STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G004	A. BUILDING _____ B. WING _____	C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE VILLAGE	1211 EAST 18TH STREET CARROLL, IA 51401

(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
W 000	INITIAL COMMENTS At the time of the survey the facility was found to be in substantial compliance with 42 CFR 483, Subpart 1, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID regulations). During the course of the annual health survey, the investigation of #74022-I was also completed. The investigation of #74022-I resulted in a determination of Immediate Jeopardy (IJ) on 2/15/18 at 10:55 a.m. based on insufficient staff training/performance related to client assisted ambulation and lack of follow up nursing care for a client who fell and hit his/her head. The facility developed and implemented a plan, which included retraining of staff regarding assisted ambulation and retraining of Certified Medication Aides (CMAs) and nursing staff regarding client falls with potential for injury. The Immediate Jeopardy was removed on 2/20/18 at 3:15 p.m. The investigation of #74022-I resulted in a condition-level deficiency cited at W158 (Facility Staffing) and standard-level deficiencies cited at W148, W192, W194 and W331.	W 000	See attached POC 4/15/18	
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.	W 148		

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

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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W 148	Continued From page 1 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify guardians of a potentially serious incident. The facility failed to notify Client #1's guardian when Client #1 fell and hit/his her head. The client had a history of an epidural hematoma (blood filled area between the skull and covering of the brain) due to a fall, which had required surgery. This affected 1 of 1 client involved in the investigation of #74022-I (Client #1). Finding follows: Record review on 2/13/18 and 2/14/18 revealed the facility's investigation report indicated Client #1 fell and hit the right side of his/her head on the evening of 2/04/18. Staff A and Staff B witnessed the fall and reported Client #1 hit his/her head hard on the hallway floor. Certified Medication Aide (CMA) A examined Client #1 and reported he saw no injuries. CMA A said he was not told the client had hit his/her head. Staff A and Staff B stated they saw an abrasion on Client #1's head and they did tell CMA A the client had hit his/her head. A nurse was not notified of the fall until the following day. An Incident Report about the fall was not written until 2/06/18. No documentation of notification to the guardians was located. When interviewed on 2/14/18 at 3:50 p.m. Client #1's guardian stated no one from the facility told her of Client #1's fall on 2/04/18. She said during a phone conversation with the Emergency Room physician regarding Client #1's fall on 2/06/18, the physician mentioned to her he had been told Client #1 had also fallen on 2/04/18. Client #1's guardian said she knew nothing of the fall on 2/04/18. Client #1's guardian stated the client had craniotomy in 2012 due to a epidural hematoma as the result of a fall and blow to the	W 148		

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W 148	Continued From page 2 head. During a follow-up interview on 2/26/18 at 3:00 p.m. Client #1's guardian stated she would have wanted to be notified of Client #1's fall on 2/04/18. She said she told the agency in the past that she wanted to be informed of everything. When interviewed on 2/14/18 at 10:00 a.m. the Residential Supervisor said she became aware of the Client #1's fall on the morning of 2/05/18. She was told Client #1 hit his/her head. The Supervisor examined Client #1's head and saw an abrasion/rug burn on the right side of the client's head. She said the abrasion was in the same area as the scar from the previous surgery (for the epidural hematoma). The Supervisor said she did not notify the guardian of Client #1's fall and subsequent injury. She did not know of any staff person who had notified Client #1's guardian of the fall that occurred on 2/04/18. When interviewed on the afternoon of 2/20/18, the Campus Residential Director reported the facility had a form signed by guardians regarding what information they wished to be notified of. The Director and surveyor reviewed the Communication Request Form signed by Client #1's guardian on 3/22/17 (date of admission). The form included only the categories of medication changes, ER (Emergency Room) visits, hospitalizations, lab results, routine medical appointments and non-routine medical appointments. The guardians checked they wanted to be notified for everything listed. However, illness, injuries or incidents were not listed on the form. The Director acknowledged the form did not have this type of information listed.	W 148		

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W 158	Continued From page 3	W 158		
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to maintain minimum compliance with the Condition of Participation (CoP) - Facility Staffing. The facility failed to provide adequate and appropriate training to ensure staff ability to effectively perform job duties to promote and ensure client safety. The facility provided staff with inconsistent information regarding how best to assist Client #1 to ambulate. These concerns resulted in a determination of Immediate Jeopardy (IJ) on 2/15/18 at 10:55 a.m. The facility developed and implemented a plan which included retraining of staff regarding assisted ambulation and retraining of Certified Medication Aides (CMAs) and nurses regarding client falls with potential for injury. The IJ was removed on 2/20/18 at 3:15 p.m. Cross Reference W192: Based on interviews and record review, the facility failed to ensure adequate staff training to ensure client safety and well-being regarding clients' health needs. Staff failed to immediately notify a nurse of fall with potential head injury. As a result, Client #1 did not receive timely or appropriate assessment and follow up following a fall with head injury. Cross Reference W194: Based on interviews and record review, the facility failed to ensure staff correctly and consistently implemented walking guidelines for a client with difficulty ambulating. .	W 158		

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W 158	Continued From page 4 Cross Referemce W331: Based on interviews and record reviews, the facility nursing staff failed to provide timely and appropriate assessment following a client fall with injury to the head. Staff failed to immediately notify a nurse following a fall with head injury; however, once aware multiple nurses failed to complete appropriate assessment and follow up of the injury.	W 158		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure adequate staff training to ensure client safety and well-being regarding clients' health needs. Staff failed to immediately notify a nurse of fall with potential head injury. As a result, Client #1 did not receive timely or appropriate assessment and follow up following a fall with head injury. This affected 1 of 1 clients involved in the investigation of #74022-1 (Client #1). Finding follows: See W 331 for additional information. Record review on 2/13/18 revealed a facility investigation and facility records indicated Client #1 fell and hit his/her head on the evenings of 2/04/18 and 2/06/18. Staff reported Client #1 was unresponsive for three to four minutes after the fall on 2/06/18. Nursing staff assessed Client #1 and called 911. Emergency personnel arrived	W 192		

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W 192	Continued From page 5 and transported the client to the emergency department at a local hospital. A CAT (Computerized Axial Tomography) scan revealed bleeding in the brain. Client #1 was then air lifted to a medical center in Des Moines. According to Client #1's guardian, he/she was in the Intensive Care Unit until 2/16/18, when he/she was moved to the neurology floor. As of 2/26/18, Client #1 remained hospitalized and slowly showed increased responsiveness. Client #1, 26 years old, had diagnoses including: severe intellectual disability, hypotonic quadriplegia, low tone, history of craniotomy due to fall (2012), cortical vision impairment, communication deficit, history of hip dislocation, Phelen-McDermid Syndrome (a rare genetic disorder, which causes various disabilities/abnormalities, including decreased sensitivity to pain), and heart abnormalities. Client #1 was non-verbal without functional communication skills, but did vocalize. Client #1 was 5'11", which was taller than many of the staff. The client was admitted to the facility on 3/22/17. Continued record review revealed Client #1's 30 day team meeting, held 4/18/17, noted at times Client #1 could be difficult to walk and was at high risk for falls. A review of incident reports, nursing notes, and physical therapy notes revealed no documentation of any falls in the three months prior to the falls on 2/04/18 and 2/06/18. Record review on 2/13/18 revealed an undated facility investigation of the fall on 2/06/18 conducted by the Residential Supervisor (RS). According to the investigation, Staff A walked with	W 192		

