DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

1/22/18 PG.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165486	A. BUILDING _____ B. WING _____	C 12/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUTHVEN COMMUNITY CARE CENTER	2701 MITCHELL STREET BOX 0 RUTHVEN, IA 51358

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F 000	INITIAL COMMENTS Correction date 01.09.2018 Complaint #72252-C, #72271-C and #72510-C were substantiated. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000	The preparation of the following plan of correction for the deficiencies does not constitueand should not be interpreted as an admission or not an agreement by the by the facility of the truth of the facts alleged or conclusions set forth in the statementof deficiencies. The plan of correction prepared for this deficiency was executed soley because of the State and Federal laws require it. The deficiencies will be corrected by January 09, 2018.	
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and facility policy review, facility staff failed to knock prior to entering resident's rooms for 2 of 9 current residents sampled (Residents #1 & #2). The facility identified a census of 34 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 10/11/17, Resident #1 had diagnoses that included heart failure, diabetes mellitus, dementia, Parkinson's disease, unspecified pain and edema. The MDS identified the resident's BIMs (brief interview for mental status) test could not be completed. According to the MDS the resident required the assistance of one with bed mobility and the assistance of two for transfers, dressing and toilet use.	F 241	Nursing Staff have been educated on 12.16.2017 regarding the importance of providing dignified care specifically knocking on resident room doors prior to entering.This education will ensure that resident #1, resident #2 and all other residents the ability to have staff knock on the door prior to entering. DON or designatee will audit staff on a random basis to ensure that staff are knocking on resident room doors prior to entering. Concerns will be brought to the QAPI committee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Lowe LNHA, MHA

TITLE: Administrator

(X6) DATE: 01/10/2018

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.

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F 241	Continued From page 1 The resident's care plan dated 7/7/17 directed staff to assist the resident with dressing, grooming, oral cares and shaving. Observation on 11/30/17 at 2:32 PM revealed Staff Q, CNA (certified nursing assistant) walked into the resident's room. Staff failed to knock prior to entering. At 2:35 PM Staff S, CNA entered the resident's room and also failed to knock before entering. 2. According to the MDS assessment dated 9/13/17, Resident #2 had diagnoses that included anxiety disorder, depression, chronic lung disease, respiratory failure, hip pain and muscle weakness. The MDS identified the resident's BIMS (Brief interview for mental status) score as 7 which indicated severe cognitive impairment. The assessment documented he required the assistance of two with bed mobility, transfers, dressing and toilet use . The resident's care plan dated 6/30/15 directed staff the resident will spend time with family and to please respect his privacy. Observation on 11/30/17 at 2:30 PM revealed Staff C, CNA and Staff Q, CNA walked into the residents room. Staff failed to knock prior to entering. The Resident's Bill of Rights dated 11/28/16 instructed staff that each resident has the right to privacy in accommodations, treatment, personal care and written and telephone communications.	F 241		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 2 CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review and family	F 309	On 12.19.2017 and 12.20.2017 licensed nursing staff were educated regarding appropriate assessment fundamentals and effective documentation. This education will ensure that Resident # 9 and Resident #10 and all other residents will have an appropriate assessment completed by a licensed nursing as necessary. This will be monitored by the DON or designatee on an ongoing basis and will be audited routinely to ensure compliance. Concerns will be brought to the QAPI committee.	

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F 309	Continued From page 3	F 309		

interview, the facility failed to always complete timely assessments and interventions for 2 of 11 residents reviewed (Residents #9 and #10). The facility identified a census of 34 current residents.

Findings include:

1. According to the MDS (Minimum Data Set) assessment dated 11/1/17, Resident #9 had diagnoses that included high blood pressure, dementia, depression, macular degeneration, hypothyroidism, spinal stenosis and ankylosing spondylitis of the spine. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact memory and cognition. According to the MDS the resident required the assistance of one with transfers, dressing, toilet use and personal hygiene.

The care plan dated 5/30/17 directed staff to ask the resident if she had pain or discomfort if she appeared jittery or had difficulty sleeping.

