STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165311	A. BUILDING _____ B. WING _____	10/11/2018

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F 000	INITIAL COMMENTS Correction date: 10-26-18 The following deficiencies relate to the annual survey and investigation of Incident #77365-I, #78999-I, and #78888-I, completed October 8-11, 2018. Incident #77365-I, #78999-I, and 78888-I were substantiated. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		

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.

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, observations and staff interviews the facility failed to update the comprehensive care plan to direct the assistance required for transfer for 2 of 8 residents reviewed for transfer, (#6 and #136). The facility census was 37 residents. Findings include: 1. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/7/2018 identified Resident # 136's mental status as fully intact, revealed the resident required extensive assistance from 1 staff with toileting and ambulation in her room and documented the resident as only able to stabilize her balance with assistance from staff. A Hospice Physician's Plan Of Care/Certification	F 656		

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F 656	Continued From page 2 Of Terminal Illness Hospice form identified the Resident as admitted to Hospice services as of 5/1/2018, due to a terminal diagnosis of aortic stenosis with comorbidities of heart failure and Chronic Obstructive Pulmonary Disease. Review of a Hospice report form dated 5/23/18, included a medication list for Ativan 0.5 milligrams (mg),with a start date of 5/4/18, every 4 hours as needed (PRN) for anxiety and Ativan 0.5 mg, with a start date of 5/10/18, every evening at 9:00 P.M. A care plan, with a initiation date of 5/16/18 and revision date of 8/15/18, identified the resident with a potential for a psychosocial well being concern, related to a history of feeling depressed and anxious, particularly in the evening. The same care plan included a goal for the resident to feel less anxious after 1:1 time with staff, family or friends when she felt worried or depressed. Care plan interventions for nursing included: allow resident to make choices whenever possible, assist with calling family as needed, monitor for medication side effects in regards to Ativan and Remeron, provide active listening as needed, provide reassurance as needed and Resident had many relatives and friends that visit. According to a Nurses Note dated 5/21/18 at 7:39 P.M., staff documented the Resident's neighbor's family reported Resident #136 had been making a loud noise in her bathroom and staff found the resident on the bathroom floor. The resident told staff she hit her head on the toilet at the time of the fall and sustained a 1.8 centimeter (cm.) by 1.8 cm. lump on the back of her head. Review of the resident's care plan in regards to	F 656		

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F 656	Continued From page 3 the resident being at risk for falls included an intervention dated 5/24/18 (after the resident's fall on 5/21/18) for 1 or 2 staff to assist the resident with a four wheeled walker when transferred or ambulated. Even though the resident was found on the floor as a result of her getting up on her own and ambulating without assistance, the facility failed to address this issue with intervention on her care plan. The resident had not been found on the floor as a result of a staff transfer issue. According to a Nurses Note dated 7/15/18 at 7:23 P.M., staff heard the resident calling from her room at 4:45 P.M. and found the resident on the floor on her left side. The resident reported she self transferred herself from her bathroom and fell. The resident was transferred to an Emergency Room at a local hospital, via ambulance. A Radiology report dated 7/15/18 confirmed the resident sustained a left pelvic/hip fracture. Review of the resident's care plan in regards to falls, revealed staff documented an intervention dated 7/15/18 (following the fall), for activity as tolerated. Again, the care plan lacked intervention in regards to supervision re: getting up on her own and the potential for falls. A Fall Risk Assessment dated 8/7/18, identified the resident at high risk for falls. According to a MDS with an ARD of 8/17/18, staff identified the resident's mental status as moderately impaired, and required extensive assistance of 2 staff with transfer and walking in her room.	F 656		

