PRINTED: 10/17/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165034	A. BUILDING _____ B. WING _____	C 10/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 10/17/2018 The following deficiency relates to the investigation of incident #77949. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C). Complaint #78522 & #78560 was not substantiated.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews and observations the facility failed to ensure the safety of 1 of 5 residents reviewed (Resident #1). The facility failed to provide other interventions for Resident #1 who was at high risk for falls other than to remind the resident to use call light. The facility reported a census of 67. Findings include: According to the Minimum Data Set (MDS) dated 8/17/18 Resident #6 had diagnoses which included bowel obstruction, stroke, abnormal gait,	F 689		

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

Admin | 10/17/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 cognitive communication deficit and Dementia. The resident had a BIMS score of 6 which indicated severe cognitive ability. The resident required supervision of 1 staff for transfers, ambulation and toilet use. The resident utilized a walker and wheelchair. Review of the resident's care plan 6/14/18 Resident #1 had a self-care deficit evidenced by weakness with a history of a stroke. The plan identified the resident needed assistance to meet his activities of daily living and directed the staff to ambulate with assistance of 1 staff, gait belt and walker. The plan indicated the resident had a risk for falls due to recent falls and impaired mobility and directed staff to reinforce the need to call for assistance. The care plan failed to contain interventions for resident's refusal to utilize call light and wait for assistance. Review of the Manor Care Investigation Report dated 9/4/18, the staff found Resident #1 on the floor of his bathroom briefs around his ankles and a bowel movement in the toilet. The staff noted resident without pulse, started CPR and activated EMS. The resident was pronounced dead at a local emergency room. Review of local emergency room notes revealed the resident arrived at the emergency room on 9/4/18 at 7:17 a.m. with a head laceration from an unwitnessed fall. The physician documented the resident had a large laceration with large amount of blood on the face, large gash over left forehead measuring 7 centimeters. Review of a statement from Staff A-C.N.A. on 9/4/18 revealed the resident was up to the bathroom by self that night and required the staff	F 689		

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F 689	Continued From page 2 assistance to clean up. The statement revealed the staff checked on him during the night because and would find him up in the bathroom by himself several times that night. Review of a progress notes revealed the following: 1. On 8/28/18 staff encouraged the resident to use their call lights for assist prior to transfers related to illness. 2. The Social Worker progress note dated 8/29/18 at 4:36 p.m. the resident had a BIMS of 6 which indicated severe cognitive ability, the resident alert but had trouble with recall. 3. Resident #1 had a fall while exiting the bathroom, lost their balance and landed on their buttocks without injuries. The staff assisted the resident into wheelchair with limited assistance of 2 staff and gibbet. 4. On 9/4 staff entered residents bathroom and found him on floor, bleeding from head and without vital signs. CPR started, resident expired at local emergency room. Review of a Physical Therapy evaluation and Plan of care dated 9/2/18, the document indicated the resident had exacerbation of illness with decrease in functional mobility, reduced ability to safely to ambulate and described the resident as a high risk for falls. The functional assessment revealed the resident required contact guard assist with transfers. During an interview with Staff B-Physical Therapy Assistance (P.T.A.) on 10/2/18 at 2:10 p.m. revealed Resident #1 required assistance of 1 staff, with gait belt and walker. Staff knew he was non-complaint with waiting for assistance and use of call lights.	F 689		

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F 689	Continued From page 3 During an interview with Resident #1's roommate on 10/2/18 at 3:09 p.m., the roommate stated the staff were constantly reminding him to use his call light and wait for help, but he just wouldn't wait. During an interview with Staff C-C.N.A. on 10/2/18 at 2:05 p.m., Staff C stated she got report from the night aide the morning of 9/4/18, she reported Resident #1 had been up a lot during the night on 9/3-9/4/18. The resident required assistance of 1 staff but he refused to use call light to get help. During an interview with A.R.N.P. on 10/1/18 at 10:05 a.m., resident #1 had a history of self-transfers and did as he chose. The A.R.N.P. indicated cause of death was cardiac arrest. During an interview with Staff D-RN Nurse Manager on 10/4/18 at 7:34 a.m., the manager stated the resident required assist of 1 staff and walker and he had a history of non-compliance with this. He would frequently get up without his walker. The care plan failed to identify interventions to prevent falls due to his non-compliance.	F 689		

ManorCare Health Services-Waterloo
201 W. Ridgeway Ave.
Waterloo, Iowa 50701

This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Iowa Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

F689
The facility ensures that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents.

Corrective action taken for residents found to have been affected by deficient practice
Resident #1 no longer resides in the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility that require assistance with transfers and ambulation that are non-compliant with waiting for assistance from staff are at risk of being affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Audit completed of care plans of residents who are cognitively impaired with a BIM's of 12 or less, that require assistance with transfers and are non-compliant with use of call light or waiting for transfer assistance, to ensure that interventions are in place to address non-compliance.
- MDS Coordinator and Unit Managers educated on putting interventions in place and careplanning such interventions if a resident is noted to be non-compliant with waiting for assistance.
- Licensed nursing staff educated on implementing interventions for residents that are at risk for falls and are non-compliant with waiting for assistance with transfers.
- DON or designee will complete random audits weekly times four weeks to validate care plan interventions related to safety.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

Date when corrective action will be completed.

October 17, 2018