely and assist as needed. Staff were to assist with completion of dressing, grooming and bathing tasks.

During observation on 9/16/13 at 10:20 a.m., during the initial tour the resident was observed sitting in a recliner in his/her room. Observation revealed the resident had approximately 1-2 inch long facial hairs on and under their chin.

On 9/16/13 at 12:24 p.m., during the lunch meal as the resident sat in the Main Dining Room (MDR) of Unit 3, the resident had approximately 1-2 inch long facial hairs on and under their chin.

On 9/17/13 at 8:40 a.m., while resident took their medications from the nurse observation revealed the resident had approximately 1-2 inch long facial hairs on and under their chin.

On 9/17/13 at 11:59 a.m. 12:45 p.m., while Staff C, CNA and Staff D, CNA provided cares there
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<tr>
<th>ID</th>
<th>PRECEED TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LCD IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PRECEED TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 312</td>
<td></td>
<td>Continued From page 18 was no attempt to remove the facial hairs on the resident's chin.</td>
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<td>On 9/18/13 at 8:00 a.m., while the resident was in the dining room observation revealed the resident had approximately 1-2 inch long facial hairs on and under their chin.</td>
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<td>During interview on 9/18/13 at 10:45 a.m., a family member indicated they did not think the resident knew they had the facial chin hairs. The family member reported the facial chin hairs were bothersome and wished staff would take care of them, maybe pluck them.</td>
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<td>During interview on 9/18/13 at 11:00 a.m., Staff C, CNA reported if they saw a resident with facial hair they would take care of the hairs.</td>
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<td>During interview on 9/18/13 at 12:00 p.m., the Director of Nursing, DON reported there was no facility policy in regards to grooming for residents in regards to facial hair. The task would be under the usual tasks for aides and the DON expected to be taken care of.</td>
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<td>F 323</td>
<td></td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td>F 323</td>
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<td>Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required.</td>
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<td>F323</td>
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<td>The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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<td>This REQUIREMENT is not met as evidenced</td>
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Based on observation, clinical record review, interviews, and Wanderguard operating instructions, the facility failed to implement care plan intervention to ensure residents received adequate supervision from hazards in the environment for 9 of 9 residents reviewed. Resident #1 left the nursing home in his/her wheelchair without the facility staff knowing his/her whereabouts for approximately 25 minutes. The resident's Wanderguard device did not alarm when the resident exited the home. The resident had fallen out of his/her wheelchair when a passerby found him/her on the sidewalk near a telephone pole. Staff interviews determined no staff heard the Wanderguard alarm sounding plus the alternative alarm system had been turned off. Record review identified Resident #1 had a diagnosis of Dementia and lacked the cognitive skills to maintain his/her safety. The findings constitute an immediate jeopardy to the resident's health and safety. The facility also failed to provide supervision related to Wanderguard (door alarm devices) for 3 additional residents (Residents #34, #35, and #36). In addition, the facility failed to implement care plan interventions to ensure residents received adequate supervision from hazards regarding falls for Residents #23, #22, #10, #4, Resident #1; and safety/supervision concerns for Resident #2. The facility reported a census of 130 residents.

Findings include:

1. A History and Physical (H & P), dated 6/22/13 documented Resident #1 had diagnoses including cardio renal, obesity, prostate cancer, high blood pressure, pacemaker, arthritis, and dementia. Resident #1 resided at an assisted living facility by the provisions of federal and/or state law.

In respect to residents #1, #34, #35, #36, and any similarly situated resident, the facility has reviewed their alarm protocol. The main alarm switch panel on station #3 continues to be covered so that staff can't turn it off. All facility staff have been re-educated regarding the alarm panel.

The Wanderguard system was adjusted on 03/08/13 and continues to be routinely tested to ensure proper functioning. Wanderguard signaling devices have been removed from wheelchairs.

The camera in the front lobby has been re-wired and functioning.

In respect to residents #10, #22 and #23 and any similarly situated resident, staff P, U, O and FF, as well as all other nursing staff have been re-educated on alarm placement and functioning on 09/27/13. Staff II is no longer employed at the facility. D.O.N./designee will perform random audits to ensure proper.
**F 323** Continued From page 20 and had been admitted to the hospital for behavioral disturbance. While in the assisted living the resident had 11 falls in the last 30 days even after being treated for a urinary tract infection (UTI). The H&P reported the resident had been irritable last night, yelled out that he/she needed to leave to go to work, and cursed at a staff. The resident transferred to the nursing home on 8/29/13.

A Resident Assessment/Data Collection Form/Initial Care Plan dated 8/29/13 documented that Resident #1 required assistance of two staff members for transfers, and care, and use of wheelchair for ambulation but could bear full weight, and described the resident as alert, friendly, talkative, hyperactive, disoriented to time, and place.

The Elopement Risk Assessment dated 8/29/13 indicated the resident had been independent with wheelchair usage.

Nurses Note dated 8/29/13 at 6:30 p.m. documented resident had been agitated attempting to stand up multiple times without assistance from wheelchair and the resident stated he/she was looking for his/her spouse.

A Fall Investigation form dated 8/30/13 documented the resident had been found on one knee looking for a fire to put out in another resident's drawer. The Fall investigation form indicated the immediate action taken to prevent another episode had been to keep the resident near the nursing station. The resident did not have an injury.

Nurses Note dated 9/01/13 at 4:00 a.m.

| F 323 | Placement/functioning of alarms. Facility QA team will monitor routinely. In respect to resident #4 and any similarly situated resident, Staff C as well as all other nursing staff have been re-educated on safe transfers/assistive devices on 09/27/13. D.O.N./designee will perform random audits to ensure safe transfers/assistive devices being provided.

In respect to resident #2 and any similarly situated resident, all nursing staff have been re-educated on intervention of unwanted physical contact on 09/27/13. Resident #2 has been discharged from the facility.

Date of compliance: 10/22/13
Continued From page 21

documented the resident had been up and
propelling self in the wheelchair wandering
around the unit.

Nurses Note dated 9/01/13 at 4:00 p.m.
documented the resident set off the door alarm
down station one 3rd floor by opening up the door,
the resident stated he/she had been trying to find
his/her spouse and catch a train, the nursing
intervention to this had been to take the resident
to 2B (locked secured unit) for safety and provide
one-to-one with a C.N.A. resident noted to have
increased confusion, the family and physician had
been notified, and monitoring continued.

Nurses Note dated 9/03/13 at 1:00 p.m.
documented the resident needs a lot of one on
one the resident had been always looking for
his/her spouse and wanted to go home and find
his/her spouse, staff members were able to visit
with the resident for distraction, and the resident
did calm down.

Nurses Note dated 9/04/13 at 9:15 p.m.
documented the resident refused to have
assessment completed, and resident noted with
wandering behaviors this evening.

Nurses Note dated 9/05/13 11:00 a.m.
documented the resident propelled
himself/herself in the wheelchair and continued
to wander aimlessly.

Nurses Note dated 9/06/13 at 8:00 p.m.
documented the resident continued to wander,
the resident had been able to self-propel his/her
wheelchair independently.

Nurses Note dated 9/08/13 at 8:00 p.m.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**HERITAGE NURSING & REHAB CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

200 CLIVE DRIVE SW  
CEDAR RAPIDS, IA  52404

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**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

- **F 323**

  Documented a C.N.A. reported to the nursing staff that Resident #1 had been observed outside of the facility. According to the C.N.A. the resident had been found on the sidewalk outside by a passerby. [The passerby's spouse came into the facility to report the resident had been outside.]

  When the staff went outside they observed the resident sitting on the ground and observed the passerby assisted the resident up from the ground back into the wheelchair, then staff escorted the resident into the building.

  The resident appeared with the C.N.A. who gave report, the resident sat in the wheelchair without signs or symptoms of pain. The resident's speech had been clear and the resident denied injuries. The resident appeared calm, and without signs of injuries upon visual assessment, neurological checks initiated, and 15 minutes checks continued, responsible party had been contacted, and fax sent to the physician.

- **F 323**

  Nurses noted dated 9/06/13 at 10:00 p.m. documented the resident's range of motion had been within normal range, and the resident had no complaints of pain on palpation of the hips, and lower extremities. The resident remained at the nurses' station for the remainder of the shift.

- **F 323**

  Nurses noted dated 9/09/13 at 10:30 a.m. documented the resident and belongings had been transferred to the secured unit.

- **F 323**

  During an interview on 9/17/13 at 10:40 a.m. a male passerby reported that on 9/08/13 at about 6:30 p.m. he had driven on first avenue north of the nursing home and found a resident [Resident #1] on the ground on the west side of the telephone pole on his/her back. The passerby stopped to assist the resident, and noticed the
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/Clinic IDENTIFICATION NUMBER: 155310

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

DATE SURVEY COMPLETED: 10/08/2013

NAME OF PROVIDER OR SUPPLIER
HERITAGE NURSING & REHAB CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE:
200 OLIVE DRIVE SW
CEDAR RAPIDS, IA 52404

ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRESENTED BY FULL REGULATORY OR LCD IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)

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Continued from page 23

...resident’s wheelchair went off the sidewalk and his/her feet were towards the street and his/her head towards the building. The wheelchair was nearby with a white plastic device and cord that had been making a beeping sound. The male passerby reported the resident wore a white blue sweater, and the resident did not have any bleeding. Then the male passerby assisted the resident to sit up, and then three ladies in uniforms arrived and appeared very concerned about the resident. The male passerby reported he had not been sure who the staff’s names were. The male passerby reported the staff then assisted the resident back into the facility.

A typed documentation (unrelated) with the Director of Nursing (DON)‘s name explained the nursing home alarm systems as follows. The main entrance is equipped with 2 alarms. The first alarm is the actual door alarm and sounds when someone attempts to open the door without putting in the alarm delay code...The alarm sounds at the door and at station three (3) nurses’ desks. If the alarm panel when turned off does not sound at the nurse’s desk. The doors are held by a magnet. When the doors have been opened without entering the code the magnet lights. The doors will change from double green to none green and one red, indicating that they must be reset at the door. To reset the magnets, the code must be entered and the doors open to full then closed. On 9/8/13, staff found the doors with the double green lights indicating that they had not been opened without the code being entered correctly.