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F 656	Continued From page 4 Further review of Nurses Notes revealed staff documented the following: 7/28/18 at 1:09 A.M.- Very restless, makes many phone calls, wants someone to sit with her all night. 7/30/18 at 6:23 A.M. - At 8:00 P.M., the resident was restless, attempted to crawl out of bed. 8/14/18 at 3:00 P.M. - Having a lot of anxiety about bedtime and being left alone. Resident wanted staff to sit with her. 8/14/18 at 4:00 P.M. - Continues to be anxious about being left alone. 8/15/18 at 1:48 A.M.- Very restless and climbing out of bed. 8/15/18 at 3:00 P.M.- Having lots of anxiety today about being alone tonight. Staff tries to distract resident by sitting with her, but she asks continuously if staff can stay in her room with her. 8/21/18 at 3:00 A.M. - Very anxious 8/29/18 at 9:20 P.M. - Was up on her own several times in the hall looking for Certified Nurse Aide (CNA), or anyone. She wanted to make sure staff knew she was still there. 8/31/18 at 6:20 P.M. - Anxious and unable to redirect. 8/31/18 at 7:13 P.M. - PRN Ativan ineffective. 8/31/18 at 8:04 P.M. - At 7:20 P.M., the resident was found on the floor in her room. The resident told staff she was going to the bathroom, lost her balance and fell on the floor. Complained of intense pain in her left shoulder and transported to the local hospital. 8/31/18 at 9:50 P.M. - Staff received a telephone call from the local hospital, reported the resident sustained a fracture of her left humerus and planned transfer to a larger hospital out of town.	F 656		

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F 656	Continued From page 5 Even though the resident reported to staff a fear of being left alone and exhibited increased anxiety, staff failed to update the resident's care plan for staff approaches in regards to her increased anxiety and need for increased supervision. 2. Resident #6 had a Minimum Data Set (MDS) assessment with a reference date of 7/10/18 that documented a score of 5 of 15 on BIMS (brief interview for mental status) test which indicated severely impaired cognitive and memory impairment. According to the MDS, the resident required the extensive assistance of 2 staff for transfers, bed mobility, walking, dressing and toilet use. A balance during transition and walking test identified the resident as not steady and only able to stabilize with staff assistance when walking, turning around, moving from a seated to standing position, and surface to surface transfers. The resident had diagnoses that included: Peripheral vascular disease, non-Alzheimer's dementia, and chronic kidney disease. The resident had no falls since the prior assessment. The Interdisciplinary Working Plan of Care, dated 12/2/15 identified the resident at risk for falls related to forgetfulness and unsteady gait. A care plan directive dated as revised on 2/13/17 directed 1 or 2 assist of staff with gait belt and front wheeled walker for transfers and ambulation. During interview on 10/9/18 at 2:45 p.m. Staff A, certified nursing assistant (CNA), stated on 10/6/18 at approximately 8:30 p.m. transferred Resident #6 from his wheelchair to bed. Staff A,	F 656		

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F 656	Continued From page 6 CNA confirmed she transferred the resident with assist of 1 and a gait belt, stated is a 1 or 2 on the care plan. Staff A clarified that a 1 or 2 on the care plan meant that the resident required the assistance of 1 or 2 staff, depended on the day. Staff A further explained that she determined if the resident required 1 or 2 based on if the resident had a normal day. Staff A confirmed that in the process of standing from wheelchair to transfer became weak and slid to ground, Staff A stated was unable to keep from falling, and observed the resident fall, landed on buttocks. Staff A stated the resident normally stands pretty well but sometimes, like this time is too weak. In an interview on 10/08/18 at 1:26 p.m. the Director of Nursing,(DON) confirmed the resident fell as transferred with one (1) staff person on 10/6/18. Confirmed the care plan directed o1 or 2 person transfer, based on how the resident is doing. The DON further stated staff CNA's are responsible to determine if the resident required 1 or 2 to transfer based on the time of day, if tired, and how doing. The DON admitted CNA's should not have been responsible for assessing if the resident required 1 or 2 to safely transfer, and admitted other residents also have directives for transfer that required the staff to determine how/how much assistance the resident required. Further admitted that should have had a second staff person for the transfer.	F 656		
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	F 689		

