

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Happy Siesta Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 423 Roosevelt St Remsen, IA 51050	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875</p> <p>Based on clinical record reviews, staff interviews, hospital record reviews, facility investigation and policy review the facility failed to provide adequate nursing supervision for 1 of 3 residents reviewed (Resident #1) for falls. Resident #1 had a fall while riding in the facility passenger van, resulting in his wheelchair tipping over backwards, hitting his head and sustaining three lacerations to the back of his head. The fall required a transfer to the emergency room three weeks later which resulted in admission to the hospital for a C2 cervical fracture that required surgical intervention and placement of a halo brace (an orthotic support that helps immobilize and protect bones in the neck following an injury). The facility reported a census of 54 residents.</p> <p>Citation considered past noncompliance as the facility completed the following interventions prior to the surveyor entering the facility on 4/15/24:</p> <ol style="list-style-type: none"> 1. Q'straint loops ordered for securement-4/3/24 2. Antitipper attached to both chairs-3/8/24 3. Van drivers retrained on Q'straint securement-4/3/2024 4. Safety inspection completed for van -3/11/2024 5. Pre-trip safety checklist for van transports -4/4/2024 6. Staff education provided on accident policy-4/3/2024 and ongoing 7. Inventory system for wheelchairs established- 3/8/2024 and ongoing <p>Findings include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 3, indicated severely impaired cognition. The MDS identified Resident #1 had signs and symptoms of delirium of disorganized thinking that fluctuates. The MDS identified Resident #1 required partial/moderate assistance of one person with transfers, toilet use and ambulation of 50 feet using a walker. Resident #1's MDS included diagnoses of cancer, benign prostatic hyperplasia, thyroid disorder, stroke, non-alzheimer's dementia, and unsteadiness on feet.</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>Resident #1's Fall Risk Evaluation documented the following scores and fall risk:</p> <p>1/27/24= 16- Total score of 10 or higher represents a high risk</p> <p>3/8/24= 15- Total score of 10 or higher represents a high risk</p> <p>The Care Plan with target date of 3/15/24 documented Resident #1 was a fall risk. The care plan interventions included the following:</p> <ul style="list-style-type: none"> a. Anticipate and meet Resident #1 ' s needs. b. Assist to bed when noted to be drowsy. c. Be sure Resident #1 ' s call light is within reach and encourage him to use it for assistance as needed. d. Encourage Resident #1 to participate in activities that promote exercise, physician activity for strengthening and improving mobility. e. Follow facility fall protocol. f. Get up in a wheelchair if awake and anxious in bed. g. Keep foot pedals off the wheelchair when not assisting Resident #1. i. Merry-walker will have a tray securely in place at all times when utilizing it. j. Use one cushion in the wheelchair. <p>A Progress Note dated 3/7/24 at 1:31 PM revealed Resident #1 was out to the dining room for lunch leaning quite a bit to the left and unable to sit himself up. Resident #1 then sat in a merry walker, continued to lean and was unable to stand on command. Resident #1 was unsteady and leaning to the left side. The note documented Resident #1 right hand grip greater than left. Resident #1's wife notified of condition and reported Resident #1 was leaning to the right a little the day before. The note further documented that the wife did not want resident assessed and would like him to stay at the facility. The note revealed the wife believed Resident #1 had another TIA(Transient Ischemic Attacks). Primary Care Physician notified via fax of condition and to keep at facility per wife request with no further aggressive treatments/evaluations.</p> <p>A Progress Note dated 3/28/24 at 1:34 PM titled Social Service Note documented a new Iowa Physician Orders for Scope of Treatment (IPOST) was filled out with Resident #1's wife and placed in Resident #1's medical record.</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>A Progress Note dated 3/8/24 titled Incident Note at 2:25 PM revealed while on bus ride, staff reported Resident #1 fell backwards in his wheelchair. Upon returning to the facility, Resident #1 was noted to have 3 lacerations to the back of the scalp with blood drainage. Vital signs and neurological checks (neuro's) were initiated upon return to the facility. The neurological checks revealed the left pupil was sluggish and Resident #1 was leaning to his left. The note documented the neurological symptoms were present on 3/7/24 and Primary Care Physician (PCP) had been updated on 3/7/24. The note documented the PCP and wife were notified regarding the fall and the wife wished to keep resident at the facility.</p> <p>An Incident Report (IR) dated 3/8/24 at 2:45 PM identified a witnessed fall during a bus ride. The report revealed Resident #1 while on the bus ride fell backwards in his wheelchair and received lacerations to the back of his scalp. The intervention was to have the bus inspected by maintenance to ensure no malfunctions.