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W 192	Continued From page 6 Client #1 during the fall on the evening of 2/04/18 and the fall on the evening of 2/06/18. The review noted appropriate documentation and notification were not completed following the fall on 2/04/18. The RS noted in the report the fall on 2/04/18 resulted in abrasions and a hematoma to the right, rear of Client #1's head, in the same area as the scar from a previous surgery. When interviewed on 2/13/18 at 12:25 p.m. Staff A confirmed she worked on the evenings of 2/04/18 and 2/06/18 and walked with Client #1 when the client fell and hit the right side of his/her head. Regarding the fall on 2/04/18: Staff A walked in the hallway with Client #1 from his/her bedroom to the dining room, around 5:30 p.m. Staff B also walked with them, but did not hold onto Client #1. Client #1 fell to the floor, hitting the right side of his/her head on the floor (carpeted hallway). Staff A recalled it happened quickly and she did not have time to break the client's fall. The client's head "smacked" on the ground, though Client #1 initially did not appear to be injured. Staff summoned CMA A, who came to check Client #1. Staff A stated she and other staff told CMA A Client #1 hit his/her head. CMA A checked Client #1 over, then assisted the client up. After Client #1 sat in a chair in the dining room, staff noticed a small abrasion on the right side of his/head that bled a little. The CMA A also saw the abrasion and seemed concerned about it. CMA A told Staff A to fill out an incident report, which she forgot to do. During a follow-up interview on 2/15/18 at 10:25 a.m., Staff A was asked if she recalled telling CMA A and/or another co-worker that Client #1's hit the ground so hard it bounced. Staff A stated she did recall this. Client #1's head bounced on the right side when it hit the ground. She did not think the client hit the left	W 192		

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W 192	Continued From page 7 side of his/her head. Staff A said if a client fell and hit his/her head, the staff were supposed to notify the nurse and not move the person until the nurse did an assessment. At the time of the fall on 2/04/18, Staff A thought CMA A was a nurse. When interviewed on 2/13/18 at 1:15 p.m. Staff B confirmed she worked second shift on 2/04/18. Staff A walked Client #1 from the bathroom to the dining room for dinner and Staff B walked a few feet behind them, also going to the dining room. Client #1 fell; he/she seemed to trip over one of his shoes/feet. Staff A lost her hold on the gait belt and Client #1 fell to the ground, hitting the right upper side of his/her head. Staff B said Client #1 hit his/her head hard. CMA A came to check Client #1. CMA A checked Client #1's head and body, then assisted the client up and to the dining room. Staff B saw a small abrasion on Client #1's head bled slightly. Staff B knew a nurse needed to assess Client #1 because he/she fell and hit his/her head. At that time, Staff B did not know whether CMA A was a CMA or a nurse. She saw CMA A check Client #1's head and body, but did not see him check vital signs or do a neurological check, such as looking in Client #1's eyes with a flashlight. Staff B said she was certain she and Staff A told CMA A that Client #1 hit his/her head. She said Client #1 seemed his/her normal self the rest of the evening. When interviewed on 2/13/18 at 3:15 p.m. Staff C confirmed she worked the evening of 2/04/18 when Client #1 fell. She said it was not unusual for Client #1 to trip over his/her own feet/shoes, but he/she typically didn't fall. Staff C was in the central area of the group home on the evening of 2/04/18 when Staff B came from the hallway and	W 192		

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W 192	Continued From page 8 said to get CMA A. Staff C went back to the hallway with CMA A. Client #1 laid on the floor, smiling. Staff A reported to CMA A Client #1's head bounced off the floor when he/she fell. CMA A felt Client #1's head and said it felt like the client might have a goose egg. CMA A helped Client #1 up and assisted the client to the dining room. Staff C saw a bump on the front side of Client #1's head (this later turned out to simply be bump Client #1 has in his/her bone structure and was not an injury). She did not see an abrasion or blood. After Client #1 sat in a dining room chair and CMA A examined the client's head further, the CMA said he saw a rug burn toward the back of the client's head. Client #1 seemed fine after the fall and ate a good dinner. The client did not seem to show signs of pain. When interviewed on 2/14/18 at 10:50 a.m. CMA A confirmed he worked as the CMA on the evening of 2/04/18. He reported Client #1 fell in the hallway around 5:30 p.m. while Staff A walked with him/her. CMA A did not witness the fall. He said Staff A told him she helped Client #1 to the ground when he/she fell. Staff A did not tell CMA A Client #1 hit his/her head. CMA A saw Client #1 lying on the floor and asked Staff A if it had been a "safe fall." Staff A replied, "Yes." CMA A checked Client #1's head and body and saw no sign of injury. Client #1 appeared alert and seemed like his/her usual self. CMA A assisted Client #1 up and walked the client to a dining room chair. He again checked Client #1's head and saw no signs of injury. Client #1 seemed fine the rest of the evening and ate well at dinner. CMA A told Staff A to call the supervisor about the fall and to write an incident report. He also asked Staff C to do a body assessment when changing Client #1 for bed. She reported she saw no	W 192		

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W 192	Continued From page 9 injuries. CMA A said he did not notify the on call nurse of the fall because he did not think there was any potential for head, neck or back injuries. He said no staff told him that Client #1 hit his/her head. CMA A said he did not check vital signs or do neuro checks because he saw no sign of injury and did not know Client #1 hit his/her head. When interviewed on 2/13/18 at 12:50 p.m. the Quality Assurance Specialist (QAS) said she conducted a more in depth facility investigation regarding Client #1's injury. She confirmed Client #1 fell and hit his/her head on the evening of 2/04/18. A supervisor and nurse should have been notified per agency protocol, but this was not done. Staff A did not complete an incident report until 2/06/18 regarding the fall on 2/04/18, but mistakenly wrote the date of the incident as 2/03/18. This was later clarified. The supervisor and nursing staff became aware of the fall on 2/05/18 when told by other staff. When interviewed on 2/13/18 at 2:40 p.m. RN B reported she was the primary nurse for the Prairie Rose group home, where Client #1 resided. RN B stated Client #1 had occasional falls at the facility, but none of the prior falls caused serious injury. Client #1's mother told the facility of a previous fall with a head injury that had resulted in brain surgery. Regarding Client #1's fall on Sunday, 2/04/18, there was a nurse on campus until 10:00 p.m. that day. Even if a nurse had not been present on campus, a nurse was always on call. The nurse should have been notified of Client #1's fall, but was not. There was no incident report, nursing note, or any documentation regarding the fall until the next day. If the nurse had been notified of a fall with a hit to the head, guidelines including checking vital signs and	W 192		

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completing neuro checks would have been done every 15 minutes for the first hour and then decreased frequency.

When interviewed on 2/14/18 at 3:50 p.m. Client #1's mother/guardian stated Client #1 was still in the Intensive Care Unit and mostly slept. She said Client #1 had a serious hematoma, deep in the brain. Surgery was not a good option. A Nasogastric (NG) Tube had been inserted for hydration and nutrition. The mother said Client #1 had an epideral hematoma in 2012 after falling from a wheelchair and striking his/her head on a curb. Client #1 had a craniotomy at that time, but the current hematoma was more serious because it was deeper in the brain. She said the hematoma was on the left side of the brain. The prior epideral hematoma had been on the right side of the head. Client #1's mother stated the client did not have any bumps on his/her head. She confirmed she had been in phone contact with the local emergency department physician on the night of 2/06/18. The physician told her that Client #1's vital signs and neuro checks were fine and he planned to release Client #1 back to the facility. Client #1's mother told the ED doctor of prior head injury and surgery in 2012 and he decided to do a CT scan of Client #1's head, which showed the hematomas/intercranial bleeding. Client #1's mother said she had no idea Client #1 fell and hit his/her head on 2/04/18 until the ED physician mentioned it to her. She said she had not gotten any details from the facility about either of the falls, but was told the facility was still investigating. Client #1's mother said it seemed odd that Client #1 had such a significant injury, but no bump on his/her head. She had noticed Client #1 was more vocal and louder in the week prior to the falls. She wondered if there

