STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165487	A. BUILDING _____ B. WING _____	C 01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY ACRES	3520 GRAND AVENUE DES MOINES, IA 50312

(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 2/3/17 The following deficiencies were identified during investigation of facility reported incidents 64571-I and 64587-I and extended partial survey conducted 12/23/16-1/5/17. Incident 64571-I was substantiated and incident 64587-I was substantiated not related to the allegation. See Code of Federal Regulations (42CFR) Part 483, subpart B-C.)	F 000		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident	F 226		

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

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.

Tom Caldwell for 2/2/17

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F 226	Continued From page 1 property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on temporary staff employment file review and interview, the facility failed to assure all temporary employees contracted through an agency completed an approved dependent adult abuse education for 1 of 1 temporary employees reviewed. Staff G. The facility reported a census of 67. Findings include: 1. The temporary agency personnel file for Staff G, certified nursing assistant (CNA), documented a hire date of 1/10/2008. The file contained documentation Staff G completed a 2 hour training of Child and Dependent Adult Abuse for Iowa Mandatory Reported on 10/5/12. Approved training must include a full 2 hours dedicated to dependent adult abuse training. The facility identified Staff G worked in the facility on 12/5 and 12/8/16 on the 2 PM-10 PM shift. The facility also identified contracts with 4 temporary staff agencies and utilized agency staff to cover 34 shifts from 12/1-12/31/16. During interview on 1/4/17 at 3:00 PM the administrator stated the facility does not check on each temporary staff credentials prior to working as temporary agency contracts state the agency	F 226		

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F 226	Continued From page 2 is responsible for maintaining compliance with applicable rules and regulations.	F 226		
F 323 SS=K	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 by: Based on record review and staff and physician interviews, the facility failed to provide adequate nursing supervision to prevent accidents and failed to protect residents from environmental hazards for 1 of 1 closed resident record reviewed (Resident #1). The facility identified a	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 3 census of 67 residents. The second floor door, leading to the stairs, had a disabled alarm. The facility disabled the alarm do to a screeching sound. The door's magnetic lock alarm on the door could not be heard throughout the 2nd floor. The staff pagers did not always alert staff when the magnetic door or stairwell door opened. The 2nd floor had 6 residents wearing Wanderguard devices and 3 of the 6 residents lived in the hallway near the stairwell exit door which placed the residents at further risk for leaving by way of the stairwell 2nd floor door. Resident #1 was found sitting on the floor landing, a few steps down from the east stairwell door. The resident's wheelchair rested on the landing too. Findings include: 1. Resident #1 had a Minimum, Data Set (MDS) assessment with a reference date of 11/27/16 which documented diagnoses that included psychotic disorder, history of falls, hearing loss, scoliosis (curvature), dysarthria (speech disorder), osteoporosis (loss of bone density), muscle weakness and difficulty walking. The same MDS documented the resident had short and long term memory loss, unclear speech, exhibited physical behaviors and wandered 1-3 days of the assessment period. The MDS indicated Resident #1 required extensive assistance for transfers, unable to ambulate, not steady and only able to stabilize with staff assistance when moving from a seated to standing position and surface-to-surface transfer. The resident utilized a wheelchair for mobility, had experienced 2 falls without injury and 1 with injury since the last MDS (completed no greater than every 92 days).	F 323		

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F 323	Continued From page 4 The Elopement Risk Assessment dated 10/12/16 documented a score of 4. A score of 2 or greater identified the resident to be at risk for an elopement and precautions must be initiated. The Fall Risk Assessment dated 10/15/16 documented a score of 10. A score of 10 or greater identified the resident at a high risk for falling. The care plan problem dated 1/22/16 identified the resident required extensive assistance with activities of daily living and unable to walk and required 1 assist to stand, pivot and transfer. The resident utilized a wheelchair for mobility which s/he could move independently. The care plan intervention dated 10/2/16 identified the resident as noted to wander on to other hall ways and into other resident's rooms and difficult to redirect. Staff placed a Wanderguard bracelet on the resident's left ankle. The Nurse's Notes entry dated 12/3/16 at 2010 (8:10 PM) completed by Staff E, registered nurse (RN), documented the east stairwell alarm sounded in a low audible tone. Staff E could not locate Resident #1 in the hallway. Staff E located the resident sitting on the landing down the steps from the east stairwell door with his/her back against a step with the resident's wheelchair resting under the open window. The resident attempted to stand up from the floor. The Nurse's Notes entry dated 12/3/16 at 2020 (8:20 PM) documented the resident observed to have a bruise on the right hip and the left side of the forehead, a red area mid-back over the spine and abrasions to the left shoulder and on and below the left knee. The resident was transported to the hospital at 2027 (8:27 PM). The hospital physical exam report dated 12/4/16	F 323		

