STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165428	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careage Hills Rehabilitation and Healthcare	725 North Second Street Cherokee, IA 51012

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to follow interventions established in the care plan to prevent falls for 1 of 5 residents reviewed. Resident #2 had a history of falls and observations revealed that staff failed to implement two of those interventions. The facility reported a census of 38 residents Findings include. According to the Minimum Data Set (MDS) dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 10 (moderate cognitive deficits). She used a walker and wheelchair for mobility and required substantial assistance with lower body dressing and footwear. The resident required supervision/touch assistance with sit to stand, toilet transfer and sit to lying. She was frequently incontinent of urine, and occasionally incontinent of bowel. Her diagnoses included renal insufficiency, non-Alzheimer's dementia, unspecified fracture fifth lumbar vertebra and muscle weakness. The Care Plan showed Resident #2 had confusion/disorientation, weakness, and history of a vertebra and pelvic fractures. An addition to the Care Plan on 4/14/24 showed that staff were to have wheel chair behind resident when ambulating. On 5/31/24, staff were to place the walker further away from resident recliner out her sight so she doesn't try to reach for it. On 4/24/24 therapy directed to evaluate and treat, encourage the resident to use call light. The following was included in Incident Reports for Resident #2: a. On 4/14/24 at 11:15 AM the resident had a witnessed fall in the bathroom. b. On 4/24/24 at 9:56 AM The resident had an unwitnessed fall in her room and said that she was trying to get up on her own and hurt her wrist. c. On 5/31/24 at 4:15 PM Resident #2 was found on the floor stated that she was reaching for her walker and slid out of her chair onto the floor. On 6/18/24 at 3:59 PM Resident #2 was in the recliner with the walker in front of her within reach. The resident said that she did not need help with ambulating and she said that she hadn't had any falls. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/24 at 9:34 AM and unidentified Certified Nurse Aide (CNA) assisted Resident #2 to ambulate down the hallway toward her room. She did not have a wheel chair behind the resident and at 9:35 AM, the resident was in her recliner and her walker was out of reach by the television where the resident could see it. On 6/20/24 at 7:00 AM, Staff F, LPN said that Resident #2 has had many falls because she self-transfers and education really doesn't help with her because she thinks she can do it on her own. On 6/20/24 at 9:50 AM, the DON said that she thought the intervention to keep the walker out of sight went against the wishes of the family and didn't know if they were still implementing that. She thought the intervention to have wheel chair behind when ambulating had been discontinued. She said that they have struggled to find effective interventions for Resident #2 because the resident believed that she was able to ambulate and transfer on her own. According to the Job Description for a Certified Nurse Assistant, the primary purpose of the job was to provide each of resident with routine daily nursing care and services in accordance with the resident assessment and care plan and as directed by the supervisor.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, interviews, record and policy review the facility failed to ensure that residents were properly supervised, and interventions were utilized to prevent accidents for 5 of 5 residents reviewed, (Residents #1, #2, #3, #4 and #5), . Staff failed to use safe transfer practices for Residents #1, and #5. Resident #3 slid off of the [NAME] pool seat, and Resident #4 sustained a broken toe when a staff's dog tripped her. Staff failed to follow care plan interventions established to prevent further falls for Resident #2. The facility reported a census of 38 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #1 was admitted on [DATE] and did not have a Brief Interview for Mental Status (BIMS) assessment because she was rarely/never understood. She was totally dependent on staff for toileting, dressing, hygiene and transfers. Her diagnoses included Alzheimer's Disease, malnutrition, anxiety disorder, lack of coordination and parkinsonism. A Care Plan updated on 4/1/24, showed that she was on an antiplatelet and she had alterations in her neurological status related to tremors. She had the potential for mood problems related to Alzheimer's Disease, staff were to administer medication as ordered, and monitor for side effects and effectiveness. She was at risk for falls related to Alzheimer's tremors, and weakness. A Fall Incident report dated 3/30/24 at 4:30 PM, showed Staff A Licensed Practical Nurse (LPN) was called to the room of Resident #1 for a witnessed fall out of her recliner. The resident fell forward and hit her head on the floor and the side of her face hit the pedal of the wheelchair. Resident #1 sustained a skin tear to her right arm with scattered bruising, and a bump to the right