| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **165243** | A. BUILDING _____ B. WING _____ | **09/28/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CHAUTAUQUA GUEST HOME #3** | **302 NINTH STREET CHARLES CITY, IA 50616** |

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 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interview and manufacturer guideline, the facility failed to follow the plan of care for a resident who sustained a fall while in a Lumex lift, (Resident #2). The facility census was 46 residents. Findings include: 1. A Quarterly Minimum Data Set (MDS) with assessment reference date 8/11/20, documented Resident #2 had [DIAGNOSES REDACTED]. The resident had a score of 10 of 15 on a BIMS (brief interview for mental status) which indicated moderate impaired decision making abilities. The resident had required extensive assistance of two persons for bed mobility, transfers, dressing, toilet use and personal hygiene. Resident #2's balance during transitions and walking was not steady, only able to stabilize with staff assistance and wheelchair used for mobility device. Resident #2's Plan of Care with a initiated date of 2/17/18, documented resident was at risk for falls related to psychoactive drug use, weakness and history of falls. Interventions include: *Be sure call light/pendent is with in reach and encourage resident to use it for assistance as needed. *Resident had a fall with right clavicle fracture in October 2017 and on 4/4/19 resulting in left femur fracture. *Resident needs a safe environment with (even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light/pendent in reach, the bed at appropriate height, side rails as ordered, personal items within reach). *Staff to refer to Resident Care Guideline posted in resident room for safety instruction. The Resident Care Guidelines with a date of 6/5/20, instructed staff to use the Lumex with two assist on the 2nd and 3rd shift, and assistive device of the gait belt, and rolling walker. The Physician Notification Form/Progress notes dated 6/28/20 at 7:25 p.m., documented upon entering resident room, the resident was sitting on floor in front of recliner, legs extended out in front of resident. The Lumex was in front of resident just out of reach of feet, gait belt around resident. Resident was being transferred back into recliner after using the restroom. Resident laughing about incident, good spirits, resident had silky pajamas on and it appears the recliner was at an incline that coupled with a silky material made it easy to slip out of chair. Staff re-education. Administrative review: incident during staff transfer-no injuries noted, with related to staff and equipment. Intervention to make sure resident has no silk pajamas on and staff discipline. Review of the LUMEX LF 1600 Stand Assist Assembly and Operation Manual dated 2007, Instructed staff to: *Raise the two split seat units so they are parallel to the side of the Stand Assist. *Have the patient positioned at the edge of the surface to be transferred from. Move the Stand Assist in front of the patient. Position the patient so that her feet are firmly on the platform and her knees an shins are in contact with the two cupped kneepads. *Lock the casters by stepping on the caster clip and pushing down. *Have the patient grasp the cross bar closest to her and, using her own strength, pull herself up into a standing position securely on the base platform. *Lower both of the split seat units down into position to form a complete seat. *Have the patient lower herself down onto the seat while keeping her knees and shins in the kneepads, and while continuing to hold the cross bar with both hands. *Unlock the casters. Place both hands on the cross bar furthest from the patient, and move the Stand Assist to the new surface. Ensure that the patient is secure and in proper position, before and during transfer. *Position the Stand Assist against the new surface, ensuring that the patient will be in a position to sit down firmly and safely on the transfer surface. *Lock the casters. *Have the patient pull herself back up to a full standing position. *Raise the two split seat units so that they are parallel to the side of the Stand Assist, to allow the patient to lower herself. *Stand beside the patient as she lowers herself down onto the new surface. *Ensure that the patient is safely positioned. Unlock the casters and move the Stand Assist to storage. Review of the video surveillance dated 6/28/20, revealed Staff A, Certified Nursing Assistant (CNA), failed to apply a gait belt to the patient prior to the use of the Lumex Stand Assist, failed to lock the casters and did the transfer with one assist instead of two. During an interview on 9/23/20 at 4:41 p.m., Staff A, confirmed and verified the gait belt was applied to the resident after the resident was on the floor and the casters to the Lumex Stand Assist were not locked and the Resident Care Guidelines state Resident #2 is a 2 person transfer and that Staff A, did the transfer alone. During an interview on 9/23/20 at 4:30 p.m., the facility Administrator stated the facility does not have a gait belt policy, however, the staff are to follow the Resident Care Guidelines (RCG) that are in the resident room, and if the RCG's states to use a gait belt than it is the expectation of staff to use a gait belt. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interview and in room video surveillance along with photographic evidence, the facility failed to use proper Personal Protective Equipment (PPE) for infection control measures in attempts to mitigate the transmission of the Covid - 19 virus with one resident, (Resident #2). The facility reported a census of 46 residents. Findings include: 1. A Quarterly Minimum Data Set (MDS) assessment with reference date 8/11/20, documented Resident #2 had [DIAGNOSES REDACTED]. The resident had scored 10 of 15 on a BIMS (brief interview for mental status) which indicated moderate impaired decision making abilities. The resident had required extensive assistance of two persons for bed mobility, transfers, dressing, toilet use and personal hygiene. Review of Resident #2's Care Plan with initiated date 1/16/20, showed resident had focus areas of heart failure, pacemaker related to heart failure, and alteration in psychosocial well being related to restrictions on visitation, communal dining, and activities during the COVID-19 restriction time. Interventions include: *Check breath sounds and monitor/document for labored breathing. *Give cardiac medications as ordered. *Monitor vital signs per facility protocol or per my physicians orders. Notify Medical Doctor of significant abnormalities. *Monitor/Document/report any signs/symptoms of [MEDICAL CONDITION], dependent [MEDICAL CONDITION] of legs and feet, periorbital [MEDICAL CONDITION], shortness of breath upon exertion, cool skin dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation. *Oxygen per doctor orders. *Monitor/document/report any signs or symptoms of altered cardiac output or pacemaker malfunction, dizziness, [MEDICAL CONDITION], difficulty breathing, pulse rate lower than programmed rate, lower than baseline blood pressure. *Pacemaker checks per physicians/manufacturers recommendations and document in chart, heart rate, rhythm, battery check. *Assist with personal request for snacks, drinks, activities, cares and alternative options for communication, care packages. *Monitor for changes in psychosocial status, decreased conversations, change in mood, decreased interactions with staff. *Provide and encourage alternate options for activities interactions such as audio books, movies on portable players, hand held games, word finds/search puzzles, crafts, interactive games in the hall from the doorways of room. Review of in room photographic images provided by the family revealed: *At 7:42 a.m., no date, Staff B, Certified Nursing Assistant, (CNA) in Resident #2's room with no mask covering their mouth. *At 5:51 p.m., no date, Staff C, CNA in Resident #2' room with the face mask below their nose, not covering their mouth. *At 7:34 a.m., no date, Staff D, CNA in Resident #2's room with the |

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

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **165243** | A. BUILDING _____ B. WING _____ | **09/28/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CHAUTAUQUA GUEST HOME #3** | **302 NINTH STREET CHARLES CITY, IA 50616** |

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 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>face mask below their chin. *At 12:57 a.m., no date, Staff D, CNA, in Resident #2's room with the face mask below their chin. *At 7:00 a.m., no date, Staff B, CNA, in Resident #2's room with the face mask below their nose. *At 9:12 a.m., no date, Staff C, CNA, in Resident #2's room with the face mask below their nose. Review of the video surveillance the family provided, revealed on 6/28/20 at 7:25 p.m., Staff E, CNA in Resident #2's room with no face mask or face covering. Review of a facility form provided by the Administrator on 9/24/20 dated 4/6/20, showed the education staff had been provided for the facility policy on wearing masks. The form noted in response to some questions related to use of masks, here is some guidance we would like to offer: 1. Use of the masks while on duty and in the facility is not negotiable-everyone is required to wear one. During an interview on 9/23/20 at 3:40 p.m., the Administrator confirmed and verified staff are expected to follow facility protocol for wearing Personal Protective Equipment during patient cares and contact. |