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W 192	Continued From page 11 might have been another fall that was not reported. When asked about a Head Injury policy/protocol, the facility was unable to find one, but they did produce a form entitled "Neurological Guidelines", which they used as a guideline, but was not a policy. The form indicated vital signs and neuro checks should be completed every 15 minutes in the first hour, every 30 minutes in the second hour, every hour for 4 hours and then every 4 hours for 24 hours. The evaluation checklist included level of consciousness, movement, hand grasp, pupil size and pupil reaction in both eyes, blood pressure, pulse, respiration, temperature and speech. Record review on 2/20/18 revealed an agency policy/procedure titled, "Nurse On-Call System." According to the policy, a nurse was on-call 24 hours per day. A nurse should be called to do a face-to-face assessment if there was potential of a head, neck or back injury or an actual injury to those areas. When interviewed on 2/27/18 at 10:45 a.m. the Health Services Director (HSD) confirmed staff should have notified a nurse of Client #1's fall on 2/04/18, due to the client hitting his/her head. She said a CMA would not have been qualified to do an assessment. The surveyor submitted questions to the Neurosurgeon who treated Client #1 at the Des Moines hospital and received written responses to the questions on 2/21/18. According to the Neurosurgeon, Client #1's fall on 2/04/18 could have contributed to or even caused the brain hemorrhage discovered on 2/06/18. The	W 192		

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(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
W 192	Continued From page 12 Neurosurgeon indicated a nursing assessment should have been done Client #1 after the fall on 2/04/18 and might have detected any changes in the client's medical status. In summary, staff failed to immediately notify a nurse when Client #1 fell and hit his/her head on the evening of 2/04/18, which was witnessed by Staff A and Staff B. Staff A, Staff B and Staff C stated CMA A was informed Client #1 hit his/her head when he/she fell. Staff A reportedly said the client's head hit so hard on the floor that it bounced. Staff A and Staff B said they saw an abrasion to the right back side of Client #1's head after the fall. CMA A claimed no one told him Client #1 had hit his/her head and he did not see an injury to the client's head when he examined it. Staff A and Staff B had been trained that a nurse needed to assess a client who had fallen and hit his/her head, but they thought CMA A might have been a nurse. No staff contacted a nurse of the fall with head injury on 2/04/18, per agency policy.	W 192		
W 194	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure staff correctly and consistently implemented walking guidelines for a client with difficulty ambulating. This affected 1 of 1 client involved in the investigation of 74022-I (Client #1). Finding follows:	W 194		

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	16G004	A. BUILDING _____ B. WING _____	C 02/27/2018

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W 194	Continued From page 13 Record review on 2/13/18 revealed a facility investigation and facility records regarding Client #. According to records, the client fell and hit his/her head on the evenings of 2/04/18 and 2/06/18. Staff reported Client #1 was unresponsive for three to four minutes after the fall on 2/06/18. Nursing staff assessed Client #1 and called 911. Emergency personnel arrived and transported the client to the emergency department at a local hospital. A CAT (Computerized Axial Tomography) scan revealed bleeding in the brain. Client #1 was then air lifted to a medical center in Des Moines. According to Client #1's mother, he/she was in the Intensive Care Unit until 2/16/18, when he/she was moved to the neurology floor. As of 2/20/18, Client #1 remained hospitalized with minimal response. Additional record review and interviews from 2/13/18 to 2/20/18 revealed conflicting information and understanding regarding how best to walk with Client #1 and a lack of certainty regarding whether Client #1's shoes were tied tightly at the time of the second fall on 2/06/18. Client #1, 26 years old, had diagnoses including: severe intellectual disability, hypotonic quadriplegia, low tone, history of craniotomy due to fall (2012), cortical vision impairment, communication deficit, history of hip dislocation, Phelen-McDermid Syndrome (a rare genetic disorder, which causes various disabilities/abnormalities, including decreased sensitivity to pain), and heart abnormalities. Client #1 was non-verbal without functional communication skills, but did vocalize. Client #1 was 5'11", which was taller than many of the staff. The client was admitted to the facility on 3/22/17.	W 194		

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W 194	Continued From page 14 Record review revealed Client #1's 30 day team meeting, held 4/18/17, noted at times Client #1 could be difficult to walk. The less physical contact staff had while walking Client #1 the better the client would walk. The report read, "All staff must be trained to walk with you." The report also noted Client #1 at high risk for falls. According to the staffing report staff should walk on Client #1's left side and put an arm under the client's right arm. The report further noted, "gait to be used for safety," which likely was meant to read "gait belt to be used for safety." Continued record review revealed Client #1 received a physical therapy (PT) evaluation prior to the 30-day staffing held 4/08/17. Client #1's chart contained a hand written PT evaluation by the physical therapist and a similar typed evaluation completed by the physical therapist and the physical therapist aide. Both PT evaluations noted Client #1's mother present for the evaluation and demonstrated how to best walk with the client. Client #1's mother also reported the client had some intermittent mobility problems with his/her right hip that made it difficult to walk at times. Both PT reports indicated Client #1 should not sit in a recliner with his/her feet up as that position could lead to instability problems in the right hip. The hand written PT report noted Client #1 could walk with minimal to moderate assistance of one person. Both PT reports indicated PT staff would train other staff how to safely walk with Client #1. The hand written report did not mention the use of a gait belt, but according to the typed PT report, "Staff should utilize a gait belt with (Client #1)." Client #1's semi-annual review, dated 10/24/17,	W 194		

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W 194	Continued From page 15 noted Client #1 saw PT twice per week. Client #1 ambulated with the assistance of one staff. The physical therapist assessed Client #1 for the semi-annual review and noticed the client's hamstrings increased in tightness, possibly due to to so much time spent sitting and suggested additional walking may help decrease the hamstring tightness. According to the semi-annual review, Client #1 wore high top shoes to assist in stabilizing his/her ankles. The report also read, "(Client #1) has a gait belt (he/she) can wear. Staff should not pull on the gait belt because it can make (Client #1) unsteady or want to lean towards staff. The shoes must be tied tight in order to give (him/her) the support (he/she) needs. (Client #1) has had several falls in the past 6 months." The reported noted Client #1 had worn Ankle Foot Orthotics (AFO's) in the past, but would likely need new ones made if the client returned to using them, which would be discussed further with the client's parents/guardians. Additional record review revealed Client #1's chart contained guidelines for staff regarding walking with Client #1 and the use of high top shoes. The high top shoe guideline had a picture of white high top tennis shoes, with tied laces. The guideline read "High top shoes are worn as (Client #1's) form of AFOs." The record contained additional information regarding high top shoes, including "Pull laces snug and tight... or ankles will roll." The guideline for walking with Client #1, last updated 1/08/18, had pictures of Client #1 walking with assistance. In the pictures, Client #1 did not wear a gait belt. The guideline entitled, "Escorting (Guiding) Technique," noted Client #1	W 194		

