STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165272	A. BUILDING _____ B. WING _____	C 06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK NURSING & REHABILITATION CENTER	**233 UNIVERSITY AVENUE DES MOINES, IA 50314**

(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 Amended following the IDR (Informal Dispute Resolution) held on July 30, 2014. F-312 and F-323 deleted. Correction date_____ Investigation of facility-reported incidents # 48571-I and 48162-I and of complaint # 48289-C resulted in deficiency. Complaint # 48200-C was not substantiated. See code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews, the facility failed to assess a resident after each fall in order to identify adverse symptoms for 1 of 7 residents reviewed (Resident #1). The facility reported a census of 99 residents. Findings include:	F 309		7/14/14

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

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1. Resident #1 had an MDS (Minimum Data Set) assessment with a reference date of 3/5/14 which identified the resident had a severe cognitive impairment and experienced delirium, inattention and disorganized thinking. The MDS reported the resident required extensive assistance of two staff to transfer from one surface to another. The MDS identified the resident had diagnoses including hypertension, diabetes, non-Alzheimer's disease, depression and had no history of falls.

On 3/7/14, the Care Plan identified Resident #1 at risk for injury related to falls and the resident needed assistance with transfers. It directed staff to provide a low bed with a floor matt next to the bed, non-skid socks/shoes, ambulate with assistance when having signs and symptoms of agitation, stand/pivot transfer with the assistance of two staff and provide periodic medication reviews.

In the Departmental Notes dated 4/4/14 at 3:55 a.m., Staff J RN (Registered Nurse), documented Resident #1 had increased agitation/combative behaviors, scratching the aides while attempting to assist the resident to bed. The resident crawled out of bed onto the floor and also broke the CNA's (Certified Nurse's Aide) headset. The resident finally laid back in bed at this time. The notes did not include documentation that Staff J assessed the resident after finding him/her on the floor. The facility could not provide an incident report dated 4/4/14 upon request.

In the Departmental Notes dated 4/13/14 (Sunday) at 1:52 a.m., Staff J documented Resident #1 had increased anxiety, crawled out of the low bed to the floor and had no injury at the

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time. The resident rested on the mattress on the floor. The notes failed to include documentation that Staff J assessed the resident after finding him/her on the floor. The facility could not provide an incident report dated 4/13/14 upon request.

The Departmental Notes dated 4/14/14 (Monday) at 3:36 a.m. written by Staff J, documented the resident yelled out when turned per the CNA's report. Staff were unsure if Resident #1 felt pain since the resident was always combative with cares. Staff J checked the resident ' s vital signs, but the note documented no further assessment as to possible pain or injury.

The Departmental Notes dated 4/15/14 (Tuesday) at 2:21 p.m. documented that with ADLs (Activity Daily Living) cares, Resident #1 moaned and displayed facial grimacing. The resident yelled out and guarded his/her right hip with a transfer from the bed to the chair. Staff contacted the Advanced Registered Nurse Practitioner (ARNP) who ordered bilateral hip x-rays due to pain and a history of falls. At 5:18 p.m., the notes documented the ARNP requested an orthopedic consult. The orthopedic physician identified the resident had a right hip fracture.

On 6/3/14 at 10:15 a.m. the ARNP was interviewed and stated she arrived at the facility on 4/15/14 and was told by Staff L that the resident screamed out in pain when staff got the resident up for the day. The ARNP barely moved the resident and the resident screamed in pain. The ARNP ordered a portable x-ray.

The x-ray report dated 4/15/14 revealed Resident #1 had a right hip fracture: acute intertrochanteric fracture with avulsion of the lesser trochanter

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(hip). The x-ray revealed no displacement [of the femoral head from the acetabulum].

The hospital History and Physical report dated 4/15/14 revealed Resident #1 had a right hip fracture.

The Operative Report dated 4/16/14 documented the resident received an open reduction of the right hip fracture on that date.

The facility Departmental Notes dated 4/25/14 documented the resident returned to the facility at 3 p.m.

During an interview on 6/3/2014 at 2:00 p.m. the DON (Director of Nursing) reported Resident #1 had falls on 3/17, 3/19, 3/30, 3/31, 4/4 and 4/13/14. The facility had no incident reports for the falls of 4/4/14 and 4/13/14. Staff J did not realize the resident had a fall when he/she moved from the low bed to the floor while unattended and

During an interview on 6/3/14 at 3 p.m., Staff J stated one night [4/13/14] the aides reported they found Resident #1 sitting on the floor by the doorway. Staff rolled the resident onto a bath blanket and they placed the resident on the mattress positioned on the floor. The resident fell asleep and had no complaints of pain the remainder of the shift. Staff J did not complete incident reports when the resident crawled out of their low bed.

During an interview on 6/3/14 at 11:00 a.m., Staff M, LPN (Licensed Practical Nurse), Unit Manager reported the facility had no incident reports dated 4/4 and 4/13/14 when staff found Resident #1 out

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F 309	Continued From page 4 of bed. During an interview on 6/3/14 at approximately 3:10 p.m., Staff G, CNA reported she worked the night shift on 4/12 - 4/13/14. Staff G stated she sat at the nurse's station and heard Resident #1's voice and witnessed the resident seated on the floor in the doorway. Staff J assisted the aides to roll the resident onto a sheet and carry him/her to the mattress on the floor. The resident complained of their leg hurting and said "mama, my leg hurts". Staff G stated Staff J did not assess the resident after they found him/her on the floor. During an interview on 6/3/14 at 12:08 p.m., Staff L (registered nurse) reported working 4/14 and 4/15/14 from 6:00 a.m. until 6:00 p.m. On Monday, 4/14/14 the resident had no signs or symptoms of pain. On Tuesday, 4/15/14 the certified nursing assistants reported the resident complained of right leg pain when they transferred the resident from the bed to the wheel chair. Staff L notified the nurse practitioner.	F 309		