STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165157	A. BUILDING _____ B. WING _____	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIOUX CENTER HEALTH ROYALE MEADOWS	1400 7TH AVENUE SE SIOUX CENTER, IA 51250

(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
JKK 8/22/18				
F 000	INITIAL COMMENTS Correction date: 8/14/18 The following deficiencies were identified during the investigation of #71543-I, #73709-I and #75083-I completed on 6/26/18 through 6/29/18. Facility reported incident 71543-I, 73709-I and 75083-I were substantiated. See Code of Federal Regulations (45 CFR) Part 483, Subpart B	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interview and policy review the facility failed to always put new interventions in place to prevent further falls and injury for 2 of 4 residents reviewed. (Resident #1 & #4) The facility identified a census of 68 current resident. Findings include: 1. According to the MDS (minimum data set) dated 12/8/17 Resident #4 had diagnoses that included hypertension, anxiety disorder, spinal stenosis, atrial fibrillation and hypothyroidism. The	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/03/2018

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.

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F 689	Continued From page 1 MDS identified the resident had a BIMs (brief interview for mental status score of 7 which indicated severe cognitive impairment. The MDS identified the resident required limited assistance with bed mobility, transfers, ambulation, dressing and toilet use. According to the MDS the resident occasionally incontinent or urine. The care plan dated 7/3/17 directed staff to do the following interventions for fall risk: a. Restorative therapy. b. Assess the environment to provide clutter free environment. c. Encourage use of call light and wait for assistance. e. Monitor for fatigue or other risk factors. d. Keep call light in reach when in room. e. Front wheeled walker for all ambulation/transfers. f. Wheelchair as needed. g. Transfer and ambulation: Assist of 1 with front wheeled walker. Frequently non-compliant and will self-rise. Review of the Fall Risk Assessment dated 12/11/17 revealed the resident had a fall risk total score of 24 which indicated the resident at a high risk. Review of the Radiology Diagnostic Imaging report dated 12/20/17 reveled the resident had a fractured right hip. Review of the List Resident Notes dated 7/29/17 at 10:30 AM revealed the resident came out of the bathroom and stated she had been dizzy and lost her balance. The roommate turned her call light on for assistance. Range of motion within normal limits, hit her head on the bathroom door	F 689		

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F 689	Continued From page 2 and no new skin issues noted. Assisted to her feet with a gait belt and assistance of 2. Review of the document identified toilet schedule dated 12/19/17, Tuesday night revealed the resident checked, remained dry and turned at 12:00 AM and 2:00 AM. At 4:00 AM the resident had a fall and moderate bowel movement. Review of the Resident Change In Care Plan dated 11/16/18 revealed the resident intervention no shoes and use gripper socks. Review of the List Resident Notes dated 8/21/17 at 12:24 PM revealed the CNA had been bring the resident from the dining room to the chair in her bedroom. The chair slid out as she sat down and caused her to hit the floor with her bottom. Denies hitting her head or additional pain. Intervention included to have Maintance to check chair for stability. Review of the List Resident Notes dated 8/25/17 at 3:49 PM revealed the resident found on the floor. Attempted to toilet self without using her call light. Denied pain or hitting her head. Intervention encourage resident to ask for assistance. Review of the List Resident Notes dated 11/12/17 at 4:55 AM revealed staff found the resident on the floor by her bed. The resident stated she had been on her way back to bed from going to the bathroom. Her walker in the bathroom. She denied hitting her head. Vital signs and range of motion within normal limits. The resident assisted up with a gait belt and assist of 2 and transferred back to bed without difficulty. Intervention to wear gripper socks at night, staff check on her during 4:00 AM rounds and remind her to call for	F 689		

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F 689	Continued From page 3 assistance to the bathroom. Review of the List Resident Notes dated 11/13/17 d at 4:16 AM revealed Resident ambulated with the CNA on the way back from the bathroom with staff assistance and a gaitbelt and fall occurred. The CNA stated the resident had been along side of the bed and lost her footing, stumbled and then proceeded to let go of her walker. The CNA unable to prevent the fall. CNA stated the resident's ambulation very unsteady at the time of the fall. Intervention to have therapy assess for safe transfers/ambulation due to 2nd fall in 24 hours and care plan updated to use standard as needed for gait instability/difficulty with transfers. Review of the List Resident Notes dated 12/20/17 at 4:00 AM revealed CNA reported to nurse that resident on the floor in the bathroom. The resident stated she had been trying to sit on the toilet and slid to the floor. Resident cannot straighten her right leg due to pain and left range of motion within normal limits. The resident brought up to the toilet with a gait belt and assistance of 2 due to the resident stated she had to go to the bathroom. Intervention included to check on the resident during rounds for toileting. At 4:30 AM County dispatch notified and at 4:52 AM the resident transferred by ambulance. Review of the Patient Care System dated 11/13/17 revealed the PTA assessed the resident due to recent falls. The assessment revealed the resident took small steps and needed cues. The resident also required moderate assist of staff to move from sit to stand position. Review of the Nurses Notes dated 11/20/17 at 8:07 AM revealed the post fall assessment	F 689		