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W 194	Continued From page 16 could be escorted by one staff unless he/she appeared unsteady or staff were uncomfortable walking the client alone. When walking with Client #1, staff should walk on his/her left side, with staff's hand on Client #1's left forearm, barely touching the client. Staff should then guide Client #1 by his/her left arm. The guideline instructed, "Allow (him/her) to walk independently. Remember-- you are just guiding (escorting) (him/her)." If staff needed to change direction when walking, they were to place their right arm around Client #1's back and place their right hand on the client's right side to guide him/her in the direction the staff wanted to go. According to the guideline, the more physical contact Client #1 felt, the more he/she would rely on staff or lean on them. Staff should "always be prepared to intervene" if Client #1 began to fall. The guideline made no mention of using a gait belt. When interviewed on 2/14/18 at 3:10 p.m. the PT Aide reported Client #1's mother showed her and other staff the best way to walk with Client #1 when the client moved to the facility. The more touch and physical support Client #1 received from staff, the more he/she would lean on the staff and the more difficult it was to walk with the client. Client #1's mother told them to walk on the client's left side, holding under his/her left arm, not firmly gripping the arm. The staff person's right arm went around Client #1's back to guide him/her. The PT Aide said it was agency policy to use a gait belt on all clients who needed assistance to walk. She said staff were trained to put the gait belt on Client #1, but not to actually hold onto it when walking the client. It was only to be used if the client began to fall. The PT Aide did not know of any documentation regarding Client #1 wearing a gait belt, but staff not holding onto it.	W 194		

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W 194	Continued From page 17 She said some staff felt more comfortable holding onto the gait belt when they walked with Client #1. The PT Aide acknowledged the escort guideline for Client #1 made no mention of the use of a gait belt. She stated there had been discussion of whether Client #1 would benefit from wearing AFO's, but his/her mother preferred the client to wear high top tennis shoes. Client #1 had not experienced frequent or serious falls at the facility, prior to February. Client #1 received therapy twice per week in the facility PT room at the Activity Building. The client usually stood in a tilt table to work on improving weight bearing. During the month of January, Client #1 attended therapy in the PT room only four times, due to weather conditions (1/4/18, 1/15/18, 1/18/18 and 1/29/18) Client #1 did not receive PT in February prior to the hospitalization on 2/06/18. The PT Aide noted Client #1 often appeared more stiff on Mondays at the Activity Building, because the client sat so much on the weekends at the group home. Record review on 2/13/18 revealed team meeting notes from a meeting held on 2/07/18 to review Client #1's recent falls. According to the meeting summary, Client #1 fell on the evenings of 2/04/18 and 2/06/18 and hit the right side of his/her head both times. Client #1 sustained a "major head injury" on the evening of 2/06/18 and was air lifted to a hospital in Des Moines. The team reviewed possible contributing factors to the falls. They noted Client #1 missed some scheduled PT times, due to bad weather. They also noted a staff person saw Client's #1's shoe untied after the fall on 2/06/18. It was unclear if the shoe was untied when Client #1 began walking, but the laces were supposed to be tied tight at all times to prevent the ankles from rolling.	W 194		

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W 194	Continued From page 18 The team discussed revising the walking protocol and pursuing the use of AFO's and a helmet when ambulating. Record review on 2/13/18 revealed an undated facility investigation of the fall on 2/06/18 conducted by the Residential Supervisor (RS). According to the investigation, Staff A walked with Client #1 during the fall on the evening of 2/04/18 and the fall on the evening of 2/06/18. According to the findings of the RS, Staff A followed Client #1's written program/guidelines for ambulation. Client #1 wore appropriate footwear, high top tennis shoes, but it could not be determined if the shoelaces were tied snuggly at the time of the second fall. The RS concluded Staff A followed Client #1's current programs (guidelines) and the falls were not preventable. When interviewed on 2/13/18 at 12:25 p.m. Staff A confirmed she worked on the evenings of 2/04/18 and 2/06/18 and walked with Client #1 when he/she fell and hit the right side of his/her head. Regarding the fall on 2/04/18: Staff A was walked in the hallway with Client #1 from his/her bedroom to the dining room, around 5:30 p.m. Staff B also walked with them, but did not hold onto Client #1. Staff A held onto Client #1's left arm with her left hand and held the back of his/her gait belt with her right hand. Client #1 wore high top tennis shoes. Staff A and Client #1 turned a corner in the hallway and Client #1 tripped over his/her foot. Client #1 fell to the floor, hitting the right side of his/her head on the floor (carpeted hallway). Staff A recalled it happened quickly and she did not have time to break the client's fall. The client's head "smacked" on the ground. Client #1 initially did not appear to be injured. Staff summoned	W 194		

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W 194	Continued From page 19 CMA A, who came to check Client #1. Staff A said she and other staff told the CMA A that Client #1 hit his/her head. CMA A checked Client #1 over, then assisted the client up. Regarding the fall on 2/06/18: Staff A worked second shift on 2/06/18, but did not work 2/05/18. Around 7:30 p.m. she went to get Client #1 from his/her room to bring him/her to the dining room for a snack. Client #1 sat in the recliner in his/her room. Staff A assisted the client up and began to walk him/her across the room toward the hallway. Staff A held onto Client #1's left arm with her left hand and held onto the gait belt with her right hand. Client #1 seemed a little wobbly so she paused a moment to let the client steady a bit. Client #1 resumed walking and fell through the doorway, hitting the right side of his/her head on the carpeted hall floor. The client appeared to hit the same spot on his/her head as on 2/04/18. No other staff person witnessed the fall. Staff A said Client #1 looked shocked and then shut his/her eyes and was unresponsive, with shallow breathing. Staff A ran to the end of the hall to call for help. Registered Nurse (RN) A came quickly. RN A saw Client #1 unresponsive and went to get a cold, wet cloth. CMA B called around that time and RN A told her to come to the group home. CMA B arrived and checked Client #1's vital signs. RN A called 911. Client #1 opened his/her eyes, but did not try to get up. Emergency personnel arrived and took over. Staff A stated she noticed after Client #1 fell that one of his/her shoes was untied. She said she didn't know if it was tied when they began walking because she did not look closely. Staff A acknowledged she did not check to ensure the laces were tied snugly. When interviewed on 2/13/18 at 1:15 p.m. Staff B	W 194		

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W 194	Continued From page 20 reported she worked at the group home on second shift 2/04/18. She noticed Client #1 seemed louder than usual and vocalized a lot, especially before dinner. Staff B stated Client #1 had a toileting accident and she took the client to the bathroom around 5:00 p.m. The client sat on the toilet and Staff A changed him/her. She put the same high top shoes back on Client #1 because they were not wet/soiled. Staff B laced up the shoes. Staff A walked Client #1 from the bathroom to the dining room, for dinner. Staff B walked a few feet behind them, also going to the dining room. Staff A had her left hand on Client #1's left arm and her right hand held onto the client's gait belt. Client #1 fell; he/she seemed to trip over one of his/her shoes/feet. Staff A lost her hold on the gait belt and Client #1 fell to the ground, hitting the right upper side of his/her head. Staff B said Client #1 hit his/her head hard. CMA A came to check Client #1. CMA A checked Client #1's head and body and then assisted the client up to the dining room. Staff B saw a small abrasion on Client #1's head that bled slightly. When interviewed on 2/13/18 at 3:15 p.m. Staff C reported she worked on the evening of 2/04/18 when Client #1 had the first fall. She said it was not unusual for Client #1 to trip over his/her own feet/shoes, but he/she typically didn't fall. The client's shoes would bump together as he/she walked. Staff C had never seen Client #1 fall. She held Client #1 by his/her left arm and by the gait belt. If the client became wobbly, staff needed to stop for a moment. Staff C was in the central area of the group home on the evening of 2/04/18 when Staff B came from the hallway and said to get CMA A. Staff C went back to the hallway with CMA A. Client #1 laid on the floor, smiling. Client #1 seemed fine after the fall and	W 194		

