STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165286	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE HILL CARE CENTER	909 6TH STREET TRAER, IA 50675

(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: 04/05/2024 The Sunrise Hill Care Center is not in compliance with the code of Federal Regulations (42 CFR), Part 483, Subpart B-C following the investigation of facility reported incidents #116289-I and #117128-I conducted April 2, 2024 to April 4, 2024. Facility reported incidents #116289-I and #117128-I were substantiated. Facility census: 47	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 observations, interviews, and record review, the facility failed to provide safety interventions required for 2 out of 4 residents reviewed (Residents #1 and #2). Resident #2 required assist of 1 staff with a gait belt (a belt placed around the waist to aide in safe transfers and ambulation) for transfers and ambulation. A Certified Nurse Assistant (CNA) let go of the gait belt resulting in Resident #2 falling and fracturing her hip. Resident #1 was to not be left unattended in his room unless he was in bed. Resident #1	F 689	See Attached POC	041024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel M. Jorgensen, MSL/NHA-L | TITLE: Administrator | (X6) DATE: 04/05/24

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.

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F 689	Continued From page 1	F 689		

was found on floor unattended at least twice in his room. The facility reported a census of 47 residents.

Findings include:

1. Resident #2's Minimum Data Set (MDS) assessment dated 8/10/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #2 required extensive assist of 1 for transfers, ambulation and toilet use. The MDS included diagnoses of a cerebrovascular accident (CVA)(Stroke).

A Care Plan Focus initiated on 6/30/22, identified Resident #2 as impulsive and tried to do more than she could safely do. Resident #2 had personal alarms. It directed the staff that Resident #2 required staff assistance of 1 person for toilet use and transfers. It documented Resident #2 received assistance of 1 person with a walker and gait belt for ambulation.

Resident #2's Clinical Census reflected she transferred to the hospital on 9/14/23 and then returned from the hospital on 9/18/23. In addition, the list reflected Resident #2 discharged from the facility on 11/6/23.

A Progress Note dated 9/14/23 at 4:45 AM, written by Staff B, Licensed Practical Nurse (LPN), documented at 4:00 AM Staff A, CNA reported that Resident #2 fell in her bathroom. Staff B, documented that Resident #2 was laying on her right side on the floor with her head resting on the wall. Resident #2 stated she hit her head on the right side behind her ear. Staff A and Staff B assisted Resident #1 up and placed her on the toilet. Resident #2 complained of sharp pain.

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F 689	Continued From page 2	F 689		

Resident #2 was placed into a wheelchair and laid on to her bed for further assessment. Staff B documented that Resident #2's right hip was splayed out wider than normal. Staff B phoned 911.

Resident #2's Incident Report dated 9/14/23 described her as sitting/laying on the bathroom floor (on her right side) with her head resting on the wall. Resident #2 had good range of motion, except for her right hip/leg. 2 Staff assisted her to standing with a gait belt. The report indicated Resident #2 had a right hip fracture repaired on 9/14/23.

The Nurses Note dated 9/14/23 at 2:49 PM, reflected the facility's physician reported Resident #2 had a right hip fracture and they admitted her to the hospital for right hip surgery.

The Nurses Note dated 9/18/23 at 5:15 PM, indicated Resident #2 returned to the facility.

The Hospital's Clinical Summary dated 9/18/23, indicated the hospital admitted Resident #2 after undergoing surgical repair for a right hip fracture (intertrochanteric, right femur). The summary included a diagnosis of acute blood loss.

The Hospital Progress Notes printed 9/18/23 indicated the provided suspected Resident #2 bled into her surgical site, resulting in Resident #2 receiving 2 units of blood. The note included Resident #2 also had a T12 compression fracture (Fracture in mid-lower back of the vertebrae bone).

