Citation Number: 6478					Date: March	10, 2017
Facility Name: Willow Gardens Care Center			Survey Dates: February 24-28, 2017			
Facility Addres	ss/City/State/Zip					
455 31st Street Marion, IA 52302		HL				
Rule or Code Section	Nature	e of Violation			Correction date	
58.28(3)e	481—58.28(135C) Safety. 58.28(3) Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)  DESCRIPTION: Based on clinical record review, observation, and staff interviews the facility failed to follow the resident's care plan and provide supervision to ensure each resident's individual safety for one of four residents reviewed (Resident #1). The facility reported a census of 74 residents.  Findings include:  1. According to the MDS (Minimum Data Set) dated 10/13/2016, Resident #1 had intact cognition, transferred and ambulated with the assistance of one staff and had diagnoses including Alzheimer's Disease, muscle weakness, difficulty in walking, and unsteadiness on feet.  The MDS dated 12/1/2016 revealed the resident had moderately impaired cognition and diagnoses including fracture of unspecified part of neck of left femur and left pubis.  The Care Plan, Date Range 2/15/2016 - 11/21/2016 identified Resident #1 had a potential for injury from falls related to a history of falls, impaired cognition and		•	\$5000 Held I Suspe		Upon Receipt
		approaches including tamper resistance pressure alarms on bed and chair; ensure proper function each				

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	1		ı	1		
	floors clean and dry, an well fitted shoes and no On 10/31/2015 the Care stay with resident when On 2/16/2016 the Care resident to be in his/her bed.  The Fall Risk Assessmer Resident #1 had an incompart #1 displayed balance provided the resident #1 fer Staff assessed the resident #1 fer Staff assessed the resident #1 room via ambulance segment with coproof alarm as the interpret.	e Plan added: Uses alarms, you take to the toilet. Plan added: Do not allow room unless supervised or in ent dated 10/12/2016 revealed emplete assessment. Resident roblems while standing.  Report dated 11/17/2016 ell at 5:30 p.m. in his/her room. Hent, notified physician and he resident to the emergency rvices. The form documented de to turn off and/or tamper rvention to prevent recurrence.				
	Practical Nurse) docum Nurse summoned and of the floor in front of room closest to bathroom, no incontinence, and slack	o.m., Staff A, LPN (Licensed ented: observed Resident #1 lying on amate's bed, face up with feet indication of bowel or bladder is half way up with no to the right and tipped on its e/she came out of the				

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Rule or Code Section	Nature	e of Violation	Class	Fine A	Amount	Correction date
rota char left On the o	ation. Staff transferred air and bed without resident and bed without resident and bed without resident admitted to the floor in his/her rosident noncompliant is sident had short terms spital records revealed Resident #1 had the left femur, fractured been unable to prove confusion and his/her deen admitted on 1 are a fall. The nursing len his/her wheelchair spital] showed a hip finderwent surgery.  Servation on 2/24/20 sident #1 seated in a rm in place with the atthe wheelchair. The resident sat at the confusion and his/her wheelchair are resident reported he coulder about two months.	ain and staff noted external d the resident to the wheel sident bearing weight on the all Services staff documented the hospital after being found om. No mood concerns. with alarms and transfers. In memory deficits.  And dated 11/17/16- 11/25/2016 and closed fracture of the neck of left pubic ramus, Alzheimer's Kidney Disease. The resident wide any meaningful history due of mental condition. The resident 1/17/16 due to left hip pain home resident fell backwards or tipped over. The workup [at reacture and the resident of the rear dining room table and ate sistance. The resident and neat and verbal with staff. The sago, had surgery and it nied hip pain and said he/she				

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Rule or Code Section	Nature	e of Violation	Class	Fine A	Amount	Correction date
	tripped over the cart and	d fell.				
	Observation on 2/24/2017 at 12:30 p.m. with DON (Director of Nursing)/RN (Registered Nurse), present, revealed Resident #1 had an alarm box with a button in the back used to silence it. The box had no code to reset the alarm.  At 12:45 p.m., observation with the DON present, revealed the resident sat in the wheelchair inside his/her room with the door partially closed. Staff E, CNA (certified Nurse's Aide) arrived and indicated the resident self-propelled from the dining room to his/her bed room. Staff E applied the gait belt and assisted the resident to the recliner. The recliner had an alarm box with a code that sounded when checked.  The Fall Risk Assessment dated 11/25/2016 revealed the resident had a high fall risk.  During an interview on 2/24/2017 at 12:15 p.m., DON revealed on 11/17/2016, Resident #1 told staff he/she transferred to the toilet and attempted to return to the wheelchair when it rolled, tipped over, and he/she fell onto it. The resident had a pressure alarm in the wheelchair at the time. The facility had two types of alarm boxes, some have a button in the back that you push to silence it; and the others had a code that staff					
	The DON thought Residual presently, and knew of resident turned off the a	to reset it.  bught Resident #1 had a box with a code d knew of no instances where the ed off the alarm. Staff checked the alarm dent fell and it functioned properly. The				

