STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

(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: 3-3-17 The following deficiencies were identified during the investigation of Complaint #65480-C and #66592-C and Incident #65623-A, #65972-I, #66005-I, #65286-I, and #65909-M conducted 2/6/17 to 3/2/17. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 206 SS=D	483.15(e)(1)(2) POLICY TO PERMIT READMISSION BEYOND BED-HOLD (e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the	F 206		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		03/14/2017

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 206	Continued From page 1 facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. (e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and guardian interviews, the facility failed to notify 1 of 8 residents' representative prior to discharging the resident from the facility. (Resident #5) The facility reported a census of 110 residents. Findings included: Resident #5's Minimum Data Set (MDS) assessment dated 1/30/17 revealed diagnoses of non-Alzheimer's dementia, restlessness, agitation, alcohol (ETOH) abuse and adult failure to thrive. A Brief Interview for Mental Status (BIMS) revealed severe cognitive impairment. The MDS indicated the resident with physical and verbal aggression toward others. An initial care plan dated 1/23/17 identified the resident at risk for impaired adjustment related to cognitive impairment. Interventions included the use of a Wanderguard (a device that notifies staff if the resident attempts to elope the facility). An updated care plan dated 1/30/17 directed staff to	F 206		

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F 206	Continued From page 2 assist the resident when sitting down in the commons area and directed staff to keep the resident away from Resident #8 at all times. An updated care plan dated 2/9/17 identified the resident at high risk for agitation and resident to resident contact. On 2/10/17 staff were directed to keep the resident separated from 2 other residents as much as possible and anticipate and prevent behaviors in a stimulated environment. Departmental notes dated 1/23/17-2/3/17 revealed at least 14 incidents of the resident wandering throughout the facility and into other resident's rooms, combative with staff when cares are attempted and one incident of the resident ambulating the hallway without any clothes. An incident report dated 2/3/17 at 11:40 p.m. documented a physical altercation between the resident and Resident #8. Resident #8 did not sustain any injuries, but the resident sustained abrasions and bruises. Departmental notes dated 2/6/17 at 3:22 p.m. The facility notified the resident's guardian and he/she waived the 48 hour notice to move the resident. Staff transferred the resident to another hall downstairs within the facility. An incident dated 2/9/17 at 1:44 p.m. documented a verbal altercation between the resident and another resident, with the resident verbally threatening the resident stating, "I'm gonna bust your head too." Notes dated 2/9/17 at 2:38 p.m. revealed the facility completed a "Red Rose" assessment and determined the resident to be at high risk for possible resident on resident contact.	F 206		

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F 206	Continued From page 3 Departmental notes dated 2/10/17 at 7:32 p.m. documented staff assigned 1:1 with the resident when Resident #6 sat beside the resident and gently touched the resident's arm. The resident raised his/her arm and hit Resident #6 in the chest with his/her fist. An incident report dated 2/10/17 at 7:00 p.m. documented a resident on resident physical altercation between the resident and Resident # 6 resulting in the resident hitting Resident #6 in the chest. Resident #6 sustained no injuries. Departmental notes dated 2/13/17 at 8:57 a.m. revealed a late entry for 2/10/17 at 8:45 p.m., the Director of Nursing (DON) called the resident's physician asking if the resident could be sent to a local hospital for admission. A physician's Telephone Order dated 2/10/17 at 7:15 p.m. ordered the resident sent to a local hospital emergency room for a psychiatric evaluation. Departmental notes: as a late entry dated 2/10/17 at 9:30 p.m., the DON reported she had received a phone call from facility staff reporting the local hospital wanted to send the resident back to the facility. The DON explained to staff that interventions were in place and this has been the third resident to resident altercation in the short time the resident has been at the facility and the facility can't take the resident back at this time. Departmental notes dated 2/16/17 at 1:07 p.m.: as a late entry for 2/10/17 at 9:30 p.m., the DON documented facility staff did not notify the hospital that the resident hadn't been discharged from the facility at that time but wanted the resident admitted to the hospital as the resident needed some medication adjustments due to the	F 206		