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F 689	Continued From page 7 §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, staff interview and record review the facility failed to implement measures to ensure adequate supervision to prevent falls and major injury for three of six residents reviewed. (Resident #6, #35, and #136) The facility reported a census of 37 residents. Findings include: 1. Resident #6 had a Minimum Data Set (MDS) assessment with a reference date of 7/10/18 that documented a score of 5 of 15 on BIMS (brief interview for mental status) indicated severely cognitive impairment. According to the MDS, the resident required the extensive assistance of two staff for transfers, bed mobility, walking, dressing and toilet use. A balance during transition and walking test identified the resident as not steady and only able to stabilize with staff assistance when walking, turning around, moving from a seated to standing position, and surface to surface transfers. The resident had diagnoses that included: Peripheral vascular disease, non-Alzheimer's dementia, and chronic kidney disease. The resident had had no falls since the prior assessment. Review of the Fall Risk assessment, dated 7/10/18 identified the resident scored a two (2) or above in the following areas which required review for possible interventions: Mental Status, Balance and Gait, Ambulation status, Medications, and Predisposing diseases and	F 689		

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F 689	Continued From page 8 scored a 12 which represented a high risk of falls. The Fall Risk assessment identified a score of 10 or abouve represented high risk: The Interdisciplinary Working Plan of Care, dated 12/2/15 identified the resident at risk for falls related to forgetfulness and unsteady gait. A care plan directive dated as revised on 2/13/17 directed one-two assist of staff with gait belt and front wheeled walker for transfers and ambulation. A fall incident report dated 10/6/18 at 9:00 p.m. reflected the staff transferred Resident #6 from his wheelchair to the bed and he slid to the floor. The nurse assessed the resident and implemented new intervention identified to prevent recurrence, two staff to assist resident at all times According to a document titled Preliminary Radiology Report dated as completed 10/7/18 reflected an x-ray of the right hip with pelvis was completed after fall on 10/6/18. The findings included a proximal right femoral fracture (hip). The resident was admitted to the hospital and remained at the hospital. During interview on 10/9/18 at 2:45 p.m. Staff A, certified nursing assistant (CNA), stated on 10/6/18 at approximately 8:30 p.m. transferred Resident #6 from his wheelchair to bed. Staff A, CNA confirmed she transferred the resident with assist of one and a gait belt, stated is a one to two on the care plan. Staff A clarified that a one to two on the care plan meant that the resident required the assistance of one or two staff, depended on the day. Staff A further explained that she determined if the resident required one	F 689		

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F 689	Continued From page 9 or two based on if the resident had a normal day. Staff A confirmed that in the process of standing from wheelchair to transfer became weak and slid to ground, Staff A stated was unable to keep from falling, and observed the resident fall, landed on buttocks. Staff A stated the resident normally stands pretty well but sometimes, like this time is too weak. In an interview on 10/08/18 at 1:26 p.m. the Director of Nursing,(DON) confirmed the resident fell as transferred with one staff person on 10/6/18. Confirmed the care plan directed one to two person transfer, based on how the resident is doing. The DON further stated staff CNA's are responsible to determine if the resident required one or two to transfer based on the time of day, if tired, and how doing. The DON admitted CNA's should not have been responsible for assessing if the resident required one or two staff to safely transfer. Further admitted that should have had a second staff person for the transfer. 2. Resident #35 had a Minimum Data Set (MDS) assessment with a reference date of 6/12/18 that documented a score of 9 of 15 on BIMS (brief interview for mental status) test which indicated moderately impaired cognitive and memory impairment. According to the MDS, the resident required the extensive assistance of two staff for transfers, bed mobility, walking, and toilet use. A balance during transition and walking test identified the resident as not steady and only able to stabilize with staff assistance when walking, turning around, moving from a seated to standing position, and surface to surface transfers. The resident had diagnoses that included: Peripheral vascular disease, non-Alzheimer's dementia, and Parkinson's disease. The resident had had one	F 689		

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F 689	Continued From page 10	F 689		

fall with no injury since the prior assessment. Review of the Fall Risk assessment, dated 7/10/18 identified the resident scored a two or above in the following areas which required review for possible interventions: Mental Status, History of falls, Balance and Gait, Ambulation status, Medications, and Predisposing diseases and scored a 18 which represented a high risk of falls. The assessment identified a score of 10 or above represented high risk.

