STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165260	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DONNELLSON HEALTH CENTER	901 STATE STREET DONNELLSON, IA 52625

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F 000	INITIAL COMMENTS Correction Date September 13, 2018 Complaints 76635-C and 75124-C were investigated 7/18/18 to 8/13/18 and resulted in the following deficiencies. Complaint 76635-C was substantiated. Complaint 75124-C was not substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide meal preparation assistance as required for 1 of 5 dependent residents reviewed (Resident #2). The facility reported a census of 51 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool dated 7/5/18 revealed Resident #2 had diagnoses that included non-Alzheimer's dementia, other fracture, anorexia, depression and adult failure to thrive, severe cognitive impairment, required extensive assistance of at least 1 staff for transfers to and from bed and chair, bathing, toileting, personal hygiene and ambulation, 1 staff required for supervision and	F 677		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheryl Ruiz | TITLE: Administrator | (X6) DATE: September 13, 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 677	Continued From page 1 physical assistance for eating, deficits of bilateral upper and lower extremities, and the resident had impaired vision. An impaired vision problem identified on the nursing care plan on 3/5/18 directed staff to ensure the resident had glasses on and that they were clean. Observations revealed: 7/19/18 at 8:03 a.m., the resident received breakfast: 2 eggs over easy and 2 pieces of toast. The staff that delivered the meal did not offer or provide assistance, there were no staff positioned at the resident's table in the assisted dining room, and the resident was not wearing eyeglasses. Continuous observation until 8:08 a.m. on 7/19/18, revealed the resident had not made any attempts to eat. When the surveyor asked who the resident was, a dietary employee went to the resident and asked her if she wanted anything else. The resident declined. Continuous observation in the assisted dining room initiated at 7:29 a.m. on 7/31/18 revealed the resident seated in a wheel chair at a table not wearing glasses. At 7:44 a.m., a dietary employee delivered the resident's breakfast: 2 eggs over easy and 2 pieces of toast. The employee offered initial set-up assistance of the meal that included placing silverware on plate, and told the resident she had hot coffee to drink. At 7:53 a.m., the resident had eaten 3 bites of eggs and drank from the coffee cup with no staff	F 677		

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F 677	Continued From page 2 assistance offered. At 8:07 a.m., the resident had not received any assistance, and had not eaten anything else. At 8:11 a.m., the resident had not received any assistance and told Staff R, registered nurse (RN), that she couldn't eat because her food wasn't cut up, and she couldn't see because she didn't have her glasses. Staff R cut the toast into bite sized pieces and she began to eat, 3 staff went to the resident's room and returned with her glasses at 8:15 a.m. Staff did not offer to reheat the resident's meal or provide a replacement meal. 2. Observation of the breakfast meal in the dementia unit on 7/19/18 between 6:45 a.m. and 8:01 a.m. revealed: 1. The breakfast meal was plated onto trays and delivered to the unit on a rack at 7:18 a.m. The trays included a fork and spoon. 2. Staff J, CNA and Staff S, CNA served the meal with assistance by Staff T, CNA and unit manager, and Staff D, licensed practical nurse (LPN). Seven of the meals served to residents seated in the dining room included a slice of ham, approximately 3 inches by 5 inches by 1/4 inch thick in size, and served to the residents uncut. 3. Continuous observation until 8:01 a.m. revealed 6 of the residents had not attempted to eat the slice of ham, and 1 resident had lifted the slice with a fork and taken a bite out of it. Staff present stated they did not have a way to cut the residents ham. During an interview on 8/1/18 at 11:35 a.m., the director of nursing (DON) stated staff should	F 677		

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F 677	Continued From page 3 assist residents during meal service as needed. .	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, physician and family member interviews, the facility failed to provide adequate nursing supervision to prevent resident injuries from falls for residents with history of falls for 3 of 6 resident records reviewed with fall histories (Residents #2, #3 and #4). Due to repeated falls, Resident #3 sustained a closed fracture of the right, 5th metatarsal bone (toe), a small rug burn on right knee, 4 small abrasions/bruises on right forearm, a closed, displaced fracture of the right greater trochanter, contusion of left hip, facial contusion, a bloody nose, and another bruise to the right arm. In addition, Resident #4 sustained an acute, mildly displaced, transcervical left femoral neck fracture due to a fall, and Resident #2 fell face forward from a wheelchair and sustained an abrasion to the forehead. The facility reported a census of 51 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment	F 689		

