STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165529	A. BUILDING _____ B. WING _____	C 12/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM HEIGHTS CARE CENTER	1203 SOUTH ELM STREET SHENANDOAH, IA 51601

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F 000	INITIAL COMMENTS Correction date 1/7/18 Investigation of facility-reported incidents #71315-I and #72038-I resulted in the following deficiencies. See Code of Federal Regulations (42CFR), Part 483, Subpart B - C.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review and staff interviews, the facility failed to immediately separate a resident from the staff member she accused of physical abuse for 1 of 5 residents reviewed (Resident #1). The facility reported a census of 43 residents.	F 610		

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

Administrator 1/5/2018

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.

POC accepted 1/8/18 VS

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F 610	Continued From page 1 Findings include: The Minimum Data Set (MDS) assessment dated 7/18/17 recorded Resident #1 had diagnoses that included dementia and visual hallucinations. According to the BIMS (brief interview for mental status) test, Resident #1 had severe cognitive impairment as indicated by the score of 5 out of 15. The Care Plan dated 5/20/16 documented Resident #1 had moderately impaired cognitive function and had hallucinations in the past. The Care Plan also noted Resident #1 wandered daily and should be cued, reoriented and supervised as needed. A Progress Note dated 9/10/17 at 10:02 p.m. and authored by Staff E, LPN (Licensed Practical Nurse) recorded that earlier that evening, Resident #1 told kitchen staff that a CNA (certified nursing assistant) slapped her across the face and grabbed her arm and shook it. That kitchen employee informed Staff F who in turn spoke to the alleged perpetrator; Staff F, CNA. The alleged perpetrator denied slapping the resident and stated she tried to redirect Resident #1 from standing in another resident's doorway yelling at them. Staff E recorded she contacted the DON (Director of Nursing and told her she would assess the situation. The DON informed Staff E to call again if she had any concerns, which she did not. An interview on 12/12/17 at 12:03 p.m. with Staff H, Dietary Aid revealed that Staff G, Dietary Aid came to her and said Resident #1 told her a nurse slapped her face and grabbed her wrist at	F 610		

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F 610	Continued From page 2 about 7:30 or 8:00 p.m. Staff H said she called her boss for guidance about how to proceed. According to Staff H, her boss told her to tell the charge nurse, which she did. During interview on 12/12/17 at 2:35 p.m., Staff G stated that Resident #1 approached the kitchen window crying about 7:00 or 8:00 p.m. Staff H then went to speak with Resident #1. Staff G said Staff H asked Resident #1 what happened and she told them "a big lady that helped her put her pants on slapped her across the face." Staff G informed Staff F that Resident #1 said she hit her. Staff G said Resident #1 had been upset and her face was kind of red from being flustered, but she did not see any marks that seemed consistent with someone hitting her. An interview on 12/12/17 at 3:45 p.m. with Staff E revealed that Staff F approached her and said Resident #1 accused her of hitting her. Staff E said by the time she finished what she had been working on, Staff H had also approached her and said Resident #1 told her Staff F slapped her across the face. Staff E said she sought out Resident #1 and found her coming out of her room. Staff F asked her where she was going and Resident #1 told her she was looking for the other nurse so she could apologize to her for being mean to her. Staff E said to Resident #1 she thought Staff F had hit her and Resident #1 replied "she did." Staff E stated she spoke with and assessed the resident, but had not talked to any other staff members. Staff E stated she was very busy because of being the only nurse on duty, so she went to finish her medication pass because she felt like nothing happened. Staff E said they are supposed to separate the alleged perpetrator from the victim when suspected	F 610		

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F 610	Continued From page 3 abuse has been reported and then call the DON so they can do their investigation. She should have pulled Staff F away from Resident #1 and put someone else over there or called the DON back and informed her of everything she knew. An interview on 12/14/17 at 12:50 p.m. with the DON revealed she told Staff E to investigate Resident #1's allegations against Staff F and to call her if she had any concerns. The DON said she delegated the investigation to the LPN because it was not uncommon for Resident #1 to make accusations like that. The DON said Staff E had not called her back so she assumed Resident #1 that was one of those situations. The DON said she found it most concerning that dietary staff began to investigate it themselves before they reported what they knew to the charge nurse. According to the DON, their protocol directs the alleged perpetrator and victim should have been separated before a thorough investigation was completed. An interview on 12/18/17 at 3:45 p.m. with the Administrator revealed the DON and Social Worker reported the allegations to her the following day. Once they informed her, the Administrator said she believed it needed to be reported to the Department of Inspections and Appeals, which they did. When asked, the Administrator said the way Staff E handled it was not consistent with how she expected it to be handled. According to the Administrator, the alleged perpetrator and victim should have been immediately separated and the investigation should have been initiated. The Administrator expected staff to follow their policy as it is written, which they will do from that day forward. The Administrator said staff seemed to lack the	F 610		