On 4/3/24 at 10:41 PM, Staff B explained Staff A called her to Resident #2's room. When she

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F 689	Continued From page 3	F 689		

arrived, she found Resident #2 sitting in the corner of the bathroom floor. Staff B explained as Staff A threw linen around the corner into the bathroom linen cart. Staff B said when Staff A reached around the corner, Resident #2 fell in that short of period of time. Staff B remarked Staff A took Resident #2 to the toilet. Staff B stated she did not remember if Resident #2 had a gait belt around her waist or not. Staff B stated they lifted Resident #2 off the floor and sat her on the toilet. Staff B stated Resident #2 said that hurts and she wouldn't bear any weight on one leg. Staff B reported she and Staff A when lifting Resident #2 off of the floor and transferring Resident #2 to the toilet, were lifting her up while holding onto Resident #2 under each arm. Staff B stated she wanted to say Resident #2 had a gait belt on when they lifted her but staff B couldn't remember. Staff B reported Resident #1 required assistance for 1 person with transfers. Staff B said of course they are supposed to have a gait belt on Resident #2. She stated they are to use a gait belt on residents that are an assist of 1 for transfers and ambulation. Staff B described Resident #2 as spring loaded, as she would pop up on her own. She always tried to do things like that. She couldn't be left alone on the toilet. Resident #2 had a bed alarm while she slept. Staff B thought that Resident #2 had a bed and a floor alarm. Staff B stated she sent Resident #2 to the hospital.

On 4/4/24 at 9:22 AM, Staff A reported Resident #2 washed her hands at the sink of her small bathroom, after having a bowel movement. Resident #2 fell back into the corner of her bathroom. Staff A explained she assisted Resident #2 with standing up from the toilet using the gait belt. Staff A turned to put the dirty towels

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F 689	Continued From page 4 on to the floor of the bathroom while Resident #2 stood at the sink. Staff A stated she had to use both of her hands to move the towels and at that moment Resident #2 fell. Staff A stated she didn't have time to turn and help Resident #2 before she fell. Staff A said she needed to move the dirty towels to the floor. The towels were in her hand and her clean hand was holding the gait belt. Staff A said she let go (of the gait belt) with her clean hand to use both of her hands to move the towels to the floor. Staff A explained she should have kept a hold of the gait belt as Resident #2 stood. On 4/3/24 at 4:30 PM, the Director of Nursing (DON), stated understanding of concern with gait belt use for Resident #2. This DON acknowledged that a fall with fracture happened a year prior related to a different CNA letting go of Resident #2's gait belt. She stated her expectations would be that a gait belt would be used with transferring off the toilet for Resident #2. The DON stated all residents with assist of 1 needed to have a gait belt and the staff should not let go of that gait belt when a resident is standing, transferring, and/or ambulating. The DON stated the facility provided education that Staff A attended after the last time Resident #2 fell and broke her hip. A Major Injury Determination Form dated 9/14/23, documented that the circumstances of the incident causing the injury was a fall. The description of the injury was a right hip fracture and fracture of T12. The form described the resident's previous functional ability as an assist of one, gait belt and walker. The facility's physician checked that after reviewing the circumstances of the incident causing the injury,	F 689		

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F 689	Continued From page 5 the previous functional ability of the patient, and the patient's prognosis, they believed Resident #2 had a major injury, pursuant to 481 Iowa Administrative Code 50.7(1)(a)(3). The Use of Gait Belt Policy dated October 2021, directed the staff to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety. 2. Resident #1's MDS assessment dated 12/14/23, identified a BIMS score of 3, indicating severe cognitive impairment. Resident #1 required substantial/maximal assistance for toilet use and transferring. The MDS included a diagnosis of non-Alzheimer's dementia. A Care Plan Focus regarding Fall/Safety initiated 5/31/23, directed the staff to encourage Resident #1 to stay out of his room unattended unless in bed. If in his bed, ensure he had a bed alarm and pressure pad in chair for safety. The Care Plan included Resident #1 fell on 6/4/23, 9/8/23, 11/3/23, 11/28/23 (resulting in a right hip fracture), 2/18/24 and 3/16/24. The Nurses Note dated 2/18/24 at 1:55 PM reflected the nurse found Resident #1 laying on the floor on his back in the bathroom. He couldn't say what happened. 2 staff assisted him to standing with a gait belt. The assessment revealed a skin tear on his left hand. The nurse cleaned the area and approximated (put together) with steri-strips. The facility notified the doctor and Resident #1's son of the incident and his new skin area. Resident #1's Incident Report dated 2/18/24 indicated the staff found him on his bathroom	F 689		

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F 689	Continued From page 6	F 689		

floor. The facility reeducated the staff to not leave Resident #1 alone in his bedroom unless he's in bed.

The Nurses Note dated 3/16/24 at 3:15 PM, reflected the staff found Resident #1 lying on the floor next to his bed, positioned flat on his back with his legs extended out. He denied pain and his assessment revealed no injuries or skin issues noted. 2 staff assisted Resident #1 to stand and transfer to his wheelchair.