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F 206	Continued From page 4 resident's behavior. Staff called the hospital the next morning and told the resident was admitted for treatment. Departmental notes dated 2/16/17 at 1:07 p.m.: as a late entry for 2/13/17 at 11:30 a.m., the DON reported she spoke to hospital staff explaining the resident gets upset very fast and with other dementia residents and the resident to resident altercations it was agreed by all that the facility is not the best place for the resident. Departmental notes dated 2/13/17 at 2:46 p.m. indicated the social worker informed by the Assistant Director of Nursing (ADON) the resident was discharged from the facility and would not be accepted back due to the resident's third alteration. The social worker contacted the resident's financial power of attorney (the resident's guardian) and explained that the resident has been discharged and the reasons for the discharge. During an interview dated 2/16/17 at 1:00 p.m., the DON reported she and the Administrator decided on 2/13/17 they wouldn't take the resident back. They did not notify the resident's guardian prior to discharging the resident from the facility. The social worker called the guardian and told him/her facility would not take the resident back. No other documentation was sent to the guardian and the long term ombudsman not notified of the discharge. During an interview dated 2/16/17 at 1:20 p.m., the resident's guardian reported the facility called on 2/13/17 informing h/her the resident wasn't appropriate for the facility. The guardian reported he/she wasn't given a choice in this decision.	F 206		

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F 223 SS=D	483.12 FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to ensure residents were free from physical abuse by staff for 1 of 8 residents reviewed (Resident #4). The facility identified a census 110. Findings include: Resident #4 had a MDS (Minimum Data Set) with an assessment date of 1/8/17. The MDS indicated the resident had diagnoses of non-Alzheimer's dementia, Parkinson's disease and a psychotic disorder. A Brief Mental Status (BIMS) documented a score of 3, which represented severely impaired cognitive functioning. The MDS indicated the resident demonstrated delusional behavior and required extensive assist of 1 staff with transfers and limited assist of 1 staff for ambulation (walking). A fall risk assessment dated 1/8/17 at 7:38 p.m. documented a score of 13. A score of 13 indicated a high risk for falls. The Care Plan with a problem onset dated of 1/18/17 identified the resident experienced altered thought processes and communication	F 223		

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F 223	Continued From page 6 related to Alzheimer's dementia, confusion and resistive behavior. The Care Plan directed staff to explain cares and interactions to keep resistance at a minimum and ask for permission before touching the resident. A problem onset dated 1/18/17 identified the resident as at risk for mood or behavior problems due to a diagnosis of dementia. The Care Plan directed to alternate staff substitute staff if the resident becomes combative. If the resident becomes verbally and/or physically abusive, ensure the resident's safety and re-approach. A problem onset dated 1/18/17 identified a risk for falls. The Care Plan directed staff to use a Merry Walker (a device that allows a resident to safely ambulate and sit if necessary and reduces the risk of falls) when the resident becomes restless. Departmental notes dated 10/24/16-1/8/17 revealed incidents of physical aggression; hitting and screaming at staff with cares and self-transferring out of his/her wheelchair and Merry Walker. Departmental notes dated 1/29/17 at 2:02 a.m. documented Staff E, RN walked into the commons area and found the resident fighting with Staff O, a certified nursing assistant (CNA). Staff O pushed the resident into the recliner, rather roughly. An incident report dated 1/28/17 at 9:45 p.m. documented an incident between staff and the resident. Staff E walked into the commons area and saw the resident attempt to stand from a sitting position. Staff O, grabbed the resident's arm and the resident struck Staff O. Staff O pushed the resident back into the recliner "rather roughly". The resident began yelling and tried to	F 223		

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F 223	Continued From page 7 stand a second time. Staff E brought the merry walker to the resident and assisted the resident into the merry walker. An investigation dated 1/28/17 completed by the facility revealed the following. In a telephone statement date 1/30/17 at 2;58 p.m., Staff E reported Staff O had been in the commons area overseeing three residents. Resident #4 made several attempts to stand but Staff O would not allow it. The resident became agitated and slapped Staff O. Staff O pushed the resident on the chest with her hand causing the resident to fall back into the recliner. Staff E told Staff O to let the resident get up if he/she wants up. Both she and Staff O assisted the resident from the recliner into the merry walker. In a written statement about the incident of 1/28/17 involving the resident, Staff O reported she had been in the commons area overseeing 3 residents, including Resident #4. Staff reported the resident tried to get out of the recliner and is at risk for falls. Staff O reported she sat beside the resident and attempted to keep the resident from self-transferring. The resident repeatedly attempted to transfer until he/she became very agitated and said to the resident, sit down you are going to fall. Staff O placed her right hand on the resident's chest and her left hand on the resident's back to support the resident. The resident slapped her and she "placed" the resident down in the chair. In a hand written statement, Staff O reported she had been sitting in the commons area watching residents, including Resident #4 who had been sitting a recliner. Suddenly the resident got up and wanted to walk. She held the resident and	F 223		

