STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(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 3-28-18 ✓ Facility self reports 73749-I and 74215-I were investigated February 20-27, 2018. Both facility reported incidents were substantiated. The following deficiency relates to the Federal Code of Regulations (42-CFR) Part 483, Subpart B-C.	F 000	Please accept the attached word document as the facility's Plan of Correction and Credible Allegation of Compliance.	02/28/2018
F 689 SS=J	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: The following deficiency relates to facility self reports 74225-I and 73220-I: Based on observation, record review and staff interviews, the facility failed to provide adequate supervision Resident #1 eloped from the facility without staff knowledge and Resident #2 sustained a subdural hematoma after a fall. The sample included 4 residents and concern identified for 2 of 4 residents. (Resident #1 and #2) The facility reported census was 52. Findings include: 1. According to Resident #1's Minimum Data Set	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ronald L Stevens — TITLE: Administrator — (X6) DATE: 03/21/2018

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 3/28/18 by JM, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165649	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(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 689	Continued From page 1 (MDS) assessment with assessment reference date of 1/3/18, Resident #1 had impaired short and long term memory deficits and severely impaired cognitive skills for daily decision making. Resident #1 was independently mobile in wheelchair and required extensive assistance with dressing, toilet use and personal hygiene needs. Resident #1's diagnosis included non Alzheimer's dementia, Parkinson's and psychotic disorder. Resident #1's plan of care identified a behavioral problem which included episodes of agitation, combativeness, and attempts to get up unassisted and past episodes of attempting to elope related to dementia. Interventions included: a. Alarms to alert staff when attempting to get up unassisted. b. When anxious and upset investigate the reason. Resident sometimes likes to be walked or needs to go to the bathroom. c. Wanderguard (alarm to alert staff resident is by external door) in place to alert staff of attempts to elope. (discontinued 12/14/17) Initial Wandering Assessment dated 3/14/16 indicated Resident #1 met criteria for use of a Wanderguard. Wanderguard was initiated at that time. Daily Nursing Notes dated 12/14/17 at 10:00 a.m. documented new order to discontinue Wanderguard. In an interview on 2/20/18 at 3:00 p.m. the Director of Nursing (DON), stated on 12/4/17 the quality assurance team met and discussed various issues including the use of the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	166549	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(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 689	Continued From page 2 Wanderguard on Resident #1. Resident #1 had been on a Wanderguard since his admission in April 2016 and had never demonstrated exit seeking behavior or verbalized wanting to leave. The team decided the Wanderguard could be discontinued, but not before a planned medication adjustment was completed. On 12/14/17 the Wanderguard was discontinued without incident. On the evening of 1/25/18 the DON was notified of Resident #1 exiting the building undetected and tipping his wheelchair over. Resident #1 sustained a small hematoma to his/her forehead and abrasions to his/her left shoulder and knee. The DON stated the front door alarm had sounded and Staff A responded. Staff A reportedly looked outside and didn't see anything and returned to work. A few minutes later a visitor arrived and reported a resident was outside and had tipped his wheelchair over. In an interview on 2/20/18 at 4:40 p.m. Staff A, certified nurse aide, stated on the evening of 1/25/18 he was working down the 200 hall and when exiting a resident's room heard a door alarm sounding. Staff A responded and looked at the alarm panel which identified the alarming door. Light #7 indicating the front door was activated. Staff A went to the door and then stepped outside, walked to the corner of the building and looked around. Staff A stated he did not see anyone and returned into the building, shut off the alarm and returned to work. Staff A stated a few minutes later he was summoned back up front and informed Resident #1 had tipped his wheelchair over outside. Staff A stated he was surprised to hear it was Resident #1 because Resident #1 was not known to exit seek. Staff A stated Resident #1 was found lying next to the front wheel of a parked car in the parking	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(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 689	Continued From page 3 space next to the south sidewalk. Resident #1 was wearing a black sweat shirt and bottoms and was difficult to see. In an interview on 2/20/18 at 4:45 p.m. Staff B, registered nurse, stated on the evening of 1/25/18 she was down hall 300 when an aide asked for her assistance on the 100 hall. Staff B went to room 103 and was assessing the resident and discussing care issues. As they walked out of the room, there was a visitor standing at the nurse's station. The visitor reported there was a man tipped over in his wheelchair outside. Staff B went out with others and found Resident #1 tipped over in his wheelchair next to a parked car. Staff B assisted Resident #1 back into his wheelchair and propelled him back inside. Staff B stated she was surprised to see that it was Resident #1 because he/she was not known to exit seek. Staff B stated she never heard an alarm sound. In an interview on 2/26/18 at 2:00 p.m. Staff C, registered nurse, stated