Review of the Progress Notes dated 11/25/17 at 7:40 AM revealed that at 5:45 AM the nurse was called to the resident's room. Upon arriving at 5:55 AM the resident sat on the toilet with her right forearm bleeding. The resident yelled out while staff were in another room and upon entering the room, found Resident #9 sitting on the toilet, bleeding from her right forearm. The resident reported feeling dizzy with tingling in her right hand and right foot (she stated the tingling had been there all night). The resident moved all her fingers and toes, had a capillary refill of less than 2 seconds on both extremities and warm, pink and dry skin. The resident's vital signs measured: blood pressure 179/91, heart rate 85, respirations 18, temperature 97.8 and O2 97% on

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F 309	Continued From page 4 room air. The resident had skin tears to her right forearm that measured: proximal,1 cm (centimeter) by 1.3 cm and edges not approximated; further distal 1.5 cm by 1.2 cm and edges not approximated; most distal 2 cm by 2.3 cm and edges well approximated. Staff made the resident's family aware and sent a fax to the physician. Review of the Progress Notes dated 11/25/17 at 7:40 AM revealed the nurse went to the resident's room at approximately 8:30 AM. The resident's vital signs measured 183/79, 98.2, 74, 18 and O2 96% on room air. Her blood pressure read manually at 186.80. The resident complained of tingling on the right side and mostly in the right arm. She denied pain and had no facial drooping or weakness noted. Staff called the resident's family and they would like her sent by ambulance to the ER (emergency room). Staff called the ER nurse, who stated she would call the medical doctor and have the doctor return a call before sending. Family members arrived and stated they would like the ambulance called and not wait for the doctor to return a call. An ambulance arrived and transported with resident at approximately 9:05 AM. At 12:45 PM, the resident returned to the facility from the ER. Review of the Emergency Room Note dated 11/25/17 revealed the following orders: a. If O2 (oxygen) saturation below 88 % at rest, then discuss with physician about possible oxygen. b. Check resident's O2 saturation every 2 hours while awake for 2 days. c. Monitor blood pressure and if persistently elevated, then contact physician for further recommendations.	F 309		

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F 309	Continued From page 5 e. Fall precautions. During an interview with the resident's family on 11/30/17 at 3:20 PM, she stated she had expected staff to call the ambulance and the resident at or on the way to the hospital. During an interview with Staff A, RN (Registered Nurse) on 11/30/17 at 10:15 AM, she stated the resident's blood pressure had been higher than normal and her family was concerned and wanted her sent to the hospital by ambulance. The resident also complained of her right hand feeling tingly. She called the emergency room and the nurse wanted the doctor to call her back. She had been waiting to get a call back. The family wanted the resident sent by ambulance without waiting for the doctor to call back. Staff A then called the ER and reported they would send her by ambulance as the family wanted this. During an interview with Staff S, RN on 12/13/17 at 6:25 AM, she stated she had been in another resident's room and called to Resident #9's room. She entered the room at 5:55 AM; the resident had yelled for help and had been found on the toilet with her arm bleeding. She did not know if the resident fell or if bumped her arm and stated she felt dizzy. She assessed the resident and then assisted her back to bed. She stated the resident also complained of some tingling in the right hand and toes. She had no complaint of pain or discomfort. She called the family and explained the incident. She stated family did not ask for her to call the ambulance at that time. 2. According to the MDS assessment dated 8/30/17, Resident #10 had diagnoses that included dementia, depression, mood disorder,	F 309		

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F 309	Continued From page 6 difficulty walking, malaise and osteoporosis. The MDS identified the resident had a BIMs score of 0 which indicated severe cognitive and memory impairment. Resident #10 required the assistance of two with bed mobility, transfers, dressing and toilet use. The resident's care plan dated 7/13/17 directed staff that when being assisted at times, the resident will close her eyes and turn her head when offered a bite (of food). Review of the Progress Notes dated 10/29/17 at 2:43 PM revealed the resident did not take lunch medication or eat lunch; she took only bites at breakfast. The resident responded to verbal stimuli, opens her eyes briefly or nods head. The resident's vital signs measured 97.6, 96, 18 blood pressure (BP) 123/80 and O2 at 96%. Her lung sounds were clear to auscultation , no shortness of breath and respirations even and unlabored. She had no signs of pain. Staff spoke with family over the phone who were concerned the resident may have a bladder infection and requested urinalysis. Staff documented they planned to continue to monitor Resident #10 and would send a fax to the physician for order to obtain a mini catheter urinalysis. On 10/29/17 at 7:45 PM, staff documented a late entry for an unknown time. The resident lay bed, When shaken lightly, she would open her eyes, smile at the nurse and then shut her eyes and go back to sleep. Staff did not give her bedtime medications as the resident wouldn't stay focused long enough to take them. Staff documented her vital signs were within normal limits (but did not document what the vital signs were) and the resident aroused easily.	F 309		