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W 194	Continued From page 21 he/she did not seem to show signs of pain. When interviewed on 2/13/18 at 12:50 p.m. the Quality Assurance Specialist (QAS) reported conducted a more in depth facility investigation regarding Client #1's injury. She confirmed Client #1 fell and hit his/her head on the evening of 2/04/18. The QAS stated the staff she interviewed told her the more Client #1 knew staff assisted him/her as they walked, the more the client would lean. Client #1 was tall. Staff were trained to hold the gait belt. Client #1 wore AFOs years ago, before he/she moved to the facility, but the client's mother preferred to use high top tennis shoes instead. When interviewed on 2/13/18 at 2:40 p.m. RN B reported she was the primary nurse for the home where Client #1 resided. She said Client #1 had an unsteady gait when ambulating. The client wore a gait belt and staff were supposed to hold onto it, but Client #1 would lean on staff if he/she felt them holding it. Staff were supposed to try not to let Client #1 feel them holding onto the gait belt. Staff were supposed to hold onto the gait belt with one hand and provide gentle support under Client #1's left elbow with their other hand. It could be difficult to walk Client #1, who might tease or get silly while walking with staff. The client's body sometimes swayed or moved side to side. Client #1 was very tall and sometimes leaned when walking. RN B said Client #1 occasionally fell at the facility, but none of the prior falls caused serious injury. Client #1's mother told the facility of a previous fall with a head injury that resulted in brain surgery. Client #1 wore AFOs in the past, prior to coming to the facility. His mother preferred the client to wear high top tennis shoes, not AFOs.	W 194		

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W 194	Continued From page 22 When interviewed on 2/14/18 at 10:00 a.m. the Residential Supervisor reported she was notified on the morning of 2/05/18 of Client #1's 2/04/18 fall and hitting his/her head. The Residential Supervisor was also a Licensed Practical Nurse (LPN) and a Paramedic. Staff C told her Client #1 fell forward to the ground and then rolled onto his/her back. Staff C said Client #1 had a "goose egg" on his/her forehead, but this was later determined to be the bone structure of Client #1's forehead and not an injury. The Supervisor checked Client #1's head on the morning of 2/05/18 and saw an abrasion or rug burn on the right side of Client #1's head. She said that she did not talk with Staff A about the fall on 2/04/18 prior to the fall on 2/06/18 because it was her understanding Staff A walked with Client #1 correctly. The Supervisor told Staff A to fill out an incident report regarding the fall on 2/04/18 when Staff A came into work for second shift on 2/06/18. During a follow-up interview on 2/15/18 at 10:10 a.m. the Supervisor was asked how staff were supposed to walk with Client #1. She said the staff should not actually hold onto the gait belt, as it was worn just in case it was needed. Client #1 usually walked worse when staff held onto the gait belt. Some staff felt more comfortable holding onto the gait belt because Client #1 was difficult to walk with. The use of the gait belt depended on the staff comfort level. When interviewed on 2/14/18 at 3:50 p.m. Client #1's mother/guardian reported Client #1 was still in the Intensive Care Unit and mostly slept. She said Client #1 had a serious hematoma, deep in the brain. Surgery was not a good option. The mother said Client #1 did not use AFOs because	W 194		

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W 194	Continued From page 23 a previous doctor said good high top shoes with tightly tied laces would be acceptable. She said she often reminded staff to tie Client #1's laces tight. The mother said she was aware the facility used a gait belt with Client #1, but she never did. She said Client #1 didn't walk as well when a gait belt was used. She said she had not gotten any details from the facility about either of the falls, but was told the facility was still investigation. In summary, walking guidelines for Client #1 made no mention of the use of a gait belt. It was known holding onto the gait belt could make Client #1 more reliant on staff and worsen the client's ambulation; however, staff commonly held onto the gait belt when walking with Client #1. The guideline also indicated staff should ensure the laces on Client #1's high top shoes were tied tightly, to provide good ankle support. Staff A stated after Client #1 fell on 2/06/18, she noticed one shoe untied and admitted she failed to check the laces before assisting Client #1 to ambulate.	W 194		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility nursing staff failed to provide timely and appropriate assessment following a client fall with injury to the head. Staff failed to immediately notify a nurse following a fall with head injury; however, once aware multiple nurses failed to complete appropriate assessment and follow up of the injury. This affected 1 of 1 client involved	W 331		

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(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
W 331	Continued From page 24 in the investigation of 74022-I (Client #1). Finding follows: Record review on 2/13/18 revealed a facility investigation and facility records regarding Client #1. According to records, the client fell and hit his/her head on the evenings of 2/04/18 and 2/06/18. Staff reported Client #1 was unresponsive for three to four minutes after the fall on 2/06/18. Nursing staff assessed Client #1 and called 911. Emergency personnel arrived and transported the client to the emergency department at a local hospital. A CAT (Computerized Axial Tomography) scan revealed bleeding in the brain. Client #1 was then air lifted to a medical center in Des Moines. According to Client #1's mother, he/she was in the Intensive Care Unit until 2/16/18, when he/she was moved to the neurology floor. As of 2/26/18, Client #1 remained hospitalized and slowly showed increased responsiveness. Client #1, 26 years old, had diagnoses including: severe intellectual disability, hypotonic quadriplegia, low tone, history of craniotomy due to Fall (2012), cortical vision impairment, communication deficit, history of hip dislocation, Phelen-McDermid Syndrome, and heart abnormalities. According to the website for the U.S. National Library of Medicine, Phelen-McDermid Syndrome is a rare genetic disorder, which causes various disabilities/abnormalities. People with the syndrome often have a decrease sensitivity to pain. Client #1 was non-verbal without functional communication skills, but did vocalize. Client #1 was 5'11", which was taller than many of the staff. The client was admitted to the facility on 3/22/17.	W 331		

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W 331	Continued From page 25 Continued record review revealed Client #1's 30 day staffing report, held 4/18/17, noted at times Client #1 could be difficult to walk and was at high risk for falls. A review of incident reports, nursing notes, and physical therapy notes revealed no documentation of any falls in the three months prior to the falls on 2/04/18 and 2/06/18. Record review on 2/13/18 revealed an undated facility investigation into Client #1's fall on 2/06/18, conducted by the Residential Supervisor (RS). According to the investigation, Staff A walked with Client #1 during the fall on the evening of 2/04/18 and the fall on the evening of 2/06/18. The review noted appropriate documentation and notification were not completed following the fall on 2/04/18. The RS noted in the report that the fall on 2/04/18 resulted in abrasions and a hematoma to the right, rear of Client #1's head, in the same area as the scar from a previous surgery. When interviewed on 2/13/18 at 12:25 p.m. Staff A confirmed she worked the evenings of 2/04/18 and 2/06/18. She walked with Client #1 when the client fell and hit the right side of his/her head. Regarding the fall on 2/04/18: Staff A walked in the hallway with Client #1 from his/her bedroom to the dining room, around 5:30 p.m. Staff B also walked with them, but did not hold onto Client #1. Client #1 fell to the floor, hitting the right side of his/her head on the floor (carpeted hallway). Staff A recalled it happened quickly and she did not have time to break the client's fall. The client's head "smacked" on the ground. Client #1 initially did not appear to be injured. Staff summoned	W 331		