The second alarm is the Wanderguard and it sounds when a resident with a Wanderguard opens the door and attempts to go through the doors. The Wanderguard is not a part of the...
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<th>F 323</th>
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| Alarm panel and staff are not able to turn off the Wanderguard in any way.  
The facility tested the Wanderguard on the night of 9/8/13 after the incident and the Wanderguard did not sound in the center of the 2 doors but did sound to the left and right of the center.  The maintenance department made adjustments to the Wanderguard system on the right of the elopement.  
The alarm panel at the station three nurse's desk had modifications made.  The main control switch to the panel has now been covered so staff will no longer be able to switch it in the off position and staff were retrained on the use of the alarm panel.  
A typed document dated 9/8/13 with the Administrator's name revealed the Wanderguard on the main door did not sound when Resident #1 passed with his/her ankle bracelet in his/her wheelchair.  The Administrator tested the front doors and the Wanderguard did not function correctly and did not sound the alarm.  
Staff Interviews:  
During an interview on 9/12/13 at 1:30 p.m.  Staff EE, C.N.A described Resident#1 as nice, confused, always wanting to go to work, wandered a lot, could self propel his/her own wheelchair pretty fast.  Staff EE reported that on 9/8/13 the resident reported he/she had pushed the front door open with his/her foot.  Staff EE reported the resident easily pushed open the main entrance door with his/her foot, which the resident identified the main entrance door as the exit he/she took.  Staff EE reported that she last saw the resident at about 7:25 p.m. in the dining room prior to his/her elopement on 9/8/13.  The
Continued From page 25

next time she saw the resident Staff B, C.N.A. from station#4 had brought the resident to station#1, and reported that the resident had been found outside the building sitting on the ground. Staff EE reported that she did not hear the WG alarm go off prior to the elopement, and a WG needs to be reset at the door that it goes off at. Staff EE reported when Resident#1 returned to the building assessments were started right away, then Staff EE, Staff FF R.N, and Staff A, LPN escort the resident around the building to see which door the resident identified as his/her exit door, and to check the WG system. Staff EE reported no WG alarm went off. Staff EE reported that the WG system did not work when tested on 9/08/13 with Resident#1 going through the door. Staff EE reported the resident had on a blue sweater with long sleeves, tan shoes, eyeglasses, long pants, a shirt, and a WG bracelet on the ankle. Staff EE reported that the resident had been known to self transfer, but had been a one assist for transfers. Staff EE reported she could not recall if a head count of the residents had been done, but usually a head count is done if alarms go off with an elopement. Staff EE reported that she had previous WG training and a control panel tells you which door is activated with lights. Staff EE reported that education had been given on the control panel for station#3. Staff EE reported that Resident#1 had been moved from station#1 to 2B (the locked unit) the next day after the elopement.

During an interview on 9/17/13 at 10:00 p.m. Staff NN, Registered Nurse (RN) reported she had been working on station#4 on 9/08/13 when, a lady entered the building at about 7:30 p.m. and told her that a resident was outside the building. Staff NN sent two C.N.A's to respond, then the
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<td>F 323</td>
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<td>resident entered back into the building at about 7:45 p.m., and no WanderGuard alarms had</td>
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<td>BB, C.N.A reported that she worked on station #4</td>
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<td>wheelchair outside. Staff BB and Staff Y, C.N.A</td>
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<td>headed towards the station #4 exit, and saw that</td>
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<td>people had helped Resident #1 into the wheelchair.</td>
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<td>7:00 p.m. because the sun had started to go</td>
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<td>down. Staff BB and Staff Y brought the resident</td>
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<td>back to the facility, then Staff BB took the resident</td>
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<td>to station #1. Staff BB reported that a head count</td>
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<td>had been completed on station #4. Staff BB</td>
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<td>reported that the staff did get education about</td>
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<td>which included to be alert to the lights above the</td>
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<td>unlocked. Staff BB reported the main entrance to</td>
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<td>Y, C.N.A reported working on station #4 on</td>
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<td>station #4 entrance and reported that a man was</td>
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<td>outside trying to stand up. Staff Y reported</td>
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<td>that she and Staff BB, C.N.A had found Resident #1</td>
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<td>by an electrical pole, and a passerby assisted the</td>
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<td>resident into the wheelchair. Staff Y reported that</td>
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<td>it had been about 8:00 p.m., and the resident had</td>
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<td>on a blue sweater, long pants, and that the</td>
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<td>resident had been in a good mood, and the</td>
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<td>resident stated he/she had been trying to go</td>
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<td>home, then Staff BB and Staff Y brought the</td>
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F 323 Continued from page 27

resident back in the building, and then Staff BB took the resident to the station#1 nurse Staff FF. Staff Y reported that no Wardeguard alarms had sounded. Staff Y reported that Resident#1 is very strong and can propel his/her wheelchair quickly and independently.

During an interview on 9/12/13 at 2:00 p.m. Staff CC, C.N.A reported that Resident#1 could be described as nice, cheerful, and could self propel his/her own wheelchair quickly. Staff CC reported she usually worked on station#1. Staff CC reported that on 9/10/13 at about 7:00 p.m. Resident#1 had been headed towards nurses' station#1, wearing a blue collar shirt, and long pants. Staff CC reported the next time she saw him/her was at about 7:40 p.m. when resident came back into the building. Staff CC reported she took the resident to the bathroom at 8:30 p.m., and then took the resident back to the station#1 dining room, the resident did not complain of pain, the resident had good balance, and had normal behavior. Staff CC reported the staff kept an eye on the resident did vitals and every 15 minute checks. Staff CC reported that each hallway has a panel that shows where a Wardeguard (WG) alarm had been set off, and then the door should be checked, and then the WG is reset by use of a pen or by putting in a code. Staff CC reported all staff had been provided with door alarm and WG education, and the front lobby has been open since August. Staff CC reported that Resident#1 could be fast enough to get out the front door with the reset time delay function of the front door. Staff CC had a WG bracelet on his/her right or left ankle since admit. Staff CC reported that no WG alarm went off prior to the resident's admission.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**HERITAGE NURSING & REHAB CENTER**

**NAME OF PROVIDER OR SUPPLIER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

200 CLIVE DRIVE SW
CEDAR RAPIDS, IA 52404

**ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)**

**ID PREFIX TAG**

**PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**

**DAY COMPLETION DATE**

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**F 323 Continued From page 28**

During an interview on 9/17/13 at 9:30 p.m. Staff I, R.N reported that on 9/06/13 staff C.N.A's reported to her that Resident#1 had been found outside the facility by the street. Staff I reported that no W.G had went off. A head count had been completed on station#2. Staff I reported that the resident had been moved to station#2 the next day after his/her elopement. Staff I reported the W.G alarms should have been heard throughout the building, and there are alarm stations in every hallway. Staff I reported the night shift staff are responsible to check the W.G bracelets on the residents' body, and chart it on the treatment sheets.

During an interview on 9/12/13 at 1:10 p.m. Staff DD, C.N.A described Resident#1 as a nice guy, easily redirected, propelled own wheelchair fast, and had short term memory loss. Staff DD reported that on 9/08/13 at about 7:15 p.m. she and Staff EE, C.N.A helped another resident to the bathroom when Resident#1 had been asleep in the station#1 dining room, then at 7:25 p.m. she saw Resident#1 awake in the station#1 dining room, and the next time she saw Resident#1 had been about 7:45 p.m. when the resident had been brought back into the building, the resident had on long pants, long sleeve shirt, sweater, socks, shoes. Staff EE reported the resident had one on one monitoring after his/her elopement. Staff EE reported resident received one on one sometimes from staff who was on light duty prior to his/her elopement or sometimes the resident would hang out in the hallway that the staff were working on, for instance when the staff were putting other residents to bed. Staff EE reported that from the beginning of the residents stay the resident could have used one on one monitoring. Staff EE could not remember if a
### F 323

Continued from page 29

head count had been done after the elopement. Staff EE reported the resident had a WG bracelet on his/her left ankle.

During an interview on 9/15/13 at 2:54 p.m. Staff AA, C.N.A., certified preceptor, reported that she had seen Resident#1 after dinner at about 7:00 p.m. on 9/08/13 in the hallway headed towards Station#3, the resident propelled his/her own wheelchair. Staff AA reported that Staff Z told her that the alarm panel was off for the nurse’s station#3. Then Staff AA alerted other staff, and Staff Z told the nurse, then Staff AA and Staff Z went outside, then saw a resident with other staff members, and the resident had been brought through to the nurse’s station#4 doors. Staff AA reported the resident had been wearing a blue sweater, and the resident did not appear distressed, and then a head count was completed on nurse’s station#3. Staff AA reported that the main door had been opened up in late August after it was remodelled and staff had received education on the doors at that time, and also more after the elopement. Staff AA reported that she had been unsure of who shut off the alarm panel.

During an interview on 9/15/13 at 12:05 p.m. Staff Z, Cook reported that he entered the facility on 9/08/13 at about 7:29 p.m. at the main entrance on the east side of the building. He walked toward nurse’s station #1 to punch in at the time clock, then headed to the kitchen up to nurse’s station#3 and noticed the lights were off on the station#3 alarm panel. Staff Z then found Staff AA, C.N.A. and told her that the alarm switch had been turned off, and they needed to start doing a head count. Staff Z then turned to go to the
F 323  Continued From page 30

kitchen and found the charge nurse and told her that the alarm panel was off and a head count needed to be done. Staff Z reported that the Station#3 alarm panel would affect north and south doors, the main front entrance, 3Ahall, and the service door to the back of the kitchen. Staff Z reported that now the off switch to the alarm panel is covered, which was fixed on 9/09/13 or 9/10/13, and all staff were educated on the doors. Staff Z reported a guy came in the station#3 south door and informed him that a resident was out on First Avenue. Staff Z found Staff AA and told her that a resident was outside on the sidewalk, then Staff Z and Staff AA headed out the station#3 south door, and took a route along the front of the building towards first avenue, then a passerby's wife had come up the hill towards the facility and stated that the facility staff got the resident up and headed towards the station#4 entrance, which both Staff Z and Staff AA could visualize from their location. Staff Z reported the Wanderguard (WG) alarm can be easily heard in the building even in the break room. Staff Z reported that co alarms had been going off when he entered the building on 9/09/13. Staff Z reported that staff were educated to do visual checks of doors, and educated that two separate buttons need to be pushed to reset the alarm. Staff also had to sign a safety in-service attendance sheet.

During an interview on 9/16/13 at 3:15 p.m. Staff W, C.N.A reported she usually worked on station#1, and you had to keep a close eye on Resident#1 because he/she may try to self-transfer and resident had been a fall risk, and could move pretty good. Staff W reported that on third shift the resident had been taken back to the locked unit because it was hard to keep tabs on.
Continued from page 31:

the resident. Staff W reported the resident had a WG bracelet on his/her ankle.

During an interview on 9/17/13 at 12:15 p.m. Staff F, LPN reported that Resident #1 had a WG on the ankle, and could self propel his/her own wheelchair at a moderate pace, and staff would provide one on one monitoring at times, and light duty staff would spend time with the resident sometimes, and the resident loved chocolate. Staff F did report that training for the front had been given to the staff that if the light on the front door was red the door needed to be reset to a green light.

During an interview on 9/18/13 at 10:10 a.m. Staff II, C.N.A reported she usually worked third shift. Staff II reported that Resident #1 could be very determined, moved pretty quickly in the wheelchair, and could read. Staff II reported that the resident had been taken back to the locked unit to be monitored at times before the elopement and used one to one monitoring help as well. Staff II reported she worked the night shift and the evening shift that the resident got out of the building and had been instructed to keep an eye on the resident and to do every one hour head count checks.

