STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165158	A. BUILDING _____ B. WING _____	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH CLARINDA	600 MANOR DRIVE CLARINDA, IA 51632

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F 000	INITIAL COMMENTS Correction Date 6-24-21 The following deficiencies relate to an investigation of complaints 89101-C, 89938-C, 89694-C, 97597-C, 97229-C and facility reported incidents 89102-I and 97656-I conducted May 17 - June 1, 2021. Complaints 89101-C, 89938-C and facility reported incident 89102-I were substantiated. Complaints 89694-C, 97597-C, 97229-C and facility reported incident 97656-I were not substantiated. See the Code of 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 observations, clinical record review, and staff and family interviews, the facility failed to provide adequate nursing supervision and assistance devices to prevent hazards for 2 of 4 residents reviewed (Resident #2 and 5). On 1/31/21, staff found Resident #2 on the floor in the bathroom. Staff A took the resident to the bathroom to use the toilet. Although the resident	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/24/2021

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 had a history of falls, experienced cognitive and memory problems, exhibited confusion, and required staff assistance for surface-to-surface transfers, Staff A left the resident in the bathroom and alone and unsupervised on the toilet. While sitting alone, the resident fell and complained of leg, hip, back and ankle pain. Staff sent her to the emergency room for evaluation and the hospital identified the resident sustained a femoral (upper leg bone) fracture. On 2/25/21 at 10:55 PM, the resident passed away. The Death Certificate identified the immediate cause of death was frailty due to or as a consequence of a femur fracture and Parkinson's disease. The facility reported a census of 49 residents. Findings include: 1. The quarterly Minimum Data Set (MDS) assessment tool dated 11/22/19 documented Resident #2 had diagnoses that included heart failure, hypertension, renal insufficiency, Parkinson's disease, history of fractured left femur, repeated falls, postural kyphosis, and abnormal posture. The MDS revealed the resident scored 12 out of 15 possible on her Brief Interview of Mental Status (BIMS) test, which indicated the resident demonstrated moderate cognitive impairment. The MDS also documented she required extensive assist of 1 staff for bed mobility, transfers, dressing, and toilet use and experienced occasional bowel and bladder incontinence. The MDS documented she had a history of falls since the last assessment. The Care Plan dated 11/28/19 identified Resident #2 as at risk for falls and required assist of 1 staff for toilet use and transfers related to a diagnosis	F 689		

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F 689	Continued From page 2 of Parkinson's disease. The care plan also documented the resident experienced memory problems and episodes of confusion. The care plan lacked any documentation to indicate whether or not staff could leave the resident unsupervised while utilizing the toilet. The Fall Risk Evaluation dated 11/22/19 revealed Resident #2 scored 75, which put her at high risk for falls. The evaluation documented she had a history of falls within the last 6 months, had impaired gait, and overestimates or forgets her limits. Resident #2's Progress Notes documented the following: a. On 10/23/20 at 2:14 AM resident fell to the floor when attempting to get out of bed to go to the toilet with the bed in the low position and a mat next to her bed. Staff documented the resident has been confused and mixed up for the past couple days. b. On 11/24/20 at 9:23 AM, staff completed an MDS quarterly review and documented the resident demonstrated increased periods of confusion and hallucinations related to progression of Parkinson's disease per her nurse practitioner. c. On 12/29/20 at 2:14 PM, staff documented the resident as very confused with hallucinations today. The resident reported she saw her brother fall outside the dining room, could not find her mother, tried to pick up chocolate chips from the floor, and attempted to get out of her recliner independently. d. On 1/6/20 at 6:25 AM, the resident had lots of hallucinations and confusion and told staff her	F 689		

