STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165197	A. BUILDING _____ B. WING _____	C 05/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET 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	INITIAL COMMENTS VKK 5/24/17 Correction date 5-10-17 The following deficiencies relate to the investigation of incident #67256, #67592 & #67593 and complaint #67755. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000	See attached.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	05/23/2017

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 157	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on clinical record review, family and staff interview, the facility failed to notify one residents family of a fall in a timely manner. (Resident #2) The facility census was sixty (60) residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/27/17, documented Resident #2 required extensive staff assistance with bed mobility, transfers, walking in room and corridor, dressing and toileting and utilized a walker or wheelchair for mobility. Progress notes dated 3/30/17 at 2:10 a.m., revealed staff found the resident laying on his/her back on the floor next to the dresser. The resident had no complaints of pain and the	F 157		

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F 157	Continued From page 2 assessment did not show abnormality. Two staff got the resident up from the floor and assisted the resident to the bathroom and back to bed. A fall report dated 3/30/17 at 1:52 a.m., revealed Staff D, licensed practical nurse, LPN documented the resident's responsible party was notified on 3/30/17 at 2:09 a.m. However during interview on 5/3/17 at 5:43 a.m., Staff D stated she did not notify the family and the documentation of notification was to indicate the family would be notified. Staff D stated the only contact information available was an email and there was no phone number on the face sheet. On 5/8/17 at 2:35 p.m., the resident's responsible party stated she was not notified of the resident's fall on 3/30/17 by either phone or email and would want notification.	F 157		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident, family, physician and staff interview, the facility failed to follow physician orders for two of five residents reviewed. The facility census was 60 residents. Findings include:	F 281		

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F 281	Continued From page 3 1. Admission orders identified Resident #2 was admitted to the facility on 3/20/17. Signed medication orders dated 3/21/17, revealed the resident had an order for B12 1000 units daily at bedtime. Review of the resident's March 2017 and April 2017, medication administration record (MAR) revealed staff administered the B12 twice a day. On 5/3/17 at 1:53 p.m., the director of nursing stated 2 nurses double check orders. One of the orders was for B12 and the other order was for cyanocobalamin. The nurse did not realize they were the same drug. 2. The Minimum Data Set (MDS) assessment dated 1/13/17, documented Resident #6 required extensive staff assistance with bed mobility and toileting and had diagnoses that included quadriplegia and psychotic disorder. A physician order dated 3/7/17, revealed the ARNP (advanced registered nurse practitioner) ordered Haldol (antipsychotic) 2 milligrams (mg.) every morning and 5 mg at bedtime "if OK with daughter". On 3/8/17 at 4:53 p.m., the care plan nurse spoke with the resident's daughter about behaviors and new orders for Haldol to assist with behaviors. The daughter stated she would discuss it with the resident and call back tomorrow about the medication. The progress notes did not contain any documentation after 3/8/17. Review of the resident's March 2017 medication administration record (MAR) revealed the	F 281		

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F 281	Continued From page 4	F 281		

resident received the first dose of Haldol on 3/8/17 at bedtime. The resident continued with Haldol 2 mg in the morning and 5 mg at night until 3/24/17, when the dosage was cut to 2 mg twice a day for 5 days and then stop.

On 5/3/17 at 2:00 p.m., the resident's daughter stated the facility contacted her about the Haldol at the beginning of March and she told the facility "no". She stated she first spoke with the MDS/care plan nurse and informed her, she wanted to speak with the resident first. The daughter called the facility and spoke with Staff K, licensed practical nurse and told Staff K she did not want the resident to take Haldol.

On 5/8/17 at 1:26 p.m., Staff K, LPN confirmed the resident's daughter phoned and said she did not want the resident to take Haldol. Staff K informed the ADON (assistant director of nursing) about the phone call.

On 5/2/17 at 6:55 a.m., the DON stated the resident's responsible party said no to using the drug and it should not have been entered into the computer. Because it was entered in the computer, the pharmacy brought it and staff administered it. The resident took the drug about 3 weeks and the Ombudsmen said the resident lost the use of the left hand but it was very limited before. However the resident said he/she could no longer use the phone.

On 5/4/17 at 3:11 p.m., the physician stated they did not think the residents decline was due to the Haldol because the resident had "very little function anyway".