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F 223	Continued From page 8 told him/her to sit down but the resident pushed her away. She never wanted the resident to fall and she held onto the resident firmly when the resident hit her. Staff E came into the area and helped calm the resident and both transferred the resident into the merry walker. It was Staff E who relieved her so she could relieve the other staff in another hall. During an interview dated 2/13/17 at 9:55 a.m., Staff E reported she had just completed checking the wanderguards residents were wearing and walked into the commons area. She saw the resident trying to get up from a seated position when Staff O held on to the resident's right arm. The resident slapped Staff O on the arm and began yelling. Staff O told the resident to sit down and continued to hold the resident's arm and then pushed the resident with an open hand on the resident's chest "forcefully" to where the resident sat back into the recliner. During an interview dated 2/9/17 at 4:00 p.m., the director of nursing reported Staff O should have allowed the resident to stand and transfer him/her to a merry walker. Staff O should not have hit the resident, causing the resident to lose h/her balance and be forced to sit back into the chair.	F 223		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.	F 279		

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F 279	Continued From page 9 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes.	F 279		

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F 279	Continued From page 10 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to establish interventions for 1 of 8 residents who presented combative behaviors toward staff when cares were given (Resident #5) and 1 resident who needed assistance with eating. (Resident #2). The facility reported a census of 110 residents. Findings included: 1. Resident #2 had a Minimum Data Set (MDS) assessment dated 11/4/16. The MDS indicated the resident had diagnoses of non-Alzheimer's dementia, diabetes mellitus, coronary artery disease, heart failure, renal failure and chronic obstructive pulmonary disease and severe cognitive impairment. The MDS indicated the resident needed setup only with eating assistance. A Hospice plan of care, with a certification period 10/22/16-1/19/17, indicated admitting diagnoses of terminal illness and moderate protein-calorie malnutrition. The plan of care established interventions directing Hospice and facility staff to	F 279		

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F 279	Continued From page 11 provide assistance with activities of daily living including eating assistance. The resident's facility care plan dated 10/26/16 had a problem onset of self-care deficit due to cognitive deficit and physical limitations established interventions directing staff to set up meals for the resident only. The care plan failed to direct staff to provide eating assistance. Departmental notes dated 11/1/16-1/8/16 revealed sporadic entries of staff assisting the resident with eating in addition to entries of the resident refusing to eat without staff offering other food items as alternatives. During an interview dated 2/14/17 at 1:50 p.m., Staff I, Licensed Practical Nurse (LPN), reported the resident needed assistance with eating for the last month the resident resided at the facility. The resident had health decline and the resident's had contracted, causing difficulty in the resident eating independently. During an interview dated 2/14/17 at 2:10 p.m. Staff J, Certified Nursing Assistant (CNA), reported the resident needed assistance with eating when the resident admitted to Hospice. Staff would assist him/her with eating but the resident would often refuse food. During an interview dated 2/14/17 at 2:20 p.m., Staff K, LPN, reported the resident had declined to where he/she needed Hospice care. The resident's weight declined and staff weighed the resident weekly. She reported there were many days with the resident wasn't able to eat independently. Staff would then assist him/her with eating.	F 279		

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F 279	Continued From page 12 During an interview on 2/14/17 at 3:45 p.m., the Hospice nurse reported the resident didn't have the ability to eat independently and staff would assist the resident. She reported she had witnessed staff assisting the resident with eating. 2. Resident #5's MDS dated 1/30/17 revealed diagnoses of non-Alzheimer's dementia, restlessness, agitation, alcohol (ETOH) abuse and adult failure to thrive. A Brief Interview for Mental Status (BIMS) indicated severe cognitive impairment and the resident displayed physical and verbal aggression toward others. An initial care plan dated 1/23/17 identified the resident at risk for impaired adjustment related to cognitive impairment. Interventions included the use of a Wanderguard (a device that notifies staff if the resident attempts to elope the facility). An updated care dated 1/30/17 directed staff to assist the resident when sitting down in the commons area and to keep the resident away from Resident #8 at all times. An updated care plan dated 2/9/17 identified the resident at high risk for agitation and resident to resident contact. On 2/10/17 staff were directed to keep the resident separated from 2 other residents as much as possible and anticipate and prevent behaviors in a stimulated environment. Departmental notes dated 1/23/17-2/3/17 revealed at least 13 incidents of the resident wandering throughout the facility and into other resident's rooms and combative with staff when cares are attempted. The care plan failed to include interventions for	F 279		