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F 689	Continued From page 3 parents were here and also found in a seated position on the side of the bed because she needed to go help the boy in the other room. e. On 1/6/20 at 2:14 PM, the resident became confused, had hallucinations, and tried to get up independently and clean her room because she believed she could walk and she needed to clean it. f. On 1/6/20 at 7:49 PM, the resident displayed continued confusion with hallucinations. Staff found her prior to supper sitting on only 3-4 inches of the recliner foot rest because she wanted to get up to sweep the floor. Reality orientation not effective. The resident's granddaughter assisted with bedtime cares. Staff checked and noted the bed in low positron with the mat on the floor. g. On 1/9/20 at 9:54 PM, staff documented resident confused today and stated that she was checked for bed bugs today but none were found. h. On 1/15/20 at 7:00 AM, the resident reported tingling in arms and weak upper arm strength and tingling in legs and feet, with legs weak with the left leg weaker than the right. Resident stated she had to use her arms to lift her legs. The nurse documented the resident required 2 staff or a lift to assist the resident. i. On 1/29/20 at 7:00 AM, Resident #2 stated she had tingling and numbness in her upper and lower extremities with leg strength weak with the left leg weaker than the right leg. The resident reported she had to lift her left leg with her arms. Staff documented the resident did not ambulate and required 2 staff assist with gait belt or lift. j. On 1/31/20 at 3:41 PM, resident found sitting on the floor in front of the toilet in the bathroom with her right leg bent under her, sitting on the leg, left leg bent up and toward her chest with the left ankle flexed upward and outward. The resident	F 689		

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F 689	Continued From page 4 screamed to get her up off the floor and complained of bilateral hip, back, and ankle pain and she could not straighten her legs due to the pain. Staff called 911 to send the resident to the emergency room, and sent her via gurney and emergency medical team. The Incident Report dated 1/31/20 at 3:57 PM, documented staff found the resident on the floor in her bathroom in front of the toilet. The nurse completed an assessment and Resident #2 reported bilateral hip, back, and ankle pain. Staff sent her to the emergency room for evaluation. The Incident Report also documented her mental status as forgetful with a lack of safety awareness and a diagnosis of Parkinson's disease which was progressing, with more frequent periods of confusion and hallucinations. The Radiology Report from the hospital dated 1/31/20 at 4:29 PM revealed Resident #2 sustained a left distal femoral fracture. The History and Physical (H&P) from the hospital dated 1/31/20 at 6:10 PM documented the Resident #2 was using the restroom, attempted to stand up, her legs felt numb and weak, and she fell forward onto her knees. The H&P described the resident as in significant pain when evaluated by the emergency medical responders and they administered 50 micrograms of Fentanyl. The H & P revealed Resident #2 sustained a fracture of the distal left femur and subsequently admitted to the hospital for physical therapy, pain control, and anticoagulation. The H & P added the resident was not a surgical candidate related to her age and complicities. During an interview on 5/18/21 at 2:55 PM with	F 689		

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F 689	Continued From page 5	F 689		

the Director of Nursing (DON) she stated staff are not to leave residents on the toilet unassisted if there has been any change in their level of consciousness or confusion. She added that she and the nurses checked on the residents every couple of days and if there has been any changes, they will communicate it to the aides.

During an interview on 5/19/21 at 10:30 AM with Staff A, she stated it was the end of her shift around 2:00 PM on 1/31/20 when she took Resident #2 to the bathroom. Staff A stated according to Resident #2's chart, staff could leave the resident on the toilet herself. Staff A stated the resident told her she needed to have a bowel movement and would be awhile. Staff A stated she told the oncoming aide that Resident #2 remained on the toilet and the aide (Staff B) responded, okay I will be there in a minute to get her. Staff A stated she clocked out and went home and added she normally would not leave Resident #2 unattended because she was usually more incoherent, but that day she was more "with it." Staff A reported when she left the room, the resident her call light and her wheelchair next to her with the brakes locked. Staff A said she knows the resident should not transfer by herself but she wanted the wheelchair next to her just to be safe.

During an interview on 5/19/21 at 10:55 AM with Staff B, she stated she was worked a 12-hour shift that day 1/31/20 doing showers. At 2:00 PM, she went to work as an aide on the resident's hall as scheduled. Staff B stated Staff A told her everything was fine and left. Staff B stated as she passed linens on Resident #2's hall around 3:00 PM, she found the resident on the floor in her bathroom with the bathroom door shut and