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F 309	Continued From page 7 Progress Notes on 10/30/17 at 2:49 PM revealed the resident was lethargic and had no response to a sternal rub. Vital signs were BP 134/82, respirations 36, pulse 125, temperature 97.9 and O2 93%. Staff placed a call to the hospital and received a verbal order to send Resident #10 to the ER via ambulance. The resident left the facility at 9:30 AM. The hospital called and reported the resident admitted for dehydration, elevated white blood count and sodium off. Family members were updated. The medical record lacked documentation of the vital signs or further assessment.	F 309		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (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.	F 323		

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F 323	Continued From page 8 (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, observation, interviews with staff & resident, and policy review, the failed to provide adequate nursing supervision to protect 2 of 11 residents from injury/physical environmental hazards. (Residents #4 & #3) The facility identified a census of 34 current residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 8/9/17 Resident #4 had diagnoses that included peripheral vascular disease, depression, chronic obstructive pulmonary disease, atrial fibrillation, osteoarthritis and chronic venous hypertension with ulcer and inflammation of lower extremity. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The care plan dated 12/28/16 directed staff to do the following due to risk for injury for very fragile leg skin: a. A pad placed along the frame of my bed to help protect legs from injury. b. Educated to take care when motating in room to avoid bumping self on furniture and nursing stand in room repositioned. c. Educated to take care when rubbing and	F 323	Resident #4 has been discharged. Resident #3 the care plan was updated with current intervention. The nursing staff have been educated on 12.19.2017 and 12.20.2017 on nursing supervision including assessment fundamentals, accident/incident investigation and reporting, falls assessment, and effective documentation. This education will ensure that resident #3 and all other residents have an appropriate assessement completed when necessary and the documentation to reflect the assessement with a follow up as necessary. This will be monitored by the DON or designatee on an ongoing basis and will audited routinely for compliance. Concerns will be brought to the QAPI committee.	

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F 323	Continued From page 9 itching at self to prevent skin areas. d. Follow provider orders with care of legs and overall skin. e. Educated to pay attention to clean and dry areas well and soft cloths provided. f. Staff changed shoes worn. g. Educated to lotion extremities well to maximize elasticity-refuses geri arms. h. Ace wraps to lower legs to help decrease/prevent edema. i. Educated by the dietary manager on the importance of extra protein at meals, please remind and encourage extra protein intake at meals as allows. j. Educated to move with care and to try to wear sturdy footwear whenever possible. k. Instructed to pay attention to what she is doing to prevent trauma. l. Juven per dietitians orders, m. Notify medical doctor if any concern regarding skin arise. Review of the Fall Risk assessment dated 11/8/17 revealed the resident had a score of 15 which indicated the resident a moderate risk for falls. Review of the Points Of Care dated 11/14/17 posted in the resident's bathroom directed staff to do the following: a. Use bed pan for toileting and use a turn sheet under her to turn her only. Do not roll her from side to side using your hands. Review of the MAR dated 11/1/17 through 11/30/17 revealed the resident received Coumadin 5 mg (milligram) daily 11/1/17 through 11/5/17.	F 323		

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F 323	Continued From page 10 Review of the Physician/Nursing Communications dated 11/6/17 revealed the resident's INR was 6.4. The order revealed to hold Coumadin 2 days and then restart at 4 mg (milligrams) daily. a.) Review of the Progress Notes dated 11/8/17 at 12:05 AM regarding the 11/7/17 incident revealed 2 CNAs were in the residents room attempting to take her to the toilet. The resident had the belt one for use with the EZ- stand lift. The CNAs were attempting to lift the resident up in the lift when 1 of them said blood had been dripping onto the stand from the left leg. This nurse walked into the room with the treatments for her legs as the CNAs lowered her back into the wheelchair. Staff lifted the pant leg to see an approximate 5 to 6 inch, deep skin tear to the outer left calf that had been squirting blood out and direct pressure had been applied using a blue towel. The CNA held pressure while the nurse went to the medication room to get bandage supplies to bandage the wound. A decision made to have the resident go to the hospital due to continued bleeding and 911 called at 9:12 PM. At 9:20 PM family notified. At 9:25 PM the ambulance arrived at the facility and transported the resident to the hospital at 9:40 PM. The resident returned to the facility at 11:40 PM and stated she wound start telling staff to make sure and take her foot pedals off the wheelchair before they try and move her. The resident's leg rubbed up against the top of the foot peddle where it connected to the chair and caused the skin tear. Orders included: change dressing daily, Bacitracin, Telfa and pressure dressing times 7 days. An INR at the hospital had been 5.5. Coumadin on hold due to past Coumadin readings.	F 323		

