STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165298	A. BUILDING _____ B. WING _____	C 02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE SPECIALTY CARE	1223 PRAIRIE ROAD CEDAR FALLS, IA 50613

(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 KK 2/23/17	INITIAL COMMENTS Correction date 2/22/17 The following deficiency relates to the investigation of incident #65491. (See code of Federal Regulations (45 CFR) Part 483, Subpart B-C). Complaint #64491 was not substantiated.	F 000		
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	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/23/2017

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 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and interviews, the facility failed to provide adequate supervision to protect against hazards for one (1) of four (4) residents at risk for falls (Resident #1). The facility reported a census of 83 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 1/20/2017, Resident #1 had modified independence with daily decision making and no long or short term memory impairment. The resident required limited assistance of one staff to transfer from one surface to another, ambulate, and to dress. The MDS revealed the resident had diagnoses including wound infection, dementia and hypertension and a fall without injury since admission on 1/13/2017. The Physician's Orders included orders for Coumadin 3 milligrams (anticoagulation therapy) every day dated 1/16/2017. The Fall Risk Assessment dated 1/13/2017 revealed Resident #1 had a high fall risk. The initial, temporary Care Plan directed staff to assist Resident #1 with transfers and ambulation with the use of two staff and a gait belt, walker and wheel chair. The care plan indicated the resident sustained a fall on 1/16/2017 and to directed staff to apply bed, pressure and tab alarms; discontinued on 1/23/2017. Interventions were added on 1/18/2017 to included: check approximately every	F 323		

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F 323	Continued From page 2 two hours and as needed, keep door open and may get details mixed up due to dementia. On 1/22/2017 the resident sustained a fall and staff transferred the resident to the emergency room for evaluation. The Nurse's Notes dated 1/13/2017 revealed Resident #1 admitted for palliative care with diagnoses including cellulitis and Atrial Fibrillation with anticoagulation therapy. The resident had orders for physical and occupational therapy, answered some questions appropriately, poor historian and had an indwelling Foley catheter. The Nurse's Notes 1/16/2017, staff found the resident next to the bed with a skin tear that measured 6 cm (centimeters) by 4 cm. Staff applied treatment and dressing to the wound. Incident Report dated 1/16/2017 revealed staff found Resident #1 lying next to the bed at 3:30 a.m.. The resident sustained a skin tear to the right upper arm. Staff dressed the wound and indicated they added a pressure bed alarm. The 200 Wing Siderail and Alarm Checklist revealed Resident #1 had a pressure alarm and tab alarm in bed on 1/22/2017. The Incident Report dated 1/22/2017 revealed staff found Resident #1 at 1:30 a.m. lying face down on the floor between the bed and chair, noted bleeding to the left side of his/her face and right hand. Staff transferred the resident to the emergency room. Added 1/22/2017 - to emergency room. On 1/23/2017 - bed in lowest positron when in bed, move furniture away from bed, room move closer to desk, bolster mattress, discontinue air	F 323		

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F 323	Continued From page 3 loss mattress. The Nurse's Notes dated 1/22/2017 at 2:00 a.m., revealed staff found the resident lying face down on the floor between the bed and chair, bleeding noted to right hand and left side of face and bilateral shoulders. The resident stated he/she rolled out of bed. Staff notified the physician and sent the resident to the emergency room. At 5:00 a.m. the Notes indicated the resident admitted to the Intensive Care Unit for a head bleed. A review of the Hospital Records included: admission on 1/22/2017, discharged on 1/26/2017. The emergency room (ER) report revealed the resident had extensive areas of ecchymosis scattered over the body, skin tears noted on some extremities. The resident had facial laceration on the left orbital rim into the eyebrow noted. The resident had a lower lip laceration and soft tissue swelling noted on the forehead. The assessment revealed traumatic intraparenchymal hemorrhage, without loss of consciousness, lip laceration, face lacerations and the resident would be admitted. The computed tomography (CT) examination of the resident's head on 1/22/2017 revealed Hyperattenuation (blood buildup) left frontal lobe likely indicating a small amount of hemorrhage. The Hospital Discharge Summary revealed the resident had recently discharged from the hospital after being admitted for multiple skin ulcers/cellulitis; and then sent to skilled care the nursing home. The resident fell from the bed on 1/21/2017 and hit his/her head, brought to the	F 323		

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F 323	Continued From page 4 hospital where he/she was found to have a left frontal lobe hemorrhage. The resident had been admitted to neurosurgical service for intracranial bleed management. The resident's INR (international normalized ration) reversed with the patient and vitamin K, acute kidney injury, laceration on lower lip sutured in the emergency room, seen and followed by neurosurgery, no surgical intervention, patient transferred to hospitalist services. The resident had an abnormal urinalysis and antibiotics were administered. The principal diagnosis listed traumatic cerebral intraparenchymal hemorrhage. The resident would return to the skilled nursing facility. On 1/23/2017, the care plan directed staff to keep all furniture away from head of bed. The resident had a low loss air mattress discontinued on 1/23/2017. On 1/23/2017 the Care Plan added a bolster mattress to the bed, move closer to the nurse's station, mat on floor on both sides of the bed and bed in lowest position. On 1/23/2017 at 11:00 a.m. staff spoke to the resident's family member and discussed removing the air mattress and changing it to a bolster mattress for safety. Family agreed to move the resident closer to the nurse's station upon return from the hospital. Staff also moved the chair in the room away from the bed. Physician progress note dated 2/1/2017 at facility. Follow up regarding increased respiratory problems with low oxygen saturation and congestion. Started on Doxycycline yesterday, and give three doses of Lasix for three days due to bilateral pleural effusions probable pneumonia.	F 323		

