

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Thomas Rest Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 217 Main Street Coon Rapids, IA 50058	

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 0689</p> <p>Level of Harm - 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>40905</p> <p>Based on observation, clinical record review, staff interview, and policy review the facility failed to provide adequate nursing supervision to prevent an accident and injury by leaving a resident that needed assistance with transfers, was a high risk for falls, and care planned to not leave unattended in the bathroom, unattended on the toilet and the resident fell and received an abrasion to the elbow and abrasion to the hip/buttock for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 36 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) for Resident #1, dated 1/23/25, documented a Brief Interview for Mental Status score of 10, indicating moderate cognitive impairment for decision-making. The MDS included diagnoses of Non-Alzheimer's Dementia, Parkinson's disease (progressive neurological condition), anxiety disorder, and depression. The MDS documented the resident required substantial/maximal assistance with toilet transfers, used a walker and wheelchair (w/c) for mobility, and used a bed and chair alarm daily. The MDS indicated the resident was always incontinent of bladder, frequently incontinent of bowel, and was dependent on staff for toilet hygiene.</p> <p>The Care Plan for Resident #1, revised on 4/30/24, included a focus area of resident at risk for falls related to impaired balance, poor safety awareness, functional impairment, and/or the use of medications that may increase fall risk and a history of falls. A Care Plan intervention of do not leave resident in bathroom unattended was initiated on 5/8/24.</p> <p>Observation on 3/31/25 at 11:28 AM, Resident #1 was in a recliner in the living room area with an alarm pad in the recliner. A Certified Nursing Assistant (CNA) placed a gait belt on the resident and attempted to assist the resident to stand, the resident was not standing well, so another CNA assisted to transfer the resident from the recliner to the w/c, with the pad alarm moved to the W/C.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Incident Report for Resident #1 for un-witnessed fall dated 1/18/25 at 4:50 PM, documented: Incident location in South Shower. Found resident on the floor, partially on top of the w/c scale in the south bath, bowel movement (BM) and blood visible. Resident awake, alert and breathing. Trauma assessment, treated wounds, staff who left the resident was sent home until investigation completed. Resident not taken to hospital. Injuries observed at time of incident: abrasion right buttock, abrasion and bruise right rear thigh, skin tear of right elbow and back of right hand. Predisposing factors: confused, gait imbalance, impaired memory, using walker, ambulating without assistance, and resident was left on the toilet in the south bath unattended by Training Nurse Assistant (TNA), nursing was unaware resident was in the bathroom, and unaware he was unattended.</p> <p>Resident #1's Progress Note titled Post Fall Evaluation, dated 1/18/25 at 5:47 PM, documented: 1/18/25 at 4:50 PM fall was not witnessed, attempting to get out of the bathroom unassisted, was left on the toilet unattended in the south bath by the TNA with the door closed, no other staff were aware resident was in there, injuries of multiple skin tears, abrasions and bruises, and skin tear on right and left elbow.</p> <p>Resident #1's Health Status Note dated 1/19/25 at 4:52 AM, documented: follow-up from fall on 1/18 25, resident complaining of pain to right arm and right flank/back area, has an abrasion to the right elbow/forearm, bandage changed due to bleeding through.</p> <p>Review of Resident #1's two Non-pressure Skin Assessments dated 1/20/25:</p> <p>a. Follow-up assessment for a skin area first observed on 1/17/25 for a skin tear of the right elbow (with multiple tears from previous fall on 1/17/25) that was 10 centimeters(cm.) length X 3.2 cm. width X 0.1 cm. in depth and described as wound bed is bright red, with moderate amount of bright red blood and physician notified on 1/17/25.</p> <p>b. Follow-up assessment for a skin area first observed on 1/20/25 for a bruise of the right buttock that was 10 cm. length X 10 cm. width and described as bruise is light purple, has an abrasion 1.5 cm. X 4 cm. X 0.1 cm. and physician notified on 1/17/25.