The Interdisciplinary Working Plan of Care, identified the resident at risk for falls related to confusion, gait/balance problems, and unaware of safety needs. A care plan directive dated as revised on 6/20/18 directed two assist of staff with front wheeled walker and gait belt for transfers and ambulation, and further directed offer to go to bathroom if restless and attempting to self-rise.

A fall incident report dated 7/19/18 at 1130 (11:30 a.m.) documented kitchen staff witnessed the resident self-rising frequently while waiting for lunch, resident fell on floor unwitnessed, and was sent to the emergency room for evaluation and treatment. The nurse further documented educated other department not to leave restless resident alone and find nursing staff as an intervention taken to prevent recurrence.

According to a hospital discharge summary dated 10/10/18 the resident was admitted after she fell at the nursing home and was unable to stand or walk. The document further revealed the resident sustained a left hip fracture and had surgical repair prior to her discharge.

According to a diagnostic imaging report dated as

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F 689	Continued From page 11 completed 7/19/18, x-ray of the left hip with pelvis was completed after an unwitnessed fall. The findings included a fracture of the left femoral neck with angulation and displacement (left hip fracture). During interview on 10/9/18 at 9:05 a.m. Staff E, Registered Nurse (RN), stated on the date of the incident, 7/19/18 she was the nurse on duty and responded to notification that the resident was on the floor in the dining room. Further revealed Staff F, Dietary aide had been talking to the resident in the dining room and reported after the fall that the resident had been anxious, but Staff F had left her alone to return to the kitchen. Staff E, RN reported she counseled Staff F, would expect to notify nursing and stay with resident when observed to be agitated. Staff E, RN confirmed Staff F failed to stay with the resident and failed to report concerns to nursing. Staff F, Dietary aide confirmed observed the resident sitting in the dining room, and no nursing staff were within sight. Confirmed observed Resident #35 wiggling in wheelchair, made a rocking motion, and repeated attempted to self-rise. Reminded the resident to stay seated, and returned to the kitchen, further stated was unaware the resident had fallen until later. Confirmed her supervisor the Dietary Manager had educated if resident is agitated and there are no nursing staff in the area would expect to stay with the resident. Confirmed should have stayed with the resident. In an interview on 10/09/18 at 1:45 p.m. the Dietary Manager confirmed after the fall had educated Staff F, dietary aide would have expected to stay with the resident until could get assistance from nursing. Further clarified Staff F should not have left when she knew the resident	F 689		

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F 689	Continued From page 12 was agitated. 3. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/7/2018 identified Resident # 136's mental status as fully intact, revealed the resident required extensive assistance from (1) staff with toileting and ambulation in her room and documented the resident as only able to stabilize her balance with assistance from staff. A Hospice Physician's Plan Of Care/Certification Of Terminal Illness Hospice form identified the Resident as admitted to Hospice services as of 5/1/2018, due to a terminal diagnosis of aortic stenosis with comorbidities of heart failure and Chronic Obstructive Pulmonary Disease. Review of a Hospice report form dated 5/23/18, included a medication list for Ativan 0.5 milligrams (mg),with a start date of 5/4/18, every 4 hours as needed (PRN) for anxiety and Ativan 0.5 mg, with a start date of 5/10/18, every evening at 9:00 P.M. A care plan, with a initiation date of 5/16/18 and revision date of 8/15/18, identified the resident with a potential for a psychosocial well being concern, related to a history of feeling depressed and anxious, particularly in the evening. The same care plan included a goal for the resident to feel less anxious after 1:1 time with staff, family or friends when she felt worried or depressed. Care plan interventions for nursing included the following:	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLYMOUTH MANOR CARE CENTER	954 7TH AVENUE SE LE MARS, IA 51031