Observation on 5/2/17 at 12:08 p.m. , revealed

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F 281	Continued From page 5 the resident was assisted with the meal by therapy. The resident used a curved fork with built up handle and was able to slowly spear food items and get them to his/her mouth. At that time, the resident stated he/she was doing better because he/she could now get the food on the utensil.	F 281		
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 record review, physician and staff	F 323		

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F 323	Continued From page 6 interviews, the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 of 5 residents. Resident #2, with cognitive impairment, admitted to the facility from home with a history of falls prior to admission. Staff interviews revealed Resident #2 was known to not wait for staff assistance or reliably use the call light. The resident fell 3/30/17. Staff documented the intervention to the fall as "education" and screen for therapy. The resident was cognitively not able to retain the education provided and the facility did not carry out the therapy screen. On 4/3/17 the resident fell sustaining intracranial hemorrhage (brain bleed) and fractured clavicle. The resident returned the facility on Hospice and expired 4/12/17. Resident #3, with cognitive impairment, had a history of multiple falls and non-cooperative with waiting for staff assistance and/or call light use. On 3/2/17 the resident fell unwitnessed and staff educated the resident to wait for assistance and to use the call light. The facility evaluated the resident room and the resident did not want to change any arrangement in the room. There was no intervention put in place following the incident. On 4/10/17 the resident fell unwitnessed during the night and sustained a fractured right hip. The facility implemented a night light and asked the resident's family to take some things from the room. The care plan did not reflect an increase in supervision for the resident. After the resident returned to the facility on 4/14/17, Resident #3 had an unwitnessed fall on 4/20/17 during the night and the facility staff did not conduct neurological checks. Later on 4/20/17 the resident's family requested Hospice and the resident expired 4/24/17. The facility identified a census of sixty (60) residents.	F 323		

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F 323	Continued From page 7 Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 3/27/17, assessed Resident #2 with a Brief Interview for Mental Status (BIMS) score of "4" (severe cognitive impairment). The resident admitted to the facility on 3/20/17 from the community. The resident had hallucinations and physical behavior symptoms 1 to 3 days out of 7. The resident did not reject care or wander. The resident required extensive staff assistance with bed mobility, transfers, walking in room and corridor, dressing and toileting. The resident used a walker or wheelchair for mobility. A "balance during transitions and walking" test identified the resident as unsteady and only able to stabilize with staff assistance. The resident was occasionally incontinent of bowel and had a urinary indwelling catheter. The resident had diagnoses that included: hypertension, diabetes mellitus and Parkinson's disease. The MDS did not identify falls since admission. The resident used an antidepressant daily. A falls CAA (care area worksheet) dated 3/30/17 revealed the resident had a history of falls. The resident required assistance with all ADLs (activities of daily living) and used a 4 wheel walker for ambulation and transferring short distances. The resident used a wheelchair for longer distances. The resident had dementia but had the ability to use the call light. The CAA identified that staff should assure the wheelchair and walker brakes were set prior to transfers. Staff should provide proper fitting and nonskid shoes while in the wheelchair and when ambulating. Provide safe, uncluttered, dry floors and good lighting in the room. An undated Kardex care plan identified the resident required staff	F 323		

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F 323	Continued From page 8 assistance of one with mobility and transfers. A siderail screen assessment dated 3/20/17 identified the resident as a fall risk. A care plan dated 3/20/17 revealed the resident needed staff assistance for mobility and transfers and assist for toileting and transfers PRN. On 5/2/17 at 11:20 a.m. the care plan nurse stated she wrote it that way because the resident used a catheter. The care plan identified on 3/30/17 that staff educated the resident following the 3/30/17 fall. There was no other interventions on the care plan following the 3/30/17 fall. Progress notes dated 3/20/17 at 1:45 p.m. revealed the resident arrived at the facility via private vehicle. Progress notes dated 3/21/17 at 7:57 p.m. revealed one staff assisted the resident with gait belt and wheeled walker for ambulation. Progress notes dated 3/22/17 at 8:10 p.m. revealed one staff assisted the resident with transfers and ADLs. Progress notes dated 3/30/17 at 2:10 a.m. revealed staff found the resident laying on his/her back on the floor next to the dresser. The resident had no complaints of pain and assessment did not show abnormality. Two staff got the resident up from the floor and assisted the resident to the bathroom and then back to bed. On the same date at 11:32 p.m. staff transferred the resident with one staff and the walker as usual. A fall report dated 3/30/17 at 1:52 a.m. revealed	F 323		

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F 323	Continued From page 9	F 323		

staff found the resident laying on his/her back next to the dresser. The resident did not sustain injury and staff assisted the resident to the bathroom. The immediate action taken was " assisted resident to the bathroom and then to bed. Will get orders for therapy to screen". The form revealed the precipitating factors were gait imbalance, and ambulating without assistance.