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F 279	Continued From page 13 when the resident was combative with staff.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to follow interventions established in resident's care plans for 3 of 8 residents reviewed (Resident #1, #4 and #7). The facility reported a census of 110 residents. Finding included: 1. Resident #1 had a Minimum Data Set (MDS) dated 11/13/16 indicated diagnoses of diabetes mellitus, Alzheimer's disease, and a history of a right hip fracture. A Staff Assessment for Mental Status indicated severe cognitive impairment. The MDS indicated the resident totally dependent with 2 staff for transfers and total dependence with 1 staff assist with ambulation. The MDS indicated the resident had verbal aggression and rejected cares. A fall assessment dated 1/18/17 revealed a score of 14, indicating a high risk for falls. A care plan with a problem/onset dated 11/23/16 revealed potential risk for altered thought, communication related to diagnoses of dementia	F 282		

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	165612	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

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F 282	Continued From page 14 and intermittent confusion. Interventions directed staff to be aware of the resident's confusion and verbal behaviors with cares and transfers. A problem onset dated 11/23/126 revealed potential risk for falls related to injuries, limited safety awareness, confusion related to dementia and a previous right hip fracture. Interventions directed staff to use 2 staff assist with transfer by Hoyer (mechanical) lift and 2 staff members. Departmental notes dated 1/13/17 at 2:45 p.m. revealed the occupational therapy staff notified Staff F, Registered Nurse (RN) that Staff H, Certified Nursing Assistant (CNA), needed staff assistance, as the resident was on the floor. The nurse went to the resident's room and the CNA reported she attempted to place a Hoyer pad (sling) under the resident but the resident had resistive behaviors and slid around the CNA feet first and the CNA lowered the resident to the floor. Three staff assisted the resident to bed. During an interview dated 2/8/17 at 8:25 a.m. and at 2:15 p.m., Staff H, CNA reported she had provided cares to the resident for the past 4 months and during the last 2 months the resident had been physically combative during cares, striking out at staff when cares were given. Two days before the fall of 1/13/17 the resident had been physically combative. On 1/13/17 at approximately 12:00 p.m. she went to the resident's room to get him/her up for lunch. Once in the room she activated the call light. She completed incontinent care, dressed the resident and placed the Hoyer sling under the resident; rolling the resident toward her. At the same time the resident became combative and his/her legs slipped off the bed with his/her legs hitting the floor. She reported the resident was unable to	F 282		

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F 282	Continued From page 15 bear weight and her concern was to keep the resident from hitting his/her head. She reported 30 minutes had gone by from the time she activated the call light. Therapy staff came into the room to see the resident's roommate and saw her and the resident on the floor. During an interview dated 2/8/17 at 8:59 a.m. Staff G, CNA, reported on 1/13/17 the resident had increased behavior of combativeness for the last 3 to 4 months. The resident had been combative toward staff; flailing his/her arms, slapping staff and rejecting cares. Two staff were needed when placing the Hoyer sling under the resident. She reported it is not safe for 1 staff to provide cares; including transfers. During an interview dated 2/8/17 at 9:37 a.m., Staff F, RN reported the resident has behavior; yelling constantly, combative, pushing, shoving and attempting to hit staff. She reported at the time of the incident she knew the resident's call light had been on between 15 minutes to 30 minutes but she couldn't leave the commons area as there were resident in the common area and they could not be left alone. She reported it would have been appropriate to have 2 staff assist with placement of the Hoyer sling. She reported staff know they can call for additional assistance if the resident becomes combative or resists cares. Departmental notes dated 1/13/17 at 9:14 p.m. revealed the resident complained of severe pain to his/her right leg when transferred from bed to a wheelchair. A nurse assessed the resident and notified the resident's physician who gave an order to transfer the resident to a local hospital emergency room for evaluation and treatment.	F 282		

