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F 000	INITIAL COMMENTS Correction date 4/25/18 Complaint #74098-C was not substantiated. Investigation of facility-reported incident #75016-I resulted in deficiency. See Code of Federal Regulations (42CFR), Part 483, Subpart B - C.	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 clinical record review, staff interviews, observations and facility policy review, the facility failed to provide immediate interventions to prevent multiple falls for one of three residents reviewed (Resident #1). The facility reported a census of 71 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/18/18 recorded Resident #1 had diagnoses that included Non-Alzheimer's dementia, seizure disorder/epilepsy, anxiety disorder, depression, muscle weakness, legal blindness, abnormalities of gait and mobility,	F 689		

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

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 4/27/18 VC

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F 689	Continued From page 1 cognitive communication deficit and osteoarthritis. The resident's BIMS (brief interview for mental status) score of 10 out of 15 rated Resident #1 with a moderately impaired memory and cognition. The MDS noted Resident #1 had unsteady balance when moving from a seated to a standing position and could stabilize without staff assistance. The resident used a walker and a wheelchair as mobility devices, walked independently in her room and walked with the support of one in the corridor. The assessment documented Resident #1 had frequent episodes of urinary incontinence and occasional episodes of bowel incontinence. The MDS also recorded Resident #1 received daily antianxiety and diuretic (which can cause frequent urination) medications. The resident's 11/27/17 revised Care Plan noted Resident #1's risk for falls related to her cognition, unawareness of safety needs and deconditioning. The Care Plan also noted the resident's generalized muscle weakness. Staff provided the following interventions related to falls on 6/19/17 - Anticipate and meet the resident's needs, encourage the resident to call for assistance and wear appropriate footwear, follow therapy recommendations for transfers and mobility and place the call light within reach. On 3/30/18, staff added the intervention of a high/low bed. On 4/2/18, staff documented adding a drop seat to the resident's wheelchair. On 4/5/18, staff documented the resident had a bolster mattress with a plastic cover. On 4/1/18, they documented installation of anti-roll back brakes to her wheelchair. Under an Activities of Daily Living deficit focus, staff added the resident was independent with toilet use on 9/5/17 and transferred independently in her room on 9/7/17.	F 689		

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F 689	Continued From page 2 The facility's Falls Management Guidelines, revised 7/14/17, directed staff on what to do when a resident fall occurs. According to the policy, the licensed nurse should assess the resident for injuries prior to moving them. The policy also instructed the licensed nurse to complete the risk report in Point Click Care (an electronic health record) and the 24 hour report. Nurses are to communicate all resident falls to the attending physician and the resident's family and document on the Incident and Accident form. The IDT (interdisciplinary team) will review all falls within 24-72 hours at the morning IDT meeting to evaluate the circumstances and probable causes of the fall. Finally, the IDT modifies and implements a care plan and treatment approach to minimize repeat falls and the risk of injury related to the fall. The resident's 2/19/18 Fall Scale-Morse assessment rated Resident #1 at a high risk for falling. A Nurses Note dated 3/19/18 at 3:35 a.m. documented Resident #1 presented with behaviors. The resident propelled her wheelchair up and down the hall and within the facility looking for her "apartment" and her "daughter in the hospital". The nurse also noted that Resident #1 continued antibiotic therapy for a UTI (urinary tract infection). A Nurses Note dated 3/19/18 at 10:16 a.m. documented that Resident #1 received her last dose of an antibiotic for the UTI. The nurse recorded a new order to follow up with a UA (urinalysis) on 3/22/18 if indicated.	F 689		