</p> <p>The IR dated 3/8/24 documented a note on 3/11/24 that revealed upon further review of the incident, the interdisciplinary team determined Resident #1 had been on a facility sponsored bus ride with Staff A, Activity Director and Staff B, Activity Assistant. Staff A was driving the van and as she completed a right turn, she accelerated and Resident #1 's chair tipped backwards. Staff A stopped the vehicle and Staff A and Staff B sat Resident #1 back up and return to the facility. The bus was taken out of use pending safety inspection. Staff C, Maintenance director completed the inspection on the morning of 3/11/24. The inspection resulted in no system concerns and the bus was placed back in use. Staff A reported that she thought she had Resident #1 strapped in correctly. The report documented it was plausible that the straps had come loose during the turn or that the resident had tried to stand.</p> <p>A Progress Note dated 3/9/24 at 9:37 PM documented the CNA (Certified Nursing Assistant) reported Resident #1 was really painful with movements getting out of the merry walker ready for bed. The note documented Tylenol was given.</p> <p>A Progress Note dated 3/10/24 at 1:39 PM documented Resident #1 complained of pain in the back of neck. Resident #1's neck was stiff and would not lift neck straight up. The note revealed Resident #1 needed full assistance with eating and drinking solids and fluids. The note documented Tylenol was given for neck pain that morning and a heat pad was applied to the neck.</p> <p>A Progress Note dated 3/11/24 at 2:38 PM documented Resident #1 self propelled in the wheelchair. Resident #1 complained of neck pain and was unable to lift head straight up. The note documented his neck was stiff. The note documented Tylenol was given and effective.</p> <p>A Progress Note dated 3/12/24 at 9:19 AM documented a new telephone order was received for Resident #1 to have Physical Therapy evaluation and treatment for wheelchair positioning and neck stiffness. The note documented Resident #1's wife notified and agreed with treatment.</p> <p>A Progress Note dated 3/12/24 at 10:32 AM documented Resident #1 complained of neck pain and Tylenol was given and a warm pack provided.</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>A Progress Note dated 3/21/24 at 12:47 PM documented Resident #1's wife at the facility for lunch and was concerned with Resident #1's neck pain. The wife reported Resident #1 had never had stiffness this long before and reported Resident #1 seemed to be in a lot of pain when touched. The note documented muscle relaxer, Tylenol and heat had been applied and effective at times. The wife wondered if a Chiropractor would be effective or able to do x-rays. The note documented a Chiropractic Office was notified of the wife's request and the office requested to talk to the wife. Resident #1's wife returned to the facility after lunch and requested for Resident #1 to be seen at Urgent Care for x-ray of the neck per Chiropractor's recommendations. The note revealed Urgent Care was notified of the situation, paperwork was given to Resident #1's wife and Resident #1 transported via facility van to Urgent Care. The note documented Resident #1's wife reported that she did not want to prolong anything, she just wanted him to be comfortable. The note revealed Resident #1 had not been able to relax his head while sleeping at night the last couple of nights.</p> <p>A Progress Note dated 3/21/24 at 12:56 PM documented Resident #1's wife was aware of the neck pain and initially refused assessment by PCP.</p> <p>A Progress Note dated 3/21/24 at 2:55 PM revealed the facility received a phone call from a Nurse Practitioner reporting Urgent Care was not able to do the x-ray as Resident #1 was in so much pain when they tried to straighten the neck. A new order was received for a CT (computed tomography) scan but would need a prior authorization through insurance first.</p> <p>A Progress Note dated 3/27/24 at 12:55 PM documented Resident #1's CT scan was scheduled for Friday, 3/29/24 at 11:00 AM. The note documented Resident #1's wife was aware.</p> <p>A Progress Note dated 3/29/24 at 4:53 PM documented the facility received a call from ARNP (Advance Registered Nurse Practitioner) who reported she had received the CT scan results and Resident #1 had a C2 fracture. The ARNP voiced she had reached out to Orthopedics for further services and would get back to the facility with orders. The note documented Resident #1's wife was updated.</p> <p>A Progress Note dated 3/29/24 at 7:55 PM documented the ARNP gave new orders to transfers Resident #1 to hospital emergency roiaognom on [DATE] via facility vehicle for placement of hard collar for acute fracture of the C2.</p> <p>A Progress Note dated 3/30/24 at 7:09 AM documented Resident #1 was out of the facility via facility van for appointment at a hospital in Sioux City.</p> <p>A Progress Note dated 3/30/24 at 10:01 AM documented Resident #1 had a hangman break (break in one or two bones in the neck) and would be admitted for surgery on 3/31/24. The note documented Resident #1's wife was aware and a bed hold was received.</p> <p>A Progress Note dated 4/2/24 at 12:25 PM revealed Resident #1 returned to the facility from the hospital with a Halo brace in place.</p> <p>Review of the IPOST dated 3/8/24 revealed Resident #1 was a DNR/Do Not Attempt Resuscitation and Comfort Measures only (Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life sustaining treatment. Transfer if comfort needs cannot be met in current location).