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F 323	Continued From page 5 Lung sounds coarse throughout. Cautiously treating pneumonia due to chronic kidney disease, eats and drinks poorly. Staff discussed hospice services with family. On 2/3/2017, staff noted the resident had diminished lung sounds bilateral bases, Oxygen saturation at 95% with oxygen, unable to take temperature due to resident breathing with mouth wide open. Observation on 2/3/2017 at 9:30 a.m. revealed Resident #1 in a low bed with a concave mattress and a blue mat beside the bed. The resident, on his/her back, appeared calm and had oxygen per nasal cannula and a Foley catheter. The resident had eyes open but failed to respond to questions. The DON (Director of Nursing) indicated the resident's family currently considered hospice. On 2/3/2017 the Care Plan added: bed up against the wall. On 2/4/2017 at 9:20 a.m., the Notes indicated the resident ate very little with assistance, took medication with applesauce and staff re positioned every two hours. At 8:20 p.m. the resident passed away, found unresponsive by CNA. During an interview on 2/3/17 at 3 p.m., the DON revealed on 1/26/2017, Resident #1 returned from the hospital and they were told the resident had a small bleed. The resident also had facial laceration. After the fall, they discontinued the alarms. The resident failed to progress in therapy and had dementia. After the resident fell, the DON measured the bed frame at 28 inches above the floor. At the time of the fall, staff reported that Resident #1 had only the pressure	F 323		

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F 323	Continued From page 6 alarm on the bed which failed to sound. Staff failed to apply the TAB alarm. On 2/8/2017 at 3:35 p.m. the surveyor measured bed height with the DON and observed: Bed frame to floor measured 12 inches if in the lowest position. A regular mattress measured approximately 6 inches and an air loss mattress measured 8 inches. During an interview on 2/8/2017 at 3:10 p.m., the Nurse Practitioner revealed the cause of death certificate had not yet been completed, and Resident #1 had failure to thrive along with multiple diagnoses. The fall with the head bleed altered the resident's mental status. The Nurse Practitioner indicated he/she could not verify that the fall on 1/22/2017 led to the resident's death on 2/4/2017. The facility investigation included a statement from witness, Staff A, CNA (Certified Nurse's Aide) by phone and documented by the DON (Director of Nursing). Staff A indicated he/she changed the resident's incontinent brief at approximately 1 o'clock a.m. on 1/22/2017. Staff A revealed the resident had a bed alarm on when he/she left the resident. Twenty minutes later the resident yelled and Staff A found the resident laying on the floor. The resident indicated he/she rolled out of bed and hit the chair next to the bed. Staff A indicated the bed alarm failed to sound but worked when he/she checked it after the fall. The bed measured approximately 2 feet from the bed. Staff A could not be reached for an in person interview during the investigation. During an interview on 2/8/2017 at 2:10 p.m.,	F 323		

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F 323	Continued From page 7 Staff B, LPN (Licensed Practical Nurse) indicated he/she worked at the time of Resident #1's fall on 1/22/2017. The resident had an air mattress with a pressure alarm over it, the resident failed to have a TAB alarm at the time of the fall. When the resident fell from the bed, the pressure alarm failed to sound but knew the alarm functioned prior to the fall when checked earlier in the day. After the resident fell, Staff B observed the bed failed to be in the lowest position, but at regular height of approximately 29 inches. Staff A told Staff B that he/she changed the resident prior to the fall and failed to lower the bed, though he/she never reported why. When Staff B checked the pressure alarm, it failed to function the first time but did function with the second check. The resident reported rolling out of bed. Staff B worked the evening the resident passed away. The resident had been declining, the resident remained in bed and refused supper. At 8:20 p.m. staff found the resident passed away and staff notified family. During an interview on 2/8/2017 at 3:00 p.m., Staff C, RN revealed on 1/16/2017, Staff added a TAB and pressure alarm to Resident #1's bed. The resident had no chair alarms. On 1/23/2017 staff discontinued the TAB alarm and on 1/25/2017 they discontinued all alarms. When the resident fell from the bed on 1/22/2017, he/she should have had a pressure alarm and a TAB alarm.	F 323		

F000 Please accept this as the facility's credible allegation of compliance as of February 22, 2017 for F323.

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 the federal and state law.

F323

Staff has been educated on an immediate intervention of placing bed in the lowest position and placing a floor mat next to the bed following a resident fall out of bed.

Staff has been educated on ensuring proper alarms are in place and are functioning however; as of February 9, 2017 the facility has been alarm free.

100% audit of air mattresses has been completed to ensure they are properly inflated and residents are not sliding out of their beds.

Nursing management staff will complete audits as needed to assure compliance. The QA committee will determine the need for continuation of such audits.