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	165367	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE AND REHABILITATION CENTER	501 SOUTH KENTUCKY AVE MASON CITY, IA 50401

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F 000	INITIAL COMMENTS	F 000		

Correction date: 7/8/2024

The Heritage Cae and Rehabilitation Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written the investigation of intakes #120192-A and #120591-M conducted June 10, 2024 to June 20, 2024.

Findings for the investigation of the intakes #120192-A and #120591-M will be sent to the facility at a later date under separate cover.

Total Census: 31

F 684 SS=G — Quality of Care — CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to provide follow-up assessments and interventions for 1 of 3 residents reviewed (Resident #1). Resident #1 had an unwitnessed fall. Resident #1 stated he hit his head and had 2 abrasions on his head. Staff A, the covering Licensed Practical Nurse (LPN), documented she completed 8 neurological

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Claire Nash	Administrator	7/8/2024

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

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assessments (neuro checks) on Resident #1. This facility's video footage and staff interviews revealed that Staff A only did the initial assessment, with no further assessments to follow. The facility reported a census of 51.

Findings include:

Resident #1's Minimum Data Set (MDS) dated 3/25/24, identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Resident #1 required total staff assistance with ambulation. The MDS listed he used walker for mobility. The MDS included diagnoses of schizophrenia disorder (mental disorder that causes paranoia), chronic ischemic heart disease (condition caused by narrowed heart arteries), non Alzheimer's dementia, and renal insufficiency (impaired kidney function).

Resident #1's Census reflected he had a paid hospital leave on 4/14/24 and returned to the facility on 4/17/24.

In a Progress Note dated 4/14/24 at 7:00 AM, Staff A documented she tried to contact Resident #1's brother to give him an update regarding Resident #1's fall at 6:00 AM that morning.

In a Progress Note dated 4/14/23 at 8:55 AM, Staff A documented that she contacted the on-call provider Advanced Registered Nurse Practitioner (ARNP), and updated her on Resident #1's fall from 6:00 AM that morning. The ARNP directed to monitor Resident #1 and call back with any changes.

In a Progress Note labeled Incident Report dated 4/14/23 at 9:02 AM, Staff A documented that

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someone called her into the resident's room. Upon arrival witnessed Resident #1 lying on the floor facing east, legs straight towards the door (west side). When asked him what was he doing he stated "I was going to the bathroom." Resident #1 didn't have on gripper socks or his walker near him. The note listed his vital signs as blood pressure 116/63 (average 120/80), Pulse 67 (average 60-100), respirations 18 (average 12-20) and oxygen level 91% (average 90-100%). Resident #1 denied having pain. Injuries were to the top of his head and measured 1. 5 centimeters (cm) by 1. 3 cm, to the top of his head right side 2. 3 cm by 1. 5 cm and to the top wrist 1 cm by 2 cm. Staff A cleansed with normal saline and covered with a dressing.

In a Progress Note labeled Transfer to Hospital dated 4/14/24 at 9:26 AM, Staff B, LPN, documented Resident #1 had a change in condition from his baseline. Resident #1 leaned to the right and had tremors more than usual. Resident #1 needed a wheelchair and couldn't walk without physical assist. The note included vital signs of pulse - 117 (average 60-100) and respirations - 22 (average 12-20).

In a Progress Note labeled Skin Note dated 4/14/24 at 9:29 AM, Staff A documented Resident #1 fell that morning at 6:00 AM. He had a bruise measuring 1. 5 centimeter (cm) by 1. 3 cm on top of his head, an area on the top right side of his head measuring 2. 3 cm by 1. 5 cm, and an area on the top of his right wrist measuring 1 cm by 2 cm.

On 6/10/24 at 1:15 PM, the Administrator stated they saved the video footage from the morning of the incident. The Administrator stated she noticed

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Staff A didn't document the fall in the progress notes until later that morning. The Administrator asked Staff A about it, who replied she really didn't have time to document. When the Administrator asked if Staff A admitted to not doing the neuro check assessments, this Administrator stated she felt like Staff A vaguely admitted to it. The Administrator asked Staff A why she documented assessments she didn't do, Staff A responded she had a bad morning and shouldn't have come into work that morning.

