FORM APPROVEDOMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		SURVEY PLETED
		161310	B, WING	•	03	C /1 7/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	7.172-0-0
ADAIR CO	UNTY MEMORIAL HOSE	PITAL		SOS SE KENT GREENFIELD, IA 50849		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	O BE	(XS) COMPLETION DATE
C 000	INITIAL COMMENTS	. , -	C 000	POC Accepted 4/6/29 Thate of Connection 4/18	cmi)	
	the Centers for Medic Kansas City Regional performed an on-site #102918-C from 3/14 survey team investiga Participation for Provi 485.635). The survey standard level deficie	investigation of complaint /22 through 3/17/22. The ated the Condition of sion of Services (42 CFR team identified the following ncy.				
C1050	NURSING SERVICES CFR(s): 485.635(d)(4) A nursing care plan mourrent for each inpat This STANDARD is rousely, and staff inter Hospital (CAH) admindered for the folial propriate fall risk assess of all appropriate fall risk assessment. Faill risk assessment and if appropriate fall risk in Patient #5 falling twice injury. The CAH identificance of 1.3 patients Findings include: 1. Review of the policy revised 5/2021, reveat to identify all patients to falls a. Each patient with the electronic Mopatient who scores 0 -	ust be developed and kept ient iot met as evidenced by: record review, document views, the Critical Access istrative staff failed ensure ed (Patient #5) had a sment and implementation isk interventions based on ure to ensure a current fall implementation of all terventions resulted in e and sustaining a minor fied an average daily	C1050	Nursing Care Plan policy ha updated as of 3/30/22 and is through approval process in Stat. (available for review up request) Initiated immediately: Huddle—care plans must be comple all patients and updated with condition changes. Reviewe 0800 and 2000 daily. Audit tool being developed feaudits to ensure: a) care plans are initiate updated. b) documentation comple fall risk and appropriate interventions according updated policy. c) Education on revised Fall risk, Care plans a hourly rounding (new) take place week of April 2022. d) CCO will begin doing chart audits on all pate effective April 18, 202 will allow feedback to within 48 to 72 hours, audits will continue or	going Policy on board eted on patient d at or chart d and ete for te ind policies: nd will pril 11, daily ients 2. This staff These	

DEPARTMENT OF HEALTH AND HUMAN SE CENTERS FOR MEDICARE & MEDICAID SE				MAPPROVED 0. 0938-0391
		that time will take	nt with policies. At random sampling place to ensure compliance.	
	g g	and Interventior 3/29/2022 and i approval proces	sment, Prevention Policy updated s going through s through policy for review upon	
LABORATORY DIRECTOR OF PROVIDER/SUPPLIER RE	PRESENTATIVE'S SIGNA	CM)	4/4	W (×6)
Any deliciency statement ending with an estarisk (*) denoted that other saleguards provide sufficient protessor above are disclosable 90 days following the date of survivand plans of correction are disclosable 14 days following an approved plan of correction is requisite to continued	ection to the patients. (See instruction to the patients. (See instruction of correct the date these documents are	uctions.) Except for nursing homes, the	e findings stated he above findings	
FORM CMS-2587(02-99) Previous Versions Obsolete	Event ID: NHG511	Facility ID: IAHC011	If continuation shee	et Page 1 of 13

