STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165211	A. BUILDING _____ B. WING _____	C 01/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OTTUMWA	2035 WEST CHESTER AVENUE OTTUMWA, IA 52501

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F 000	INITIAL COMMENTS Correction Date_____ The following deficiencies relate to the investigation of complaint 72691-C and facility reported incident 73282-I conducted January 11-17, 2018. Both the complaint and the incident were substantiated. See Federal Code of Regulations (42-CFR) Part 483, Subpart B.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: The following deficiency relates to facility self report 72691-C: Based on record review and staff interview, the facility failed to make sufficient preparation and orientation for a resident to ensure a safe and orderly discharge from the facility. (Resident #1). The facility reported a census of 137 residents. Findings include: According to the Minimum Data Set (MDS) with an assessment reference date of 11/20/17 Resident #1 had a Brief Interview for Mental	F 624		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/26/2018

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Status score of 8 indicating a moderately impaired cognitive status. Resident #1 required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included congestive heart failure, diabetes mellitus, Non-Alzheimer's dementia and respiratory failure.

Discharge Report dated 11/21/17 by Resident #1's physician stated PLAN: Resident #1 will need a bath aide and in-home physical and occupational therapy. Resident #1 will need a wheelchair and glucometer and testing supplies for blood sugars to be checked daily at variable times. Follow up with physician 1-2 weeks post discharge.

In an interview on 1/17/18 at 8:48 a.m. Staff F, social services, stated she was involved with Resident #1's discharge planning. On Tuesday, 11/21/17, Staff F met with the rehabilitation department to discuss Resident #1's needs when discharged home on 11/24/17. Staff F stated she recalls Resident #1 needing physical and occupational therapy, a bathe aide and a nurse. That same day, Staff F contacted Staff H at the home health agency which Resident #1 had used in the past. Staff F faxed Resident #1's history and physical, face sheet, physical and occupational therapy reports and medication administration records to Staff H. Staff F stated to Staff H she would fax the physician discharge order when she received it and have a nurse contact their office when Resident #1 was discharged.

In an interview on 1/18/18 at 8:32 a.m. Staff H, home health agency, stated on 11/22/17 she received a call from Staff F making a referral for

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F 624	Continued From page 2	F 624		

home services for Resident #1. Staff H requested information regarding Resident #1, which was sent. Staff H stated she reviewed the information and had concern with Resident #1's decline and whether they would be able to provide in home services. Staff H stated she called Staff F that same day and left a message for her to return the call. Staff H stated it was the day before Thanksgiving and she never received a call back. Staff H stated she was off during the holiday and following Friday. On Friday 11/24/17 the home health agency received a call from the facility nurse, Staff G, stating Resident #1 had been discharged. Staff H stated the person who had taken the call from the home health agency informed Staff G that they had concerns and were not going to provide services. Staff G responded that it didn't matter to her, she was just asked to make the call. The home health agency staff then asked if she could speak with someone else and Staff G stated "no" and hung up.

In an interview on 1/17/18 at 9:33 a.m. Staff G, registered nurse, stated on the morning of 11/24/17 she was preparing for the discharge of Resident #1. A family member was in and out and left to the pharmacy to pick up Resident #1's medications. The family member returned stating the pharmacy did not have any discharge orders. Staff G contacted the pharmacy and eventually resolved the pharmacy issue. Staff G stated when she reviewed the discharge file there was a note stating to call the home health agency upon the discharge of Resident #1. Staff G stated she called the home health agency and spoke with a female. The female stated she didn't think they were going to accept Resident #1 and that they had been waiting for a return call from Staff F. Staff G stated she didn't know anything about that

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F 624	Continued From page 3 and the conversation ended. Staff F stated she did not contact anyone regarding the home health agency not accepting Resident #1.	F 624		
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 ensure Resident #2 received adequate supervision to mitigate the risk for falls and injury. The facility reported a census of 137 residents and the sample consisted of 4 residents. The facility identified Resident #2 to be at risk for falls due to a history of a cerebrovascular accident (stroke), anxiety and previous fall. Due to the risk, the facility planned to not leave the resident alone in the resident's room alone and in a wheelchair. The plan directed staff to place the resident at the nurse's station. The staff did not know this and pushed the resident in the wheelchair to her room and left her alone. The resident rose from the chair and fell. The fall resulted in a fractured hip and a change in level of care to hospice care. Findings include: 1. Resident #2 had a Minimum Data Set (MDS) assessment with a reference date of 11/1/17.	F 689		

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Resident #2 had a Brief Interview for Mental Status score of 11. A score of 11 identified the resident had a moderately impaired cognitive status. The MDS indicated the resident required extensive assistance with transfers, dressing, toilet use and personal hygiene needs. The MDS indicated the resident had diagnosis that included Alzheimer's disease, cerebrovascular accident (stroke), osteoporosis (weak bone disease), anxiety and a history of falling.