On 6/18/24 at 11:24 AM, Staff C, Certified Nurse Aide (CNA), stated Resident #1 fell and it happened shortly after they did their walk through around 6:05 AM. Staff C stated at the time of walk through, Resident #1 laid in bed. Staff C stated her partner, Staff D, CNA, was down that hallway and said oh my god Resident #1 is on the floor. Staff C stated they immediately called the nurse (Staff A) and they didn't receive a response from her. Staff C stated that Staff E, Certified Medication Aide (CMA), worked that morning came and then Staff E called the nurse (Staff A), and the nurse still didn't answer, so Staff C went and got Staff A. Staff C stated Resident #1 laid on his stomach/side with his head on the heater floor board (heater was not on). Staff C stated she didn't remember Resident #1 saying anything. Staff C stated he didn't seem to be in pain. Staff C noticed some red marks after they got Resident #1 up into a wheel chair (w/c). Staff C noticed his arm that he fell on, had skin tears. Staff C stated they had tried to reach Staff A by walkie first. Staff C stated she didn't remember if Staff C had her walkie on and didn't know why Staff A didn't answer. Staff C said that when staff A got to the room Staff A did something with Resident #1, she maybe took his temperature or his pulse oximetry

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or something. Staff C stated that she did notice later on Resident #1 in a wheelchair and stayed by the CMA (Staff E), and then Staff D after breakfast sat with Resident #1 for a little bit. Staff C stated they did have to transfer Resident #1 to another wheelchair just because he was leaning to the side. Staff C stated she vividly remember asking Resident #1 if he was feeling okay and he answered 'I'm just going through the motion'. He was saying weird like hippie stuff like going the waves, he was kind of shaky, and he usually wasn't shaky. Staff C stated they told the nurse that he didn't look like himself. The nurse responded, oh I'll check later. Staff C stated that she trusted Staff A would follow up when Staff A finished up with whatever she was doing in that moment. Staff A stated she knew on that day that Staff A had to leave early and Staff A had someone coming in to cover for her after she left. Staff C stated the ambulance came to the facility probably around 9 10 AM, but it could have been earlier. Staff C stated that Staff A had to stay later than planned because she was behind. Staff C stated that on the day she wrote the statement for the facility of what she knew regarding this incident, Staff A approached Staff C and said "Hey I told them that you were the one who brought (Resident #1) up to me so I could take his vitals and assessments". Staff C stated she told Staff A that she didn't remember that. Staff C stated that Staff A then she also said "here's my statement, do you want to read it?" as Staff A went to give it to the Administrator. Staff C stated she just pushed the statement back to Staff A and didn't say anything to her. Staff A stated that it was very awkward and it wasn't true.

On 6/18/24 at 11:48 AM, Staff F, LPN, worked the opposite side (west side) of the facility on the day

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of this incident, so not on the side Resident #1 resides. Staff F stated she had a staff member that called to say she was sick with Covid and Staff F told the staff member to come to the building and Staff F would go outside to test the staff member for Covid. Staff F stated she went over to the east side to get the tests. Staff F stated she saw Resident #1 in a wheelchair sitting with Staff E. Staff F stated she looked at Resident #1 really quick and he didn't look quite right and a little pale. Staff F stated she told Staff E, who asked her to let Staff A know because Staff E tried to get Staff A to look at him again, but Staff A wouldn't assess Resident #1. Staff F stated that Resident #1 looked dehydrated and/or septic (a potentially life threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). Staff F stated she told Staff A that if she was her, she would call the doctor to see if they would like to send him out. Staff F stated that Staff A really didn't say anything, she just kind of nodded but didn't say what she was going to do. Staff F stated at lunch time Staff E said that she didn't think Staff A checked on Resident #1. Staff F stated she looked in the computer and saw Staff A did the assessments. Staff F stated she then told Staff E, who replied that there was no way Staff A did the neurological checks. Staff E thought it was around 9 AM when she talked with Staff A. Staff F stated she had also told reminded Staff A of the facility policy that if the doctor doesn't think Resident #1 needed to go by ambulance and wants him to go by van, then Staff A would need to get a hold of a driver. Staff F stated she told Staff A that she should send him either way because he had a fall that morning and even though he maybe the fall didn't hurt him, they should question what made Resident #1 fall?