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F 610	Continued From page 4 training they needed to implement the policy as it should have been. The Administrator said she expected everyone to take all allegations seriously. Point 8 of the facility's Abuse Investigations policy dated 3/30/06 instructed that facility employees who have been accused of resident abuse may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed.	F 610		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to provide adequate supervision to protect one (1) of three (3) residents from hazards (Resident #2). Record review revealed Resident #2 had dementia and required assistance with waking/transfers. On 10/5/17, staff failed to provide supervision and assistance with transfers/ambulation to Resident #2 when she attempted to stand and fell and fracturing her hip. Staff interviews revealed some staff were unaware Resident #2 was at risk for falls. The facility reported a census of forty three (43) residents.	F 689		

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F 689	Continued From page 5 Findings include: The Minimum Data Set (MDS) assessment dated 8/29/17 identified dementia and persistent mood disorder for Resident #2's diagnoses. The MDS assessment revealed Resident #2 required a walker and/or wheelchair for mobility. Resident #2's assessment identified she required staff assistance to stabilize her balance when walking or when moving from a seated to standing position. Resident #2 required extensive assistance of two staff for most ADLs (activities of daily living) including when transferring or walking. The MDS documented Resident #2 had at least one fall within the two to six month period before being admitted to the facility. According to the MDS, Resident #2 had both long and short term memory problems, inattention, severely impaired cognitive skills for daily decision making, sometimes understood others and they rarely understood her. The Care Plan dated 9/5/17 noted Resident #2 had dementia that affected her cognition, communication abilities, and she required assistance with making all decision. Her care plan revealed she required assistance of 1 to 2 staff and a gait belt when ambulating and for ADLs (including transferring). The 9/6/17 Care Plan indicated Resident #2 had been considered a high risk for falls related to 2 falls she had in July prior to admission. The Care Plan noted Resident #2 required 1 to 2 staff and a gait belt for transfers. The Care Plan also documented that Resident #2 sustained a fractured right hip as a result of a 10/6/17 fall. The Care Plan noted a new intervention (10/5/17) for staff not to leave Resident #2 unsupervised in the dining room.	F 689		

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F 689	Continued From page 6 The document titled "Morse Fall Scale" dated 8/24/17 revealed Resident #2 had been considered a high risk for falls based on the score of 105; (a score of 45 or higher identified the resident at High Risk for falls.) Resident #2's gait was described as weak, impaired when rising from chair, cannot walk unassisted. An Incident Review dated 9/26/17 at 4:00 p.m. identified a CNA (certified nurses' assistant) entered Resident #2's room and found her lying on the floor. According to the document, nobody witnessed the fall and noted Resident #2 had been confused/disoriented prior to the fall. The Nurses' Note for the above fall dated 9/26/17 at 4:30 p.m. indicated Resident #2 had been found lying on her side at the foot of her recliner. The foot rest was elevated and recliner tipped forward, appears the resident scooted forward in chair causing it to tip. An Incident Review dated 10/5/17 at 4:40 p.m. revealed a staff member found Resident #2 on "her bottom leaning over" in the dining room a few feet away from her wheelchair. The Review indicated nobody knew what happened or how the resident fell because nobody witnessed the fall. According to the document, Resident #2 had been alert, disoriented and on fall alert prior to the incident. According to the document, Resident #2 had been sent to ER for an evaluation per facility van. The nursing home received a call later stating resident had been admitted to the hospital for a right hip fracture. A Nurses' Note dated 10/5/17 at 5:17 p.m. indicated Resident #2 fell in the dining room.	F 689		