side of her head. On 6/18/24 at 11:50 AM, Staff A, Licensed Practical Nurse (LPN) remembered the evening that Resident #1 fell from the recliner. She said Staff D and Staff G, Certified Nurse Aides (CNA), came and told her that the resident fell and had a hematoma and a couple of skin tears. When Staff A entered the room, the resident was in the recliner. She said the CNA's must've picked her up off the floor and put her in the chair before she had an opportunity to assess her. She asked them what happened, and they only said that she fell out of the chair and didn't know how it happened. Staff A then called the Director of Nursing (DON) and the Administrator. The resident was bleeding from the skin tear on her left arm, and from hematoma on her head. Staff A said that she had concerns with Staff D before this incident because she had observed that the CNA didn't know how to properly transfer residents. She also had concerns about Staff G and her job performance and reliability. She said that she had expressed those concerns to the DON previously. On 6/19/24 at 12:10 PM, Staff B, Registered Nurse (RN) said that it was unusual for Resident #1 to have a fall because she really wasn't moving around on her own or trying to get up without assistance. With a previous stay, the resident had been restless, and had many falls but with this stay (admit, 3/8/23) she wasn't able to move around much. She had a decrease in the Seroquel shortly before the fall, so they thought that may have been a factor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a Counseling /Disciplinary Notice to Staff D, dated 4/1/24, it was documented that the CNA did not use a gait belt while transferring a resident and she did not notify the nurse immediately. Staff D was also counseled not to move a resident after a fall until the nurse could assess for injuries. The CNA was terminated from employment. On 6/20/24 at 7:40 AM, the DON said that Staff D told her she left the pedals on the wheelchair when she transferred Resident #1 from the wheel chair to the recliner. The resident was just on the edge of the seat of the recliner when she leaned forward and fell on her face on the floor. On 6/20/24 at 9:00 AM, the DON said that Staff D put the resident back into the chair by herself but did not report the fall to the nurse immediately. Staff G saw the scratch on the resident's face and she was the one that reported to the nurse. The DON acknowledged that the written warning for Staff D was related to the fall that Resident #1 had on 3/30/24. In a written statement by Staff D, the CNA indicated that Resident #1 was sitting half way in recliner, as she moved the wheel chair out of the way, the resident reached forward and fell , hitting her head on the floor and her cheek on the pedal of the wheel chair. 2) According to the MDS dated [DATE], Resident #4 had a BIMS score of 14 (intact cognitive ability). The resident was independent with toileting, dressing, transfers and walking. Her diagnosis included Cerebrovascular Accident (CVA), non-Alzheimer's Dementia, osteoporosis and chronic pain. A Care Plan updated on 3/1/24, showed the resident had acute confusion, staff were to monitor for signs and symptoms of delirium. She was at risk for communication problems related to a hearing deficit and wore a cochlear implant in her right ear. According to an Emergency Department (ED) report dated 3/24/24, Resident #4 presented to the ED on that date and was diagnosed with nondisplaced fracture of the fifth metatarsal bone in her right foot. Upon presentation, the resident reported that a large dog stepped on her foot and she was in severe pain. She was sent back to the facility with an orthopedic support shoe, and a follow up appointment with orthopedic doctor. A Nursing Note dated 3/24/24 at 2:59 PM, showed that Resident #4 had been walking through a doorway when a dog slid into her legs, causing her to twist her right foot and fall to the floor. She complained of pain to the right side of her foot. The doctor was called and she was sent to the ED. In an observation on 6/19/24 at 11:14 AM, Resident #4 was walking independently in the hallway and said hadn't had any falls. When asked about a dog, the resident said she loved to have dogs around the nursing home, makes it feel like home. On 6/19/24 at 11:15 AM, Staff H, Registered Nurse (RN) said that she witnessed the fall that Resident #4 had when she broke her toe. She said that a dog belonging to a staff person, had just come in from outside and his feet were probably a little wet. The dog slid into the resident as she was walking down the hallway. The dog was not on a leash and he hadn't been back to the facility since the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 10:22 AM, Staff I, Certified Medication Aide (CMA) said that the dog that ran into Resident #4 was her German [NAME] and he would come to work with her the majority of her shifts. The dog was suspended after the incident. She said that it had been raining outside that day and, without her knowledge, a nurse let the dog out to be toileted while Staff I was in with a resident. When he came back inside, Resident #4 was in a doorway near the kitchen. He picked up speed coming around the corner, when he saw the resident in the doorway, he tried to slow down, but slid into her as she was in the middle of a step. She fell and rolled her foot. According to an undated facility policy titled: Pet Parent Responsibilities: staff or visitors were allowed to bring pets into the facility and must be responsible for pet's behavior the entire time. Staff were to keep pets with them and control them throughout the day. They would ensure that the pets behavior did not cause interference with daily activities. 