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did he have a UTI? was he dehydrated? Staff F stated she felt Resident #1 needed seen.

On 6/18/24 at 12:13 PM, Staff E stated after they did the walk through, they found Resident #1 on the floor. Staff E stated they called Staff A several times and then Staff C went to find her. Staff E stated she came, took a set vital signs, a pulse oximetry reading, and looked at a couple of rug burn-like issues on his head. Staff E stated they saw a skin tear on Resident #1's right wrist and Staff A wrapped it. Staff E said Resident #1 had something like a rug burn on his forehead and further back on his scalp. They couldn't remember what side of his head, and knew they weren't bleeding. Staff E stated they found Resident #1 lying on the floor at the bottom of the bed kind of on his side with his head up against the register vent with his leg's kind of in the fetal position. Staff E stated that it was pretty obvious Resident #1 hit his head because it appeared he scooched away from the register vent. Staff E stated after Staff A looked at Resident #1, she told her to keep eyes on him at all times. Staff E stated Resident #1 went with her when she passed pills. Staff E stated Resident #1 and her were friends that morning, he stayed with her. Staff E stated that Resident #1 normally walked. Staff E described Resident #1 as very jittery with bad anxiety. Staff E said that a couple of times his eyes rolled back in his head and he had a high respiration rate. His skin color looked very pale and he didn't look right. Staff E stated she called Staff A couple of times, who passed her in the dining room (Resident #1 sat beside Staff E when she passed the pills in the dining room). Staff E called Staff A, who said she would come and look at Resident #1 but she never came and assessed him. Staff E stated in the dining room

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when she asked again, Staff A said "oh he looks good." Staff E stated she felt very uncomfortable. Staff E stated that she was just a medication aide and she felt like Staff A should have followed up with Resident #1. Staff E reported other residents and staff members said Resident #1 had something wrong. Staff E explained she worked at the facility for about 5 years and knew Resident #1 very well. She knew something wasn't right. Staff E stated normally he would walk. Staff E stated when they went to change him due to being incontinent, he couldn't stand, so they just kept him in his wheelchair. Staff E stated all she knew was he ended up admitted to the hospital. Staff E stated it was close to 6:15 AM, when they found Resident #1 on the ground. Staff E stated that all she knew was she had Resident #1 with her for about 3 hours that morning after he fell. Staff E stated Resident #1 was up and in a wheelchair about 6:30 AM, then with her throughout her entire medication pass. Staff E thought it was about 9/9:30 AM when someone sent Resident #1 out. Staff E stated at one point his blood pressure was lower and Staff E let Staff A know that. Staff E stated that she wouldn't say Resident #1 really had tremors, he was more restless, and he was all over in the w/c. Staff E didn't think this resident's speech was any different than his normal but it seemed as though his response time was a little slower. Staff E stated that Staff G, CNA was one of the staffs who asked what's wrong with Resident #1 and Staff C, Staff D, and Staff F had all said he doesn't look right. Staff E stated she didn't see Staff A reassess Resident #1. Staff E stated Staff A didn't once come back to do anything for him. Staff E stated the only time Staff A assessed him was when he was still on the ground. Staff E stated she maybe said something to Staff A 3 or 4

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times (asking her to take another look at him). Staff E stated Staff A zipped all over the place trying to get her stuff done so she could get out of the facility at 9:00 AM and never once checked his pupils. Staff E stated she knew the nurses are supposed to do more than just vital signs and a pulse oximeter reading when someone hits their head.