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F 689	Continued From page 3 A Nurses Note dated 3/25/18 at 9:56 a.m. documented staff notified the resident's doctor of the lab results and obtained a new order for antibiotic therapy for 10 days. A Nurses Note dated 3/27/18 at 2:13 a.m. documented that Resident #1 continued on antibiotic therapy for a UTI. The nurse noted that the resident as alert and oriented times 1 - 2 with baseline dementia/Alzheimer's disease process. A Nurses Note dated 3/28/18 at 2:48 a.m. documented that Resident #1 continued on antibiotic therapy for a UTI with continued orientation x 1 - 2 with baseline dementia/Alzheimer's disease process. A Nurses Note dated 3/29/18 at 9:57 a.m. documented that Resident #1 continued on antibiotic therapy for a UTI. The nurse noted the resident as alert with confusion an without behaviors. An Incident Report dated 3/29/18 at 2:55 p.m. revealed they found Resident #1 sitting on the floor in front of her recliner; assessment revealed no injuries. The nurse described the resident as alert with confusion and indicated the resident slid out of her recliner while trying to get into her wheelchair. The nurse named confusion, incontinence, UTI and a recent change in medication as predisposing factors to the fall. An update on 3/30/18 documented Resident #1 had orders for PT (physical therapy) to evaluate and treat because the resident said her legs felt weaker at the time of the incident. A Nurses Note dated 3/29/18 at 3:41 p.m. documented that a new order had been obtained	F 689		

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F 689	Continued From page 4 for PT to evaluate and treat for weakness. A Nurses Note dated 3/30/18 at 1:13 a.m. documented Resident #1's as alert with confusion. Resident #1 declined supper and required the assistance of one as needed. The resident went to bed early because she stated she did not feel well and continued on antibiotic therapy for a UTI. A Nurses Note dated 3/30/18 at 9:51 a.m. documented Resident #1 as alert with confusion. Resident #1 stated she still felt weak and staff educated her on the need to call for assistance with transfers. The nurse also noted the resident's forgetfulness and/or denial that she needed help; the resident continued on antibiotic therapy. A Nurses Note dated 3/31/18 at 1:21 a.m. documented Resident #1 as alert with confusion and she continued antibiotic therapy for a UTI. The resident misplaced her TV remote, staff could not find it and the resident stated it was a plot to kill her. Attempts at redirection did not work. The Incident Report dated 3/31/18 at 2:50 a.m. recorded staff heard yelling at 1:45 a.m. and found Resident #1 on her knees beside the bed with her head on a pillow and her feet twisted in a blanket. The nurse described the resident as confused and that she said "she pushed me out of bed because of papers". The resident complained of her right foot hurting; her range of motion was within normal limits and she walked without grimacing or limping. The nurse named confusion, incontinence and a current UTI as predisposing factors to the fall. An update on	F 689		

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F 689	Continued From page 5 4/2/18 documented a scoop mattress as placed on the resident's bed as a fall prevention intervention as she told the CAN (certified nursing assistant) she slid off her bed. The Incident Report dated 4/1/18 at 7:56 a.m. revealed that as a result of being called to the resident's room, the nurse saw Resident #1 lying on the floor on her left side next to the bed with her walker tipped over at her feet. The resident denied injury and moved all extremities without pain or discomfort. The Resident #1 stated the wheelchair rolled out from under her as she transferred from her recliner to the wheelchair; the wheels were not locked. The nurse noted confusion, UTI and gait imbalance as predisposing factors to the fall. An update on 4/2/18 documented a request to maintenance to place an anti-roll back device on Resident #1's wheelchair as a safety intervention. A Nurses Note dated 4/1/18 at 8:41 a.m. documented Resident #1 continued on antibiotic therapy for a UTI. The nurse noted that the resident as alert and oriented x 1 - 2 with baseline dementia/Alzheimer's disease process. An Incident Report dated 4/1/18 at 11:20 a.m. documented when called to the resident's room, the nurse saw Resident #1 sitting on the floor with her legs extended in front of her and her back resting on the front of her recliner. The resident denied injury and could move all extremities without any problems. Resident #1 told her the wheelchair rolled away because the wheels were not locked as she tried to transfer to it. The nurse noted confusion, UTI, gait imbalance and impaired memory as predisposing factors to the fall. Additional notes dated 4/2/18 documented	F 689		

