

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165550	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Solon Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 523 East Fifth Street Solon, IA 52333	

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** 20331</p> <p>Based on observation, clinical record review, facility investigation report, and staff interviews, the facility failed to supervise one of four residents reviewed in order to prevent a fall with major injury (Resident #2). The facility reported a census of 67 residents.</p> <p>Findings include:</p> <p>The MDS (Minimum Data Set) dated 10/19/2023 revealed Resident #2 had moderately impaired cognitive abilities, required moderate assistance to transfer from one surface to another, use the toilet, and dress. The resident required supervision with eating, had urinary and bowel incontinence, and a fall resulting in a fracture. The MDS reported the resident had diagnoses including stroke, coronary artery disease, hypertension, dementia, and repeated falls.</p> <p>The MDS dated [DATE] revealed Resident #2 had moderate cognitive impairment, required extensive assistance of one staff for transfers and ambulation, unsteady balance, and had two falls without injury.</p> <p>The Care Plan identified the resident had a risk for falls due to impaired cognition initiated on 11/12/2022 and updated. The Care Plan instructed staff to provide stand and pivot transfer assistance with two staff and the use of a gait belt.</p> <p>Fall interventions included: green pool noodle behind the pummel cushion in chair to prevent cushion from moving, keep tray table within reach of resident at all times, encourage resident to lay in bed at night, Velcro remote to stand beside chair, medication reviews, gripper socks, lipped mattress, moved to assisted dining table, low bed, non skid strips in front of chair, restorative program, and staff education.</p> <p>The Fall Risk assessment dated [DATE] revealed Resident #2 had a high fall risk.</p> <p>A nursing Progress Note dated 10/9/2023 at 6:28 P.M. included:</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>Patient was yelling in her room for help, and observed patient lying on the floor in supine position (on her back), near the roommate's bed. Patient was bleeding from her forehead, nose and mouth. A 7 x 2 cm (centimeter) injury noted and bleeding, covering the face. Patient stated: I was taking myself to check my closet, and go to the bathroom and I felt dizzy, and lost balance and went down. Staff called 911 and patient taken to UIHC ER (University of Iowa Health Care emergency room) for further evaluation.</p> <p>A Progress Note dated 10/04/2023 at 5:00 A.M. included:</p> <p>Resident observed on the floor next to the bathroom door, laying on her left side on 10/4/23 at 5:00 A.M. Range of Motion within normal limits, moves all extremities without pain and discomfort. Resident is alert and oriented to self per baseline. Resident failed to use the call light to call for help. Call light and personal belonging are within reach.</p> <p>A Progress Note dated 10/03/2023 2:00 A.M. included:</p> <p>Resident observed on the floor laying on her left side at 10/3/23 at 2:00 A.M. Resident reported I climbed off the recliner to see what's happening out there. Resident is alert and oriented to self, reported no pain, able to communicate needs but did not use the call light to call for help. Range of Motion within normal limits, and moved all extremities without pain.</p> <p>Observation on 3/26/2024 at 9:15 A.M. revealed the resident in her room, in the recliner with the foot rest up. The alert resident watched television, had call light available and had no signs of bruises or injury, and wore gripper socks. The resident appeared restless, concerned with dirt in her recliner.</p> <p>At 11:30 A.M., two staff transferred the resident from the recliner to the wheel chair and transported her to the dining room. The resident refused to use the bathroom.</p> <p>On 4/1/2024 at 10:20 A.M. the resident rested in the recliner, covered with a blanket, had eyes shut and restless legs.</p> <p>At noon, the resident sat at the assisted dining room table with staff present. She stated she did not want to eat the food on her plate and waited for a peanut butter sandwich.</p> <p>At 12:25 P.M., observation revealed the resident ate 100% of her sandwich. She remained alert and verbal with staff.</p> <p>The Resident's UIHC History and Physical report dated 10/10/2023 included:</p> <p>The resident admitted on [DATE] and patient states she fell while going to the restroom to get her walker.</p> <p>Assessment: fall with frontal scalp hematoma, multiple fractures face bones, nausea likely due to pain. Right 5th metacarpal (finger) fracture. Recommend resident return to care facility when medically appropriate with hospice services.</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>Findings: no acute intracranial (within the skull) findings, right inferior wall frontal lobe hematoma extending inferiorly along the nasal bridge, comminuted right nasal bone fracture, left nasal bone fracture, fracture of the right frontal process of the maxilla (jaw bone), fracture of the zygomatic arch (bone beneath the eye), likely fracture anterior nasal septum.</p> <p>The Resident's fall history revealed she had 15 falls from 6/30/2023 - 11/26/2024. The fall on 10/9/2024 resulted in a major injury.</p> <p>The facility Post Fall/Incident assessment dated [DATE] revealed Resident #2 fell in her room at 5:20 P.M. Staff found the resident laying supine with a 7 cm. (Centimeter) by 2 cm. forehead laceration. The resident reported she attempted to go to the closet and then the bathroom, felt dizzy and fell The resident yelled from her room for help. Staff E, RN (Registered Nurse) went in and observed her lying on the floor near the roommate's bed. Patient was bleeding from her forehead, nose and mouth. Staff called 911 for help and the resident transferred to the emergency room for evaluation.