STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. BUILDING _____ B. WING _____	C 04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANDALE HEALTH CARE CENTER	4614 NW 84TH STREET URBANDALE, IA 50322

(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_____ The following deficiency relates to the investigation of facility reported incident #67672 & mandatory #67664. (See code of Federal Regulations (42CFR) Part 482, 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:	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/18/2017

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F 323	Continued From page 1 Based on observation, record review, and interviews, the facility failed to ensure each resident received adequate assistance devices to prevent accidents for 1 of 5 residents reviewed (Resident #2). During a transfer from a bed to wheelchair, a staff member failed to use proper safety measures and it caused the resident to fall. As a result, the resident sustained a left femur fracture. The facility identified a census of 86 residents. Findings include: According to the Minimum Data Set (MDS) Assessment tool dated 4/3/17, Resident #2 had diagnoses that included dementia, peripheral vascular disease, high blood pressure, and osteoarthritis. The MDS documented the resident required limited assist of one staff for bed mobility and personal hygiene, and limited assist of two staff for transfers. The MDS also documented the resident required extensive assist of two staff for toilet use. The Resident's Care Plan dated 1/13/17 identified the resident displayed impaired cognitive function and had a diagnosis and dementia. The Care Plan directed staff to monitor, document, and report to the physician changes in decision making, memory, general awareness, expression, comprehension, level of consciousness, and mental status. The Resident's Care Plan initiated 7/27/13 identified the resident had a potential for falls related to unawareness of safety needs, confusion, psychoactive drug use, and gait/balance problems. The Care Plan directed staff to ensure the resident wore their left (AFO) leg brace, and had transfer loops to the bed.	F 323	Past noncompliance: no plan of correction required.	

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The Care Plan revised 1/13/17 identified Resident #2 experienced a self-care deficit related to history of a stroke. The Care Plan directed staff to use one staff to assist the resident with transfers.

The Fall Report dated 3/28/17 at 10:15 p.m. revealed the resident rolled out of bed and documented the root cause of the fall as confusion. The Fall Report documented the fall as unwitnessed and revealed the resident sustained a contusion to the left side of the head and the left elbow. The reported revealed staff sent the resident to the emergency room for evaluation, and returned with orders to follow up with their primary care doctor in two days. The facility put a scooped mattress in place after the fall.

The Fall Report dated 4/3/17 at 8:20 a.m. documented the Certified Nursing Assistant (CNA) assisted the resident into the wheelchair. The resident reported left leg pain and refused to wear their AFO. The resident was using a transfer bar to transfer to the wheelchair, the resident's hand slipped, and he/she fell. The report documented the root cause of the fall as failure to follow the Care Plan. As an immediate intervention, the facility educated the CNA to follow the set sheets (mini care plans the CNAs carry with them).

The Resident Summary Investigation dated 4/10/17 documented the resident as alert and oriented to person but exhibited confusion regarding place and time. The resident required assist of one staff for transfers, and the summary documented the resident as nonambulatory (did not or unable to walk).

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According to the CT Final Report dated 4/3/17, the resident sustained a left femur fracture.

The Progress Note dated 4/8/17 revealed the X-ray report documented a mottled appearance of the proximal femur that suggested the possibility of marrow infiltrative disorder such as multiple myeloma or less likely metastatic disease. However, the findings may simply be related to bony demineralization related to the patient's age.

During an interview on 4/24/17 at 10:53 a.m., Staff A, Licensed Practical Nurse (LPN), described Resident #2 as confused and related he/she often searched for his/her deceased spouse while the resident propelled a wheelchair throughout the facility. Staff A reported prior to the fall the resident required staff assist of one with the use of a left lower extremity AFO, shoes, and a gait belt. It's the facility policy to use a gait belt unless the care plan directed staff otherwise. Staff A reported she did not witness the fall, although Staff J, CNA came to alert her Resident #2 fell in his/her room during a transfer from the bed to the wheelchair. Staff A reported the resident fell on 4/3/17 at about 8:20 a.m. and related she saw the resident lying on his/her left side with feet under the bed when she entered the room and added the resident was still in the hospital. Staff A, stated Staff J, told her she did not use the AFO, shoes, or gait belt during the transfer and added CNAs carry set sheets that contained documentation that directed residents' care needs. Staff A reported the facility had an inservice regarding all types of transfers after Resident #2 fell.

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During an interview on 4/24/17 at 12:59 p.m., Staff B, CNA described Resident #2 as confused and revealed the resident's care plan directed staff to transfer Resident #2 with assist of one and an AFO, a gait belt, and shoes. Staff B, reported the resident experienced left-sided weakness due to a past stroke and tried to talk staff out of the use of the gait belt, leg brace, and shoe. Staff B added if the resident tried to avoid gait belt use, she educated the resident about safety, or asked the nurse to do so. Staff B stated there is no excuse not to use a gait belt because there are plenty available.

