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	165156	A. BUILDING _____ B. WING _____	C 01/03/2017

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FORT DODGE HEALTH AND REHABILITATION	728 14TH AVENUE NORTH FORT DODGE, IA 50501

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F 000	INITIAL COMMENTS Deficiency identified during investigation of self report 64508-M.	F 000	This plan of correction constitutes my written credible allegation of compliance. Correction date 01//20/2017r all Tag F 323 as listed. The response or providers plan of correction contained herein shall not be considered to be or construed as an admission of the validity of the citation or alleged deficiency to which it is addressed.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure that the resident environment remained as free of accident hazards as possible; and each resident received adequate supervision to prevent	F 323	Correction date: Jan. 20th, 2017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra K Koenig	Administrator	01/23/2017

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 323	Continued From page 1 accidents for 1 of 1 resident reviewed for accidents. Resident #13 admitted to the facility 10/1/16 and had 11 falls from admission until 12/22/16; with the fall on 12/22/16 resulted in fracture. Facility census was forty-eight (48) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 10/12/16 and 11/18/16 assessed Resident #13 with a brief interview for mental status (BIMS) score of "12" (moderate cognitive impairment). The MDS revealed the resident admitted to the facility on 10/1/16 from "other". The resident had no behavior symptoms including rejection of care. The resident required extensive assistance of staff with bed mobility, transfers, ambulation in room, dressing, toileting, personal hygiene and bathing. A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize with staff assistance. The resident used a walker and wheelchair for mobility. The 11/18/16 MDS revealed the resident was frequently incontinent of bowel and bladder. According to the MDS the facility did not try a scheduled toileting or prompted toileting program for the resident. The resident had diagnoses that included: dementia, cognitive communication deficit and difficulty walking. The 11/18/16 MDS identified the resident with 2 or more falls since the prior assessment. Nursing progress (NP) notes dated 10/1/16 at 11:51 a.m. revealed the resident admitted to the facility with physical therapy (PT) and occupational therapy (OT) orders.	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS SUPERVISION/DEVICES. Resident #13 and all residents of Fort Dodge Health and Rehabilitation shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. Staff were educated by the Administrator and designee's on the following educational information on 01/20/2017. FALL PREVENTION •Residents who are identified as fall risk and need assistance to transfer, are to be offered assistance to the toilet after every meal. •Residents who are fall risk and has a history of falls while attempting to transfer self are not to be left unattended in their rooms unless they have been assisted to the toilet and back to their usual chair or bed after meals. •One staff person is to stay in the dining room while other staff are assisting residents out of the dining room after meals until all residents have left the dining room. •At least one CNA is to be assigned to monitor the resident rooms during meals so that they are available to answer call lights and monitor that residents who require assistance to transfer are not attempting to transfer unassisted.	

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F 323	Continued From page 2 An OT discharge summary identified the resident started OT on 10/4/16 and ended 11/18/16. OT documented the resident had poor insight into balance deficits which put the resident at risk for falls without CGA (contact guard assistance) and verbal cues for safe and efficient use of a front wheeled walker (FWW). The resident required assistance with pants over ankles and verbal cues for safety and physical assistance with balance in bringing pants over hips. The resident is at risk for fall without physical support by staff. The resident reached maximum rehab potential due to decreased cognition and balance deficits. The discharge recommendations were: "toileting schedule". A PT discharge summary identified the resident started PT on 10/5/16 and ended 11/18/16. PT discharge recommendation was for one staff to assist the resident with transfers and daily ambulation. The current care plan contained a problem dated 10/3/16 of with the resident being at risk for ADL (activities of daily living) self-care performance deficit related to disease process of Parkinson ' s disease. The care plan contained interventions dated 10/3/16 that directed staff to provide standby assistance for transfers and standby assistance and one staff with dressing. There were no toileting interventions until 10/5/16 when the care plan directed staff to toilet the resident every 1.5 hours. The care plan also identified on 10/3/16 the resident as at risk for falls related to gait and balance problems related to Parkinson ' s disease. 1). Fall NP notes dated 12/22/16 at 1:45 p.m.	F 323	To further enhance Fall Prevention education, an additional online education has been made available for Nurses and C.N.A's to complete in the month of January. The additional 30 minute training on the Prevention of Falls contains the following education: A.) What Causes Falls B.) Fall Risk Assessment C.) Fall Prevention Program D.) Post Fall Assessment E.) Conclusion/Test The Interdisciplinary Team will review falls daily, attempt to determine root cause and add appropriate preventative measures to the plan of care. This will continue on an ongoing basis. The Director of Nursing and or designee will Continue to monitor falls monthly through the facility Quality Assurance Program and assess the need for new systems on a monthly process. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	

