STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Retirement Community	2104 12th Street Harlan, IA 51537

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, clinical record review, and staff interviews, the facility failed to review and revise the care plan to reflect the resident's current status for 4 of 4 residents reviewed (Resident #1, #2, #3, #4). The facility reported a census of 44 residents. Findings include: 1. Record review of the Minimum Data Set (MDS) assessment for Resident #1, dated 5/1/24 documented a Brief Interview of Mental Status (BIMS) score of 99 indicating a severe cognitive impairment. The resident was frequently incontinent of bladder. The resident completed wheelchair mobility with partial/moderate assistance for distances up to 150'. The resident required partial moderate assistance for transfers and substantial/maximal assistance for toilet hygiene. The MDS revealed the resident did not have a toileting program (scheduled, prompted or bladder training). The MDS also documented diagnosis of fractures, Alzheimer's Disease, Non-Alzheimer's Dementia, other displaced fracture of the upper end of the left humerus subsequent for fracture with routine healing. The document revealed the resident received an active range of motion 2 days in the look back period. Resident's Short Term Post Falls Care Plan dated 3/25/24 indicated routine toileting schedule. Review of Resident #1's Care Plan revealed the resident's restorative nursing program for transfers was on hold due to a pelvic fracture in 2/24. The resident does not have current restrictions due to the pelvic fracture. Resident #1 had a focus area that indicated the resident is independent with walking in the room and corridor with a walker, and may use a wheelchair. The interventions for staff indicated the resident requires 2 staff for all transfers and does not ambulate. An intervention on 3/2024 indicated staff will inform the resident it is time to toilet or lie down vs. asking as the resident may refuse and then attempt a self transfer later. Observed Resident #1 on 7/19/24 at 11:57 AM self propelling a wheelchair using bilateral lower extremities (BLE) in the hallway. On 7/19/24 at 1:05 PM the resident refused assistance for wheelchair mobility and followed staff and another resident into the day room. On 7/20/24 at 1:27 PM Resident #1 self propelled the wheelchair from the dining room to the day room without signs or symptoms of pain, and without assistance. The distance was over 100 ' . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Retirement Community	2104 12th Street Harlan, IA 51537

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/20/24 at 1:58 PM Staff E, Certified Nursing Assistant (CNA), assisted Resident #1 to the bathroom. The resident required assistance x1 for transfers, hygiene, and clothing management. Staff F, CNA, stated on 7/19/24 at 5:00 PM Resident #1 stands really well and required limited assistance of 1 for transfers. On 7/20/24 at 11:36 AM Staff F, CNA, stated the resident liked to self transfer. Staff stated if the resident was taken to the bathroom, she would remain with her to prevent self transferring. The staff stated even with staff present the resident may attempt to get up or complete transfers prior to cues for completion. Staff B stated on 7/20/24 at 3:08 PM the resident transfers easily with 1 assist. The staff stated the resident will continue to attempt to self transfer. 2. Record review of Resident #2's Admission MDS assessment dated [DATE] revealed a BIMS score of 13 indicating intact cognition. The resident had a fracture of the neck of the right femur. At the time of admission the resident required partial/moderate assistance for transfers, supervision or touching assistance for walking 10' . Resident #2's Care Plan revealed interventions of modified independence using a 4 wheeled walker and walking with a wheeled walker, gait belt and assistance of 1 using a gait belt. An activity of daily living (ADL) intervention for resident indicated to provide assistance for putting on edema wear every morning and taking off every evening. The ADL interventions further included assisting resident with hygiene, setting up clothes for getting dressed in the morning, assist of 1 with toileting and moderate assistance with toileting hygiene, and having a toileting schedule. A Progress Note dated 7/19/24 revealed Resident #2 was moderate independent using a 4 wheeled walker for transfers and ambulation with plan to discharge to home on 7/23/24. On 7/19/24 at 12:54 PM observed the resident walking independently using a 4 wheeled walker. The resident was not wearing edema garments. On 7/21/24 at 9:27 AM observed the resident walking alone with a 4 wheeled walker. On 7/20/24 at 3:08 PM Staff B, CNA, stated the resident currently uses a walker and gait belt. 3. Record review of Resident #3's MDS assessment dated [DATE] revealed a BIMS score of 13 indicating intact cognition. The resident was dependent for toileting, required substantial/maximal assistance for transfers, frequently incontinent, and diagnosis including cerebrovascular accident (CVA) with hemiparesis of the non dominant side, long term anticoagulants, unspecified atrial fibrillation. The document further provided the resident had not fallen since the last assessment, and was on a restorative nursing program for active range of motion, transfers, and dressing. Resident #3's Care Plan, revised date of 4/10/24, revealed the resident required maximum assistance x2 staff for stand pivot transfers and required 2 staff assist for toileting. Review of occupational and physical therapy recommendations dated 2/23 and 2/27/23 revealed the resident required minimal/moderate assistance of 1-2 staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Retirement Community	2104 12th Street Harlan, IA 51537

