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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	161310	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAIR COUNTY MEMORIAL HOSPITAL	609 SE KENT GREENFIELD, IA 50849

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C 000	INITIAL COMMENTS The State Survey Agency (SA), at the direction of the Centers for Medicare and Medicaid (CMS) Kansas City Regional Office (KCRO) staff, performed an on-site investigation of complaint #102918-C from 3/14/22 through 3/17/22. The survey team investigated the Condition of Participation for Provision of Services (42 CFR 485.635). The survey team identified the following standard level deficiency.	C 000	POC Accepted 4/6/22 cmd Date of Correction 4/18/22	
C1050	NURSING SERVICES CFR(s): 485.635(d)(4) A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: I. Based on medical record review, document review, and staff interviews, the Critical Access Hospital (CAH) administrative staff failed ensure 1 of 6 patients reviewed (Patient #5) had a current fall risk assessment and implementation of all appropriate fall risk interventions based on that assessment. Failure to ensure a current fall risk assessment and implementation of all appropriate fall risk interventions resulted in Patient #5 falling twice and sustaining a minor injury. The CAH identified an average daily census of 1.3 patients. Findings include: 1. Review of the policy, "Fall Prevention", last revised 5/2021, revealed in part: "It is the policy ... to identify all patients at risk of physical harm due to falls ... Each patient is assessed at least daily with the electronic Morse Risk Assessment tool. A patient who scores 0 - 24 is considered at no risk (unless staff or family feel otherwise), 25 - 50 is	C1050	Nursing Care Plan policy has been updated as of 3/30/22 and is going through approval process in Policy Stat. (available for review upon request) Initiated immediately: Huddle board – care plans must be completed on all patients and updated with patient condition changes. Reviewed at 0800 and 2000 daily. Audit tool being developed for chart audits to ensure: a) care plans are initiated and updated. b) documentation complete for fall risk and appropriate interventions according to updated policy. c) Education on revised policies: Fall risk, Care plans and hourly rounding (new) will take place week of April 11, 2022. d) CCO will begin doing daily chart audits on all patients effective April 18, 2022. This will allow feedback to staff within 48 to 72 hours. These audits will continue on 100% of patient records until evidence shows that staff are	

compliant with policies. At that time random sampling will take place to ensure ongoing compliance.

Fall Risk Assessment, Prevention and Intervention Policy updated 3/29/2022 and is going through approval process through policy stat. (Available for review upon request)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[redacted]	CNO	4/4/22

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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C1050	Continued From page 1 low risk, and 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 daily. 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 of bed. 3. Place a Yellow Clasp on the patient's ID bracelet to show all staff the patient is a High Fall Risk. 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." 2. Review of Patient #5's medical record revealed the following: a. On 2/17/22 Patient #5 was admitted for pneumonia (lung infection), sepsis (potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues), and hypoxia (low oxygen in the blood). b. On 2/21/22 Patient #5 had a fall. Patient #5's medical record lacked documentation the CAH staff had assessed Patient #5's fall risk, thus preventing the CAH staff from identifying Patient #5 as at a high risk for falling and implementing appropriate fall precautions.	C1050		

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C1050	Continued From page 2 Medical record lacked any information related to a fall risk assessment so CAH was unaware that Patient #5 was at high risk for falls. c. On 2/23/22 Patient #5 fell a second time, and sustained a skin tear on their left wrist. Medical record still lacked any information related to a fall risk assessment so CAH was unaware that Patient #5 was at high risk for falls. 3. During an interview on 3/17/22 at 12:40 PM, the CEO confirmed that the medical record did not contain any documentation of fall risk assessment or interventions prior to Patient #5 sustaining two falls, including one with injury, and acknowledged that the CAH did not follow their policy. II. Based on medical record review, document review, and staff interviews, the Critical Access Hospital (CAH) administrative staff failed to ensure the nursing staff documented and implemented all appropriate fall risk interventions for 2 of 6 patients reviewed (Patient #1 and Patient #2) whch scored "high" for a fall risk. Failure to ensure documentation and implementation may result in patients falling which may result in serious injury or death. The CAH identified an average daily census of 1.3 patients. Findings include: 1. Review of the policy, "Fall Prevention", last revised 5/2021, revealed in part: "It is the policy...to identify all patients at risk of physical harm due to falls...Each patient is assessed at	C1050		

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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 daily. 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 of bed. 3. Place a Yellow Clasp on the patient's ID bracelet to show all staff the patient is a High Fall Risk. 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,	C1050		

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C1050	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 available 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. m. Keep the bed in low position if patient is left unattended. 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 pills, analgesics" 2. On 2/4/22 Patient #1 was admitted to the CAH for osteomyelitis (inflammation of bone usually	C1050		