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F 323	Continued From page 11 No incident report presented for the incident on 11/7/17. Review of the ED (emergency department) note dated 11/7/17 revealed the resident presented with a lower extremity left skin avulsion. The injury occurred when the resident struck her leg on the furniture. A pressure dressing with Bacitracin and Telfa applied and orders to dress daily until healed. The area measured 7 cm (centimeter) linear avulsion separated by 2 cm gap. The depth less than 2 mm (millimeters). During an interview with Staff O, CNA on 11/16/17 at 10:30 AM she stated she assisted the resident to transfer with another CNA (11/7/17). She further stated they forgot to take the wheelchair pedals off the wheelchair. The resident mentioned it as they were lifting her. They saw a large amount of blood and lowered her back to the wheelchair. The resident did not have the ace wraps on due to she just had a bath. Staff tried to stop the bleeding and the nurse called 911. b.) Review of the Incident report dated 11/8/17 revealed the nurse called to the resident's room. The resident lying on the floor with wheelchair tipped on her, legs in footrest. A large pool of blood had been under her legs. Staff put towels under and around the leg and applied pressure and bleeding appeared to stop. Staff placed a pillow under her head and noticed a large bump on her forehead. The resident alert and oriented the entire time. Review of the Progress Notes dated 11/8/17 at 9:03 PM revealed the skin note at 9:03 PM the nurse called to the resident's room. The resident had been lying on the floor with the wheelchair	F 323		

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F 323	Continued From page 12 tipped on her and the legs were in the foot rests. A large pool of blood had been gathering under her leg. Staff were unable to see where the blood had been coming from. Staff placed towels under and around the leg to apply pressure and the bleeding appeared to stop. Staff placed a pillow under her head and noted a large bump on her forehead. The resident remained alert and oriented through out. The ambulance called due to the blood loss and head injury. The resident transported to the emergency room at approximately 9:50 PM. Review of the ED Note dated 11/8/17 revealed the resident fell at the facility. She had been waiting to get assistance to void and lost her balance. The following injuries identified: a. Yesterday's laceration about 4 cm long, not bleeding. 14 cm by 7 cm oval skin tear, not bleeding over left knee, no depth, basically a second degree burn. b. 7 cm laceration, linear, mid left shin, transversely oriented. c. 7 cm laceration, linear, anterior proximal right thigh, transversely oriented. d. 14 cm by 7 cm gaping laceration, deep with large defect, over right knee, not to periosteum but close to bone depth. No joint exposed. e. Large hematoma above the right eye on the forehead measured 8 cm by 3.5 cm. f. Left ankle bruising, swelling. During the hospitalization the resident received blood transfusion and underwent surgical repair of lacerations. During an interview with Staff H, CNA on 11/15/17 at 11:30 AM she stated she had worked on 11/8/17 and had been on break around 6:30 to 7:00 PM. She went to break around 6:30 PM to	F 323		

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	165486	A. BUILDING _____ B. WING _____	C 12/15/2017

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F 323	Continued From page 13 7:00 PM and the nurse called for assistance for another resident outside. She went to assist. Staff M went to assist and had told Staff H the resident had used the call light and asked to use the restroom and she had told her she could not with 1 staff and she would have to wait. Staff M stayed with the other resident and I stayed on the floor to answer call lights. She saw the resident's light come on and had forgotten she had it on earlier to request toileting so went to the room right away. She found the resident on the floor on her stomach and the call light string by her hand. Blood had been slowly running on the floor. The wheelchair had been tipped forward and both pedals were under her shins. Her calves were holding the wheelchair up so it did not fall on her. She called for assistance and slid a pillow under her head. The nurse tried to find the bleeding spot to apply pressure. She further stated only 2 CNAs and 1 nurse on duty and normally have 3 CNAs. Additional Interviews: During an interview with Resident # 4 on 11/15/17 at 12:00 p.m., she reported waiting for staff to come help her and stated it took staff forever. Resident #4 reported 1 hour must have passed and the next thing she knew, she was on the floor. During an interview with the ER Physician on 11/28/17 at 110 AM she stated the resident had so many wounds and had been seen in the ER the night[11/7/17] before for a wound you have to ask why. She stated she had a concern of the communication and never had a report of the etiology of the wounds. The facility only reported a fall and this had not been a simple fall. She has	F 323		