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/19/24 at 12:30 PM J, Restorative Nurse, stated Resident #3 would stand at the bar, pull to stand, and walk distances greater than 100 ' using a walker and wheelchair behind. The resident would complete Restorative Nursing close to 5x/week for approximately 30 minutes a session. On 7/20/24 at 1:18 PM Staff H, CNA/Certified Medication Aide (CMA) stated Resident #3 required 1-2 staff assistance for transfers. The resident would actively participate in transfers. On 7/20/24 at 3:01 PM Staff B stated the resident would complete transfers with assistance x1-2 staff. On 7/20/24 at 3:25 Staff I, Registered Nurse (RN), stated Resident #3 completed transfers with 1-2 staff and walked with Restorative Nursing. 4. Record review of Resident #4's Significant Change MDS assessment dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. The resident required substantial/maximal assistance for toileting, partial/moderate assistance for hygiene, upper body dressing, partial/moderate assistance for sit to stands, and substantial/maximal assistance for transfers. Resident #4 participated in a restorative program for range of motion, transfers, and dressing and/or grooming. Resident #4's Care Plan indicated an intervention for receiving Percocet routinely per hospice orders for a focus area of pain. The document revealed an intervention for notification to hospice with signs/symptoms of respiratory distress. Resident #4's Care Plan had fall interventions of visual checks every 30 minutes until the end of shift dated 11/7/23 and visual checks every 15 minutes until the end of the 10-6 shift dated 12/16/22. Review of Resident #4's Clinical Physician Orders revealed hospice services were discharged on [DATE]. On 7/20/24 at 12:15 PM observed the resident being pushed by his spouse back to his bedroom. On 7/21/24 at 9:42 AM observed the resident self propelling his wheelchair from the dining room to his bedroom. On 7/19/24 at 1:25 Resident #4 s spouse stated the resident had been discontinued from hospice services as he was no longer needing them after a year and half. The spouse stated the staff were keeping a closer eye on the resident as a result of his falls. On 7/21/24 at 10:45 AM the Director of Nursing (DON), provided blank documents the facility would use for completion of visual accountabilities for a resident. The staff concurred according to Resident #4's Care Plan it would appear 15 minute accountabilities would still be in place for the 10-6 shift. The staff was unsure if this was still occurring as documentation could not be located. On 7/21/24 at 11:10 AM Staff C, and Staff D, Administrator, expected the care plans to reflect the residents' current needs and provide guidance for staff to assist the residents with their care and safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Retirement Community	2104 12th Street Harlan, IA 51537

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility document Person Centered Care Plans dated 2024 revealed the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment, describe the services that are to be furnished to attain or maintain the resident's highest practicable level of well-being and who is responsible. The document further revealed the interventions are chosen after data gathering, proper sequencing of events, consideration of the problem areas and causes, and clinical decision making.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Retirement Community	2104 12th Street Harlan, IA 51537

