STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165188	A. BUILDING _____ B. WING _____	C 12/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BRIDGE CARE & REHABILITATION	1015 WEST SUMMIT WINTERSET, IA 50273

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F 000	INITIAL COMMENTS Correction Date 12/29/17 The following deficiency was identified during investigation of facility-reported incidents #64608-I and #64609-I. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.)	F 000	Please accept this facility's credible allegation of compliance as of 12/29/16. The preparation of the following plan of correction does not constitute admission or agreement by the provider of the truth or alleged violations or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provision of federal/state law. Without waiving the foregoing statement, the facility states:	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323	It is the intent of the facility to plan and provide direct nursing care and services to ensure residents receive adequate supervision from hazards. Staff A was counseled immediately on 11/19 following the incident of resident #1. All staff was further educated on fall risk residents and their identification by education and in-service on 11/22 and 11/23. The facility implemented monitoring through QAPI process with further ongoing education of all staff and monitoring through QAPI team with target and completion date of 12/17/16. DON and/or designee has and will continue to monitor compliance of fall risk residents with random audits weekly x 3 months. Findings and results of rounds will be presented to the QA committee for ongoing compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/12/2017

POC accepted 1/20/17 SK mmm

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F 323	Continued From page 1 by: Based on record review and interview, the facility failed to provide adequate supervision to protect one (1) of four (4) residents from hazards. Resident #1 fell and sustained a hip fracture. Staff interviews the resident had been left unattended in his/her room in the wheelchair and no staff acknowledged they assisted the resident back to his/her room. Staff interviews and record review revealed Resident #1 had a history of attempts to self-transfer and lacked the safety skills to self- transfer independently. The facility reported a census of 59 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 9/19/16 revealed Resident #1 had diagnoses which included Schizophrenia, and depression. The resident had impaired cognitive ability with a BIMS (Brief Interview for Mental Status) score of 7/15. Resident #1 required supervision of 1 staff for transfer, ambulation, toileting, and dressing. A "balance during transitions and walking" test identified the resident as not steady and only to stabilize with staff assistance when moving from seated to standing, walking, turning around while walking, moving on and off the toilet and surface to surface transfers. The MDS revealed Resident #1 had a fall with no injury since the prior assessment. Review of the Care Plan, dated 9/26/16, identified Resident #1 at risk for falls related to weakness, psychotropic medications, poor judgement and safety awareness. Interventions included but not limited to the following:	F 323		

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F 323	Continued From page 2 a. Assure the floor is free of glare liquids, and foreign objects. b. Encourage resident to assume a standing position slowly. c. Give the resident verbal reminders not to ambulate/transfer without assistance. d. Keep a call light in reach at all times. e. Keep personal items and frequently used items within reach. f. Observe frequently and place in supervised area when out of bed. g. Offer toileting assistance after rising, before and after meals, at bedtime and when doing rounds. h. Provide proper, well maintained footwear. i. Provide resident an environment free of clutter. The Care Plan included an intervention dated 10/15/16 that directed staff assist the resident from the dining room and do not leave in wheelchair in his/her room. A review of previous falls indicated the following Incident Reports : a. 9/28/16 at 6:00 p.m. Resident #1 was found on the floor near the bed. Staff educated the resident to call for assistance prior to transfer. The resident demonstrated use of the call light. b. On 10/4/16 at 5:00 p.m. Resident #1 was found up without his/her walker. The resident was lowered to the floor after his/her legs gave out. A room change was implemented to allow higher staff visibility. Additionally, a sign was placed in the resident's room with pictures to remind use of call light prior to self-transfer. c. On 10/13/16 at 5:00 a.m. Resident #1 was found on the floor near his/her bed. A floor mat	F 323		

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F 323	Continued From page 3 was placed near his/her bed as an intervention. d. On 11/12/16 at 1:10 p.m. Resident #1 voiced self-transfer from wheelchair to recliner when he/she slipped during self-transfer. Staff were directed to assist the resident from the dining room following a meal. Nurses notes dated 11/15/16 at 3 a.m., and 1:15 a.m., documented the resident reported no pain. The Incident Report dated 11/19/16 at 9:30 a.m., identified Resident #1 attempted to self-transfer from wheelchair to recliner and fell on the floor. Resident #1 complained of left thigh pain. The form noted the staff (Staff A) had been counseled on pushing Resident #1 ' s [wheelchair] back to room and not leaving him/her in the hallway. The nurse ' s notes dated 11/19/16 documented Resident #1 had been assessed after the self-transfer which resulted in a fall. Resident #1 complained of pain of left thigh pain and the physician had been notified. Staff would continue to monitor. The fax dated 11/19/16 documented Resident #1 attempted to self-transfer and fell and complained of pain 9 out of 10 (high) in left thigh. The physician had spoken with staff at 9:45 a.m., to continue neurological checks for six hours then per shift; and call the physician if his/her pain worsens. Nurses Notes included the following documentation: On 11/20/16 at 3:3o a.m., Resident #1 complained of pain to left lower extremity and	F 323		