The Care Plan identified Resident #2 at a risk for falls related to the cerebrovascular accident and a history of fall. The interventions included and directed the staff to not bend over to pick up dropped items, encourage resident to use grabber, ensure resident is wearing appropriate footwear. On 11/16/17, the interventions initiated included resident is to be positioned at the nurse's station when spouse not visiting and do not leave resident in wheelchair when in room.

The Progress Notes dated 1/5/18 at 6:10 p.m. written by Staff A, Licensed Practical Nurse stated: CNA (certified nursing assistant) called the attention of the nurse to the resident's room. Resident #2 was found on floor in front of the dresser on her right side. Resident #2 assessed and reported pain to right elbow. Upon examination, a bruise was noted on lateral aspect of right forearm measuring 3 centimeters by 1 centimeters and a reddened area on the back lateral right arm measuring 9 centimeters by 3 centimeters. Resident #2 stated she was going to see her folks and then fell. Resident #3 assessed and she reported pain on the right elbow and could not rate her level of pain. The vital signs checked and all within normal limits. Staff lifted the resident off the floor with the help

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F 689	Continued From page 5	F 689		

of a Hoyer lift and transferred into bed. Once in bed, the nurse noted the right leg was rotated outwardly. The nurse notified the physician and received orders to transfer to the hospital [emergency room].

On 1/16/18 at 2:00 p.m. Staff B, case manager, was interviewed and stated following Resident #2's fall on 1/5/18, she amended Resident #2's Care Plan to include not leaving Resident #2 unattended while in her wheelchair in her room. Staff B insisted she was certain she made the change under the fall risk section of the Care Plan and documented the revision in the progress notes 1/8/18.

On 1/16/18 at 2:20 p.m. Staff C, case manager skilled unit, stated Resident #2 was initially on the skilled unit and following a second fall on 11/15/17, she added interventions to include having Resident #2 up at the nurse's station after her spouse leaves and to not leave Resident #2 in her wheelchair while in her room. These interventions were added on 11/16/17 and remained in place when Resident #2 was moved off of the skilled unit.

Progress Notes dated 11/16/17 at 6:33 a.m. Care Plan Change, written by Staff C states: Intervention: ensure/provide a safe environment: Resident up to nurse's station after spouse leaves. Don't leave in wheelchair in room. Note Text: Review of resident fall. Resident stated she was getting ready for breakfast when she was found on the bathroom floor. Spouse had just left. Resident does not remember to use call light. Staff to bring resident up to nurse's station when spouse leaves. Staff instructed not to leave resident sitting up in wheelchair in her room.

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On 1/16/18 at 12:52 p.m. Staff D, certified nurse aide, stated he worked the 2:00 p.m. to 10:00 p.m. shift on the afternoon of 1/5/18. Sometime around shift change and after supper, he was involved with laying residents down. Resident #2's spouse and son visited and left 15-30 minutes earlier. Staff D stated he checked on Resident #2 shortly after the family had left and she was in her room, in her wheelchair with a bedside table in front of her. Staff D stated he had a conversation with his co-worker, Staff E, unrelated to Resident #2 and went about assisting other residents. Within a few minutes, Resident #2's roommate came out into the hall and alerted them Resident #2 had fallen. Staff D and Staff A responded and assessed Resident #2. Initially Resident #2 complained of right arm pain. Resident #2 was confused, stating she needed to meet her folks. They put a Hoyer sling under Resident #2 and lifted her into bed. At that time Resident #2 complained of hip pain and her right leg was turned outward. They called emergency medical services and had Resident #2 transported to the hospital. Staff D stated he was not aware that Resident #2 was not to be left alone in her wheelchair when in her room. Staff D stated that information would be in the Kardex (electronic Care Plan).

On 1/16/18 at 1:26 p.m. Staff E, certified nurse aide, stated she worked a 10:00 a.m. to 6:00 p.m. shift on 1/5/18. Staff E stated after supper she assisted resident back to their rooms and thought she had propelled Resident #2 back to her room, placed the bedside table next to her and gave her the call light. Staff E stated she then left to assist other residents. At around 5:50 p.m. Resident #2's roommate entered the hallway and alerted

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F 689	Continued From page 7 staff Resident #2 had fallen. Staff E and Staff D responded to the room and found Resident #2 on the floor. Staff E stated she was not aware Resident #2 was not to be left unattended in her room while in her wheelchair. Staff E stated that information should be in the Kardex (electronic Care Plan), but didn't recall seeing it.	F 689		