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W 331	Continued From page 26 CMA A, who came to check Client #1. Staff A said she and other staff told the CMA A that Client #1 hit his/her head. CMA A checked Client #1 over, then assisted the client up. After Client #1 sat in a chair in the dining room, staff noticed a small abrasion on the right side of his/head bled a little. The CMA A also saw the abrasion and seemed concerned about it. CMA A told Staff A to fill out an incident report, which she forgot to do. During a follow-up interview on 2/15/18 at 10:25 a.m., Staff A was asked if she recalled telling CMA A and/or another co-worker that Client #1's hit the ground so hard that it bounced. Staff A said she did recall this. Client #1's head bounced on the right side when it hit the ground. She did not think the client hit the left side of his/her head. Staff A said if a client fell and hit his/her head, the staff were supposed to notify the nurse and not move the person until the nurse did an assessment. At the time of the fall on 2/04/18, Staff A thought CMA A was a nurse. When interviewed on 2/13/18 at 1:15 p.m. Staff B confirmed she worked second shift on 2/04/18. Staff A walked Client #1 from the bathroom to the dining room for dinner and Staff B walked a few feet behind them, also going to the dining room. Client #1 fell; he/she seemed to trip over one of his shoes/feet. Staff A lost her hold on the gait belt and Client #1 fell to the ground, hitting the right upper side of his/her head. Staff B said Client #1 hit his/her head hard. CMA A came to check Client #1. CMA A checked Client #1's head and body, then assisted the client up and to the dining room. Staff B saw a small abrasion on Client #1's head bled slightly. Staff B knew a nurse needed to assess Client #1 because he/she fell and hit his/her head. At that time, Staff B did not know whether CMA A was a CMA	W 331		

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W 331	Continued From page 27	W 331		

or a nurse. She saw CMA A check Client #1's head and body, but did not see him check vital signs or do a neurological check, such as looking in Client #1's eyes with a flashlight. Staff B said she was certain she and Staff A told CMA A that Client #1 hit his/her head. She said Client #1 seemed his/her normal self the rest of the evening.

When interviewed on 2/13/18 at 3:15 p.m. Staff C confirmed she worked the evening of 2/04/18 when Client #1 fell. She said it was not unusual for Client #1 to trip over his/her own feet/shoes, but he/she typically didn't fall. Staff C was in the central area of the group home on the evening of 2/04/18 when Staff B came from the hallway and said to get CMA A. Staff C went back to the hallway with CMA A. Client #1 laid on the floor, smiling. Staff A reported to CMA A Client #1's head bounced off the floor when he/she fell. CMA A felt Client #1's head and said it felt like the client might have a goose egg. CMA A helped Client #1 up and assisted the client to the dining room. Staff C saw a bump on the front side of Client #1's head (this later turned out to simply be bump Client #1 has in his/her bone structure and was not an injury). She did not see an abrasion or blood. After Client #1 sat in a dining room chair and CMA A examined the client's head further, the CMA said he saw a rug burn toward the back of the client's head. Client #1 seemed fine after the fall and ate a good dinner. The client did not seem to show signs of pain.

When interviewed on 2/14/18 at 10:50 a.m. CMA A confirmed he worked as the CMA on the evening of 2/04/18. He reported Client #1 fell in the hallway around 5:30 p.m. while Staff A walked with him/her. CMA A did not witness the fall. He

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W 331	Continued From page 28 said Staff A told him she helped Client #1 to the ground when he/she fell. Staff A did not tell CMA A Client #1 hit his/her head. CMA A saw Client #1 lying on the floor and asked Staff A if it had been a "safe fall." Staff A replied, "Yes." CMA A checked Client #1's head and body and saw no sign of injury. Client #1 appeared alert and seemed like his/her usual self. CMA A assisted Client #1 up and walked the client to a dining room chair. He again checked Client #1's head and saw no signs of injury. Client #1 seemed fine the rest of the evening and ate well at dinner. CMA A told Staff A to call the supervisor about the fall and to write an incident report. He also asked Staff C to do a body assessment when changing Client #1 for bed. She reported she saw no injuries. CMA A said he did not notify the on call nurse of the fall because he did not think there was any potential for head, neck or back injuries. He said no staff told him that Client #1 hit his/her head. CMA A said he did not check vital signs or do neuro checks because he saw no sign of injury and did not know Client #1 hit his/her head. When interviewed on 2/13/18 at 12:50 p.m. the Quality Assurance Specialist (QAS) said she conducted a more in depth facility investigation regarding Client #1's injury. She confirmed Client #1 fell and hit his/her head on the evening of 2/04/18. A supervisor and nurse should have been notified per agency protocol, but this was not done. Staff A did not complete an incident report until 2/06/18 regarding the fall on 2/04/18, but mistakenly wrote the date of the incident as 2/03/18. This was later clarified. The supervisor and nursing staff became aware of the fall on 2/05/18 when told by other staff. A facility nurse then checked Client #1, but the QAS did not know if a neuro check was done.	W 331		

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W 331	Continued From page 29 When interviewed on 2/13/18 at 2:40 p.m. RN B reported she was the primary nurse for the Prairie Rose group home, where Client #1 resided. RN B stated Client #1 had occasional falls at the facility, but none of the prior falls caused serious injury. Client #1's mother told the facility of a previous fall with a head injury that had resulted in brain surgery. Regarding Client #1's fall on Sunday, 2/04/18, there was a nurse on campus until 10:00 p.m. that day. Even if a nurse had not been present on campus, a nurse was always on call. The nurse should have been notified of Client #1's fall, but was not. There was no incident report, nursing note, or any documentation regarding the fall until the next day. If the nurse had been notified of a fall with a hit to the head, guidelines including checking vital signs and completing neuro checks would have been done every 15 minutes for the first hour and then decreased frequency. On the morning of 2/05/18 staff showed the day nurse, LPN A, a slight abrasion on the left side of Client #1's head. LPN A made a note in the nursing communication log regarding the injury and apparent fall on 2/04/18. RN B said to her knowledge, no nurse checked Client #1's vital signs or did neuro checks after the fall on 2/04/18 or on 2/05/18. She said staff reported Client #1 fell and hit the right side of his/her head, but the abrasion found on the morning of 2/05/18 was on the back left side of Client #1's head. RN B did not know why that was. She wondered if there might have been another undocumented fall, but did not know. RN B did not work on 2/05/18. When she arrived to work on 2/06/18 she saw LPN A's note in the nursing log regarding an abrasion to the back left side of Client #1's head. RN B checked Client #1's head and saw no injuries. She said Client #1	W 331		

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W 331	Continued From page 30 seemed like his/her normal self when she checked the client's head on the morning of 2/06/18. RN B was not present when Client #1 fell on the evening of 2/06/18. She said Client #1's mother told her the emergency department doctor at the local hospital planned to release Client #1 back to the facility because the client's vital signs and neuro checks were fine. Client #1's mother requested a CT scan, which showed the brain bleed. RN B reported she worked 2/03/18 and 2/04/18 and noticed Client #1 to be very vocal and louder than usual. This was prior to the fall on the evening of 2/04/18. When asked about a head injury policy/protocol, the facility could not locate one, but did produce a form entitled, "Neurological Guidelines," which they used as a guideline. The form indicated vital signs and neuro checks should be completed every 15 minutes in the first hour after a head injury, every 30 minutes in the second hour, every hour for 4 hours and then every 4 hours for 24 hours. The evaluation checklist included: level of consciousness, movement, hand grasp, pupil size and pupil reaction in both eyes, blood pressure, pulse, respiration, temperature and speech. When interviewed on 2/15/18 at 10:15 p.m. LPN A confirmed she worked the first shift on 2/05/18. An overnight staff reported she noticed a small abrasion and slight bleeding on the back left side of Client #1's head while washing the client's hair that morning. LPN A checked Client #1's head and saw an older looking scab in the client's hair. She saw no bleeding, but did see a small reddened area on the back left side of the client's head. LPN A assumed an old scab had come off while the staff person washed Client #1's hair.	W 331		