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F 689	Continued From page 6 that lab work had been ordered as an intervention. A Nurses Note dated 4/2/18 at 6:16 a.m. documented that Resident #1 continued on antibiotic therapy for a UTI and the resident was alert and oriented x 1 - 2 with baseline dementia/Alzheimer's disease process. A Social Services note dated 4/2/18 at 10:16 a.m. and authored by the Administrator documented that at 10:11 a.m., he heard a yell down hall 4 and found Resident #1 on the floor. The Incident Report dated 4/2/18 at 2:31 p.m. recorded staff found Resident #1 lying on her right side at 10:15 a.m. The resident bled from a small area on the right side of her head. Resident #1 denied pain as staff rolled her onto her back for further assessment and the head laceration stopped bleeding. Staff assisted the resident to a sitting position; at which time she complained of some dizziness that resolved quickly. After standing, the resident continued to deny pain and had no apparent signs of other injury. The nurse documented the resident slipped out of the chair as she bent over to take her shoes off. The nurse documented confusion, incontinence, UTI, gait imbalance and impaired memory as predisposing factors to the fall. An additional note documented that Resident #1 had been sitting in her wheelchair at the time she bent over to take her shoes off and she went head first out of the wheelchair. Staff documented they changed out the resident's wheelchair applying an anti-roll back device and a drop seat. A Nurses Note dated 4/2/18 at 1:25 p.m. documented that Resident #1 complained of right	F 689		

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hip pain during transfers or movement. Staff obtained a new order for a right hip X-ray.

A Nurses Note dated 4/3/18 at 12:11 a.m. documented that X-ray results showed Resident #1 sustained a mid-displaced subcapital fracture of the right hip. The nurse notified the on-call doctor who gave orders to send the resident to the ER (Emergency Room) and the resident left the facility at 10:00 p.m.

The ED Provider Notes dated 4/2/18 at 11:13 p.m. documented Resident #1 arrived at the ER due to increasing pain over her right hip and the inability to walk since being found on the floor at 10:15 a.m. today. The resident had a 3 cm (centimeter) laceration over her right temple with mild bleeding. Resident #1 was confused and reported pain over her right hip, right knee and right ankle.

The final result of a hip X-ray dated 4/3/18 at 3:59 a.m. revealed Resident #1 sustained an impacted, non-displaced right femur fracture.

A Nurses Note dated 4/3/18 at 4:44 a.m. documented Resident #1 admitted to the hospital with a hip fracture.

An interview on 4/5/18 at 3:25 p.m. with Staff D, CAN revealed she went to the basement before Resident #1 fell on 3/29/18. Staff D said the resident's call light was off when she left about 3:20 p.m. and on when she returned about 3:30 p.m. Staff D saw Resident #1 sitting on the floor between her recliner and walker. She asked the resident, but she denied being in pain. Staff D reported it to the nurse. Staff D said the nurse did vital signs and they helped Resident #1 into

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her wheelchair. Staff D believed Resident #1 required the assistance of one for transfers and she only used her call light when she was in bed. Staff D said Resident #1 fell twice more in the next couple days. They told her to keep an eye on Resident #1 and provide help even if she did not ask for help. Staff D stated she did not know Resident #1 had a UTI until after she fell the third time at this point, they told her to keep a closer eye on the resident. Staff D said their pocket care plans do not let them know if residents have UTIs, although they should. Staff D said the nurses should tell them that stuff without having to ask. Communication is a real problem.

An interview on 4/9/18 at 9:40 a.m. with Staff C, CAN revealed when she returned from lunch break on 4/2/18 she learned that Resident #1 needed a shower because there was blood in her hair. Resident #1 had just fallen in her room. Staff C said they told her at shift change to keep a close eye on Resident #1 because she had a couple falls recently. Staff C believed Resident #1 required the assistance of one but the resident had a problem with using her her call lights or asking for help.

An interview on 4/9/18 at 2:05 p.m. with Staff A, CAN revealed that she found Resident #1 after both falls on 4/1/18. The resident fell first before breakfast. Resident #1 yelled for help as she helped another resident across the hall, Staff A saw her lying on the floor on her left side in front of her recliner and the resident seemed to be fine. Resident #1 told her she fell while transferring from the recliner to the wheelchair and it slid away from her because the wheels were unlocked. Staff A stated she told the nurse what happened and the nurse stayed with the

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resident while she went to find someone to help get her up. Resident #1 fell again before lunch. Staff A responded to Resident #1's call light and found her sitting on the floor. The resident told her she slid out of the chair while trying to self-transfer. Before the falls, Resident #1 was supposed to call for help to transfer, but she would not use her call light most of the time. Staff A said she told Resident #1 after the first fall she needed to lock her wheelchair and call for help. The CAN said she was late for work and the overnight shift had already left by the time she got there that morning. Staff A said the overnight shift should have told someone on the day shift the resident fell during the night; that information should have been relayed to her, but it was not. Staff A also said she had not asked and nobody told her anything about what was going on with her residents before she started her shift. Staff A said she told the next shift that Resident #1 fell twice during her shift and staff should keep a close eye on her. Staff A said she did not know that Resident #1 already fell twice that weekend.