(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 689	Continued From page 13 a. Allow resident to make choices whenever possible. b. Assist with calling family as needed. c. Monitor for medication side effects in regards to Ativan and Remeron. d. Provide active listening as needed. e. Provide reassurance as needed. f. Resident has many relatives and friends that visit. A facility Fall Assessment Policy and Protocol dated 2/2012, included the following direction: At the time a resident falls, the charge nurse will complete a Fall Assessment Form and Incident Report with a purpose to identify specific information about the circumstances surrounding a fall and any precipitating events. The Director of Nursing (DON) or designee needed to review the fall assessment form within 72 hours and reviewed by the Quality Assurance Team monthly. Changes to the resident's plan of care needed to be made. According to a Nurses Note dated 5/21/18 at 7:39 P.M., staff documented the Resident's neighbor's family reported Resident #136 had been making a loud noise in her bathroom and staff found the resident on the bathroom floor. The resident told staff she hit her head on the toilet at the time of the fall and sustained a 1.8 centimeter (cm.) by 1.8 cm. lump on the back of her head. Further review of the resident's record lacked a fall investigation and/or incident report in regards to the fall 5/21/18. Review of the resident's care plan revealed the resident at risk for falls and included an intervention dated 5/24/18 (after the resident's fall	F 689		

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F 689	Continued From page 14 on 5/21/18) for 1-2 staff to assist the resident with a four wheeled walker when transferred or ambulated. The facility failed to implement intervention on her care plan related to the staff transfer issue. According to a Nurses Note dated 7/15/18 at 7:23 P.M., staff heard the resident calling from her room at 4:45 P.M. and found the resident on the floor on her left side. The resident reported she self transferred herself from her bathroom and fell. The resident was transferred to an Emergency Room at a local hospital, via ambulance. A Radiology report dated 7/15/18 confirmed the resident sustained a left pelvic/hip fracture. Further review of the resident's record lacked a fall investigation and/or incident report in regards to the fall 7/15/18. Review of the resident's care plan in regards to falls, revealed staff documented an intervention dated 7/15/18 (following the fall), for activity as tolerated. Again, the care plan lacked intervention in regards to supervision re: getting up on her own and the potential for falls. A Fall Risk Assessment dated 8/7/18, identified the resident at high risk for falls. According to a MDS with an ARD of 8/17/18, staff identified the resident's mental status as moderately impaired, and required extensive assistance of 2 staff with transfer and walking in her room.	F 689		

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F 689	Continued From page 15 Further review of Nurses Notes revealed staff documented the following: 7/28/18 at 1:09 A.M.- Very restless, makes many phone calls, wants someone to sit with her all night. 7/30/18 at 6:23 A.M. - At 8:00 P.M., the resident was restless, attempted to crawl out of bed. 8/14/18 at 3:00 P.M. - Having a lot of anxiety about bedtime and being left alone. Resident wanted staff to sit with her. 8/14/18 at 4:00 P.M. - Continues to be anxious about being left alone. 8/15/18 at 1:48 A.M.- Very restless and climbing out of bed. 8/15/18 at 3:00 P.M.- Having lots of anxiety today about being alone tonight. Staff tries to distract resident by sitting with her, but she asks continuously if staff can stay in her room with her. 8/21/18 at 3:00 A.M. - Very anxious 8/29/18 at 9:20 P.M. - Was up on her own several times in the hall looking for Certified Nurse Aide (CNA), or anyone. She wanted to make sure staff knew she was still there. 8/31/18 at 6:20 P.M. - Anxious and unable to redirect. 8/31/18 at 7:13 P.M. - PRN Ativan ineffective. 8/31/18 at 8:04 P.M. - At 7:20 P.M., the resident was found on the floor in her room. The resident told staff she was going to the bathroom, lost her balance and fell on the floor. Complained of intense pain in her left shoulder and transported to the local hospital. 8/31/18 at 9:50 P.M. - Staff received a telephone call from the local hospital, reported the resident sustained a fracture of her left humerus and planned transfer to a larger hospital out of town. Even though the resident reported to staff a fear	F 689		

