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 02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

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F 000	INITIAL COMMENTS	F 000	See attached.	

VK 2/23/18 Correction date 3-12-18

The following deficiency relates to the investigation of incident #72245. (See code of Federal Regulations (45 CFR) Part 483, Subpart B-C).

Complaint #72238 was not substantiated.

F 684 SS=G Quality of Care
CFR(s): 483.25

§ 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.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and interviews, the facility failed to timely assess and provide interventions for one (1) of four (4) residents reviewed. Record review revealed Resident #1 reported to staff she thought she had a stroke and her ability to speak worsened the next few hours. Staff interviews revealed the nurses did not promptly address Resident #1's significant change in condition. The facility reported a census of 64 residents.

Findings include:

1. According to the Minimum Data Set assessment (MDS), dated 10/26/2017, Resident

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 2-22-18

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 684	Continued From page 1 #1 had no cognitive impairment and no difficulty being understood or understanding others. The MDS revealed Resident #1 had no signs or symptoms of delirium. The resident required the assistance of two staff to transfer and dress and had diagnoses including an artificial hip joint and depression. The Progress Notes dated 10/19/17 & 10/23/17 revealed Resident #1 had been admitted to the nursing home from the hospital after hip surgery. The resident demonstrated she was alert and oriented. The Progress Notes effective date 10/29/107 at 1:20 p.m., created at 2:18 p. m. by Staff C documented a CNA (Certified Nurse Aide) reported the resident states "I feel like I had a stroke". The resident had slurred speech, delayed thought process, aphasia, hand grips equal and strong, and pupils dilated with assessment (vitals). CNA's reported yesterday the resident's talked normal. The resident wished to go to the hospital. Physician notified and order received if family agrees. The Progress Note effective date 10/29/2017 at 9:30 a.m., created by Staff B on 10/29/2017 at 4:07 p.m. reported the resident sat in the recliner in the room, requested medications be given whole in apple sauce and then without apple sauce, alert and oriented to self and pleasant. The resident had easy and unlabored respirations, grips strong and equal, regular heart rhythm; will continue to monitor. Hospital Records included:	F 684		

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F 684	Continued From page 2 Discharge Documentation - Admit date 10/29/2017. Reason for visit: Stroke. Final Diagnoses: cerebral infarction due to cerebral venous thrombosis (CVT), nonpyogenic, artificial hip joint, long term (current) use of anticoagulants, acute post hemorrhagic anemia. The Emergency Documentation included: History of Present Illness: Presents with trouble speaking from the nursing home. Nursing home notified family at 1 o'clock p.m., but nursing home staff reported Resident #1's symptoms started early when the resident was unable to speak on examination or able to follow commands. Last seen normal around 8:00 a.m. Started with slurred speech and hard time finding words at 9:30 a.m. Stopped talking around 12:00 noon. Family notified at 1:10 p.m. Transported to emergency department for evaluation. The resident did not have history of stroke; however the resident had a right hip revision 2 weeks ago. During an interview on 1/31/2018 at 2:57 p.m. via phone, Resident #1's family member said the resident had a stroke that affected his/her speech. The resident returned home since December 2nd 2017. From the hospital, the resident went to a (different) nursing facility for therapy and speech continued working with the resident at home. During an interview on 2/2/18 at 11:30 a.m., the Physician reported checking the emergency room records and said staff should have notified the physician and followed up when the resident had a change in condition. The resident's speech was difficult at 9:30 a.m., and then stopped speaking later. The physician reported the resident is 94 years old and current on anticoagulant therapy,	F 684		

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F 684	Continued From page 3 and he would not have recommended treatment with tPA (tissue plasminogen activator) as it's contraindicate. During an interview on 2/1/2018 at 5 o'clock p.m., Director of Nursing (DON) revealed the investigation showed the progress note dated Sunday, 10/29/2017 at 9:30 a.m. had actually been created at 4:07 p.m. by Staff B, RN. Staff B also entered the vitals for Resident #1 into the resident's record at 3:34 p.m. when he/she returned to the facility (later that day). The progress note dated 10/29/2017 had been created by Staff C, LPN (Licensed Practical Nurse) at 1:20 p.m.. Staff C came to the DON on Monday, 10/30/2017 and voiced a concern regarding Staff B. Resident #1's family member also came to the facility and voiced a concern. The DON checked the progress note at 9:30 a.m. and it failed to identify a concern at the time. Staff B said he/she told Staff C and Staff C said he/she had not been told about the resident. Staff C had checked the progress notes and saw no notes. The DON told Staff B that he/she should have called the physician when a resident reported feeling as if they had a stroke. The facility suspended Staff C for a delayed assessment. Staff D's written documentation dated 10/31/17 on the Risk Management Statement form revealed the following for the events on 10/29/17: Around 9:00 to 9:30 a.m. she answered Resident #1's call light and the resident reported she felt like she had a stroke. Staff D went to get Staff B who was nearby and she came right away. Staff D was asked to get the vitals cart and when she	F 684		

