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
	165474	A. BUILDING _____ B. WING _____	C 07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE AMBASSADOR SIDNEY INC	115 MAIN STREET SIDNEY, IA 51652

(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 7/30/21 - The Iowa Department of Inspections and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C conducted this investigation. The facility was found to be NOT IN COMPLIANCE. Total residents: 33 Onsite dates: 6/18/21 - 7/7/21 Facility Reported Incident and Complaint #'s reviewed: #87456-I not substantiated #92771-C not substantiated #92775-I substantiated #92783-I not substantiated #97950-I 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 observations, record review, facility	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/22/2021

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 689	Continued From page 1 investigation review, staff interviews and facility policy review the facility failed to ensure the safety of 2 of 3 Residents (R) (R6 and R7) reviewed with known fall risks by not ensuring care planned interventions in place at all times. The facility also failed to prevent environmental hazards in the bathhouse that resulted in resident sustaining a right femoral fracture from fall for 1 of 3 (R2) residents reviewed. The facility reported a census of 33 residents. Findings include: 1. According to the Quarterly Minimum Data Set (MDS) dated 3/30/21, R2 had the following diagnoses: non-traumatic brain dysfunction, severe intellectual disabilities, peripheral vascular disease, dementia, and depression. The MDS documented a Brief Interview of Mental Status (BIMS) score of 1, indicating severe cognitive impairment. R2 required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Showed always incontinent of urine, frequently incontinent of bowel, noted no falls, and did not utilize alarms. Review of R2's Care Plan with a revision date of 8/4/2020 revealed she was at risk for falls, needed assistance with transfers and other tasks, cognitive impairment, impaired balance, and poor safety awareness. Required assistance of two staff with transfers, used a tilt back wheelchair for locomotion, dependent on staff to push, and unable to transfer independently. Hand written on Care Plan after fall on 8/4/2020 - transferred to hospital for right femoral fracture-will put in place to wheelchair shower chair backwards out of shower area to avoid this.	F 689		

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F 689	Continued From page 2 Review of R2's Electronic Health Record (EHR) revealed the following Progress Notes: a. 08/04/2020 3:06 PM - Fall: the writer (Staff F) was sitting at nurse's station charting when heard CMA knocking on shower house window at 1:52 PM. This nurse entered bathhouse and observed resident sitting on floor in front of shower stall still secured in shower chair. Shower chair had slid up onto resident's back, and resident was sitting flat on her buttocks. Her left leg slightly bent to the side and her right leg bent at a 90-degree angle out. This nurse unstrapped bar and removed shower chair off resident and requested staff get the other Registered Nurse (RN) on duty. This nurse moved resident's right leg to assess alignment; shortening and internal rotation noted. When this nurse asked if her leg hurt resident stated I do not want to talk right now, while placing her hand on her right hip. Staff instructed not to move resident or attempt transfer. CMA remained with resident while this nurse placed call to the hospital and received order to transfer to the emergency room for an X-RAY of her right hip/knee. b. 08/04/2020 at 4:04 PM: received a call from the hospital reporting that resident has a severe right femoral facture and is being transferred to another hospital to consult with orthopedics for possible surgery. c. 08/08/2020 2:20 PM: R2 returned to the facility at 11:00 AM following a right femoral fracture repair. Resident was transported via facility van and 2-pivot transfer from wheelchair. Observation on 6/18/2021 at 11:21 AM, revealed R2 in tilt back wheelchair by the nurse's station. Observation on 6/22/21 at 11:51 AM, revealed R2 in tilt back wheelchair by the nurse's station.	F 689		