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F 689	Continued From page 16 of being left alone and exhibited increased anxiety, staff failed to update the resident's care plan for staff approaches in regards to her increased anxiety and need for increased supervision. Further review of the resident's record lacked a fall investigation and/or incident report in regards to the fall 8/31/18. Review of a Hospitalist History and Physical (completed at the out of town hospital) dated 8/31/18 at 11:59 P.M., a Physician documented the resident sustained a fracture of the left humerus, had pain and planned for Orthopedic surgeon visit on 9/1/18. The Physician documented the resident required admission to the hospital for inpatient services. Review of a Nurses Note dated 9/2/18 at 2:00 P.M. revealed staff documented the resident returned to the facility following hospitalization. Further review of Nurses Note revealed the following: 9/3/18 - 12:02 A.M.- Crying out in shoulder pain while in bed. 9/3/18 - 4:49 A.M. - Yelling out in shoulder and arm pain and restless. 9/4/18 at 8:04 P.M. - On comfort measures for hospice care. 9/5/18 at 2:34 P.M. - Resident passed away. During interview on 10/10/18 at 7:20 A.M., the DON confirmed no investigations into the resident's falls on 5/21/18, 7/15/18 or 8/31/18. She identified the past DON as being in charge at the time of the falls and could not speak for the past DON as to why the investigations had not	F 689		

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F 689	Continued From page 17 been completed. The DON confirmed fall investigations and incident reports had been completed in the past. She identified the resident's bedroom as in the back of the facility and one of the last rooms at the end of the hall. She stated the resident preferred a private pay larger room, and that was the location of those rooms. The DON stated if an anxious resident received a PRN Ativan and was ineffective, she expected staff to then attempt 1:1 supervision, snack, toileting, assess for pain etc. She reported Resident #136 had not liked to be in her room alone and always wanted someone with her in her room. During interview on 10/10/18 at 7:30 A.M.- Staff D, CNA identified Resident #136 as always anxious and not able to ambulate steadily. She reported the resident hadn't liked to be alone. During interview on 10/10/18 at 8:30 A.M., Staff D Registered Nurse (RN), reported being on duty at the time of the resident's fall on 8/31/18. He described Resident #136 as routinely overly anxious and got "worked up" about being alone. He stated prior to the resident's fall on 8/31/18, she exhibited increased anxiety and confirmed he administered the resident a PRN of Ativan at 6:29 P.M. Staff D confirmed the PRN Ativan had been ineffective when he assessed the resident again on 8/31/18 at 7:13 P.M. and the resident continued to be anxious. Staff D stated in the past the staff would need to provide 1:1 attention to the resident if continued to be anxious, or her friends or family would sit with her. Staff D confirmed the resident's friends or family had not been in the facility at that time and stated the staff may not have provided 1:1 attention to the resident prior to finding her on the floor on	F 689		

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F 689	Continued From page 18 8/31/18 at 7:20 P.M., as that was a busy time of the evening and staff had been busy with other residents. During interview on 10/10/18 at 2:20 P.M., the DON stated she had not been aware if anyone had talked to the resident and/or her family in regards to moving her to a room closer to the nurses station due to her not liking to be alone and in order for staff to provide closer supervision. Observation on 10/10/18 at 2:40 P.M. revealed the resident's room had been approximately 46 paces from the nurses station in the back of the building. During interview on 10/11/18 at 8:25 A.M., the facility DON confirmed if Resident #136 received a PRN of Ativan, and it had been ineffective, staff needed to provide interventions such as 1:1 supervision etc.	F 689		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0449	A. BUILDING: _____ B. WING _____	10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLYMOUTH MANOR CARE CENTER	954 7TH AVENUE SE LE MARS, IA 51031