An interview on 4/9/18 at 2:40 a.m. with the Director of Nursing (DON) revealed she worked on Saturday (3/31/18) and Sunday (4/1/18). With the first fall, the CAN told her she found Resident #1 on the floor about 8:00 a.m. The DON said she saw Resident #1 lying on the floor on her side. The resident told the DON her wheelchair slid out from under her as she tried to transfer from her recliner to her wheelchair. The DON saw the wheelchair about a foot away from the resident and the brakes were not on. The DON said that although the resident was not in any distress, she got upset because she fell. The resident squirmed around and got herself up on her knees at her chair. At that point, Resident #1

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let them help her up into the recliner. They transferred her back into her wheel chair shortly after to go down for breakfast. Staff made sure to keep the brakes on her wheelchair locked and to keep it far enough away from her so she would not be tempted to self-transfer again. The resident had a history of self-transferring. Resident #1 fell again about 11:20 a.m. The DON said the same CAN told her she found Resident #1 on the floor again. The DON went in there and saw the resident sitting on the floor perpendicular to her recliner with the wheelchair a couple of feet away. The DON said she asked what happened and the resident went off on a tangent about something that seemed irrelevant. The resident finally said something about the wheelchair falling out from under her. The DON said her assessment determined the resident did not have any injuries. The DON said that although the resident was independent to transfer in her room, they had been trying to give her assistance and encourage her to use her call light since she had a UTI but the resident continued to self-transfer. The DON said they had already implemented the installation of an anti-roll back device on her wheelchair as an intervention, but maintenance was not there to do it. The DON said she could not think of what else they might have done to try to prevent her from falling. The DON said information about a resident's change in status gets relayed by word of mouth and the 24 hour report.

An interview on 4/10/18 at 8:09 a.m. with Staff B, LPN (Licensed Practical Nurse) revealed he worked the overnight shift on 3/31/18 when Resident #1 fell. Staff B and a CAN met in the hallway about 2:30 a.m. on their way to find out the source of a yell they heard. They entered

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F 689	Continued From page 11 Resident #1's room together and found her on her knees with her head on the bed and her feet twisted up in a blanket. Staff B completed as assessment. Resident #1 complained about her right ankle, but he did not see any apparent signs of injuries. The CAN got the resident up to take her to the bathroom and he did not notice any problems as he watched the resident walk. Staff B asked the CAN later if Resident #1 complained about her ankle anymore and she said no. Staff B saw Resident #1 at about 8:00 p.m. shortly after the beginning of his shift as he had to give her an antibiotic for a UTI. Staff B said the resident was alert and very confused per her normal. Staff B said Resident #1 told him the "woman pushed her out of bed because she wanted the papers" but Resident #1 did not have a roommate. Staff B recalled a time when Resident #1 misplaced her TV remote. Resident #1 told people staff took her remote because they wanted to steal her social security check. Staff B said nobody reported anything unusual about Resident #1 at shift change and he last worked on 3/27/18 before she fell that night. Resident #1 had been independent in her room before the falls, but he did not know her transfer status now because she had moved up front. An interview on 4/10/18 at 9:35 a.m. with the PT (physical therapist) revealed that she was told on 4/6/18 that they expected Resident #1 back from the hospital on 4/7/18 and she should be prepared to come in on 4/8/18 to evaluate her needs. The PT said she talked to staff and they said Resident #1 had been doing pretty well after surgery, but was confused as normal. The PT said they changed the resident's room to keep her closer for safety due to the fact that she had several falls.	F 689		