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F 689	Continued From page 3 Observation on 6/29/2021 at 12:23 PM, Staff E Certified Nursing Assistant (CNA) demonstrated how she would assist a resident in the shower chair into the shower stall. She stated she would put the belt on the resident and then push them forward to the stall. After shower completed she would then push the resident backwards with resident facing her out of the shower stall. There is a black threshold over the change in flooring leading to the shower stall. Visual of shower stall did not find any bumps or areas of uneven tiles. Small mounds/hills were present but not appearing to cause chair tires to catch. The shower chair moved through the shower stall with safety belt in place displaying no issues. Review of the facility's Investigative File revealed the facility investigation determined that policy and Care Plan followed. Interventions put in place-included education to CNAs who provide showers to exit the stall by pulling the resident backward to allow more control over the chair. Maintenance Director purchasing new heavy-duty wheels to prevent the same issue from occurring. Review of the hospital x-ray report dated 8/4/2020 revealed frontal view of pelvis, single frontal view of right femur. Impression: femoral diaphyseal fracture with associated rotational displacement. During interview on 6/29/2021 at 12:23 PM, Staff E stated once she has a resident in the shower chair, she would strap them in with the safety belt and back them in and out of the shower stall. She stated the residents would face her as they go in and out of the shower stall. Staff E stated there used to be bumps in the shower stall but not now. She stated they replaced the flooring about 6 months ago.	F 689		

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F 689	Continued From page 4 During interview on 6/29/2021 at 1:49 PM, the Administrator stated she was a Social Worker at the time of this incident. She stated after R2's fall, they changed out the shower chair wheels until they got a new chair with a wider base and they replaced the flooring in the bathhouse. She was unsure if the prior flooring had a bump or anything that would have caused the wheels to catch. Stated she believed it was the wheel on the shower chair that was faulty, caught, and turned sideways which caused the resident to fall forward. She stated after the fall staff were educated on pulling residents backwards down the ramp and out of the shower stall. During interview on 6/30/21 at 9:38 AM, Staff J stated when she arrived in the bathhouse; R2 was already on the floor. She does not remember what the CNA told her happened. She remembered the resident was on the floor and could tell by the way she was sitting that she was uncomfortable. She stated R2 was sitting on her bottom with her right foot by her bottom with some internal rotation noted which is indicative of a hip fracture. The CNA sat with R2 the whole time and provided support for the resident until the emergency management staff showed up. During interview on 7/1/21 at 11:38 AM, Staff I stated she was walking backward out of the shower stall. At the end of the ramp, there was a good-sized hump, by the threshold. She stated the resident sat in the shower chair, with the cross bar across her, the resident was facing her and the chair must have hit that spot on the floor. When they hit the bump/hump the resident went down as staff attempted to hold her up but R2 continued to slide down, off the chair, under the	F 689		

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F 689	Continued From page 5 cross bar onto the floor. She stated the center of gravity took the resident down to the ground. Staff I stated she had been giving baths in that shower room for over a year and never had an accident like this. Staff I stated when R2 landed, her right leg was outward and hip looked dislocated. She stated she sat with the resident until she left the facility for the emergency room. She stated after incident with the shower chair, the facility got rid of it and got a new one. The new chair has less chance of tipping with a safety belt and larger wheel span. The facility also replaced the bathroom floor so it is all one type of flooring with no difficulties between flooring transitions. She stated she now pushes residents backwards into the shower stall and when exiting the shower stall she walks backwards out of stall with resident facing her. She concluded that the new floor and chair make moving the residents smoother and less worrisome. 2. According to Admission MDS with a reference date of 12/29/2020 R6's had the following diagnoses: fractures, anemia, coronary artery disease, gastro-esophageal reflux disease, left hip fracture, dementia, malnutrition, depression, and chronic obstructive pulmonary disease (COPD). The MDS indicated she had a BIMS score of 2 indicating severe cognitive impairment. The MDS noted that if R6 required extensive assistance of two staff for bed mobility, transfers, dressing, and bathing. The MDS indicated she was occasionally incontinent of urine and bowel. R6 had a fall in the last month prior to her admission/entry or reentry, had a fall in the last 2-6 months prior to her admission/entry or reentry. The MDS indicated she used a bed and chair alarm daily.	F 689		