3) The MDS dated [DATE], showed that Resident #3 had a BIMS score of 11 (moderate cognitive deficits). Sit to stand and toilet transfers were not attempted during the look-back period. The resident's diagnoses included Anemia, Renal insufficiency, anxiety, asthma and respiratory failure. The Care Plan updated on 1/16/24, showed Resident #3 had chronic bronchitis, staff were to monitor for difficulty breathing, and to remind the resident not to push beyond her endurance. Staff were to work with the Hospice team to keep the environment calm. Resident #3 had impaired cognitive function, dementia, impaired mobility, self-care performance deficit, weakness and she was totally dependent on staff for bathing /showering On 6/19/24 at 9:05 AM, Resident #3 was in bed with supplemental oxygen and noted to have a rattily cough, and an obvious skin tear on her elbow. She said that she had been at the end of her whirlpool bath one day, and as the water was draining, she slid off the seat. She had a seat belt on and there were 2 or 3 people in there trying to scoot her back up. She stated that she had pain in her knee and arm, with scratches on her knee and leg. She did not remember how she got out but she said that she loved to take a bath but hadn't used the whirlpool jets since that incident because she was afraid of it happening again. According to the Fall Incident Report dated 3/22/24 at 2:50 PM, Resident #3 slid almost all the way out of the whirlpool seat on that date. She had pain with movement and skin tears. The skin assessment showed a 2 centimeters (cm) x2 cm tear to her right forearm with bright red serosanguinous drainage. She had a 7 cm x 11.5 cm bruise on her left scapula, an abrasion to left ribs measured 1.5 cm x 11 cm, An abrasion to the left ribs 1.5 cm x 11 cm, and a bruise, 0.5 cm x 9 cm to the right ribs. On 6/19/24 at 4:30 PM, Staff J said that she gave Resident #3 a whirlpool bath the day that she slid from the chair. She said that the resident tended to slide down because she did not have much upper body strength. She said that she secured one plastic safety belt attached to the whirlpool chair, under the breast, like a gait belt but when the jets were turned on, the water shot up into the hole of the seat and the force of the water pushed the resident's bottom forward. When she drained the tub and opened the door, the resident slid down so far that Staff J could not pull her back up into the seat alone. By the time other staff could get there to help, the resident had half of her body on the floor. Her shoulders where on the seat and the belt was up into her arm pits. Staff J said that she was no longer the bath aide and chose to work the overnight shifts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/24 at 4:40 PM, the DON demonstrated how the two straps were attached on the back of the seat in the whirlpool; one at the top and one at the bottom. When asked how the resident would be secured, she said that the straps were to be crossed over the residents to the opposite sides of the seat and attached to the back. A review of the orientation/training list, dated 2/24/22, for Staff J lacked specific training on giving whirlpool baths. On 6/20/24 at 7:21 AM, Staff K, Bath Aide, demonstrated that she secured the residents to the whirlpool seat with two straps, the bottom strap to go around the waist, and the top strap around the torso. When asked if she had training on the whirlpool and how to ensure the safety of the residents, she said that she had many years of experience and she knew how it worked. She did not know of a book or directions on proper use of the whirlpool or the straps. On 6/20/24 at 9:20 AM, the DON and the Administrator said that staff were taught how to use the safety straps in the whirlpool. She said that Resident #3 slid down the seat because she had a bowel movement while she was in the water and when the water was drained, the BM caused her to slide down. On 6/20/24 at 9:50 AM, the DON provided the training checklist for Staff K, and showed that she had been trained on the whirlpool bath. She said she that Staff K had been directed to watch the training video from the manufacturer. She pointed out that the video showed the straps crossed in front, but nowhere in the training did it say that the straps must be crossed. An Inservice Operation and Training Advantage Bath System video showed the straps attached to the whirlpool seat were crossed to the opposite side of the chair, under the resident's breast and attached on the back. 4) According to the MDS dated [DATE], Resident #5 had a BIMS score of 6 (severe cognitive deficit). She required substantial assistance with toileting hygiene, showers