STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165550	A. BUILDING _____ B. WING _____	C 06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLON NURSING CARE CENTER	523 EAST FIFTH STREET SOLON, IA 52333

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: _____ The following deficiency relates to the investigation of Complaints #96404 and #97677 and Facility Self-Reported Incidents #97645 and #97659 conducted May 26 - June 2, 2021. Both Incidents substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on facility and hospital record review and staff interview, the facility failed to ensure that each resident received adequate supervision and assistance when transferred with a mechanical lift (Hoyer Lift) to prevent accidents. Concerns were noted for one out of six residents (Resident #1). Staff failed to safely transfer Resident #1 in accordance with the individual plan of care which resulted in the resident falling and sustaining an injury which required hospitalization. The facility reported a census of 61 residents. Findings include: According to documentation in the Medical Record/Face Sheet, Resident # 1 had diagnoses	F 689		

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

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F 689	Continued From page 1	F 689		

which included Multiple Sclerosis (MS), nutritional deficiency, personal history of poliomyelitis, personal history of traumatic brain injury and age related osteoporosis.

The Minimum Data Set (MDS) dated 5/5/21, documented Resident # 1 scored 10 out of 15 points on the Brief Interview for Mental Status (BIMS) indicating moderately impaired for decision making skills. The assessment also described Resident #1 as requiring extensive staff assistance with all activities of daily living (ADL's) including bed mobility, transferring, ambulation, dressing, toilet use, personal hygiene and bathing.

The individual Care Plan dated/revised 5/10/21 identified Resident #1 at risk for falls due to impaired mobility from MS and post-polio syndrome. The plan directed staff to transfer Resident #1 via the Hoyer lift and the assist of two staff. Resident #1's used a wheel chair for her primary mobility and able to propel herself short distances.

Documentation in the facility Nurse's Notes dated 5/22/21 indicated at 11:40 a.m. a Certified Nursing Assistant (CNA) transferred Resident #1 via the Hoyer lift and the strap slipped, dropping Resident #1 first on the shoulder and then the left orbital brow impacted the floor. The entry included the following assessment: Blood noted, the Resident voiced a painful response but confused, Vital signs: blood pressure 147/123 per automatic arm monitor, heart rate (HR) 101, temperature (T) 97.7, oxygen (O2) 90%, respirations (RR) 24. The resident complains of shoulder pain, moves upper extremities/lower extremities per baseline, pupils fixed, dilated, and

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F 689	Continued From page 2	F 689		

vision blurry. A hematoma noted on the left brow and the resident, alert and oriented times 0 (zero). Noted her speech slightly slurred, unable to tell nurse name, date of birth, location, and season, year. Per baseline, resident knows name, date of birth, most of the time location and can identify season, month, often day of week and year, 911 called and paramedics arrived at 11:50 a.m. to perform assessment.

Documentation in the Hospital History and Physical dated 5/22/21, indicated Resident #1 fell when being transferred via Hoyer lift. The entry also indicated that at the facility Resident #1's baseline is confused, but was more so after her fall. The resident indicated not having significant pain, but clutching at her left temple and left forehead and when asked if she had a headache, she said "yes".

The Hospital Record (also dated 5/22/21) indicated the Computerized Tomography (CT) of the head without contrast, showed an acute appearing 1 centimeter (cm) x 4.5 cm x 8 cm left-sided subdural hematoma. Resident #1 also had a temporal laceration which required sutures.

Hospital Progress Notes dated 5/23/21 indicated a repeat CT scan showed a left subdural hematoma, unchanged from yesterday's (5/22/21) scan.

A Hospital Radiology Report dated 5/23/21 documented results of a CT of Resident #1's head which read: A 4 millimeter (mm) focus of increased attenuation along the cortical surface of the right frontal lobe is unchanged compared to yesterday's exam but not present on the exam of 2/25/21 and could represent a tiny focus of

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F 689	Continued From page 3	F 689		

parenchymal hemorrhage (a bleed that occurs in the brain and can lead to disruption of oxygen in brain cells and subsequent functional tissue death).

Documentation in the facility Nurse's Notes dated 5/25/21 revealed Resident # 1 returned to the facility at 2:08 p.m.. Resident #1 rolling her head back and forth, rubbing her eyes and head and complaining of a "very bad pain"; left head and all over. She was moaning and crying off and on.

According to a typed report dated 5/22/21, the Director of Nursing (DON) reported Staff A, Certified Nursing Assistant (CNA) was getting residents up for lunch on 5/22/21. Staff A indicated she looked for a nurse to help her with Resident #1 because she required a Hoyer lift transfer. Staff A could not find the nurse, so she decided to do the transfer herself. Staff A hooked the resident up with the sling, and when she had the resident approximately 3-4 feet in the air, the top loop of the harness came off the Hoyer hook, and the resident fell to the floor landing on her left shoulder and left side of her head. Staff A noticed a hematoma and blood from the left side of Resident #1's head, and went to find a nurse.

The DON reported he asked Staff A if Resident #1 was in a hurry to get up and Staff A said she was not. The DON also confirmed with Staff A that she knew that Hoyer lift transfers always required assist of two staff. When asked why Staff A then made the decision to go ahead and do the transfer herself, she responded that Resident #1 is "always an easy transfer with the second person just being there and not having to do anything and it has always gone smoothly".