</p> <p>Interview on 4/7/25 at 5:00 PM, Staff A, Registered Nurse (RN) stated she works 2 days a week and completes the skin assessments. Staff A stated skin assessment forms were not completed on 1/18/25, the day of Resident #1's fall, so she completed the skin assessments on 1/20/25 for the injuries from Resident #1's fall on 1/18/25. Staff A reviewed the skin assessments dated 1/20/25 and confirmed the skin assessments she completed on 1/20/25 she had incorrectly dated as 1/17/25 and should have been dated as 1/18/25 for the date first observed and related to the fall on 1/18/25. Staff A stated at the time of the assessment, the skin tear on the right elbow was large, as the tear started above the right elbow, continued down, around and to below the elbow and had areas where the top layer of skin was missing and open and then patches that did have the top layer of skin in place. Staff A stated she completed the weekly assessment of the right elbow skin tear today and has healed to 0.2 cm. length X 0.5 cm. width X 0.1 cm. depth.</p> <p>Review of Fall Scales completed 11/13/24 - 1/18/25 for Resident #1, documented a total score of 45 and higher represented a high risk for falling: 11/13/24 with score of 80, 1/4/25 and 1/18/25 both with score of 110.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 3/31/25 at 11:29 AM, Staff B, Certified Nursing Assistant (CNA) stated Resident #1 is an assistance of 1 staff for transfers. Staff B stated she knows the residents as she has worked at the facility awhile but staff can look up the residents' level of care in the CNA binder, also had pocket care plans when the facility had agency staff but she does not use personally. Staff B stated if a resident's status changes the changes are put in the communication book. Staff B stated Resident #1 is not to be left alone on the toilet as the resident has an alarm and any resident with an alarm she would not leave alone on the toilet.</p> <p>Interview on 3/31/25 at 11:33 AM, Staff C, CNA stated Resident #1 is a staff assistance of 1 with transfers but sometimes she uses 2 staff due to the alarm pad getting transferred also. Staff C stated the resident has a history of falling. Staff C stated the facility has a communication book for resident care changes and also has pocket care plans. Staff C stated any resident with an alarm she would not leave on the toilet alone, that Resident #1 is not to be left alone in the bathroom and he has an alarm.</p> <p>Interview on 3/31/25 at 11:50 AM, the Administrator/Director of Nursing (ADM/DON) stated the Kardex is the most updated information for staff to look for the residents' care needs and the facility is no longer using pocket care plans. The ADM/DON stated on 1/22/25 she put a note in the communication book for the staff, due to Resident #1 being left alone on the toilet and falling on 1/18/25.</p> <p>Review of Resident List Report dated 1/22/25, revealed a list of the current residents with a note stating: People highlighted do not leave in the bathroom or on the bedside commode alone. Make sure you are following the Kardex in the computer. We do not use pocket care plans any more. Resident #1 was highlighted, with a total of 9 resident names highlighted. Note was signed by the ADM/DON.</p> <p>Interview on 4/1/25 at 9:30 AM, Staff D, TNA started working at the facility 11/5/24 and received orientation with another CNA for 1 month. Staff D stated on 1/18/25 around 4:15 PM, Resident #1 was in the living room and trying to get up on his own to go to the bathroom. Staff D stated he took the resident to the south shower bathroom. Staff D stated he couldn't find a big enough brief for the resident so he went to the resident's room to get a brief and left the resident on the toilet. Staff D stated about 4:30 PM, while he was getting the brief from the resident's room, Staff G, Licensed Practical Nurse (LPN) radioed and told him to go to dinner. Staff D stated he was intimidated by Staff G, as she liked to pick on him and just was not thinking and Staff D went to dinner as he was told and forgot to tell someone that the resident was in the shower room on the toilet. Staff D stated it was his mistake. Staff D stated he came back after his meal break and Staff G asked Staff D if he had left Resident #1 alone in the bathroom. Staff D told Staff G that he did leave the resident alone in the bathroom. Staff D stated Staff G told him to leave for the rest of the day. Staff D stated he received a 3-day suspension and the ADM/DON educated him on not leaving residents alone, to look at the sheet in the communication book for residents' transfer assistance needed, and to call for help if needed. Staff D stated he was aware Resident #1 should not be left alone on the toilet as he had been verbally told by other CNAs during his training.