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F 689	Continued From page 7 According to the document, staff did not know what happened because nobody witnessed the fall and Resident #2 could not tell them what happened. The author noted Resident #2's ROM (range of motion) seemed normal so they transferred her into the wheelchair and transported her to the nurses' station for further evaluation. The nurse indicated Resident #2 started to show nonverbal signs of right knee pain with movement. A "Diagnostic Imaging Results Review" dated 10/5/17 at 7:22 p.m. indicated Resident #2 sustained a right hip fracture. The hospital report dated 10/6/17 revealed Resident #2 returned to the floor from surgery at 2:04 p.m., and her blood pressure began to drop, with blood pressure reading from 40-80/20-50. Resident #2 passed away on 10/6/17. An interview on 12/13/17 at 10:30 a.m. with Staff C, RN revealed she had been summoned to the dining room about 5:00 p.m. The RN said she saw Resident #2 lying on the floor with her head on someone's lap. Staff C said Resident #2 had been sitting at the table for supper, stood up and fell to her "bottom." The RN said she did not believe any staff members were actually in the dining room to see what happened. Staff C said Resident #2 was non-verbal and could not tell her what happened or if she had any pain. According to the RN, they transferred Resident #2 into the wheelchair after her assessment revealed the resident had normal ROM. Once they took her to the nurses' station and further assessed her, Staff C said Resident #2 started to grab one of her knees and nodded yes when the nurse asked her if she had pain. Staff C said they sent the resident	F 689		

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F 689	Continued From page 8 to ER because she also noticed redness and swelling in her knee. An interview on 12/13/17 at 10:40 a.m. with the Dietary Supervisor revealed that she and Staff B, Dietary Aid were in the kitchen. According to the supervisor, Staff B looked into the dining room from the kitchen window and said "I see feet". The Dietary Supervisor said they both went to the dining room and saw Resident #2 lying on the floor next to a different table than the one she usually sat at. The Supervisor said Resident #2's wheelchair remained at her usual table, so she assumed the resident had gotten up and fallen. The Dietary Supervisor said Resident #2's body was kind of twisted; lying on her back/right hip. The Dietary Supervisor said she put her hand under Resident #2's head to comfort/steady her head while someone else paged the nurse. The Supervisor said she had not noticed any apparent injuries. The Supervisor said she did not know how long Resident #2 had been in the dining room before she fell. The Dietary Supervisor said she really did not know who else was in the dining room because she primarily focused on Resident #2. The Supervisor said they would leave ambulatory residents unattended in the dining room, but now they try and have the dining room supervised whenever residents are in there. When asked, the Supervisor said Resident #2 had not been ambulatory before the incident. According to the Supervisor, dietary staff would only have known which residents were non ambulatory based on previous observations and how familiar they were with each resident. The Dietary Supervisor said they did not have a written policy about dining room supervision, but it is their protocol to supervise it now since Resident #2's fall with fracture. According to the	F 689		

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F 689	Continued From page 9 Supervisor, they never had any problems with anyone falling in the dining room prior to that. The Supervisor said she could not ensure resident safety when they are left unsupervised. According to the Dietary Supervisor, although they do their best to keep them safe, they cannot be by the residents' sides 24 hours a day and 7 days a week. An interview on 12/13/17 at 11:05 a.m. with Resident #5 revealed she had been in the dining room when Resident #2 fell. According to the resident, no staff members were supervising the dining room at the time when Resident #2 stood up from a seated position and fell very hard. An interview on 12/12/17 at 1:07 p.m. with Staff A, CNA revealed she saw Resident #2 lying on the floor with her head on Staff B, Dietary Aid's lap when she arrived to the dining room. Staff A said she did not think any staff members were present when the fall occurred. Staff A said they serve supper about 5:00 p.m. The CNA said she did not know what time Resident #2 arrived to the dining room, but she typically started transporting residents about 4:30 p.m. Staff A said she tried to bring the residents at risk for falling last so they were not left unsupervised for very long. Staff A admitted that she did not know Resident #2 was a fall risk. According to Staff A, they did not know if the resident hit her head because she could not say and nobody saw the fall. An interview on 12/14/17 at 10:20 a.m. with Staff D, CNA revealed what she understood about Resident #2's transfer status and the facility's policy on dining room supervision. Staff D said their policy is to not leave anyone in the dining room unsupervised if they are a known fall risk.	F 689		