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W 331	Continued From page 31 Staff C worked that morning and told LPN A Client #1 fell the night before and hit his/her head. LPN A examined Client #1's head and documented in the nursing communication log, noting Client #1 apparently fell on second shift 2/04/18 and had a slight abrasion to left back side of head. She did not check Client #1's vital signs, complete neuro checks, or document in nursing notes. LPN A recalled Client #1 acted like his/he normal self. LPN A stated she did not notify Client #1's physician or guardian of the fall on 2/04/18. She said she didn't know any of the details about the fall. When interviewed on 2/13/18 at 4:45 p.m. Staff D confirmed he worked on second shift 2/05/18. He thought Client #1 did not seem his/her usual self, as the client was quieter and held his/her head, while making a face. Staff D reported to CMA B that Client #1 might have a headache. CMA B gave Client #1 an over the counter pain reliever. Staff D reported he didn't really notice if the pain reliever seemed to help, but Client #1 continued to seem quiet. After Client #1 received the pain reliever, someone told Staff D Client #1 fell the night before and hit his/her head. Staff D later checked Client #1's head. He thought he noticed some kind of bump or minor injury, but did not recall exactly. Staff D stated Client #1 walked like usual; the client was always kind of unsteady when ambulating. When interviewed on 2/13/18 at 4:00 p.m. CMA B reported she gave Client #1 an over the counter pain reliever on 2/05/18 around 4:00 p.m. because Staff D reported the client might have a headache. Staff D said Client #1 held his/her head and appeared he/she may be in pain. CMA B did not see any signs of pain or discomfort	W 331		

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W 331	Continued From page 32 when she gave Client #1 the pain medication. At the time she gave the pain reliever, she did not know Client #1 had fallen and hit his/her head the day before. Someone told her later in the shift. CMA A did not check Client #1 for injuries related to the fall on 2/04/18. She thought Client #1 seemed fine. On the evening of 2/06/18, CMA B called RN A to ask about something else and RN A told her to come to Prairie Rose right away because Client #1 had fallen. When arriving at the home, CMA B saw Client #1 lying on the floor with eyes open, but not moving. The ambulance was on the way. CMA B checked Client #1's vital signs, which she did not document, but she recalled they were OK. She did not check Client #1's pupils. She checked Client #1's head and felt a bump, but saw no injuries. The emergency personnel arrived and transported Client #1 by ambulance to the hospital. When interviewed on 2/14/18 at 10:00 a.m. the Residential Supervisor reported she was notified on the morning of 2/05/18 of Client #1's 2/04/18 fall and hitting his/her head. The Residential Supervisor was also an LPN and a Paramedic. Staff C told her Client #1 fell forward to the ground and then rolled onto his/her back. Staff C said Client #1 had a "goose egg" on his/her forehead, but this was later determined to be the bone structure of Client #1's forehead and not an injury. The Supervisor checked Client #1's head on the morning of 2/05/18 and saw an abrasion or rug burn on the right side of Client #1's head. The Supervisor discovered staff failed to notify a supervisor or nurse of the fall after it happened, and no documentation regarding the fall or injury to Client #1's head had been completed. On the afternoon of 2/05/18 the Supervisor sent an email to Nurse B, the Campus Residential Director and	W 331		

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W 331	Continued From page 33 the Health Services Director sharing her concerns regarding the lack of follow up after the fall on 2/04/18. The Supervisor said to her knowledge no one checked Client #1's vital signs or completed neuro checks after the fall on 2/04/18 or the following day. Client #1 did not seem any different than usual on 2/05/18. Client #1 was more vocal and louder than usual on 2/06/18, but quieted when watching preferred videos. The Supervisor didn't get the impression Client #1 appeared to be in distress or discomfort during the day on 2/06/18. When interviewed on 2/14/18 at 3:50 p.m. Client #1's mother/guardian stated Client #1 was still in the Intensive Care Unit and mostly slept. She said Client #1 had a serious hematoma, deep in the brain and surgery was not a good option. A Nasogastric (NG) Tube had been inserted for hydration and nutrition. The mother reported Client #1 had an epideral hematoma in 2012 after falling from a wheelchair and striking his/her head on a curb. Client #1 had a craniotomy at that time, but the current hematoma was more serious because it was deeper in the brain. She said the hematoma was on the left side of the brain. The prior epideral hematoma had been on the right side of the head. Client #1's mother stated the client did not have any bumps on his/her head. She confirmed she had been in phone contact with the local emergency department physician on the night of 2/06/18. The physician told her that Client #1's vital signs and neuro checks were fine and he planned to release Client #1 back to the facility. Client #1's mother told the ED doctor of prior head injury and surgery in 2012 and he decided to do a CT scan of Client #1's head, which showed the hematomas/intercranial bleeding. Client #1's	W 331		

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W 331	Continued From page 34 mother said she had no idea Client #1 fell and hit his/her head on 2/04/18 until the ED physician mentioned it to her. She said she had not received any details from the facility regarding either of the falls, but was told the facility was still investigating. Client #1's mother said it seemed odd Client #1 had such a significant injury, but no bump on his/her head. She noticed Client #1 was more vocal and louder in the week prior to the falls. She wondered if there might have been another fall that was not reported. Record review on 2/20/18 revealed an agency policy/procedure titled, "Nurse On-Call System." According to the policy, a nurse was on-call 24 hours per day. A nurse should be called to do a face-to-face assessment when potential of a head, neck or back injury or an actual injury to those areas occurred. The surveyor submitted questions to the Neurosurgeon who treated Client #1 at the Des Moines hospital. The Neurosurgeon provided written responses to the questions on 2/21/18. According to the Neurosurgeon, Client #1's fall on 2/04/18 could have contributed to or even caused the brain hemorrhage discovered on 2/06/18. The Neurosurgeon indicated a nursing assessment should have been completed after Client #1's fall on 2/04/18 and might have detected any changes in the client's medical status. When interviewed on 2/27/18 at 10:45 a.m. the Health Services Director (HSD) confirmed staff should have notified a nurse of Client #1's fall on 2/04/18, due to the hitting his/her head. She said a CMA would not have been qualified to complete an assessment. When asked if facility nursing	W 331		

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W 331	Continued From page 35 staff should have followed the neurological guidelines once they learned of the 2/04/18 fall on the morning of 2/05/18, the HSD stated if there was any question about an injury, the facility typically sent the client to the physician or emergency room. Nursing staff did not know about the fall until the next morning, approximately 12 hours later. Client #1 seemed fine at that time, but the HSD acknowledged the nursing staff should have followed the neurological guidelines by checking vital signs and completing neuro checks until the 24 hour period passed. She said the facility typically notified primary physicians of significant changes in client condition, but Client #1 seemed fine after the fall on 2/04/18. In summary, facility staffing failed to notify a nurse of Client #1's fall and head injury on the evening of 2/04/18 in a timely manner. The on-call nurse should have been notified immediately, per agency policy. LPN A stated she learned Client #1 fell and hit his/her head on the morning of 2/05/18. She checked Client #1's head for injuries, but did not check vital signs or complete a neuro check, per the neurological guidelines. LPN A wrote a brief note in the nursing communication log, but did not document in Client #1's Nursing Notes. The Residential Supervisor, who was an LPN, also became aware of the 2/04/18 fall on the morning of 2/05/18. She expressed concern to administration staff in an email on the afternoon of 2/05/18 regarding the lack of documentation and follow up, but she also failed to check vital signs or complete neuro checks. Nursing staff failed to notify Client #1's physician of the fall on 2/04/18 and failed to provide appropriate follow up assessment.	W 331		

OK 4/9/18

New Hope Village
Plan of Correction
DIA Annual Survey
2/12/-2/15/18

Summary

The Department of Inspection and Appeals conducted an 'Annual Survey' at New Hope from February 12-15th, 2018. In addition to the survey, two investigations were completed: #74214-M and 74022-I.

Investigation 74022-I was identified on 2/15/18 as Immediate Jeopardy to clients' health and safety. The IJ was removed on 2/20/18.