</p> <p>The facility Device Activity Report dated 10/9/2023 revealed room [ROOM NUMBER]'s call light was activated from 4:57 P.M. until 5:27 P.M.</p> <p>The facility investigation revealed the resident activated her call light at 4:57 P.M. and was shut off at 5:27 P. M. Cameras revealed Staff E, RN stood in the middle of the hallway directly in front of the call light board from 4:30 P.M. until the resident called out for help shortly before 5:30 P.M. Staff E reported during that time, he checked his MAR (Medication Administration Records) to be sure medications were signed off. He heard someone yelling for help, entered room [ROOM NUMBER], and saw Resident #2 on the floor with copious amounts of blood coming from a forehead laceration, and her nose and mouth. Staff E reported he forgot to check the call light board, and blamed the CNA's (Certified Nurse's Aides) for not getting her out to dinner by that time.</p> <p>On 4/1/2024 at approximately 2 o'clock P.M., Staff A, Administrator reported the facility used the current call light system for about three years and never really had any issues with it. Staff used pagers in the past and they decided to stop using them because staff either lost them or forgot to charge them. A couple of months ago, they upgraded the call light system, reintroduced wireless pagers for staff to carry that alert them when a call light is on and when an exit door alarms. When Resident #2 fell on [DATE], video footage showed Staff E, RN standing in front of the hall monitor on East hall for 30 minutes and did not respond to the resident's call light. They terminated Staff E because he failed to take his job seriously. Staff F, CNA received a discipline for not working on East hall that evening from 5 - 6 P.M. The resident presented a challenge, you could have your eyes on her one minute and the next, she would fall. The facility tried several interventions such as room change, alarms, and medication changes involving hospice, the medical director and the nurse practitioner. The resident seemed calmer and clearer recently and had no fall since November. The resident prefers to sleep in the recliner and does occasionally use the call light. When the resident first admitted , she ambulated independently, and moved to the first room on East hall for closer supervision due to falls.</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 3/26/2024 at 2 P.M., Staff B, DON (Director of Nursing) reported Resident #2 occasionally used the call light and on October 9, 2023, she did put her call light on. Call light records revealed the call light was on for about 30 minutes before staff found her on the floor. The resident said she intended to go to her closet to get something when she fell . The resident had a history of falls and this was the only fall that resulted in a major injury. When she returned from the hospital, she had one on one supervision until 10/24/2023 and then staff checked on her every fifteen minutes until 2/8/2024. Currently staff check on her every hour, and her room is the first on the hall with staff frequently passing by. The resident's room door is kept open so staff can visualize her as they pass by. The fall investigation revealed Staff E stood near the call light monitor in the middle of East hall and failed to respond to her light during the 30 minutes it was on. Two CNA's also worked on East hall and were assisting residents to the dining room during that time. Staff E reported he checked the MARS during that time, and he failed to check the call light monitor. When he heard the call for help, he responded. The call light monitor shows all activated call lights. Currently, staff also carry pagers that are hall specific. Staff F, CNA arrived at 5 o'clock P.M. and was supposed to help out on East from 5-6 P.M. Staff F failed to work on her assigned hall during that hour, leaving one CNA assigned to East hall. The resident graduated from hospice services.</p> <p>On 4/1/2024 at 1:45 P.M., Staff C, CNA reported working on East hall on 10/9/2023 from 2 - 10 P.M. Staff C assisted Resident #2 to the bathroom earlier in her shift, prior to her falling around 5:30 P.M. After the resident fell , Staff C observed the resident on the floor with another staff present. Staff C worked alone on the hall from 5 - 6 P.M., however another staff came at some point and assisted with getting residents to dinner. Staff C worked at getting residents to dinner and had no recall if call lights were on.</p> <p>On 4/1/2024 at 10:35 A.M., Staff D, CNA reported working on 10/9/2024 from 2 - 10 P.M. on [NAME] hall. When Staff D finished assisting residents to dinner, he went to East hall to help. When he walked passed Resident #2's room, he observed her on the floor, bleeding, and near the roommate's bed with Staff E present. Staff D stayed with the resident while Staff E assessed her and called for the ambulance. The fall occurred during the one hour juncture when there was only one staff on East hall. When Resident #2 resided on the end of [NAME] hall, she frequently thought she could self transfer and sustained falls. The resident moved to the first room on East hall for closer supervision. The resident preferred to sleep in the recliner and is able to use the call light. The resident had no recent falls and seemed calmer with no complaint of pain. The resident now required the assistance of two staff for transfers.</p> <p>The facility's new hire Orientation Packet included:</p> <p>Call lights appear on screens in every hall and must be answered in 15 minutes.</p> <p>The facility's Registered Nurse job description and requirements signed by Staff E on 10/26/2022 included:</p> <p>General job summary: The registered nurse assists in the supervision and administration of the quality of nursing care for the facility. The Registered Nurse assists in maintaining a physical, social and psychological environment which will be conducive to the best interest and welfare of the residents.</p> <p>Job Descriptions:</p> <p>(continued on next page)</p>		

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