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F 689	Continued From page 6 immediately alerted the nurse to assess her. She reported the resident sat on the floor in front of the toilet, leaning. It was one of the reasons they were not supposed to leave her unattended on the toilet as she leaned, displayed confusion, could not transfer herself independently, and likely could not remember to use the call light. Staff B stated that she could not recall anything being on her chart saying the staff could leave her unattended; she had worked with the resident for over a year and they were never to leave her. The resident had declined a lot, saw things that were not there and showed confusion. Staff B stated she knew to never leave a resident that could not transfer themselves independently and exhibited confusion alone on the toilet. She stated it was around when she was passing linens and found the resident She added that the resident had reported so much pain that they did not transfer her from the floor prior to the time emergency personnel arrived at the building. During a follow up interview on 5/19/21 at 1:25 PM with the DON she stated there was nothing on Resident #2's care plan that directed staff to stay with Resident #2 but she expected Staff B to be with her once Staff A left for the day. She stated that she really expected everyone to be watched in the bathroom unless they are independent. She reported the care plan directed staff to remind the resident to use her call light and commented Staff A insisted she stayed in the doorway of the resident's room until she told Staff B that the resident remained in the bathroom. During an interview with a family member on 5/26/21 at 1:20 PM, she stated after Resident #2 fell and broke her hip, she went to another nursing home and passed away there. She said	F 689		

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F 689	Continued From page 7 staff should have supervised the resident in the bathroom at all times due to her confusion. She added if Resident #2 had not fallen, she might still be alive. The State of Iowa Certificate of Death dated 2/29/20 documented Resident #2's date of death was 2/25/20 at 10:55 PM and the immediate cause of death was frailty due to or as a consequence of a femur fracture and Parkinson's disease. 2. The quarterly Minimum Data Set (MDS) assessment tool dated 5/4/21 documented Resident #5 had diagnoses that included Parkinson's disease, cancer, hypertension, peripheral vascular disease, dementia and depression. The MDS revealed the resident demonstrated severe cognitive impairment. The MDS also documented he required extensive assist of 2 staff for bed mobility, transfers, ambulation (walking), dressing, and toilet use with occasional bowel incontinence and frequent bladder incontinence. The MDS revealed Resident #2 had a history of falls since the last assessment; he fell two or more times with no injury and two or more times with minor injury. The Care Plan dated 2/4/21 identified Resident #5 had a risk for falls related to dementia and directed staff to place a fall mat by the bed, apply non-skid strips to the bathroom floor, and ensure the resident wore proper footwear with (initiated 2/4/21). The care plan also contained an update on 2/16/21 that directed remove the strips and floor mat. The Fall Risk Evaluation dated 5/4/21 revealed	F 689		

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F 689	Continued From page 8 Resident #5 scored a 17, which meant he was at risk for falling. The evaluation documented he had a history of falling 3 or more times in the past 3 months, was disoriented at all times, had a balance problem while standing, a balance problem while walking, and should wear rubber-soled shoes or non-skid slippers for ambulation (walking). Resident #5's Progress Notes documented: a. On 2/16/21 at 12:24 PM during the telehealth appointment, staff updated the physician regarding the resident's recent falls and reported the resident had been observed stepping over the non-skid strips and fall mats. He told staff he was afraid to step on them because they looked like a hole. Housekeeping team notified to remove the strips and mat, as they seem to be a contributing to the resident falling instead of trying to prevent falls. b. On 2/23/21 at 4:12 AM resident had an unwitnessed fall with injuries and sustained a gash on his right temple, right side of head behind the ear, and large skin tear to the back of his right hand. Resident seen in ER. c. On 2/25/21 at 11:02 AM resident fell while walking in the hall. d. On 2/27/21 at 2:48 PM, staff found the resident on the floor in his room between the wall and the recliner. e. On 3/3/21 at 4:04 PM, staff found the resident was found on the floor in the hallway. f. On 3/11/21 at 10:15 PM, the resident had an unwitnessed fall. g. On 3/12/21 at 7:58 PM, the resident tried to stand up, lost his balance, and fell. h. On 3/19/21 at 10:40 PM, the resident slid out of bed onto the fall mat and re-opened the skin tear	F 689		

