STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165243	A. BUILDING _____ B. WING _____	C 08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA GUEST HOME #3	302 NINTH STREET CHARLES CITY, IA 50616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS VKK 9/10/18 Correction date 8/31/18 The following deficiency relates to the investigatoin of mandatory #76740 and complaint #77145-A. (See code of Federal Regulations (45 CFR) Part 483, Subpart B-C).	F 000	F000 Chautauqua Guest Home #3 respectfully states that the facility was in substantial compliance with F689 on August 31,2018.	
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 and staff interviews the facility failed to provide adequate supervision and assistance when staff transferred one of three residents without the use of a gait belt (Resident #1) that resulted in a fall and a right hip fracture. The facility reported a census of 55 residents. Findings include: 1.According to the MDS (Minimum Data Set) dated 4/28/2018, Resident #1 had moderately impaired cognitive skills for daily decision making, and transferred and ambulated in the room with extensive assistance of one staff. The MDS revealed the resident had diagnoses including heart failure, hypertension, diabetes, dementia, anxiety, depression and a history of falling.	F 689	F689 The facility denies that the alleged facts as set forth constitute a deficiency under the interpretations of federal and state law. The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waiving the forgoing statement, the facility states the with respect to F689, the facility does maintain adequate supervision and assistance occurs while transferring residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Thorpe	Administrator	08/31/2018

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 689	Continued From page 1 The Care Plan initiated on 11/1/2017, identified Resident #1 dependence on staff to meet his intellectual, physical and social needs related to physical limitations. It instructed staff to refer to the RCG's (Resident Care Guidelines) posted in the resident's room for all direct care needs and safety instruction. It instructed staff to encourage the resident to use the call light to call for assistance and not expect the resident's use of call light. The Care Plan documented the resident had a risk for falls due to being unaware of safety needs. It instructed staff to provide a high-low bed when occupied, provide a safe environment, footwear and call light. It directed staff to refer to RCG's in the resident's room for safety instruction and attempt to anticipate the resident's needs. The resident had a fall risk prior to being admitted to the facility. The RCG's dated 3/29/2018 directed staff to provide transfers and ambulation with Contact Guard Assistance with the use of a gait belt and a rolling walker. The Major Injury Determination Form signed by the physician on 6/24/2018 revealed Resident #1 sustained a major injury when he had a witnessed fall in the bathroom on 6/23/2018. The Physician Notification Form dated 6/23/2018 revealed Resident #1 fell with Staff A, CNA (Certified Nurse's Aide) in the resident's bathroom. Staff A attempted to help the resident pull his pants down, the resident lost his balance and fell to the floor. The resident had no gait belt on. The resident also sustained skin tears to the left elbow, right hand and right wrist.	F 689	Staff A received individual training from the Occupational Therapist and the Director of Nursing regarding the proper use of gait belts and Resident Care Guidelines. Staff A also completed additional educational training courses. All nursing staff received education regarding the proper use of gait belts and Resident Care Guidelines by the Occupational Therapist and the Director of Nursing. Random audits of resident transfers involving nursing staff have been conducted to ensure that proper transfer techniques per the individual Resident Care Guidelines are being followed by the nursing staff. Chautauqua Guest Home's Continuous Quality Improvement Nurse will continue to complete periodic audits on nursing staff following Resident Care Guidelines.	8-31-18

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F 689	Continued From page 2 The Emergency Room Report dated 6/24/2018 revealed Resident #1 fell at the nursing home and sustained a right femoral neck (hip) fracture. The emergency department transferred the resident to a larger hospital. The computed tomography CT (provides cross section images) scan dated 6/24/2018 revealed Resident #1 had diagnoses including comminuted and mildly angulated right femoral neck fracture, degenerative changes in the lumbar spine and left hip gamma nail. The Chest x-ray indicated the resident had cardiomegaly and no consolidation to suggest pneumonia. The Right Hip x-ray revealed the resident had a possible nondisplaced greater trochanteric fracture on the right. No femoral neck fracture is identified. The Hospital History and Physical dated 6/25/2018 included: The patient with multiple underlying chronic comorbidities who had presented with ongoing sepsis, acute hypoxic respiratory failure, acute renal and heart failure. The patient's condition deteriorated despite medical management and family decided no further aggressive medical management or hospitalization and requested comfort care and symptom management under hospice care. The Discharge Summary dated 6/27/2018 revealed the resident received hospice care services. The State of Iowa Certificate of Death filed on 7/9/2018 included: Immediate cause of death: Sepsis Due to or as a consequence of right hip fracture due to accidental fall Other significant conditions: dementia.	F 689		

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F 689	Continued From page 3 During an interview on 8/17/2018 at approximately 1:00 p.m. and 8/21/2018 at 3:30 p.m., Staff B, RN (Registered Nurse), DON (Director of Nursing) revealed when Resident #1 fell on 6/23/2018 Staff A, CNA failed to use a gait belt during the transfer to the toilet. As Staff A pulled the resident's pants down, the resident lost his balance, fell to the floor and initially had no complaints of pain. The pain progressed into third shift and staff transferred the resident to the emergency room where tests determined the resident had a right hip fracture. The resident's RCG's documented staff were required to transfer the resident with Contact Guard Assist and a gait belt. The RCG's are posted in each resident's room. Contact Guard Assist means at least one hand on the gait belt at all times. During an interview on 8/17/2018 at 1:00 p.m., Staff A reported working on 6/23/2018 when Resident #1 fell in the bathroom. Staff A revealed he/she transferred the resident from the recliner to the wheel chair without a gait belt, transported the resident to the bathroom doorway. Next Staff A ambulated the resident from the doorway with a walker to the toilet without a gait belt. The resident held onto the grab bar while Staff A lowered the resident's pants and the resident lost his balance and fell landing on his right side. The resident had no complaint of pain but did sustain skin tears. Staff A received re-education regarding gait belt use. Staff A reported knowing the gait belt policy to use it for all residents who require assistance.	F 689		