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F 689	Continued From page 4 tool dated 6/4/18 revealed Resident #3 admitted to the facility's dementia unit on 2/5/18, with diagnoses that included diabetes, dementia, and depression. The MDS identified the resident scored 5 out of 15 points possible on the Brief Interview of Mental Status (BIMS) cognitive assessment (severe cognitive impairment), and displayed symptoms of delirium. The MDS documented the resident required extensive assistance of at least 1 staff for transfers to and from the bed and chair, bathing, dressing, toilet use and personal hygiene. The MDS documented the resident as always incontinent of bowel and frequently incontinent of bladder, and revealed the resident experienced 2 or more falls without injury since the previous assessment completed on 4/4/18. A fall risk problem on the nursing care plan initiated on 2/5/18 contained interventions and information that included: 2/5/18 - Assist resident with appropriate footwear with ambulation (walking) or transfers. 2/5/18 - Ensure call light within reach and remind resident to use it for assistance, as the resident required prompt response to all requests for assistance. 2/12/18 - Remind the resident to use front-wheeled walker for ambulation. 2/22/18 - Apply sign to the walker: "Please use me," and follow order for physical and occupational therapy for evaluation and treatment. 4/29/18 - Contact physician for concerns with antidepressant medication, order MRI scan, and start 15 minute checks. 5/8/18 - Pressure alarm at all times. 5/8/18 - Resident to wear hipsters (hip pads).	F 689		

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F 689	Continued From page 5 5/21/18 - Staff to encourage hydration as ordered by physician. 6/9/18 - Lower clothing rod in closet. 7/13/18 - Apply non-skid strips on the floor by the closet. A dementia problem on the nursing care plan, initiated 2/12/18, contained interventions and information that included: 2/12/18 - Resident exhibited unsteady gait. 2/12/18 - Staff assistance for toilet use every 2 hours and as needed. 2/12/18 - Staff assistance for personal hygiene and perineal care. 2/12/18 - Staff assistance for dressing and undressing. 5/7/18 - Staff assistance of 1 with gait belt for transfers with four wheeled walker. 6/7/18 - Staff assistance of 1 with gait belt for ambulation with four wheeled walker. 7/19/18 - Resident had and used E-cigarettes Physician order dated 5/30/18 directed staff to offer 8 ounces of water every 2 hours while awake for hydration. Nurse's Notes and facility incident reports documented the resident had the following falls and outcomes as noted: 1. 2/12/18 at 1:30 p.m., Staff D, licensed practical nurse (LPN), documented the resident opened the door to the patio with her buttocks, and landed on her buttocks in the snow. The staff sent the resident to the hospital emergency room (ER), where a closed fracture of the right 5th metatarsal bone was diagnosed. The resident returned to the facility in a cam-boot with weight	F 689		

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F 689	Continued From page 6 bearing as tolerated, and a referral to an orthopedic physician. 2. 2/22/18 at 2:10 a.m., Staff E, LPN, wrote the resident ambulated in the hall without her walker, tripped over the cam-boot, fell, landed on her right side with a sliding motion, and sustained a small rug burn on the right knee and 4 small abrasions/bruises on right forearm. A certified nursing assistant (CNA) witnessed the fall and staff reminded the resident to use a walker with ambulation. 3. 2/26/18 at 7:00 p.m., Staff F, LPN, documented the resident reported an unwitnessed fall when she fell out of her roommate's recliner. Staff found no injuries and educated the resident regarding the importance of using her call light. 4. 2/27/18 at 4:05 p.m., Staff F wrote the resident reported an unwitnessed fall in which she slipped and fell on spilled soda on the floor, and hit her knees and head. No injuries were identified and staff assisted the resident to a common area for closer monitoring. 5. 3/1/18 at 8:45 a.m., Staff G, RN, described an unwitnessed fall in the shower room, when staff found the resident unclothed and on her right side. The resident stated she hit her head and complained of right arm and right hip pain. Staff sent the resident to the ER where she was diagnosed with a urinary tract infection and returned with an antibiotic prescription, her medications reviewed, and an MRI scan scheduled. 6. 3/8/18 at 6:44 a.m., Staff D documented an unwitnessed fall, when staff found the resident on her hands and knees. The resident stated she could not feel her legs and complained of right hip pain. Staff, sent to the resident to the ER, where she was diagnosed with musculoskeletal pain	F 689		

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F 689	Continued From page 7	F 689		

and the need for close outpatient follow up. The record contained no incident report for the event.
7. 4/4/18 at 5:30 a.m., Staff A, LPN, wrote a CNA saw the resident stood from the couch, took a few steps without her walker, stumbled to the couch, flipped over, and fell to the floor. Staff noted no injuries and educated the resident to use her walker.
8. 4/8/18 at 12:40 a.m., Staff A documented an unwitnessed fall when the resident ambulated without her walker and ran into the night stand. Staff found her on top of the night stand and against the dresser with no injuries. Facility staff recommended no new interventions.
9. 4/18/18 at 2:00 a.m., Staff E described an unwitnessed fall when resident ambulated without her walker and complained of pain in the right thigh area. Staff noted the resident could ambulate with her walker, but sent her to the ER, where she was diagnosed with a urinary tract infection and hip contusion. Resident #3 returned to the facility with orders for an antibiotic. Interventions included the resident to ambulate with assist of 1 or 2 staff and walker, and physical therapy to treat the resident's mobility.
10. 4/19/18 at 1:10 p.m., Staff E described an unwitnessed fall near the nurse's station. Staff found the resident on the floor with her walker near her head. The resident complained of right hip pain. Staff transferred the resident to a bed via mechanical lift, and applied a personal alarm.
11. 4/25/18 at 7:15 a.m., Staff D, LPN, described an unwitnessed fall near the nurse's station. The resident lay on her left side on the left wheel chair foot pedal. The right foot pedal was over her, with the wheel chair tipped over and folded around her, right arm stuck between the side of the wheel chair and the arm rest. The resident had pain with range of motion, so staff sent her to the ER. She