Progress notes dated 4/3/17 at 9:38 p.m. revealed staff found the resident lying on the floor on his/her right side next to the bathroom door. The resident's glasses were off his/her face and the resident's head laid on top of the glasses. The resident complained of right hip pain. On the same date at 7:57 p.m. the emergency room (ER) called and stated the resident admitted to the hospital with a brain bleed.

A fall report dated 4/3/17 at 9:22 p.m. revealed the resident had increased confusion. Staff found the resident on the floor laying on the right side next to the bathroom door. The resident laid on top of his/her glasses and complained of right hip pain. Staff called the ambulance. The form identified the precipitating factors as confusion, gait imbalance, impaired memory and ambulating without assistance.

An emergency department nursing assessment dated 4/3/17 with ER arrival time of 6:51 p.m. revealed the resident had pain and swelling over the right orbit (eye) with a large area of ecchymosis noted over the area. There was pain and swelling over the posterior occipital scalp. There was no active bleeding. The resident responded to verbal stimuli but speech was slurred and garbled. The resident had difficulty understanding and following verbal commands.

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The report identified the ER physician spoke with the facility nurse and who informed the physician that staff last saw the resident between 5:30 p.m. and 5:50 p.m. The resident fell in the room unwitnessed onto the right side. The resident complained of right hip pain and broke his/her glasses. This was the second fall in the last 30 days since resident arrived at the nursing home. The resident took baby aspirin as a blood thinner.

The emergency department chart dated 4/3/17 at 7:05 p.m. identified the resident with a fractured clavicle and traumatic intracranial subarachnoid hemorrhage. A hospital history and physical, dated 4/3/17 identified the resident admitted to the intensive care unit (ICU). The consultation report dated 4/4/17 documented the CT scan (computer tomography) of the resident's head showed a small amount of acute subarachnoid hemorrhage with a small acute subdural hemorrhage overlying the anterior left frontal lobe measuring 2.5 centimeters (cm) and 3 millimeters (mm) in thickness.

A transfer form dated 4/5/17 revealed the resident returned to the facility on with Hospice to follow and comfort measures.

Nursing progress notes identified the resident continued to decline after readmission to the nursing home and expired on 4/12/17 at 3:50 a.m.

A death certificate identified the time and date of death as 4/12/17 at 3:50 a.m. The manner of death was "accident". The immediate cause of death was cardiac arrhythmia due to hypertension with other significant conditions of: subdural bleed due to recent fall, Parkinson's disease, diabetes

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F 323	Continued From page 11 mellitus and colon cancer remote. Staff Interviews: Staff that worked when the fall occurred: On 5/3/17 at 10:21 a.m. Staff A RN (registered nurse) stated she went down the hall and when she walked by the resident's room, she observed the resident on the floor laying on their right side. She called for help and stayed with the resident until help arrived. The resident complained of pain when touched so staff called 911. Staff A stated the resident was supposed to have assistance ambulating but the resident would get up and walk by self at times. The resident did not always use the call light. It was not activated at the time of the fall. Staff A stated the resident's responsible party informed the facility of the resident's falls at home when admitted to the facility. On 5/2/17 at 1:38 p.m. Staff B CNA (certified nurse aide) stated the resident needed assistance but he/she would try and do things on their own. The resident would get up per self a couple times a shift to use the bathroom for bowel movements. She stated staff was just in the resident's room with a food tray prior to the incident and the resident appeared confused. The resident was pretty good about using the call light and appeared steady on his/her feet when he/she paid attention. When the resident got distracted, then he/she would get unsteady. On 5/2/17 at 5:15 a.m. Staff D LPN (licensed practical nurse) stated she came on duty and had not taken over the shift yet when they found the resident on the floor. Staff A found the resident.	F 323		

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Staff D stated the resident was noncompliant. The resident didn't wait or use the call light. In response to that, staff just counseled the resident and gave the resident reminders. On 3/30/17 the resident fell on the way to the bathroom so after staff got the resident up from the floor, they assisted the resident to the bathroom. Staff D stated staff isn't sure where the resident tried to go when he/she fell on 4/3/17. They found the resident parallel to the wall in the same direction as the bathroom with the head to the hallway and feet by the bathroom. The resident's glasses were smashed and the resident had a black eye. They sent the resident to the hospital right away.