During an interview on 9/12/13 at 10:00 a.m. Staff FF, LPN he had worked on 9/8/13 and at 7:05 p.m. he came back from break and started medication pass on BH Unit station one. Staff FF reported that on 9/8/13 at about 7:45 p.m. Staff B8, C.N.A brought Resident #1 in a wheelchair from station #4, and notified him that the resident had been found sitting on the ground outside by a passerby and helped the resident back into the wheelchair. Staff FF reported the resident had
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| F 323 | Continued From page 32 | been assessed without evidence of injury, appeared pleasantly confused per normal, and displayed no distress. Staff FF reported he informed Staff BB to write up a statement, and then called the Administrator, the director of nursing, and the resident’s responsible person. Staff FF reported the Administrator came in promptly, and then Staff FF proceeded to test alarms on all the doors with Staff A, LPN and with the resident. Staff FF reported the resident had a WG on his/her ankle. Staff FF reported that the resident identified the main entrance door as the exit door he/she used to get out of the building. Staff FF reported that he tested the front door WG system four times and it did not go off. The Administrator called the maintenance staff right away. Staff FF reported that he did not do a head count of the residents, but he should have. Staff FF reported that upon reenactment of opening the front door it took 40 seconds for the door to relock, and that it would have easily given the resident enough time for the resident to get out of the building. Staff FF reported that he checked the door alarms and WG system at midnight prior to going home at the end of his shift on 9/08/13. During an interview on 9/12/13 at 8:20 a.m. the Director of Nursing (DON) reported that the front door camera capability had not been available due to it not being turned back on after the remodeling had been completed. During an interview on 9/12/13 at 8:30 a.m. the facility Administrator reported there had not been any front door camera capability due to it being disabled had been a work in progress related to wire work. The Administrator reported that the front main entrance opened on 8/12/13. The Administrator reported that the WG alarms had
F 323 Continued From page 33
been checked the morning of 9/08/13 by Staff X, Maintenance Staff, and checked by the Maintenance Supervisor and by himself post elocement. The main entrance WG system had been functioning on 9/08/13 but at a knee or hip range, the range had been extended to cover the range from the chest to the ankle range when an individual is in the standing position. The Administrator and Maintenance Supervisor both reported that all the exits were checked for the ranges daily. The Administrator educated Staff X, Maintenance staff on the importance to get all levels checks accurately. The Administrator reported that Staff FF, LPN had called him at about 8:00 p.m. on 9/08/13. The Administrator reported that staff interviews did not establish who had turned off the door alarms on station #3.

During an observation on 9/12/13 at 8:00 a.m. the Administrator and the Maintenance Supervisor checked all the doors in the building for alarm status, and all alarms and WG systems were working correctly. The alarm range of the WGs spanned from the chest to below five (5) inches from the floor on all WG exits. The doors are checked every day to include the weekends.

During an interview on 9/12/13 at 12:55 p.m. Staff X, Maintenance Staff reported on 9/09/13 that he had been notified and instructed to check the WG system at three different ranges, and before he had checked three ranges, but now the WG bracelet is lowered to the ground, so he needed to be checking the WG even lower. Staff X reported that he did do the WG checks the morning that Resident #1 got out of the building. Staff X reported that the weekend manager also checks the WG's daily.
During an interview on 9/19/13 at 10:15 a.m. the Director of Nursing (DON) reported that the Administrator handled the 9/08/13 elopement, but did assist with staff education about door safety and assisted with the investigation process. The DON reported that the resident had been witnessed exiting a door before and Resident #1 had been easily redirected. The DON reported Resident #1 wandered frequently, and could go back to the locked unit for safety. The DON reported that the resident had been moved back to the locked unit the day after the elopement.

Wanderguard System Operation-Bracelet Activation and Use document without a date labeled page 17 directs facilities to place the bracelets on the resident's dominant wrist. The metal in a wheelchair (or any other metal items) may interfere with the bracelet's signal to the door modules. Before proceeding with alternate placement you must contact technical service for further instructions. Page 18 Wheelchair Placement revealed the following directions for facilities: Facilities often ask about attaching the bracelet to a wheelchair. It attempts to use wrist placement have failed, mount the bracelet away from the metal frame of a wheelchair at a height of approximately three feet from the floor (in the center of the back of the wheelchair).

The Director of Nursing provided the survey team a document titled Heritage Nursing and Rehab with a date of 9/09/13 with the 33 names of residents highlighted that are confused, and independently mobile, that do not reside in the locked unit.

Observations on 9/17/13 at 8:20 a.m. revealed Resident #1 propelled himself/herself in a
F 323 Continued from page 35

wheelchair down the hallway independently at a moderate pace.

During an interview on 9/23/13 at 2:50 p.m. the Administrator reported the Residents #34, #35 and #36 did not reside in the locked unit of the facility. The Administrator reported that the five doors affected by the station #3 alarm panels would be the back kitchen entrance, the furthest north door on station #3 hallway, the two doors in the stations #3 dining room, and the main entrance. The Administrator pointed out the affected doors on the facility map.

During an interview on 9/12/13 at 2:00 p.m. Staff CC, C.N.A reported that Resident #1 could be described as nice, cheerful, and could self propel his/her own wheelchair quickly. Staff CC reported she usually worked on station #1. Staff CC reported that on 9/08/13 at about 7:00 p.m. Resident #1 had been headed towards nurses station #1, wearing a blue collar shirt, and long pants. Staff CC reported the next time she saw him/her was at 7:40 p.m., when resident came back into the building. Staff CC reported she took the resident to the bathroom at 8:00 p.m., and then took the resident back to the station #1 dining room, the resident did not complain of pain, the resident had good balance, and had normal behavior. Staff CC reported the staff kept an eye on the resident did vital and every 15 minute checks. Staff CC reported that each hallway has a panel that shows where a Warden guard (WG) alarm had been set off, and then the door should be checked, and then the WG is reset by use of a pen or by putting in a code. Staff CC reported all staff had been provided with door alarm and WG education, and the front lobby had been open since August. Staff
**Continued From page 36**

CC reported that Resident#1 could be fast enough to get out the front door with the reset time delay function of the front door. Staff CC had a WG bracelet on his/her right or left ankle since admit. Staff CC reported that no WG alarm went off prior to the resident’s elopement.

During an interview on 9/17/13 at 9:30 p.m. Staff I, R.N reported that on 9/08/13 staff C.N.A.’s reported to her that Resident#1 had been found outside the facility by the street. Staff I reported that no WG had went off. A head count had been completed on station#2. Staff I reported that the resident had been moved to station#2 the next day after his/her elopement. Staff I reported the WG alarms should have been heard throughout the building, and there are alarm stations in every hallway. Staff I reported the night shift staff are responsible to check the WG bracelets on the residents’ body, and chart it on the treatment sheets.

2. A Minimum Data Set (MDS) with reference data of 9/12/13 documented Resident#34 had a brief interview for mental status score of 12 out of 15, which indicated the resident had moderately impaired cognitive skills for daily decision making. The MDS revealed the resident had the diagnoses including a heart dysrhythmia, arthritis, stroke, dementia, asthma, and depression. The MDS documented the resident had a history of falls with injuries.

The Care Plan directed staff to remind the resident why the resident needed to stay at the facility when the resident talked of going home. The Care Plan identified a problem for the resident as impaired mobility with potential for elopement and injury related to brain injury.
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<td>F 323</td>
<td>Continued From page 37</td>
<td>trauma due to a motor vehicle accident. The Care Plan directed staff to provide a WG for the resident, and monitor for its placement routinely and as needed. The Care Plan also directed staff to monitor the resident for elopement type attempts, and provide the resident with redirection.</td>
<td>F 323</td>
<td>Observation on 9/23/13 at 3:20 p.m. the resident sat in a wheelchair in the station #1 dining room with a WG bracelet attached to the metal bar under the resident’s wheelchair about 24 inches from the floor.</td>
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<td>A MDS with reference date of 7/23/13 documented Resident #55 had a brief interview for mental status score of 8 out of 15, which indicated severely impaired cognitive skills for daily decision making. The MDS revealed the resident had diagnoses including high blood pressure, dementia, traumatic brain injury, and anxiety. The MDS documented the resident had a fall history. The Care Plan with admitted date of 4/24/13 documented an approach with a date of 5/17/13 that directed staff to implement a WG, and to monitor routinely for placement, and to monitor for elopement type attempts and to provide the resident with redirection and reassurance. The Care Plan documented the resident’s primary form of locomotion had been a wheelchair and directed staff to provide as needed propulsion.</td>
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<td>Observation on 9/23/13 at 3:00 p.m. revealed the resident sitting in a wheelchair in the resident’s room, the WG bracelet had been attached to the metal frame of the wheelchair close to the right wheel.</td>
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4. A MDS with reference date of 8/05/13 for Resident#36 documented the resident had moderately impaired cognitive skills for daily decision making. The MDS documented the resident had potential indicators of psychosis listed as hallucinations, and delusions. The MDS documented the resident had diagnoses including dementia, anxiety, depression, and psychotic disorder. The MDS revealed the resident had a history of falls with injuries.

The Care Plan identified a problem for the resident related to exit seeking behaviors, and directed staff to observe for the potential that the resident may wander and redirect the resident from the exits, and to keep a VG on the resident and check per facility policy. The Care Plan indicated the resident had been propelling the resident's wheelchair independently.

Observation on 9/23/13 at 3:05 p.m. revealed the resident sitting in the hallway in a wheelchair with a VG brooch attached to the posterior metal portion of the right armrest of the wheelchair. The resident propelled the wheelchair without difficulty.

Falls:

5. A MDS with reference date of 9/06/13 documented Resident#23 had a score of 10 out 15 for a brief interview for mental status, which indicated moderately impaired cognitive skills for daily decision making. The MDS revealed the resident required extensive assistance of two staff members for transfers, and toilet use, and extensive assistance of one staff member for walking. The MDS indicated the resident had been only able to stabilize with staff assistance.
**F 323** Continued From page 59

during transitions of moving from a seated to standing position, when walking, when turning around, and when moving on and off the toilet. The MDS documented the resident impairments to both upper extremities. The MDS indicated the resident had diagnoses including anemia (low blood levels), irregular heart rhythm, high blood pressure, arthritis, and dementia. The MDS documented the resident had a fracture related to a fall in the last six months prior to admit to the facility.

The ADL Plan of Care from the AccuNurse system directed staff that the resident had been a fall potential, with an unsteady gait, with balance problems, and to test and reapply a bed and chair alarm.

The Fall Risk Evaluation dated 9/03/13 documented the resident score as 18, with a score of 10 or above to represent a high risk resident for potential of falls.