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F 689	Continued From page 4 completed for falls on 11/12/17 and 11/13/17. No major injury received from either fall. The resident denied any new pain/discomfort from falls. Range Of Motion and activity with in normal limits for the resident. The resident bears full weight and ambulation with 1 assist and walker per usual. All fall interventions reviewed and will initiate gripper socks when not wearing shoes and have Physical Therapy to assess for safe ambulation/transfers. Dated 12/20/17 revealed the resident on the floor in the bathroom. The resident stated she had been trying to sit on the toilet when she slid to the floor. The resident denied hitting her head, vital signs taken. The resident unable to straighten her right leg due to pain and left range of motion within normal limits. The resident brought up to toilet with a gait belt and assist of 2 due to she stated she had to go to the bathroom. Intervention included to check on the resident during rounds for toileting. During an interview with Staff D, CNA on 6/28/17 at 2:10 PM she stated the resident did get up on her own quite a lot and go to the bathroom. Sometimes the resident called for help on the call light. When interviewed on 6/29/18 at 6:00 AM Staff E reported when the resident's call light came on she was in another room assisting another resident. She stated she finished with the resident whom was a slow walker. She waited until the resident walked back to bed and she gave her the call light. She then went to the residents's room and found the resident on the floor in her bathroom. And called the nurse to come to the Pod. She further stated the resident had gotten up on her own several times and she found her	F 689		

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F 689	Continued From page 5 walking or already in the bathroom. She stated the resident always wore gripper socks and had them that night. During an interview with Staff F, RN (Registered Nurse) on 6/29/18 at 7:50 AM she stated the facility looks at the cause of a fall. If needed they re-educate staff. If interventions are there and working and followed but not to full extent staff re-educated. She stated if new interventions are made for a resident or a change, it goes on the resident change in care plan sheet. Staff sign off that they are aware and educated. She further stated the MDS coordinator responsible to update the care plan with the new interventions. She stated the facility had 4 Pods (halls) and 1 CNA scheduled per Pod on the night shift (10:00 PM to 6:00 AM) and one (1) nurse on the night shift who help when a CNA calls for assistance. 2. According to the MDS dated 5/11/18 Resident #1 had diagnoses that included Alzheimer's Disease, schizophrenia and depression. The MDS identified the resident had a BIMs score of 11 which indicated moderately impaired cognition. According to the MDS the resident required extensive assistance with bed mobility and extensive assistance with transfers, ambulation, dressing and toilet use. The care plan dated 1/19/17 directed staff to transfer the resident with 2 to 3 staff assistance and use a wheelchair for distances from one place to another. Do not leave unattended in the wheel chair. Transfer to other chair. Observation on 6/28/18 at 8:05 AM revealed the resident sat in the wheelchair in the dining area. Staff G pushed the resident to the lounge area for	F 689		

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F 689	Continued From page 6 a distance of approximately 20 feet. The resident held his feet up off the floor with his ankles crossed. At 9:45 AM the resident requested to lay down. Staff G and Staff B, CNA transferred him from the recliner to the wheelchair. The resident appeared to have difficulty holding his feet above the floor. Staff B grabbed his pant leg and held his feet up while Staff G pushed the wheelchair to his room. Review of the Policy and Procedure titled Falls Prevention and Interventions dated 4/14 directed staff to do the following: a. Initial Fall Follow-up completed. b. Fall Risk Assessment filled out. c. Fall Care plan reviewed. d. Appropriate intervention put in place. e. Interdisciplinary team reviews falls and intervention on first week day following incident and request Physical therapy referral as appropriate. f. Post Fall huddle completed.	F 689		

August 14, 2018

[redacted]

Health Facilities Division
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Plan of Correction—Annual Survey – Conducted June 26 - June 29

§483.25(d) Accidents: The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Sioux Center Health Royale Meadows accepts this standard not being met and accepts that the facility failed to always put new interventions in place to prevent further falls and injury for 2 of 4 residents reviewed.

- Education was provided to all charge nurses regarding appropriateness of interventions for residents whose BIMs score indicate the resident has cognitive impairment via email on July 16, 2018 and will be reviewed again at the charge nurse meeting on August 21.
- New interventions will be put in place if any change in a resident's physical or cognitive condition are noted. Royale Meadows nursing staff will document all intervention changes on care plan. Resident Change in Care Plan Sheets will be reviewed daily by all CNA staff members during each transfer of care to oncoming staff members.
- Care Coordinators and Director of Nursing will huddle each workday to review falls and new interventions and make sure they are put into care plans. The appropriateness of each intervention will be reviewed and updated during the Care Coordinator/DON workday huddle.
- Education regarding appropriate use of wheelchair pedals when pushing a residents has been provided to Royale Meadows CNA staff members. CNA Coordinator has completed one-on-one education with regularly scheduled staff members, and all CNA team members received communication regarding expectations via email on June 29, 2018. Bags have also been ordered to place wheelchair pedals on the back of resident chairs who like to self-propel without pedals on their wheelchair.
- A random audit will be completed of 4 charts per month to ensure appropriateness of new interventions. Random spot checks will be conducted and documented on appropriate wheelchair pedal usage twice per week by the CNA Coordinator. Results will be documented on the department quality indicator report (dashboard) monthly. Dashboards are reported to the Quality Improvement Board. This monitoring will

remain in place until substantial compliance is achieved. The Director of Nursing will be responsible for ongoing compliance.

- Substantial Compliance achieved on August 14, 2018.

Sincerely,

Joe Heitritter
Senior Services Officer
Sioux Center Health
Provider #165157