On 6/18/24 at 12:37 PM, Staff D stated they had just finished walk through, around 6:15ish, and found Resident #1 on the ground on his side with his arm tucked and his head was kind of up on the heater/register. Staff D stated they tried to get a hold of the nurse (Staff A). Staff A did take his vital signs. Staff D stated she took Resident #1 to breakfast and sat with him. Staff D stated Resident #1 leaned to his side, poked at his food, and brought it to his mouth but couldn't get the food all the way to his mouth. Staff D stated Resident #1 acted different as he was leaning and he couldn't feed himself. Staff D thought she ended up feeding him a little bit and he fed himself some too. After breakfast, Staff D stated they got him back to his room, where Staff D and Staff E got him cleaned up. Staff D said when they went to assist him to stand up they noticed Resident #1 drooling. She stated they put him back in his w/c. Staff D stated she only saw Staff A get his vital signs once, right when they got him up off the floor and into a w/c. Staff D stated that she was either with Resident #1 or Staff E was with him. Staff D stated that Resident #1 was doing this weird marching thing the whole time he was in the w/c and leaning. Staff D stated she probably went up to Staff A's cart and asked her twice like what the plan was for him, and what was she going to do. Staff D stated Staff A didn't really seem concerned about Resident #1. Staff D

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stated she would ask Staff A, maybe you should recheck him? Staff D didn't think Staff A ever did recheck Resident #1. Staff D thought Resident #1 went to the hospital around 9:00 AM . Staff D stated from the time of the fall to 9:00 AM, Resident #1 marched with his legs and leaned. Staff D stated Resident #1 talked to her and his speech seemed pretty normal. Staff D could not give specific times that she actually asked Staff A to assess Resident #1 again, but said it was probably every hour that she asked Staff A what they were going to do. Staff D stated that Staff A kept saying it's normal, he's fine. Staff D stated she didn't really get a good response from Staff A. Staff D thought she asked Staff A would you check him and she just kind of kept doing what she was doing at the medication cart computer, passing medications.

On 6/18/24 at 12:52 PM, Staff G stated the fall happened right after the overnight shift. Staff G stated she knew someone discovered him on the floor. Staff G stated she worked with Resident #1 off and on and checked on him. Staff G stated Staff E kept Resident #1 by her that morning and Staff G would kind of walk by him to see how he was doing. Staff G said Resident #1 would answer when asked if he felt well, he had appropriate speech and response. Staff G stated he had more of a physical difference. Staff G stated Resident #1's eyelids fluttered, he leaned, bobbed, and then he lifted up his leg and bobbed with it (leaning torso forward and back and lift his leg in sync with torso, and do it over and over). Staff G stated she knew Staff A didn't do his neuro checks like she should have. Staff G stated she thinks that's what they call them, "neuro checks." Staff G helped him the most when the paramedics came. She said Resident #1 did a lot

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of leaning she thought to his right. She said he moved his leg up and down, with his eyes fluttering back in his head. Staff G stated she told the nurse from the other side to go ask Staff A why she wouldn't check on Resident #1. Staff G thought Staff F talked to Staff A between 7:00 AM and 8:00 AM.

On 6/18/24 at 1:35 PM, the review of the facility's video footage, during the approximately 3 minutes of the facility's video ending on 4/14/24 at 8:52:21 AM, Staff E brought Resident #1 to the nursing station between the northeast and southeast halls. Resident #1 sat in his wheelchair with his hair pulled up in a bun. Resident #1 leaned to the right and rocked back and forth. When asked about the footage, the Administrator described the leaning and rocking as not normal for Resident #1.