Heritage Nursing and Rehab Center Bed/Chair Alarm List dated 9/2013 directed staff to use a chair clip alarm and a bed pressure alarm for the resident.

The Nurses Note dated 8/30/13 at 11:20 a.m. documented the resident had been a fall risk and a chair and bed pressure alarm had been applied.

The Nurses Note dated 9/12/13 at 5:16 p.m. documented the resident had been found lying on the floor with his/her feet towards the bathroom door. When asked the resident stated, it hit my head and upper back on this, the resident pointed towards the foot of the bed. The resident had a small amount of bleeding from the right hand.
F 323  Continued from page 40
from a skin tear between the 4th and 5th digit.
The resident had a scant amount of blood to the
middle center of the upper back from an open
wound 0.8 centimeters by 0.4 centimeters (cm) on
top of the 3cm by 3cm bump. The resident had
redness to the posterior head. The resident
denied dizziness, headache, or pain. The resident
had normal range of motion, and had been able
to move all extremities upon command without
complaint of discomfort.

The Nurses Note dated 9/12/13 at 5:45 p.m.
documented the physician had been called and
agreed to continue to monitor the neurological
assessment.

The Nurses Note dated 9/12/13 at 5:50 p.m.
documented the resident had been in her room
watching television, while eating dinner,
neurological assessment unchanged.

Nurses Note dated 9/12/13 at 6:30 p.m.
documented the resident remained in the recliner
denied pain, and the neurological assessment
remained stable.

Nurses Note dated 9/12/13 at 7:30 p.m.
document the resident complained of pain in the
shoulder, and the resident had been given
Tylenol.

Nurses Note dated 9/12/13 at 7:40 p.m.
documented the resident complained of shoulder,
upper back and neck pain. The resident's head
appeared to leaned towards the left side when
ask to lean to the right side, the resident stated
that it hurt. The staff called the physician.

Nurses Note dated 9/12/13 at 7:45 p.m.
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<td>F323</td>
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<td>Continued From page 41: documented the physician called an order and the resident had been sent to the emergency for evaluation. The family had been notified of the trip to the emergency room.</td>
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<td>anteriorly and pae posteriorly, superimposed on a isodense subacute left subdural hematoma.</td>
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<td>A Spine CT dated 9/12/13 documented the resident had a cervical neck fracture.</td>
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<td>The Emergency Department note dated 9/12/13 by a physician documented unfortunately the CT was positive for a sizable acute on a chronic subdural hematoma and likely a new epidural hematoma. These results discussed with the family, and they recalled a fall two weeks ago and since then the resident had been much more unsteady and slighted decreased in mental state and is normally demented. This likely caused the instability that made the resident fall. The resident had been referred to hospice care.</td>
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<td>During an interview on 9/18/13 at 10:10 a.m. Staff II, C.N.A reported that she usually worked third shift on station 2A, and also worked on second shift, and did not work much on station 2B. Staff II reported that if you had questions on how to take care of a resident you could use Accuraise, or you could ask coworkers. Staff II reported that Resident #23 had safety alarms for the bed and chair, and assist of one staff member for cares and transfers, and most residents in the locked unit had alarms. Staff II reported that on 9/12/13 at 4:45 p.m. she took Resident #23 to the resident's room, and sat the resident in the recliner with the alarm in place, but did not check to see if it was on. Staff II then went to lunch break and came back to the floor at about 5:15 p.m. and Staff II, RN told her that the resident had fallen, then Staff II went to check on the resident. Staff II reported the resident sat in a</td>
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**HERITAGE NURSING & REHAB CENTRE**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/ SUPPLIER CLA A IDENTIFICATION NUMBER:**

185310

**(X2) MULTIPLE CONSTRUCTION CHECKBOX:**

A BUILDING _______________

II. WMC _______________

**(X3) DATE SURVEY COMPLETED:**

10/08/2013

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

260 CREVE DRIVE SW

CEDAR RAPIDS, IA 52404

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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 323</td>
<td>Continued From page 43 reclin in the resident's room and the chair alarm under the resident worked. The Orientation Checklist for a Nursing Assistant dated 7/10/13 documented that Staff II, C.N.A had been trained on personal alarms and the CCD unit (secured locked up for confused residents). A Corrective Action Form dated 9/19/13 signed by Staff II, and the Director of Nursing documented that the results of our investigation (the facilities investigation) of the fall from 9/12/13 that resulted in a major injury, lead us to conclude that you failed to place an alarm in the recliner, however you documented that you had done so, and that Staff II had been terminated. During an interview on 9/18/13 at 5:00 p.m. Staff JJ, C.N.A. reported that on the day Resident#23 fell he had been in another room close by and heard a thud. Staff JJ then went into the resident's room and found the resident leaning up against the foot of the bed, the resident's right leg had appeared turned outward and the left leg pointed towards the bathroom. Staff JJ reported he yelled for help, and Staff Y, C.N.A entered the room, and then Staff Y went to get the nurse. Staff JJ reported that no alarms were sounding upon entering the room. Staff JJ reported that the resident was supposed to have both a bed and chair alarm. Staff JJ reported that the resident commented that he/she had been trying to use the restroom. Staff JJ reported that prior to the fall he saw the resident in the dining room, and was unsure how the resident got to the resident's room. Staff JJ reported that he usually worked on station#2. Staff JJ reported that the resident had a history of trying to transfer him/her...</td>
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Independently, and the resident could move pretty quickly. Staff J reported that there had been an alarm book at the nurse's station that told staff members which residents had what type of alarms. Staff JJ reported that the resident couldn't remove alarms.

During an interview on 9/17/13 at 10:15 p.m. Staff Y, C.N.A reported that she had been helping another resident when Staff II, C.N.A took Resident#23 to his/her room prior to the resident falling. The resident required a bed and chair arm. Staff II reported that staff members are to always check alarms for functioning prior to use for the residents, and the press alarm worked well for the resident. Staff Y reported that she had found Staff JJ sitting on the floor with the resident, and then proceeded to call the nurse for help. Staff JJ reported that the resident had never taken his/her alarms off.

During an interview on 9/17/13 at 3:00 p.m. Staff U, R.N reported that the resident had been an assist of one for walking and transfers; and used bed and chair alarms for safety. Staff U, R.N, reported she last saw the resident before the fall on 9/12/13 at 4:00 p.m. sitting in the television lounge getting nail care. Staff U reported that the resident wanted to eat dinner in his/her room, staff II C.N.A took the resident to his/her room. Staff U reported that on 9/12/13 at about 5:15 p.m. she had been informed that the resident was on the floor. Staff U entered the resident's room; the resident had been on the floor with Staff JJ. Staff U reported the resident's feet were pointed towards the bath room door and the resident's head towards the foot of the bed. Staff U noted a slight pink color to the back of the resident's head, an old small sore between the shoulder
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<td>blades with a skin tear to it. Staff U reported that the resident denied a headache, or any other pain. Staff U located only a bed alarm in the room which functioned correctly. Staff Y, C.N.A reported that Staff II C.N.A had put the resident in the chair earlier in the residents room. Staff U, RN reported that upon assessment the resident did not complain of and pain, and moved all extremities equally. Staff U reported that no alarm had sounded, and upon search of the room the bed alarm did function, but there had been no alarm in the recliner. Staff U reported that Staff II, C.N.A came back from break and reported to Staff U that she had put the resident in the recliner. Staff U reported that Staff II commented, am I supposed to put an alarm in the recliner, there was no alarm in the recliner, and sorry I forgot. Staff U reported that she called the physician, family, and completed the assessments per facility policy. Staff U, R.N. reported that the resident complained of pain to hand and shoulder, so she gave the resident Tylenol, then complained of neck pain, and the resident's head appeared to lean towards the left, and the resident could not lean his/her head to the right. The physician and family were notified and the resident had then been taken to the hospital for evaluation at about 8:15 p.m... Staff U reported the resident passed away at the hospital the next day. Staff U, R.N. reported that the resident did not take his/her alarms off.</td>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be remedied by full regulatory or lic. identifying information).</th>
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**NAME OF PROVIDER OR SUPPLIER**

HERITAGE NURSING & REHAB CENTE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

200 CLIVE DRIVE SW

CEDAR RAPIDS, IA 52404

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

CENTERS FOR MEDICARE & MEDICAID SERVICES

**PRINTED:** 10/22/2013

**OMB NO. 0938-0391**
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<td>the chair, Staff U, R.N. reported that there had been a chair alarm in the lounge area that had been available for Staff II to use.</td>
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<td>During an interview on 9/23/13 at 3:15 p.m. Staff Y, C.N.A reported that Staff II, C.N.A reported that there had been no chair alarm in the room on 9/12/13. Staff Y reported that Staff II, C.N.A. admitted to not putting an alarm on the resident’s chair before the resident fell.</td>
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<td>During an interview on 9/23/13 Staff LL, LPN reported that the resident did not remove his/her alarms.</td>
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<td>During an interview on 9/18/13 at 3:45 p.m. Staff BB, C.N.A reported that the resident could not remove the pressure chair alarm.</td>
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<td>During an interview on 9/17/13 at 10:30 p.m. Staff FF, LPN reported that the resident would not be able to remove the bed or chair alarms.</td>
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<td>6. The MDS dated 7/31/13 documented Resident #22 required extensive assistance of one staff member for dressing, had total dependence on two staff members for transfers. The assessment revealed Resident #22 had limited assistance of one staff member for eating, extensive assistance of two staff members for personal hygiene. The MDS revealed that the resident had been unsteady with surface-to-surface transfers. The MDS documented the resident had functional limitations in both upper and lower extremities. The MDS indicated the resident had a brief interview for Mental Status score of 10 out of 15, which indicated the resident had moderately impaired cognitive skills for daily decision making.</td>
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The MDS indicated the resident normally used a wheelchair for mobility. The MDS documented the resident had diagnoses including poor circulation to extremities, diabetes, dementia, anxiety disorder, depression, psychotic disorder, and chronic respiratory disease. The MDS indicated the resident had a history of falls without injury. The MDS indicated the resident had been on medications to treat anxiety, depression, and psychosis.

The Care Plan with date of 9/9/2009 indicated the resident had a problem identified as impaired mobility with a potential for falls related to the diagnosis of dementia, a left above the knee amputation, weakness, osteoporosis, history of a stroke, poor safety awareness, and a history of falls. The Care Plan directed staff to use bed and chair pressure alarms, post a sign in the resident's room as a reminder to use the call light, apply a seatbelt when up in the wheelchair, and to monitor the resident for independent attempts to transfer independently. The Care Plan documented the resident had been non-ambulatory, and required a transfer assist of two staff members with a mechanical lift. The Care Plan directed staff to check and change the resident every hour.

The ADL Plan of care from the Accurse system dated 8/23/13 directed staff to test and reapply bed or chair alarm under the monitoring category.