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F 689	Continued From page 8 returned with diagnoses of urinary tract infection and dehydration. 12. 4/28/18 at 6:30 p.m., Staff H, RN, described an unwitnessed fall in which the resident stood from bed. The pressure alarm remained in wheel chair and had not been used. The resident presented with an abnormal neurological examination. Staff sent the resident to the ER. She returned to the facility with a diagnosis of closed displaced fracture of the right greater trochanter and orders for partial weight bearing with use of walker at all times and referral to orthopedic physician. The record did not contain an incident report that described the event, and staff implemented no new interventions. 13. 4/29/18 at 10:20 a.m., Staff E described an unwitnessed fall. The resident removed the alarm, stood by the dresser without her walker, fell, and hit her head and nose on dresser. The resident's nose bled and she complained of head, left wrist, nose and right leg pain. Staff sent her directly to the ER and she returned to the facility with contusions of the left hip and face. Staff implemented 15 minute checks. 14. 5/4/18 at 1:00 p.m., Staff E described an unwitnessed fall from the wheel chair. The resident's alarm sounded when she attempted a self-transfer to a recliner chair. Staff found no injuries. 15. 5/8/18 at 2:45 p.m., Staff E described an unwitnessed fall when the resident self-transferred from her recliner to wheel chair. The note contained no documentation related to the use of walker or alarm. The resident complained of pain in the coccyx area. Interventions included staff to apply hipsters to the resident's hips and a bed alarm to the resident's bed. 16. 5/12/18 at 1:45 p.m., Staff E documented the	F 689		

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F 689	Continued From page 9 resident sat unattended outside on the patio in her wheelchair; staff heard alarm and found the resident on her right side. The resident reported she hit her head. Staff documented no injuries identified and staff to perform 15 minute checks if patio door unlocked. 17. 5/21/18 at 6:30 a.m., Staff D described an unwitnessed fall when the resident stood from the wheel chair to obtain clothes from her closet (no mention of alarm or walker in note). The resident stated she fell because the floor was wet. Staff identified the resident had urinated on the floor and noted a bruise on the resident's right arm. 18. 5/29/18 at 9:00 a.m., Staff D described an unwitnessed fall when the resident tripped over the wheel chair foot pedals and lost her balance. Resident #3 complained of right wrist pain. The alarm in the wheel chair did not sound. Staff were to remove foot pedals from wheel chair unless in use by resident. 19. 6/9/18 at 12:45 p.m., Staff E described an unwitnessed fall by the resident's closet. The resident had placed clothes in her wheel chair "packing to go home." The alarm did not sound. Intervention: staff to provide activities for resident. 20. 6/27/18 at 5:45 a.m., Staff A described staff witnessed the resident rise from the wheel chair, the wheel chair moved, and the resident fell. No injuries identified. 21. 7/3/18 at 3:15 p.m., Staff I, RN, described an unwitnessed fall when staff responded to the alarm. The resident reported she slipped when she attempted to transfer to her wheel chair. Staff to provide frequent reminders. 22. 7/4/18 at 4:15 p.m., Staff I documented the staff witnessed Resident #3 fell backwards when she stood with the walker. Staff to prompt the resident to get up between 3:00 p.m. and 4:00 p.m.	F 689		

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F 689	Continued From page 10 23. 7/31/18 at 6:30 a.m., Staff J documented the resident found on floor in common area upon her return to the unit. The facility's undated Smoking Contract policy directed: 1. Smoking status will be assessed prior to or upon admission. 2. The Smoking Assessment form utilized on admission and as needed to assess resident safety. 3. Electronic cigarettes may be permitted inside. The resident's record lacked any completed Smoking Assessment forms. Observations revealed: 7/18/18 at 2:55 p.m. - Resident #3 seated in her wheel chair in the common area. The resident held an electronic cigarette that wasn't powered with the chair pad alarm in use. 7/31/18 at 8:10 a.m. and 12:50 p.m., Resident sat in her wheel chair, chair pad alarm in use, foot pedals off the wheel chair while she self-propelled it with her feet. The resident held an electronic cigarette that wasn't activated. Staff, physician and family interviews revealed: 7/31/18 at 9:05 a.m., Staff D stated the resident was impulsive and had many falls from self-transfers. Staff D reported the resident had an electronic cigarette and the CNA's charged the batteries. Staff D added the resident used the electronic cigarette by herself on the dementia unit.	F 689		