</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>Review of the CT Scan completed on 3/29/24 revealed the following impression:</p> <ol style="list-style-type: none"> Acute fracture C2 involving the junction bilateral pedicle with vertebral body. Minimally displaced. C2 shows 2 mm (millimeter) anterolisthesis (the upper vertebral body is positioned abnormally compared to the vertebral body below it) relative to C3. Wedge configuration anterior body C3 new compared to prior CT from 2/7/2020. Age indeterminate consistent with mild anterior column wedge compression fracture. <p>A Hospital Consultation report dated 3/30/24 documented Resident #1's head was tilted to the left about 70 degrees with his left ear almost on his shoulder. Attempts to straighten them up produced severe neck pain. The consultation note documented Resident #1 had a hangman's type C2 fracture right rotation slight angulation anteriorly of C2. The note revealed the Physician recommended treatment with distraction under sedation anesthesia then stabilized in a halo thoracic brace.</p> <p>A Hospital Progress Note dated 4/1/24 documented Resident #1 appeared to be tolerating his halo well. The note revealed Resident #1 was stable and could go back to the nursing home and to follow up in the office in one month for x-rays.</p> <p>On 4/15/24 at 12:45 PM, Staff B, Activity Assistant reported the bus ride occurred between 2-2:30 PM. Staff B reported Staff A loaded the residents on the van. Staff B reported it was her first time going in the van. She stated Resident #1 sat in the back of the van in a wheelchair directly behind the bench seats. She stated she remembered Staff A bending over and hooking some things up on his wheelchair but apparently it was not everything. Staff B reported she was riding along as an extra staff member for the activity. Staff B stated she had not been trained on the van. She stated she has now done the computer training (after the incident). Staff B reported Staff A was driving and she was in the passenger seat. She stated when they got to LeMars, they toured a residential area, she stated Staff A slowed down for a corner then quickly accelerated and that was when she heard a noise. Staff B stated she turned around and saw Resident #1 had tipped over. Staff B stated Staff A stopped the van on the street, they both got out of the van and went around to the back. She stated Staff A opened the back door and put the lift down. Staff B stated Resident #1 was still in the wheelchair that had tipped over backwards, his head was resting on the floor of the van. She stated they got Resident #1 upright. She stated Resident #1 was alert and conscious the whole time. She stated when they sat him up they noticed the laceration on the back of his head. Staff B stated she did not recall if safety straps were in place prior or after the incident. Staff B stated she was more concerned at that time if Resident #1 was okay. She stated once he was sat back up she recalled Staff A putting hooks to the wheelchair and putting a front strap across him. Staff B stated she wondered if the front strap was not in place before. She stated after the incident they returned to the facility. Staff B stated when they got back, Staff A unloaded Resident #1 and took him into the facility. Staff B stated some of the nurses asked her what had happened and she stated she thought Resident #1 was not strapped in correctly but she did not know for sure as she had not been trained.</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>On 4/15/24 at 1:15 PM, Staff A, Activity Director reported Staff B and herself loaded the bus with five residents. Staff A stated everyone was buckled in and they went on a bus ride. She stated she went around a corner, Resident #1 tipped over in his wheelchair. She stated Staff B and herself got Resident #1 upright in the chair, buckled back in place and then headed back to the facility. Staff A stated she was the one who loaded Resident #1 into the van. She stated she thought she had applied the Q'straints to the wheelchair to hold it in place on the bus. Staff A stated two Q'straints go on the front of the wheelchair and two Q'straints go on the back of the wheelchair. When asked if she had applied the front seat belt, she stated she did not think so. She stated she thought she had totally forgotten to put the front strap on. She stated unless it got unbuckled. Staff A reported she was not going too fast around the corner. She stated she accelerated too fast. She stated she stopped the van on the road. She stated Staff B and herself went to the back of the bus and opened the door. Staff A stated she observed Resident #1 had tipped over backwards in his wheelchair. She stated he was still in his wheelchair but his butt was off the seat. Staff A stated Staff B and herself assisted Resident #1 upright by taking ahold of the wheelchair and tipping Resident #1 and the wheelchair up at the same time. Staff A stated Resident #1's head was bleeding. She stated there was a laceration on the top of his head. Staff A stated she was not sure what he hit his head on. Staff A reported she used some gauze from the 1st aid kit to clean the laceration and wipe off the blood. She stated she applied the Q'straints to the wheelchair and placed the front seat belt on the way back to the facility. She stated she did not call the facility prior to returning. She stated, I just brought him back. Staff A stated Resident #1 was awake, smiling and denied any pain. She stated she took Resident #1 into the facility and talked to Staff C, RN (Registered Nurse) and Staff E, RN/DON (Director of Nursing). Staff A stated Staff C and Staff D took Resident #1 to evaluate him. Staff A reported after the incident she took a class on the computer regarding the Q'straints. She stated she was fired on Friday, April 5th due to safety concerns with the residents. She stated after Resident #1 had tipped over in the bus, she was not sure what had happened with the Q'straints. She stated the Q'straint by the door was all the way unrolled, it appeared it had been in place but had come off the wheelchair. She stated the Q'straint across from the door appeared as it had not been put into place as it was still rolled up the mechanism/mount and the two Q'straints back of the wheelchair were in place.