On 4/27/17 at 2 p.m. Staff E CNA stated she was getting ready to leave on 4/3/17 when she heard Staff A yell. She grabbed the vitals cart and went to the resident's room and the resident was on the floor. The resident laid by the bathroom door. She stated the resident thought he/she needed the bathroom and would try to go by self a lot. Staff E would catch the resident going by self to the bathroom 3 to 4 times a shift. The resident needed help due to unsteadiness. The resident would not use the call light. She stated when she asked the resident if he/she needed anything, the resident would never request the bathroom and then shortly after that, the resident would go by self to the bathroom.

On 4/27/17 at 1:05 p.m. Staff F RN stated she was giving report when Staff A found the resident on the floor. The bathroom door was wide open. Staff F stated she was in the resident's room at 5:15 p.m. to check the resident's blood sugar. Staff F stated she thought the resident was a "1 assist". The call light was not activated. After the incident, Staff F found out the resident still

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CEDAR FALLS HEALTH CARE CENTER	1726 WEST EIGHTH STREET CEDAR FALLS, IA 50613

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F 323	Continued From page 13 thought he/she needed to urinate and would keep trying to go the bathroom. The resident used a Foley catheter. The resident was not consistent with call light use or waiting for help. On 4/27/17 at 1:47 p.m. Staff G CNA stated she was in the front of the building when the resident fell. The resident required 1 to 2 staff to assist with ambulation. The resident would sometimes try to self transfer. The resident was good about using the call light. They always walked the resident with 2 staff because the resident leaned when walking. Other staff: On 5/2/17 at 6:25 a.m. Staff C CNA stated the resident would sometimes use the call light and sometimes would not use the call light. Sometimes when going down the hall, staff would catch the resident standing up by self. The resident was not always steady on feet. On 5/2/17 at 6:55 a.m. the Director of Nursing (DON) stated the resident required assistance of one staff for transfers and ambulation. The DON stated she educated the resident on falls and use of the call light. She stated the intervention following the 3/30/17 fall was to educate the resident. They planned to do a therapy screen on Monday 4/3/17 but they couldn't get insurance verification until Monday so the screen was not done. Some staff said the resident used the call light frequently and other staff said he/she did not but staff would sometimes catch the resident halfway to the bathroom. The DON stated staff just did the normal supervision on the resident by looking in when going by the room. They did not have the	F 323		

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F 323	Continued From page 14	F 323		

resident on a toileting plan since the resident used an indwelling urinary catheter. When the second fall occurred, the resident was off balance from the prior fall.

On 5/2/17 at 5:50 a.m. Staff I (CNA) stated she was told in report (before the resident's falls) that the resident was independent.

2. A MDS with assessment reference date of 2/8/17, assessed Resident # 3 with a BIMS score of "11" (moderate cognitive impairment). The MDS identified the resident as independent with transfers and toileting and needed supervision with ambulation. A "balance during transitions and walking" test revealed the resident with a score of "1" in all areas of testing. A score of '1" identified the resident as not steady but able to stabilize without staff assistance. The resident used a wheelchair for mobility. The resident was continent of bowel and bladder. The resident had diagnoses that included: dementia and Parkinson's disease. The resident had 2 falls without injury since the prior assessment.

A self care deficit care problem with initiation date of 4/5/15 revealed the resident required assistance if one staff with transfers, ambulation, toileting, dressing and showers as resident allowed. An intervention dated 11/8/16 revealed the resident frequently took self to the bathroom, transferred and ambulated in room by self and refused to use the call light for assistance. A care plan with problem initiation date of 3/26/15 revealed the resident was at risk for falls. An intervention dated 3/24/16 identified the resident as noncompliant with using call light when needing assistance.