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F 282	Continued From page 16 Departmental notes dated 1/14/17 at 1:05 p.m. indicated staff contacted hospital staff who reported the resident had been admitted with a diagnosis of a right femur fracture. During an interview dated 2/8/17 at 12:10 p.m. the Director of Nursing stated the resident had a history of combative behaviors, striking out and being verbally and sexually aggressive toward staff. Staff have been directed to seek additional staff when needed. Two staff are needed when preparing the resident for a Hoyer transfer; including placement. 2. Resident #4 had a MDS with an assessment date of 1/8/17. The MDS indicated the resident had diagnoses of non-Alzheimer's dementia, Parkinson's disease and a psychotic disorder. A Brief Mental Status (BIMS) documented a score of 3 indicating severe cognitive disorder. The MDS indicated the resident had demonstrated delusional behavior. The resident needed extensive assistance of 1 staff with transfer and limited assistance of 1 staff with ambulation. A fall risk assessment dated 1/8/17 at 7:38 p.m. documented the resident with a high risk for falls. The Care Plan with a problem onset date of 1/18/17 identified altered thought and communication due to a diagnosis of Alzheimer's dementia, confusion and resistive behavior. Interventions directed staff to explain cares and interactions to keep resistance at a minimum and ask for permission before touching the resident and to use a Merry Walker when the resident becomes restless. A problem onset dated 1/18/17 identified at risk for mood or behavior due to a diagnosis of dementia. Interventions directed staff substitute staff if the resident becomes	F 282		

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F 282	Continued From page 17 combative. If the resident becomes verbally and/or physically abusive, ensure the resident's safety and re-approach. An incident report dated 1/28/17 at 9:45 p.m. documented Staff E walked into the commons area and saw the resident attempt to stand from a sitting position with Staff O, CNA in attendance. Staff O pushed the resident back into the recliner. The resident began yelling and tried to stand a second time. Staff E brought the merry walker to the resident and assisted the resident into the merry walker. Staff E stated staff are to explain what needs to happen to ensure his/her safety. If the resident wanted to stand or ambulate staff are directed to transfer the resident to a merry walker. During an interview dated 2/9/17 at 4:00 p.m., the Director of Nursing reported Staff O should have allowed the resident to stand and transfer h/her to a merry walker. 3. Resident #7 had a MDS with an assessment date of 12/11/16. The MDS indicated the resident had diagnosis of non-Alzheimer dementia and severe cognitive impairment. The resident ambulated independently. A Fall Assessment dated 10/2/16 documented a score of 14 indicating high risk for falls. A care plan with a problem/onset dated 12/21/16 revealed potential risk for injury related to falls due to unsteady gait at times. Interventions directed staff to observe the resident when ambulating around the unit and around obstacles Departmental notes dated 2/9/17 at 9:57 p.m. documented a nurse sitting at the nurse's station noted the janitor vacuuming the floor in the unit.	F 282		

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F 282	Continued From page 18 At 7:50 p.m. she heard heard a thump, looked up and found the resident on the floor between the nurse's station and the medication cart lying on h/her right side. A nurse and a CNA assisted the resident up to a chair. The nurse assessed the resident, and noticed the resident's right foot pointed outward. The physician ordered the resident be taken to the local hospital emergency room to be evaluated. Notes dated 2/9/17 at 11:50 p.m. indicated hospital staff reported the resident sustained a left femur (leg) fracture and would be admitted for treatment. A witness statement from Staff M reported he was vacuuming in the commons area near the table close to the nurse's station. About 12 feet away he heard the vacuum shut off, turned around and saw the resident on the floor. During an interview dated 2/14/17 at 3:05 p.m., Staff M reported he failed to place a hazard sign when he vacuumed. He reported he tries to watch the residents because the power cord is a tripping hazard. He reported he hadn't told anyone to watch for residents if they come close to the power cord.	F 282		
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.	F 323		

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F 323	Continued From page 19 (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 interviews, the facility failed to provide adequate nursing supervision to protect residents against hazards from themselves, others, or the physical environment for 2 of 8 residents reviewed (Resident #1 & Resident #7). The facility identified a census of 110 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment tool dated 6/5/16, Resident #1 had diagnoses of diabetes mellitus and Alzheimer's dementia. The MDS documented the resident experienced severe cognitive impairment and displayed verbal behavioral disturbances toward others. The MDS also documented Resident #1 required extensive assist of 1 staff for transfers, but could ambulate (walk) independently. A fall assessment dated 9/4/16 revealed a score	F 323		

