

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Kingsley Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 305 West Third Box 10 Kingsley, IA 51028	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420</p> <p>Based on clinical record review, policy review and staff interview the facility failed to revise and update care plans to include appropriate interventions for residents to prevent repeated fall and injuries for 3 out of 3 residents reviewed (Resident #1, #2 and #3). The facility reported a census of 34 residents.</p> <p>Findings included:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 documented diagnoses of neurological disorder, dysphagia, and stroke. The MDS showed Resident #2 ' s cognitive skills for daily decision making as moderately impaired.</p> <p>Review of the facility Incident Reports from a look back period starting on admission 11/8/24 through 12/31/24 showed Resident #2 fell four times.</p> <p>The Incidents Reports for Resident #2 showed the following falls:</p> <ul style="list-style-type: none"> a. On 11/8/24 at 11:00 PM- resident found with his back on the floor. b. On 11/9/24 at 4:53 PM- resident found sitting on the floor. c. On 11/25/24 at 10:47 PM- resident found on the floor sitting on both knees. d. On 12/7/24 at 9:47 AM- resident found with his stomach on the floor. <p>The Care Plan for Resident #2 showed no focus area or fall interventions for November or December 2024.</p> <p>2. The MDS assessment dated [DATE] for Resident #3 documented diagnoses of coronary artery disease, diabetes, and arthritis. The MDS showed the Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment.</p> <p>Review of the facility Incident Reports from a look back period starting on 10/1/24 through 12/31/24 showed Resident #3 fell six times.</p> <p>(continued on next page)</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Incidents Reports for Resident #3 showed the following falls:</p> <ul style="list-style-type: none"> a. On 10/2/24 at 5:30 AM- resident found sitting on the floor. b. On 10/6/24 at 10:30 PM- resident found sitting on a box in her closet. c. On 10/19/24 at 10:00 PM- resident found laying on the floor. d. On 10/24/24 at 2:00 PM- resident found laying on the floor. e. On 11/17/24 at 8:00 AM-resident found with right hip slightly sitting on floor. f. On 11/20/24 at 4:50 PM- resident found on the floor in the fetal position. <p>The Care Plan for Resident #3 showed no fall interventions added to the care plan for the following dates:</p> <ul style="list-style-type: none"> a. 10/6/24 b. 10/24/24 c. 11/17/24 d. 11/20/24 e. 11/29/24. <p>3.The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented the initial reentry to the facility from a short term general hospital stay.</p> <p>The Clinical assessment dated [DATE] for Resident #1 showed the Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. On 10/14/24 reassessment of the BIMS showed a score of 1 which indicated severe cognitive impairment.</p> <p>The Medical Diagnosis for Resident #1 showed diagnoses of dementia, blindness, cerebral infarction, and heart failure.</p> <p>The Fall Risk Evaluation dated 10/8/24 for Resident #1 showed the fall risk score of 13, which indicated a high risk of falling.</p> <p>The Care Plan for Resident #1 identified the resident unable to ambulate and required an assist of two persons for transfers. The care plan interventions for the look back date of October 2024 through December 2024 identified the following fall interventions:</p> <ul style="list-style-type: none"> Initiated on 10/31/24- Body pillow along edge of bed to help establish a bed boundary. Initiated on 12/19/24- I have lateral support in my wheelchair to prevent leaning to the side. <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Incident Report dated 10/14/24 at 11:23 PM for Resident #1 identified resident found sitting on the floor in front of the bed, legs crossed, and with the call light cord wrapped around her legs. Resident #1 noted to have new dark purple bruises to the right arm, chest and back. Predisposing physiological factors included confusion, gait imbalance, impaired memory, weakness/fainted. The facility failed to take measures to reduce falls and injuries by not placing appropriate fall interventions onto the care plan.</p> <p>The Incident Report dated 10/19/24 at 7:50 AM for Resident #1 identified resident attempted to stand without assistance, tripped over wheelchair pedals then fell to the floor, which resulted in an injury to the forehead and subsequently sent by emergency medical services to the emergency department where had steri strips placed to the 3cm laceration to mid forehead. The facility failed to take measures to reduce falls and injuries by not placing appropriate fall interventions onto the care plan.</p> <p>The Incident Report dated 10/30/24 at 8:15 AM for Resident #1 identified resident found sitting on the floor at the bedside. A new lump occurred to the back of the resident ' s head and a skin tear to the left elbow. The facility initiated an intervention for a body pillow along the edge of bed to help establish a bed boundary.</p> <p>The Incident Report dated 11/4/24 at 4:20 AM for Resident #1 identified staff responded to a noise in the hallway to find the resident lying on her left side in front of the wheelchair in the hallway. Resident unable to give a description of what she was trying to do. The Resident sustained an abrasion to the left side of her scalp and a new red bruise to the left shoulder. The facility failed to initiate a care plan intervention with the previous fall from wheelchair on 10/19/24 which resulted in a ER visit. The facility failed to take measures to reduce falls and injuries by not placing appropriate fall interventions onto the care plan after this fall on 11/4/24.