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F 323	Continued From page 5 at 5:49 AM documented the resident's active problems as a right pleural effusion (fluid in the space between the lung and the chest cavity) and a traumatic compression fracture of T 11 (thoracic vertebra #11) and a tiny subdural hematoma (bleeding outside the brain). The resident returned to the facility on 12/4/16. The Initial Nursing Assessment form dated 12/4/16 documented the resident had a reddened area over the lower spine which measured 3 centimeters (cm x [by] 1 cm, an abrasion on the left knee which measured 1 cm x 3 cm, and an abrasion on the left shoulder which measured 2 cm x 1.2 cm, a bruise on the right lower back which measured 2.5 cm x 2.5 cm and a bruise on the left temple which measured 2 cm x 3 cm. On 12/29/16 at 5:45 PM, Staff E (Registered Nurse) was interviewed and stated she came out of a resident ' s room around 7:45 PM on 12/3/16 and observed a resident with his/her hands on the bar to the open east hall stairwell door. Staff E responded to the door and moved this resident away from the door. Staff E stated the door alarm sounded but it was very low and she could not hear it until she reached the second resident room adjacent to the stairwell door. Staff E stated she could not recall the code to reset the alarm so she called security personnel to do so. Staff E stated she checked the hall and room of Resident #1 and could not locate him/her. Staff E returned to the door, looked through the glass window, and observed Resident #1 sitting on the landing at the bottom of the stairs at approximately 7:55-8:00 PM. Staff E stated she observed Resident #1 move all his/her extremities and reaching for the railing in order to get up. Staff E yelled for help and Staff A and D,	F 323		

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F 323	Continued From page 6 certified nursing assistants (CNA's) responded. Staff E stated the door alarm did not alert on her pager. After the incident, she checked the pagers of all staff on duty on 2nd floor (another nurse and 4 CNA's), as well as the pagers in the box at the desk that were on and not in use, and none of them showed an alert for the east hall stairwell door. Staff E stated the on-call nurse called her and asked about the door alarm as her phone showed the east hall alarm sounded, but Staff E stated the call came after the resident had been located and awaiting transport to the hospital. On 12/29/16 at 10:31 PM, Staff C, CNA, was interviewed and stated she was assigned to Resident #1's hallway on 12/3/16 on the 2 PM-10 PM shift. Staff C stated she did not hear the door alarm sound while in another resident room at the opposite end of the hall. Staff C stated that Staff E checked her pager after the incident and the door alarm had not alerted her pager. On 12/29/16 at 2:26 PM, Staff A (CNA) was interviewed and stated she was assigned to the opposite hall on 12/3/16 during the 2 PM-10 PM shift. She did not hear the door alarm sound on the other hallway. Staff A stated the door alarms used to be really loud but were not at the time of the incident. Staff A stated Staff E checked her pager after the incident and it did not alert her pager. Staff A stated her pager goes off all the time and when providing resident care she cannot always pull it out of her pocket to check it. Staff A stated [the pager] had no differentiation in vibration or sound of the pager between call lights and alarms.	F 323		

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F 323	Continued From page 7 On 12/29/16 at 2:35 PM, Staff D (CNA) was interviewed and stated she had been assigned to the opposite hall on the 2 PM-10 PM shift on 12/3/16. She had been assisting a resident's spouse with a task when she heard Staff E yelling for help. She and Staff A responded to Staff E's call for help at the end of the opposite hall. Staff D stated she could not hear the door alarm sounding and did not check her pager. Staff D stated her pager goes off constantly, but stated the door alarms are now really loud and can hear them sound on both halls and even in the dining room. On 12/29/16 at 2:04 PM, Staff B, RN, was interviewed and stated he was the charge nurse on the opposite hall on the 2 PM-10 PM shift on 12/3/16. He stated he never heard the door alarm sound and his pager never registered a door alarm alert. Staff E stated security personnel told him after the incident that some of the door alarm audible level had been shut off because were very loud and the new call light system had the door alarms linked to the pagers. On 12/30/16 at 1:15 PM, the maintenance supervisor was interviewed and stated the magnetic alarms on the stairwell doors are not super loud but may be able to hear then [alarms] about halfway down each hallway. The audible on the large alarm boxes had been disabled because nursing staff complained they were too loud and would wake up the residents. On 12/30/16 at 4:15 PM the security guard on duty on 12/3/16, scheduled on the 2 PM-10 PM shift stated the previous administrator had directed the large box alarm be turned off as it startled residents because of the loudness. The	F 323		

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F 323	Continued From page 8	F 323		

magnetic lock still sounded but in a very low tone and he had concerns staff would not be able to hear the alarm on the doors when necessary. Observation at the east hall door at 4:35 PM revealed the security guard disabled the loud alarm box and opened the door. The magnetic lock sounded very faintly and could not hear it past the first set of resident rooms adjacent to the stairwell door. The security guard stated the loud alarm boxes were enabled on all the stairwell doors on 12/3/16 after the incident occurred and the facility has additionally installed Wanderguard alarms on these doors.