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F 689	Continued From page 9 on his elbow. i. On 3/28/21 at 3:38 PM, staff found the resident on the floor in his room and noted the floor wet with urine. j. On 3/30/21 at 4:47 PM, staff found the resident on the floor. k. On 4/21/21 at 7:04 PM, the resident fell to the floor in the hallway. l. On 4/22/21 at 3:20 AM, the resident lay in his low bed with a landing mat next to the bed - still on fall follow-up. m. On 4/27/21 at 10:18 PM, staff found the resident on the floor in front of the nurse's station wearing no shoes or socks with gripper tread. n. On 5/9/21 at 4:22 AM, staff found the resident on the floor in the opening of the closet in his bedroom with a skin tear to his left elbow. The resident reported he needed to use the toilet. o. On 5/11/21 at 2:31 AM and 5/13/21 at 3:07 AM, the resident had the low bed in use with landing mat next to the bed - still on fall follow-up. During an observation on 5/18/21 at 11:05 AM, Resident #5 sat in his wheelchair with staff present preparing him for a transfer to the toilet. A fall mat sat on the floor next to his bed with non-skid strips visible on the bathroom floor. During an observation on 5/25/21 at 11:25 AM, Resident #5 sat in his wheelchair right outside his room. A fall mat sat on the floor next to his bed with non-skid strips visible on the bathroom floor. During an interview with the DON on 5/25/21 at 1:55 PM, she stated they should have removed the strips and mat on 2/16/21. She added she alerted the housekeeping staff and they will remove them today.	F 689		

Tag # F689 Free of Accident Hazards/Supervision/Devices

1. **Immediate action(s) taken for the resident(s) found to have been affected include:**

Resident # 2 has since discharged 02/06/2020, no further action is required.
Resident # 5 a fall risk assessment was completed on 05/18/2021 with a score of 19, at risk. A review of his current fall interventions was completed on 05/25/2021. His current fall interventions were verified these were in place by Director of Nursing on 05/25/2021. A review of resident's current toileting status was completed on 05/18/2021, the care plan was updated as indicated. Staff Education was completed with clinical staff on 5-30-21 regarding updates of care plan, Kardex, and review of the fall protocol. Family continues to be involved in providing guidance to best support resident with progressive disease process. Discussion of hospice was completed on 6-21-21 due to resident's progressive disease process, social services will discuss further with family.

2. **Identification of other residents having the potential to be affected was accomplished by:**

A review of resident current Fall Risk Evaluation was completed on 05/18/2021, any resident noted to be at risk, a review of their care plan was completed and updated as indicated, a visual observation was completed on 05/25/2021 to ensure fall interventions were in place.
A review of current resident toileting status was completed on 05/18/2021, care plans and Kardex was updated as indicated.
Education was completed with clinical staff regarding falls protocol, Kardex, cand care plan updates on 5/30/21. The attached education will be completed with staff prior to their next worked shift and add to new hire orientation.
Education was completed on 5/30/21 with Clinical Leadership by Megan Toney, RN, RNC regarding falls protocol, and the Interdisciplinary team approach, review and follow up process.
Implementation of review of fall interventions to the guardian angel program was completed on 6-4-2021.
Implementation of licensed staff notifying on call nurse of falls, to review the incident, and immediate interventions to put in place was completed on 5-30-21.

3. **Actions taken/systems put into place to reduce the risk of future occurrence include:**

Outcomes of Guardian Angel Rounds will be turned into Barb O'Dell, ADON, the Administrator and DON will review and address any concerns noted.
Risk Management will be reviewed during clinical start up, an IDT note will be entered following review. DON or designee will complete a visual observation of intervention in place. Each fall incident will be discussed in clinical start x 72 hours following incident.
Each admission will have a fall risk evaluation completed, each resident identified "at risk" will be discussed by the Interdisciplinary team, and interventions put in place at this time.
A screen will be completed by PT/OT for residents following a fall. Further treatment will be determined based off the outcome of the screen.

4. **How the corrective action(s) will be monitored to ensure the practice will not recur:**

An audit of resident fall interventions by the DON or Designee will be completed 3 x's weekly x 4 weeks, then weekly x 4 weeks.
An audit of resident toileting status by the DON or Designee will be completed 3 x's weekly x 4 weeks, then weekly x 4 weeks.

An audit of staff knowledge of current resident fall interventions and toileting status by the DON or designee will be completed on all shifts by DON or designee 3 x's weekly x 4 weeks and then weekly 4 weeks.

The DON or designee will be bringing these audits to QAPI for review.

Corrective action completion date: 6-24-2021