STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165034	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES	**201 WEST RIDGEWAY AVENUE WATERLOO, IA 50701**

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** Based on clinical record review, policy review, and staff interview, the facility failed to complete timely post-fall assessments, interventions, and physician notification for 1 of 3 residents reviewed (Resident #8). The facility reported a census of 75 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] listed [DIAGNOSES REDACTED]. A Brief Interview for Mental Status (BIMS) test conveyed a score of 13, indicating no cognitive deficits. A care plan focus dated 1/3/20 identified a problem of self-care deficit related to weakness from [MEDICAL CONDITION] and hospitalization . The care plan revealed the resident transferred with the use a gait belt and assistance of 1 staff. On 1/8/20 at 7:04 a.m., Staff C, Licensed Practical Nurse (LPN) documented the resident's right knee as swollen and tender to touch and the resident stated the discomfort occurred after a fall earlier in the week. Review of the progress notes revealed no entries when the resident returned from the hospital on [DATE] through the 1/8/20 entry at 7:04 a.m. regarding a fall. On 1/9/20, Staff A, Licensed Practical Nurse, (LPN), documented a late entry progress note and an incident report revealing Staff A had observed resident #8 kneeling on the floor at her bedside at 6:05 a.m. on 1/5/20 without apparent injury. The resident had been assisted back into bed by two staff. An untitled, undated handwritten note provided by the facility from Staff D, LPN, documented that Staff D, LPN, assisted Staff A to move the resident from the floor back to bed. The note disclosed Staff D, LPN, believed Staff A, LPN, would document the resident's fall since Staff D's shift was ending. During an interview on 7/9/20 at 12:30 p.m., Staff A, LPN, stated the expectation that the night nurse (Staff D) would document the incident since report from night shift to day shift had not occurred at the time of the fall. Staff A, LPN, completed the incident report and progress note on 1/9/20 after being instructed to do so by the Administrator. Staff A, LPN, stated neurological assessments (checking of vitals, pupil reaction, hand grips equal) are expected when no one witnesses a fall. Neurological assessments are recorded on a neuro sheet in the chart and fall updates are recorded in the progress notes. During an interview on 7/8/20 at 5:00 p.m., the Administrator said she reviewed the resident's chart after the reported fall, and noting no documentation regarding a fall she investigated further and asked one of the nurses on duty at the time of the fall (Staff A, LPN) to complete an incident report and progress note. On 7/8/20 at 4:20 p.m. Staff B, Registered Nurse (RN), stated she could not recall the fall, but if a fall was unwitnessed by staff nurses are to complete a neurological assessment every 15 minutes, then every 30 minutes, and eventually once a shift and follow-up on the fall on the neuro sheet or in the progress notes a minimum of every shift. During an interview with Staff C, LPN, on 7/14/20 at 5:30 a.m., she stated she could not recall the fall, but if she had known the resident fell she would have documented vital signs and filled out the neuro sheet. The facility's Falls Practice Guide dated 12/2011 directed an evaluation of the patient is to be completed timely following a fall. Post-fall evaluations are documented in the patient's clinical record. Upon completion of the evaluation the physician is notified and orders are documented, noted and implemented as indicated. On 7/14/20 at 6:50 a.m. the Director of Nursing (DON) acknowledged no neuro sheet existed in the resident's chart and that a neurological assessment is expected after an unwitnessed fall. The DON further acknowledged no documentation in the progress notes related to fall follow-up from 1/5/20 until 1/8/20 when staff assessed the resident and notified a nurse practitioner.

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.