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C1050	Continued From page 5 due to an infection)of right toe and underwent a right toe amputation. On 2/18/22, Patient #1 was discharged from the CAH. Medical record revealed: a. Patient #1's fall risk scores -- i.On 2/5/22 at 7:59 PM RN, A documented Patient #1's as 95 (high risk of falling). ii. On 2/6/22 at 12:15 AM, RN A documented a fall risk score of 95 (high risk of falling) iii. On 2/7/22 at 1:40 AM, RN A documented a fall risk score of 95 (high risk of falling) iv. On 2/7/22 at 6:35 AM, RN A documented a fall risk score of 95 (high risk of falling) v. On 2/9/22 at 9:00 PM, RN C documented a fall risk score of 95 (high risk of falling) vi. On 2/10/22 at 12:16 AM, PM RN C documented a fall risk score of 95 (high risk of falling) vii. On 2/10/22 at 5:50 AM, RN C documented a fall risk score of 95 (high risk of falling) viii. On 2/10/22 at 7:25 PM, RN A documented a fall risk score of 95 (high risk of falling) ix. On 2/11/22 at 5:19 AM, RN A documented a fall risk score of 95 (high risk of falling) x. On 2/11/22 at 7:23 PM, RN C documented a fall risk score of 95 (high risk of falling) xi. On 2/12/22 at 12:09 AM, RN C documented a fall risk score of 95 (high risk of falling) xii. On 2/12/22 at 5:17 AM, RN C documented a fall risk score of 95 (high risk of falling) xiii. On 2/12/22 at 1:31 PM, RN D documented a fall risk score of 95 (high risk of falling) xvi. On 2/12/22 at 8:06 PM, RN C documented a fall risk score of 95 (high risk of falling) xv. On 2/12/22 at 11:20 PM, RN C documented a fall risk score of 95 (high risk of falling) xvi. On 2/13/22 at 6:24 PM, RN C documented a	C1050		

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C1050	Continued From page 6 fall risk score of 95 (high risk of falling) xvii. On 2/13/22 at 12:54 PM, RN D documented a fall risk score of 95 (high risk of falling) xviii. On 2/13/22 at 8:10 PM, RN A documented a fall risk score of 95 (high risk of falling) xiv. On 2/13/22 at 10:04 PM, RN A documented a fall risk score of 95 (high risk of falling) xv. On 2/14/22 at 5:56 AM, RN A documented a fall risk score of 95 (high risk of falling) xvi. On 2/14/22 at 8:57 AM, RN D documented a fall risk score of 95 (high risk of falling) xvii. On 2/14/22 at 8:43 PM, RN C documented a fall risk score of 95 (high risk of falling) xviii. On 2/15/22 at 5:14 AM, RN C documented a fall risk score of 95 (high risk of falling) xix. On 2/15/22 at 8:21 AM, RN D documented a fall risk score of 95 (high risk of falling) xx. On 2/15/22 at 11:15 AM, RN E documented a fall risk score of 85 (high risk of falling). xxi. On 2/15/22 at 2:54 PM, RN D documented a fall risk score of 95 (high risk of falling) xxii. On 2/15/22 at 9:40 PM, RN F documented a fall risk score of 80 (high risk of falling) xxiii. On 2/16/22 at 6:15 AM, RN F documented a fall risk score of 80 (high risk of falling) xxiv. On 2/16/22 at 5:59 PM, RN B documented a fall risk score of 80 (high risk of falling) xxv. On 2/16/22 at 7:20 PM, RN A documented a fall risk score of 80 (high risk of falling) xxvi. On 2/16/22 at 11:29 PM, RN A documented a fall risk score of 80 (high risk of falling) xxvii. On 2/17/22 at 6:18 AM, RN A documented a fall risk score of 80 (high risk of falling) xxviii. On 2/17/22 at 8:00 AM, RN G documented a fall risk score of 80 (high risk of falling) xxiv. On 2/17/22 at 12:00 PM, RN G documented a fall risk score of 80 (high risk of falling) xxx. On 2/17/22 at 2:00 PM, RN G documented a fall risk score of 80 (high risk of falling)	C1050		

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C1050	Continued From page 7 xxxi. On 2/17/22 at 8:21 PM, RN C documented a fall risk score of 75 (high risk of falling) b. Patient #1's fall risk interventions: i. On 2/11/22 at 5:30 AM, RN A's documented fall risk interventions included orienting patient to environment, call light within reach, and answering call light promptly; routinely assisting patient with tolieting; ensuring path to the bathroom is clearly lit and free of obstructions. ii. On 2/12/22 at 5:32 AM, RN C's documented fall risk interventions included orienting patient to environment, call light within reach, and answering call light promptly; routinely assisting patient with tolieting; ensuring path to the bathroom is clearly lit and free of obstructions. iii. On 2/13/22 at 6:28 AM, RN C's documented fall risk interventions included orienting patient to environment, call light within reach, and answering call light promptly; routinely assisting patient with tolieting; ensuring path to the bathroom is clearly lit and free of obstructions. iv. On 2/13/22 at 9:46 PM, RN A's documented fall risk interventions included orienting patient to environment, call light within reach, and answering call light promptly; routinely assisting patient with tolieting; ensuring path to the bathroom is clearly lit and free of obstructions. v. On 2/15/22 at 6:44 AM, RN C's documented fall risk interventions included orienting patient to environment, call light within reach, and answering call light promptly; routinely assisting patient with tolieting; ensuring path to the bathroom is clearly lit and free of obstructions.	C1050		