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F 689	Continued From page 10 When asked how she knew which residents were fall risks, Staff D said those residents' rooms are labeled with a star on their door. Staff D said Resident #2 was not a fall risk as far as she knew. The CNA said she did not know that Resident #2 had fallen a couple times before being admitted to the facility. Staff D also denied knowing that Resident #2 had fallen in the facility another time before she fell and broke her hip. Staff D reported when they had transferred Resident #2 prior to this, she would not even stand with us (staff), or stand on her own. An interview on 12/14/17 at 11:05 a.m. with Staff B, revealed they start serving supper about 5:00 p.m. When asked, Staff B said the CNAs typically start transporting the residents to the dining room for supper about 4:30 p.m. Staff B said as far as she knew, they did not bring them in any particular order. The Dietary Aid said she did not know what time Resident #2 arrived to the dining room the night she fell and broke her hip. Staff B said other residents were in the dining room at the time of the fall, but she did not remember who. Staff B said she had been in the kitchen about 4:45 p.m. when she looked and saw someone's feet in a position that indicated they had fallen. Staff B said she and the Dietary Supervisor went into the dining room and saw Resident #2 lying on the floor. According to Staff B, the Dietary Supervisor went over and held Resident #2's hand and asked her if she was OK. Staff B said the resident shook her head yes. The Dietary Aid said she did not notice any signs of blood or other obvious signs of injury. When asked if the dining room was being supervised at the time of the fall, Staff B said she did not notice because she only focused on attending to	F 689		

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F 689	Continued From page 11 Resident #2's needs. Staff B said there are times when dietary staff supervises the residents. When asked, Staff B said she would not have known which residents were fall risks and which ones were not. Staff B said she assumed that anyone would be at risk of falling. Staff B said "I don't know" when asked how residents' safety could be ensured when they leave the dining room unsupervised. Staff B said she really did not know Resident #2, she only recognized her from meal service. The Dietary Aid said she had no idea whether or not Resident #2 had been a fall risk. According to Staff B, she did not know what the policy said about supervising the dining room before the incident. The Dietary Aid said the policy they implemented after Resident #2's fall indicates that someone should be supervising the residents in the dining room. An interview on 12/14/17 at 12:50 a.m. with the DON (director of nursing) revealed she did not know what time they took Resident #2 to the dining room or how long she went unsupervised before she fell and broke her hip. The DON said normally they took the residents to the dining room for supper between 4:30 and 5:00 p.m. The DON said Resident #2 might have had liquids already served to her, but most of the time she had to either be fed or have someone prompt her to eat. The DON said they did not have a dining room supervision protocol prior to this incident, but now someone has to be supervising the dining room whenever residents are in there.	F 689		

ELM HEIGHTS CARE CENTER

1203 South Elm Street
Shenandoah, Iowa 51601
712-246-4627 phone
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This facility denies that the alleged facts as set forth constitute a deficiency under interpretation of federal and state law. The preparation of the following plan of correction does not constitute and should not be interpreted as an admission of an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies.

F610
The facility will prevent further potential abuse, neglect, exploitation or mistreatment by immediately separating those involved and conduct a thorough investigation at the time of the alleged incident.

9-12-17 Updated Abuse, Prevention, Identification, Investigation and Reporting Policy

9-12-17 Social Worker began providing all staff education on updated policy with special emphasis on immediately separating those involved if witnessed or alleged report of abuse.

DON or designee will meet daily with charge nurse to ensure that any alleged incidents have been followed per policy-ongoing

Nurse educator will track compliance on all new hires as well as current employees for Mandatory Reporting certification-ongoing

To assure ongoing compliance- Education on the abuse policy will be included in the new hire orientation and biannually for all staff, including competency testing.

Corrected date: 1-7-2018

F689
The facility will ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision.

10-5-17 Department supervisors developed a schedule to ensure that the dining room will be supervised at all meal times.

11-1-17 Quality Assurance Coordinator implemented a Performance Improvement Plan (PIP) on fall prevention including Root Cause Analysis and PDSA (Plan, Do , Study, Act) with gap analysis.

12-17-17 Quality Assurance Coordinator implemented yellow stars for resident falls and all staff education done.

1-4-18 Updated Fall Policy

1-4-18 Administrator and Director of Nursing reviewed updated Fall Policy and provided staff education on how to identify those residents that are a moderate or high fall risk by placing a yellow ribbon on their walker and/or wheelchair on admission, quarterly and PRN.

To assure ongoing compliance- Education on fall prevention will be included in the new hire orientation and biannually for all staff, including competency testing. Systems review will be conducted daily by Administrator or DON through observation to ensure safety. Monthly safety meetings will be conducted as well as fall team meetings at Shenandoah Medical Center. Daily huddles where falls or any safety concerns will be addressed. Bulletin boards updated to provide daily visual reminders on fall prevention/safety.

Corrected date: 12-28-2017