| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165171 | A. BUILDING _____ B. WING _____ | C 02/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOW GARDENS CARE CENTER | 455 31ST STREET MARION, IA 52302 |

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| F 000 | INITIAL COMMENTS 3/2/17<br><br>Complaint # 64621-I was investigated and substantiated with a deficiency.<br>See code of Federal Regulations (45 CFR) Part 483, Subpart B-C. | F 000 | | |
| F 323 SS=G | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(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.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, observation, and staff interviews, the facility failed to follow the resident's care plan and provide supervision to | F 323 | Please See Attached. | |

VKK 3/15/17

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

Administrator | 03/10/2017

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.

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| F 323 | Continued From page 1<br>ensure each resident's individual safety for one of four residents reviewed (Resident #1). The facility reported a census of 74 residents.<br><br>Findings include:<br>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.<br><br>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 limited mobility. On 10/23/2015 the Care Plan added approaches including tamper resistance pressure alarms on bed and chair; ensure proper function each shift, keep frequently used items within easy reach, floors clean and dry, and encourage resident to wear well fitted shoes and nonskid socks.<br>On 10/31/2015 the Care Plan added: Uses alarms, stay with resident when you take to the toilet.<br>On 2/16/2016 the Care Plan added: Do not allow resident to be in his/her room unless supervised or in bed.<br><br>The Fall Risk Assessment dated 10/12/2016 revealed Resident #1 had an incomplete assessment. Resident #1 displayed balance problems while standing.<br><br>The Incident/Accident Report dated 11/17/2016 | F 323 | | |

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| F 323 | Continued From page 2<br>revealed Resident #1 fell at 5:30 p.m. in his/her room. Staff assessed the resident, notified physician and family and transferred the resident to the emergency room via ambulance services. The form documented "Pressure alarm with code to turn off and/or tamper proof alarm" as the intervention to prevent recurrence.<br>Incident Reports revealed the resident also fell on 10/27/2015, 12/2/2015, and 2/8/2016.<br><br>The Progress Note included:<br>On 11/17/2016 at 5:30 p.m., Staff A, LPN (Licensed Practical Nurse) documented:<br>Nurse summoned and observed Resident #1 lying on the floor in front of roommate's bed, face up with feet closest to bathroom, no indication of bowel or bladder incontinence, and slacks half way up with no underwear. Wheelchair to the right and tipped on its back. Resident stated he/she came out of the bathroom and tipped his/her cart. The resident complained of left hip pain and staff noted external rotation. Staff transferred the resident to the wheel chair and bed without resident bearing weight on the left leg.<br>On 11/25/2017 the Social Services staff documented the resident admitted to the hospital after being found on the floor in his/her room. No mood concerns. Resident noncompliant with alarms and transfers. Resident had short term memory deficits.<br><br>Hospital records revealed dated 11/17/16-11/25/2016 revealed Resident #1 had closed fracture of the neck of the left femur, fracture left pubic ramus, Alzheimer's Dementia, and Chronic Kidney Disease. The resident had been unable to provide any meaningful history due to confusion and his/her mental condition. The resident had | F 323 | | |

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| F 323 | Continued From page 3<br>been admitted on 11/17/16 due to left hip pain after a fall. The nursing home resident fell backwards when his/her wheelchair tipped over. The workup [at hospital] showed a hip fracture and the resident underwent surgery.<br><br>Observation on 2/24/2017 at 9:50 a.m. revealed Resident #1 seated in a wheelchair with a pressure alarm in place with the alarm box attached to the rear of the wheelchair.<br>The resident sat at the dining room table and ate breakfast with set up assistance. The resident appeared alert, clean and neat and verbal with staff.<br>The resident reported he/she fell and injured his/her shoulder about two months ago, had surgery and it healed. The resident denied hip pain and said he/she tripped over the cart and fell.<br><br>Observation on 2/24/2017 at 12:30 p.m. with the 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.<br>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.<br><br>The Fall Risk Assessment dated 11/25/2016 | F 323 | | |