During interviews on 4/24/17 at 1:07 p.m. and 4/26/17 at 1:04 p.m., Staff C, CNA described Resident #2 as confused and reported the resident needed staff to transfer him/her with assist of one person, a gait belt, a lower extremity AFO, and shoes. Staff C also reported facility policy directed staff to use gait belts and added the belts were located in the break and shower rooms and on med carts in each hallway.

During interviews on 4/24/17 at 2:10 p.m. and 4/26/17 at 12:55 p.m., Staff D, CNA described Resident #2 as confused and reported the resident needed transfer assist of one staff with a gait belt, leg brace, and shoes. Staff D also reported the resident told staff he/she could transfer independently and tried to talk them out of safety equipment use. Staff D stated they educated the resident staff needed to use the devices for safety or told him/her to talk with the nurse or therapy about changing the transfer technique. Staff D reported the gait belt is part of their uniform and should be used with all transfers and added set sheets were in a binder at the nurse's station to find changes and to see how to

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take care of the residents. Staff D related she had not seen other staff transfer a resident without a gait belt and reported it was easy to get Resident #2 to use the gait belt.

During an interview on 4/25/17 at 2:35 p.m., Staff E, LPN reported she worked both day and evening shifts and she did not have staff who very often told her Resident #2 refused the gait belt, shoes, or AFO. Staff E, reported she just needed to chat with the resident for bit so the resident would cooperate.

During an interview on 4/26/17 at 12:40 p.m., the Director of Nursing (DON) reported Staff J told her she ran late for work and left her gait belt in her car. The DON reported she completed interviews and conducted a reenactment of the incident. The DON related Staff J told her Resident #2 grasped the transfer bar and then started to fall, so Staff J tried to put the wheel chair under the resident. Staff H stated facility policy directed and she expected staff to use a gait belt with assist of one for transfers, and added gait belts were at the nurse's station, on the med carts.

During an interview on 4/26/17 at 1:14 p.m. Staff I, LPN reported that she had not seen a resident being transferred without a gait belt, and wouldn't let that happen, it would not be a safe transfer. Staff I added it was facility policy to use a gait belt with all transfers (unless otherwise directed on the care plan).

During an interview on 4/25/17 at 2:04 p.m. Staff K, C.N.A reported she had no problems persuading Resident #2 to use the gait belt.

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During an interview on 4/24/17 at 1:23 p.m. Staff J, C.N.A, stated she began employment at the facility on 1/25/17 and reported she was with the resident when the resident fell. Staff J, reported she went to the resident's room to get the resident up for a shower, and the resident didn't want to put on the AFO because his/her foot hurt. Staff J reported she put slipper socks on the resident, and the resident stood up and used the rail on the bed (small buddy rail). Staff J stated the resident lost his/her grip on the transfer bar on the bed and fell. Staff J said the resident was holding the wheelchair and couldn't get it under the resident before the resident fell. Staff J, reported she did not use the gait belt because the resident always complained of using the gait belt. Staff J added the resident always did fine before, and the resident didn't weigh that much anyway, so she thought he/she would be fine. Staff J, reported upon hire everyone is given a gait belt, but she thought she thought she left hers in the break room or at the nurses station. She stated assignment sheets at the nurse's station directed staff how to transfer the resident and listed other care needs. Staff J reported if the resident refuses the AFO and shoes next time she would get the nurse and tell her. The resident only refused to use the AFO and shoes the day he/she fell. Staff J, didn't try and put a gait belt on the resident, because she didn't have it with her.

The Gait Belt Policy dated 4/18/11 policy documented the use of a transfer belt is for safety measures for both residents and staff when transferring or ambulating. A transfer belt will be placed on each resident prior to transfer or prior to ambulation with assistance. The only exception is when a resident is transferred by using a mechanical lift. In order to accomplish this

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efficiently, all nursing personnel will have immediate access to a transfer belt while on duty. The expectation is the gait belt be a part of the uniform dress code (must be worn at all times). Noncompliance may result in disciplinary action. This policy had been signed by Staff J with the date of 1/25/17, and had been in her personnel file.

Observation on 4/25/17 at 3:00 p.m. revealed C.N.A staff all wore gait belts. Nurses at the nurse's stations able to show surveyor gait belts at the nurse's station, and on the medication carts.

Observation on 4/26/17 at 2:00 p.m. revealed all C.N.A staff members wore gait belts. All shower rooms and medication carts at the nurse's station contained gait belts.

Observation on 4/25/17 at 2:20 p.m. revealed a gait belt on a recliner in Resident #4's room.

The investigation revealed the facility corrected the noncompliance prior to the Department representative's entrance to the facility to initiate review of the incident and therefore was in substantial compliance on 4/3/16.

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