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identified an unwitnessed fall in the bathroom. Staff found the resident on the floor with the right leg bent at the knee ad under the resident's body. The resident's right ankle was painful to the touch, swollen and bruised. Staff phoned and faxed the physician's office. On the same date at 7:13 p.m. the facility had not heard back from the physician. NP notes dated 12/23/16 at 2:41 a.m. revealed the resident activated the call light at 10 p.m. and complained of increased pain. The resident identified the pain as 10/10 on a scale of 0 to 10 with 10 being the worst imaginable pain. The resident stated he/she wanted to go to the hospital. At 10:30 p.m. staff notified the resident's responsible party of the resident's request. At 10:55 p.m. the facility informed the physician who stated the resident could transfer to the ER for evaluation. At 11:37 p.m. the resident loaded in the ambulance and transferred to ER. At 1:50 a.m. the resident returned to the facility with right tibia fracture and ordered for Tramadol (narcotic) 50 mg. every 4 hours as needed for pain.

An IR dated 12/22/16 at 6:42 p.m. revealed an unwitnessed fall in the resident's bathroom. On 12/23/16 the director of nursing (DON) added the intervention of "keep resident out of room when not in recliner or bed" (The resident already had the intervention of do not leave resident in room in wheelchair on intervention was already in place 10/18/16).

An investigation dated 12/22/16 at 1:45 p.m. revealed Staff A (registered nurse) saw the resident on the dining room 5 minutes prior to the fall. Staff A identified checked "yes' that staff followed the toilet plan and that staff toileted the resident before lunch. The resident did not use the call light.

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F 323	Continued From page 4 On 12/27/16 at 9:38 p.m. Staff A RN stated she just saw the resident coming down the hall in his/her wheelchair. She went to give a medication and when she came back the DON was in the resident's room and the resident was on the floor. 3 staff got the resident out of the bathroom. She stated she was not familiar with staff names so she was not sure who the CNA was. Staff A stated the resident was wheeling in the direction of his/her room when she last saw the resident but the resident's door was shut was she didn't think the resident would go in there. She stated there were no other staff in the dining room at the time because they were taking residents back to their rooms after lunch. She stated she estimated the resident was alone for only 3 minutes. She stated the resident forgets and does not remember he/she can ' t toilet self. On 12/27/16 at 5:40 p.m. the DON stated she walked by the resident's room and saw the resident on the floor. She stated staff was in the dining room but no one saw the resident go in his/her room. She stated the resident moved to that room with the intent for more supervision. The resident used to be at the end of the hall. On 1/3/17 at 10:53 p.m. Staff E CNA stated she was on the resident's hall that day. She heard a page from the DON and entered the resident's room. She observed the resident on the floor in the bathroom with his/her foot twisted around. She stated she did not see the resident go to his/her room because she was in another room repositioning a resident. She stated she tried to keep the resident out of his/her room most of the day by redirecting him/her.	F 323		

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A radiology report dated 12/23/16 identified the resident slipped while trying to stand around 2 p.m.. The resident had generalized right ankle pain with lateral bruising. The x-ray identified a comminuted mildly displaced fracture of the distal fibula at the level of the ankle joint. An after visit summary identified the diagnosis as "broken ankle".

NP notes dated 12/23/16 at 12 p.m. revealed the resident returned from the physician. The resident was nonweightbearing to right lower leg. Staff was directed to keep the new splint on and not remove it.

A major injury determination form dated 12/23/16 at 1 p.m. revealed the injury sustained was not a major injury.

2). Fall NP notes dated 12/19/16 at 11:49 a.m. revealed staff observed the resident laying on the floor on the left side with feet at the base of the stool and upper half of the body out into the room. The resident's knee was by the door jam. Staff did not observe injury. The resident identified self as going to the bathroom and fell off the stool. An IR dated 12/19/16 at 3:55 p.m. revealed an unwitnessed fall in the resident's bathroom. The resident toileted self.
An investigation form dated 12/19/16 at 3:55 p.m. identified staff took the resident to the front 10 minutes prior to the fall. The area for "toileting plan" indicated N/A (not applicable). The investigation did not identify when staff last toileted the resident. The resident did not use the call light. The area for "toileting plan" indicated N/A (not applicable) The investigation did not identify when staff last toileted the resident. The care plan did not identify a new intervention

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following the incident other than to say the resident started on antibiotics on 12/15/16 for UTI.
NP notes dated 12/15/16 at 7:14 p.m. revealed the physician ordered Bactrim DS (antibiotic) 800/160 mg. twice a day for 7 days to treat urinary tract infection (UTI).