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F 323	Continued From page 4 staff administered pain medication. At 10:40 a.m., Resident #1 complained of left hip pain with movements; and the resident walked with walker to bathroom. The resident ' s gait was slow and unsteady at times. Staff assess the resident with no shortening or internal rotation, and no sign/symptoms of pain with ROM (range of motion); Staff administered prn (as needed) pain medication. On 11/21/16 at 12:15 a.m. ROM was identified as normal and the resident denied pain. At 2:30 p.m., Resident #1 complained of pain on the top of right thigh. Resident walked with front wheeled walker with the assistance of one staff. The physician reported to call if resident needed an x-ray or needs to be seen. On 11/22/16 at 11 a.m., resident continued to complain of left hip pain and refused pain medication. ROM showed no shortening or internal rotation of left lower leg. At 5:30 p.m., Resident has been the assist of two for transfers this shift and continues to complain of left leg pain. Staff documented the resident will have an x-ray tomorrow. On 11/23/16 at 3:30 a.m. Resident #1 denied pain when questioned and no indication of pain. At 9:45 a.m., Resident went to the physician ' s office for evaluation of right thigh pain. Nurse's Notes dated 11/23/16 at 11:30 a.m. revealed Resident #1 was transferred for surgical repair of a fractured left proximal femur fracture. The physician ' s history dated 11/23/16 documented the resident had fallen over the weekend and now complains of left hip pain and will not stand; wearing bearing up until yesterday. The resident has a history of dementia and	F 323		

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F 323	Continued From page 5 schizophrenia. The reported noted the resident had refused treatment over the weekend and refused. The report noted past right hip surgery of some sort. The operative procedure report dated 11/23/16 documented the resident is found to have a minimally displaced femoral neck fracture. The resident had pinning of his/her fractured hip on 11/23/16. Staff interviews as follows: a. On 12/28/16 at 10:29 a.m. Staff A, certified nursing assistant (CNA), stated Resident #1 finished his/her meal so she helped him/her to the hall. Staff A took Resident #1 for treatment in the hall, and she pushed Resident #1 to Staff D. Staff A requested Staff D, a CNA take Resident #1. Staff A then provided assistance to another resident. Staff A was aware Resident #1's Care Plan directed staff to not leave Resident #1 unsupervised in his/her wheelchair in his/her room. Staff A stated Staff D and Staff E, CNA, provided assistance to Resident #5, Resident #1's roommate, so she thought they would provide assistance to Resident #1 also. Staff A could not recall who took Resident #1 back to his/her room and had passed him/her off to Staff D. Staff A reported she got blamed for the incident. b. On 12/28/16 at approximately 10:00 a.m. Staff D, CNA, stated on 11/19/16 Staff AA, CNA, oriented her. Staff D provided toilet assistance to Resident #5 before breakfast. She stated cares were not provided by her prior to Resident #1's fall. Staff D stated Resident #1 fell because someone left the resident unattended in his/her room in the wheelchair.	F 323		

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F 323	Continued From page 6 c. On 12/28/16 at 11:01 a.m. Staff E stated she recalled she was the float aide on 11/19/16. Staff E stated care was not provided for Resident #1 or Resident #5. Staff E thought Staff A propelled Resident #1 from the dining room into his/her room and left the resident unattended in the wheelchair. Staff E was aware Resident #1 was not to be unattended in the wheelchair in his/her room because he/she frequently attempted to self-transfer. d. On 12/28/16 at 1:25 p.m. Staff F, CNA, stated she fed Resident #1 breakfast. After breakfast Staff A propelled Resident #1 out of the dining room. Staff F remained in the dining room with residents, and assisted other residents. Staff F was aware Resident #1 was to be transferred from the wheelchair after meals because of self-transfer attempts which resulted in falls. On 12/27/16 at 2:38 p.m. the Administrator stated prior to Resident #1's fall and fracture staff were directed to transfer Resident #1 from the wheelchair after meals while in his/he room because he/she attempts to self-transfer.	F 323		