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F 323	Continued From page 20 of 16. A fall assessment dated 1/18/17 revealed a score of 14. The assessment form indicated a score of 10 or greater meant the resident was at high risk for falls. An MDS dated 11/13/16 revealed the resident displayed severe cognitive impairment and verbal aggression. The MDS documented Resident #1 rejected cares and did not ambulate in his/her room or off unit during the assessment period. The MDS also documented the resident as totally dependent on 2 staff for surface to surface transfers. A care plan with a problem/onset date of 6/15/16 identified the resident as at risk for falls related to diagnoses of weakness, limited safety awareness, confusion and dementia. The care plan directed staff to provide 1 staff assist with ambulation during the night and provide standby assistance when the resident attempted to sit due to decreased depth perception. A problem/onset dated 6/15/16 revealed the resident experienced a self-care deficit due to a diagnosis of dementia and intermittent confusion. The care plan directed staff to assist with transfers as needed (prn). A care plan with a problem/onset date of 11/23/16 revealed the resident was at risk for altered thought, communication related diagnoses of dementia and intermittent confusion. The care pain directed staff to remain aware of the resident's confusion and verbal behaviors with cares and transfers. A problem onset dated 11/23/16 revealed the resident was at risk for falls related to previous injuries, limited safety awareness, confusion related to dementia, and a previous right hip fracture. The care plan directed	F 323		

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F 323	Continued From page 21 staff to provide assist of 2 staff for transfer by Hoyer (a mechanical device used to transfer a resident by placing them in a sling, lifting them and physically taking them from one surface to another.)	F 323		
	Departmental notes dated 8/13/16 at 1:33 p.m. documented Resident #1 became weak when he/she ambulated for long distances and had depth perception problems when aligning to sit in a chair. The notes revealed the resident required assist of 2 staff for both situations. An incident report dated 8/14/16 at 11:44 p.m. revealed the resident got up independently to go to the bathroom and staff found him/her on the floor. Departmental notes dated 8/14/16 at 10:05 p.m. revealed at 9:33 p.m. the resident got up independently to go to the bathroom and fell. The resident complained of hip, back, and neck pain. The facility notified the resident's family and they gave consent for staff to transfer Resident #1 to a local hospital emergency room for evaluation and treatment Departmental notes dated 8/15/16 at 4:05 a.m. revealed hospital staff notified the facility the resident had been admitted with a right hip fracture. Notes dated 8/18/16 at 9:50 p.m. revealed the resident returned to the facility at 3:00 p.m. Departmental notes dated 9/30/16 at 2:49 p.m. revealed during an occupational therapy assessment, Resident #1 was unable to bear weight.			

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F 323	Continued From page 22 Departmental notes dated 1/12/17 at 12:01 a.m. revealed a late entry dated 1/11/17. During the 2:00 p.m.-10:00 p.m. shift an aide had called a nurse into the shower room to help because Resident #1 was combative with cares. Departmental notes dated 1/13/17 at 2:45 p.m. revealed the occupational therapy staff notified the nurse that a certified nursing assistant (CNA) needed staff assistance because the resident was on the floor. The nurse went to the resident's room and the CNA reported she attempted to place a Hoyer pad (sling) under the resident, but he/she displayed resistive behaviors and slid around the CNA feet first. The CNA then lowered the resident to the floor. The notes revealed during a nursing assessment, the resident's range of motion was within indicated normal limits. Three staff then assisted the resident to bed. Departmental notes dated 1/13/17 at 9:14 p.m. revealed the resident complained of severe pain to the right leg when staff transferred him/her from bed to wheelchair. During assessment, the resident complained of pain to the right upper leg. The nurse documented the right leg looked swollen compared to the other. Staff notified the resident's physician ,who gave an order to transfer the resident to a local hospital emergency room for evaluation and treatment. Departmental notes dated 1/14/17 at 1:05 p.m. revealed hospital staff notified facility staff Resident #1 had been admitted due to right femur fracture. Notes dated 1/17/17 at 9:53 p.m. documented the resident returned from the hospital via ambulance	F 323		