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C1050	Continued From page 8 Patient #1's medical record lacked any documentation of appropriate fall risk interventions on 11 of 15 days that Patient #1 was at the CAH (2/4/22, 2/5/22, 2/6/22, 2/7/22, 2/8/22, 2/9/22, 2/10/22, 2/14/22, 2/16/22, 2/17/22, and 2/18/22). 3. On 2/17/22 Patient #2 was admitted to the CAH for shortness of breath, chest pain and congestive heart failure. On 2/21/22 Patient #2 was discharged from the CAH. a. Patient #2's fall risk scores: i. On 2/18/22 at 9:00 PM, RN F documented a fall risk score of 85 (high risk of falling) ii. On 2/19/22 at 9:25 PM, RN F documented a fall risk score of 85 (high risk of falling) iii. On 2/20/22 at 12:25 PM, RN F documented a fall risk score of 85 (high risk of falling) iv. On 2/20/22 at 8:00 AM, RN G documented a fall risk score of 85 (high risk of falling) v. On 2/20/22 at 10:45 PM, RN F documented a fall risk score of 85 (high risk of falling) b. Patient #2's medical record lacked any documentation of appropriate fall risk interventions. 4. During an interview on 3/16/22 at 3:36 PM, the CEO confirmed that the medical records did not contain any further documentation of fall risk interventions and acknowledged that the CAH staff did not follow their policy to assess, document, and implement interventions to address a patient's fall risk.	C1050		

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C1050	Continued From page 9	C1050		

III. Based on medical record review, document review, and staff interviews, the Critical Access Hospital (CAH) administrative staff failed to follow ensure the nursing staff initiated a nursing care plan for 3 of 5 patients reviewed (Patient #2, Patient #4, and Patient #5). Failure to initiate a nursing care plan may result in patients receiving nursing care that was not individualized for each patient, which may result in substandard nursing care that could put patients at risk for harm. The CAH identified an average daily census of 1.3 patients.

Findings include:

1. Review of the policy, "Care Plans", revised 8/2019, revealed in part, The purpose of the nursing care plan is "To ensure all patients/residents (including skilled, observation, acute, hospice, and respite) have a comprehensive care plan that includes measurable objectives and time lines to meet the medical, nursing,
mental, and psychosocial needs of each patient ... All nursing care plans are to be instituted within 24 hours of admission to the facility."

2. Review of medical records revealed the following:

a. On 2/17/22 Patient #2 was admitted to the CAH for shortness of breath, chest pain and congestive heart failure.
On 2/21/22 Patient #2 was discharged from the CAH. Patient #2's medical record lacked any

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C1050	Continued From page 10 evidence of a nursing care plan. b. On 2/20/22 Patient #4 was admitted to the CAH for chest pain, chronic obstructive pulmonary disease, and chronic kidney disease. On 2/28/22 Patient #4 was discharged from the CAH. Patient #4's medical record lacked any evidence of a nursing care plan. c. On 2/17/22 Patient #5 was admitted for pneumonia (lung infection), sepsis (potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues), and hypoxia (low oxygen in the blood). On 3/2/22 Patient #5 was discharged from the CAH. Patient #5's medical record lacked any evidence of a nursing care plan. 3 .During an interview on 3/16/22 at 3:36 PM, the CEO acknowledged medical records lacked any documentation that a nursing care plan was initiated for Patient #2, Patient #4, and Patient #5. IV. Based on medical record review, document review, and staff interviews, the Critical Access Hospital (CAH) administrative staff failed to ensure the nursing staff updated the care plan for updated for 2 of 5 patients reviewed (Patient #1 and Patient #3). Failure to ensure the nursing plan of care was routinely updated may result in patients receiving nursing care that was not individualized for each patient, which may result in substandard nursing care that could put patients at risk for harm. The CAH identified an average daily census of 1.3 patients.	C1050		

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C1050	Continued From page 11 Findings include: 1. Review of the policy, "Care Plans", revised 8/2019, revealed in part, The purpose of the nursing care plan is "To ensure all patients/residents (including skilled, observation, acute, hospice, and respite) have a comprehensive care plan that includes measurable objectives and time lines to meet the medical, nursing, mental, and psychosocial needs of each patient ... All nursing care plans are to be instituted within 24 hours of admission to the facility ... The nursing care plan is kept current by ongoing assessments of the patient/resident's needs and of the patient/resident's response to interventions, and updating or revising the patient's nursing care plan in response to assessments at least daily. Upon discharge each care plan will be resolved or discontinued." 2. Review of medical records revealed the following: a. On 2/21/22 Patient #3 was admitted to the CAH for urosepsis (blood infection), acute kidney injury, and congestive heart failure. On 2/24/22, RN C initiated Patient #3's care plan. Patient #2's medical record lacked any further documentation of review or update of the care plan, or Patient #3's progress toward goals. On 2/28/22 Patient #1 was discharged back to a long term care facility. b. On 2/4/22, Patient #1 was admitted to the CAH for osteomyelitis (inflammation of bone usually due to an infection) of their right toe and	C1050		

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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 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 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 #3.	C1050		