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F 684	Continued From page 4 did, she watch Staff B complete vitals and then Staff B told her she was going to consult with Staff C who was in the dining room. Staff B told Staff D they were just going to watch Resident #1 for the time being. Staff D was not with Staff B when she spoke with Staff C. At 11:00-11:30 a.m. Staff D noticed Resident #1's speech was not the same as had been in the morning and she told Staff C who reported "ok". Staff D did not see Staff C go in and assess Resident #1. At noon, Staff D told Staff E that her speech had gotten worse and no one seemed concerned or had looked in on Resident #1. Staff E and her tried to get Resident #1 to tell them what was wrong and they could barely make out what she was saying. They obtained vitals and gave them to Staff C. Staff D didn't see Staff C go into Resident #1's room. Around 1:30-1:45 p.m., Staff C asked them to get Resident #1 ready for ER (emergency room) transport. During an interview on 1/31/2018 at 2:30 p.m., Staff D, CNA reported sometime after breakfast and before lunch between Resident #1 had the call light on and said "I had a stroke". Staff D reported this to Staff B, RN and Staff B did an assessment with Staff D present. Staff D said Staff B talked to Staff C, LPN. Staff F, Medication Aide took over when Staff B left. The resident had the call light on again and Staff D reported it to Staff C. Staff C, in the dining room, had asked staff to check the resident's vitals. Staff D and Staff E checked the resident's vitals and reported to Staff C. The resident's speech had been affected. Staff D said Staff C should have responded quicker. Staff C called the ambulance to transfer the resident.	F 684		

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F 684	Continued From page 5 During an interview on 1/31/2018 at 2:15 p.m. Staff B, RN reported working on 10/29/2017 from 6 a.m. until 10 a.m. and returned at 2 p.m. near the end of the 10 a.m. shift, Staff B went into Resident #1's room and administered his/her pills with no problem. About 15 minutes later, Staff D, CNA came to Staff B and said Resident #1 was not feeling well. Staff D and Staff B went into the resident's room. The resident had normal vital signs, denied pain and said he/she did not really know what was wrong. Staff B went into the medication room and told Staff C the vital signs were fine and hand grips were normal. The resident never mentioned feeling as though he/she had a stroke. When Staff B returned to the facility at 2 p.m., the ambulance had arrived and he/she heard Resident #1 went to the hospital. Staff E said the resident sat up for lunch and after that, stopped talking. The hospital called and asked when the resident's symptoms started. Staff B relayed the information that Staff E reported. During an interview at 2/1/2018 at 3:55 p.m., Staff C, LPN reported the facility terminated his/her employment. Staff C normally did MDS's at the facility but agreed to work on 10/29/2017 from 6 a.m. until 2 p.m. on B wing. Resident #1 resided on A wing. Staff C had not met the resident prior to that day. Staff B worked A wing, Staff C overheard Staff D tell Staff B that Resident #1 reported feeling like he/she had a stroke and did not feel well. Staff B reported to Staff C that the resident's vitals were normal. Staff C told Staff B to do what she thought needed to be done. Staff B walked away and Staff C continued with passing medications. Staff F, CMA (Medication Aide) replaced Staff B at 10 o'clock. When Staff	F 684		

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F 684	Continued From page 6	F 684		

C went to the dining room to monitor lunch after 12 o'clock, staff came and reported Resident #1 had an increase in symptoms. Around 12:50 p.m. Staff F gave Staff C Resident #1's vitals. That was the first Staff C knew of the concern. Staff C went to the resident's room and called the physician. Staff C checked the progress notes and Staff B failed to document earlier. The physician ordered the resident be sent to the emergency room. Staff B said the resident was fine when she left at 10 a.m. Staff C felt frustrated because Staff B failed to report the resident's assessment. Staff B documented late and incorrectly. Staff E, CNA never came to report a concern and Staff D never reported anything until closer to 1 o'clock p.m. Nobody told Staff C at 11:30 a.m. as reported.

During an interview on 1/31/2018 at 1:40 p.m., Staff E, CNA said around 11:30 a.m., Staff D came and said something was wrong with Resident #1. Staff E went in and the resident mumbled "stroke". The resident failed to speak clearly, a change in condition. Staff E reported the findings to Staff F, Med Aide. Staff F asked Staff E to get a set of vitals. The vitals appeared normal except for a slightly elevated temperature. Staff E reported to Staff F and observed Staff C in the dining room passing pills. Staff E told Staff F that the resident had a stroke and she needed to tend to the resident. Staff E never said anything to Staff C. Staff E went and held the resident's hand and tried to comfort the resident for about an hour. Lunch trays are served at 11:30 a .m. and Staff E never saw a lunch tray in the resident's room. At 12:30 p.m., Staff C entered the resident's room. Staff E told Staff C the resident had a stroke, failed to speak and had a droopy left face. The resident nodded "Yes" (up

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F 684	Continued From page 7 and down) when asked if she wanted to go to the hospital. Staff E heard the resident went to another facility. During an interview on 1/31/2018 at 3:15 p.m., Staff F, Medication Aide reported working on 10/29/2017 at 10 o'clock a.m. Staff F received a report from Staff B and failed to recall anything specific. Around 11:30 a.m., Staff E came and said Resident #1 had something going on and failed to talk. Staff F checked the resident who appeared distressed. Staff F reported to Staff C and Staff C said Staff B had taken care of it prior to leaving. At 12:05 p.m. Staff F checked the resident again and observed her shaky and not able to talk. Staff F asked Staff E to check vitals and reported to Staff C. Around 1 o'clock p.m., Staff C called the physician and sent the resident to the hospital.	F 684		

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

F-684

It is the practice of Cedar Falls Health Care to ensure that assessments are performed timely and timely interventions are put in place.

#1- Resident #1 no longer resides at Cedar Falls Healthcare, no further action necessary.

#2- The Director of Nursing reviewed health status through progress notes review for current residents over past 30 days to identify any resident with change in condition. Education completed on 2/12/18 to nursing staff regarding appropriate assessments and interventions for significant condition changes.

#3- Director of Nursing and/or designee will conduct resident reviews and hold staff huddle meetings to identify resident condition changes and assessment needs three times per week for one month then two times per week for one month followed by one time per week for one month and randomly thereafter.

#4- The Director of Nursing and/or designee will report on the progress of this plan of correction to the Quality Assurance Performance Improvement Committee for three months to ensure ongoing compliance.