A Nurses Note dated 3/16/13 at 7:40 p.m. documented the Resident#22 had been observed sitting on the floor mat in front of the bed, and the resident stated that he/she wanted to get up so he/she slid himself/herself off the bed. The resident denied hitting his/her head. The nurse's
Continued from page 48
note indicated the resident had no injuries, and the resident could complete range of motion without difficulty, then the physician and family had been contacted.

Internal Quality Assurance Investigation Form dated 3/16/13 documented that the interventions of pressure alarms were not in place according to the plan of care, and staff had been educated to ensure that preventative measures would be implemented, as in to ensure that proper alarm placement occurs.

Nursing Note dated 6/16/13 at 2:00 a.m. documented that a nurse had been informed by a C.N.A. that the resident had been on the floor, then the nurse entered the residents room to find the resident lying on the floor with the resident's upper body on the floor mat and lower body in direct contact with the floor. The Nursing Note revealed the resident had hit his/her head, and the resident did not sustain any injury. The Nursing Note documented the pressure alarm had not been hooked up at the time of the fall, and the C.N.A. had been educated to make sure alarms are on when putting the residents to bed and during rounds. The C.N.A. reported the fall at 11:35 p.m., and the physician had been faxed.

Fall Investigation for C.N.A.s dated 6/15/13 documented the fall description as the resident had been yelling, help me, and help me so the C.N.A. entered the residents room, and the C.N.A. found the resident on the floor, and the resident had been continent. The Fall Investigation indicated the C.N.A. last saw the resident at 10:00 p.m., and the resident had been continent at that time. The Fall Investigation documented that if the fall could have been
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| F 323      | Prevented if the staff made sure that the bed alarm had been hooked up properly. Nurses Note dated 7/14/13 at 2:40 p.m. documented the resident had been observed sitting on the floor mat beside the bed, the resident denied pain, and could move the lower extremity without pain or discomfort, no contact sites to head, and no nearby objects for contact observed. The resident had been assisted up with assist of three staff and a gait belt, and the resident did not have visible marks or injuries to the body during visual assessment. Fall Investigation for C.N.A. dated 7/14/13 indicated that the resident had last been seen at 1:45 p.m. and had been incontinent. The contributed factor to the fall could be that the resident seemed restless, and what could have prevented the fall from happening could be that staff could have made sure the resident had been comfortable. Incident/Accident/Unusual Occurrences Form dated 7/19/13 at 8:15 p.m. documented the resident's alarm had sounded and the resident had been found on the floor mat against the bed, and the resident sustained no injuries, but complained of some back pain from sliding on the edge of the bed. The Internal Quality Assurance Investigation Form dated 7/19/13 indicated a possible contributing factor to the fall as the resident had been soiled and wanted to get up. Fall Investigation dated 7/19/13 indicated the resident was responding to the need to toilet, and the resident had been yelling, "Get me up.", The
F 323  Continued From page 50

Fall Investigation documented that the resident could be placed in a recliner after dinner to be better monitored to help prevent another episode.

Incident/Accident/Unusual Occurrences Form dated 7/28/13 at 9:05 p.m. documented the resident alarm sounded, staff intervened and found the resident hanging on the bed with half of the resident’s body in bed and the other half not. The resident had been yelling for help to get up, the resident’s left arm hanging on the top rail, with gate on the floor, but upon assessment no injuries found, and the resident had normal range of motion.

The Internal Quality Assurance Investigation Form dated 7/28/13 the staff had been educated to respond to the resident yelling, and all care plan interventions had been in place.

Fall Investigation for C.N.A.s dated 7/28/13 indicated the resident had been incontinent at 8:00 p.m. which had been the last time the resident had been checked, and changed, and at the time of the fall the resident had been dry.

Incident/Accident/Unusual Occurrences Form dated 7/30/13 at 3:15 p.m. documented the resident had rolled out of the bed onto the floor mat needing to be cleaned up and wanting to get up.

Internal Quality Assurance Investigation Form dated 7/30/13 indicated the contributing factor to the fall had been the resident wanting to get up and the resident had been covered in feces.

The Fall Investigation dated 7/30/13 documented the resident had been responding to the need to
SUMMARY STATEMENT OF DEFICIENCIES

(Each deficiency must be preceded by full regulatory or LEC identifying information)

F 323 Continued From page 54

Toilet. The Fall Investigation indicated the action to prevent another episode would be to put the resident in a recliner in the lounge for staffing to better see the resident.

Nurses Note dated 8/2/13 at 10:00 p.m. documented the resident had been observed sitting with legs half on the floor beside the bed lying on top of safety side rail. The resident denied hitting his/her head and initially stated pain in left lower extremity and stated there was a bar under him/her, once repositioned the resident denied pain, the resident had normal range of motion, and no visible injuries.

A Fall Investigation dated 8/2/13 documented the alarms were sounding, the resident had been seen 10 minutes prior to the fall, and immediate action had been to reposition the resident.

Incident/Accident/Unusual Occurrences Form dated 8/7/13 at 9:10 p.m. documented the alarm had been sounding, and the resident had been yelling. Staff entered the room and found the resident on the floor next to the mat laying on the left side, the resident had been incontinent of stool and urine, and the gate was pushed away. Upon assessment the resident had no apparent injury, had normal range of motion and denied discomfort. The resident had been cleaned up and transferred the bed with assistance of three staff members.

The Fall Investigation dated 8/7/13 documented to prevent another episode the staff should respond to the alarm and the resident yelling as soon as possible and also the resident had been seen 20 minutes prior to the fall in his/her bed.
F 323 Continued From page 52

The Internal Quality Assurance Investigation Form dated 8/7/13 indicated staff had been educated to respond as soon as possible to the residents alarm and the resident yelling.

The Care Plan for Resident#22 included an approach dated 8/07/13 which directed staff to provide one hour check and change.

Upon survey request for all documents related to hour check and change the facility provided the survey team with documentation for the dates of 8/6/13, 8/9/13, 8/10/13, 8/11/13, 8/12/13, 8/13/13, and 8/15/13, which lacked consistent documentation of interventions being completed.

The One Hour Check Location sheet dated 8/9/13 lacked 16 hours of 24 hours documentation.

The One Hour Check Location sheet dated 8/9/13 lacked 10 out of 24 hours documentation.

The One Hour Check Location sheet dated 8/10/13 lacked 15 out of 24 hours documentation.

The One Hour Check Location sheet dated 8/11/13 lacked 20 out of 24 hours documentation.

The One Hour Check Location sheet dated 8/12/13 lacked 14 out of 24 hours documentation.

The One Hour Check Location sheet dated 8/13/13 lacked 8 out of 24 hours documentation.

The One Hour Check Location sheet dated 8/15/13 lacked 8 out of 24 hours documentation.

The survey team did not receive one hour
Continued From page 53

documentation for the dates 8/14/13 or for the dates 8/16/13 or 8/17/13.

Nurses Note dated 8/17/13 at 8:00 p.m. Resident observed laying on the floor in the resident's room beside the wheelchair on his/her back with head against the floor appeared alert with orientation per usual, speech clear. The resident stated he/she hit his/her head, and upon examination no bump or marks identified to the contact site. The resident complained of pain at a 8 on a scale of 1 to 10 to the right hip, no swelling or redness or contact marks to the site. During palpation to right hip resident complained of pain at a 8 on a scale of 10 to 10, no complaints of pain to the left hip. Resident had been given a pillow and directed to remain on the floor, with a staff member present. The physician, and family had been contacted and the resident had orders to go to the hospital for evaluation.

Nurses Note dated 8/17/13 documented the resident had been admitted to the hospital with diagnosis of a fractured right hip.

Fall Investigation dated 8/17/13 documented the resident had been seen 30 minutes prior to the fall, and then the resident had been found in the resident's room beside the wheelchair, and alarms were sounding.

The Internal Quality Assurance Investigation Form dated 8/17/13 documented contributing factors revealed the resident stated he/she slid out of the chair, and staff had been educated on chair alarms.

A Hospital Imaging study dated 8/17/13 indicated the resident sustained a femur fracture.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X) PROVIDER/ SUPPLIER/ICF/CJA IDENTIFICATION NUMBER:**

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<td>Summary Statement of Deficiencies</td>
<td>A Hospital Chest x-ray dated 8/17/13 documented findings suggestive of pneumonia. A right and left hip x-ray dated 8/17/13 documented a fracture to right femur (upper leg bone), with mild to moderate displacement of fragments. The x-ray also identified osteonecrosis (a painful condition when the blood supply to the bone is disrupted and ultimately would lead to the destruction of the femur) more to the left femur head than the right. A Head CT dated 8/17/13 completed due to the resident being on Coumadin had been found to be negative. Nurses Note dated 8/19/13 documented the resident returned to the facility. Nurses Note dated 8/20/13 documented the resident remained on bed rest, and repositioned every two hours with head of bed up, oxygen on at 3 liters. the resident had a congested cough, harsh breath sounds in the middle lung area, and diminished in the lower lung fields. the resident complained of pain all over, the resident had a Foley catheter with drainage of amber cloudy urine. Nurses Note dated 8/20/13 the Hospice nurse had visited to admit the resident to Hospice care. Nurses Note dated 9/5/13 at 7:40 a.m. Resident#22 pulse less and breathless, post mortem care provided. Interviews: During an interview on 9/18/13 at 10:30 a.m. Staff</td>
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P, C.N.A. reported she usually worked second shift on station #2. Staff P described Resident#22 as a resident who yells out a lot. Staff P reported the resident was able to communicate basic needs and can propel his/her own wheelchair. Staff P stated she had been working with Staff LL, C.N.A. on 8/17/13 when the resident fell and had been sent to the hospital, and previous to the resident falling they did frequent checks on the resident. The resident ate his/her meals in the 2B (located unit dining room). Staff P reported that at about 6:45 p.m. after dinner the resident had been sitting in his/her wheelchair yelling out in his/her room, then Staff P reported she put a gown on the resident. Staff P reported the next time she saw the resident had been when she and Staff LL entered the room to put the resident to bed and the resident was on the floor in front of the wheelchair, the call light had not been in place, and there were no alarms on the wheelchair. Staff LL stated the Hoyer sling had been in the wheelchair. Staff P reported that this had been the first shift that she had ever taken care of Resident #22. Staff LL stayed with the resident and she went to get the nurse. The resident reported that him/her slide out of the wheelchair. Staff FF, LPN checked the resident then called to get orders, then the ambulance came and took the resident to the hospital.