</p> <p>Interview on 4/1/25 at 10:08 AM, Staff E, CNA stated areas to find the residents' care status are the resident's care plan or Kardex and communication book. Staff E stated she would not leave any resident alone on the toilet that needs assistance. Staff E stated the residents that are in the living room are the residents they keep an eye on due to risk for falls, and she would not leave Resident #1 on the toilet alone as he is one of the residents in the living room that they keep a close eye on.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/7/25 at 12:45 PM, Staff F, Certified Medication Aide (CMA) stated on 1/18/25 after 4 PM, she was doing the afternoon medication pass and did not see Resident #1 in the living room, so she figured staff had the resident in the bathroom or dining room. Staff F stated she then went looking for Resident #1 and found him in the south bath. Staff F stated the resident was on the floor by the scale, with his pants down to his knees and his legs out in front of him, with a huge skin tear on his right arm, and his arm bleeding a lot. Staff F stated she assumed the resident had been on the toilet and tried to get out of the bathroom. Staff F stated she called for the nurse on the walkie-talkie and Staff G came in and checked the resident, got stuff for the resident's arm, and staff got the resident cleaned up. Staff F stated at the time she did not know who had left the resident in the bathroom as are not supposed to leave the resident alone on the toilet. Staff F stated she was later told Staff D had left Resident #1 alone on the toilet.</p> <p>Interview on 4/7/25 at 1:00 PM, Staff G stated she was working on 1/18/25 and it was after 4:00 PM. Staff G stated Resident #1 was typically in the recliner in the living room, as he was a high fall risk and had a chair alarm. Staff G stated the CNAs started breaks at 4:00 PM and staggered their breaks every 15 minutes, so there are 2 CNAs on the floor. Staff G stated she and Staff F noticed Resident #1 was not in his recliner and started to question where the resident was. Staff G stated Staff F found the resident in the south bath. Staff G stated the resident had a skin tear on his right arm at the elbow and there was blood and BM on the floor, with the resident lying partially on the weight scale and partially on the floor. Staff G stated she completed an assessment on the resident and the resident was alert, conscious, and cussing he wanted to get up. Staff G stated staff got the resident cleaned up and out to the living room. Staff G stated she asked Staff D if he put the resident in the south bath and Staff D said yes. Staff G stated Staff D told her he took the resident to the south bath right before another staff went to break, which would have been approximately 4:15 PM. Staff G stated Staff D reported to her that he went to answer another call light. Staff G stated Staff D went to break at 4:30 PM and was on break when the resident was found in the south bath. Staff G stated she notified the ADM/DON and told Staff D to go home per the ADM/DON's instruction. Staff G stated the resident also had an abrasion on his right hip area and the next day had bruising on his right hip/buttock.</p> <p>Facility policy Falls Assessment Protocol revised 1/4/17, revealed residents identified as high risk for fall will have fall interventions implemented and interventions for reducing the residents' risks for falls will be resident specific and based on assessment findings.</p> <p>Facility policy Minimum Standards of Personal Cares dated 2024, revealed: Minimum standards will be used for all aspects of personal care for residents. If a resident requires care other than that established in the minimum standards, that care will be described in the resident's care plan. It is each staff member's responsibility to be knowledgeable of each resident's care plan and to meet each resident's individual need by following these minimum standards and the resident care plan.</p> <p>Interview on 4/1/25 at 3:45 PM, the ADM/DON stated she felt Staff D knew not to leave Resident #1 alone on the toilet, felt he was busy, made a mistake, and listened to the charge nurse when she told him to go to break. The ADM stated Staff D received a 3-day suspension and education due to the incident. The ADM/DON stated her expectation to not leave any resident that needs assistance alone on the toilet.</p>		