If continuation sheet Page 1 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A, BUILDING		
		181310	B. WING		1	G 17/2022
NAME OF P	ROVIDER OR SUPPLIER	101010		REET ADDRESS, CITY, STATE, ZIP CODE	001	177422
ADAIR CO	DUNTY MEMORIAL HOSF	PITAL.	1.	9 SÉ KENT		
ADAIROC			G	REENFIELD, IA 50849	<u>î</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	11	(X5) COMPLETION DATE
C1050	"Procedure: 1. Initial Morse Fall R patients is completed daily. 2. Morse score > 51, the patient room advishelp before getting out of bed. Parand as needed to call of bed. 3. Place a Yellow Clabracelet to show all strick. 4. Initiate a Fall Risk Feligh Fall Risk interveroutside of the patients' chart. 5. Place the Fall Risk patient's door on the fellowing: a. On 2/17/22 Patient pneumonia (lung infed life-threatening conditions)	isk Assessment of all upon admission and then a Fall Risk sign is placed in sing the patient to call for tients will be educated daily for help before getting out sp on the patient's ID aff the patient is a High Fall Plan of Care and place the ntion reminder on the Magnet outside the frame." 5's medical record revealed #5 was admitted for ction), sepsis (potentially ion that occurs when the	C1050	DEFICIENCY	## 6: = 1 **********************************	
	tissues), and hypoxia b. On 2/21/22 Patient medical record lacked staff had assessed Pa preventing the CAH st	infection damages its own (low oxygen in the blood). #5 had a fall. Patient #5's I documentation the CAH attent #5's fall risk, thus aff from identifying Patient falling and implementing utions.			4	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		161310	B, WING		ı	C /17/2022
	ROVIDER OR SUPPLIER		609	EET ADDRESS, CITY, STATE, ZIP CODE SE KENT EENFIELD, IA 50849	03/	1112022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
C1050	a fall risk assessment at the condition of the record still lacked a risk assessment so the condition of the	eed any information related to ent so CAH was unaware that igh risk for falls. ent #5 fell a second time, and ear on their left wrist. Medical iny information related to a fall o CAH was unaware that	C1050			
	review, and staff int Hospital (CAH) admensure the nursing implemented all approximates for 2 of 6 patients repatient #2) which so Failure to ensure do implementation may which may result in CAH identified an apatients. Findings include: 1. Review of the po	y result in patients falling serious injury or death. The verage daily census of 1.3 icy, "Fall Prevention", last				
	revised 5/2021, rev	ealed in part: "It is the I patients at risk of physical	i.			

harm due to falls...Each patient is assessed at

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PRINTED: 03/25/2022 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) ĎATE SÚRVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 03/17/2022 B, WING 161310 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 609 SE KENT ADAIR COUNTY MEMORIAL HOSPITAL GREENFIELD, IA 50849 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C1050 C1050 Continued From page 3 least daily with the electronic Morse Risk Assessment tool. A patient who scores...51 or greater is considered to be at high risk..." "Procedure: 1. Initial Morse Fall Risk Assessment of all patients is completed upon admission and then 2. Morse score > 51, a Fall Risk sign is placed in the patient room advising the patient to call for help before getting out of bed. Patients will be educated daily and as needed to call for help before getting out 3. Place a Yellow Clasp on the patient's ID bracelet to show all staff the patient is a High Fall 4. Initiate a Fall Risk Plan of Care and place the High Fall Risk intervention reminder on the outside of the patients chart. 5. Place the Fall Risk Magnet outside the patient's door on the frame." Anyone felt to be at risk for falls will have some or all of the following interventions. a. Have side rails up x 2 at all times, unless the patient is climbing over the side of the rails. b. Call light within patient's reach at all times. Call light may be attached to the patient's gown as appropriate. c. Answer the call light promptly. d. Observe the patient hourly and document the observation. If the patient is awake, offer assistance to toilet, assess pain level, offer a position change

and check proximity frequently used items.

