STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165592	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH HEIGHTS	601 S PRAIRIE STREET MOUNT PLEASANT, IA 52641

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F 000	INITIAL COMMENTS Correction date: 9/20/19 The following deficiency relates to investigation of facility reported incident #84023-I. See Code of Federal Regulations, 42 CFR, Subpart B-C.	F 000	Please accept this plan of correction as my credible allegation of compliance. The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission or an agreement by the facility for the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction for the deficiencies was executed solely because it is required by provision of state and federal law.	9/20/2019
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 record review, and staff interviews, the facility failed to follow fall interventions for 1 of 3 sampled (Resident #1). The Care Plan directed the staff to transfer the resident from the wheelchair when in her room. The staff left the resident in the wheelchair in her room unattended. The resident fell and sustained a fractured femur. The facility reported a census of 24. Findings include: The Minimum Data Set (MDS) Assessment tool dated 5/7/19 revealed Resident #1 had diagnoses that included diabetes and anemia. Resident #1 had severe cognitive impairment with symptoms of delirium present. The MDS dated 5/7/19 revealed Resident #1	F 689	F 689 PLAN OF CORRECTION • Education was provided to all nursing staff on access to care plan and Kardex information to ensure staff provide adequate supervision and assistance to residents according to their care plans. • Visual reminders with information about how to access care plans were placed in areas used for resident documentation. • Staff education will be completed upon hire and annually during competency evaluations. • 5 weekly random audits were completed to ensure staff ability to access care plans per week from 8/26 – 9/28. Random audits will continue until 100% compliance ability is demonstrated over a 2 week basis. • The results of these audits will be presented to the quality assurance team for review on a monthly basis. EXPECTED OUTCOME The facility will develop and implement a comprehensive person-centered care plan for each resident in order to ensure that they remain free from accident hazards while providing sufficient supervision and assistance to prevent accidents that are within our ability to control. Staff will adhere to care plan direction in caring for residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/14/2019

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.

Julie Schulte RC

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required extensive assistance of one staff with bed mobility, transfers, walking, dressing, bathing, toilet use and personal hygiene. Resident #1 had one fall without injury since the previous assessment on 2/7/19.

The Care Plan initiated on 5/8/18 directed one staff to do provide a walker and a gait belt for transfers and walking, transfer to a recliner after each meal or/and activity, provide call light and a blanket.

The Care Plan initiated on 1/14/19 and revised on 5/7/19 directed the staff to use the wheelchair for transport only, place in a standard chair for meals and activities, transfer to recliner in the morning, transfer to recliner or bed 30 to 40 minutes after meals, and do not leave in wheel chair.

The COMS - Fall Risk Evaluation - V 2 sheet dated 5/7/19 revealed Resident #1 scored "13". A score of 10 or greater indicated a HIGH RISK for falls.

The Background sheet revealed on 5/28/19 at 6:57 p.m., the Registered Nurse found Resident #1 on the floor. The staff transported Resident #1 to her room at 6:22 p.m. (after supper) and she remained upright due to reflux. Resident #1 stated she was going to the bathroom. Resident #1 complained of severe left hip pain. At 7:55 p.m., Medics transported Resident #1 to the Emergency Department. Resident #1 admitted to the hospital due to left hip fracture related to the fall. The sheet revealed the staff did not act perfectly in this matter since Resident #1's Care Plan specifically stated the wheelchair is for transport only. The intervention is due pain but also to prevent falling forward out of the

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wheelchair. The staff found Resident #1 on her back with the wheelchair parallel to her (3 - 4 feet away). Resident #1 readmitted to the facility on 5/31/19.

The Diagnostic Radiology report dated 5/28/19 revealed Resident #1 sustained a displaced fracture through the neck of the left femur. The report dated 5/29/19 at 2:08 p.m. revealed Resident #1 had surgical repair of the left hip without postoperative complications.

The Care Plan revised on 5/23/19 directed two staff to transfer Resident #1 with a sit to stand lift.

During an interview on 9/18/19 at 9:02 p.m., Staff A (Certified Nurse Aide) stated Resident #1 asked to return to her room. Staff A transported Resident #1 to her room and left her seated in the wheelchair next to her bed with the call light. Staff C, informed the assigned aide that she left Resident #1 in her room. Staff A stated at that time it was okay to leave Resident #1 in her wheel chair in her room.

During an interview on 9/18/19 at 6:35 p.m., Staff B (Registered Nurse) stated the staff knew not to leave Resident #1 in the wheelchair in her room. The staff needed to transfer her to the recliner or in bed. The staff could also leave Resident #1 in her wheelchair by the nurse for observation until they could transfer her to bed. Staff B walked by Resident #1's room and observed her on the floor near the bathroom. Resident #1's wheelchair had the braked on and sat near Resident #1. Staff B reported Resident #1 did not have the ability to unlock the brakes. Staff B called for help and Staff C responded. Staff C reported she did not know who put Resident #1 in her room.

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During an interview on 9/19/19 at 8:02 a.m., Staff C (Certified Nurse Aide) stated Resident #1 usually returned to her room after supper and the staff assisted her to bed. Staff C reported Resident #1 did not like to sit in the wheel chair. Staff C reported the care plan directed the staff not to leave Resident #1 in the wheelchair in her room. Staff C reported she had Resident #1 on her assigned section the evening of the fall. Staff C did not know that Resident #1 was in her room until she responded to Staff B's call for help and saw Resident #1 on the floor in her room.

During an interview 9/18/19 at 5:40 p.m., Staff D (Certified Nurse Aide) stated Resident #1 required two staff for transfers. Staff D reported being surprised when she heard staff left Resident #1 in her room in her wheelchair.

During an interview on 9/18/19 at 6:21 p.m., Staff E (Licensed Practical Nurse) stated Resident #1 remained seated for 20 to 30 minutes after supper and then the staff assisted her to bed. Resident #1 remained in the common area for observation until the staff had time to assist her to her bed or recliner. Staff E reported they staff knew not to leave Resident #1 in the wheelchair in her room.

During an interview on 9/18/19 at 7:58 p.m., Staff F (Certified Nurse Aide) stated the resident was a fall risk, she was not supposed to be left alone in her wheel chair in her room, she was supposed to be transferred to the recliner if she wanted to stay up, or to bed.

During an interview on 9/19/19 at 8:58 a.m., Staff G (Certified Nurse Aide) and Staff H (Certified

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Nurse Aide) stated the resident was a fall risk and had an alarm because she attempted to self-transfer. Staff G and Staff H reported the staff did not leave Resident #1 in her room in the wheelchair. The staff transferred her to the recliner or to bed.

During an interview on 9/19/19 at 9:34 a.m., the Director of Nursing stated she would not have wanted or directed staff to leave the resident in her wheelchair alone in her room.

The facility's undated Certified Nurse Aide (CNA) Job Description revealed a nursing care function and duty that directed the CNA's to review the care plans daily.