on the evening of 1/25/18 she was down hall 100 assessing a resident. When she came out of the room, a visitor at the front desk reported there was a man that had fallen outside. Staff C went out and found Resident #1 laying on the ground next to his tipped over wheelchair. Staff C and others got Resident #1 back into his wheelchair and into the facility. Staff C stated she never heard an alarm sound and was surprised Resident #1 had went outside, because he hadn't attempted to do so since first being admitted over 1 1/2 years ago. Staff C stated she had last seen Resident #1 in the dining room at around 7:45 p.m. and he was found outside at around 8:00 p.m. When asked about how door alarms are responded to, Staff C	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(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 689	Continued From page 4 stated if a door alarm sounds staff are to respond and if not certain who set the alarm off they are to look outside and if they do not see anyone they can come in an shut the alarm off. Staff C stated there was no expectation to do a resident head count. Review of the facilities Door Alarms and Wanderguard (old) policy found there is no instruction or expectation of staff response to door alarms, no instruction or expectation to investigate the cause of the alarm and when the cause was unknown no instruction or expectation of staff to expand a search and to ensure all residents are accounted for. 2. According to Resident #2's Minimum Data Set (MDS) assessment with assessment reference date of 11/29/17, Resident #2 had a Brief Interview for Mental Status score of 11 indicating moderately impaired cognitive skills for daily decision making. Resident #2 required limited assistance with transfers, ambulation and personal hygiene needs and extensive assistance with dressing and toilet use. Resident #2's diagnosis included Alzheimer's dementia, malnutrition, coronary artery disease and osteoporosis. Resident #2's plan of care identified a high risk for falls. Interventions included: a. Resident #1 requires extensive assistance of one staff, gait belt and walker to ambulate/transfer. b. Non-skid footwear. c. Call light within reach and encourage Resident #1 to use it for assistance.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(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 689	Continued From page 5 d. Sensor alarm in chair and wheelchair. (discontinued 11/20/17) There was no reevaluation of the removal of the personal alarm. Radiology report dated 2/15/18 noted impression: Moderate to large size acute left subdural hematoma measuring up to 2 centimeters in thickness with 1.8 centimeters of midline shift. In an interview on 2/27/18 at 10:30 a.m. Staff D, certified nurse aide, stated on the afternoon (1:55 p.m.) of 2/15/18 she was down 200 hall attending to other residents and in proximity of Resident #2's room, when she heard someone say "Oh" followed by a crash. Staff D entered Resident #2's room and found her lying on the floor in front of her roommate's recliner with the roommates walker tipped over. Resident #2 immediately complained of a headache and was assisted up and moved to the nurse's station to be monitored. Resident #2 did not comment as to why she had gotten up. Staff D stated Resident #2 had been taken to the bathroom by Staff E just 15-20 minutes earlier. Staff D stated she frequently looks in on Resident #2 because she gets up unassisted so often throughout the day. Staff D stated Resident #2's floor alarm was discontinued a while back and she doesn't believe it should have been. Staff D stated the alarm was effective for Resident #2. Staff D stated when the alarm sounded, Resident #2 would usually stop and wait for staff to arrive. In an interview on 2/27/18 at 10:50 p.m. Staff E, certified nurse aide, stated on 2/15/18 around 1:30 p.m. to 1:45 p.m. she had assisted Resident #2 up to the bathroom and back into his/her	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(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 689	Continued From page 6 recliner. Staff E stated she went to break and upon returning discovered Resident #2 had fallen. Staff E stated Resident #2 used his/her call light, but was known to get up unassisted throughout the day. Staff E stated Resident #2 used to have an alarm and she would use the alarm to get staff's attention. At that time, Resident #2 was not getting up unassisted so the alarm was discontinued. In an interview on 2/27/18 at 2:45 p.m. Staff F, certified nurse aide, stated Resident #2 was pleasant and alert. When Resident #2 was admitted (11/9/16) she got up unassisted a lot. They used an alarm and that helped a lot. Resident #2 would use the alarm to get staff's attention and wait instead of getting up without help. The alarm was discontinued and although Resident #2 would use her call light, he/she often got up unassisted. Staff E stated recently Resident #2 was getting up unassisted very frequently. Staff E stated the floor alarm was effective and she had mentioned to nursing a couple of times that they should reinstate the alarm. In an interview on 2/27/18 at 3:04 p.m. Staff A, certified nurse aide, stated Resident #2 was a nice lady, but a little impatient. Staff A stated when Resident #2 had an alarm she would use it instead of the call light to get staff's attention. Resident #2 would activate the alarm and wait for staff to take her to the bathroom. When the alarm was discontinued, Resident #2 began getting up unassisted to use the bathroom without using the call light. In an interview on 2/26/18 at 4:40 p.m. the Director of Nursing (DON), stated Resident #2	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165549	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA WOODS CARE CENTER	THREE PENNSYLVANIA PLACE OTTUMWA, IA 52501

