STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165266	A. BUILDING _____ B. WING _____	C 04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY SPIRIT RETIREMENT HOME	1701 WEST 25TH STREET SIOUX CITY, IA 51103

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F 000	INITIAL COMMENTS Correction date ____9/15/17_____ The following deficiency relates to the investigation of incident #62939. (See the Code of Federal Regulations (42CFR) 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 (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 clinical record review, facility policy	F 323	Past noncompliance: no plan of	

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

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F 323	Continued From page 1 review and staff interviews, the facility failed to provide adequate nursing supervision to prevent accidents for 1 of 4 current residents sampled (Resident #1). The facility identified a census of 90 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/12/16 documented the pertinent diagnoses of a displaced hip fracture, anemia, hypertension, and diabetes mellitus for Resident #1. The same MDS documented the resident admitted to the facility on 9/7/16 for Medicare A skilled nursing services and had a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. Resident #1 required extensive assistance of one staff for completion of transfers, ambulation, and toileting. Resident #1 had limited functional range of motion (ROM) of one leg and assessed the resident as unsteady and only able to stabilize with staff assistance to complete movement from a seated to a standing position, walking or moving to and from the toilet, and for surface-to-surface transfers. The assessment revealed Resident #1 used a walker and wheelchair for mobility. The MDS also documented the resident had a fracture related to a fall in the 6 months prior to admission. The Admission Care Plan dated 9/7/16 identified the resident only able to bear partial weight on the right leg and required 1 staff assistance for completion of transfer/s using his/her front wheeled walker. The care plan identified staff to assist Resident #1 with toileting as s/he directs; and provide resident care per facility protocol. The care plan revealed Resident #1 scored 75 on the Morse Fall Score, which indicated he/she at	F 323	correction required.	

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F 323	Continued From page 2	F 323		

high risk
for falls.

The Daily Skilled Nurses Notes dated 9/13/16 at 4:30 PM documented the resident had 4+ (severe) pitting edema of both ankles and lower legs. The 6:30 PM entry documented the physician ordered the resident's blood pressure taken 2 times a day (BID) for 2 weeks and to fax the results to the physician weekly.

The Incident/Accident Report dated 9/13/16 at 5 p.m., revealed Resident #1 insisted to walk to the bathroom with his/her walker. A certified nurse aide (CNA) walked with him/her to the bathroom. Resident #1 unable to void with CNA present, and CNA stepped [away] for privacy. When the CNA returned, he/she brought w/c (wheelchair) to pull up behind him/her when resident fell down. The assessment revealed Resident #1's blood pressure of 140/62 after the fall with right hip/back/leg pain. The incident report revealed the resident's diagnosis prior to fall as post surgical right hip fracture.

The Daily Skilled Nurses Notes entry dated 9/13/16 at 11:00 p.m. documented the resident fell in the bathroom at 5:00 p.m., and observed in the corner with his/her head resting against the wall and most of his/her weight positioned on the right hip. The certified nursing assistant (CNA) stated the resident insisted on walking to the bathroom using a walker. The resident stood to void but could not do so with the CNA present. The CNA then stood right outside the bathroom door. The resident yelled when finished in the bathroom. The CNA brought in the resident's wheelchair to pull up behind the resident but the resident lost balance and fell. The resident could

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not stand any movement of the area. The resident transferred to the emergency room and subsequently admitted to the hospital.

The Hospital consultation report & History and Physical dated 9/14/16 revealed the physician had been familiar with Resident #1 after his/her basicevical fracture of the right hip; which occurred on 8/16/16. At that time Resident #1 had surgical repair for his/her right intertrochanteric fracture of the hip and had been in rehab at the nursing home. The consultation report revealed he/she was admitted on 9/13/16 after the Resident #1 slipped and fell directly onto his/her hip, suffering a comminuted fracture of the femoral shaft (thighbone). The previous intertrochanteric fracture fixation remained intact; however he/she broke through the shaft (thighbone) from the mid portions of the nail distally. The physical examination and x-rays showed a comminuted fracture of the right femoral shaft (thighbone). Resident #1 underwent surgery and tolerate the procedure well.

Review of the Fall SBAR dated 9/13/16 revealed the resident may have gotten dizzy and had an unsteady gait. The CNA brought in the wheelchair and the resident had been standing by the sink. The CNA brings the wheelchair up behind and the resident falls to the floor.

Staff B's statement dated 9/13/16 revealed she walked into Resident #1's room to talk with Staff A. Staff A had been standing outside the bathroom while the resident was going to the bathroom. Staff B reported Staff A continued to check in with the resident. Staff B documented when Resident #1 was all done, Staff A started to put the wheelchair into the bathroom for Resident

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#1 to sit in. Staff B documented Resident#1 had turned and walked to sit down but fell on his/her right side and hit his/her head on the wall. Staff B documented she went to get the nurse and this occurred around 5 p.m.
The Administrator reported Staff B no longer an employed by the facility.

During interview on 4/20/17 at 2:40 p.m. Staff A CNA, stated before supper, Resident #1 wanted to go to the bathroom. At this time the resident sat in a recliner is his/her room. Staff A told the resident she would be right back; when she returned the resident had already self-transferred to the wheelchair. Staff A stated the resident refused to allow use of a gait belt and the resident ambulated independently into the bathroom after she placed the wheelchair where s/he could grab the bar. Staff A stated she stood outside the bathroom door per the resident's request but peeked in the door frequently. When the resident indicated s/he being done in the bathroom she pushed the wheelchair into the bathroom and place it behind the resident so s/he could turn and sit. Resident #1 fell when turning to sit in the chair.
Staff A stated it is the facility's policy to use a gait belt during transfer if the resident required assistance. She stated she did not know if she told anyone at the time of the fall or investigation that the resident refused the gait belt. Staff A receive disciplinary action for failure to use the gait belt.

The Employee Counseling/Coaching Record (final warning) dated 9/22/16 documented Staff A disciplined for the following concerns:
1) transferring a resident who required assistance with transfer and ambulation without the use of a

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F 323	Continued From page 5 gait belt. 2) failure to follow a resident's care plan of care on assistance level and not reviewing activities of daily living on the care plan or asking the supervising nurse on any changes. 3) left a resident alone or within reaching distance that required contact assistance with transfers and ambulation. During interview on 4/14/17 at 1:39 p.m., the Director of Nursing (DON) stated if the resident could not void with the CNA present the CNA should have encouraged the resident to sit on the toilet to void or use the urinal while seated in the chair or bed. The DON stated all CNA's were re-educated to the gait belt policy at the monthly CNA meeting on 9/15/16 because of this incident. The investigation identified the facility corrected the noncompliance prior to the arrival of this investigation and was in substantial compliance on 9/15/16.	F 323		