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	165513	A. BUILDING _____ B. WING _____	C 10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR RETIREMENT HOME	3131 HILLCREST ROAD DUBUQUE, IA 52001

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F 000	INITIAL COMMENTS Correction date_____ The following deficiency relates to the investigation of Mandatory #62282. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review, and staff interviews, the facility failed to ensure one of four residents received adequate supervision during transfers to protect against accidents. Resident #1 required one staff assistance with a gait belt and a walker for ambulation. Record review & staff interviews revealed staff let go of the gait belt and left the resident standing/unattended to tidy up the resident's bedding as Resident #1 fell and sustained hip & pelvic fractures. The facility census was 96 residents. Findings include The Minimum Data Set (MDS) dated 5/27/2016 revealed Resident #1 had no cognitive	F 323		

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

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impairment, no speech, and usually made him/her self-understood and understood others. The MDS revealed Resident #1 ambulated and transferred with extensive assistance of one staff and used a walker and wheelchair for mobility. The assessment identified Resident #1's balance as unsteady and only able to stabilize with staff assistance; and impairments on one side of upper and lower extremities. The MDS reported the resident had diagnoses including hypertension, diabetes, aphasia, CVA, hemiplegia, aphonic, depression, gastrostomy, cognitive deficits and insomnia.

The Care Plan dated 3/23/16 identified the resident had self-care deficit related to history of CVA, need for assist with Activities of Daily Living (ADL's) and a potential for falls related to unsteady gait, poor balance, history of falls. The care plan directed staff to provide set up assist as needed, encourage and praise, transfer with assist of one with gait belt above the chest and ambulate with hemi-walker and assist of one. The resident had a yellow plaque in the bathroom and staff to transfer with a gait belt.

The wing sheets used by staff revealed the resident was a full code and transferred with one and a hemi-walker with the gait belt above chest.

Nurse Notes dated 8/14/2016 at 7:11 p.m., documented the resident fell while being transferred from recliner to bed by nurse aide. The resident landed on right side of body, unable to speak, but did shake head "yes" to clarify that she/he was in pain. Resident first stated pain was in right hip, resident able to move lower extremities, but would not use either arm. Both hands were in fists, and resident denied pain to

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both arms. Resident then denied pain to hip. Resident breathing very labored, but 96% oxygen saturation on room air. Staff used a Hoyer lift to assist Resident #4 from the floor to bed. Resident then confirmed pain to right shoulder and had a small skin tear to right elbow. At 8:19 p.m., the resident transferred to the emergency room and admitted with a urinary track infection (UTI) and sepsis.

The Incident Report dated 8/14/2016, revealed the resident fell while being assisted with transfer from recliner to bed. Resident had gait belt on, landed on right side of body. Resident unable to speak, only shook head "yes" or "no" to verify whether or not she/he was in pain and where pain was located. The nurse obtained vitals, assessed the resident's range of motion and attempted neurological checks. The resident had a small tear on the right elbow with bruising. The resident agreed to be seen at the hospital emergency room. The resident's spouse was notified as well.

The Fall Risk Assessment dated 5/27/2016 revealed the resident had a high risk for falls.

The History and Physical dated 8/16/2016 reported the nursing home indicated the patient fell and landed on his/her right shoulder. The family reported every time she/he had a fall or an event he/she most likely had a UTI. The nursing home reported the patient had no fever, chills or diarrhea. The computed tomography (CT) scan of the cervical spine, head and brain were negative. While in the emergency room he/she started having emesis and looked uncomfortable.
The physician reviewed the shoulder x-ray and felt it did not reveal any acute fracture. The physician wanted to further evaluate the resident

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and ordered a CT of the resident ' s abdomen and pelvis.

A CT of the abdomen and pelvis dated 8/15/2016, documented an acute appearing fracture through the proximal right femoral neck (hip fracture) with mild impaction. Potential chip fracture off the anterior aspect of the right acetabulum (hip joint). Acute appearing right inferior pubic ramus fracture (pelvic). Age-indeterminate left inferior pubic ramus fracture.

The Discharge summary dated 8/18/2016 revealed the resident was discharged with principal diagnoses of sepsis and a right hip fracture. Orthopedic consult determined the resident was not a candidate for surgery; and the resident's family indicated he/she would not want to live like this and made the decision for comfort care measures. Resident #1 would be transferred back to the nursing home for hospice care.

The Use of Gait/Transfer Belt Policy, revised 8/29/2016, and received from the Director of Nursing on 9/2/2016 included:
Responsibility: All nursing and rehab staff
Purpose: 1. To safely transfer and ambulate residents. 2. To prevent unnecessary injuries to staff and residents.
Guidelines: Keep the gait/transfer belt available at all times, you never know when you will need it to assist a resident.
Review the manufacturers' recommendations for application and securing the belt.
Supplies: Gait/transfer belt.
Procedure:
4. Apply the gait/transfer belt around the waist and over clothing for all residents that require contact guard assist of 1 or 2.

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5. The resident's plan of care will provide information on any differences to policy.

During interview on 9/6/2016 at 1:45 p.m., the Administrator stated on August 14, 2016 she received an email from the facility reporting the residents fall. On Monday, the hospital called and said Resident #1 had a fracture. Initially it appeared the residents care plan had been followed. The Administrator state during interview Staff H, certified nurse aide, CNA said she was not sure how the resident fell and said she did not use a gait belt. Staff A, licensed practical nurse, LPN reported Staff H told him the gait belt was on. It did not add up. How did the resident fall backwards if Staff H held onto the gait belt. On August 24, 2016, they met with Staff H again and asked her to recount [review] the story again. Staff H reported she and Staff A put the gait belt on the resident. They terminated Staff H for safety related to not using the gait belt. Staff H told the Administrator that she had seen other CNA's fail to use a gait belt while transferring the resident.