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F 689	Continued From page 6 Review of R6's initial baseline Care Plan with a date of 12/17/20 revealed she required assistance of 1 staff for dressing, positioning, transfers, and toileting. The Care Plan indicated she ambulated with assistance of 1 staff, walker, and a gait belt. She also utilized side rails while in bed: 2 1/4 side rails for positioning and bed control access, bed mobility. The following interventions listed after her falls: a. 12/17/2020 pull-tab alarm applied, due to resident getting up without assistance. b. 12/19/2020 changed alarm to sensor pad that is hooked to the call light due to resident's agitation. c. 1/4/2021 1:1 supervision during waking hours, pull-tab and sensor pad alarm at all times, 30-minute checks while sleeping. Review of Care Plan with a revision date of 1/14/2021 showed R6 at risk for falling related to diagnoses of dementia, impaired cognition, poor balance, poor judgement, and safety awareness. History of bilateral hip fractures, right humerus fractures, and falls. The Care Plan listed the following interventions: 1/4/21 R6 under 1 to 1 supervision during waking hours. She was to have a pull-tab and sensor pad alarm on at all times, and staff instructed to do 30-minute visual checks on her while she was sleeping. Staff instructed to provide her with an environment free of clutter, ensure her call light within reach at all times, and to keep personal items and frequently used items within reach as able. Staff encouraged to give R6 verbal reminders not to ambulate/transfer without assistance. Review of R6's EHR revealed the following progress notes related to falls: a. 12/17/2020 at 2:20 PM: Admission- resident	F 689		

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F 689	Continued From page 7 admitted today via facility van. Resident in wheelchair and transferred to bed. Alert and oriented to self only. Hand grips equal and firm, right foot press stronger than left foot, left leg shorter than right, pedal pulses faint bilateral, with 1+ pitting edema to left upper thigh with deep purple/pink bruising from surgical repair of L hip fracture, dressings intact to left lower extremity. b. 12/17/2020 at 5:00 PM: Resident has been up and ambulating by herself with her walker on 3 different occasions this afternoon. Appears very confused and difficult to redirect. A pull-tab alarm has been utilized at this time for resident's safety. c. 12/19/2020 10:30 AM: Resident has been getting up on her own and wandering into hall multiple times this shift. She has been wanting to go home, does not know why she is here, or what she should be doing. Redirected multiple times. Alarm sounded all but one time when resident was carrying pull-tab with her. This nurse educated multiple times on the importance of using call light for staff assistance and not getting up on own. Resident reports she understands but would ask again frequently. In her room there is a sheet typed out by her family to remind her of what is going on and reminded to use the call light. Has been toileted multiple times, her television is on westerns per request, snacks and drinks given. Resident was asked what she likes to do and reported cross words. Staff provided large print cross words and word searches. Staff educated to answer alarms ASAP as resident gets up fast and often not using walker. Walker within reach. Alarm on and call light within reach. d. 12/19/2020 at 2:15 PM: Resident continues to be getting up and down, setting off her personal alarm. At times she uses her walker, other times not. Alarm sounds and staff responds immediately but resident is usually already up and	F 689		

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F 689	Continued From page 8 to door. Staff changed her alarm to a silent alarm that sounds to the call light and pagers given to staff. Staff educated to watch pager closely for alarm. Resident educated on new alarm and the importance of waiting for assistance. e. 12/19/2020 at 5:10 PM: Call light alarm activated and CNA responded. Staff called the nurse to her room reporting resident was on the floor. Upon entering room resident noted to be lying on floor, face down. Resident rolled self to back and pillow provided for head. Denies hitting head and no abrasions noted. Resident completed of right hip pain, stated she could not move it. Staff noted that her right leg was shorter than left and rotated out. Resident wanted to get up off floor and the nurse educated that because of the fall and her having pain we have to call the doctor prior. CNA stayed with resident at this time. f. 12/19/2020 at 7:07 PM: the facility received report from the hospital that R6 had a right hip fracture. g. 12/22/2020 at 4:33 PM: R6 readmitted to facility. She was to receive skilled services due to her right hip fracture with repair. R6 is to transfer and ambulate with staff assistance of 2, a gait belt and her walker. h. 12/23/2020 at 7:30 AM: Alarm sounding and staff responded. Resident was sitting in recliner with legs thrown over the side moving in a rocking motion as if resident was trying get out of recliner without assist. The nurse assisted her legs back to proper place, and asked resident what was needed. Resident stated well I think I will leave now, and get some watermelon. This nurse educated resident that breakfast was coming. Resident denies pain to the nurse and denied need for restroom. i. 12/25/2020 at 11:18 AM: Alarm sounding and	F 689		