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F 689	Continued From page 12 An interview on 4/10/18 at 10:30 a.m. with the MDS Coordinator revealed she thought everyone should know what every resident needs and what cares should be provided to them 24/7. Falls and changes in status should be entered into the 24 hour/communication book. When asked, the MDS Coordinator verified that nobody entered anything in the communication book related to Resident #1's falls prior to hospitalization or her transfer status upon being readmitted from the hospital. An interview on 4/10/18 at 1:50 p.m. with the Administrator regarding post fall interventions revealed they usually have IDT meetings on Monday mornings to discuss falls, what interventions were implemented and what needs to be changed. The Administrator said every fall is different and they try to determine the root cause of the fall and go from there. Regarding PT, it should be implemented as soon after a fall as possible which depends on when they obtain the order and consult with family, etc. When asked about implementation of a scoop mattress as an intervention after one of Resident #1's five falls, the Administrator said he did not know when they put the scoop mattress on the resident's bed and would speak with the old DON. The Administrator said spare mattresses are kept downstairs, including scoop mattresses. When asked how he could be sure they had a spare scoop mattress to use, the Administrator said he believed they had a spare because nobody asked him to rent one or obtain one. The Administrator would have expected maintenance to install the anti-roll back device specified as an intervention on Resident #1's wheelchair on the Monday morning following the falls and he saw the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165399	A. BUILDING _____ B. WING _____	C 04/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE CENTER	815 HIGH ROAD NORWALK, IA 50211

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F 689	Continued From page 13 antirollback bars installed on Monday 4/2/18. He did not think labs ordered over the weekend would have been picked up Sunday and the facility would have to store them. When asked who decides which post fall interventions should be implemented on the weekends in the absence of the IDT, the Administrator said nursing staff. The Administrator said he expected them to make good clinical decisions to keep the residents safe. The Administrator offered he though staff did everything they could do at that time considering the circumstances. Another interview on 4/10/18 at 4:15 p.m. with the Administrator revealed they did not get lab results back before the resident's fifth fall with fracture. The Administrator also acknowledged he could not find any documentation or information to know when the scoop mattress was placed on the resident's bed. A subsequent interview on 4/11/18 at 11:40 a.m. with the Administrator revealed they did not bill Resident #1 for the scoop mattress because they had one in storage. An interview on 4/11/18 at 8:20 a.m. with the Maintenance Assistant revealed a nurse asked him to put an anti-roll back device on Resident #1's wheelchair when he came in on the Monday morning after Easter. The Maintenance Assistant said Resident #1 sat in her wheelchair in the dining room when the nurse asked him and that wheelchair did not have an anti-roll back device on it at the time. The Maintenance Assistant said he asked an aid to transfer Resident #1 out of the wheelchair so he could work on it. The Maintenance Assistant went about his business, returned to work on the wheelchair and saw	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 14 Resident #1 on the floor with about 4 other people in her room. The Maintenance Assistant said this was the first request for him to install the device. An interview on 4/11/18 at 9:00 a.m. with the Maintenance Supervisor revealed that nobody had submitted a request to have an anti-roll back device installed on Resident #1's wheelchair. The Supervisor said they apparently just asked his assistant to do it when they saw him. Additional interview on 4/11/18 at 11:55 a.m. with the PT revealed they notified her at some point after a fall that Resident #1 would need to be evaluated and treated pending payment verification. The PT said she could not recall exactly when they first notified her, but she did not work with the resident until after she readmitted after surgery.	F 689		

Regency's Plan of Correction for Survey ending 04/11/2018

F000 Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency.

Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of appeal of these matters solely because of the requirements under State and Federal law that mandate submission of a plan of correction within ten (10) days of the receipt of survey findings. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admission by the facility.

This constitutes my credible allegation of compliance as of 04/25/2018.

F689

The standard of Regency Care Center is to ensure residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

1. For resident 1 identified, her environment remains as free of accident hazards as is possible; and she received adequate supervision and assistance devices to prevent accidents. Resident 1 care plan updated as well as C.N.A sheets.
2. All residents' environment within the facility remains as free of accident hazards as is possible; and all received adequate supervision and assistance devices to prevent accidents. All residents' care plans and C.N.A sheets have been reviewed/audited to ensure assistant devices are in use. Date of compliance is 04/25/2018
3. Education has been initiated and will continue to be provided to all staff during a mini in-service starting 4/11/2018.
4. The director of nursing and/or the designee will audit assistance devices and/or interventions are in place to prevent accidents. The findings will be reported at QAPI for 3 months and then as needed thereafter.
5. Date of Compliance 04/25/2018.