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C 139	50.7(1)a(2) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(1) Of any accident causing major injury. a. "Major injury"shall be defined as any injury which: (2) Requires admission to a higher level of care for treatment, other than for observation; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report a fall with major injury to the Iowa Department of Inspections and Appeals as required for 1 of 3 Residents with falls (Resident #136). The facility reported a census of 37 residents. Findings included: According to Minimum Data Set (MDS) assessment with an ARD of 8/17/18, staff identified the resident's mental status as moderately impaired, and required extensive assistance of 2 staff with transfer and walking in her room. A Hospice Physician's Plan Of Care/Certification Of Terminal Illness Hospice form identified the Resident as admitted to Hospice services as of 5/1/2018, due to a terminal diagnosis of aortic stenosis with comorbidities of heart failure and Chronic Obstructive Pulmonary Disease.	C 139		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 139	Continued From page 1 A care plan, with a revision date of 8/15/18, identified the resident at risk for falls and included an intervention for 1-2 assist of staff with transfers. A facility Fall Assessment Policy and Protocol dated 2/2012, included the following direction: At the time a resident falls, the charge nurse will complete a Fall Assessment Form and Incident Report with a purpose to identify specific information about the circumstances surrounding a fall and any precipitating events. The Director of Nursing (DON) or designee needed to review the fall assessment form within 72 hours and reviewed by the Quality Assurance Team monthly. Changes to the resident's plan of care needed to me made. A Fall Risk Assessment dated 8/7/18, identified the resident at high risk for falls. A Nurses Note dated 8/31/18 at 8:04 P.M., revealed staff documented the resident was found on the floor in her room at 7:20 P.M. The resident told staff she was going to the bathroom, lost her balance and fell on the floor. The resident complained of intense pain in her left shoulder and transported to the local hospital. A Nurses Noted darted 8/31/18 at 9:50 P.M., revealed staff received a telephone call from the local hospital, reported the resident sustained a fracture of her left humerus and planned transfer to a larger hospital out of town. Review of a Hospitalist History and Physical (completed at the out of town hospital) dated 8/31/18 at 11:59 P.M., a Physician documented the resident sustained a fracture of the left	C 139		

DEPARTMENT OF INSPECTIONS AND APPEALS

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C 139	Continued From page 2 humerus, had pain and planned for Orthopedic surgeon visit on 9/1/18. The Physician documented the resident required admission to the hospital for inpatient services. Review of a Nurses Note dated 9/2/18 at 2:00 P.M. revealed staff documented the resident returned to the facility following hospitalization. Even though Resident #136 required admission to a hospital on 8/31/18 and required at least an overnight stay, the facility failed to report the incident to the Department of Inspections and Appeals (DIA) until 9/4/18. A facility Major Injury Reporting form dated 7/20/18 included the following information: The director (DIA Director) or the director's designee shall be notified within 24 hours or the next business day of any accident causing major injury. A "Major Injury" definition included admission to a higher level of care. During interview on 10/11/18 at 8:28 A.M., stated the weekend of 8/31/18 had been a Holiday weekend, the past DON had been off the long weekend and no other staff member had been trained on how to report a major injury to DIA.	C 139		

Plymouth Manor Care Center-ID#165311

Coleen McCarty, Administrator

This Plan of Correction constitutes a written state of compliance with State licensure and Federal participation requirements for long term care facilities participating in the Medicare and/Medicaid programs. The submission of this Plan of Correction is not an admission that a deficiency does exist or that one was cited correctly. The Plan of Correction date is October 26, 2018.

F656 481-58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:

58.20(4) Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident's family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:

b. The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III). Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment.

The facility is responsible to provide adequate supervision to protect all residents to prevent falls and major injury. The MDS Coordinator provided updates to the resident's plan of care for two residents reviewed for required transfer (resident #6 and #136).