During interview on 8/26/2016 at 1:00 p.m., the Director of Nursing, DON reported Staff H transferred the resident with a walker and without a gait belt from the toilet to bed. Staff H was straightening the resident's bed blankets and left the resident standing alone. Staff H heard a crash and the resident was on the floor. Staff A responded, the resident complained of elbow pain mainly but they transferred the resident to the emergency room. When Staff A arrived on the scene the resident had a gait belt. Staff H admitted to putting the gait belt on after the fact.

During interview on 9/2/2016 at 12:30 p.m. Staff

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A, Licensed practical nurse, LPN said he got called to the resident ' s room and saw the resident was on the floor on their right side in front of the recliner. Staff H was kneeling by the resident and said she was transferring the resident to bed, had been doing okay and then the resident fell backwards. Staff H was very worked up and the resident shook their head " yes" to pain and right shoulder pain. The resident ' s right elbow had bruising and his/her fists were clenched. They used a Hoyer lift and transferred the resident to bed. Staff A said he thought the resident had a gait belt on when he got to the room and he documented that. Staff H told Staff A she had transferred the resident with a gait belt. Later, Staff H admitted she transferred the resident without a gait belt.

During interview on 9/2/2016 at 2:45 p.m., Staff B, LPN said she was called to the resident ' s room and saw the resident on the floor with a gait belt on. Staff B never witnessed Staff H not use a gait belt. Staff H told Staff B she was transferring the resident to the bed and had a gait belt on and the resident fell. It did not make sense as the resident had one good side and held onto the cane. Staff B said Staff H left the resident to fix the sheets.

During interview on 9/6/2016 at 11:00 a.m., Staff C, certified nurse aide, CNA primarily worked on BV hall, but the night the resident fell, Staff C worked on WW hall and the resident was not on her list, but they all worked together. Staff C and Staff D had just finished assisting the resident ' s roommate and Staff H was going to assist Resident #1. Staff C and Staff D left the room to go chart. Staff C had taken care of the resident

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and knew the resident was an assist of one with a gait belt (placed high) and a hemi walker. Staff C never witnessed anyone not use a gait belt.

During interview on 9/6/2016 at 2:12 p.m., Staff D, CNA stated the resident transferred with assistance of one staff, a gait belt and a four legged cane. Staff D had never witnessed Staff H transfer a one assist resident. Staff D had only assisted Staff H when residents required two assist. Staff D stated a lot of staff transfer residents without using a gait belt, but Staff D had never reported it.

During interview on 9/2/2016 at 12:40 p.m., Staff E, CNA stated they had worked with the resident and knew the resident was an assist of one with a gait belt under the arms due to the resident's feeding tube and the resident used a cane. Staff E had never observed anyone not use a gait belt and stated facility policy was to always use a gait belt with any transfer and staff are told that upon hire.

During interview on 9/2/2016 at 11:30 a.m., Staff F, CNA stated she had always transferred the resident with a gait belt underneath their arms due to the feeding tube and a hemi walker. Staff F stood on the right side of the resident and held onto the gait belt and elbow that was on his/her weak side. Staff F had never witnessed any staff not use a gait belt including Staff H. Staff F reported all staff are expected to use the gait belt with any resident that required assist of one to two.

During interview on 9/2/2016 at 11:40 a.m., Staff G, CNA stated they cared for the resident on SV hall. Staff G stated the resident was an assist of

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one to transfer with a gait belt high around their chest and a cane. The resident had a yellow plaque in the bathroom which meant staff could leave the resident on the toilet, but remain in the room. The gait belt policy was explained upon hire and they were given a gait belt. Staff G would never let go of the resident as he/she was not steady. Staff G had worked with the resident often enough to know the resident was picky about their bed and Staff G would straighten out the bedding before she got the resident off the toilet. Staff G never saw Staff H transfer a resident without a gait belt. Staff H stated most residents on W/W were an assist of one.

During interview on 9/13/2016 at 4:00 p.m., Staff H, CNA revealed she knew the resident and had worked with the resident a couple of times a week though the resident may not have been on her list. Staff worked together and answered lights. The resident had a roommate who Staff H assisted and had seen other staff assist the resident without the use of a gait belt. When Staff H was trained she was told to use a gait belt but it was not enforced. One aide told her to use it if necessary. There were times when Staff H entered the resident ' s room and he/she would be standing with the lift chair all the way up so she would walk with him/her without a gait belt. Staff H stated the night of the fall the resident had the call light on which meant the resident wanted to go to bed. Staff H transferred the resident from the lift chair and ambulated the resident to and from the toilet without using a gait belt. Staff H had a gait belt with her but did not put it on the resident. The resident had a yellow plaque in the bathroom which meant the resident could be left on the toilet but staff had to remain in the room. While the resident was on the toilet, Staff H pulled

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F 323	Continued From page 8 the bed sheets back, assisted the resident up from the toilet and walked the resident towards the bed. Staff H hovered around the resident ' s elbows and the resident had the walker. When they reached the bed, the resident pointed to the sheets. Staff H knew the resident did not like the way the sheets were crumpled and wanted it straightened because the resident kept pointing to it and would not move until Staff H fixed it. The resident seemed fine and steady so Staff H left the resident standing and straightened the sheets. That's when the resident fell.	F 323		