The Device Activity Report for the east stairwell door for 12/3/16 documented the door alarm activated at 7:42 PM and sounded for 23 minutes and 47 seconds before staff responded.

On 12/28/16 at 3:30 PM the Administrator was interviewed and stated at the time of the incident, the pagers carried by the staff on a hall would alert approximately 8 seconds into the 15 second delay before the door would open on the hall. The pager would then beep or vibrate every minute. After 5 minutes the alert would then be sent to the CNA's on the opposite hall and continue to beep or vibrate every minute. After 10 minutes the alert would be sent to the charge nurse pager and beep or vibrate every minute and 15 minutes after the alarm activated the alert would be sent to management staff phones. On 12/3/16 after the incident, staff adjusted the system to activate on-duty nursing staff pagers and department head phones immediately and will alert every 15 seconds until response.

The Administrator stated the loud alarm boxes had been disabled at some undetermined time

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F 323	Continued From page 9 but were reactivated on 12/3/16 after the incident. Facility management staff came to the facility and checked all pagers and door alarms and found them functional. The Administrator stated on-duty staff did not report their pagers failure to alert on 12/3/16 and felt that unusual as all staff on duty were disciplined regarding failure to respond to the door alarm alert on their pagers. On 12/23/16 at 10:40 a.m., the resident ' s physician was interviewed. The physician stated the resident had expired in the facility on 12/9/16 but did not die as a result of the fall. Note: On 12/3/16, the facility had abated the immediate jeopardy and enabled the door alarm, reprogrammed the staff pagers and provided in-service to nursing staff about alarms and pagers. Do to the abatement of the jeopardy, the deficiency scope and severity was lowered from a "K" to an "E".	F 323		
F 497 SS=D	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on personnel files reviews and interview, the facility failed to assure all certified nursing	F 497		

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F 497	Continued From page 10 assistants (CNA's) receive 12 hours of inservice education annually for 3 of 6 sampled CNA's employed greater than 1 year. Staff A, C and F. The facility identified a census of 67. Findings include: 1. The personnel file for Staff A documented a hire date of 2/21/11. The Relias Learning transcript for Staff A documented only 3.9 hours of inservice education completed for the period of 12/1/15-12/1/16. 2. The personnel file for Staff C documented a hire date of 3/2/11. The Relias Learning transcript for Staff C documented only 2.6 hours of inservice education completed for the period of 12/1/15-12/1/16. 3. The personnel file for Staff F documented a hire date of 8/16/07. The Relias Learning transcript for Staff F documented only 2.0 hours of inservice education completed for the period of 12/1/15-12/1/16. During interview on 1/5/17 at 8:35 AM the administrator and human resources director stated the facility management team recently discussed reviewing employee files on a scheduled basis in order to assist with compliance.	F 497		

R000
PLAN OF CORRECTION 2/3/2017

Wesley Acres denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.

F226 481.12(b)(1)-(3), 483.95(c)(1)-(3) Develop/Implement Abuse/Neglect, etc. Policies 2/3/2017

1. To correct the deficiency, the temporary agency staff member G was removed from the schedule until the required Dependent Adult Abuse training was completed. The required Dependent Adult Abuse training was completed on 1/31/2017.
2. To ensure the problem does not recur, Executive Director provided education with the specific Staffing Agency on Monday, January 30th, 2017, that all temporary agency staff members must meet the required Dependent Adult Abuse training and all other regulatory requirements prior to providing any services at Wesley Acres. Temporary Staffing Agency will provide proof of required regulatory training on all temporary agency staff prior to providing services.
3. As part of Wesley Acres ongoing commitment to quality assurance the Director of People & Culture and/or designee will conduct monthly audits of agency staff to ensure that temporary agency staff members meet regulatory educational requirements and report through Quality Assurance program.

F323 483.25(d)(1)(2)(n)(1)-(3) Free of Accident Hazards/Supervision/Devices

1. No Plan of Correction required per 2567. 12/3/2016

F497 483.35(d)(7) Nurse Aide perform review-12/hr/year inservice

2/3/2017

1. All direct care staff not completing their 12 hour annual requirement have been removed from the schedule until they have completed the required 12 hours of annual education.
2. To ensure the problem does not recur, Director of People & Culture and/or designee will audit monthly education assignments to ensure the required 12 hour annual education is completed.
3. As part of Wesley Acres ongoing commitment to quality assurance the Director of People & Culture and/or designee will ensure compliance with the required 12 hours annual education requirements for direct care staff and report through Quality Assurance program.