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F 689	Continued From page 11 7/19/18 at 1:24 p.m., Staff K, CNA, reported the resident used electronic cigarettes in the dementia unit. Staff D stated the facility staff recharged the batteries and notified family when the resident needed more cartridges. 7/19/18 at 1:36 p.m., Staff J, CNA, stated the resident used electronic cigarettes independently and staff charged the batteries and helped the resident with the cartridges. Staff J added all staff aware the resident had it. Staff J reported the nurses instructed the aides when the residents required checks every 15 minutes due to fall risk, although they didn't have any resident currently on the 15 minute checks. 8/1/18 at 11:35 a.m., the DON stated residents could use electronic cigarettes in the facility and in the dementia unit, she expected staff to charge the batteries, switch cartridges, notify family if more supplies were needed, and didn't expect staff to supervise the residents when they used them. The DON stated she expected staff to identify factors that contributed to a resident's fall and get ahead of it, such as take the resident to the toilet every few hours, if an alarm used the resident should be able to stand for 30 seconds so staff could get to them. The DON reported the resident fell at 6:30 a.m. on 7/31/18 when she self-transferred from her wheel chair in the common area with only 1 of the brakes locked. The CNA's were in resident rooms for cares and the nurse had left the unit for a few minutes to obtain a pitcher of ice water for her morning med pass. 7/23/18 at 7:20 p.m., the physician of record for Residents #2, #3, and #4 stated she was very concerned about the nursing supervision and	F 689		

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F 689	Continued From page 12 number of falls the residents at the facility sustained. She reported the facility notified her via fax (facsimile) of the residents' falls and it was not uncommon to have from 4 to 8 of the notifications daily. She added facility residents were dehydrated as confirmed through laboratory tests and several observations in the dementia unit where the resident's seldom had anything to drink. The physician stated the dehydration contributed to the residents' dehydration diagnoses (where applicable) and she met with the DON in April to state her concerns. 8/13/18 at 6:35 p.m., the resident's family member stated the resident experienced many falls when she lived in her own at home and that was the reason why Resident #3 had to go to the nursing home. The family member reported being concerned about the resident's injuries from the falls. 2. The MDS dated 7/9/18 revealed Resident #4 had diagnoses that included diabetes, hip fracture, other fracture, non-Alzheimer's dementia, and depression and displayed severe cognitive impairment. The MDS revealed the resident required extensive assistance of at least 1 staff for transfers to and from bed and chair, bathing, dressing, toilet use, personal hygiene and ambulation, and had 2 or more falls without injury since the previous assessment completed 6/20/18. A fall history problem on the nursing care plan, initiated 7/25/17, had interventions and directives that included: 8/15/17 - Assist resident with appropriate	F 689		

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F 689	Continued From page 13 footwear for ambulation and transfers. 3/23/18 - Non-skid socks at night. 5/25/18 - Request physical and occupational therapy for strengthening and safety with transfers. 5/31/18 - Educate staff to leave wheel chair within the resident's reach. 6/1/18 - Pressure alarm on bed. 6/1/18 - Transfer and ambulate with 2 staff assist, gait belt and four wheeled walker. 6/3/18 - Staff to remove foot pedals from wheel chair when not in use. 6/13/18 - Resident to wear hipsters. Nurse's Notes and incident reports revealed the resident had the following falls and outcomes: 1. 5/25/18 at 3:00 p.m., Staff F, LPN described an unwitnessed fall when staff found the resident on the floor next to a recliner with no injuries identified. 2. 5/31/18 at 10:30 p.m., Staff I, RN described a witnessed fall when staff saw the resident ambulating in the hall without a walker and no injuries identified. Staff to positron walker where the resident would see it before attempting ambulation. 3. 6/1/18 at 8:00 p.m., Staff I described an unwitnessed fall when staff found the resident on the bathroom floor as she had ambulated there without the walker. The resident reported she hit her head and the assessment revealed a small purple mark on the left side of the neck. Staff placed a bed alarm on the bed due to the resident's repeated attempts to self-transfer. No other injuries assessed. 4. 6/3/18 at 12:45 p.m., Staff D, LPN documented an unwitnessed fall when the resident self-transferred from wheel chair to bed	F 689		

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F 689	Continued From page 14 and landed on the left wheel chair foot pedal. Staff found no other injuries. Staff to remove the wheel chair foot pedals when not in use. 5. 6/3/18 at 9:40 p.m., Staff L, RN described an unwitnessed fall when staff responded to the bed alarm and found the resident on their left side by bathroom entry. The resident complained of pain to the left mid side and pain to knee with previous abrasion area, no other injuries assessed. Staff encouraged the resident to use the call light. 6. 6/4/18 at 6:30 p.m., Staff E described the resident's fall in the dining room. After she stood up, her left foot caught behind the other foot and she fell to the floor. The resident complained of left arm pain and cried out in pain when staff attempted to assist her to stand and she rubbed her left leg. Staff sent the resident to the ER. The hospital identified an acute mildly displaced transcervical left femoral neck fracture. The resident admitted to the hospital with surgical repair required and returned to the facility on 6/11/18 with orders for fall precautions, ambulation with walker at all times, and resident to drink at least 6 glasses of water during the day. 7. 6/25/18 at 3:15 a.m., Staff M, LPN described an unwitnessed fall when staff found the resident on the bathroom floor with no injuries found and no mention of the resident's walker or alarm in the report. The resident to wear non-skid socks when in bed. 8. 7/8/18 at 3:55 a.m., Staff N, RN, described an unwitnessed fall when the resident rolled out of bed. Staff assessed no injuries and would place a fall mat next to the resident's bed. A facility Daily Census sheet dated 6/4/18 revealed 18 residents in the unit that day, 9 of the 18 had recent fall histories.	F 689		

