STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166439	A. BUILDING _____ B. WING _____	C 12/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAIR HOUSE	1212 INDIAN HILLS DRIVE BURLINGTON, IA 52601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 12-22-17 On December 20-21, 2017, facility reported incident #73012-I was investigated and substantiated.	F 000		
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 observation, record review, resident and staff interview the facility failed to provide adequate nursing supervision and assistance devices to prevent accidents for 1 of 3 residents reviewed. Resident #1 required assist of 2 staff for transfers. On 12/2/17, Staff A transferred the resident alone rather than summoning another staff's assistance. As a result, Resident #1 fell and sustained a subdural hematoma (brain bleed) and a fracture of the cervical (neck bones) spine, 4th vertebrae (C-4). The facility reported a census of 51 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 11/15/17, Resident #1 had diagnoses that included heart failure, anxiety disorder, depression, history of unspecified	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jean Westerbeck — TITLE: Administrator — (X6) DATE: 1/8/18

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 689	Continued From page 1 venous thrombosis (clot) or embolism (air bubble in one's bloodstream) and unspecified intellectual disabilities. The same MDS documented Resident #1 displayed severely impaired cognitive abilities and required extensive assistance of 2 staff for bed mobility, transfers, ambulation (walking), toilet use, and personal hygiene. The MDS identified the resident's balance as unsteady for all activities and documented the resident could not turn around while walking, but noted Resident #1 was independent with locomotion because she self-propelled her wheelchair throughout the facility. The MDS also documented the resident received an anti-coagulant (medication to prevent blood clots) 7 days per week. A Fall Risk assessment completed 11/11/17 indicated the resident should be considered at risk for falls and fall interventions should be initiated. The resident's Care Plan plan identified the need for assistance with activities of daily living. The following intervention was initiated on 4/4/13 and revised on 3/14/17: Ambulate with assist of two staff members using a walker, and pull the wheelchair behind the resident for safety. Resident #1 had a history of sitting down without telling staff. Monitor for changes in gait and balance with therapy as needed/ordered. An intervention dated 12/29/15 and revised on 3/14/17 directed the staff to transfer the resident with assist of two persons. The resident's Care Plan also identified the resident took an anticoagulant and an intervention initiated 4/4/13 and updated 11/16/17 directed staff to monitor Resident #1 for abnormal bleeding or bruising and if found, report it to the resident's physician.	F 689		

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F 689	Continued From page 2 The CNA Care Card for Resident #1 dated and initialed on 8/10/17 directed staff to transfer the resident with assist of 2 staff, ambulate with assist of 2 staff and wheeled walker, and follow behind with a wheelchair. The Radiology Report for CT Cervical Spine without contrast dated 12/2/17 revealed acute appearing mildly displaced oblique fracture of the C-4 spinous process, which is new from the prior exam in 2013. The Radiology Report for CT Brain without contrast dated 12/2/17 revealed parafalcine subdural hematoma, extending along the bilateral tentorial leaves measuring 6 mm in maximum thickness is stable to mildly increased in size. An Incident Report dated 12/2/17 at 8:00 a.m. documented Staff A, Certified Nursing Assistant (CNA) summoned Staff B, Registered Nurse (RN) to Resident #1's room. The nurse saw the resident on the floor on her back, crying, "I hit my head, my head hurts." The resident's right leg appeared shortened and rotated outward. Documentation revealed a hematoma (mass of clotted blood formed due to a broken blood vessel - can be spontaneous or caused by trauma) and an abrasion on the back, left side of the resident's head. Resident #1's vital signs read as follows: T 98.4 Fahrenheit (F), P 90, R 17, and BP 140/88. The Incident Report revealed staff notified the family and physician and received an order to transfer the resident to the Emergency Room (ER). The Progress Notes dated 12/2/17 at 8:10 a.m. documented by Staff B, RN revealed Staff A, CNA	F 689		

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F 689	Continued From page 3	F 689		

summoned Staff B to Resident #1's room. Staff B noted the resident on the floor on her back, crying, "I hit my head, my head hurts." Upon assessment, Staff B saw a hematoma on the back, left side of Resident #1's head with no open areas, although the resident complained of severe headache and pain all over, but denied nausea. Staff B documented neuros (neurological checks to determine possible head injury or internal bleeding) completed and within normal limits. The Progress Notes revealed Staff A reported she assisted Resident #1 to ambulate to the bathroom with a gait belt and wheeled walker and the resident lost her balance and fell back. Staff A reported she was not able to hold the resident up. At 8:30 a.m., the ambulance arrived and transferred the resident to the local hospital's ER. At 12:14 p.m., Staff C, Licensed Practical Nurse (LPN) documented the local hospital staff called and reported they had to send Resident #1 to a higher level of care due to the discovery of a small, subdural hematoma (bleeding into the space between the dura, or brain cover, and the brain itself) and a C-4 fracture.