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F 689	Continued From page 9 resident sitting on the edge of bed attempting to stand without staff assist. The nurse entered room and assisted resident with needs. Resident reported she was heading home, and needed to pay the bill. This nurse explained that insurance was covering the stay. Resident currently in chair with alarms on and functioning. j. 12/26/2020 at 1:36 AM: Resident resting quietly with her eyes closed in her recliner. The footrest on her recliner elevated. Sensor pad alarm in place in recliner, on, and working properly. k. 12/26/2020 at 9:39 PM: Resident was very restless this evening and difficult to redirect from attempting to self-transfer. She was found walking by herself with her walker in the hallway after the sensor pad alarm was activated. Her call light was in reach at the side of her chair. She doesn't comprehend when educated not to self-transfer. She has stood up in her room many times by herself. Will monitor closely. l. 12/27/2020 at 8:13 PM: Resident has been very restless this afternoon and evening. She self-transferred frequently and stood up from her wheelchair activating the sensor pad alarm multiple times. Verbal redirection effective for a short time only. Will continue to monitor. m. 12/29/2020 at 10:03 AM: Resident self-transferring frequently this morning, setting off her alarm. Attempted to meet resident's needs, but continued to self-transfer yelling out help what do I do. Resident brought to nurses station in her wheelchair and provided activity and 1:1. n. 12/29/2020 at 8:05 PM: Alarm sounding, CNA entered room observed resident on the floor, summoned nurse. Upon entering room, observed resident sitting upright on the floor with her back resting against the wall. Resident had her right	F 689		

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F 689	Continued From page 10 pant leg pulled up above her knee; 2 pinpoint abrasions noted with scant amount of bleeding present. Denies having new onset of pain. o. 1/04/2021 at 1:24 PM: at 12:15 PM R6 was in her room hollering for help. When staff entered her room observed resident lying flat on her back next to her recliner. She complained of right arm pain. During the assessment, it was noted her right shoulder looked abnormal compared to previous assessments. Resident denies hitting her head no lacerations, bleeding or swelling noted. Denies hip pain. Informed resident not to move, a staff member sat with resident while the physician was notified. The nurse received a verbal order to send resident to emergency room for evaluation and treatment if indicated. p. 01/04/2021 at 3:45 PM: R6 returned to facility from the emergency room. Resident has diagnosis of right proximal humerus fracture. Her arm needs to be in sling at all times, someone at her bedside at all times. q. 01/04/2021 at 5:01 PM: discontinued staff at bed side at all times, started 1:1 supervision during waking hours, pull tab and pad alarms in place at all times, and 30 minute checks while resident sleeping. Review of the facility's investigative file revealed an initial report: Investigation: On 1/4/21, fall occurred at approximately 12:15 PM, found resident laying on the floor on her back with no alarms going off complaining of right shoulder pain. Resident was sent to the emergency room and X-ray confirmed a right proximal humerus fracture. New interventions put in place: 1:1 supervision at all times during waking hours, pull-tab and pad alarms to be in place at all times and 30 minute checks while resident is sleeping. Previous Care	F 689		

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F 689	Continued From page 11 Planned intervention to have an alarm under her was in question. Alarm was not present under resident at the time of fall but was unplugged and placed in her wheelchair. Review of the radiology report completed on 1/4/21 revealed 2 views of the right shoulder performed. Findings included: comminuted fracture (a break or splinter of the bone into more than two fragments) of the proximal (situated near the center of the body) humerus with the fracture predominantly involving the surgical neck. During interview on 6/22/2021 at 12:22 PM, Staff A stated R6 required a lot of assistance with cares and would try to get up on her own. Resident was on 1:1 supervision for a while because constantly trying to get up on her own. She stated resident's personal alarm would go off and by the time staff would get down there resident would already be on the floor. Stated R6 did not require much assistance when transferring because she would assist by using her walker and depending on the day, compliant with waiting for help. Resident would usually not use call light but had bed and chair alarm. She stated the bed alarm was like a mat on her mattress and the same for her chairs and at one time resident had a pull-tab, they had trialed many different options. She stated R6 had a lot of falls and on the day in question, they were in the middle of lunch; staff had just peeked in on her before going to the dining room about noon and resident was in her recliner, with feet elevated. Did not see her alarm but also was not looking for it. Next thing she knew DON came out and said resident was on the floor. Staff A stated she did	F 689		

