STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165318	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor of Amana	3207 220th Trail Amana, IA 52203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, policy review, and staff interview, the facility failed to further assess and intervene after a change in mental status after a fall for 1 of 4 residents reviewed for assessment and intervention (Resident #2). The facility reported a census of 42 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment tool, dated [DATE], listed diagnoses for Resident #2 which included high blood pressure, stroke, respiratory failure, insomnia, and cognitive communication deficit. The MDS stated the resident was independent with walking and listed the resident's Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition. A [DATE] Care Plan entry stated the resident was independent with walking in his room. A [DATE] Family Practice clinic note stated the resident had no cognitive impairment and no disorientation to person, place, or time. A [DATE] at 12:30 a.m. untitled nursing note stated staff found the resident on the floor. The resident stated he was trying to get up and sustained a hematoma (bruise) to the right eyebrow and skin tears to the right eyebrow, right elbow, and right hand and an abrasion to the right knee. Nurse charting revealed the facility conducted neurological assessments at the following times with normal results: [DATE] 1:30 a.m. [DATE] 2:30 a.m. [DATE] 3:30 a.m. [DATE] 9:09 a.m. [DATE] 11:28 a.m. [DATE] 11:13 p.m. [DATE] 3:26 a.m. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A [DATE] 9:27 a.m. untitled nursing note stated the resident was alert and oriented x 2 and stated the town was Channel 9. A [DATE] 3:14 p.m. untitled nursing note stated the resident was alert and oriented to self and month. A [DATE] 7:30 p.m. untitled nursing note stated staff went into the room to administer medications and the resident responded but did not open his eyes. A [DATE] 8:10 p.m. untitled nursing note stated the resident sat in the recliner and frothed at the mouth with apneic spells (periods of not breathing). The resident had blue hands and was sluggish with fixed pupils. Staff was unable to obtain a blood pressure and obtained an order to send the resident to the hospital. The resident had a pulse when the ambulance arrived but when they listened to the apical pulse(a pulse point on the chest at the bottom tip of the heart), it was absent and the resident had no respirations. The paramedics initiated Cardiopulmonary Resuscitation(CPR). The resident's pulse and blood pressure were restored at the hospital. A [DATE] 11:22 p.m. untitled nursing note stated the facility was notified at 10:52 p.m., that the resident passed away. The facility lacked documentation of provider notification or further assessment and intervention after the resident had a mental status change during the [DATE] 9:27 a.m. and [DATE] 3:14 p.m. assessments. The undated facility policy Charting Protocol directed staff to notify the physician when a behavior change occurred. On [DATE] at 1:05 p.m., the Director of Nursing (DON) was queried with regard to her expectations if a resident had a change from alert and oriented x 4 (person, place, time, and situation) to not being able to state the town. She stated that if there was a change, she would expect staff to notify the physician. On [DATE] at 10:11 a.m., via phone, Staff C Doctor of Medicine (MD) stated he would have wanted staff to inform him and the resident's family of the resident's mental status changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to ensure staff utilized a gait belt in accordance with the care plan for 1 of 3 residents reviewed for transfers(Resident #1). The facility reported a census of 42 residents. Findings include: 1. The Annual Minimum Data Set(MDS) assessment tool, dated 4/4/24, listed diagnoses for Resident #1 which included heart failure, arthritis, and Alzheimer's disease. The MDS stated the resident required supervision or touching assistance with toileting hygiene and toileting transfers. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 13 out of 14, which indicated intact cognition. The facility Gait Belt Policy, reviewed 1/5/24, directed staff to utilize a gait belt with all residents who required any physical assistance to stand, transfer, or ambulate, unless contraindicated as identified on the care plan. Each staff member will have a gait belt readily available for use when on duty. A gait belt will be provided to staff upon hire. A 2/20/24 at 1:21 a.m. Progress Note documented the resident was on her back on the floor and fell trying to reach her tissues. A 3/2/24 11:23 p.m. Progress Note stated the resident was on the floor and tried to pick up tissue paper from the floor and lost her balance. A 3/11/24 Progress Note stated the resident sat on the floor next to her bed and stated she reached for a mint when she slid out of bed. A 4/6/24 untitled nursing progress note stated the resident was seated on the toilet and staff attempted to assist her to a standing position when the resident sat back down after only raising up approximately an inch. The resident stated she would need more help than that and staff used more effort in the next assist. The resident was unable to straighten her knees and moved in a forward motion. The staff member was able to slow the resident's motion but was unable to prevent the resident from kneeling on the floor in front of the toilet. On 4/16/24 at 2:23 p.m., staff walked the resident from her room to the shower room utilizing a gait belt. On 4/16/23 at 3:00 p.m., Resident #1 stated on the night of the fall, she had to go to the bathroom and a staff member kept pulling on her arm to get her off the toilet. She stated she ended up falling on the floor in her own urine. She didn't know the staff member's name but stated she was never rough or unkind but she was in a hurry. She stated she did not feel the staff member was intentionally being mean but stated she was supposed to utilize a gait belt and did not. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current undated Care Plan as of 4/17/24 stated the resident required the assistance of 1 staff with ambulation and transfers. On 4/17/24 at 10:47 a.m., via phone, Staff A Certified Nursing Assistant (CNA) stated Resident #1 required the assistance of 1 staff and could be a difficult transfer. On 4/18/24 at 10:54 a.m., via phone, Staff B Registered Nurse (RN) stated on the night of the fall, the resident was in bed and needed to go to the bathroom. She reported the resident started walking to the bathroom with her walker. Staff B assisted the resident to pull down her pants and sit on the toilet. She stated when she was finished she (Staff B) took the resident under her arm in order to attempt to help her stand up and the resident could not. Staff B stated the resident then looked at her and stated she needed more help than that. Staff B stated (on the second attempt) the resident's knees did not unbend and instead of standing, the resident went forward almost head first and she could not prevent her from going to the floor. Staff B reported she assessed her for possible injuries and then other staff members assisted her off the floor. Staff B stated that the resident required the assistance of 1 staff with a walker and stated she would normally use a gait belt with her. She stated she did not use a gait belt with the resident on the night of the fall because she did not have one with her. On 4/18/24 at 1:05 p.m., the Director of Nursing (DON) stated if a resident required the assistance of staff for transfers, staff should utilize a gait belt. She stated if staff did not have a gait belt, they should locate one to use in the transfer.