Resident #6 care plan reflects the assistance of two nurse aides for transferring resident.

Resident #35 fall intervention included that employees were educated not to leave restless resident alone and find nursing staff to intervene to prevent recurrence of falls.

Resident #136 required extensive assistance from staff with toileting and ambulation in room. The MDS coordinator need to review fall assessment form within 72 hours and reviewed by the Quality Assurance committee monthly. Changes were made to resident care plan.

The facility Fall Assessment Policy and Protocol for Fall investigation and/incident report will be completed regarding falls or incidents. Comprehensive Care Plans will be implemented for person-centered care plans for each resident and updated as needed and quarterly by the MDS Coordinator. Appropriate interventions on individualized care plans will be updated on each resident regarding their needs. MDS Coordinator reviewed all current resident care plans and updated with individualized residents and specified one or two assists with transfers.

Director of Nursing provided in-service on October 23, 2018 regarding fall policy and procedure. Along with updating careplans with new interventions related to reason resident fell and to prevent further falls. Included in the in-service was fall assessments and reporting Major Injury to the Department of Inspections and Appeals.

The facility will attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under Code 483. Director of Nursing and MDS Careplan coordinator will be responsible for updating and educating employees to maintain compliance.

C 139 50.7 (1)a(2) 481-Additional Notification

The Director of Nursing or designee will notify the Department of Inspections and Appeals within 24 hours, or next business day, by the most expeditious means available. Of any accident causing major injury which requires admission to a higher level of care for treatment; other than for observation.

The Director of Nurses, Assistant Director of Nurses, and MDS Coordinator nurse have been educated and trained on the policy and procedure on how to report Major Injury to the Iowa Department of Inspections and Appeals. Director of Nursing provided in-service on October 23, 2018 regarding fall policy and procedure. Along with updating careplans with new interventions related to reason resident fell and to prevent further falls. Included in the in-service was fall assessments and reporting Major Injury to the Department of Inspections and Appeals.

The specified nurses will respond immediately and provide a self-report to the Department of Inspections and Appeals within 24 hours of any Major Injury requiring admission to a higher level of care for treatment; other than observation. Director will be responsible for correct policy and procedure.

F689 Free of Accident Hazards/Supervision/Devices

The facility mist ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

The MDS Coordinator updated the working care plan for resident #6, to include resident is assist of two for transfers. Nursing assistants will not make the decision of one or two assist for resident transfers. The daily worksheets for the nurse aides have been updated for appropriate two assist for named residents. The Quality Assurance nurse will provide investigations along with the documentation record with all fall investigations.

Director of Nursing provided in-service on October 23, 2018 regarding fall policy and procedure. Along with updating careplans with new interventions related to reason resident fell and to prevent further falls. Examples of interventions for resident showing signs and symptoms of restlessness. Please see attached form. Staff educated on supervision of residents with fall risk. Included in the in-service was fall assessments and reporting Major Injury to the Department of Inspections and Appeals.

Director of Nurses will be responsible for educating nurses on supervision to maintain compliance.

58.28(3)e Resident Safety. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment.

The facility Fall Assessment Policy and Protocol for Fall investigation and/incident report will be completed regarding falls or incidents. Comprehensive Care Plans will be implemented for person-centered care plans for each resident and updated as needed and quarterly by the MDS Coordinator. Appropriate interventions on individualized care plans will be updated on each resident regarding their needs. MDS Coordinator reviewed all current resident care plans and updated with individualized residents and specified one or two assists with transfers

Director of Nursing provided in-service on October 23, 2018 regarding fall policy and procedure. Along with updating careplans with new interventions related to reason resident fell and to prevent further

falls. Examples of interventions for resident showing signs and symptoms of restlessness. Please see attached form. Staff educated on supervision of residents with fall risk.

Director of Nurses will be responsible for in-service education for all nursing staff to maintain resident safety an adequate resident supervision.