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F 689	Continued From page 12 not hear alarm go off from the last time she saw her to when she saw the DON come out of resident's room. Stated that resident's room was the first room down the 100 hall, if the alarm had sounded, would not have been able to hear it in the dining room. However, if others were around that area like the nurse's station they would hear it. During meals, they always have one aide or nurse on the halls to answer call lights while the other staff are assisting residents with their meals in the dining room. Stated she did not remember if resident messed with her personal alarms, if she would unplug them, turn them off, or move them from the chair or bed. She believed there might have been one time where she did and thinks that is why they did the pull-tab alarm. During interview on 6/29/2021 at 11:53 AM, Staff F, RN advised that R6 was alert to herself only, had dementia, was non-compliant with call light use and would self-transfer a lot. R6 was an assistance of 1 staff, and was unsure if she had personal alarms when she first admitted to the facility. Staff F indicated they ended up putting a personal alarm on her because of her frequently self-transferring. Stated room was located at the beginning of the 100 hall towards the nurse's station. Staff F indicated that during meal time there is supposed to be a staff member on the hall and if that person was not in a room and her alarm went off they would have heard it. She stated that she never had issues with resident messing with her alarms when she was there. She did recall an event, on her day off, where the resident had taken the pull-tab off. During interview on 6/29/21 at 12:23 PM, Staff E CNA stated R6 admitted to the facility with a hip fracture, fell again, and had to go to the hospital.	F 689		

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	165474	A. BUILDING _____ B. WING _____	C 07/07/2021

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F 689	Continued From page 13 According to Staff, E R6 required assistance of 1 staff, would self-transfer, and not use her call light. Staff E provided that she had alarms on her bed and chair. She stated R6 would disconnect the alarm cords but the alarm would still sound. She indicated that R6 would not mess with the alarms in a way that would not allow them to function properly. She was not present at the time of the incident; she was off the clock at that time. Staff E stated she did not hear the alarm going off due to the bathhouse being soundproof, she added she could not hear anything outside of the bathhouse. During interview on 6/29/2021 at 1:49 PM, Administrator stated on 1/4/2021, they started to do 1:1 supervision with R6 during the waking hours and completed 15-30 minute checks while she slept. She believed it was Care Planned that way. She was unsure but believed that R6 had personal alarms prior to the fall on 1/4/2021 but would have to look to confirm for sure. She was unsure if the alarm sounded that day because it was a Sunday and she was not in the facility. The Administrator stated she did not personally know if R6 had messed with her personal alarms but did know she was fidgety and anxious. R6 had a hospital bed and was not sure if discussed for her to have a high-low bed; she would need to talk to the clinical staff about that. She stated R6 was non-compliant with the use of her call light and had a short recall of 15 seconds, it seemed. During meal times, not all staff are in the dining room because there are residents that chose not to go to the dining room and they need someone on the floor to monitor lights. During interview on 6/29/2021 at 2:17 PM, DON stated that after R6's first fall they put pull alarms	F 689		

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

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F 689	Continued From page 14 on her and believed they were checking on her more frequently, like every time staff would go down the hall. The alarm that they used was a pad alarm that went under her bed sheets or on top of her chairs. The DON indicated staff usually in her room because she was hollering or her call light was on; she would not sit still. After the fall on 1/4/21, they initiated 1:1 supervision while she was awake and if she were asleep, they would do 30-minute checks. A majority of her falls happened when she was trying to get out of bed; believed one may have been when she was trying to get out of her recliner. R6 had a hospital bed with side rails; she had the half rail at the top of the bed according to the DON. She advised she was not aware if a high-low bed discussed for this resident and believes that they did not think of it because she would still get up all the time. DON stated that R6 loved to watch The Lone Ranger on her television, with her door closed and lights dimmed. She felt she was overstimulated with people going up and down the halls, the call light sounds etc. She said when she was 1:1 supervision they were working on trying to decrease the stimulus for her. She stated on 1/4/21 around lunchtime staff had brought meal trays down the hall and the loudness may have been what triggered R6. She stated she would have assumed the alarm went off but did not do the investigation so not positive. The DON stated during meals, they always have at least one staff left on the floor to answer call lights, alarms, and assist residents' needs while the other staff in the dining room. During interview on 6/30/21 at 11:14 AM, Staff C stated on 1/4/21 about lunchtime she heard R6 yell for help, R6 had transferred herself and lost balance. She did not remember if R6 alarm was	F 689		