and dressing, and supervision with toilet transfer and sit to stand. Her diagnosis included non -Alzheimer's Dementia, Traumatic [NAME] Injury (TBI), anxiety, dysphagia, oral phase, and pain in left knee. The Care Plan updated on 1/7/24 showed that Resident #5 had alteration in neurological status, she was at risk for impaired thought processes related to depression and anxiety and staff were directed to give step by step instructions one at a time. The resident had self-care performance deficits, she had anxiety and was unsteadiness on her feet. Resident #5 ambulated independent with a walker and required maximum assistance to transfer on and off toilet. A Nursing Note dated 4/10/24 at 8:30 AM, showed the nurse was called to the resident's room and found her on the floor in front of toilet. Resident #5 did not have a gait belt on and was not wearing non-skid socks. The resident had been left unattended on the toilet and she stated that her back and legs were sore. On 6/19/24 at 3:16 pm, Staff E, LPN said that she was the nurse on duty when Resident #5 fell in the bathroom. She said that Staff G transferred Resident #5 to the toilet and the resident didn't have a gait belt on. Staff G left the resident on the toilet, which typically would have been okay, but she had left her there too long and the resident then tried to get up by herself, got weak, and fell . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Counseling/Disciplinary Notice dated 4/15/24 for Staff G showed that she had a written warning for leaving a resident unattended on toilet. The resident did not have proper footwear or gait belt on at the time. On 6/20/24 at 9:00 AM, the DON acknowledged that the fall from the toilet on 4/10/24 for Resident #5 was the reason for the written warning dated 4/15/24 for Staff G. The staff member had been terminated shortly thereafter. 5) According to the MDS dated [DATE], Resident #2 had a BIMS score of 10 (moderate cognitive deficits). She used a walker and wheelchair for mobility and required substantial assistance with lower body dressing and footwear. The resident required supervision/touch assistance with sit to stand, toilet transfer and sit to lying. She was frequently incontinent of urine, and occasionally incontinent of bowel. Her diagnosis included renal insufficiency, non-Alzheimer's dementia, unspecified fracture fifth lumbar vertebra and muscle weakness. The Care Plan showed Resident #2 had confusion/disorientation, weakness, and history of a vertebra and pelvic fractures. An addition to the Care Plan on 4/14/24 showed that staff were to have wheel chair behind resident when ambulating. On 5/31/24, staff were to place the walker further away from resident recliner out her sight so she doesn't try to reach for it. On 4/24/24 therapy directed to evaluate and treat, encourage the resident to use call light. The following was included on Incident Reports for Resident #2: a. On 4/14/25 at 11:15 AM the resident had a witnessed fall in the bathroom. b. On 4/24/24 at 9:56 AM The resident had an unwitnessed fall in her room and said that she was trying to get up on her own and hurt her wrist. c. On 5/31/24 at 4:15 PM Resident #2 was found on the floor stated that she was reaching for her walker and slid out of her chair onto the floor. On 6/18/24 at 3:59 PM Resident #2 was in the recliner with the walker in front of her within reach. The resident said that she did not need help with ambulating and she said that she hadn't had any falls. On 6/19/24 at 9:34 AM and unidentified Certified Nurse Aide (CNA) assisted Resident #2 to ambulate down the hallway toward her room. She did not have a wheel chair behind the resident and at 9:35 AM, the resident was in her recliner and her walker was out of reach by the television where the resident could see it. On 6/20/24 at 7:00 AM, Staff F, LPN said that Resident #2 has had many falls because she self-transfers and education really doesn't help with her because she thinks she can do it on her own. On 6/20/24 at 9:50 AM, the DON said that she thought the intervention to keep the walker out of sight went against the wishes of the family and didn't know if they were still implementing that. She thought the intervention to have wheel chair behind when ambulating had been discontinued. She said that they have struggled to find effective interventions for Resident #2 because the resident believed that she was able to ambulate and transfer on her own. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An undated facility policy titled: Gait Belts, indicated that the gait belt must be used when transferring and ambulating resident who are not independent throughout the facility. An undated facility policy titled: Fall Management System showed that it was the policy of facility to provide each resident with appropriate assessment and intervention to prevent falls and to minimize complications if a fall occurs. An undated policy titled: Incidents and Accidents, showed that in the case of an accident, the resident would be provided immediate attention by a license nurse. Any staff witnessing an accident/incident render immediate assistance do not move the victim until he/she had been examined for possible injuries.