| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165149 | A. BUILDING _____ B. WING _____ | C 10/10/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROWLEY MEMORIAL MASONIC HOME | 3000 EAST WILLIS AVENUE PERRY, IA 50220 |

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| F 000 | INITIAL COMMENTS<br><br>Correction date _____<br><br>Investigation of facility-reported incident # 67777-I resulted in deficiency.<br><br>Investigation of facility-reported incidents #70396-I and #70397-I did not result in deficiency.<br><br>See Code of Federal Regulations (42CFR) Part 483, subpart B-C.) | F 000 | | |
| F 309 SS=G | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:<br><br>(k) Pain Management.<br>The facility must ensure that pain management is | F 309 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/17/2017

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.

POC accepted 10/19/17 VV

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| F 309 | Continued From page 1<br>provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record reviews, facility policy reviews and interviews, the facility failed to provide appropriate assessment and intervention for a resident after a significant change in condition. On 4/11/17, staff found Resident #1 on the floor after a fall and notified the nurse (Staff B). The nurse (Staff B) directed staff to lift the resident from the floor to the wheelchair as Resident #1 cried out in pain when moved. Staff interviews revealed they did not want to lift the resident but had to follow the nurse ' s directions. Staff interviews revealed Resident #1 could not stand on both feet, could not move his left leg and had significant pain. The hospital records revealed the resident sustained a hip fracture. The resident's physician stated he would expect staff not transfer residents when staff suspected injury or actual injury. Concerns were identified for 1 of 2 discharged residents with a facility census of 46 residents<br>Findings include:<br><br>1. The Minimum Data Set (MDS) dated 1/5/17 documented the pertinent diagnosis of Alzheimer's disease for Resident #1. The same MDS documented a Brief Interview of Mental | F 309 | | |

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| F 309 | Continued From page 2<br>Status (BIMS) score of 3 which indicated severe cognitive impairment, required minimal assistance for for transfer, independent with ambulation with the use of a walker, had no limitations in functional range of motion, and had one fall with non-major injury since the last MDS dated 10/20/16.<br><br>The care plan problem revised 7/22/15 identified the at risk for falls due to poor safety recognition and directed to staff to anticipate resident needs. The care plan problem dated 7/22/15 documented the resident independent with ambulation.<br><br>The Fall Risk Assessment dated 4/5/17 documented a score of 65; a score of 45 or more indicates high risk for falls. A facility report titled Incidents by Incident Type for Resident #1 documented the resident had 2 witnessed and 2 unwitnessed falls 11/20/16-4/17/17.<br><br>A Progress Notes entry dated 4/11/17 at 5:24 PM completed by Staff B, licensed practical nurse (LPN) from a temporary agency staff, document staff found Resident #1 lying on the left side on the floor of his/her room. The resident reported he slipped and fell coming out of the bathroom. Staff B documented the resident could not stand on both feet, could not move the left leg, moved the right leg minimally and complained of pain greater than 10 on a 1-10 scale. The resident transported to the emergency room. The entry contained no further assessment of the resident other than vital signs.<br><br>The Progress Notes entry dated 4/11/17 at 22:10 documented the resident transferred to another hospital for a possible fracture of the hip and | F 309 | | |

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| F 309 | Continued From page 3<br>possible surgery tomorrow.<br><br>According to the Emergency Department (ED) report dated 4/11/17, Resident # 1 (90 years old) presented to the ED after an unwitnessed fall. The resident was unable to move his left lower leg due to pain. Resident #1 complained of back, pain, neck pain, left hip pain.<br>The radiology results revealed Resident #1 sustained intertrochanteric fracture associated with varus angulation ( left hip fracture).<br>The hospital admitted Resident #1 and he underwent open reduction and internal fixation surgery. On 4/17/17, the resident had been readmitted to the facility for skilled care.<br><br>During interview on 8/25/17 at 4:11 PM Staff F, CNA stated that Staff E, CNA and she found the resident lying on his/her left side and notified Staff B (nurse). Staff F stated that Staff E stated the resident's left leg abnormally turn out to the left side when Staff B rolled the resident to lay on his/her back. Staff F stated Staff E is not a nurse and had worked as a CNA for a long time and knew that observation could indicate the resident had a hip fracture.<br>Staff F stated Staff B instructed them (Staff E and herself) to transfer the resident from the floor to the wheelchair. Staff F said the CNAs looked at each other when told to transfer the resident because they did not think it was a good idea to move the resident but CNAs are supposed to follow what the nurse instructs them to do. Staff F could not recall exactly how they (Staff E and herself) assisted the resident off the floor but recall the resident could not bear weight on the left leg. Staff F stated they did not use a mechanical lift to transfer the resident. Staff F stated the resident tried to get off the floor | F 309 | | |

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| F 309 | Continued From page 4<br>independently but could not bear weight on his/her left leg.<br><br>During interview on 8/29/17 at 4:20pm Staff E stated Staff F and herself found Resident #1 lying on his/her back but trying to roll to the left side. Staff E went to get the nurse (Staff B). Staff E stated Staff F asked the resident if s/he could move his/her arms and legs; the resident cold move both arms independently, and could move the right leg some, but couldn't move the left leg and grimaced in pain when trying to do so. Staff E stated Staff B did not perform a "hands on" assessment of the resident.<br>Staff B told Staff F and Staff E to transfer the resident from the floor to the wheelchair; she stated that she did not think it was a good idea to do so, but proceeded with Staff F to use a gaitbelt around the resident's waist to lift the resident up and placed him in the wheelchair. The resident cried out in pain during the transfer. Staff B then instructed Staff F and Staff E to transfer the resident from the wheelchair to the bed and Staff E stated she told Staff B it was not a good idea and refused to do so. Staff E then left the unit and asked the DON and ADON to come to the resident's room.<br><br>During interview on 8/29/17 at 10:10 AM the ADON stated it is the facility's expectation that staff fully assess resident/s, including vital signs, treat any injuries if able and to leave the resident when found on the floor, etc; and if the resident needs to be transferred to the emergency room have the ambulance personnel transfer the resident. She stated the current falls policy does not direct to leave the resident where found but is revising the policy today to include that. | F 309 | | |

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| F 309 | Continued From page 5<br>During interview on 8/30/17 at 4:52 PM the resident's primary care physician stated he would expect resident/s be left on the floor when found for ambulance personnel to transfer in the event of an actual or suspected injury.<br><br>During an interview with Staff B, licensed practical nurse (LPN) on 8/25/17 at 1:30 p.m. revealed she could not recall anything about this incident or with Resident #1. Staff B reported she could not recall that far back. | F 309 | | |