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F 323	Continued From page 15 History of falls and self transfers: An incident report dated 12/6/16 at 4:45 a.m. revealed staff responded to a call light and found the resident sitting on his/her buttocks at the bedside. The resident denied injury. The report and care plan did not identify an intervention after the incident. An incident report dated 12/7/16 at 11 p.m. revealed staff found the resident sitting on the floor onto his/her bottom. The resident claimed he/she slid off the bed. The resident did not sustain injury. The care plan identified staff initiated assist bars on the right side of the bed on 12/13/16. An incident report dated 1/7/17 at 3 p.m. revealed the resident sat at the side of the bed and slid off to the floor. The resident did not sustain injury. The care plan identified staff initiated a scoop mattress on 1/16/17. An incident report dated 2/6/17 at 9:45 p.m. revealed staff found the resident seated on the floor in front of the wheelchair. The resident tried to get something from his/her new fridge. The resident did not sustain injury. The care plan updated 2/7/17 identified staff asked the resident's family to provide a table for the fridge to sit on to elevate to a safer level for easier access. An incident report dated 2/27/17 at 10:30 a.m. revealed staff found the resident lying on his/her left side between the bed and TV stand. The	F 323		

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resident's head was towards the foot of the bed and legs pointed toward the head board. The resident tried to walk to his/her wheelchair from the bathroom. The resident did not sustain injury. The incident report identified that staff educated the resident on the importance of using the call light. On 2/28/17 the physician ordered lactaid (for milk intolerance) for the resident's diarrhea to decrease bathroom urgency/need.

An incident report dated 3/2/17 at 6:30 a.m. revealed staff observed the resident sitting by his/her bed. The resident stated he/she slid from the wheelchair. The report identified the resident as incontinent and ambulating without assistance. The resident did not sustain injury. The report identified staff educated the resident on using the call light and getting assistance before transferring. Staff assessed the resident's room and the resident declined to make any changes in room arrangement. The care plan did not reflect a new intervention in response to the incident.

(The care plan contained an intervention, dated 8/5/15 to toilet the resident every two hours.) The incident report dated 3/2/17 did not identify when staff last toileted the resident.

Progress notes identified the resident was hospitalized from 4/3/17 to 4/8/17 with atrial fibrillation and congestive heart failure. After return to the facility the resident returned to ER (emergency room) twice that day finally returning on 4/9/17 at 6:17 p.m.

An incident report dated 4/10/17 at 1 a.m. revealed staff found the resident laying on his/her back next to the closet. The resident stated he/she hit the back of the head hard on the floor.

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F 323	Continued From page 17 The resident complained of back, neck, lower back and leg pain. The resident stated he/she tried to get to the bathroom. The resident transferred to the emergency room (ER). The report identified the facility would call the family and ask them to remove some items from the resident's room and provide a night light. The incident report did not identify when staff last tolleted the resident. An ER note, dated 4/10/17 revealed history was obtained from the resident who had a history of dementia. The resident denied hitting their head. The resident fell trying to get out of bed and no complains of right leg pain. The ER discharge identified the resident with a closed fracture of the hip. The resident admitted to medical/surgical. The ER non-portable report dated 4/10/17 identified Resident #3 had a right intertrochanteric hip fracture. A transfer form identified the date of transfer as 4/14/17 back to the facility for skilled services following ORIF for right hip fracture. A physician visit note dated 4/18/17 revealed the ARNP (advanced registered nurse practitioner) stated the resident was in a lot of pain following right hip fracture. The ARNP added additional pain medication for the resident's pain. The ARNP documented no concerns with the resident's respiratory status. On 5/2/17 at 5:15 a.m. Staff D LPN stated she worked when the resident fell on 4/10/17. Staff D found the resident on the floor when she did rounds. Staff D stated staff checked the resident every 2 hours. If the resident got up by self, staff	F 323		

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would counsel the resident on the need to use the call light and wait for help. Staff D asked the resident if anything hurt. They rolled the resident to his/her back and the resident screamed in pain. The call light was not activated. Staff D called the doctor and the resident went to ER. She didn't know when staff last checked the resident. She assumed it was at 10 p.m. or 10:30 p.m. The resident just went downhill after the hip fracture.

An incident report dated 4/20/17 at 2:13 a.m. staff found the resident laying on the left side on the floor with head and shoulders under the bed and legs extended towards the sink. The resident did not sustain injury. The resident stated he/she was looking for "red" and denied hitting his/her head. The intervention was for staff to check on the resident at the end of first rounds.

The progress notes dated 4/20/17 at 2:23 a.m., revealed Resident # 3 was found lying on his/her left side on the floor with his/her head and shoulders under the bed (by the foot of the bed); and his/her legs were extended out towards the sink. Staff documented the resident denied hitting his/her head and staff assessed the resident. The resident then tried to climb/pull curtains off the wall. Staff notified the nurse manager.