On 6/18/24 at 3:32 PM, Resident #1's Primary Care Provider (PCP), ARNP, reported being Resident #1's PCP since June of 2023. This PCP indicated Resident #1 was very complicated to manage. He had a really awful cardiac history. His heart and then overall health were steadily declining. Psychology, Nephrology, and Cardiology followed him. They watched him steadily decline. He became very difficult. The PCP stated she really didn't think that sending him out 3 hours earlier would have made a difference in his recovery for his hospital stay beginning on 4/14/24. She stated the girls at the facility knew the residents. The PCP acknowledged understanding that the nurse didn't assess Resident #1 after his head injury. She stated Resident #1's psychiatrist made medication adjustments and he had a lot of psychotropic medications (drugs that effect

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behavior, mood, thoughts, perceptions) that he had tried. She stated that Resident #1 was not a good fluid drinker and had severe mental illness. The hospital gave the diagnosis of sepsis and they do that because they follow a protocol. They started him on an antibiotic and hoped they can hit the right infection.

On 6/19/24 at 10:59 AM, Staff B stated that she picked up a partial shift for Staff A. Staff B stated she went into the facility that day at 9:00 AM to relieve Staff A. Staff B stated she noticed Resident #1 sitting in a wheelchair. Staff B stated Resident #1 didn't have a w/c. Staff B stated one of the CNAs told Staff B that Resident #1 fell. Staff B stated she assumed it had just happened. Staff B stated when she looked at him, he did a lot of rocking back and forth, in addition he was kind of leaning. Staff B stated she was getting report from Staff A, and found out he fell earlier and she was monitoring. Staff B stated that what she was seeing when looking at Resident #1, she told Staff A that he didn't look right to Staff B, and that Staff B was going to call the doctor. Staff B stated she did an assessment on him and he was good mentally. Staff B stated she then called the doctor. Staff B then told the on-call provider what Staff B was seeing. The on-call provider said okay that was a change and they needed to send him out. Staff B stated Resident #1 looked a little off, staff reported to Staff B that Resident #1 was in a wheelchair, leaning, and couldn't walk on his own. Staff B told her that was a change in Resident #1's normal and he needed seen. Staff B repeated she called the doctor and told her it was a change and she agreed, so they sent him out. The on-call doctor didn't know Resident #1. Staff B stated she asked Staff A, who responded she told the doctor and all the doctor said was to

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	165367	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE AND REHABILITATION CENTER	501 SOUTH KENTUCKY AVE MASON CITY, IA 50401

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monitor. Staff B stated that when she walked in to the facility the CNAs told Staff B they had trouble getting him walking with his walker. Staff B stated that Staff F said she thought someone should have sent him out. Staff B stated that Staff F came over to help send him to the hospital. Staff B described Resident #1 as hesitant to go to the hospital but ended up accepting that he should go up there. Staff B stated that sometimes Resident #1 can have behaviors. Staff B stated she would have let the on-call doctor know that it was a change from Resident #1's norm if she would have been there after the fall. Staff B stated Resident #1 normally walked with minimal assist and he could stand pretty straight and tall. This nurse explained the process for unwitnessed falls as you automatically start neuro checks. and then the computer assigns the follow up ones. At that time, when she received report from Staff A, Staff B was just worried about sending him out. Staff B stated that Staff A told her that she did the neuro checks and Staff B took Staff A's word for it. Staff B stated she didn't judge whether or not if Staff A did the assessments or not, Staff B just saw him and knew it was a change for him.

On 6/19/24 at 1:28 PM, Resident #1's PCP stated she didn't come across any one falsifying neuro checks. She stated that someone should have done neuro checks Resident #1's. The PCP stated she expect a nurse would follow up with an assessment when staff go to that nurse regarding concerns about a resident. When told that staff reported approaching Staff A numerous times asking her to look at Resident #1 as he was not doing well, and she didn't go assess him after the first assessment after his fall, the PCP stated that should never have happened. She stated doing neuro checks and assessments on residents is

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nursing 101.