The undated facility policy "Safety Device Utilization Policy" included the following statement under the Disciplinary Procedure heading: "It is the policy of Blair House to enforce a zero tolerance for failure to transfer residents properly according to their plan of care..."

During an interview on 12/20/17 at 4:24 p.m., Staff A, CNA reported on 12/2/17 she was running late assisting residents out of bed. She stated Resident #1 was soaked in urine and the CNA students wanted to "ambulate (walk with)" the resident. Staff A reported she searched the pod, could not find the other CNA or nurse and

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F 689	Continued From page 4	F 689		

did not know where they were. Staff A confirmed transferred Resident #1 by herself and admitted she never looked at the care card. She acknowledged the facility had instructed her to follow the care cards and she knew they were posted in the rooms.

In an interview on 21/20/17 at 12:36 PM, Staff B, RN reported she had been 4 doors away in another resident's room, walked into the hallway, and saw Staff A, CNA standing in the doorway of Resident #1's room with a look of "panic" on her face. Staff A saw the resident on the floor with her head about 2 feet away from from the bed; Staff A and the resident were the only ones in the room. Staff B reported Staff A verified she transferred Resident #1 by herself even though she was supposed to transfer the resident with assist of another staff member (2 person transfer). Staff B stated the Care Card that notified staff the resident required 2 persons for transfers was on Resident #1's wall for the staff to follow, and she had no idea why Staff B did not do so. She then commented the facility had been fully staffed that day.

On 12/21/17 at 10:15 a.m., the Director of Nursing (DON) was interviewed. She reported the incident occurred on a Saturday, but she had come to the facility to assist the visiting podiatrist. She stated when she walked to the front desk, she saw Staff A, CNA holding her head, crying. Staff A stated she "F'd up" and transferred Resident #1 by herself and the resident fell. When the DON asked Staff A why she transferred Resident #1 alone, she first said the facility was short-staffed. The DON reported she challenged Staff A and Staff A then stated she was running behind and she thought she could just take the

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F 689	Continued From page 5	F 689		

resident to the toilet quickly. The DON added the CNA Care Cards were in resident rooms, and on the CNA clipboard located either in the pod kitchenette or the Nurse's Station. She explained staff were trained upon hire and annually regarding transfers and the use of the Care Cards and resident transfers and she expected staff to follow the Care Cards. The DON reported the requirement that mandated Resident #1's transfer required 2 persons had been in place for 2 years.

In an interview on 12/21/17 at 11:35 a.m., Staff C, CNA reported the Administrator, DON, Restorative, and all the facility's nurses reiterate to the staff they must follow Care Cards because a resident could get hurt; if they do not comply they would be terminated. He added he has never seen or knew of any staff that did not follow the Care Cards, even if the facility was "short-staffed."

During interviews with Staff D, CNA on 12/21/17 at 8:45 a.m. and 11:40 a.m., she reported the facility provided CNA Care Cards that directed staff how to transfer residents and included the amount of staff required as well. She also reported the cards were printed on a sign and located in the CNA Communication book, too. Staff D said CNAs are taught annually about transfers and lifts and they had to complete a return demonstration for management. She stated she had never seen or heard of anyone other than Staff A not follow the Care Cards, and related they were taught in orientation that failure to follow Care Cards would result in termination.

An observation on 12/20/17 at 1:15 p.m., revealed the resident's Care Card on the closet

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F 689	Continued From page 6 door; Resident #1 was seated on the toilet in the bathroom. Staff E, CNA and Staff F, LPN applied the gait belt to the resident's waist and transferred her from the toilet to the wheelchair. The resident reported the back of her head still hurt when she donned her clothes and also the pain in her upper right shoulder remained.	F 689		

Blair House Nursing and Rehabilitation
Provider #165439
Incident #73012-I
Investigation Completed: December 20-21, 2017
Plan of correction completed: December 22, 2017

Please accept this as our credible allegation of compliance.

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the 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 Federal and State laws. Without waiving the foregoing statement, the facility states as follows:

F 689

All nursing staff are trained upon hire and annually regarding safe lifts and transfers as well as the use of the care signs and care plans. Tools are available on nursing units which note changes in resident cares and care plans for staff to review. All nursing staff were reeducated regarding safe lifts and transfers on 12/5-12/7/2017. Interventions are implemented immediately post falls. All falls are again reviewed at the weekly falls committee meeting. Staff A was immediately suspended following this incident and subsequently terminated.

The above is monitored by the Director of Nursing and Administrator.