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F 689	Continued From page 15 Observations of the resident revealed: 7/18/18 at 12:15 p.m., resident seated in a wheel chair in the dining room, dressed, shoes on with feet on foot pedals of wheel chair. 7/18/18 at 2:55 p.m., the resident remained seated in the wheel chair and at a large round table in the common area with other residents. 7/31/18 at 9:42 a.m., the resident sat in a wheel chair at a large table in the common area. The resident was dressed with their shoes on and feet on the foot rests of wheel chair. Staff interviews revealed: 7/31/18 at 2:48 p.m., Staff E stated she worked in the unit the evening shift on 6/4/18, was not in the dining room when the resident fell and didn't observe the fall. She stated the aides would have been in the dining room. 8/1/18 at 10:08 a.m., Staff O, CNA stated she worked in the unit on the evening shift on 6/4/18. Staff O reported she was in the dining room and assisted Resident #5 with the evening meal. She stated she faced away from the exterior wall and did not see the resident fall. She stated she was made aware of the fall when a visitor said the resident had fallen and there were no other staff in the dining room at the time. 8/1/18 at 11:05 a.m., Staff P, agency CNA, stated she worked at the facility from 6:00 p.m. to 10:00 p.m. on 6/4/18 on the unit, but she was not in the dining room when a resident fell. She added she did remember a resident had fallen that night. 8/1/18 at 11:35 a.m., the DON stated the resident's foot got caught behind the other when she fell on 6/4/18, but she must have gotten up by herself. She stated the fall wasn't investigated and at least 1 staff was required in the dining	F 689		

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F 689	Continued From page 16 room on the unit. The DON stated the unit was staffed with 1 nurse and 2 CNA's on the day shift, 1 nurse and 2 CNA's on the evening shift, with a companion employee between 4 p.m. and 7 p.m. if available, and 1 CNA on the night shift, with a nurse available from the other side of the facility when needed. 3. The MDS dated 7/5/18 revealed Resident #2 had diagnoses that included non-Alzheimer's dementia, other fracture, anorexia, depression and adult failure to thrive. The MDS revealed the resident displayed severe cognitive impairment and documented the resident required extensive assist of at least 1 staff for transfers to and from bed and chair, bathing, toilet use, personal hygiene, and ambulation (walking). The MDS also documented the resident exhibited deficits of bilateral upper and lower extremities, and experienced no falls since the previous assessment completed on 6/12/18. The nursing care plan included a fall risk problem, initiated on 1/24/18, with interventions that directed staff: 1/24/18 - Assist resident with appropriate footwear for ambulation or transfers. 7/17/18 - Hipster garment for safety. 7/18/18 at 2:44 p.m. - Staff education for daily bathroom checks. 7/18/18 at 6:45 p.m. - Lab work and medication review. 7/26/18 - Staff education and occupational therapy for wheel chair. Observation on 7/31/18 at 7:29 a.m. revealed the resident had a purple colored circular shaped	F 689		

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F 689	Continued From page 17 bruise located on the center of her forehead approximately 3 to 4 centimeters in size, with evidence of abrasion. A Nurse's Note transcribed on 7/27/18 at 11:23 p.m. by Staff A, LPN revealed the protocol for a scrape on forehead was initiated. The abrasion/scrape was sustained when the resident fell forward from wheel chair on 7/26/18. Nurse's Notes did not describe a fall on 7/26/18. An incident report dated 7/26/18 at 9:00 a.m. by Staff C, RN documented the resident fell out of a wheel chair face forward when a certified nursing assistant, (CNA), pushed her in the wheel chair. The report didn't identify which staff involved or witnessed the event, and did not describe any injury received. The form documented first aid that included normal saline, pat dry, Vaseline gauze, and gauze and tape administered. During an interview on 8/1/18 at 11:35 a.m., the DON stated Staff B, CNA pushed Resident #2 in the wheel chair without foot pedals, the resident had shoes on, and leaned forward in the chair. The DON reported the resident fell face forward out of the wheel chair and hit her head on the floor. The DON stated the resident received an abrasion on the forehead as a result of the fall. The DON stated staff should not push a resident if the foot pedals are not on the wheel chair, or resident's feet not positioned on the foot pedals.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		