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| F 323 | Continued From page 4<br>revealed the resident had a high fall risk.<br><br>During an interview on 2/24/2017 at 12:15 p.m., the 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 had to enter to reset it.<br>The DON thought Resident #1 had a box with a code presently, and knew of no instances where the resident turned off the alarm. Staff checked the alarm after the resident fell and it functioned properly. The fall happened before supper and the resident had been in his/her room.<br>After the fall on 11/17/2016, staff added the Care Plan intervention, directing staff not to leave the resident alone in the room unless in bed. The resident had no further attempts to self-transfer since returning from the hospital.<br><br>On 2/24/2017 at 1:15 p.m., the DON reported they added a tamper resistant alarm to the resident's wheelchair. The alarm from the recliner is also used in the resident's bed. The DON verified the tamper resistant alarm required staff to enter a code to silence and reset it.<br><br>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. | F 323 | | |

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| F 323 | Continued From page 5<br>The resident self-propels the wheelchair and showed improvement.<br><br>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 alarm after the incident and it functioned appropriately. Staff A reported the resident had a history of attempting to self- transfer. Staff A felt the resident had the ability to turn off the alarm by pressing the button. After the fall, Staff A added the intervention to place a tamper resistant alarm; one that required a code to be entered. Staff A checked resident alarms at the beginning of the shift and documented it on the TAR (Treatment Administration Record).<br><br>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 | F 323 | | |

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| F 323 | Continued From page 6<br>wheelchair. The resident can only be left alone in the room if he/she is in bed or the recliner.<br><br>During an interview on 2/28/2017 at 10:50 a.m., Staff D, LPN (Licensed Practical Nurse) reported Resident #1 had pressure alarms in the chair and bed and nurses checked the alarms every shift to ensure they functioned. Staff D reported the resident had no attempts to turn off the alarm and probably would not 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.<br><br>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.<br><br>During an interview on 2/24/2017 at 12:04 p.m., Staff H, CNA reported Resident #1 had a low bed with an alarm and a chair alarm. Since the resident fell, he/she made no attempts to get up | F 323 | | |

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| F 323 | Continued From page 7<br>unassisted. Staff H had no knowledge of the resident using the call light or tampering with the alarm boxes.<br><br>During an interview on 2/28/2017 at 10:30 a.m., Staff C, CNA reported Resident #1 needed supervision in his/her room if not in bed or recliner with an alarm. The resident self-propelled the wheelchair and made attempts to self-transfer. Staff C failed to recently work with the resident, but had no knowledge of the resident using the call light or turning off the alarms.<br><br>During a phone interview on 2/28/2017 at 11:50 a.m., Staff K, CNA had no recall of the incident.<br><br>The facility investigation completed when Resident #1 fell on November 17, 2016 reported Staff K, CNA observed the resident on the floor on his/her back with pants half way down the legs, and the wheelchair tipped backwards lying on the resident's right side. Staff K last saw the resident at approximately 4:30 p.m. in the room with a call light within reach and denied needing to use the bathroom.<br>Staff J, CNA last saw the resident between 4:00 - 4:30 p.m. in the room in the wheel chair.<br>Staff A, LPN, Staff J, CNA and Staff K, CNA checked the alarm after the resident fell and it functioned. Staff asserted the resident turned off the alarm, though they never witnessed the resident doing so.<br><br>The facility Fall Prevention Program included: When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into place an intervention to prevent this from happening again. | F 323 | | |

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.

F-323
S/S=G

I. Resident #1's care plan was reviewed and revised to meet current fall preventative measures. Resident #1 is receiving supervision to meet current fall preventative measures.

II. Residents with alarms as a fall risk measure have been assessed. Their care plans have been reviewed/revised to meet current assessed needs. Residents are receiving fall risk measures as per their plan of care.

III. Nursing management and nursing staff have been educated on 12/16/16 and 2/8/17 on reviewing, revising and following care plan interventions and supervision of residents.

IV. The Director of Nursing, RNAC and/or Designee will complete random audits of residents with fall risk interventions weekly for four weeks, monthly for two months, then quarterly for two quarters. Results of the audits will be reviewed at the QAPI meetings for revisions as needed.

V. Compliance Date: March 2, 2017