STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165483	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALCYON HOUSE	1015 SOUTH IOWA AVENUE WASHINGTON, IA 52353

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F 000	INITIAL COMMENTS Correction Date 2/26/18 On 2/1/18, facility reported incident 72845-I was investigated and substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000	This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
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 residents received adequate supervision during transfers to prevent accidents for two (2) of four (4) residents at risk for falls. Resident #4 fell on 11/28/17 and sustained an arm fracture when staff transferred her without a gait belt for her safety. Resident #2 sustained minor injuries when staff failed to follow her care plan for transfers. The facility census was 47 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/2/17 Resident #4 had diagnoses of hypertension, anxiety, depression, multiple myeloma (not in remission), pain and palliative	F 689	**F689 PLAN OF CORRECTION** In continuing compliance with F689, State Regulation 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices: 1. Gait belts are required for all nursing team members as part of their uniform, and will be used for the individuals involved as well as to protect other residents in similar situations as directed by their pocket care guides. 2. Education for all nursing team members at multiple meetings between 11/28/17 and 12/8/17 on wearing gait belts and use of pocket care guides. Ongoing reminders are included intermittently at daily huddle meetings. 3. As part of Halcyon House's ongoing commitment to quality assurance, DON and/or designee will monitor gait belt usage and use of pocket care guides to ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christine L. Marshall — TITLE: Executive Director — (X6) DATE: 2/26/18.

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 care. The MDS revealed Resident #4 had no cognitive impairments. Resident #4 required extensive assistance of two staff with transfers. Resident #4 had balance issues and only able to stabilize with staff assistance. The CNA (Nurse Aide) Pocket Care Plan directed staff to transfer Resident #4 with assist of one staff and a walker; if not using a walker provide assistance of two staff, refuses walker at times and prefers to spend time in bed. The Care Plan revealed Resident #4's abilities vary from day to day and during the day based on level of pain, weakness, fatigue and shortness of breath and may need more help at times than others. The Incident Report dated 11/28/17 revealed the Nurse walked with Resident #4 to the bathroom using the front wheeled walker. Resident #4's gait slow and steady. Resident #4 complained of the right arm hurting on the way to the bathroom. Resident #4 pivoted in front of the toilet and grabbed the grab bars on both sides of the toilet. Resident #4's hands grasped the bars and elbows rested on the bar. Resident #4 lowered on the toilet and ended up crooked on the toilet with a thud. Three popping sounds heard and then Resident #4's arm went slack to the floor and Resident #4 complained of pain. The Nurse administered pain and anxiety medications and called hospice. An interview on 2/1/18 at 1:26 p.m. Staff B reported he/she answered Resident #4's call light. Resident #4 wanted pain medication. Staff B left	F 689		

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F 689	Continued From page 2 to get the pain medication. When Staff B returned with the pain medication Resident #4 reported he/she needed to go to the bathroom really bad. Staff B assisted Resident #4 to the toilet without a gait belt. The Radiology Consultation Report dated 11/28/17 of the right shoulder revealed Resident #4 sustained a mildly displaced mid right humerus fracture. Resident #4 had degenerative changes of the right shoulder. The Care Plan updated 11/28/17 revealed Resident #4 sat down hard on the toilet and sustained a right arm fracture from the safety rail. The Care Plan directed the staff to provide assistance of two staff with transfers and ambulation. An interview on 2/1/18 at 2:17 p.m. the Interim Director of Nurses reported she expected staff to use a gait belt for all transfers that require one to two staff physical assist. The Interim Director of Nurses reported the staff received education on the use of gait belts and also implemented the nurses wear a gait belt as part of the uniform in addition to the nurse aides. 2. According to the Minimum Data Set (MDS) assessment dated 12/28/17 Resident #2 had diagnoses of anemia, hypertension and dementia. The MDS revealed Resident #2 had moderate cognitive impairments. Resident #2 required extensive assistance of two staff with bed mobility, transfers, dressing, toilet use and personal hygiene. Resident #2 had balance issues and only able to stabilize with staff	F 689		

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F 689	Continued From page 3 assistance. The Care Plan updated 9/7/17 directed the staff to transfer with a sit to stand lift and two staff. The CNA (Certified Nurse Aide) Pocket Care Plan directed the staff to transfer Resident #2 with a sit to stand lift and two staff. The Incident Report dated 1/29/18 at 3:50 p.m. revealed Resident #2 at the edge of the bed and Nurse Aide assisting Resident #2 to get up. The Nurse Aide had a gait belt in place and providing assistance of one staff. The Nurse Aide reported the wheelchair slipped backwards and Resident #2 fell to the floor. Resident #2 sustained skin tears to both wrists. The staff administered first aid. The fall investigation revealed the Nurse Aide called in to cover the evening shift. The Nurse Aide failed to have a pocket care plan and transferred Resident #2 without the sit to stand lift. The investigation revealed a coaching session completed with the staff. The Care Plan updated 1/29/18 revealed an intervention of teaching for staff on transferring Resident #2 safely. An interview on 2/1/18 at 4:51 p.m. Staff A reported he/she just started working at the facility. Staff A reported this was his/her first time working on Resident #2's household. Staff A did not get a pocket care plan at the start of the shift. Staff A did not know how much assist Resident #2 required for transfers. Staff A asked Resident #2 if he/she required one or two staff. Resident #2 told Staff A one staff. Staff A reported he/she took Resident #2's word. Staff A reported he/she placed a gait belt around Resident #2. Resident	F 689		

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F 689	Continued From page 4 #2 was sitting in the recliner. Staff A locked the wheelchair. Staff A assisted Resident #2 to stand and pivot to the wheelchair. Resident #2 started to sit in the wheelchair. The wheelchair moved backwards and Resident #2 grabbed Staff A's arms. Staff A reported he/she lowered Resident #2 to the floor. Resident #2 had skin tears on each wrist. Staff A reported it was his/her mistake and he/she should have had a pocket care plan. Staff reported feeling awful that Resident #2 has bandages on both wrists.	F 689		