At the time of the 4/20/17 fall the resident received Eliquis (anticoagulant) 5 milligrams (mg.) twice a day.

Facility policy identified staff should conduct neurological (neuro) checks if there was suspected head injury. On 5/3/17 at 12:50 p.m. the DON stated staff did not conduct neuro checks following the 4/20/17 fall. She stated head

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injury was not suspected.

On 4/20/17 at 11:13 a.m. the resident's family requested a Hospice consultation. On 4/20/17 at 5:04 p.m. the resident appeared very lethargic, restless and confused. The resident admitted to Hospice. The resident continued to decline and expired on 4/24/17 at 7:20 a.m.

On 5/4/17 at 3:11 p.m. the resident's physician stated the facility should perform neuro checks after any falls especially an unwitnessed fall. She stated she completed the resident death certificate and thought she identified COPD as the cause of death. .

Additional Interviews:

On 5/2/17 at 6:15 a.m. Staff J CNA stated she heard the resident yell for help and found the resident on the floor on his/her side by the closet. Staff J guessed the resident planned to go to the bathroom. The resident stated he/she tried to get up. Staff J stated she checked the resident on rounds at midnight and the resident didn't need anything. The resident is not supposed to transfer per self. The resident wasn't good about using the call light and would get up without help.

On 5/3/17 at 10:21 a.m. Staff A RN stated the resident got up all the time by self to the toilet and did not use the call light.

On 4/27/17 at 2 p.m. Staff E CNA stated the resident rarely ever waited for help or used the call light. Staff E stated she would catch the resident in the bathroom. The resident also self transferred from bed to wheelchair and wheelchair to bathroom. The resident would get

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F 323	Continued From page 20 unsteady. Staff would offer to help the resident but the resident declined help. On 5/1/17 at 2:50 p.m. Staff H CNA stated Resident #3 was independent with transfers. On 4/27/17 at 10:25 a.m. the care plan nurse stated the resident would not use the call light and did attempt to self transfer. The care plan reflected this. The resident was supposed to have assistance. On 5/2/17 at 5:50 a.m., Staff I CNA stated sometimes the resident was totally independent and other nights the resident was total care.	F 323		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types	F 353		

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F 353	Continued From page 21 of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, the facility failed answer resident call lights in a timely manner in order to meet resident needs for three of five residents reviewed. (Resident #10, #11 & #7) The facility census was 60 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/22/17, documented Resident #10 had a brief interview for mental status (BIMS) score of	F 353		

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F 353	Continued From page 22 15, indicating intact cognition. The resident required extensive assistance for bathing, bed mobility and transfers. The care plan contained a problem dated 2/2/17, of self care deficit related to pain, right above the knee amputation, left knee replacement, history of skin ulcers, activity intolerance, and frequent refusals to get out of bed. On 5/8/17 at 3:38 p.m., the resident stated he/she did not get 2 baths a week and would take them if offered. Review of the resident's April 2017 and May 2017 bath schedule revealed the resident received baths on 4/5/17, 4/12/17, 4/15/17, 4/26/17 and 5/3/17. The resident stated the week of 4/24/17, the call light was on for an hour. The resident monitored the time with the TV. 2. The MDS assessment dated 3/8/17, documented Resident #11 had a BIMS score of 13, indicating intact cognition and required extensive assistance with toileting and hygiene and total assistance with baths. The resident was always incontinent of bowel and frequently incontinent of bladder. On 5/8/17 at 3:45 p.m., the resident stated the call light was on for an hour during the week of 4/24/17. The resident stated he/she wore a watch. The resident stated he/she was lucky to get one bath a week and would take more if offered. Review of the resident's April 2017 and May 2017 bath schedule revealed the resident received baths on 4/1/17, 4/5/17, 4/12/17, 4/15/17, 4/29/17 and 5/3/17. 3. The MDS assessment dated 3/8/17,	F 353		

