STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165340	A. BUILDING _____ B. WING _____	C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	800 FIFTH STREET SE OELWEIN, IA 50662

(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 The following deficiency relates to the investigation of incident #84106. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C). The "G" level deficiency will be considered past non-compliance as it was corrected on May 20, 2019, prior to surveyor entrance on July 31, 2019. Complaint #84894 & #83952 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 and staff interview, the facility failed to ensure one of eight resident reviewed received adequate supervision and assistance to prevent accidents. (Resident #1) Findings include: 1. Resident #1 entered the facility on 6/7/17, with diagnoses of dementia, history of falls, abnormal posture and abnormal gait.	F 689	Past noncompliance: no plan of correction required.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165340	A. BUILDING _____ B. WING _____	C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	800 FIFTH STREET SE OELWEIN, IA 50662

(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 1 The Minimum Data Set (MDS) assessment dated 4/4/19, documented the resident had severe cognitive impairment, required extensive staff assistance with transferring, bed mobility, ambulation, bathing and toilet use and required limited assistance with personal hygiene. The facility developed "Home Therapy Program" dated 4/9/19, directing staff to ambulate the resident to and from meals and activities with a front wheeled walker, gait belt and the assistance of two staff. The individual plan of care identified a focus area of activities of daily living (ADL's) indicating the resident required assistance with personal cares and mobility related to diagnoses of dementia and fractures in the past. The plan of care directed staff to ambulate the resident to/from meals and activities with front wheeled walker, gait belt and assistance of two staff. Nurse notes dated 5/19/19 at 8:45 p.m., documented a nurse was called to the resident's room and found the resident laying on their back with their feet towards the window and head towards the door. The resident was holding their right wrist complaining it was broken and hurt really bad. The resident was alert but confused. Upon asking the CNA (certified nurse aide) what happened, the CNA stated they were walking back to the bed when all of a sudden the resident yelled "whoa" and fell backwards. The CNA stated their hand slipped from the gait belt when the resident fell. The CNA was able to prevent her from hitting her head but unfortunately not the fall. The CNA stated the resident was steady when she was walking the resident to the restroom and back to bed.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165340	A. BUILDING _____ B. WING _____	C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	800 FIFTH STREET SE OELWEIN, IA 50662

(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 2 Nurse notes dated 5/20/19, indicated the resident sustained a fall which resulted in a right wrist fracture. The resident was sent to the hospital for surgical repair of the right wrist. During interview on 8/20/19 at 10:10 a.m., Staff A, CNA stated the resident was in bed and requested to use the restroom. Staff A stated the resident did not have slipper socks on so she put slipper socks on prior to ambulation and assisted the resident to the restroom and the resident did not have any difficulty with ambulation. Staff A stated she and the resident were almost to the bed when the resident said "whoa" and fell backwards. Staff A stated at the time of the incident she was unaware the resident was to be assisted by two staff. Staff A stated she was unaware of the "home therapy sheet" or how to access the resident care plan on the I-pad until after the incident. Staff A stated she went by what other CNA's told her about the resident's and they all indicated the resident was a one person assist to transfer. During interview on 8/20/19 at 9:14 a.m., Staff B, CNA stated she was aware the resident had been changed to a two staff transfer just shortly prior to the fall, (maybe just a few days before). Staff B stated she was aware because the careplan coordinator alerted and informed staff working that day. During interview on 8/20/19 at 9:31 a.m., Staff C, licensed practical nurse, LPN stated she thought the resident required one staff to assist with transfers prior to the fall. During interview on 8/20/19 at 9:40 a.m., Staff D,	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165340	A. BUILDING _____ B. WING _____	C 08/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	800 FIFTH STREET SE OELWEIN, IA 50662

(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 3 registered nurse, RN stated the resident required two staff assistance with transfers prior to the fall. Staff D stated this information would have been on the resident's care plan in the room and it was the staffs responsibility to check the care plans. During interview on 8/20/19, the Administrator stated reminders were put in the staff newsletter for at least four days following the incident reminding staff that resident ambulation and transfer status can change and should be verified on the care plans. The director of nursing stated on 5/20/19 one on one education was provided with staff that worked on the wing where the resident resided. In addition, all staff were educated on how to access transfer status on any resident in the facility. The director of nursing indicated changes in a resident's care was passed along in report and available on "Point Click Care" for all staff to access and added the facility has about ten I-pads for staff to use and update themselves on the resident's plan of care. This is considered past non compliance as the facility placed corrective actions in place on 5/20/2019 and no current concerns were identified.	F 689		