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F 692	Continued From page 18 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and physician interviews, the facility failed to provide adequate hydration to dependent residents, prevent symptoms of dehydration for 2 residents on the dementia unit (Residents #3 and #4), and failed to identify interventions to prevent dehydration on the care plan of 1 resident identified as at high risk for dehydration on the Minimum Data Set (Minimum Data Set) Assessment tool (Resident #2). The facility reported a census of 51 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool dated 6/4/18 revealed Resident #3 admitted to the dementia unit of the facility on 2/5/18, with diagnoses that included diabetes, dementia and depression. The MDS revealed the resident	F 692		

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F 692	Continued From page 19 scored 5 out of 15 points possible on the Brief Interview of Mental Status (BIMS) cognitive assessment, (indicating severe cognitive impairment), displayed symptoms of delirium present, and required extensive assistance of at least 1 staff for transfers to and from bed and chair, bathing, dressing, toileting and personal hygiene. The MDS documented the resident as always incontinent of bowel, frequently incontinent of bladder, and with 2 or more falls without injury since the previous assessment completed on 4/4/18. An unintentional weight loss problem listed on the nursing care plan on 3/29/18 directed staff to monitor, document, and report significant changes in nutrition (such as excessive thirst), and to provide daily snacks. According to the hospital Emergency Room discharge report dated 4/25/18, the hospital treated the resident for injuries sustained from a fall at the nursing home, and diagnosed the resident with a urinary tract infection and dehydration. A physician order dated 5/30/18 directed staff to offer 8 ounces of water every 2 hours while awake for hydration. 2. The MDS dated 7/9/18 revealed Resident #4 had diagnoses that included hypertension (high blood pressure) diabetes, hip fracture, non-Alzheimer's dementia and depression, and displayed severe cognitive impairment. The MDS documented the resident resided in the dementia unit, required extensive assistance of at least 1 staff for transfers to and from bed and chair,	F 692		

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F 692	Continued From page 20 bathing, dressing, toileting, personal hygiene and ambulation, and experienced 2 or more falls without injury since the previous assessment completed 6/20/18. A diabetes problem identified on the nursing care plan on 6/26/17 directed staff to assist with compliance of treatment regimen. Physician orders dated 6/11/18 directed staff to: 1. Administer Lasix (a diuretic medication that can cause dehydration) 80 milligrams oral daily. 2. Ensure the resident had at least 6 glasses of water during the day. Hospital discharge summary documents revealed the resident discharged to the facility on 6/11/18 after surgical repair of a hip fracture, returned to the hospital on 6/11/18 and was treated for gastrointestinal bleeding, and discharged to the facility on 6/13/18. Review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June, 2018 and July, 2018 revealed an order for administration of 6 glasses of water during the day was not implemented, and staff failed to carry the the order forward upon the resident's return to the facility on 6/13/18. Observations on the dementia unit revealed: 7/18/18 at 10:01 a.m. - water pitchers approximately 1/2 full of ice water (approximately 16 to 20 ounces) and located on the night stands of most resident rooms, with empty glasses near the pitchers.	F 692		

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F 692	Continued From page 21 7/19/18 at 7:10 a.m. - water pitchers approximately 1/2 full of ice water on the night stands in most resident rooms, empty glasses located near the pitchers. Continuous observations on the dementia unit revealed: 7/18/18 between 10:01 a.m. and 1:38 p.m., and again between 1:46 p.m. and 5:06 p.m. revealed 3 residents that included Resident #3 received a beverage without snack at 2:55 p.m. at a large round table in the common area, 9 residents were seated in the area and awake, and 4 additional residents located in the living room area adjacent to the table. 7/19/18 between 6:45 a.m., and 8:01 a.m. and again between 8:39 a.m. and 3:10 p.m. revealed no snacks or additional hydration between meals offered. 7/31/18 between 8:46 a.m. and 12:51 p.m., and again between 1:14 p.m. and 4:08 p.m. revealed no snacks or additional hydration between meals offered. The observations revealed breakfast served at 7:15 a.m., lunch served at 11:30 a.m. and supper served at 6:00 p.m. Staff interviews revealed: 7/19/18 at 1:24 p.m. Staff K, certified nursing assistant (CNA), stated snacks are passed after they provided their last resident cares on the day shift and would be passed soon (day shift 6:00 a.m. to 2:00 p.m.)	F 692		