During an interview 9/17/13 at 11:30 a.m. Staff LL, C.N.A. reported that she entered Resident #22's room and saw the resident on the floor horizontal with the foot pedals of the wheelchair, about one and a half feet from the wheelchair. Staff LL reported the Hoyer sling had been in the wheelchair, and there were no alarms going off, but could not recall if the call light had been in reach. Staff LL reported that the resident had...
GOOD UPPER BODY STRENGTH. STAFF LL REPORTED THAT SHE SAW THE RESIDENT AT ABOUT 5:00 P.M. BEFORE DINNER. STAFF LL REPORTED THAT THE RESIDENT SEATS IN THE 2B DINING ROOM, AND SHE HAD NOT BEEN AWARE IF THE RESIDENT COULD SHUT OFF ALARMS OR NOT. STAFF LL REPORTED THAT HER PRIMARY WORK STATION IS STATION#1, BUT DID FILL IN AT STATION 2A.


BOTH STAFF REPORTED AFTER THE RESIDENT TOOK MEDICATION THE RESIDENT HAD BEEN USUALLY TAKEN OVER TO THE 2B DINING ROOM. BOTH STAFF REPORTED THE RESIDENT COULD PROPEL HIS/HER OWN WHEELCHAIR. BOTH STAFF REPORTED THEY DID NOT BRING THE RESIDENT BACK TO HIS/HER ROOM.

DURING AN INTERVIEW ON 9/23/13 AT 3:30 P.M. STAFF OO, C.N.A REPORTED THAT AFTER THE RESIDENTATE DINNER ON 8/17/13 AND THE STATION#2 STAFF HAD RETURNED SHE PUSHED THE RESIDENT BACK TO STATION#2, BUT COULDN'T RECALL WHAT TIME THAT WAS. STAFF OO REPORTED THE RESIDENT WAS TO HAVE A CHAIR ALARM, BED ALARM AND A SEATBelt ALARM.

DURING AN INTERVIEW ON 9/23/13 AT 2:50 P.M. STAFF KK, LPN REPORTED THAT THE RESIDENT HAD NOT BEEN KNOWN TO REMOVE ALARMS.
During an interview and observation on 9/23/13 at 2:50 p.m. Staff KK, LPN, Staff LL, C.N.A and Staff P, C.N.A agreed that when the seatbelt alarm had been activated it was not very loud, and could not be heard if in another room.

During an interview on 9/17/13 at 10:30 p.m. Staff FF, LPN reported that he had been on duty when Resident#22 had fallen on 8/17/13. Staff FF reported he had been called to the resident's room by Staff P, C.N.A. The resident had been lying on the floor beside the bedroom door, and could not remember if alarms were sounding or not. Staff FF reported when he palpated the resident's hips, and the resident yelled out in pain. Staff FF then called the doctor and family, and the resident had been sent to the hospital for evaluation. Staff FF reported that the resident could propel his/her own wheelchair with use of his/her one leg, had been alert but confused and in good spirits, and the resident had been on either on 15 minute or one hour checks, had a seat belt alarm, and Dycom (a non skid product) in the wheelchair to prevent a sliding out of the wheelchair. Staff FF reported the resident returned to the facility, the resident had not been a good surgical candidate, and then went on Hospice with a poor respiratory status then died.

During an interview on 9/17/13 at 8:55 p.m. Staff U, R.N described the resident as confused, yelled a lot, had been moved closer to the nurse's station at one time, had a low bed, press bed alarm, press chair alarm, Dycom in the wheelchair to prevent the resident from sliding out of the wheelchair, and only had one leg. Staff U reported that staff would ask the resident what the resident wanted, and the resident would
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<td>Continued From page 58 say nothing. Staff U reported the resident had been confused and would normally yell out. Staff U reported the resident had not been a surgical candidate after the fall on 8/17/13, and had been on Hospice, and respiratory problems before his/her death.</td>
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near bathroom with alarms sounding. No injuries.
f. On 9/5/13 at 8:00 a.m., resident stood without
assist and fell to floor slowly when attempted to
sit back down in wheelchair, alarm sounding. No
injuries.
g. On 9/13/13 at 4:30 p.m., resident observed on
floor while in dining room and pressure alarm
sounding, had been sitting on foot rests of
wheelchair laughing. No injuries.

During initial Resident Tour on 9/16/13 at 10:00
a.m. with Staff O, Registered Nurse and North
Assistant Director of Nursing reported that
Resident #10 had a history of falls and had bed
and chair alarms and an alarmed floor mat near
the bed. Upon observation of the resident's room,
noted the alarm box for the bed alarm under the
bed connected to the pad and no alarm box
connected to the floor alarm at that time.

During observation on 9/16/13 at 2:40 p.m. to
3:15 p.m., observed Staff P, Certified Nurse Aide
(CNA) assisted the resident to bed. When
Resident #10 sat on the bed the bed alarmed
beeped indicating in working order. Staff P, CNA
situated the resident in bed and made sure the
call light in reach and when left the room when
done with cares did not connect an alarm box to
the floor mat. Observations made on the resident
again at 3:20 p.m., 3:40 p.m. and 4:00 p.m. while
in bed and no alarm box connected to the floor
mat.

Observations made on 9/17/13 at 5:05 a.m. and
again at 7:30 a.m. noted the resident in bed
asleep and no alarm box connected to the floor
mat.

During observations on 9/17/13 at 7:50 a.m. to
8:35 a.m. observed Staff C, CNA and Staff D, CNA provide morning cares to the resident and at no time noted an alarm box connected to the floor mat.

During an interview on 9/17/13 at 7:55 a.m., Staff C, CNA reported the resident was at risk for falls and the mat on the floor was for padding. Staff C reported the floor mat alarmed at one time but now pad alarm placed on the bed.

An observation made on 9/18/13 at 8:00 a.m. noted the resident in the dining room area in a wheelchair with an alarm in place. Observation of the resident's room revealed the floor mat remained on the floor next to the bed with no alarm box connected to the pad and no alarm box in site.

During an interview on 9/18/13 at 11:30 a.m., Staff J, CNA in Resident #10's room checking on the roommate. Staff J indicated the floor mat next to Resident #10's bed was an alarmed mat in case the resident tried to get out of bed, but no connected anymore and not sure if still there for a pad. Staff J reported the resident had a pad alarm on the bed.

An observation on 9/18/13 at 3:15 p.m., noted the resident in bed asleep with bed alarm in place, floor mat on the floor next to the bed with no alarm box connected to the pad and no alarm box near or in site.

During an interview on 9/18/13 at 3:25 p.m., Staff N, CNA reported worked with Resident #10 and had alarms on bed/chair and floor. Staff N indicated pretty sure all 3 alarms in place. Staff N showed a book where alarm documentation
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<td>written down in, but unsure about floor alarm as showed a bed and chair alarm for Resident #10 on the list.</td>
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<td>At 3:32 p.m., during an interview with Staff O, RN/North ADN indicated as far as knew the floor alarm not discontinued. During review of the alarm lists for residents, Staff O noted a discrepancy for Resident #10 back in July 2013. On the week of July 19, 2013 to July 25, 2013 the resident marked off to have an alarmed floor mat. The next week check list dated for July 26 to August 1, 2013 noted a new intervention added for Resident #10 and the alarmed floor mat not carrying over from the week before. Staff O admitted must have missed that and the alarmed floor mat not carried over. Review of further weeks of the Alarms Lists noted the last the alarmed floor mat on the list for Resident #10 had been the week ending for July 25, 2013. Review of list for the present week of 8/13/13 to 8/19/13 revealed no documentation included the alarmed floor mat for Resident #10 had been checked off.</td>
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<td>At 3:50 p.m. on 8/18/13, Staff O went to the resident's room and upon review concurred the alarmed floor mat not connected to an alarm box and should be.</td>
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<td>At 4:05 p.m. on 9/18/13, Staff O presented self and reported own fault the alarmed floor mat not transcribed over to the next alarm list back in July 2013. Staff O indicated added a new intervention and left off the alarmed floor mat without realizing doing so.</td>
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<td>During an interview on 9/19/13 at 10:30 a.m., Staff O, when asked about the alarmed floor pad for Resident #10 not noted yet this morning,</td>
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</table>
F 323 | Continued From page 63

reported looked throughout the resident's room for the alarm box to connect to the pad, and unable to find. Staff 0 reported thought a whole new alarm pad being ordered or already ordered.

At 11:56 a.m., the DON reported no facility policy on alarms for residents, but residents are Care Planned for the alarms if used.

At 12:10 p.m. on 8/19/13, the DON presented an invoice/purchase order for new replacement floor pads and alarm boxes and reported the items to be shipped immediately to the facility (hopefully at the facility by the next day.)

8. A Incident/Accident/Unusual Occurrences Form dated 9/09/13 with time 9:30 p.m. for Resident #1 documented the resident has been found sitting on the floor next to the bed and the bed alarm box had not been hooked into the pressure alarm, and the resident commented that he/she had been trying to get up and had slid off. The documentation indicated that no injuries had been sustained.

The Fall Investigation form dated 9/09/13 documented the immediate action to prevent another episode revealed staff education to make sure alarm is properly in place when resident is transferred into bed or wheelchair.


The MDS noted the resident required extensive assistance of 2 staff persons for transfers, bed mobility, toilet usage, and noted functional limitation of both lower extremities. The MDS
<table>
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<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
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<tbody>
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<td>F 323</td>
<td>Continued From page 64</td>
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</tbody>
</table>

noted the resident was not steady with moving on and off the toilet, surface to surface transfers, moving from seated to standing position and was only able to stabilize with staff assistance.

Resident's #4's Care Plan dated 09/11/13 identified the resident with a problem of impaired mobility and potential for injury from falls related to dementia, mild mental retardation, limited range of motion to both lower extremities and an unsteady balance at times. The interventions on the care plan included to transfer the resident with 1 to 2 staff persons. The resident may take a few steps in the room from the wheelchair to the bed and or commode with assistance of 1 to 2 persons, gait belt and walker.

Observation on 09/17/13 at 10:05 a.m., revealed Staff C, Certified Nurse Aide toileting the resident. Staff C stood the resident with a gait belt while the resident took a few steps into the bathroom, onto the stool. After voiding a, Staff C had the resident reach forward to a hand bar on the wall straight ahead. The resident stretched out their right arm (full extension) really stretching forward, while bending forward to grab the bar. Staff C assisted the resident with the use of a gait belt while the resident stood up, with knees bent, leaning forward to be wiped with toilet paper. Staff C and the resident waited for another staff person to come with peri wash and towels. The resident was holding onto the bar with both hands, with the right left turning inward. The resident's legs started to dip down toward the floor in which Staff C pulled up on the gait belt and told the resident to stand straight up. The resident stood while waiting for another staff person to assist. When the Staff D, Certified Nurse Aide, came in to help, mentioned the resident might want to sit down for...
### Continued From page 55

A bit, while they prepared for the peri-wash and then lowered the resident down to the stool. After a few minutes staff assisted the resident to a standing position again using the grab bar on the far wall. The resident was breathing hard to order to stand up and reach for the bar. After cans were completed the resident sat on the toilet again to rest. After a few minutes the resident stood up, with staff assistance (and gait belt) by using the arm of the wheelchair, close by, for steadiness. The resident did not use a walker for balance with the transfer, as the care plan stated.