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F 323	Continued From page 14 a concern with the facilities process. During an interview with the resident's Physician on 12/1/17 at 11:30 AM he stated the resident had risk factors prior to the accident of age, fragile skin and on Coumadin. She now has skin failure and on hospice. There is still a chance for the wounds to heal but now the resident bed ridden and continues to have the risk factors. Review of the Major Injury Determination Form dated 11/15/17 revealed the Physician believed the injury sustained is a major injury pursuant to the Iowa Administrative Code. During an interview with Staff M, CNA on 11/16/17 at 6:00 AM she stated she assisted with a transfer using the EZ stand lift (11/7/17). She stated 1 wheelchair pedal had still been on and must have caught the residents leg. They saw bleed and stopped immediately. She grabbed a washcloth and applied pressure. She continued to applied pressure until the EMTs came. The other CNA had stated it should be OK to leave the wheelchair pedal on. She further stated she was on duty on 11/8/17. She assisted another resident that had gone out the front door and into Assisted living. She heard a call for the residents room and ran to the resident's room. The resident had been face down on the floor. Staff placed a pillow under her head and her legs were tangled in the wheelchair pedals. She helped get the wheelchair out and the resident had been bleeding. They could not see the injuries. She stayed with the resident and talked to her until the ambulance came and they then rolled her onto a sling. The ambulance personnel cut the resident's pants off and she saw the injuries. She further stated the resident had put the call light on to toilet and she	F 323		

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F 323	Continued From page 15 had told her she had to go get some help. She did not know how long it had been prior to the fall. During an interview with Staff P, RN on 11/16/17 at 2:00 PM she stated she heard the resident's call light so went in to do the treatment to the leg (11/7/17). She walked into her room and she was bleeding and in the EZ stand and staff were putting her back into the wheelchair. She pulled up the pant leg and she was bleeding all over. She had the CNA put pressure on the area and went to get bandage supplies. After pressure applied, it still did not stop and she sent the resident to the hospital. She did see the wheelchair pedals on during the transfer. She further stated wheelchair pedals should be taken off prior to transfers. She stated the resident had told her she the CNAs had told her it would be fine to leave the pedals on. Observation on 11/15/17 at revealed Staff I, CNA and Staff F, CNA assisted the resident with toilet use. Staff assisted the resident onto the bed pan. No turn sheet under the resident to assist in turning. An incontinent pad had been under the resident but out of reach for staff. Staff handled the resident to assist turning to her side and placed their hands on the resident's shirt and unclothed hip. Staff did use the palm of their hands when handling the resident. 2. According to the MDS (minimum data set) dated 8/30/17 Resident #3 had diagnoses that included diabetes mellitus, Parkinson's disease, psychotic disorder, history of falling and muscle weakness. The MDS identified the resident had a BIMs (brief interview for mental status) score of 11 which indicated moderate cognitive impairment. According to the MDS the resident	F 323		

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F 323	Continued From page 16 required extensive assistance with bed mobility, transfers and toilet use and limited assistance with ambulation. The MDS identified the resident had 1 fall with no injury since the prior assessment. The care plan updated on 9/22/17 to include string on alarm shortened to allow it to activate in the event the attempt to self transfer. The care plan did not include personal alarm prior to 9/22/17. The fall risk assessment dated 9/3/17 revealed the resident had a total score of 18 which indicated a high risk for falls. Review of the incident report dated 9/22/17 revealed the Activities Director yelled down the hallway for help. The resident in the bathroom and lowered to the floor per staff. Alarm attached and call light within reach. The resident had proper footwear on and moved all extremities times 4 with no injury noted. The resident transferred with the assist of 3 and Hoyer lift. Review of the Hospital History of Present Illness report dated 9/22/17 revealed the resident had a right distal fibular fracture, closed, minimally displaced. The resident admitted for a urinary tract infection. Review of the Major Injury Determination Form dated 9/22/17 revealed the injury sustained is not a major injury. Review of the Progress Notes dated 9/22/17 at 11:40 AM revealed staff arrived in the resident's room quickly after Activities director summoned for help. The resident had been squatting in the corner of the bathroom with both feet angled	F 323		