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F 689	Continued From page 15 going off or not and was not sure if R6 had alarms before this incident. R6 would transfer herself a lot. Staff C stated after she returned from the hospital that day she was 1:1 supervision with alarms. R6 had an alarm in her chair, not sure if it was there after or before the fall where she fractured her shoulder. She had fallen before this time, which was when she broke her other hip or leg. Stated on the day of her fall the last time she saw her was when she gave her morning pills about 8am. R6 was confused at times, did not use call light often, very spontaneous so staff would remind her to use light and ask for help but she would not remember to do so. Staff C indicated once they started doing the 1:1 supervision that seemed to help with her not self-transferring, she would still attempt, but someone would be right there to help. When asked if she felt the facility did everything to prevent this fall, she said she thought so. During staff interview on 7/1/21 at 11:30 AM, Staff D CNA stated on 1/4/21 R6 fell that day and had fallen a lot previously. She stated her personal alarm, which was a pressure pad, was under her the last time she saw her that early morning. Staff F did not think she was around when R6 had fallen later that day. She stated R6 would always move about in her room and would get up on her own. The alarms would go off a lot, if it were in place. R6 was very confused and her steadiness was dependent on her day. She stated that she was normally not on the hall unless a call light was going off. She indicated she believed that fall happened because the staff that was on the hall that day, Staff H was always on her phone, never doing what she was supposed to be doing, which was why others staff members, had to go down	F 689		

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F 689	Continued From page 16 that hall to help. During interview on 7/1/21 at 1:24 PM, Staff B stated she did not remember much about the fall that happened on 1/4/21 with R6, just that it was between breakfast and lunch. She stated, she had just delivered lunch, found R6 standing up in room and it looked like she could not get the footrest on her recliner to go down. The resident stated she could not get the chair to go down. She provided there was no alarm going off while she was in R6's room. She added she did not know she required staff assistance while up in her room. Once she sat R6 back down in her recliner, she sat up her lunch and left room. She stated she left R6 in her room in the recliner, with her lunch tray, and her footrest down. While the resident was standing up, she did not remember if she saw an alarm pad in her chair. She added she had heard an alarm going off before while on the hall because she saw staff going in a lot. Staff B stated R6 seemed restless while in her room. During interview on 7/7/2021 at 11:05 AM, Administrator stated R6 liked to mess with the alarms, the facility investigation concluded that the alarm was in her wheelchair not alarming. She stated through their interviews the staff that had been in the room before the fall and stated the alarm was in place. Review of the facility's Safety Alarm Policy dated 8/2015 revealed the purpose of this policy is to maintain resident safety with the least restrictive method possible. Ensure the clip is correctly positioned and attached, check that the alarm is on, and functioning; should be done at a minimum of every shift. This should be documented on the Medication Administration	F 689		

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F 689	Continued From page 17 Record (MAR) 3. According to the Quarterly MDS with a reference date of 1/5/21, R7 had the following diagnoses: progressive neurological conditions, Parkinson's disease, dementia, anxiety, depression, and benign prostatic hyperplasia. R7's BIMS score and his cognitive skills for daily decision-making not assessed during this review. The MDS indicated he required extensive assistance of 2 staff for bed mobility, transfers, walking in his room, when toileting and utilized a walker. The MDS indicated he had an indwelling catheter and was frequently incontinent of his bowels. The MDS indicated he had a fall since he was admitted to the facility, has had two or more falls with no injuries, he had two or more falls that resulted in an injury (except major injury), and no falls that resulted in a major injury. According to the MDS Resident used a bed, chair, and wander/elopement alarm daily. Review of Care Plan with a revision date of 7/20/2020 showed R7 at risk for falls due to history of falling, self-transfers, walking without assist of walker or staff and his diagnosis of Parkinson's disease. Interventions of recliner chair changed to regular chair, a sensor pad alarm put in bed and on chair/wheelchair at all times. Staff to offer a lap blanket when in his chair; his bookcase moved next to recliner with DVDs, handgrip lite reacher given to resident and he demonstrated he knew how to use it. Staff to complete fall risk assessments quarterly and as needed. Increase supervision and assistance based on resident needs, assist with walking and encourage nonskid footwear, staff are to anticipate needs as able; 1 assistance with transfers and ambulation with walker; uses	F 689		