</p> <p>The Care Plan Process policy dated January 2015 identified:</p> <ol style="list-style-type: none"> a. The care plan will be reviewed and revised by the team at least quarterly. b. All problems needs, occurrences, goals and approaches will be evaluated at each care plan meeting. Determination we made as to whether or not a problem, need, or concern has been resolved or needs to be readdressed. If resolved, clearly indicate and date.If a problem, need, or concern is not resolved within six months, the problem, need, or concern and approach needs to be re-evaluated and revised. Documentation completed on interdisciplinary notes. c. The residents condition will be a reassessed new problems comma's needs, or concerns would be added as identified. d. The care plan will be an ongoing reflection of the current treatment plan. And deletions can be made on the plan of care with residents approval without holding a care plan conference, as long as the change does not constitute a permanent, significant change. <p>The Falls Protocol Quick Reference policy dated January 2015 identified follow up after a fall occurs:</p> <ol style="list-style-type: none"> a. Evaluate effectiveness of interventions that were implemented. <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Revised residents' plan of care with the additional interventions that are identified.</p> <p>c. Communicate care plan changes interventions to the resident and direct care staff.</p> <p>In an interview on 1/9/24 at 12:26 PM, the Administrator reported she expected the nurse to initiate a fall intervention immediately after a resident fell . The Administrator reported she expected a new fall focus area be initiated with fall interventions the first time a resident falls after admission.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420</p> <p>Based on clinical record review, observation, staff interviews, and facility record review, the facility failed to provide adequate fall interventions and communicate interventions via the care plan to prevent falls that resulted in injury for 1 of 3 residents reviewed (Residents #1). The facility reported a total census of 34 residents.</p> <p>Findings included:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented the initial reentry to the facility from a short term general hospital stay.</p> <p>The Clinical assessment dated [DATE] for Resident #1 showed the Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. On 10/14/24 reassessment of the BIMS showed a score of 1 which indicated severe cognitive impairment.</p> <p>The Medical Diagnosis for Resident #1 showed diagnoses of dementia, blindness, cerebral infarction, and heart failure.</p> <p>The Fall Risk Evaluation dated 10/8/24 for Resident #1 showed the fall risk score of 13, which indicated a high risk of falling.</p> <p>The Care Plan for Resident #1 identified the resident unable to ambulate and required an assist of two persons for transfers. The care plan interventions for the look back date of October 2024 through December 2024 identified the following fall interventions:</p> <p>Initiated on 10/31/24- Body pillow along edge of bed to help establish a bed boundary.</p> <p>Initiated on 12/19/24- I have lateral support in my wheelchair to prevent leaning to the side.</p> <p>1. The Incident Report dated 10/14/24 at 11:23 PM for Resident #1 identified resident found sitting on the floor in front of the bed, legs crossed, and with the call light cord wrapped around her legs. Resident #1 noted to have new dark purple bruises to the right arm, chest and back. Predisposing physiological factors included confusion, gait imbalance, impaired memory, weakness/fainted. The facility failed to take measures to reduce falls and injuries by not placing appropriate fall interventions onto the care plan.</p> <p>2. The Incident Report dated 10/19/24 at 7:50 AM for Resident #1 identified resident attempted to stand without assistance, tripped over wheelchair pedals then fell to the floor, which resulted in an injury to the forehead and subsequently sent by emergency medical services (EMS) to the emergency department (ED). The facility failed to take measures to reduce falls and injuries by not placing appropriate fall interventions onto the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The emergency room Record dated 10/19/24 at 8:51 AM for Resident #1 revealed the provider noted the resident presented via ambulance after a fall in which the resident tripped, fell and hit her head. The resident sustained a forehead laceration. The resident required a computed tomography (CT) to rule out brain injury. No brain injury found. Resident #1 received steri-strips to the 3 cm laceration located on the mid forehead then discharged back to the facility.</p> <p>3. The Incident Report dated 10/30/24 at 8:15 AM for Resident #1 identified resident found sitting on the floor at the bedside. A new lump occurred to the back of the resident ' s head and a skin tear to the left elbow. The facility initiated an intervention for a body pillow along the edge of bed to help establish a bed boundary.