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F 323	Continued From page 17 under her buttocks not touching the floor. The resident had been holding onto the railing angled from the corners of the bathroom. Her alarm was on and intact. Staff attempted to lift her but unable and lowered her to the ground. The resident had complaints of pain in the right ankle/foot area. A reddened area noted on the right elbow and turned ankle to staff. The resident stretched out to allow her legs to stretch. The pained facial expressions and noises subsided and she indicated she was no longer having discomfort. The resident assisted into her wheelchair by a Hoyer lift with 3 staff. The resident choose to go to the dining room for lunch. No facial grimacing noted and no longer moaning. On 9/23/17 at 2:38 PM staff documented the resident returned to the facility at 11:30 AM via wheelchair van with staff driver. Review of the medical record revealed the facility failed to document further assessment of the resident following the fall or transfer to the facility. During an interview with the Activity Director on 11/15/17 at 10:10 AM she stated she had been in her office and the resident's roommate told her the resident needed help. She went to the residents room and the resident in the bathroom holding on to the bar and her left leg turned under her. She yelled for help and staff came to the room. She went to get more help and the Hoyer lift. At some time, after noon, she saw the resident in her recliner and she denied pain. When she saw the resident the alarm box had been on the resident's wheelchair and the string remained in tact clipped to her clothing. The alarm had a long string and did not activate to sound.	F 323		

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F 323	Continued From page 18 During an interview with the Nurse Manager on 11/15/17 at 8:30 AM she stated she went to the resident's room and the resident had been lowered to the floor. She complained of general discomfort and her body was sore. The transferred the resident to the wheelchair and staff administered Tylenol with the noon medications. The resident then ate lunch. During an interview with Staff G, CNA (certified nursing assistant) on 11/15/17 at 10:45 AM she stated she went to the residents room and she had been in the bathroom holding onto the bar. The resident had been way down, to her knees and her right ankle twisted under her. They tried to lift her but were unable and lowered her to the floor. She did not complain of ankle pain. The transferred her to the wheelchair with a lift. The alarm box still on the wheelchair and intact. She further stated she had seen the resident transfer before and the string just long enough to not activate sound. Review of the Policy and Procedure titled Fall Risk Assessment and Prevention dated 2/20/16 directed staff to do the following: a. During resident assessment, the fall risk will be determined, If resident's risk is high, resident considered at risk for falls. b. After fall risk determined, the nurse will review resident's condition and put appropriate interventions into place and update the care plan. c. The care plan will be monitored for effectiveness of interventions and changes will be made as deemed necessary/or reviewed and updated at least every quarter. d. The resident/family will be included as part of the care plan process. e. Resident's at risk will be identified, so staff are	F 323		

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F 323	Continued From page 19 aware of the increased need for monitoring. f. Falls/Incident reports will be reviewed in the Quality Assurance Meeting. g. All facility staff will be educated and responsibilities of responding to high risk residents as needed.	F 323		
F 353 SS=D	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 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 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	F 353	Resident # 4 has been discharged. Resident #8 care plan has been reviewed for current interventions. Staffing has been reevaluated and assessed. The staffing pattern process will include a continued review of the needs of the residents within their plan of care and acuity to meet the needs of the residents including responding to call lights. DON or designtee will monitor this on a ongoing basis and will be audited routinely for compliance. Concerns will be brought to the QAPI committee.	

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F 353	Continued From page 20 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 record review, interviews with residents and staff, the facility failed to answer call lights in a timely manner for 2 residents reviewed (Residents # 4 & #8). The facility identified a census of 34 current residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 8/9/17 Resident #4 had diagnoses that included peripheral vascular disease, depression, chronic obstructive pulmonary disease, atrial fibrillation, osteoarthritis and chronic venous hypertension with ulcer and inflammation of lower extremity. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use.	F 353		