During an interview on 9/19/13 at 9:30 a.m., Staff E, Licensed Practical Nurse, (who witnessed the transfer) remarked the staff handled the resident’s transfer well and maybe the only thing that needed changing was a more extended grab bar.

During an interview on 9/19/13 at 2:20 p.m., the Director of Nursing remarked of having a Therapy evaluation done regarding transfers for the resident.

### Supervision

10. The Resident Assessment-Data Collection Form/Initial Care Plan dated 7/24/13 documented Resident #2 had diagnoses including dementia, and bipolar affective disorder, and indicated that the resident was independent with transfers, and ambulation.

The Care Area Triggers (CAT’s) dated 8/06/13 documented the resident had severely impaired cognitive skills, displayed independence with mobility without the use of an assistive device but staff also provided cueing and hand held assist.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEGAL IDENTIFYING INFORMATION)</th>
</tr>
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| F 323 | Continued From page 86
with the residents mobility for purposeful destinations, the resident displayed a steady gait, staff reported they provided assist to the resident with bed mobility, dressing, bathing, toileting, hygiene, and staff also indicated the resident had been resistant to cares, but the resident did display independence with eating. The CAT revealed the resident had made sexually inappropriate comments at times.
The Social Service Admission Assessment note dated 8/6/13 documented the resident scored 3 out of 15 on the brief interview for cognitive skills (BIMS), and that the resident had made sexually inappropriate comments to the staff but had been easily redirected.

Nurses Notes dated 7/26/13 documented the following: Early evening the resident told staff he/she missed his/her spouse, while the resident put his/her hands down his/her pants and asked the staff if he/she can make love to him/her, the resident had been redirected without agitation, and staff explained to the resident that he/she could only do this with his/her spouse, the resident voiced understanding, then asked this nurse if he/she could kiss the resident, again the resident had been redirected.

Nurses Notes dated 8/5/13 documented the following: Staff reported that the resident asked the staff if he/she could make love to him/her when the staff member gave the resident a shower, the resident did not display agitation when redirected.

Nurses Notes dated 8/18/13 at 1:30 p.m. documented that Resident #2 touched a Resident #31 on the breast, the residents were
Continued From page 67.

separated and then Resident #2 went down to the lounge and attempted to straddle Resident #32 while the resident sat in a chair. again staff separated the residents. Resident #2 went to his/her room and stated, "But I want you so bad can you help me."

Nurses Note dated 8/16/13 at 2:15 p.m. documented Resident #2 stood by in Resident #33's room with arms around Resident #33 and Resident #2 had his/her pants around the ankles, the residents were separated, and Resident #2 was taken back to his/her room.

Nurses Note dated 8/16/13 at 2:30 p.m. documented that a physician had been called and the staff were directed to transfer Resident #2 to the emergency room for evaluation.

Nurses Note dated 8/16/13 at 3:45 p.m. documented that Resident #2 had been sent to the emergency room.

Nurses Note dated 8/16/13 at 5:15 p.m. documented that the emergency room staff were unable to keep the resident at the hospital as the resident had not shown such behavior and suggested the resident see a psychiatrist, and the resident returned to the facility.

All Incident/Accident/Unusual Occurrence Forms for the 8/16/13 events at 1:30 p.m. and 2:30 p.m. indicated that the physicians and family members were contacted and no apparent injuries occurred to any of the residents involved.

a. A Minimum Data Set (MDS) Assessment Tool with reference date of 7/15/13 documented that Resident #31 had severely impaired cognitive...
### Statement of Deficiencies and Plan of Correction

**Heritage Nursing & Rehab Center**

**Name of Provider or Supplier:**

**Address:**
200 Clive Drive SW
CEDAR RAPIDS, IA 52404

**Street Address, City, State, Zip Code:**

**December 2013**

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**Summary Statement of Deficiencies**

**Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information**

<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>Description</th>
<th>Action Taken</th>
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<td>F 323</td>
<td>Continued</td>
<td>From page 68</td>
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</tbody>
</table>

**ID**

**Prefix**

**Tag**

**Provider's Plan of Correction**

*(Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)*

- **F 323**

*skills for daily decision making.*

The MDS indicated the resident required extensive assist of two staff members for ambulation, transfers, bed mobility, and dressing. The MDS documented the resident had high blood pressure, arthritis, osteoporosis, and dementia.

A Nurses Note dated 8/19/13 at 3:30 p.m. documented that Resident #2 touched Resident #31 on the breast, the residents were separated, Resident #31 had been smiling, and Resident #31 did not have any injuries or discomfort.

b. A MDS with reference date of 7/24/13 documented that Resident #32 had severely impaired cognitive skills for daily decision making. The MDS indicated the resident required extensive assist of two staff members for transfers, dressing, and toileting. The MDS documented the resident had anemia, Alzheimer's disease, anxiety, depression, and schizophrenia.

A Nurses Note dated 8/19/13 at 3:30 p.m. documented that Resident #32 had been sitting in the lounge and Resident #2 attempted to straddle Resident #32, the resident were separated, Resident #32 smiled and laughed.

c. The MDS with reference date 7/10/13 documented Resident #33 scored 3 out of 15 on the brief interview for mental status questions, which indicates severely impaired cognitive skills for daily decision making. The MDS revealed Resident #33 required extensive assistance of one staff member for transfers, bed mobility, dressing, toileting, and hygiene, and limited assistance of one staff member for ambulation. The MDS documented the resident had the...
<table>
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<tr>
<th>ID</th>
<th>Prefix/TAG</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or ID identifying information)</th>
<th>Other Information</th>
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<tr>
<td>F 323</td>
<td>Continued From page 60</td>
<td>diagnoses including high blood pressure, Alzheimer's disease, depression, and a psychotic disorder. A Nurse's Note dated 8/15/13 at 2:30 p.m. documented a staff member reported that Resident#33 was hugged by Resident#2 whose pants were down to his/her ankles, the residents were separated with agitation, and Resident#33 stated &quot;I'm just fine Resident#2 was just hugging me.&quot;</td>
<td>F 323</td>
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Interviews:

During an interview on 8/15/13 at 1:15 p.m. Staff 1, Licensed Practical Nurse (LPN) reported that on 8/15/13 at about 1:30 p.m. Resident #2 tried to adjust Resident#31's shirt, and then Resident#2 gently squeezed Resident#31's breast and stated "I just wanted to touch," (both residents were fully clothed) then Staff 1 immediately redirected Resident#2 towards the television lounge. Staff 1 then went to get supplies to complete the proper paperwork, and heard someone call out the statement, we need a nurse down here, which came from the direction of the television lounge. Staff 1 went to the television lounge. Staff 1 reported that Resident #31 was sitting in a chair, and Resident#2 was facing Resident#31 with both legs straddling Resident#31's lap, a staff member was attempting to intervene. Staff 1 took Resident#2 to his/her room and Resident#2 tried to pull Staff 1 into the bed with him/her, and Resident#2 stated he/she wanted to have intercourse with Staff 1. Staff 1 then left the room. Staff 1 reported that all residents involved were fully clothed, and upon assessment no injuries were found. Staff 1 reported passing on the behavior of Resident#2 onto the next shift.
During an interview on 9/15/13 at 1:15 p.m. Staff 1, LPN reported that on 9/16/13 at about 2:15 p.m. she got called into a resident room. Staff 1 entered a resident room and Resident#2 was hugging Resident#33. Staff 1 reported that Resident#2 had his/her pants down to the ankles, but otherwise clothed, and Resident#33 was fully clothed. Staff V, Certified Nurse Aide (C.N.A) had been separating the residents by taking Resident#2 out of the room. Resident#33 stated, "You Scallywag" and laughed and patted Resident#2 on the shoulder, then Staff U, Registered Nurse (RN) entered the room, and started resident assessments. Staff 1 reported talking with a physician and Resident#2 was sent out to on the next shift to an emergency room for evaluation.

During an interview on 9/18/13 at 3:00 p.m. Staff V, C.N.A reported that a visitor called her to the television lounge on 8/16/13. Staff V reported that Resident#2 had been facing Resident#32 and Resident#2 straddled Resident#32's legs. Both residents were fully clothed. Staff V reported that the visitor told her that Resident#2 had touched Resident#32's breasts. Staff V reported that she separated both residents, and the nurse entered the television lounge while separation of residents took place. Staff V reported that one on one monitoring started for Resident#2 a couple days after the 8/16/13 behaviors on a regular bases. Staff V reported that the care plans for the residents are at the nurse's station.

During an interview on 9/18/13 12:50 p.m. Staff U, RN reported that on 8/16/13 Staff 1 reported the Resident #2 had been inappropriate with three residents, and had called a physician, and
Continued from page 71

The Director of Nursing (DON), the spouse of Resident#2, had come to the facility as well, and the resident had then been sent out to an emergency room for evaluation. Staff reported that Resident#2 had been sent back to the facility at about 7:30 p.m. on 8/16/13, and the emergency room recommended that Resident#2 see a psychiatrist. Staff reported that Resident#2 had masturbated in the lounge, and by the nurses' station, and made inappropriate comments of a sexual nature towards staff before the events on 8/16/13, but not sure exactly when.

Staff reported that Resident#2's behaviors have been much better since some medications changes. Staff reported that one monitoring for Resident#2 started on 8/19/13 and documentation is on the treatment sheet.

During an interview on 9/16/13 at 9:20 a.m. Staff KK, LPN, Assisted Director of Nursing (ADON) for stations one and two reported that Resident#2 behaviors on admit consisted of wandering, and then in a couple weeks the sexual comments towards staff started, then a couple weeks later the resident escalated to inappropriate sexual behaviors toward residents. Staff KK reported Resident#2 had been put on one to one monitoring by staff after Resident#2 had inappropriate behavior with three residents. Staff KK reported that the facility Administrator scheduled the additional staff to complete the one to one monitoring with Resident#2. Resident#2 had one to one monitoring from the time the resident woke up until the resident went to bed, and then a bed alarm had been put in place while the resident slept. Staff KK reported that the one to one monitoring documentation could be found on Resident#2's treatment sheets. Staff KK reported that Resident#2 and the resident's
family had been given a written notice to find another facility due to the resident's inappropriate behavior.

During an interview on 9/18/13 at 3:15 p.m. Staff W, C.N.A reported that on 8/16/13 at about 1:20 p.m. the head nurse had asked her to monitor Resident#2 one on one, and when second shift came in Staff W reported that she had passed on the behaviors of Resident#2, and did not know if one on one monitoring continued for Resident#2.

d. The MDS with reference date of 8/13/13 for Resident#30 documented the resident scored 1 out of 15 on the BIMS. The MDS indicated the resident required extensive assist of one staff member for bed mobility, transfers, dressing, and personal hygiene, and two staff members assistance for toilet use, and limited assistance of one staff member for walking. The MDS documented the resident had diagnoses including anemia, high blood pressure, arthritis, osteoporosis, and Alzheimer's disease.