To identify any patient with a potential for physical harm from falls due to perceptual, environmental,

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING .	С
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161310 B, WING0	3/17/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ADAIR COUNTY MEMORIAL HOSPITAL	
GREÉNFIELD, IA 50849	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 4 mental, or age factors. e. Have patient visible from the door when the need is deemed appropriate. (There may be a need to leave the room door open, if no one is attending the patient.) f. Give assistance with daily activities. Instruct the patient and designated others to ask for assistance for patient activities. g. Non-skid footwear is to be worn while walking or transferring. h. Use a gait belt if the patient needs any type of assistance with transfer or ambulation. i. Obtain walker, cane, or wheelchair if the patient uses them at home. j. Ensure patient's hearing aids and/or glasses are availiable for the patient to use. k. Keep a small amount of light on in rooms at all times. l. Reorient the patient to the environment as needed. n. When applicable, communicate to other ancillary departments any patients with a fall risk potential. o. If restraints are needed, see restraint policy. p. Do not leave the patient unattended when up to the commode or toilet. Commode, wheelchair, room chair, and bed wheels are to be in the locked position at all times. q. Monitor the patient for side effects from anesthesia, sleeping list, analgesics*	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		101010		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	11112022
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ADAIR CO	OUNTY MEMORIAL HOS	PITAL		609 SE KENT		
, in the co	ii " a dayani ii ji			GREENFIELD, IA 50849		
(X4) ID		ATEMENT OF DEFICIENCIES	ÍD.	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		DATE
IAG	.,	,		DEFICIENCY)		
	· · · · · · · · · · · · · · · · · · ·					
C1050	Continued From page	5.5	C1050			
			0.000			
		right toe and underwent a On 2/18/22, Patient #1 was				
	discharged from the (,	1
ļ	revealed:	SALI. Micaldal 100014		•		1
	·				;	
	a. Patient #1's fall risl	c scores			1	l.
	<u> </u>					
	i.On 2/5/22 at 7:59 Pf	M RN, A documented Patient				}
	#1's as 95 (high risk o					
,	ii. On 2/6/22 at 12:15	AM, RN A documented a fall				
	risk score of 95 (high			<u>.</u>		
		AM, RN A documented a fall				
1	risk score of 95 (high			'	1 1	
i		AM, RN A documented a fall				
1	risk score of 95 (high					
:		M, RN C documented a fall				
	risk score of 95 (high					
	vi. On 2/10/22 at 12:1	o AM, PM RN C cscore of 95 (high risk of		,		
<u> </u>	falling)	(score or 95 (night risk or				
	- ,) AM, RN C documented a				
	fall risk score of 95 (h	-				
		5 PM, RN A documented a	1.		i	
	fall risk score of 95 (h		1			
		AM, RN A documented a				
	fall risk score of 95 (h		ar quine			
	•	PM, RŇ C documented a	:	,		
T T	fall risk score of 95 (hi	igh risk of falling)				
	xi. On 2/12/22 at 12:0	9 AM, RN C documented a				
	fall risk score of 95 (h					
		' AM, RN C documented a		1		
	fall risk score of 95 (hi					
		1 PM, RN D documented a				
1	fall risk score of 95 (hi	,	ž.	77		
		6 PM, RN C documented a			•	7
	fall risk score of 95 (hi					
بد		20 PM, RN C documented a	ł			#
1	fall risk score of 95 (hi	gn risk of failing) 4 PM, RN C documented a				.1
	xvi. Oii 2/ 13/22 at b:2	+ FW, KN C documented a				