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F 353	Continued From page 21 The care plan dated 1/6/16 directed staff to educate the resident on the use of the call light for assist and assist as she requests with transfers. Review of the Fall Risk assessment dated 11/8/17 revealed the resident had a score of 15 which indicated the resident a moderate risk for falls. Review of the Incident report dated 11/8/17 revealed the nurse called to the resident's room. The resident lying on the floor with wheelchair tipped on her, legs in footrest. A large pool of blood had been under her legs. Staff put towels under and around the leg and applied pressure and bleeding appeared to stop. Staff placed a pillow under her head and noticed a large bump on her forehead. The resident alert and oriented the entire time. Review of the Progress Notes dated 11/8/17 at 9:03 PM revealed the skin note at 9:03 PM the nurse called to the resident's room. The resident had been lying on the floor with the wheelchair tipped on her and the legs were in the foot rests. A large pool of blood had been gathering under her leg. Staff were unable to see where the blood had been coming from. Staff placed towels under and around the leg to apply pressure and the bleeding appeared to stop. Staff placed a pillow under her head and noted a large bump on her forehead. The resident remained alert and oriented through out. The ambulance called due to the blood loss and head injury. The resident transported to the emergency room at approximately 9:50 PM. Review of the ED Note dated 11/8/17 revealed	F 353		

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F 353	Continued From page 22 the resident fell at the facility. She had been waiting to get assistance to void and lost her balance. During the hospitalization the resident received blood transfusion and underwent surgical repair of lacerations. During an interview with Staff H, CNA on 11/15/17 at 11:30 AM she stated she had worked on 11/8/17 and had been on break around 6:30 to 7:00 PM. She went to break around 6:30 PM to 7:00 PM and the nurse called for assistance for another resident outside. She went to assist. Staff M went to assist and had told Staff H the resident had used the call light and asked to use the restroom and she had told her she could not with 1 staff and she would have to wait. Staff M stayed with the other resident and I stayed on the floor to answer call lights. She saw the resident's light come on and had forgotten she had it on earlier to request toileting so went to the room right away. She found the resident on the floor on her stomach and the call light string by her hand. Blood had been slowly running on the floor. The wheelchair had been tipped forward and both pedals were under her shins. Her calves were holding the wheelchair up so it did not fall on her. She called for assistance and slid a pillow under her head. The nurse tried to find the bleeding spot to apply pressure. She further stated only 2 CNAs and 1 nurse on duty and normally have 3 CNAs. During an interview with Staff M, CNA on 11/16/17 at 6:00 AM she stated she was on duty on 11/8/17. She assisted another resident that had gone out the front door and into Assisted living. She heard a call for the resident ' s room and ran to the resident's room. The resident had been face down on the floor. Staff placed a pillow	F 353		

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F 353	Continued From page 23 under her head and her legs were tangled in the wheelchair pedals. She helped get the wheelchair out and the resident had been bleeding. She further stated the resident had put the call light on to toilet and she had told her she had to go get some help. She did not know how long it had been prior to the fall. During an interview with Resident # 4 on 11/15/17 at 12:00 p.m., she reported waiting for staff to come help her and stated it took staff forever. Resident #4 reported an hour must have passed and the next thing she knew, she was on the floor. 2. According to the Minimum Data Set assessment (MDS) dated 11/1/17 Resident #8 had diagnoses that included heart failure, diabetes mellitus, anxiety disorder and depression. The MDS identified the resident had a BIMS (Brief Interview for Mental Status) score of 15 which indicated intact cognition. According to the MDS the resident required supervision with bed mobility, transfers and toilet use. The care plan dated 9/26/17 directed staff to encourage the resident to have assist of 1 with transfers, but has the right to ask for or refuse assist as wants to be independent at times. During an interview with Resident #8 on 11/16/17 at 2:30 PM she stated does use the call light and it can be greater than 15 minutes at times a half an hour. The waiting had caused incontinence and she did cry with embarrassment. On 11/30/17 at 11:30 AM she stated the staff do turn off the call light and state they will come back later frequently. It can take a long time for staff to come back.	F 353		

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F 353	Continued From page 24 3. Review of the Location Section Activation Report (call light) dated 11/7/17 through 11/18/17 and 7/14/17 through 7/15/17 revealed the following call lights with greater than 15 minute response time: a. 11/7/17; 5:32 AM- 33 minutes 51 seconds, 8:57 AM- 25 minutes 29 seconds, 9:21 PM 17 minutes 51 seconds. b. 11/8/17; 7:18 AM-24 minutes 21 seconds, 7:41 AM 17 minutes 5 seconds, 8:36 AM 22 minutes 7 seconds, 9:34 AM 19 minutes 16 seconds, 9:08 PM 27 minutes 31 seconds, 9:23 PM 22 minutes 41 seconds, 9:55 PM 35 minutes, 52 seconds. c. 11/14/17; 6:15 AM-19 minutes 41 seconds, 2:34 PM-27 minutes 27 seconds, 11/14/17- 6:38 PM 28 minutes 7 seconds. d 11/15/17; 6:14 AM 17 minutes 53 seconds, 1:26 PM 18 minutes 57 seconds, 6:22 PM-34 minutes 10 seconds. During an interview with the (DON) Director of Nursing on 12/1/17 at 11:40 AM she stated staffing includes a mixture of high school students that may come in at 4:00 PM instead of 2:00 PM. The Nurse Manager and DON planed to be on the floor prior to the students coming on the floor. They are out there and do what they need to cover.	F 353		