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F 323	Continued From page 23 at 3:00 p.m. and remained totally dependent on staff for all care needs. A Follow-up/Conclusion to the resident's the fall on 1/13/17 completed by the director of nursing revealed the resident had a fall on 4/8/16. The report indicated the resident had more weakness during ambulation at times in the last few weeks and staff monitored for possible physical therapy involvement. The resident required more help with ambulation at night because he/she had not been fully awake when getting up to the toilet. Staff documented they had been monitoring the resident became the resident had become weaker with ambulation. During an interview dated 2/8/17 at 8:25 a.m. and at another at 2:15 p.m., Staff H, CNA reported had cared for the resident for the past 4 months; during the last 2 months, the resident had been physically combative during cares and he/she had tried to strike staff when cares were given. Two days before the fall on 1/13/17, the resident had been physically combative. Staff H stated on 1/13/17 at approximately 12:00 p.m., she went to the resident's room to assist him/her to get up for lunch. Once in the room, she activated the call light, completed incontinence care, dressed the resident and placed the Hoyer sling under him/her as she rolled the resident toward her. At the same time, the resident became combative and his/her legs slipped off the bed and hit the floor. Staff H reported the resident was unable to bear weight and she tried to keep the resident from hitting his/her head. She reported 30 minutes went by from the time she activated the call light. Then, therapy staff came into the room to see the resident's roommate and saw her on the floor with the resident. Staff H stated there is	F 323		

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F 323	Continued From page 24 not enough staff to assist with transferring residents. During an interview dated 2/8/17 at 8:59 a.m. Staff G, CNA reported on 1/13/17 she went to lunch from 11:00 a.m.-11:30 a.m. When she returned, occupational therapy staff told her she needed to go to the resident's room because staff needed help. When she arrived, she saw Staff H sitting on the floor with the resident. Staff F, RN had completed an assessment and the resident screamed for help. Staff G reported the resident's combative behavior had escalated during the last 3 - 4 months; Resident #1 flailed his/her arms, slapped staff and rejected cares. Staff G stated the resident needed 2 staff to assist with transfers and positioning the Hoyer sling under the resident. Staff G reported it is not safe for 1 staff to provide cares. During an interview dated 2/8/17 at 9:37 a.m. Staff F, RN reported she knew the resident well and he/she yelled constantly and was combative, i.e. pushed, shoved, and attempted to strike staff. Staff F reported at the time of the incident she knew the resident's call light had been on between 15 minutes to 30 minutes, but she couldn't leave the commons area because there were residents in the common area and they could not be left alone. She reported it would have been appropriate to have 2 staff assist with placement of the Hoyer sling and added staff knew they could call for additional assistance if the resident became combative or resisted cares. During an interview dated 2/8/17 at 12:10 p.m., the Director of Nursing (DON) stated the resident had a history of combative behaviors such as striking out and being verbally aggressive toward	F 323		

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F 323	Continued From page 25 staff. The DON reported staff have been directed to seek additional staff when needed. Two staff are needed when preparing the resident for a Hoyer transfer; including placement. 2. According to the MDS dated 12/11/16, Resident #7 had a diagnosis of non-Alzheimer's dementia and displayed severely impaired cognition. The MDS documented the resident required limited assist of one staff for bed mobility and required oversight, encouragement or cueing with ambulation during the assessment period. A Fall Assessment dated 10/2/16 documented a score of 14. A score of 10 or greater meant the resident was at high risk for falls. A care plan with a problem/onset dated 12/21/16 revealed the resident's potential for injury related to falls due to unsteady gait at times. Interventions directed staff to observe the resident when he/she ambulated around the unit and observe when he/she ambulated around obstacles Departmental notes dated 11/21/16 at 2:26 p.m. revealed the resident limped on the right lower extremity and leaned toward the right side. Notes dated 11/23/16 at 1:55 p.m. documented the resident limped slightly throughout the evening shift. Notes dated 12/2/16 at 2:01 p.m. documented staff saw the resident sitting on the floor. Two staff with a gait belt assisted the resident with ambulating in the hallway. Notes dated 12/7/16 at 9:34 a.m. documented the resident ambulating independently but unsteady.	F 323		