NAME OF PROVIDER			1 '	-	<u>, u s</u>		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER			1				С	
NAME OF PROVIDER		161310	B. WING	·····		03/	17/2022	
	OR SUPPLIER		f	S	TREET ADDRESS, CITY, STATE, ZIP CODE	* ·		
ADAIR COUNTY!	MEMODIAL HOSE	DITA!		60	09 SE KENT			
ADAIR COUNTY	BEMORIAL ROSI	TIAL		G	REENFIELD, IA 50849			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES, Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
fall ris xvii. C a fall i	on 2/13/22 at 12 risk score of 95	igh risk of falling) :54 PM, RN D documented (high risk of falling)	C1	050				
fall ris xiv. O fall ris xv. O fall ris xvi. O fall ris xvi. O fall ris	ik score of 95 (h in 2/13/22 at 10: ik score of 95 (h n 2/14/22 at 5:5 ik score of 95 (h n 2/14/22 at 8:5 ik score of 95 (h	10 PM, RN A documented a igh risk of falling) 04 PM, RN A documented a igh risk of falling) 6 AM, RN A documented a igh risk of falling) 7 AM, RN D documented a igh risk of falling)						
fall ris xviii. 0 fall ris xix. O	k score of 95 (h Dn 2/15/22 at 5: k score of 95 (h n 2/15/22 at 8:2	i3 PM, RN C documented a igh risk of falling) 14 AM, RN C documented a igh risk of falling) 1 AM, RN D documented a		14.1.1.27				
xx. Or fall ris xxi. O fall ris xxii. C	n 2/15/22 at 11: k score of 85 (h n 2/15/22 at 2:5 k score of 95 (h n 2/15/22 at 9:4	igh risk of falling) 15 AM, RN E documented a igh risk of falling). 4 PM, RN D documented a igh risk of falling) 10 PM, RN F documented a		· main.				
xxiii. 0 fall ris xxiv. 0 fall ris xxv. 0	On 2/16/22 at 6: k score of 80 (h On 2/16/22 at 5: k score of 80 (h In 2/16/22 at 7:2	igh risk of falling) 15 AM, RN F documented a igh risk of falling) 59 PM, RN B documented a igh risk of falling) 00 PM, RN A documented a						
xxvi. () a fall r xxvii. () fall ris. xxviii. a fall r xxiv. () a fall r	On 2/16/22 at 11 isk score of 80 ion 2/17/22 at 6 ik score of 80 ion 2/17/22 at 8 isk score of 80 ion 2/17/22 at 12 ion 2/17/22	igh risk of falling) :29 PM, RN A documented (high risk of falling) :18 AM, RN A documented a igh risk of falling) :00 AM, RN G documented (high risk of falling) ::00 PM, RN G documented (high risk of falling)		THE PARTY OF THE P		٠		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

1	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING			(X3) DATE SURVEY COMPLETED			
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		161310	B, WING		<u> </u>	03/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
Tenana Or 1	104100110110111			509 SE KENT			
ADAIR CO	DUNTY MEMORIAL HOS	PITAL	1	GREENFIELD, IA 50849			1
(VA) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF COR	RECTION	(%5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET	
0.4050	<u> </u>	_	0,1050	· companie · .		Table 1	
C1050			C1050			y .	
		:21 PM, RN C documented a				1	
Ī	fall risk score of 75 (h	nigh risk of failing)		7		1	
	b. Patient #1's fall ris	k interventions:				1	
	b. r duone ii r o raii rio		Î	•		1	
	i. On 2/11/22 at 5:30	AM, RN A's documented fall					
	risk interventions inc	luded orienting patient to	ļ,	STATEMENT			
	environment, call ligh		:				
ī		promptly; routinely assisting		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Ì	patient with tolieting;						
	bathroom is clearly li	t and free of obstructions.		og and a second a second and a second a second and a second a second and a second a second a second a second and a second a second a second a second a second a second a secon		1	
	ii On 2/12/22 at 5:32	AM, RN C's documented				4	
		included orienting patient to					
	environment, call ligh		;	annuage and the second			
		promptly; routinely assisting		-			
	patient with tolieting;						
	bathroom is clearly li	t and free of obstructions.	Age and a second				
	iii. On 2/13/22 at 6:28	8 AM, RN C's documented				1	
		included orienting patient to					1
	environment, call ligh	- ,				,	7.0
		promptly; routinely assisting		Y		1	į
	patient with tolieting;		1			Į.	1.
	bathroom is clearly li	t and free of obstructions.	***************************************				. 1
	iv On 2/13/22 at 0:44	6 PM, RN A's documented					
		included orienting patient to		•			•
	environment, call ligh					+	
		promptly; routinely assisting					3
	patient with tolieting;			.			
	bathroom is clearly li	t and free of obstructions.				ļ	•
	On 2/45/00 at 6:44	I AM DN C'e documented				ľ	
		I AM, RN C's documented included orienting patient to					
	environment, call ligh		-				•
		romptly; routinely assisting				* •	ı
	patient with tolieting;						
		t and free of obstructions.	4	1			:

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING		(X3) DATE SURVEY COMPLETED	
		161310	B. WING		C	
NAME OF B	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	03/17/2022	
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ADAIR CO	DUNTY MEMORIAL HOS	PITAL	1	SE KENT		
	·		GR	EENFIELD, IA 50849	as .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		TION
		dom and the second		DEFICIENCY)		
	-					
C1050	Continued From page	98	C1050			
ł	Patient #1's medical ı	record lacked any				
	documentation of app					
		f 15 days that Patient #1 was				
		/5/22, 2/6/22, 2/7/22, 2/8/22,				
		22, 2/16/22, 2/17/22, and	1			
	2/18/22).	and the second of the second	l,			
			lı.			
			<u>'</u>			
	3. On 2/17/22 Patient	#2 was admitted to the				
	1	breath, chest pain and			,	
		re. On 2/21/22 Patient #2				
	was discharged from		;			
	J-2					
1	a. Patient #2's fall risk	scores:	P 2		1	
			1,		}	
	i. On 2/18/22 at 9:00 I	PM, RN F documented a fall				
	risk score of 85 (high	risk of falling)			ļ	
]	ii. On 2/19/22 at 9:25	PM, RN F documented a	4			
	fall risk score of 85 (hi	igh risk of falling)				
	iii. On 2/20/22 at 12:2	5 PM, RN F documented a				
.]	fall risk score of 85 (hi		,			
•		AM, RN G documented a			•	
	fall risk score of 85 (hi		1		1	
		PM, RN F documented a				
	fall risk score of 85 (hi	gh risk of falling)	1		1	
	h Dalland HOL	ton and to store to	.		•	
Į.	b. Patient #2's medica		,			
•	documentation of app	ropriate fall risk			1	
	interventions.		1			
I						
	4 During on intention	on 3/16/22 at 3:36 PM, the			1	
		on 3/16/22 at 3:36 PM, the le medical records did not			ļ	
		•	 			
		cumentation of fall risk			.	
	staff did not follow the	nowledged that the CAH				
	document, and implen					
	address a patient's fal				1	
1	audiess a patients fai	HISK.	1 1)	1

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONST	C	(X3) DATE SURVEY COMPLETED	
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER.	A.BUILDI	NG		, COIN	
		161310	B. WING_			03	C 3/17/2022
NAME OF P	ROVIDER OR SUPPLIER		* 1	STREET	ADDRESS, CITY, STATE, ZIP CODE		, , ,
				609 SE K	KENT		
ADAIR CO	DUNTY MEMORIAL HOSE	PITAL	٠	GREEN	FIELD, IA 50849		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID ID	P	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	ı.	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	COMPLETION DATE
			Sin		E Section Sect	*	ì
C1050	Continued From page	9	, C10)50			
			 				
