

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2016
FORM APPROVED
OMB NO. 0938-0391

7/25/16 PS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2016
NAME OF PROVIDER OR SUPPLIER CHEROKEE SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 NORTH ROOSEVELT CHEROKEE, IA 51012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Correction date: <u>7-18-16</u> Investigation of facility-reported incidents #60605-I and #60372-I which was conducted 6/7/16 - 6/24/16, resulted in the following deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C, 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 000			
F 279 SS=D		F 279			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 279	Continued From page 1 facility failed to revise the Care Plan for Resident #4. The Care Plan directed staff to raise the lower side rail but gave no direction to staff which rail to raise in order to prevent the resident from falling. The sample consisted of 5 residents and the facility reported a census of 45 residents. Findings include: Resident #4 had a Minimum Data Set (MDS) assessment, with a reference date of 3/23/16. The MDS indicated the resident had short and long term memory problems and severely impaired cognitively. The MDS indicated the resident experienced signs and symptoms of inattention and disorganized thinking. The resident required extensive assistance of one staff for mobility, dressing, toileting and hygiene. A balance during transitions and walking test identified the resident as not steady and only to stabilize with staff assistance when walking, moving from seated to standing position, and surface to surface transfers. The clinical record Face Sheet identified the resident had diagnoses that included: anxiety, diabetes, postural kyphosis, history of falling and unspecified lack of coordination with abnormalities of gait and mobility. The resident had 1 fall with no injury since the prior assessment. Review of the Fall Risk Assessment dated 5/19/16 identified the resident scored a 16 on the assessment scale. A score of 10 or above represented the resident at a high risk for falling. The Care Plan, target date 6/12/16, identified the resident at risk for falls with interventions that			F 279			

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F 279	Continued From page 2 included: utilize a bed alarm, chair alarm, and baby monitor. The alarms were to be placed up and out of reach so audible. The falls Care Plan directed both top side rails up and one lower rail up while in bed. The Care Plan did not indicate which lower side rail to be in a raised position. An x-ray report dated 6/10/16 reflected the resident sustained a subcapital fracture seen with impaction (right hip fracture). On 6/21/16 at 1:44 p.m. Staff G, CNA, was interviewed and stated she walked by Resident #4's room and observed him/her standing beside a walker. She did not hear an alarm, and then observed the alarm "stuffed" under blankets. She encouraged the resident lie down in bed and did not toilet the resident. Staff G stated she observed three side rails up, the upper side rails and the lower side rail. Staff G indicated the lower side rail near the door was up, and then indicated it was the lower side rail near the window. Staff G was aware Resident #4 climbed out both sides of the end of the bed. Staff G stated when the resident fell, she noted the alarms were placed under blankets again. On 6/23/16 at 1:00 p.m. Staff H, CNA was interviewed and stated he assisted Resident #4 to bed prior to the fall. Staff H stated he put the top two side rails up and the left, lower side rail up (door side) on the bed. Staff H stated he was not aware the right lower side rail (window side) was to be up. Staff H stated he went to break at approximately 12:00 a.m. and noted Resident #4 was awake and lying in bed. Upon return from break he observed the resident sitting beside the walker and complained of leg pain. Staff B, licensed practical nurse (LPN), informed him the	F 279			

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F 279	Continued From page 3 right lower side rail (window side) was to be up because Resident #4 tried to climb out of the right side of bed. Staff H stated the head set directed three side rails were used but did not indicate which three. Facility staff now places a piece of paper on the head of the bed to indicate which specific side rails are to be up. On 6/22/16 at 3:13 p.m. Staff B, LPN, observed Staff G exit Resident #4's room approximately 10 minutes prior to the fall. Staff B heard the resident's alarm sound, but thought Staff G was with Resident #4 because typically, she doesn't turn off the alarm while in the room with the resident. She heard Staff G ask the resident why he/she was on the floor. Upon entry to the resident's room, she observed Resident #4 on the floor between his/her roommate's walker. The side rails at the head of the bed were up and the left lower side rail (near the door) was up rather than the lower side rail near the window. Initially, the resident did not complain of pain, however upon rising he/she was not able to bear weight. Staff B stated Resident #4 fell between his/her bed and window and always attempted to climb out of bed on that side. The intervention implemented was to raise the lower side rail near the window because that was the side Resident #4 attempted to climb out of. Staff B had observed Resident #4 attempt to climb out of bed between the upper and lower side rail before. On 6/21/16 at 1:35 p.m. the Director of Nursing stated three side rails were to be up, two on top and the lower side rail near the window. The lower side rail provided a boundary after Resident #4 fell between the bed and window. The raised side rail was effective because he/she did not try			F 279			

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F 279	Continued From page 4			F 279			
F 323	to climb out after raised.			F 323			
SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES						
	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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide Resident #4 with adequate supervision and assistive devices to prevent an accident which resulted in a fractured hip. The sample consisted of 5 residents and the facility reported a census of 45 residents. Findings include: Resident #4 had a Minimum Data Set (MDS) assessment, with a reference date of 3/23/16. The MDS indicated the resident had short and long term memory problems and severely impaired cognitively. The MDS indicated the resident experienced signs and symptoms of inattention and disorganized thinking. The resident required extensive assistance of one staff for mobility, dressing, toileting and hygiene. A balance during transitions and walking test identified the resident as not steady and only to stabilize with staff assistance when walking, moving from seated to standing position, and surface to surface transfers.						