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F 323	Continued From page 26 Notes dated 12/9/16 at 1:38 p.m. documented the resident as unable to make his/her needs known as the resident did not speak. Departmental notes dated 12/19/16 at 3:04 p.m. documented the resident as severely impaired cognitively and unable to locate his/her room. Departmental notes dated 1/10/17 at 9:08 a.m. documented a CNA reported she found the resident on the floor lying on top of his/her side rail. The resident sustained a skin tear to the right upper arm near the elbow. Departmental notes dated 2/9/17 at 9:57 p.m. documented a nurse sitting at the nurse's station noted the janitor vacuuming the floor in the unit. At 7:50 p.m., she heard the vacuum turn off and heard a thump. The nurse looked up and saw the resident on the floor between the nurse's station and the medication cart lay on his/her right side. A nurse and a certified nursing assistant (CNA) assisted the resident up and to a chair. The nurse assessed the resident and didn't find any bruises or bumps. The nurse noticed the resident's right foot pointed outward so staff took the resident to his/her bed by wheelchair and called the resident's physician, who ordered staff to send him/her to the local hospital emergency room for evaluation. At 11:50 p.m. an entry documented hospital staff notified the facility Resident #7 sustained a left femur fracture and would be admitted for treatment. A radiology "Final Report" dated 2/9/17 at 10:57 a.m. documented the resident sustained a "subcapital fracture (a fracture line that extended through the junction of the head and neck of the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

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F 323	Continued From page 27 right femur (long bone of the leg). A facility investigation dated 2/9/17 documented the resident as alert to self and unable to make needs known due to an inability to verbally communicate. The investigation revealed the resident had abnormal involuntary movements, ambulated with a slouch, and leaned to the right causing falls due to the loss of balance. The resident at times walked throughout the unit during a 16 hour shift at a fast pace, but looked and understood when to step over objects. The investigation documented the resident's speed and leaning to the right side caused one foot to step in front of the other and made the resident trip. Surveillance video of the event showed Staff M, housekeeping vacuumed the commons area as the resident walked up to the vacuum cord, stopped, looked, saw the cord, and started to lift one foot at a time to cross the cord. The video revealed as the resident crossed the cord, his/her toe caught it. The resident then took two more steps, regained his/her balance, took another step, stepped on the interior side of the left foot, and fell. A witness statement from Staff M reported as he vacuumed the commons area near the table close to the nurse's station, he heard the vacuum shut off, turned around and saw the resident on the floor about 12 feet away He yelled to the nurse who came and assessed the resident. Staff M received a one day suspension because staff is to keep the walking path for residents clear. During an interview dated 2/14/17 at 3:05 p.m.,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 03/02/2017

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F 323	Continued From page 28 Staff M reported he failed to erect a hazard sign when he vacuumed. He reported he tried to watch the residents because the power cord is a tripping hazard. He reported he hadn't told anyone to watch for residents if they come close to the power cord. During an interview dated 2/14/17 at 3:15 p.m. the facility's Housekeeping Supervisor reported staff are not to string electrical cords when they can't keep an eye on the cord at all times.	F 323		

F000 This plan of correction constitutes our credible allegation of compliance. Date Completed: 03-03-17.

F206

A facility Emergency Involuntary Discharge communication form was developed. This form includes all required notifications pursuant to 481 I.A.C. §58.40(1); 58.40(6), 42 C.F.R. 483.15(c) and 483.15(c)(4)(ii). Continued monitoring will be a part of the facility QA process. Date complete: 3-3-17.

F223

Resident #4 was assessed and facility investigation was completed. Staff O was placed on administrative leave on 1-28-17 pending investigation. Staff O employment was terminated on 02-02-17 after completion of the facility investigation. Facility staff receive CCDI train upon hire and annually. Continued monitoring will be a part of the facility QA process. Completed: 3-3-17.

F279

Resident care plans were updated to reflect the need for assistance during meals and to reflect additional interventions for residents with a history of behaviors during cares. Education and training was provided to nursing staff. Continued monitoring will be a part of the facility QA process. Date complete: 3-3-17.

F 282

Resident care plans including resident #1 were updated if needed to reflect two assist while preparing resident for transfer. Education and training was provided to nursing staff to follow resident care plans and for nurses to update interventions as needed. Facility staff receive CCDI train upon hire and annually. Education and training was provided to Environmental Services and Nursing staff on the importance of providing an environment free from accident hazards as is possible. Continued monitoring will be a part of the facility QA process. Date complete: 3-3-17.

F 323

Resident care plans including resident #1 were updated as needed to reflect potential for combative behavior during cares or transfers. On 2-10-17 education and training was provided to Environmental Services and Nursing staff on the importance of providing an environment free from accident hazards as is possible. Continued monitoring will be a part of the facility QA process. Date complete: 3-3-17.