</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>On 4/15/24 at 3:39 PM, Staff E RN/DON reported she believed Staff B brought Resident #1 to the nurse station from the bus ride. Staff E stated Staff B reported Resident #1 had fallen out of the wheelchair on the bus. She stated Staff A and Staff B picked Resident #1 up and came directly back to the facility. She stated Resident #1 was calm and had four lacerations to the back of his head. Staff E stated she talked to Staff A after parking the bus and Staff A reported Resident #1 had tipped backwards and thought he had hit his head on the ramp behind him. She stated the lacerations were oozing so Staff D, RN cleansed the areas and completed the neuro's exam. Staff E stated one pupil was sluggish and one hand grip weaker which were the same findings as the day before. She stated Resident #1's wife reported Resident #1 had frequent TIAs and Resident #1's symptoms had been consistent with previous TIAs. Staff E stated Resident #1's wife was at the facility the day of the bus trip and encouraged him to go. Staff E stated Staff A was going around a corner, when she accelerated, Resident #1 tipped back in his wheelchair. Staff E stated Staff A reported she had applied the Q'strains but could not verify she had tightened them. Staff E reported she did not recall Staff A making the statement about not charting Resident #1 wasn't buckled in correctly. She stated she took Staff A to the office to call the Administrator to tell her what had happened. Staff E stated she called the wife, and reported Resident #1 had fallen out of the wheelchair. She stated Resident #1's wife stated he had probably tried to stand up and pushed himself back. Staff E stated she told the wife that nobody saw the incident happen and the facility would do an investigation and check the Q'strains to make sure they were working properly. Staff E stated she reported the abnormal neuro's to the wife and the wife was not concerned regarding the findings. She stated the wife did not want any further evaluations or Resident #1 to be sent out. Staff E stated the wife commented about the TIA and was not concerned. Staff E stated she could not comment if the front seat belt was in place. She stated she was more concerned about the chair tipping backwards and if the chair was secured down with the Q'strains in the front. Staff E reported Resident #1's head tilted to the left and became more pronounced with the recent stroke symptoms. She stated the wife reported his neck issue would usually get better after a few days and it did not. She stated she called Resident #1's PCP to get a Physical Therapy order for neck stiffness. Staff E stated Resident #1's wife was okay with the order for PT. Staff E stated Therapy suggested a soft collar which was ordered by the PCP. She stated Resident #1's wife obtained the soft collar and brought it to the facility. She stated Resident #1 wore the soft collar during the day and off at night. She stated his neck was straight when he laid in bed and did not have the tilt. She reported that his pain varied. He would wax and wane. She stated there were periods of time his pain was improving. She stated the soft collar did hold his neck up a little. She stated she was surprised with the CT scan results.</p> <p>On 4/15/24 at 4:19 PM, Staff A, Activity Director re-interviewed and asked if she had stated not to chart Resident #1 wasn't buckled in correctly as she couldn't afford to lose her job. Staff A stated she may have said it out of fear and worry. She stated she says a lot of stuff when she is not thinking. She stated sometimes she says things she does not mean. She stated she does not always think before she speaks. She stated it is a problem she has and something she would like to change. She stated she was in tears after the incident. She stated she cannot say for sure if she said it or not.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Happy Siesta Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 423 Roosevelt St Remsen, IA 51050	