DEPARTMENT OF INSPECTIONS AND APPEALS

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RUTHVEN COMMUNITY CARE CENTER	2701 MITCHELL STREET BOX 0 RUTHVEN, IA 51358

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N 101	50.7(1) 481- 50.7 (10A,135C) 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 (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: ased on record review, staff interview and policy review, the facility failed to report to the Department of Inspections and Appeals (DIA) a	N 101	The preparation of this following plan of correction for the deficiencies does not constitute and should not be interpreted as an admission or not an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed soley because of the State and Federal Laws require it. The deficiencies will be corrected by January 09th, 2018. Resident #4 has been discharged from the facility. Licensed professional nursing staff and management have been educated on the "major injury reporting criteria" that defines and identifies the criteria for reporting. The education will ensure the staff understand the criteria and will report incidents as necessary for the remaining residents. DON or designatee will monitor on an ongoing basis to ensure complaince and report any concerns to the QAPI committee.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Lowe LNHA, MHA	Administrator	01/10/18

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0964	A. BUILDING: _____ B. WING _____	C 12/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 101	Continued From page 1 fall experienced by Resident #4 which resulted in hospitalization for 1 of 11 residents reviewed. The facility identified a census of 34 current residents. Findings include: 1. According to the MDS (minimum data set) assessment dated 8/9/17, Resident #4 had diagnoses that included peripheral vascular disease, depression, chronic obstructive pulmonary disease, atrial fibrillation, osteoarthritis and chronic venous hypertension with ulcer and inflammation of lower extremity. The MDS identified the resident had a BIMs (brief interview for mental status) score of 15 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility, transfers, dressing and toilet use. The care plan dated 1/6/16 directed staff to educate the resident on the use of the call light for assist and assist as she requests with transfers. Review of the Progress Notes dated 11/8/17 at 9:03 PM revealed the nurse called to the resident's room. The resident had been lying on the floor with the wheelchair tipped on her and the legs were in the foot rests. A large pool of blood had been gathering under her leg. Staff were unable to see where the blood had been coming from. Staff placed towels under and around the leg to apply pressure and the bleeding appeared to stop. Staff placed a pillow under her head and noted a large bump on her forehead. The resident remained alert and oriented through out. The ambulance called due to the blood loss and head injury. The resident transported to the emergency room at approximately 9:50 PM.	N 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	Continued From page 2 Late entry On 11/14/17 at 6:35 AM the resident [re]admitted to the nursing facility using a wheelchair from the hospital. Review of the ED (emergency department) Note dated 11/8/17 revealed the resident fell at the facility. She had been waiting to get assistance to void and lost her balance. The following injuries identified: a. Yesterday ' s laceration about 4 cm long, not bleeding. 14 cm by 7 cm oval skin tear, not bleeding over left knee, no depth, basically a second degree burn. b. 7 cm laceration, linear, mid left shin, transversely oriented. c. 7 cm laceration, linear, anterior proximal right thigh, transversely oriented. d. 14 cm by 7 cm gaping laceration, deep with large defect, over right knee, not to periosteum but close to bone depth. No joint exposed. e. Large hematoma above the right eye on the forehead measured 8 cm by 3.5 cm. f. Left ankle bruising, swelling. During the hospitalization the resident received blood transfusion and underwent surgical repair of lacerations. Review of the Major Injury Determination Form dated 11/15/17 revealed the Physician believed the injury sustained is a major injury pursuant to the Iowa Administrative Code. The incident was not reported to the Department. During interview on 12/5/17 at 1:30 PM, the Administrator stated the incident on 11/8/17 did not get reported. The facility was waiting on a major injury form to be returned from the doctor, received the faxed form on 11/14/17 and missed the reporting date.	N 101		