NP notes dated 12/17/16 at 6:03 a.m. and 1:31 p.m. identified the resident with intermittent confusion

NP notes dated 12/14/16 at 7:54 p.m. revealed the physician ordered Levaquin (antibiotic) 500 milligrams (mg.) daily for 7 days, a chest x-ray and Albuterol nebulizer treatments for wheezing.

NP notes dated 12/8/16 at 8:07 a.m. revealed the resident self transferred into the bathroom. Staff reminded the resident to use the call light.

NP notes dated 12/11/16 at 3:22 p.m. identified increased confusion. The resident forgot recent past and wanted to go to the hospital out the front door.

3). Fall NP notes dated 11/28/16 at 10:30 a.m. revealed staff went to the resident's room to answer the call light and found the resident on the floor at the foot of the recliner. The resident slid out of the recliner when he/she tried to get up to go to the bathroom. NP notes dated 11/29/16 at 6:49 a.m. revealed staff would move the resident to a new room with increased visual observance. An IR dated 11/28/16 at 10:30 a.m. revealed an unwitnessed fall in the resident's room. An investigation dated 11/28/16 at 10:30 p.m. The investigation identified staff last saw the resident at 10 p.m. The investigation did not identify what

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staff did or what the status of the resident was at that time. The resident tried to use the walker when the fall occurred. The investigation identified "yes" when asked if staff followed the toileting plan.

On 12/28/16 at 4:27 p.m. the Administrator emailed the surveyor to clarify the time of the incident on 11/28/16 as 10:30 p.m. The Administrator stated the nurse did not put it in military time.

NP notes did not identify the actual date or time of the room change. However NP notes dated 11/30/16 at 2:46 p.m. revealed the resident adapted well to the room change.

Past history of falls/interventions:

NP notes dated 11/13/16 at 1:42 a.m. identified the resident with difficulty repositioning on memory foam mattress. NP notes dated 11/15/16 at 5:08 a.m. identified the resident in a hospital bed.

4). Fall NP notes dated 11/10/16 at 7:06 p.m. revealed the resident fell. An IR dated 11/10/16 at 4:40 p.m. revealed an unwitnessed fall in the resident's room. Staff found the resident on the floor when staff went to get the resident for supper. The IR identified the resident ambulated without assistance. An investigation dated 11/10/16 at 4:40 p.m. identified staff peeked in on the resident 10 minutes earlier and observed the resident in the recliner. The resident did not use the call light and didn't remember what he/she tried to do. The area for "toileting plan" indicated N/A (not applicable) The investigation did not identify when staff last toileted the resident. The

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F 323	Continued From page 8 care plan contained an addendum dated 11/10/16 that identified the resident received a hospital bed and staff rearranged the room. On 12/27/16 at 9:38 p.m. Staff A RN (registered nurse) identified herself as the nurse when the 11/10/16 incident occurred. She stated the resident was in the recliner prior to the incident and that he/she had the recliner controller. Staff A stated the resident could get the recliner high enough so he/she could step out of the recliner. She stated the resident was trying to reach his/her walker but it was out of reach. NP notes dated 10/25/16 at 5:42 a.m. revealed the resident was noncompliant with the call light and staff caught the resident ambulating to the bathroom without assistance twice that shift. NP notes dated 10/24/16 at 2:49 p.m. identified staff would toilet the resident hourly. NP notes dated 10/23/16 at 6:50 p.m. revealed staff checked on the resident and found the resident in the process of taking self off the toilet. Staff educated the resident about safety issues. 5). Fall NP notes dated 10/23/16 at 10:55 a.m. revealed staff found the resident sitting on the floor next to the bed with legs crossed under the resident, arms at side. Two staff assisted the resident into the wheelchair. The resident identified self as going to the bathroom when the fall occurred. The NP note identified that staff would try a hospital bed for the resident because he/she had trouble getting in and out of bed. Staff education provided on answering the call light as soon as possible. An IR dated 10/23/16 at 10:45 a.m. identified an unwitnessed fall in the	F 323		

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resident's room. The resident activated the call light prior to the fall. An investigation dated 10/23/16 at 10:45 a.m. did not identify when staff last saw the resident other than staff toileted the resident after breakfast. The investigation was checked "yes" when asked if staff followed the toilet plan. The resident did not have shoes on.