Resident #1's Incident Report dated 3/16/24 listed Resident #1 as not to be alone in room unless in bed. He tried to self-transfer from his recliner in his room. The Incident Report directed the staff to have Resident #1 at the nurse's station for closer supervision.

On 4/4/24 at 10:05 AM, the DON explained she educated all of the staff including nurses that Resident #1 should not be left alone in his room unless he had his alarms on and laid in bed. She expected them to follow that. She said Resident #1 should sit in in the recliner by the nurses' station when the staff couldn't observe him in his room. The DON acknowledged that on the incident reports indicated Resident #1 fell twice while unattended in his room. She stated the staff received reeducation both times.

A Fall Assessment Protocol updated August 2022, directed to complete fall risk assessments with Care Plan reviews and would be reviewed with the QA (Quality Assurance) committee weekly. It directed to review the incidents at the weekly meeting with team input. In addition, the DON monitors all falls and attempts to determine patterns regarding day of the week, time of the

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F 689	Continued From page 7 day, and where the fall occurs. The form reflected to implement changes and update the written plan of care with input from all members of the interdisciplinary team.	F 689		

Sunrise Hill Care & Rehab Center

April 25, 2024

DIAL Review of Self Reports

#116289-I & #117128-I

Response to 2567 & Citation

Plan of Correction:

The following narrative action plan components will serve as Sunrise Hill Care & Rehab's *allegation of compliance* referencing the following identified concerns. Systems corrective action plans were in place earlier, however for purposes of this DIAL visit for the identified self reports of the Facility is: Correction Date: 04/05/2024

F689 SS=G 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices

483.25(d)(1) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and

483.25(d)(2) The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

Provider Response:

As the facility is committed to ensuring the residents being served are participating in a quality, safe, and engaging environment, the facility's "Falls Program" has been discussed, enhanced, and educated to all facility TEAM members. All Department managers were educated on the facility "Falls Program" and instructed to share the basics with their team members, encouraging them to speak up and support the residents by saying something supportive if they have any concern observations.

The facility's "Falls Program" is known as the "Falling Star" program, and is targeted for those residents that have been identified as at a "high risk" for falling. The key components of the program include 1) assessment, 2) gait/transfer belts, 3) room placements, 4) low bed positioning, 5) bed position identifiers, 6) Falling Star room identifiers, 7) all shift(s) nursing staff audit documentation.

*All residents identified as being at high risk for falls are being placed in rooms closest to the Nursing/charting station.

*All residents identified as being at high risk for falls are care planned accordingly, and direct care staff have access to Care Plan "Help" sheets that they can carry with them at all times, or until they have internalized the resident' needs.

*Falling Star icons have been produced that are magnetically applied to the resident metal door frame next to their name and room number.

*A major provision of the "Falling Star" program is that no identified resident is to be placed in their room(s) unattended, unless they are placed in their bed, bed positioned in low position, and if Care Planned for a landing mat to be in place.

*Identified Residents with low bed positioning have a bright yellow decal placed on the visual space of the bed foot board.

*Audit sheets have been developed for use in auditing that all staff have their gait/transfer belt on their person or their resident at all times, (prime auditing times are during daily shift reports for possession, and throughout the shift to observe being used appropriately). Audit sheets have been developed for bed positioning checks, and for ensuring that when gait/transfer belts are applied to a resident they are being used to assist and stabilize the resident. They are never to be let go of when they are applied to the resident until they are placed at their determined destination.

*Audit sheets will be issued several times daily and weekly and after completed during a staff members tour of duty, they are to be turned into the Assistant Director of Nursing for review and disposition. Audits are to be completed by not only the DON, ADON, Charge Nurses, but medication aides, other CNA's, and other TEAM Members to impart the importance of the program components.

*The Falling Star program and all its components are a high priority sharing for anytime there may be a Agency participant in the Sunrise Hill Care and Rehab program.

* A minimum of 5 audit assignments will be issued each week, and turned in to the ADON.

*Falls reviews are completed 4 times weekly at the daily QAPI meeting. Falls huddles are conducted at the time of each fall, documented, and given to the DON for TEAM disposition.

Correction Date: 04/05/2024

_____ _____

Daniel M. Larmore, MS/NHA-L Date