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** 49628 Based on clinical record review, staff interviews, and policy review the facility failed to provide the needed services in accordance with professional standards by not completing assessments on individuals who sustained ground level falls with major injury for 2 of 4 residents (Resident #1 and #3) reviewed and failed to implement facility protocol by transferring without a full body lift after a fall for Resident #1. The facility reported a census of 44 residents. Findings include: 1. Record review of the Minimum Data Set (MDS) assessment for Resident #1, dated 5/1/24 documented a Brief Interview of Mental Status (BIMS) score of 99 indicating a severe cognitive impairment. The resident was frequently incontinent of bladder. The MDS also documented diagnosis of fractures, Alzheimer's Disease, Non-Alzheimer's Dementia, and other displaced fracture of the upper end of the left humerus subsequent for fracture with routine healing. The MDS, Change of Status, assessment dated [DATE] for Resident #1 documented a BIMS score of 00 indicating a severe cognitive impairment. The resident was frequently incontinent of bladder. The MDS also documented diagnosis of fracture of the right pubis, subsequent for fracture with routine healing, other fracture of the left pubis, subsequent for fracture with routine healing, dementia with mood disturbance, Alzheimer's disease with last onset. Resident #1's Progress Note titled, N Adv - Post Fall Evaluation, dated 3/26/24 provided it was a late entry for the fall on 3/25/24 at 4:15 PM. Review of the assessment noted the vitals within the assessment were dated 3/29/24. The vitals provided on the assessment were 4 days post the fall. Further review of the document noted it was completed by a different staff on 3/29/24 at 11:42 AM. 2. Record review of Resident #3's MDS assessment dated [DATE] revealed a BIMS score of 13 indicating intact cognition. The resident was dependent for toileting, required substantial/maximal assistance for transfers, frequently incontinent, and diagnosis including cerebrovascular accident (CVA) with hemiparesis of the non dominant side, long term anticoagulants, unspecified atrial fibrillation. The document further provided the resident had not fallen since the last assessment, and was on a restorative nursing program for active range of motion, transfers, and dressing. Resident #3's Progress Note titled, N Adv - Post Fall Evaluation, dated 6/18/24 revealed the N Adv- Post Evaluation document had incomplete sections including contributing factors, medication changes, vitals, actioned clinical suggestions, and comments. The Progress Notes further revealed the resident was moved to the bed with subsequent transfer to the hospital. On 7/20/24 at 3:01 PM, Staff B Certified Nursing Assistant (CNA), stated the resident was on the floor upon entering the bathroom. The staff stated the resident was alert and talking. Staff A with the nurse and a float staff picked the resident up off the floor and placed in a wheelchair. Staff B stated he left the room at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165372	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Crest Retirement Community	2104 12th Street Harlan, IA 51537

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	On 7/20/24 at 3:15 PM Staff A, Licensed Practical Nurse, stated the Resident #3 fell while on break. The resident was seated in her wheelchair when the staff approached the room. The resident was responding and talking with staff. The staff stated the resident became unresponsive when transferred to the bed. Staff A stated she left the room to call 911 and when returned the resident was alert, talking, and rubbing the staff's cheek. Staff A stated an assessment post fall included taking the resident's blood pressure first, and completing an assessment on the floor. The staff further revealed if it were safe to get the resident up, a non weight bearing lift would be used to get the resident up and move to either a chair/wheelchair or bed. If the fall was unwitnessed, neuro checks were completed for 72 hours. If witnessed and no head injury vitals are completed for 72 hours. The staff stated the assessment would be completed with documentation in the Fall Evaluation in the EHR. On 7/20/24 at 3:42 PM Staff C, Registered Nurse, Director of Nursing, stated the nurse would complete an assessment before the resident is allowed to get up from the floor. Staff C stated the staff utilize a dependent mechanical lift if the resident is unable to assist in getting up. Staff C stated the staff are to follow the complete fall assessment/packet. On 7/21/24 at 10:00 AM Staff C expected the N Adv Post Evaluation would be completely finished as soon after the fall as possible. The staff expected that staff would not leave until documentation was completed. Staff C stated she has called staff back to work to complete assignments. The staff stated with Resident #1 the nurse was a traveling nurse and refused to come back to complete the documentation. Staff C completed the document with the available information. The staff indicated she was not aware of the different date with the vitals in the N Adv Post Evaluation from the date of the fall. Staff C indicated she was not aware that the N Adv Post Evaluation was not fully completed for Resident #3. On 7/21/24 at 10:40 AM Staff D, Administrator, indicated she would expect that the assessment(s) and needs of the resident were to be completed and documented by the nurse on duty immediately. The facility policy and procedure titled Fall Risk Prevention Program dated 7/24 revealed documentation after fall needs to be completed to prevent further falls. Documentation should include all risk factors, possible causes, interventions and effectiveness. The undated facility document, Fall Scene Investigation, revealed the following: Never move/lift a resident until a nurse has evaluated the person. Use Hoyer (full body mechanical lift) to get ALL residents off the floor. Fill out the Risk Management in Point Click Care. Fill out the Fall Risk Assessment in Point Click Care.