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F 323	Continued From page 5 The clinical record Face Sheet identified the resident had diagnoses that included: anxiety, diabetes, postural kyphosis, history of falling and unspecified lack of coordination with abnormalities of gait and mobility. The resident had 1 fall with no injury since the prior assessment. Review of the Fall Risk Assessment dated 5/19/16 identified the resident scored a 16 on the assessment scale. A score of 10 or above represented the resident at a high risk for falling. The Care Plan, target date 6/12/16, identified the resident at risk for falls with interventions that included: utilize a bed alarm, chair alarm, and baby monitor. The alarms were to be placed up and out of reach so audible. The falls Care Plan directed both top side rails up and one lower rail up while in bed. The Care Plan did not indicate which lower side rail to be in a raised position. The Side Rail Rationale Screen, dated 3/23/16, indicated three (3) side rails were used, two top rails and one bottom rail. A fall incident report dated 6/9/16 at 10:50 p.m. reflected Staff G, certified nursing assistant (CNA), discovered Resident #4 lying on the floor between his/her roommate's walker. A Fall Investigation for CNAs, dated 6/9/16, indicated at the time of the fall, the left side rail was up instead of the right side rail. The contributing factors could have been hallucinations and wearing no gripper socks. At 11:25 a.m. on 6/9/16, the nurse notified the physician. The physician informed the nurse to	F 323			

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F 323	Continued From page 6 call him if pain worsens to the right leg or if the resident would stop weight bearing on the right leg for a new order. The Nurse ' s Notes dated 6/10/16 at 2:15 a.m. indicated the staff attempted to stand the resident and the resident had no weight bearing on the right leg. The note indicated the resident had vocalized pain since 11:00 p.m. with attempts to stand or roll the resident. The resident cried but no tears. The nurse administered antianxiety medication. The physician was notified and ordered the resident sent to the emergency room for an evaluation. The Nurse ' s Notes indicated the resident returned to the facility at 5:10 a.m. on 6/10/16. The hospital discharge instructions indicated an x-ray of the right hip, femur and pelvis indicated no fractures seen. At 8:35 a.m. on 6/10/16, the physician notified the facility that the resident had a fractured hip and to transfer back to the hospital. The ambulance arrived at 8:45 a.m. and transported the resident to the hospital. The note indicated the resident had not had pain until moved. An x-ray report dated 6/10/16 reflected the resident sustained a subcapital fracture seen with impaction (right hip fracture). The Resident Assessment Data Collection/initial Care Plan indicated the resident returned from the hospital on 6/13/16 at 2:30 p.m. The note indicated the resident had a dressing on the incision (repair of hip) along the lateral side of the right hip.			F 323			

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F 323	Continued From page 7 On 6/21/16 at 1:44 p.m. Staff G, CNA, was interviewed and stated she walked by Resident #4's room and observed him/her standing beside a walker. She did not hear an alarm, and then observed the alarm "stuffed" under blankets. She encouraged the resident lie down in bed and did not toilet the resident. Staff G stated she observed three side rails up, the upper side rails and the lower side rail. Staff G indicated the lower side rail near the door was up, and then indicated it was the lower side rail near the window. Staff G was aware Resident #4 climbed out both sides of the end of the bed. Staff G stated when the resident fell, she noted the alarms were placed under blankets again. On 6/23/16 at 1:00 p.m. Staff H, CNA was interviewed and stated he assisted Resident #4 to bed prior to the fall. Staff H stated he put the top two side rails up and the left, lower side rail up (door side) on the bed. Staff H stated he was not aware the right lower side rail (window side) was to be up. Staff H stated he went to break at approximately 12:00 a.m. and noted Resident #4 was awake and lying in bed. Upon return from break he observed the resident sitting beside the walker and complained of leg pain. Staff B, licensed practical nurse (LPN), informed him the right lower side rail (window side) was to be up because Resident #4 tried to climb out of the right side of bed. Staff H stated the head set directed three side rails were used but did not indicate which three. Facility staff now places a piece of paper on the head of the bed to indicate which specific side rails are to be up. On 6/22/16 at 3:13 p.m. Staff B, LPN, observed Staff G exit Resident #4's room approximately 10 minutes prior to the fall. Staff B heard the	F 323			

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F 323	Continued From page 8 resident's alarm sound, but thought Staff G was with Resident #4 because typically, she doesn't turn off the alarm while in the room with the resident. She heard Staff G ask the resident why he/she was on the floor. Upon entry to the resident's room, she observed Resident #4 on the floor between his/her roommates walker. The side rails at the head of the bed were up and the left lower side rail (near the door) was up rather than the lower side rail near the window. Initially, the resident did not complain of pain, however upon rising he/she was not able to bear weight. Staff B stated Resident #4 fell between his/her bed and window and always attempted to climb out of bed on that side. The intervention implemented was to raise the lower side rail near the window because that was the side Resident #4 attempted to climb out of. Staff B had observed Resident #4 attempt to climb out of bed between the upper and lower side rail before. On 6/21/16 at 1:35 p.m. the Director of Nursing stated three side rails were to be up, two on top and the lower side rail near the window. The lower side rail provided a boundary after Resident #4 fell between the bed and window. The raised side rail was effective because he/she did not try to climb out after raised.	F 323			

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 conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and/or state law.

Regarding F279: The care plan for resident #4 was revised related to the specific side rail placement. All other resident care plans will be reviewed and updated for specific side rail placement. To be completed July 18, 2016. DON and MDS nurse to monitor weekly for three months.

Regarding F323 58.28(3)e 58.20 (4): The facility will ensure residents environment remains free of hazards and will provide adequate supervision and assistive devices as needed, to prevent accidents. All supervision and assistive devices are in place for resident #4. All other resident assistive and safety devices were reviewed for adequate supervision to prevent accidents. Completed July 14, 2016. DON and charge nurse monitor weekly for three months.