NP notes dated 10/23/16 at 5:28 a.m. revealed the resident continued to self-transfer.

NP notes dated 6:21 p.m. contained a late entry for 10/22/16 (no time given). The NP notes identified the resident continued to self transfer.

NP notes dated 10/22/16 at 3:12 p.m. revealed staff caught the resident self transferring to the bathroom. Staff reminded the resident to ask for help.

6). Fall NP notes dated 10/20/16 at 9:45 p.m. revealed staff observed the resident in the prone position on the floor with legs straight back and arms bent at the side. Staff observed the left chair in the high position. Staff removed the recliner controller at that time. NP notes dated 10/21/16 at 9:30 a.m. identified staff unplugged the lift chair. An IR dated 10/20/16 at 9:45 p.m. revealed an unwitnessed fall in the resident's room. The resident did not use the call light and was trying to get to the bathroom. The IR identified the resident ambulated without assistance. An investigation dated 10/20/16 at 9:40 p.m. identified the resident did not wait for assistance and did not use the call light. The resident was seen 10 minutes before the incident when staff attempted to assist the resident with bedtime care but the resident refused. The area for "toileting plan" indicated N/A (not applicable)

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F 323	Continued From page 10 The care plan did not contain an intervention to ensure staff unplug the recliner. The Kardex directed staff to keep controller away from the resident. On 12/29/16 at 4:22 p.m. Staff C RN stated she thought the resident raised the recliner and slid out. 7). Fall NP notes dated 10/18/16 at 5 p.m. revealed staff found the resident lying on the floor on his/her back. The resident stated he/she hit their head. An IR dated 10/18/16 at 6:33 p.m. revealed an unwitnessed fall in the resident's room. The resident identified self standing up from the wheelchair and when he/she sat back down, the wheelchair went out from under the resident. An investigation dated 10/18/16 at 5 p.m. identified staff saw the resident 10 minutes prior to the fall. Nothing was documented in the area that identified what staff did with or for the resident when last seen. The resident did not activate the call light. The area identifying whether staff followed the toilet plan was blank. Staff checked "yes" in the area asking whether there was evidence the resident toileted self or was incontinent. An entry dated 10/18/16 at 7:52 p.m. revealed staff observed a bruise to the top back of the resident's head by the intact staples. The entry also identified that an intervention after the incident was "hipster pads". A late entry dated 10/18/16 at 8:50 p.m. identified staff tightened the resident's wheelchair brakes following the incident and directed staff not to leave the resident in his/her room in the wheelchair. The care plan did not contain the intervention to not leave the resident in his/her room in wheelchair.	F 323		

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F 323	Continued From page 11 The Kardex did contain the intervention and also identified the wheelchair brakes were tightened/repaired. NP notes dated 10/19/16 at 3:29 p.m. revealed staff removed 17 staples from the scalp laceration. On 12/20/16 at 12 p.m. Staff D RN stated she did not recall if there was a problem with the wheelchair brakes or if the resident didn't lock them. She stated the resident was incontinent at the time of the incident. She stated the resident had a recliner that he/she lifted up and then would try to self-transfer independently. 8). Fall NP notes dated 10/11/16 at 11 p.m. revealed staff observed the resident laying sideways on the floor in front of the recliner with walker nearby. The call light was not activated. The resident sustained a v-shaped scalp laceration measuring 3 centimeters (cm.) by 2.5 cm.) to the back of the head on the right side. Staff notified the physician who directed staff to send the resident to the emergency room (ER) for evaluation. NP notes dated 10/12/16 at 12:20 a.m. revealed ER called and reported a CT (computerized tomography) scan was negative and the resident received 15 staples to the back of the head. They would be sending the resident back to the facility. The resident returned to the facility at 1 a.m. with a dry dressing covering the wound on the back of the head. NP notes dated 10/12/16 at 4 p.m. revealed the resident complained of headache throughout the day. The staples and bandage contained a moderate amount of dried blood. The resident self transferred once that day. An IR dated 10/11/16 at 11 a.m. revealed an unwitnessed fall in the	F 323		

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	165156	A. BUILDING _____ B. WING _____	C 01/03/2017

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F 323	Continued From page 12	F 323		

resident's room. The resident ambulated without assistance. An investigation dated 10/11/16 at 11 p.m. stated it appeared the resident fell asleep in the recliner and slid out. The resident was seen 30 minutes prior to the fall. Nothing was documented in the area that identified what staff did with or for the resident when last seen. The resident did not activate the call light. The investigation identified the resident as independent in the resident's room. The area for "toileting plan" indicated N/A (not applicable) NP notes dated 10/13/16 at 9:23 a.m. revealed staff added Dycem (nonskid mat) to the resident's recliner. The care plan did not contain the Dycem intervention. The Kardex did contain the Dycem intervention.