</p> <p>4. The Incident Report dated 11/4/24 at 4:20 AM for Resident #1 identified staff responded to a noise in the hallway to find the resident lying on her left side in front of the wheelchair in the hallway. Resident unable to give a description of what she was trying to do. The Resident sustained an abrasion to the left side of her scalp and a new red bruise to the left shoulder. The facility failed to initiate a care plan intervention with the previous fall from wheelchair on 10/19/24 which resulted in a ER visit. The facility failed to take measures to reduce falls and injuries by not placing appropriate fall interventions onto the care plan after this fall on 11/4/24.</p> <p>In an interview on 1/8/25 at 10:22 AM, Staff D, Register Nurse (RN) reported past non-compliance actions and forms completed for lack of fall interventions being updated on care plans. Staff D stated, the interdisciplinary team failed to update and monitor care plans in the morning meeting.</p> <p>In an interview on 1/9/25 at 7:42 AM, Staff A, Licensed Practical Nurse (LPN) reported the nurse is expected to immediately initiate a new intervention after a fall. Staff A stated, Even if it's not going to be a long term intervention we still put it on the care plan then the management staff reviews the falls the next day in their meeting. When asked if the nurse is expected to place the intervention onto the care plan after the fall, Staff A replied, I will place the intervention into the care plan if it's not a repeated fall. If it's an easy intervention then I will immediately put it in the care pan but if not, I will reach out to the MDS/Care Plan nurse. When asked if Resident #1 had bruising to her face and or forehead, Staff A stated, both. They were from falls that occurred pretty close together, both falls the resident hit her head.</p> <p>In an interview on 1/9/25 at 8:12 AM, when asked what she would do for interventions if a resident fell , Staff B, Certified Nursing Assistant (CNA) stated, I would follow what the nurse tells me to do for an intervention. If the resident falls out of bed I make sure the bed is lowered to the floor. Staff B reported, I don't put anything into the care plan. When asked where she would look to find fall interventions, Staff B replied in the kardex or charting.</p> <p>In an interview on 1/9/25 at 9:35 AM, the MDS/Care Plan Nurse reported after a fall the floor nurse should initiate an intervention and document the intervention in risk management. The next day the Director of Nursing (DON) reviewed the falls then reported to the MDS/Care Plan Nurse if the care plan needed to be changed or updated. The MDS/Care Plan Nurse reported the plan after today is for the management team to review the falls in the morning meeting. When asked why the care plan failed to be updated after falls for Resident #1 the MDS/Care Plan Nurse stated, I think the old DON tried to handle everything himself, there was no collaboration. When asked if the MDS/Care Plan Nurse was informed of when Resident #1 fell , she stated, no. When asked if Resident #1 had bruising to her face and body, MDS/Care Plan Nurse stated yes, from falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/9/25 at 10:27 AM, Staff C, CNA reported the charge nurses developed interventions for residents after a fall. Staff C reported fall interventions could be found on the kardex. When asked if Resident #1 had injuries to her forehead or face, Staff C stated, yes from falls. Staff C explained she found the resident after an unwitnessed fall in the dining room which resulted in an injury to the resident's forehead. Staff C recalled another fall where Resident #1 fell from bed which resulted in a bump to the forehead and head.</p> <p>The Falls Protocol Quick Reference policy dated January 2015 identified follow up after a fall occurs:</p> <ol style="list-style-type: none"> All falls are reviewed during daily quality assurance meetings with interdisciplinary team. Review completed investigation for cause/ Contributing factors. Evaluate effectiveness of interventions that were implemented. Revised residents' plan of care with the additional interventions that are identified. Communicate care plan changes interventions to the resident and direct care staff. Conduct staff education/re-education/disciplinary action as needed. <p>Quality assurance and Assessment</p> <ol style="list-style-type: none"> All falls are reviewed weekly by Fall Safety Committee. Evaluate the effectiveness of interventions that have been implemented for each resident following a fall. Compile a log of falls who assist in evaluation of problems. Review on a quarterly basis to identify trends and patterns to assist in further prevention actions. <p>In an interview on 1/9/24 at 12:26 PM, the Administrator reported she expected the nurse to initiate a fall intervention immediately after a resident fell . The nurse should then enter the intervention into risk management.The Administrator reported the next day the management team reviewed the fall and intervention then after an appropriate intervention decided would enter the intervention onto the care plan which would also update the kardex. When asked which staff was responsible for entering the intervention onto the care plan, the Administrator reported she left that up to the DON and MDS to decide. When asked how the facility failed to ensure appropriate fall interventions were initiated and failed to enter the interventions onto the care plan after a fall, the Administrator reported, she didn't know but thought the DON must have communicated the information verbally to staff and the DON and MDS miscommunicated as to who was going to update the care plan.</p>		