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į							
	f						•
		record review, document					
		views, the Critical Access histrative staff failed to follow	ŀ	.]			
		aff initiated a nursing care					
	plan for 3 of 5 patient						
		nt #5). Failure to initiate a		ž ,			
		y result in patients receiving		ľ			
	nursing care that was not individualized for each		1				
		sult in substandard nursing	1	1			
		itients at risk for harm. The					
		erage daily census of 1.3					
,	patients.						
	Findings include:			I.			
•	4. Daview of the police	u "Caro Blanc" rovined		3			
		y, "Care Plans", revised art, The purpose of the					2
	nursing care plan is "			ļ			1
ì		cluding skilled, observation,					a E
	acute, hospice, and re			3			
	comprehensive care p	olan that includes		1			1
	measurable objective	s and time lines to meet the	-				
į	medical, nursing,			1			4
		cial needs of each patient	4	1			: P 11
1		ns are to be instituted within					"
	24 hours of admission	to the facility."					
	2. Review of medical i	ecords revealed the]
	following:	Cooling to realist title					ļ.
•							
	a. On 2/17/22 Patient	#2 was admitted to the					1
		breath, chest pain and					ļ .
j	congestive heart failu						<u>[</u>
Į.		was discharged from the					
İ	CAH. Patient #2's me	diçal record lacked any		Ί			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A_BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	,	161310	B. WING		C 03/17/2022
	ROVIDER OR SUPPLIER		- 60	REET ADDRESS, CITY, STATE, ZIP CODE 19 SE KENT REENFIELD, IA 50849	03/1/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
C1050	evidence of a nursing b. On 2/20/22 Patient CAH for chest pain, of pulmonary disease, a On 2/28/22 Patient #4 CAH. Patient #4's me evidence of a nursing c. On 2/17/22 Patient pneumonia (lung infe- life-threatening condit body's response to ar tissues), and hypoxia On 3/2/22 Patient #5 CAH. Patient #5's me evidence of a nursing 3 .During an interview CEO acknowledged r documentation that a	#4 was admitted to the thronic obstructive and chronic kidney disease. Was discharged from the edical record lacked any care plan. #5 was admitted for ction), sepsis (potentially the thronic damages its own (low oxygen in the blood). Was discharged from the dical record lacked any	C1050		
	review, and staff inter Hospital (CAH) admin ensure the nursing sta updated for 2 of 5 pati and Patient #3). Failur plan of care was routin patients receiving nurs individualized for each in substandard nursing	m. The CAH identified an	And matrices and contains the second state of		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLANO	CONNECTION	BERTH TOATTON NOMBER.	A, BUILD	ING.		1	
		161310	B, WING			1	·C
NAME OF B	DOMBED OD CHODINED	101310			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/17/2022
NAMEOFF	ROVIDER OR SUPPLIER			ı	• • • •		
ADAIR CO	DUNTY MEMORIAL HOSE	PITAL		609 SE KENT			
				<u></u> '	GREENFIELD, IA 50849		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(XS) COMPLETION DATE
	***************************************				Advance will.		
C1050	Continued From page	۽ 11	C1	050	under a constitution of the constitution of th	-	
	Findings include:					*	
	_					ì	
		cy, "Care Plans", revised					
		art, The purpose of the					
	nursing care plan is "					F.	
1		cluding skilled, observation,				:	
	acute, hospice, and re comprehensive care					1	ľ
		es and time lines to meet the				:	
	medical, nursing,	S dire line into to most the					
		ocial needs of each patient				,	
		ans are to be instituted within			e e	***	1
	24 hours of admission	n to the facility The			•		
		ept current by ongoing	,				
		atient/resident's needs and				đ	
		t's response to interventions,	ľ		1	;	
		ing the patient's nursing care			River and the second se		
	plan in	ents at least daily. Upon	ľ			:	
		plan will be resolved or			ar'. •		
	discontinued."	, a				3	
!							
1						•/	
;	2. Review of medical	records revealed the		1			
·	following:					į	
	,			:		J	
		#3 was admitted to the	ŀ			IJ	
1		ood infection), acute kidney	Ė		î		-
		e heart failure. On 2/24/22, #3's care plan. Patient #2's	ľ				#
1		any further documentation					
]		the care plan, or Patient					
		goals. On 2/28/22 Patient				Ц	
ĺ		ack to a long term care					
	facility.	_				***************************************	
	•			į			
		#1 was admitted to the CAH	-	1			
		mmation of bone usually					
,	due to an infection) of	their right toe and	:				1