On 6/19/24 at 3:00 PM, the Administrator stated on 4/15/24 at 10 AM, Staff E reported she felt Staff A didn't do neuro assessments on Resident #1. The Administrator stated she asked Staff A what happened the day before. Staff A told the Administrator that he fell around 6:00 AM . The Administrator asked Staff A if she did neuro checks and Staff A said yes. This Administrator stated she then looked in Resident #1's chart and found that the neuro assessments were completed. The Administrator stated she then watched all the video footage and the video footage clearly showed that Staff A didn't do the neuro checks and other staff voiced concerns to Staff A.

On 6/19/24 at 3:44 PM, the on-call provider stated she took calls from this facility on 4/14/24 at 8:46 AM, 9:21 a. m, and 9:23 AM.

On 6/20/24 at 12:53 PM, the Director of Nursing (DON), stated Monday, 4/15/24 between 10:00 AM and 10:30 AM, Staff E came to her office and said she didn't think that Staff A actually took vital signs on Resident #1 after his fall. This DON stated they then looked at the schedule to see who worked and got their statements. The DON stated after she and the Administrator started watching videos, they decided she definitely was falsifying documentation. The DON stated that Staff A told them when they called her that she did take vital signs and she sounded credible. The DON stated they had the documentation in the chart that Staff A did neuro checks. The DON stated Staff F called her that day, 4/14/24, regarding something else as this DON was on call that day. Staff F asked the DON if the DON

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heard Resident #1 fell, she said no. The DON stated she asked Staff F if someone did the neuro checks, and Staff F said "well let me look." Then Staff F said "yes, they were done." The DON said good. The DON stated she received a call later from Staff B, saying she sent Resident #1 up to the hospital for a change in condition and leaning. The DON stated she didn't hear from Staff A that day. The DON stated when the hospital called the facility back they usually say he's admitted, they don't usually tell us a whole lot. The DON stated that Resident #1 has a history of seizures and the facility heard that he had a heart attack prior to arriving at the hospital and then another at the hospital.

Staff A filled out the Neurological Assessment template in Resident #1's chart on 4/14/24 at 6:00 AM, 6:15 AM, 6:30 AM, 6:45 AM, 7:15 AM, 8:15 AM, 8:45 AM, and 9:15 AM.

On 6/25/24 at 3:15 PM, Staff A stated she didn't recall falsifying neuro checks. Staff A stated Resident #1 should have had neuro checks done. Staff A stated that Resident #1 did have abrasions on his head. Staff A stated someone should have documented his changes in neuro checks and she should have notified the provider. Staff A said that neuro checks needed done after a fall with a head injury or suspected head injury. Staff A stated she didn't deny that she falsified the neuro check assessments, she stated she just didn't recall doing it.

A timeline put together by the facility of the video footage from the morning of 4/14/24, revealed that Staff A didn't do all of the neuro checks as she documented. Per the video footage, Staff A went into Resident #1's room at approximately

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F 684	Continued From page 15 6:16 AM, and walked away from him at approximately 6:39 AM. The video footage lacked any additional times Staff A tended to Resident #1. A Family and Physician Notification Relating to Accident or Change in Medical Condition policy dated April 2012, directed the facility to immediately notify the resident, the resident's responsible party and physician of an accident resulting in injury or a change in the resident's medical condition.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to ensure documentation accurately reflected assessments for 1 of 3 residents reviewed (Resident #1). Staff A, Licensed Practical Nurse (LPN), documented that she completed assessments on Resident #1 that she didn't do. The facility reported a census of 31 residents.

Findings include:

On 6/10/24 at 1:15 PM, the Administrator stated they saved video footage from the morning of this incident. The Administrator stated that she noticed that Staff A didn't document the fall in the progress notes until later that morning. The Administrator asked Staff A about it, she replied she really didn't have time to document. When inquired if Staff A admitted to not doing the neuro check assessments, the Administrator said she felt like Staff A vaguely admitted to it. The Administrator asked Staff A why she documented assessments she didn't do, she responded she had a bad morning and shouldn't have come into work that morning.