Nurses Notes dated 8/17/13 for Resident#2 documented that Resident#2 had attempted to kiss Resident#30, and verbalized grabbing the C.N.A behind.

Upon Nurses Notes review for Resident #30 there lacked documentation of any event related to any contact with Resident#2, and the facility did not provide the surveyor with any nurses notes related to events on 8/17/13 as described by Staff R, C.N.A during an interview on 9/18/13.

A written statement dated and signed by Staff R described the events that occurred on 8/17/13 at 11:30 a.m. as Staff R reported in an interview on
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6/9/13 at 11:30 a.m. with a survey.

During an interview on 6/9/13 at 11:30 a.m. Staff R, C.N.A reported that she walked past
Resident#2’s room on 6/7/13 at about 11:30
a.m. and Resident#2 had his/her pants down.
Staf R then asked the resident if
the resident needed to use the bathroom, the
resident replied “why do you want some”, Staff R
then directed the resident to the bathroom. Staff
R reported the resident had been independent
with toileting, but staffs were directed to assist the
resident with morning cares. Staff R reported
about 15 to 20 minutes later in the television
lounge Resident#2 gave Resident#1 a kiss, then
Staff R corrected the behavior, and then
Resident#2 touched Resident#30’s breast, both
residents were fully clothed, Staff R separated the
residents. Staff R reported that Resident#30 the
conduet of Resident#2 did not seem to bother
Resident#30. Staff R reported that at one point
Resident#2 was in bed at least until
lunch time. Staff R that she tells other staff
members, Staff R, C.N.A and Staff E, LPN.
Staff R reported that the Director of Nursing then
had her write up a statement the next day.

During an interview on 6/9/13 at 11:05 a.m. Staff
E, LPN reported that the nurses notes entry on
6/17/13 at 2:45 p.m. had been documented by
her. Staff E reported that there was an attempt
not actual contact so no incident report had been
written. Staff E reported that she asked Staff R if
actual contact was made and Staff R said no, so
no incident report was made.

During an interview on 6/18/13 at 2:00 p.m., the
Administrator reported that there had been no incident
report on 6/17/13 due to there being no contact.
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between the residents.

During an interview on 9/19/13 at 8:20 a.m. Staff KK, LPN reported she did not get an incident report related to Resident#2 and Resident#30.

During an interview on 9/19/13 at 10:25 a.m. the Director of Nursing reported that the Administrator and Staff KK dealt with the 8/16/13 three incidents related to Resident#2 and got a phone call about the 8/18/13 event which Resident#2 had been sent to the emergency room and started on Prozac medication which decreases the sexual drive and one to one monitoring had been started.

e. The MDS with reference date 7/02/13 for Resident#11 documented the resident had severely impaired daily decision making. The MDS indicated the resident required limited assistance of one staff member for bed mobility, transfers, and walking, the resident required extensive assistance of one staff member for dressing, eating, toilet use, and personal hygiene. The MDS documented the resident had diagnoses including high blood pressure, diabetes, dementia, and insomnia.

Nurses Note from Resident#11’s chart dated 8/19/13 at 12:00 p.m. documented Resident#11 found lying in bed in room 2B16 with Resident#2. Resident#11 had his/her shirt and bra up and Resident#2 had been touching Resident#11’s breast, the residents were separated, and Resident#11 did not complain of discomfort and Resident#11’s skin showed no discoloration.

Nurses Note from Resident#2’s chart dated 8/19/13 at 11:20 a.m. documented Resident#2 in
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Room 2B16 is a single room with Resident#11. Resident #11 had his/her shirt up and Resident #2 had his/her hands on Resident #11’s breast. Resident #2 refused to leave the room when directed to do so. Resident #2 had to be physically removed from the room. Then Resident #2 had been observed in a doorway with pants down and had an erection. Resident #2 refused several times to pull his pants up.

Nurses Note dated 8/18/13 at 11:40 a.m. documented a physician order had been obtained for Resident #2 to be evaluated at the hospital.

Nurses Note dated 8/18/13 at 11:45 a.m. noted Resident #2 had been provided one to one monitoring since occurrence of incidents early in the day.

Nurses Note dated 8/18/13 at 2:30 p.m. noted Resident #2 had returned from the hospital with a new order of Prozac.

Nurses Note dated 8/20/13 at 1:30 p.m. documented a fax sent to a psychiatrist, and social services notified.

A Medication Administration Record dated August 2013 documented an entry with start date of 8/19/13 which directed staff to place a clip alarm at night and to remove in the morning with times of 8:00 a.m. and 10:00 p.m. The documentation started on 8/19/13 for Resident #2.

A Medication Administration Record dated September 2013 directed staff to provide a clip alarm at night in place of one on one monitoring for Resident #2.
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The Care Plan for Resident#2 documented a problem with onset date of 8/06/13 as Resident#2 made sexually inappropriate comments at times and need reminder to not do so.

The Care Plan for Resident#2 documented a problem with onset date of 8/19/13 as Resident#2 made sexually inappropriate contact and comments at times to other residents and staff.

The Care Plan lacked staff direction to provide one on one monitoring for Resident#2.

The ADL (activities of daily living) Plan of Care with documentation date of 8/12/13 lacked direction for staff to provide one on one monitoring.

During an interview on 9/18/13 at 2:20 p.m. Staff T, CNA reported that on 8/18/13 at about 11:30 a.m. Resident#2 and Resident#11 were sitting on a bed, Resident#11 had his/her shirt and bra pulled up and Resident#2 had been touching Resident#11's breast. Resident#2 had been fully dressed and Resident#11 had only his/her bra and shirt pulled up. Staff T reported that it took physical intervention to separate Resident#2 from Resident#9, Resident#2 resisted the separation, and made the comment, "No I want him/her.

Staff T reported that Resident#11 appeared calm, and showed no signs of distress. Staff T reported to have taken Resident#2 to his/her room after separation of the residents. Staff T reported not being aware of one to one monitoring prior to this event. Staff T reported then going to Staff E, LPN to report the event, and that is when Staff T had been instructed to provide one on one monitoring for Resident#2, then when Staff T went to do one to one for Resident#2 the resident had been standing in the doorway of
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:**
HERITAGE NURSING & REHAB CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
203 CLYDE DRIVE SW
CEDAR RAPIDS, IA 52404

**DATE SURVEY COMPLETED:**
10/08/2013

<table>
<thead>
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<th>(X4) Prefix</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
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| F 323       |     | Continued From page 77
his/her room with his/her pants down to his/her ankle fondling himself/herself in an aroused state. Staff T then redirected the resident. Staff T reported that Resident had been inappropriately with female staff a week after admission to the facility.

During an interview on 9/18/13 at 2:45 p.m. Staff AA, C.N.A. and certified preceptor reported that the AccuNurse system (ADT Plan of Care) accessed through the staff headsets are a way to find out how to care for the resident or the hard copy Care Plans in the residents charts.

During an interview on 9/18/13 at 10:10 a.m. Staff II, C.N.A reported that Resident had been stanced on one to one monitoring for day and evening shifts a couple of days after the resident inappropriately touched three other residents in one day.

During an interview on 9/16/13 at 3:04 p.m. Staff KK, LPN reported the AccuNurse system that goes through the headsets that the staff use for charting and also can be used to review how to care for the resident or use the care plans in the residents charts.

The facility abated the LI on 9/9/13 when they completed the following:

Moved Resident #1 to the secure unit and added a second WanderGuard to the resident's wheelchair.

On 9/8/13-9/9/13 the Administrator and maintenance staff measured Resident #1's wheelchair to identify the height of his/her ankle brace based to the floor. The maintenance staff and the Administrator helped to capture the alarm sound at the correct height.
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The Wondrughad been reinstalled at the main entrance, at station 1 and station 3 dining, 1C hall door, station 4 main entrance and at the service entrance door to the garage area.

On 9/10/13 the OON held meetings for staff and educated all staff to reset the alarms. The staff were trained that when the alarm sounds at station three (3) alarm panels, 2 lights will appear. 1 for the relay and the other for the actual opened door. To staff were instructed to never push the main power switch which was now covered by a box.

These actions lowered the UI from the K to E level as the facility would need to monitor supervision interventions to maintain residents safety.

483.65 INFECTION CONTROL, PREVENT SPREAD, LINESNS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it:
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

In respect to resident #3 and any other similarly situated residents, Staff A as well as all other nursing staff were re-
<table>
<thead>
<tr>
<th>INFRACTION NO.</th>
<th>F 441</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>CONTINUED FROM PAGE 75</td>
<td>Continued From page 75</td>
<td>determined that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</td>
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<td>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</td>
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<td>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</td>
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<td>(c) Linens</td>
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<td>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure staff utilized proper infection control techniques during a dressing change for one of three residents reviewed with wound care. (Resident #3) The facility census was 130 residents.</td>
</tr>
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<td>Findings include:</td>
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<tr>
<td></td>
<td></td>
<td>1. The Minimum Data Set (MDS) assessment dated 8/3/13, documented Resident #3 had diagnoses of anemia, heart failure, hypertension and diabetes mellitus. The MDS assessment noted the resident had a skin condition requiring surgical wound care.</td>
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<td>The Care Plan updated on 8/22/13, identified a</td>
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<td>educated on 09/27/13 on proper dressing change technique.</td>
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<td>D.O.N./designee will perform random audits to ensure protocol is being followed.</td>
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<td>Date of compliance: 11/08/13</td>
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</tbody>
</table>

**Heritage Nursing & Rehab Center**

**Street Address:** 700 Clive Drive SW

**City, State, Zip Code:** Cedar Rapids, IA 52404

**ID prefix tag:** HER

**ID Number:** 160310

**ID Tag:** F 441

**ID prefix:** F 441
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risk for skin breakdown, on 8/26/13 noted an
abrasion on a chest incision. An intervention was

to monitor the wounds for healing routinely and as
needed.

The Treatment Administration Record dated
September 2013, directed staff to cleanse the
residents chest wound with normal saline, paint
the distal wound with Betadine and apply a dry
dressing twice a day.

Observation on 9/16/13 at 3:40 p.m., revealed
Staff A, Licensed Practical Nurse, performing
wound care to the residents chest wound. Staff A
removed the old dressing that contained a
moderate amount of sero-sanguineous drainage
and disposed of it into the garbage bag. Staff A
went on to cleanse the area and apply a new
gauze and tape without changing their gloves
which were used to handle the soiled gauze.

During interview on 9/19/13 at 9:30 a.m., Staff E,
Licensed Practical Nurse noted Staff A did not
change gloves between the soiled dressing and
cleansing and applying the clean dressing.

The facility's procedure for Dressing Change
Clean revised on 8/12/16 included to remove
gloves, discard, and wash hands after the
removal of a soiled dressing.