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F 689	Continued From page 18 wheelchair at times for long distances; and remind him to use call light for assistance. Review of R7's EHR revealed the following progress notes related to falls: A. 02 /02 /2021 at 1:45 PM, the nurse was called to R7's room. Staff had reported resident was on the floor after staff responded to a sounding alarm. b. 02/06/2021 at 11:40 AM, R7's chair alarm sounding. Upon entering room, observed resident on his bottom slightly leaning toward to the left, left arm resting on trash can. Resident was on the floor in front of his recliner; bed alarm on, in place and working properly. c. 02/08/2021 at 3:50 PM the nurse was called to R7's room by staff reporting alarm was sounding and resident was found on the floor. Upon entering room resident noted to be on hands and knees in front of recliner. d. 02/12/2021 at 10:06 PM R7's bed alarm was sounding. Upon entering room observed resident standing up next to the bed. e. 03/06/2021 at 11:19 PM staff responded to a call light in resident's room and found him on floor sitting next to the bed. The bed alarm was not placed on his bed. Review of R7's progress notes revealed they lacked documentation of him messing with his personal alarm. During interview on 7/6/2021 at 2:34 PM, Administrator stated they do fall risk assessments with the MDS reviews. In a follow-up interview on 7/7/21 at 11:05 AM, she stated R7 would take the alarms off. She stated he has had a lot of falls because he likes to self-transfer a lot. Nurses have told her he has had the alarm on a majority	F 689		

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F 689	Continued From page 19 of the time but he also messes with it.	F 689		

Plan of Correction

The Ambassador Sidney **Survey Date:** 7/7/2021

115 Main Street, Sidney, Iowa 51652 **PROVIDER #:** 165474

TAG	STATEMENT OF COMPLIANCE:	COMPLETION DATE:
F 689	**CORRECTION TO RESIDENT AFFECTED:**	
	1. Resident #6 Discharged from facility on 2/17/2021	
	2. Implemented every 2-hour alarm device checks on Resident #7 on 7/23/2021 to ensure interventions are in place, this is on the TAR.	07/23/21
	3. Sign placed in resident #7 room as of 7/23/21, as entering and exiting, as a reminder for all staff to ensure that safety devices are in place as coming and going.	07/23/21
	4. Resident #2 Staff education began on 8/4/2020 for staff that work in bathhouse to exit shower stall with assistance, or by pulling backward. New wheels for shower chair were ordered by Maintenance on 8/5/2020. On 9/4/2020, new shower chair was ordered by DCS.	09/04/20
	FACILITY INTERVENTIONS:	
	1. Facility began every 2-hour facility rounds by Nurse or Departments heads looking for environmental hazards and to ensure that safety devices are in place starting on 7/26/2021, will complete every 2 hours x 1 week ending on August 2nd, then will do Q Shift x 30 days then daily x 60 days.	7/26/21-10/29/21
	2. All staff education began on 7/26/21 regarding safety devices being checked and the timeliness of reporting environmental hazards to Administrator or DCS as soon as these are seen to be completed by 07/30/21.	07/30/21
	3. New Flooring placed in Bathhouse as of September 2020.	09/30/20
	MONITORING SYSTEM:	
	1. DCS or Designee to review TAR and "rounding sheets" to ensure completion, these are to be monitored throughout each week and ongoing through 10/29/21. These results will be brought to QAPI and reviewed	10/29/21
	2. All falls will be reviewed in daily stand-up Monday through Friday by department heads to ensure appropriateness of interventions, root cause analysis and any further concerns. This is an ongoing process.	