On 6/19/24 at 3:00 PM, the Administrator stated that on 4/15/24 at 10 AM, Staff E, Certified Medication Aide (CMA) reported that she felt Staff A didn't do neuro assessments on Resident #1. The Administrator stated she asked Staff A what happened the day before. Staff A told the Administrator Resident #1 fell around 6:00 AM. The Administrator asked Staff A if she did neuro checks and Staff A said yes. This Administrator

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explained she looked in Resident #1's chart and found completed neuro assessments. The Administrator stated she then watched all the video footage and the video footage clearly showed Staff A didn't do all of the neuro checks and that staff voiced concerns to Staff A.

On 6/20/24 at 12:53 PM, the Director of Nursing (DON), stated Monday, 4/15/24 between 10:00 AM and 10:30 AM, Staff E came to her office and said she didn't think that Staff A actually took vital signs on Resident #1 after his fall. This DON stated they then looked at the schedule to see who worked and got their statements. The DON stated after she and the Administrator started watching videos, they decided she definitely was falsifying documentation. The DON stated that Staff A told them when they called her that she did take vital signs and she sounded credible. The DON stated they had the documentation in the chart that Staff A did neuro checks. The DON stated Staff F called her that day, 4/14/24, regarding something else as this DON was on call that day. Staff F asked the DON if the DON heard Resident #1 fell, she said no. The DON stated she asked Staff F if someone did the neuro checks, and Staff F said 'well let me look'. Then Staff F said 'yes, they were done'. The DON said good. The DON stated she received a call later from Staff B, saying she sent Resident #1 up to the hospital for a change in condition and leaning. The DON stated she didn't hear from Staff A that day. The DON stated when the hospital called the facility back they usually say he's admitted, they don't usually tell us a whole lot. The DON stated that Resident #1 has a history of seizures and the facility heard that he had a heart attack prior to arriving at the hospital and then another at the hospital.

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A timeline put together by the facility of the video footage from the morning of 4/14/24, revealed that Staff A didn't do all of the neuro checks as she documented. Per the video footage, Staff A went into Resident #1's room at approximately 6:16 AM, and walked away from him at approximately 6:39 AM. The video footage lacked any additional times Staff A tended to Resident #1.

The facility didn't have a policy related to falsification of documentation.

Heritage Care & Rehabilitation Center

501 South Kentucky Avenue • Mason City, IA 50401 • Ph: (641) 423-2121

Submitted 7/12/2024

Plan of Correction for survey ending 6/20/2024

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction Date 7/8/2024

F684 Quality of Care 483.25

§483.25 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

For the required plan of correction, the facility submits:

1. Upon licensure, nurses receive comprehensive training on the Iowa Nurse Practice Act, which stipulates that falsifying records is unacceptable and potentially illegal. The facility ensures there are adequate and competent nursing staff available to provide comprehensive care for residents.
2. Education was provided by the Administrator and Director of Nursing to nurses via in-service on 4/19/2024 at 1:30 p.m. regarding the proper procedure to follow after a resident injury to include assessments and interventions as appropriate.
3. The Director of Nursing or designee will review documentation to ensure appropriate assessments and interventions are completed. Reviews will occur weekly x 1 month, then monthly x2. Results of the audits will be reviewed through the facility quality assurance process.
4. The facility Director of Nursing and Administrator will continue to discuss and educate on the procedure after falls via in-service monthly x3.

F842 Resident Records- Identifiable Information 483.20(f)(5), 483.70(i)(1)-(5)

§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized.

For the required plan of correction, the facility submits:

1. The facility terminated staff A on 4/19/2024.
2. Education was provided by the Administrator and Director of Nursing to all nurses via in-service on 4/19/2024 at 1:30 p.m. regarding the importance of

accurately completing medical documentation and proper documentation of incidents.

3. The facility Director of Nursing and Administrator will continue to discuss and educate staff of the importance of accurate documentation of assessments via in-service monthly x3. Understanding of the education will be reviewed through the facility quality assurance process.