DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165617	A. BUILDING ______ B. WING ______	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION CENTER OF LISBON	905 WEST MAIN STREET LISBON, IA 52253

(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: 05/26/2021 Amended July 28, 2021 following an IDR conducted on July 14, 2021. The following deficiencies relates to the recertification survey completed 5/10-17/2021. See Code Federal Regulations (42CFR) Part 483. Subpart B-C).	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 observation, record review, resident and staff interviews the facility failed to identify an environmental hazard when they left a shower chair unlocked while a resident showered. The staff member stepped away from Resident #11 to obtain a towel, the resident attempted a self-transfer, and fell when the shower chair rolled away. The fall resulted in a right hip fracture for 1 of 2 residents reviewed for accidents. (Resident #11). The facility reported a census of 50 residents. Findings include: Resident #11's Minimum Data Set (MDS)	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Krystal Klostermann
TITLE: Administrator
(X6) DATE: 07/29/21

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 Assessment dated 2/12/21 showed the resident required assistance of one staff for bathing. The MDS identified the resident with a Basic Interview for Mental Status (BIMS) score of 12 indicating the resident had mildly impaired cognitive skills. The MDS also showed the resident with diagnoses of Non-Alzheimer's Dementia, Muscle Weakness, and other abnormalities of gait and mobility. The Care Plan with a revision date of 2/17/21 showed Resident #11 with a Focus Area in regards to Activities of Daily Living (ADL's) noting the resident with the potential for alteration in functionality related to activity intolerance that is exacerbated by his dementia, anxiety and dyspnea (problem breathing) with his Chronic Obstructive Pulmonary Disease (COPD) that is potentiated by his anxiety. The resident has a chronic cough. Due to his multiple co-morbidities including Diabetes, hypertension (high blood pressure) and above mentioned diagnosis, and use of psychoactive medications, he is at risk for decline in ADL/mobility independence. The Care Plan directed staff to provide assistance of one with bathing and showering as an intervention for Resident #11. The Progress Note dated 4/29/21 at 2:45 p.m., titled Incident Report stated the Nurse summoned to the shower room, where upon entering noted the resident lying on the floor of the shower, under the shower head, on his left side with his knees bent and the resident holding them with his hands. The shower floor wet and the water to the shower turned off with the resident lying naked with no shoe covers, there was a towel placed under his head. The Certified Nursing Assistant (CNA) assisting Resident #11 with a shower	F 689		

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F 689	Continued From page 2 stated the resident was sitting on the shower chair that was not locked and washing himself under the shower head. The CNA stated he went around the corner of the shower room to obtain more towels and he noted the resident was grabbing the grab bar affixed to the wall and at the sink to the left of the shower and he attempted to stand up unassisted and lost his balance. The resident went to sit on the shower chair which rolled away from the resident and he fell to the floor, landing on his right hip and right side. The CNA stated the resident did not hit his head or lose consciousness and independently rolled from his right side to his left and immediately reported pain. The Progress notes during the assessment of Resident #11 The Progress Note revealed Resident #11 was sent to the emergency department. The History and Physical from a hospital admission dated 4/29/21 revealed right intertrochantric (hip) fracture. The notes from the physician revealed Resident #11 presented to the emergency room after a fall in the shower. Resident #11 reported pain is 10 out of 10. (Pain scale rating 1-10 with a 1 indicates mild pain to a 10 severe pain). During an observation on 5/11/21 11:49 a.m., Resident # 11 propelled self to the dining room in the wheelchair with upper extremities. During an observation on 5/12/21 at 8:38 a.m., surveyor viewed the Kepler shower room, the towel cabinet is in a separate area from the shower in the room. The towel cabinet was 12 steps from the shower head area and on the other side of the south wall of the shower.	F 689		