Findings of this investigation are as follows:

N148-Communication with clients, parents and CFR's
N158 Facility Staffing
N192 Staff Training Program
N194 Staff Training Program
N331 Nursing Services

The following Plan of Correction has been developed to correct these deficiencies.

Tag #	Deficiency Cited	Plan of Correction/Compliance monitoring	Person(s) Responsible	Target Date for Completion	Status
N148	The facility failed to notify guardians of a potentially serious incident. The facility failed to notify the guardian when the client fell and hit his/her head. **Note: Items 1,2 and 3 were added to this Plan of Correction on 4/5/18.**	**Action Plan:** 1. **Nursing department will be retrained on the Emergency Care policy regarding initial and ongoing notification to guardians for medical emergencies.** 2. **The Client Incident report policy will be modified to include appropriate notifications to guardians for incidents resulting in actual or potential significant incidents or changes in the client's condition.** 3. **All residential, supervisory and nursing staff for the ICF/ID will be trained on the revised policy.** 4. The communication request form is pending review to be modified to include more detailed information for the guardians to indicate preferences for notifications.	Virginia Tuel, AHSD Kim Platt, DORS LeAn Taylor, AED Lynn McGuire, CRD Virginia Tuel, AHSD QIDP's Record review committee Lynn McGuire, CRD	4/15/18 4/15/18 4/15/18 4/15/18	Complete NH is reviewing the Communication request form and proposing revisions to the form to capture notification of injuries (minor, major, other),

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		Compliance monitoring: 1. This will be monitored by follow up completed for client incident reporting and ensuring proper notifications occurred.	Residential Supervisors, Nurses, QIDP's, Lynn McGuire, CRD Virginia Tuel, AHSD	In Effect	behaviors requiring restrictions or emergency restraint and an "other" section if there are other things they request notification of.
158	The facility provided staff with inconsistent information regarding how best to assist the client to ambulate. These concerns resulted in a determination of an IJ on 2/15/18 @ 10:55am ***A Plan of Correction to address the Immediate Jeopardy was completed, submitted and accepted by the Department of Inspections and Appeals on 2/15/18.**	**Action Plan:** 1. To ensure the safety of clients who are assisted with ambulation, staff in each home will be retrained on the ambulation protocol for the client(s) in their home 2. The area specific information regarding assisted ambulation for clients has been added to the orientation checklists of each home. 3. Assisted ambulation observations have been added to the monthly observation forms completed by leadership personnel in the homes. 4. Protocols for assisting clients with ambulation will be reviewed by the Therapy Coordinator to ensure they match the assessment recommendations by the Physical Therapist and that the pictures accurately represent how staff are to assist clients with ambulation. 5. Corrective action for the staff for failing to ensure the shoes	Residential Supervisors Residential Supervisors Residential Supervisors Residential Supervisors Residential		1.Completed except for a few staff not back from college yet. There is a plan to ensure they are trained before working again 2.Completed 3/9/18 3.Completed 2/15/18 4.Completed 2/16/18 5.Completed 2/27/18

		were tied tightly per protocol was completed. **Compliance monitoring:** 1. This will be monitored through monthly assisted ambulation observations completed in the homes by leadership personnel and routinely by Physical Therapy.	Supervisor of employee Residential Supervisors Lynn McGuire, CRD Virginia Tuel, AHSD	In Effect	
192	Facility failed to ensure adequate staff training to ensure client safety and well-being regarding health needs. Staff failed to immediately notify a nurse of a fall with potential head injury. **(Also refer to Plan of Correction for W158)**	**Action Plan:** On Wednesday, February 7th all nursing staff received an email from the AHSD to remind that them a Nurse is notified for potential head/neck back injuries so they can perform a proper assessment and that an CMA or HSA cannot perform this assessment. On Wednesday, February 7th a reminder was placed in CareTracker for all direct care staff to remind them about reporting injuries to a licensed nurse. Staff must call the 1st Nurse on call at 712-830-4109. In addition, as part of the Immediate Jeopardy, New Hope initiated a plan of correction where all staff were trained on this between 2/15/18-2/19/18 (see action plan for W158)	Virginia Tuel, AHSD Lynn McGuire, CRD		Completed 2/7/18 Completed 2/7/18

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		Compliance monitoring: 1.This will be monitored through completion of client incident reporting and ensuring proper notifications occurred for any potential head, neck or back injuries. 2. Appropriate follow-up will occur if proper notifications are not evident.	Residential Supervisors Lynn McGuire, CRD Virginia Tuel, AHSD	In Effect	
194	Facility failed to ensure that staff correctly and consistently implemented walking guidelines for a client with difficulty ambulating. **(Also refer to Plan of Correction for W158)**	**Action Plan:** 1. To ensure the safety of clients who are assisted with ambulation, staff in each home will be retrained on the ambulation protocol for the client(s) in their home 2. The area specific information regarding assisted ambulation for clients has been added to the orientation checklists of each home. 3. Assisted ambulation observations have been added to the monthly observation forms completed by leadership personnel in the homes. **Compliance monitoring:** 1.This will be monitored through monthly assisted ambulation and lifting observations completed by Supervisors and PT department.	Residential Supervisors Lynn McGuire, CRD Residential Supervisors Lynn McGuire, CRD Heidi Pudenz, PT Coordinator Lynn McGuire, CRD Residential Supervisors, RS2's, Heidi Pudenz, PT Coordinator	In Effect	1.Completed except for a few staff not back from college yet. There is a plan to ensure they are trained before working again 2.Completed 3/9/18 3.Completed 2/15/18
331	Facility nursing staff failed to provide timely and appropriate assessment following a client fall	**Action Plan:** 1.All nursing staff, including Health Services Assistants (HSAs) were	Virginia Tuel, Allied	4/15/18	1.All nursing staff,

	with injury to the head. Staff failed to immediately notify a nurse following a fall with head injury; however, once aware, multiple nurses failed to complete appropriate assessment and follow up of the injury.	retrained on Client Incident Reporting responsibilities, completing appropriate follow-up for potential or actual head, neck or back injuries including neurological assessments for head injuries by a licensed nurse, consultation with physician, etc., as well as proper documentation and nurse's notes. Training Sessions for nursing staff were as follows: • 2/15/18 at 2:00PM for nursing staff working on 2/15/18. • Mandatory training on 2/16/18 at 1:00PM • Training will also occur during the weekend for any nursing staff who have not been trained. All training sessions will be documented and staff will sign documentation that they have been re-trained.	Health Services Director (AHSD)		with the exception of 3 that are flex nurses, have been trained. The 3 flex nursing staff will be trained before they work their next shift.
		2.Follow up completed with the staff responsible for failure to ensure appropriate assessments and follow up.	Virginia Tuel, AHSD		2.Follow up completed on 2/27/18
		Compliance monitoring: 1.This will be monitored through completion of client incident reporting and ensuring proper notifications occurred for any potential head, neck or back injuries.	Virginia Tuel, AHSD	In Effect	
		2. At least annually, the procedure for completing appropriate assessments and follow up for potential head injuries including neurological checks and documentation will be reviewed at a	Virginia Tuel, AHSD	In Effect	

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		nurse's department meeting. 3. Appropriate follow-up will occur if proper notifications are not evident. 4. Appropriate follow-up will occur if proper assessments and documentation are not evident.	Virginia Tuel, AHSD Virginia Tuel, AHSD	In Effect In Effect	

Ryan McGuire CKP
n McGuire, Campus Residential Director — 4/5/18 Date

Tim Platt DoRS
Platt, Dir. Of Residential Services — 4-5-18 Date

John Taylor
An Taylor, Assistant Executive Director — 4/5/18 Date