(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 689	Continued From page 7 was admitted in November 2016 and had a fall in December 2016, but had since been fall free. Resident #2 was placed on alarms and seemed to use the alarms as a way of getting staff attention. Resident #2 would also use her call light. Over several months her fall risk remained high, but was decreasing. They were trying to toilet her more frequently, which was decreasing her tendencies of getting up unassisted. They made an alarm change in October 2017 and following a push to become alarm free, they discontinued Resident #2's alarm on 11/20/17. Resident #2 continued to get up unassisted periodically, but hadn't fallen until the 2/15/18 incident. On 2/27/18, the facility abated the IJ when they updated the door alarm & Wanderguad policy on if an alarm was triggered and the cause was unknown, staff should go outside the door and do a visual sweep of the area and account for all residents by doing a head count. The facility educated staff of these changes. These findings lowered the IJ from a "J" severity level to an "G" with ongoing monitoring to ensure residents safety/supervision (including falls).	F 689		

F000

The following Plan of Correction is the Facility's Written Credible Allegation of Compliance.

Completion Date: 02/28/2018

F689

The facility denies that the alleged fact as set forth constitute a deficiency under the interpretations of Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law required it.

With respect to Residents #1, #2 and all similarly situated residents, the facility will assure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Regarding Resident #1, the facility placed a wanderguard bracelet on the Resident immediately after the incident and assessed by the physician on 01/25/2018. The care plan was updated to address the new intervention.

Regarding Resident #2, the Resident was immediately assessed by the physician, monitored and later transferred to the hospital.

Facility administration updated the Door Alarm and Wanderguard Policy on 01/26/2018 and then again on 02/26/2018 adding that if a door alarm is triggered and the cause is unknown, staff should go outside the door to do a visual sweep of the area and account for all residents by doing a head count to match the current census. Facility staff were in-serviced and educated on the policy changes on 01/26/18 and again on 02/27/18. On 02/22/18, another in-service was conducted on dementia care, resident safety and supervision and the Missing Resident policy and procedures were reviewed.

The Director of Nursing (D.O.N.) and/or Designee will review incidents after occurrence and implement new interventions as possible. In addition, the facility commenced to begin weekly Fall/Safety Committee meetings which will include input from direct care workers. The committee will review recent incidents, concerns and interventions with residents having a higher safety risks. Residents will be assessed for elopement risks, falls and interventions upon routine care plan meetings.

F689 (Continued)

Performance shall be monitored by the Quality Assurance Committee (QA&A) quarterly to make sure solutions are permanent.