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F 689	Continued From page 3 During an interview on 5/12/21 at 10:02 a.m., Resident # 11 stated he recalled the fall he had in the shower. I was in the shower and the chair I was in got loose underneath me and I slipped right underneath it and fell. I had lot of pain on a scale of 1-10, I would rate it a 10. Resident #11 reported still having a lot of pain and continue to rate it at a 8 out of 10. During an interview on 5/12/21 at 10:01 a.m., with Staff G, Certified Nursing Assistant (CNA) and Staff H, CNA stated they would never leave a resident unattended in the shower to get towels from the cabinet and always have the brakes locked on the shower chair. During an interview on 5/12/21 at 10:47 a.m., Staff E, Registered Nurse (RN) stated on 4/29/21 Staff F, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) summoned her to the Kepler shower room. She observed Resident #11 in the shower laid out on the wet floor with legs drawn up to his chin. Resident #11 appeared alert and verbal. Staff F, CNA/CMA told Staff E, RN Resident #11 was in the shower chair with the brakes unlocked and he had gone around the corner to get some towels. He came back and Resident #11 stood, attempted to grab onto the shower bar and sink and fell. Staff E, RN stated I will probably get in trouble for telling you this but Staff F, CNA/CMA should have had the brakes on the shower chair and should never have left him unattended to get the towel. During an interview on 5/12/21 at 1:51 p.m., Staff F, CNA/CMA stated on 4/29/21 he gave Resident #11 a shower. Staff F reported Resident #11 sat on the shower chair with the brakes unlocked.	F 689		

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F 689	Continued From page 4 Staff F reported he went around the corner of the shower to get towels and left Resident #11 unattended. Resident #11 attempted to stand to wash his bottom and lost his balance as he attempted to sit back down. The shower chair rolled out from under him. Staff F stated we have iphones and can look up the Kardex which tell you exactly what type of assistance the resident needs. Staff F stated he could see Resident #11 when he went to get a towel. The Surveyor asked to clarify the location of the towels in reference to where the towels were located. Staff F reported, "well, you got me there I could not see him the whole time." Staff F stated he did go over to the cabinet to grab towels and did not have his eyes on the resident. Staff F confirmed when he went over to grab the towels is when the resident fell. During an interview on 5/12/21 at 2:04 p.m., the Director of Nursing (DON) stated the Kardex is what is on the Care Plan. The DON stated would expect staff to follow what is on the Kardex which is on the iphone they carry with them and flows directly from the Care Plan. Staff F should have followed the Care Plan and provide assist if that is what it says for Resident # 11. In a follow-up interview on 5/12/21 at 3:13 p.m. Staff F, CNA/CMA reenacted Resident #11 fall on 4/29/21 in the Kepler shower room. Staff F stated I left him out of sight for a few seconds to grab the towels out of the cabinet to put on the floor and the chair. I did leave him unattended to grab the towels. He should have been supervision with the shower when he fell. In another follow-up interview on 5/12/21 at 4:17 p.m. with Staff F, CNA/CMA stated he could not recall where the privacy curtain on the shower	F 689		

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F 689	Continued From page 5 was located at the time of the fall. He did loose sight of the resident when he was getting the towels out of the cabinet but then when coming back he could see out of the corner of his eye the resident was standing and he rushed to get to the resident but he fell any way. The Administrator provided a statement dated 5/13/21 stated we do not have a bathing policy. Staff are trained on how to bath a resident in their CNA course and after they are hired. We expect staff to provide individualized cares tailored to each resident's needs and preferences. The shower chair noted with a label from Direct Supply with a Model #VL SC17 P FRSB. The Manual provided by the facility during the IDR entitled Operation Instructions directed under the Operating Information: Showering - Transfer user into the chair. Move user into shower area and lock casters.	F 689		

Date submitted: June 4, 2021

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 correction date: 5/26/21

F 689 §483.25(d)(2) Free of Accident Hazards/Supervision/Devices
The facility ensures that each resident receives adequate supervision and assistance devices to prevent accidents.

The facility is disputing the deficiency and is submitting a response with additional information in a separate document. However, for the required plan of correction, the facility submits the following:

1. Resident #11 received occupational therapy evaluation and treatments beginning 5/5/21 to determine his ability for independence while showering, including use of assistance devices. Resident #11's care plan was updated to include direction to staff to the lock shower chair brakes during resident's shower. Resident agrees at this time not to self-propel his shower chair while showering per the Iowa Department's directive and staff will attempt to hand him his shower items as needed, while maintaining as much privacy as possible.
2. Nursing staff were educated on 5/17/21 at daily nursing huddle and via written nurse communication form that resident care plans were updated as needed to provide detailed instructions for bathing/showering including locking the shower chair brakes when not in use.
3. On 5/27/21 nursing staff reviewed and were educated on the operations manuals for shower chairs that are used in facility and copies of shower chair operations manuals are posted in all shower rooms for staff reference at any time.
4. Through the quality assurance process, the Director of Nursing or designee will perform audits weekly for 1 month and then monthly for 6 months, to ensure staff follow resident care plans during showering and shower chair brakes are locked when not in use. The frequency of audits thereafter will be based on the outcomes.