On 12/29/16 at 4:22 p.m. Staff C RN (registered nurse) stated she initially thought the resident tried to walk per self. After she finished taking care of the resident and the resident's injury, she went back to the room and observed the recliner in a raised high position. Staff C thought the resident raised the recliner up with the controller and slid out. She stated didn't think the resident could be independent in room at that time but needed to check the care plan to be sure. She stated she wrote N/A by toilet schedule because she needed to check with the CNA. She stated the resident would not wait for help.

9). Fall NP notes dated 10/10/16 at 10:50 p.m. revealed staff found the resident on the floor next to the sink laying on the left side with his/her head laying against the bathroom floor. Three staff assisted the resident up from the floor. Staff instructed the resident to wear the correct shoe size. An IR dated 10/11/16 at 5:05 a.m. identified an unwitnessed fall in the resident's room. The

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resident stated he/she attempted to go to bed from the recliner the resident used the wheeled walker without assistance and wore improper footwear. In the "other information" section of the IR, the nurse documented that the resident's shoes don't fit and the resident needs to call for assistance. The resident needs a hospital bed instead of a regular bed because the mattress sinks down too much. An investigation dated 10/10/16 identified the resident did not use the call light and DID use the walker when the fall occurred. The area indicating whether a toilet plan was followed, staff checked N/A (not applicable) Staff saw the resident one hour and 20 minutes before the fall. At that time the resident sat in the recliner. NP notes dated 10/11/16 at 5:11 p.m. identified the intervention following the fall was to keep the walker close to the resident at all times due to the resident's self transfers to make the resident as safe as possible. (The resident fell using the walker.)

10). Fall NP notes dated 10/4/16 at 10:31 p.m. revealed the resident stated he/she took self to the bathroom and when he/she took slippers off to apply a new brief, he/she slipped and bumped his/her head on the wall. An incident report (IR) dated 10/4/16 at 9:40 p.m. revealed an unwitnessed fall in the resident's bathroom. Staff found the resident sitting on the bathroom floor with arms at sides and knees bent with legs out in front of the resident. The resident ambulated without assistance and wore improper footwear. According to the facility investigation form, staff toileted the resident 20 minutes prior to the fall. The investigation stated the call light was on but that the resident activated it after the fall. NP notes dated 10/5/16 at 4:38 p.m. identified staff would assist the resident to the bathroom every

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F 323	Continued From page 14 1.5 hours. The resident did not sustain injury. (The resident self transferred and fell 20 minutes after toileting so lengthening toileting to 1.5 hours not effective.) 11). Fall NP notes dated 10/3/16 at 4:40 a.m., revealed staff observed the resident laying supine on the floor between the bed and wheelchair with legs bent at the knees and arms at his/her side. The resident identified self as transferring from bed to wheelchair and then losing his/her balance. The resident did not sustain injury. After the fall, the care plan revealed staff would order PT/OT evaluation and treatment per orders. (Already ordered on 10/1/16) An incident report (IR) dated 10/3/16 at 440 a.m. revealed an unwitnessed fall in the resident room. The resident did not sustain injury. The investigation identified the resident did not use the call light and the resident attempted to self-transfer when the fall occurred. Staff saw the resident one hour and 10 minutes before the fall when they passed ice water and emptied the urinal. NP notes dated 10/2/16 at 10:30 a.m. revealed one staff assisted the resident with walking and toileting. Observation On 12/27/16 at 3:13 p.m. observation showed the resident in a wheelchair with the right lower extremity resting in a half splint wrapped with an ace wrap on an elevated leg extender. The resident identified the leg as sore. The resident stated he/she did not know what happened to the leg. At that time, the OT asked the resident if he/she remembered going to the hospital. The resident replied no and then asked, "Did I go to the hospital?" On the same date at 5:20 p.m.	F 323		

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F 323	Continued From page 15 observation showed the resident in the dining room for supper. At that time, the surveyor asked Staff B CNA when the resident last used the toilet. Staff B stated she toileted the resident at 2 p.m. and 4:30 p.m. Staff B stated the resident was on a 2 hour bathroom schedule.	F 323		