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455 31st Street Marion, IA 52302		HL				
Rule or Code Section	Nature	e of Violation				Correction date
	Len			I		
	in his/her room. After the fall on 11/17/20 intervention, directing st alone in the room unless further attempts to self-the hospital.  On 2/24/2017 at 1:15 p. added a tamper resistar wheelchair. The alarm f the resident's bed. The	pper and the resident had been 016, staff added the Care Plan raff not to leave the resident is in bed. The resident had no transfer since returning from m., the DON reported they not alarm to the resident's rom the recliner is also used in DON verified the tamper staff to enter a code to silence				
	and reset it.  During an interview on 2/28/2017 at 12:00 p.m., the DON reported the resident had no major injuries from prior falls and the falls occurred when the resident attempted to self-transfer. When the resident returned from the hospital, staff updated the Care Plan to reflect the resident could be in the room unsupervised since the resident made no further attempts to self-transfer. The resident self-propels the wheelchair and showed improvement.  During an interview on 2/28/2017 at 1:20 p.m., Staff A, LPN (Licensed Practical Nurse), reported working on November 17, 2016 when Resident #1 had a fall and sustained a hip fracture. Staff A found the resident on the floor with his/her pants half way up with no underwear or brief on. Staff A observed the resident's wheelchair tipped over. Staff A checked the resident's					

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	alarm after the incident	and it functioned appropriately		<u> </u>		
	Staff A reported the resi attempting to self- trans the ability to turn off the After the fall, Staff A add tamper resistant alarm; entered. Staff A checke- beginning of the shift an (Treatment Administration	fer. Staff A felt the resident had alarm by pressing the button. ded the intervention to place a one that required a code to be d resident alarms at the ad documented it on the TAR on Record).				
	During an interview on 2/28/2017 at 2:10 p.m., Staff J, LPN reported on November 17, 2016 when Resident #1 fell, Staff J had just returned from break. Staff K, CNA informed Staff J that Resident #1 fell. Staff J found the resident on the floor and he/she failed to recall where the resident sat prior to leaving on break. The resident never used the call light, often attempted to self-transfer, and Staff J never witnessed the resident turn off the alarm. Since the fall, the resident changed rooms closer to the nurse's station. Staff gets the resident ready for bed immediately after supper. After meals the resident will go to his/her room and attempt to transfer to the recliner, therefore staff cannot leave the resident alone in the room in the wheelchair. The resident can only be left alone in the room if he/she is in bed or the recliner.					
	D, LPN (Licensed Pract #1 had pressure alarms nurses checked the alar functioned. Staff D repo	Ouring an interview on 2/28/2017 at 10:50 a.m., Staff D, LPN (Licensed Practical Nurse) reported Resident 11 had pressure alarms in the chair and bed and surses checked the alarms every shift to ensure they unctioned. Staff D reported the resident had no ttempts to turn off the alarm and probably would not				

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	he able to The resident	now resided closer to the		<u> </u>		
be able to. The resident now resided closer to the nurse's station. Prior to the fall and fracture, the resident often made attempts to self-transfer, but had decreased since the fall.						
	During an interview on 2/28/2017 at 1:55 p.m., Staff I, CNA reported prior to Resident #1's fall in November, 2016, the resident made attempts to self-transfer, had safety concerns and required an alarm at all times. Prior to that fall, staff ambulated the resident to and from meals, now the resident walked to the bathroom only with staff assistance. Staff I indicated the resident, though unpredictable, had no further attempts to self-transfer since the fall. Prior to the fall, the resident gained confidence and had progressed nicely. Staff I observed the resident fumble with the alarm box. Staff I never saw the resident turn the alarm off. After the fall on November 17 [2016], staff placed a tamper resistant alarm in the recliner. Staff I stated staff never leave the resident unsupervised in the room in the wheelchair. The resident self-propels the wheelchair to the room after meals.					
	H, CNA reported Reside alarm and a chair alarm made no attempts to ge knowledge of the reside					
	C, CNA reported Reside	ring an interview on 2/28/2017 at 10:30 a.m., Staff CNA reported Resident #1 needed supervision in /her room if not in bed or recliner with an alarm. The				

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Rule or Code Section	Nature	e of Violation			Correction date	
raci	ident self-propelled th	ne wheelchair and made				
atte with usin Dur Sta The fell obs partipp Sta p.m den Sta the ass nev	empts to self-transfer in the resident, but had any the call light or turning a phone interview of K, CNA had no received facility investigation on November 17, 20 served the resident of the half way down the bed backwards lying of K last saw the resident in the room with a chied needing to use the facility CNA last saw the in the room in the vote of the half way the half and the resident to the resident the resident the resident the resident the resident the resident and resident is found the facility Fall Prevention and the resident is found the resident in the resident is found the resident in the resi	Staff C failed to recently work d no knowledge of the resident ning off the alarms.  No on 2/28/2017 at 11:50 a.m., all of the incident.  completed when Resident #1 16 reported Staff K, CNA in the floor on his/her back with a legs, and the wheelchair on the resident's right side. In the resident's right side. In the resident at approximately 4:30 call light within reach and the bathroom.  The resident between 4:00 - 4:30 wheel chair.  NA and Staff K, CNA checked ent fell and it functioned. Staff rined off the alarm, though they				
to p	prevent this from hap CILITY RESPONSE:					Page 8 o

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