161310 B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER ADAIR COUNTY MEMORIAL HOSPITAL (X4) ID PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) C1050 Continued From page 12 underwent a right toe amputation. On 2/5/22, RN A initiated Patient #1's care plan. On 2/11/22 (6 days after care plan initiated), RN A documented Patient #1's progress toward goals. On 2/16/22 (3 days after care plan last reviewed), RN B documented Patient #1's progress toward goals. On 2/18/22 Patient #1 progress toward goals. On 2/18/22 Patient #1 progress toward goals. On 2/18/22 Patient #1 was discharged to a skilled nursing facility. 3. During an interview on 3/16/22 at 3:36 PM, CEO acknowledged medical records lacked any documentation of ongoing review and update of the nursing care plan for Patient #1 and Patient				A, DOLLONG		***************************************	С		
ADAIR COUNTY MEMORIAL HOSPITAL (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (CACH DEFICIENCY) COntinued From page 12 underwent a right toe amputation. On 2/5/22, RN A initiated Patient #1's care plan. On 2/11/22 (6 days after care plan initiated), RN A documented Patient #1's progress toward goals on the care plan. On 2/13/22 (2 days after care plan last reviewed), RN A documented Patient #1's progress toward goals. On 2/16/22 (3 days after care plan last reviewed) RN B documented Patient #1's progress toward goals. On 2/18/22 Patient #1 was discharged to a skilled nursing facility. 3. During an interview on 3/16/22 at 3:36 PM, CEO acknowledged medical records lacked any documentation of ongoing review and update of the nursing care plan for Patient #1 and Patient			161310	310 B. WING			1		
Cx4) D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG CACH CORRECTIVE ACTION SHOULD BE COMPLETION FROM TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C1050 C1050	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS,	CITY, STATE, ZIP CODE	 		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C1050 Continued From page 12 underwent a right toe amputation. On 2/5/22, RN A initiated Patient #1's care plan initiated), RN A documented Patient #1's progress toward goals. On 2/11/22 (6 days after care plan initiated), RN A documented Patient #1's progress toward goals. On 2/16/22 (3 days after care plan last reviewed), RN A documented Patient #1's progress toward goals. On 2/18/22 Patient #1 was discharged to a skilled nursing facility. 3. During an interview on 3/16/22 at 3:36 PM, CEO acknowledged medical records lacked any documentation of ongoing review and update of the nursing care plan for Patient #1 and Patient	ADAIR COUNTY MEMORIAL HOSPITAL								
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) C1050 Continued From page 12					GREENFIELD, IA 50849				
underwent a right toe amputation. On 2/5/22, RN A initiated Patient #1's care plan. On 2/11/22 (6 days after care plan initiated), RN A documented Patient #1's progress toward goals on the care plan. On 2/13/22 (2 days after care plan last reviewed), RN A documented Patient #1's progress toward goals. On 2/16/22 (3 days after care plan last reviewed) RN B documented Patient #1 progress toward goals. On 2/18/22 Patient #1 progress toward goals. On 2/18/22 Patient #1 was discharged to a skilled nursing facility. 3. During an interview on 3/16/22 at 3:36 PM, CEO acknowledged medical records lacked any documentation of ongoing review and update of the nursing care plan for Patient #1 and Patient	PREFIX	(EACH DEFICIENC	MUST BE PRECEDED BY FULL	PREF	X (EACH	I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA	E	COMPLETION	
	C1050	underwent a right toe A initiated Patient #1's days after care plan ir Patient #1's progress plan. On 2/13/22 (2 di reviewed), RN A docu progress toward goals care plan last reviewed Patient #1 progress to Patient #1 was dischafacility. 3. During an interview CEO acknowledged in documentation of ong the nursing care plan	amputation. On 2/5/22, RN s care plan. On 2/11/22 (6 nitiated), RN A documented toward goals on the care ays after care plan last umented Patient #1's s. On 2/16/22 (3 days after ed) RN B documented oward goals. On 2/18/22 urged to a skilled nursing	C1	050				