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F 692	Continued From page 22 7/19/18 at 1:36 p.m. Staff J, CNA, stated she passed snacks when finished with cares and prior to arrival of the 2nd shift at 2:00 p.m. 7/31/18 at 2:48 p.m., Staff E, licensed practical nurse (LPN) stated the kitchen prepared the snacks and distributed throughout the building by an employee that works on the unit at 1:30 p.m. and 7:30 p.m., and there are snacks available on the unit to offer. Staff E stated the residents were usually thirsty, but would push food away. 8/1/18 at 11:35 a.m., the director of nursing (DON) stated she expected staff to offer snacks and beverages in the afternoon or if a resident was hungry on the dementia unit. The DON also stated staff offer residents drinks when they come to the dining room for a meal, and reported she identified a resident every day staff needed to offer fluids to. When asked which resident on the unit was identified when, the DON stated Resident #6 on the unit was identified last Thursday or Friday. She stated had probably identified Resident #3, but she did not maintain records of which residents were identified for fluid encouragement. 8/1/18 at 2:00 p.m., the administrator asked what recommendations the surveyor had that ensured residents received adequate hydration from staff. During an interview on 7/23/18 at 7:20 p.m., the physician of record for Resident's #2, #3 and #4 stated the residents were dehydrated as confirmed through laboratory tests and several observations in the dementia unit where the residents seldom had anything to drink. The physician stated she met with the DON in April	F 692		

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F 692	Continued From page 23 and, when she stated her concern about lack of hydration on the unit, the DON responded that it led to compulsive drinking and bathroom frequency. The physician reported her office nurse witnessed the conversation. During an interview on 7/25/18 at 9:39 a.m., Staff Q, office nurse for the physician, stated she was with the physician at the nursing home on 4/26/18 when the physician told the DON she was concerned about the number of falls and the fact that the residents weren't adequately hydrated. Staff Q reported the DON said something that meant the resident's would drink incessantly if water was left out for them to drink, there would be more incontinence and wet beds and they didn't have the staff for that. Staff Q stated the facility gave both the doctor and herself a bottle of water when they arrived, and the doctor poured a glass of water from the bottle for Resident #4 when she said she was thirsty. Staff Q reported the resident drank it immediately, so the physician poured another glass of water for the resident. 3. The MDS dated 7/5/18 revealed Resident #2 had diagnoses that included hypertension (high blood pressure) non-Alzheimer's dementia, other fracture, anorexia, depression and adult failure to thrive. The MDS documented the resident displayed severe cognitive impairment, required extensive assistance of at least 1 staff for transfers to and from the bed and chair, bathing, toileting and personal hygiene and ambulation. The MDS also documented the resident displayed deficits of bilateral upper and lower extremities, and had experienced no falls since the previous assessment completed on 6/12/18.	F 692		

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F 692	Continued From page 24 The resident's admission MDS Assessment, completed on 1/26/18, documented the resident as at risk for dehydration and revealed the facility needed to address the risk on the resident's nursing care plan. The resident's nursing care plan since admission to the facility on 1/19/18 revealed the risk of dehydration not addressed, and no interventions listed that directed staff to meet the resident's hydration requirements or monitor for signs or symptoms of dehydration. Observation on 7/18/18 at 1:43 p.m. revealed a water pitcher half filled with iced water positioned on the resident's night stand, without glass, and not within the resident's reach if in bed. Observation on 7/19/18 at 8:02 a.m. revealed the water pitcher half filled with iced water and empty glass positioned on the night stand and out of the resident's reach if in bed. Observation on 7/31/18 at 7:28 a.m. revealed water pitcher half filled with iced water on the night stand and without a glass.	F 692		

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with State and Federal regulations the facility has completed the following actions set forth in the plan of correction. All deficiencies have been completed by September 13, 2018.

F677:

The facility does and will continue to provide meal preparation assistance as required.

1. On August 13, 2018 certified nursing assistants are to carry printed kardex with them so residents plan of care such as glasses and eating assistance are available where computers are not located. The dining room was reconfigured so all residents requiring physical assistance to eat are seated together were certified nursing assistants can help them.

Measures Taken: Kardex to be printed daily. Education provided to certified nursing assistant to carry kardex with them and review during shift change as computers are not accessible in resident rooms and dining areas. Individual I-Pads have been ordered for the certified nursing assistants to carry with them. This will provide them with computer access to kardex from anywhere in the facility. The restorative nurse will be responsible for reviewing the seating arrangement as residents needs change.

2.On August 13, 2018 Dietary staff was instructed to send all meat to the dementia unit cut into bite size pieces.

Measures taken: Dietary Staff was educated. Instructions were added to each residents' ticket in the dementia unit and any other resident that may not have a knife or are not capable of cutting their own meat.

F689:

The facility does and will continue to provide adequate nursing supervision and assistant devices to prevent injury.

1. All residents are evaluated for fall risk upon admission to the facility, quarterly and as further needs arise. All residents that have sustained a fall will have an intervention placed on kardex by the shift nurse at the time of fall. All resident falls will be evaluated by the facility fall committee on a weekly basis. All interventions put into place by the fall committee will be reviewed by the attending physician. The facility has been working on falls through the QAPI committee and PIP team members to aid in prevention of further falls for identified residents. This process will continue to aid in prevention of future falls in the facility. Falls are reviewed with the medical director at quarterly QA meetings.

The November 2011 CMS smoking policy remains in effect stating that E-Cigarrettes are not considered a smoking device. The smoking policy has been updated to reflect the May 2018 article on the DIA website.