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F 353	Continued From page 23 documented Resident #7 had a BIMS score of 15, indicating intact cognition and required limited assistance with bed mobility, transfers, dressing and ambulation in room. The resident required extensive staff assistance with toileting and bathing. The care plan identified the resident with a self care deficit related to spina bifida and limited mobility, An intervention dated 4/5/16 revealed one staff assisted the resident with bathing and staff should allow the resident to so as much of the bath as possible. On 4/27/17 at 2:40 p.m., the resident stated he/she did not receive 2 baths a week and would take them if offered. Review of the April 2017 and May 2017, bathing records revealed the resident received baths on the following dates: 4/13/17, 4/17/17, 4/20/17, 4/27/17 with no baths documented after 4/27/17. (The resident went to the hospital on 5/5/17) During interview on 5/8/17 at 5:00 p.m., when asked why residents were not getting baths, the director of nursing stated she would need to check into it but staff did not always document the baths correctly and residents also refused. Resident council minutes dated 2/8/17, identified call light concerns. Resident council minutes dated 1/18/17, addressed call light and bathing concerns.	F 353		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law.

Date of compliance 5-10-2017

F157 It is the practice of Cedar Falls Health Care Center to notify resident representative of falls in a timely manner.

1. Resident number #2 no longer resides in facility, no further action necessary.
2. For similar residents, progress notes were reviewed by the Assistant Director of Nursing on 5-10-2017 any concerns identified were addressed. An in-service for nurses regarding notification requirements was completed on 5-10-17.
3. The Director of Nursing or designee will conduct audits of notification requirements a minimum of 3 times per week for 3 months to ensure compliance.
4. DON or designee will report progress to QAPI committee for minimum of three months to assure on going compliance.

F281 It is the practice of Cedar Falls Health Care Center to follow physician orders.

1. Resident #6 the provider addressed the Haldol medication prior to survey, no further action was necessary. For resident #2 the provider had already addressed the B12 medication prior to survey, no further action necessary.
2. For similar residents, an in-service for nurses was completed on 5-10-17 regarding physician order compliance.
3. The Director of Nursing or designee will audit physician orders a minimum of three times a week. Any concerns identified will be addressed.
4. The Director of Nursing or designee will report progress to QAPI committee for minimum of three months to assure ongoing compliance.

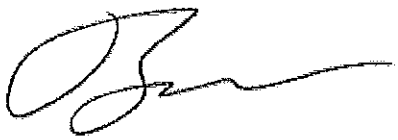
F323 It is the practice of Cedar Falls Health Care Center to ensure residents received adequate supervision to prevent accidents.

1. Resident #2 and #3 no longer reside in facility, no further action necessary.
2. For similar residents, an in-service for staff was completed on 5-10-17 regarding falls, interventions and proper assessments.
3. The Director of Nursing and Intradisciplinary Team will review any falls during morning meetings to ensure appropriate interventions and documentation are in place.
4. The Director of Nursing or designee will report progress to QAPI committee for a minimum of three months to ensure ongoing compliance.

F353 It is the practice of Cedar Falls Health Care Center to ensure that call lights are answered in a timely manner and baths or showers

1. For residents #10, #11 and #7, an in-service was held on 5-10-2017 to reeducate staff on timely response to call-lights and bathing requirements.
2. For similar residents, an in-service was held on 5-10-2017 to reeducate staff on timely response to call-lights and bathing requirements.

3. The Administrator or designee will perform call light audits a minimum of 5 times per week. Any concerns identified will be addressed. The Administrator or designee will randomly interview residents a minimum of 5 times per week to evaluate call-light response times. Any concerns identified will be addressed. The Director of Nursing or designee will audit bathing a minimum of 3 times per week to ensure compliance. Any concerns identified will be addressed.
4. The Administrator and Director of Nursing or designee(s) will report progress to QAPI committee for a minimum of three months to ensure ongoing compliance.



DEPARTMENT OF INSPECTIONS AND APPEALS

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CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

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C 139	50.7(1)a(2) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(1) Of any accident causing major injury. a. "Major injury"shall be defined as any injury which: (2) Requires admission to a higher level of care for treatment, other than for observation; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report a major injury that resulted in fracture and admission to the hospital as required per Chapter 50.7(1)a(2) for 1 of 5 fractures reviewed. According to physical therapy discharge summaries dated 7/20/16 and 2/24/17 Resident #4 required supervision with standing activities, contact guard assistance (CGA) with ambulation and standby assistance (SBA) for transfers. The care plan in place when the fall/fracture occurred, reflected the resident as independent in room. On 3/7/17 the resident fell and sustained a fracture and was admitted to the hospital for treatment. Facility census was sixty (60) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 12/6/16, assessed Resident #4 with a brief interview for mental status (BIMS) score of "14" (no cognitive impairment). The MDS	C 139	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0708	A. BUILDING: _____ B. WING _____	C 05/09/2017