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>On 4/16/24 at 8:00 AM, the Administrator reported the probable conclusion from the facility investigation was that the Q'straints were not applied properly. She stated if they were applied properly along with the seat belt the chair would have not tipped. She stated the facility does not know for sure as the driver, Staff A was not able to recall details and Staff B was an activity assistant that rode along for the activity and did not pay attention to the restraints. The Administrator reported Staff A had been trained previously. She stated the training did not change and the bus was the same. She stated after the facility learned of the severity of the injuries they did a deeper dive into the incident and did a reenactment. She stated at that time they concluded that Staff A was intentionally careless and was terminated on 4/5/24. She stated after the incident Staff A did not drive the bus. The Administrator stated if you look at Staff A's employee file there were other concerns related to carelessness. The Administrator stated she did not think Staff A intentionally tried to hurt someone. When asked if she thought Staff A was driving too fast, she stated no. The Administrator stated sometimes Staff A acts before thinking. The Administrator reported Resident #1's wife had reported his neck stiffness and posture was a symptom of his TIAs. She stated Resident #1 had a gradual decline and his wife wanted him to go see the chiropractor as she thought his poor neck posture was leading to his neck being stiff. She stated the x-rays and CT scan were needed for him to be able to see the Chiropractor. She stated they were not suspecting an injury and were surprised by the results. The Administrator reported the Q'straint posters were added to the bus after the incident occurred as an intervention and reminder to staff. She stated the expectations for the Q'straints had not changed, they were the same before and after the incident. The Administrator reported during the investigation the facility learned they had different wheelchairs and needed different attachments to be secured in the van correctly. She stated they ordered and recieved Q'straint loops.</p> <p>On 4/16/24 at 8:30 AM, Staff C, Maintenance Director reported he had assessed the van after the incident and did not find anything wrong with the Q'straints. He stated Q'straints were working appropriately. Staff C reported if the Q'straints were properly placed the wheelchair should not have tipped backwards. He stated after the incident he completed training and became certified. He stated after watching the training videos he identified the [NAME] in the van needed to be moved to ensure the Q'Straints were applied correctly and at the right angle. Staff C demonstrated inside the van how he moved the [NAME] and how to attach the Q'straints correctly along with the seat belt. Staff C also demonstrated where the [NAME] and wheelchair would have been during the incident/fall. He stated after doing the training the facility learned that with the tilt-n-space wheelchairs need additional equipment (Q'straint loop) to secure the chair appropriately and to have the straps at the right angle. Staff C demonstrated that the Q'straints do not retract on their own and that you have to push a red button for the strap to retract. He stated if the Q'straints are applied correctly and tightened, he did not think the restraints would be able to come off on their own. He verified that if the Q'straint had not been pulled out from the mechanism (unrolled) then it had not been applied to the wheelchair. Staff C reported Resident #1 was now using a Care Foam Chair and showed surveyor Resident #1's tilt-n-space wheelchair that was in the therapy room. The Administrator came to the therapy room. The Administrator stated during the investigation the facility could not determine which wheelchair Resident #1 was in during the ride (tilt-n-space) or standard wheelchair. She stated Staff A or Staff B could not recall. She stated the facility applied anti-tippers to both of the chairs after the incident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Happy Siesta Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 423 Roosevelt St Remsen, IA 51050	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/15/24 at 9:35 AM, Resident #1's wife reported she thought he had a mini stroke. She stated his whole upper body would tip when he had a stroke. She said his head tilted more than normal but she thought it was from the stroke. She stated a week or two after the fall he started hurting. She stated his head was going down and he could not lift it. She stated before he would snap out of it and straighten out. She stated it didn't happen this time and his head kept falling down. She stated she was visiting on the day of the bus ride and she had asked that he go along as he enjoyed going on rides. She stated he was switched to a regular wheelchair so he could sit up and see better. She stated she asked the nurse about going to the Chiropractor because she thought sometime might be out of place. She stated her Chiropractor suggested doing an x-ray first. She stated it was a good thing we did. She stated the staff was giving pain pills and muscle relaxers and they were not helping him and not loosening him up. She stated the DR told her the CT scan showed a lot of little strokes. She stated he couldn't raise his head and if they tried to raise his head, he would say ouch. She stated his chin was on his chest. She stated she thought something needed to be done as he was having a hard time eating and had to use a straw to drink. She stated that after the fall and as time went on his head tipped more and more. She stated she had met him at Dr ' s appointments before and would see the staff load and unload him from the bus. She stated during those times, the wheelchair was secured in the bus. She stated the day of the bus ride she did not see him get loaded on the bus so she does not know if the wheelchair was secured or if he had the seat belt on during the ride.</p> <p>On 4/16/24 at 1:49 PM, Staff F, RN reported Resident #1 was ve [TRUNCATED]</p>		