Measures taken: Education provided to falls committee with plan of correction. Smoking policy reviewed and updated. Residents using E-cigarette devices will be provided smoking safety assessment per the Pearl Valley smoking procedures and guidelines of state and federal regulations. These assessments will be performed quarterly and as indicated needs arise.

2. Staffing in the dementia unit will be staffed with 2 certified nursing assistants and 1 nurse on day and evening shift. 2 staff shall be on the dementia unit at all times for day and evening shift. Night shift will be staffed with 1 certified nursing assistant in the dementia unit and 1 nurse in the building, (2 certified nursing assistants in the front on night shift for a total of 5 staff in the building)

All residents are evaluated for fall risk upon admission to the facility, quarterly and as further needs arise. All residents that have sustained a fall will have an intervention placed on kardex by the shift nurse at the time of fall. All resident falls will be evaluated by the facility fall committee on a weekly basis. All interventions put into place by the fall committee will be reviewed by the attending physician. The facility has been working on falls through the QAPI committee and PIP team members to aid in prevention of further falls for identified residents. This process will continue to aid in prevention of future falls in the facility. Falls are reviewed with the medical director at quarterly QA meetings.

Measures taken: Practice has been updated to include only 1 person may be off the unit at any given time during day and evening shift. 1 certified nursing assistant or 1 nurse must be present in the dining room until the last resident has finished eating. Companion positions have been added to the evening shift from 4-8 and to night shift from 10pm to 6:30 am in the dementia unit. The companion can aid the certified nursing assistant in providing one to one with residents, completing 15 minute checks and half hour rounds. They can provide snacks and drinks to residents for the certified nursing assistants and engage residents in activities when awake. Walkie talkies have been provided to staff to improve communication and request for assistance if needed.

3. Individual staff education was provided. Group staff education was provided. Bags were applied to the back of wheelchairs to hold residents pedals who can sometime propel themselves.

F692:

The facility does and will continue to provide adequate hydration to all residents.

1. Fluids are offered and encouraged between breakfast and lunch, again between lunch and supper, and throughout the night when residents are awake. Fluids are offered with each med pass. Residents who are dependent will have fluids poured by staff and placed within reach of resident to drink as they desire.

Fluid intake is reviewed at weekly weight meetings with the dietician. Any concerns are addressed with the attending physician and care plan to be updated.

Measures taken: Although the facility provides residents with fluids and snacks whenever they want, a specific time has been set to offer and assist fluid intake for all residents on our dementia unit. The times are approximately 10a.m, approximately 2:30 p.m., and approximately 7 p.m. Intake sheets will be completed with each hydration and snack time. The dietician will work with the MDS coordinator to update care plans based on dietician recommendations or concerns.

2. If a resident of the facility is admitted to an outside facility, the DON or ADON will compare the readmission MAR/TAR with the previous discharge MAR/TAR. Any discrepancies will be clarified with the attending/ordering physician.

Measures taken: Education provided to DON and ADON on new admission procedure.

Fluids are offered and encouraged between breakfast and lunch, again between lunch and supper, and throughout the night when residents are awake. Fluids are offered with each med pass. Residents who are dependent will have fluids poured by staff and placed within reach of resident to drink as they desire.

Fluid intake is reviewed at weekly weight meetings with the dietician. Any concerns are addressed with the attending physician and care plan to be updated.

Measures taken: Although the facility provides residents with fluids and snacks whenever they want, a specific time has been set to offer and assist fluid intake for all residents on our dementia unit. The times are approximately 10a.m, approximately 2:30 p.m., and approximately 7 p.m. Intake sheets will be completed with each hydration and snack time. The dietician will work with the MDS coordinator to update care plans based on dietician recommendations or concerns.

3. Education provided to staff to pour water in glass and have next to bed when resident is in bed if appropriate for that resident. Night shift certified nursing assistants are to make sure each appropriate resident has water pitcher and glass at bedside. Night shift snack and hydration has been added to the intake sheets.

Measures taken: Education provided to night shift certified nursing assistants to make sure each water pitcher has a glass and they are next to bed with water poured for appropriate residents. Education provided on documentation of nutrition and fluid on intake sheets. Education provided to housekeeping staff to make sure when providing fresh ice water, to pour fresh water into glass at bedside. Water pitchers are only provided for those residents on thin liquids. Residents requiring thickened liquids are offered hydration in common areas were they can be observed.

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with State and Federal regulations the facility has completed the following actions set forth in the plan of correction. All deficiencies have been completed by September 13, 2018.

C139

Call was placed to DIA Southeast Iowa Program Coordinator on August 9th by this Administrator, DON, and Pearl Valley Regional Consultant. Education was provided by DIA Southeast Iowa Program Coordinator on interpretation of 481-50.7.

Measures taken: Education was provided by DIA Southeast Iowa Program Coordinator regarding the interpretation of 481-50.7. A copy of 481-50.7 is kept in the Administrator and DON office to be reviewed each time a resident sustains an injury. This administrator also carries a copy for reference if outside the facility.