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C 139	Continued From page 1 identified the resident required supervision of one staff with bed mobility, transfers and ambulation in room. The resident required limited staff assistance with toileting. The resident was incontinent of bladder. The resident had 2 falls since the previous assessment. One with injury and one without injury. A "balance during transitions and walking" test revealed the resident as not steady but able to stabilize without staff assistance in all areas of testing. The resident had diagnoses that included: dementia. A physical therapy (PT) discharge summary with end of care date 2/24/17 revealed the resident could walk with assistive device and contact guard assistance (CGA). The resident required stand by assistance (SBA) with transfers. A care plan with initiation date of 12/26/14 identified the resident with a self care deficit related to incontinence, risk for skin alteration and osteoarthritis. An intervention dated 7/20/16 identified the resident could be independent in room and facility for ambulation. Another intervention dated 10/15/15 revealed the resident was independent in the facility with a walker. An incident report dated 3/7/17 at 2:20 p.m. revealed staff observed the resident laying on the bathroom floor on the left side with head towards the toilet. The resident stated he/she attempted to go to the bathroom but slid. The resident complained of pain so staff called 911. The ambulance arrived and transported the resident to the hospital. A hospital history and physical dated 3/7/17 revealed the resident had a history and of stroke with gait ataxia. The resident ambulated minimally with a walker and was not supposed to	C 139		

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C 139	Continued From page 2	C 139		

mobilize unsupervised. The resident walked by self to the bathroom for urinary urgency and fell landing on knees sustaining a distal femur fracture. The diagnoses included: mechanical fall and traumatic left distal femur, periprosthetic fracture.

A transfer form dated 3/11/17 revealed the resident underwent ORIF (open reduction and internal fixation) to repair the fracture on 3/8/17. The transfer form revealed the resident should wear an immobilizer to the left extremity at all times except for showers. Hospital progress notes dated 3/10/17 revealed the resident also suffered acute blood loss which would not be treated.

On 5/2/17 at 6:55 a.m., the DON stated the facility did not receive the 2/24/17 PT recommendations because PT never gave them to the facility. She stated the resident was independent in the room and staff encouraged the resident to ask for help.

On 5/3/17 at 2:53 p.m. the Physical Therapist stated she did not give the resident anything after PT discharge on 2/24/17 because nothing changed with the resident. No progress was made. The resident was always supposed to have CGA with ambulation and SBA with transfers. The resident required this level of assistance because the resident's need for assistance varied and he/she had weakness and frequent falls. Review of the previous PT/OT discharge summaries, dated 7/20/16 identified the resident required supervision with standing activities. On 5/8/17 at 2:07 p.m. the PT stated the resident needed supervision while standing so the resident would also need supervision with transfers and ambulation.

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C 139	Continued From page 3 A therapy status communication sheet dated 7/19/16 identified the resident could be independent in room and facility for ambulation. On 5/8/17 the Administrator stated the facility follows an accident/fall reporting flow sheet for guidelines on what to report to should report state agency. On 5/2/17 at 12:25 p.m. the DON stated the accident was not reported because the resident was independent. Progress notes dated 3/12/17 at 4 p.m. revealed the resident returned to the facility following hospitalization for surgical repair of hip fracture. Progress notes dated 3/31/17 the facility received an order for a Hospice evaluation. Progress notes dated 4/6/17 at 6 p.m. the resident expired. The death certificate revealed the resident expired 4/6/17 at 6:p.m. with the cause of death as accident. The immediate cause of death listed respiratory failure due to failure to thrive due to recent fractured femur.	C 139		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal law.

Date of compliance 5-10-2017

C 139 It is the practice of Cedar Falls Health Care Center to report major injury per Chapter 50.7(1)a(2).

1. Resident #4, she no longer resides in the facility and no further action necessary.
2. For similar residents, records were reviewed 5-10-2017, no other reporting requirement concerns were identified. An in-service was held with staff on 5-10-2017 regarding reporting requirements.
3. The Director of Nursing and Intradisciplinary Team will review any falls during morning meetings to ensure appropriate interventions and documentation are in place. The facility has a new Administrator effective, 3-31-2017 who monitors compliance with reporting requirements regularly.
4. The Administrator or designee will report compliance with this process to the QAPI committee for a minimum of 3 months to ensure compliance.