STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165283	A. BUILDING _____ B. WING _____	C 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FELLOWSHIP VILLAGE	**300 EAST JEFFERSON INWOOD, IA 51240**

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F 000	INITIAL COMMENTS Correction Date_____ Investigation of a facility complaints #78692-I and #81993-I resulted in the following deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, review of the facilities call light system and facility policy review, the facility failed to ensure staff maintained a safe and secure environment for 1 of 4 residents reviewed. Resident #1 fell and sustained a right hip fracture when the alarm was not in place. The facility identified a census of 40 residents. Findings include: A Minimum Data Set (MDS) assessment form dated 9/3/18 indicated Resident #1 had diagnoses that included diabetes mellitus (DM), cerebrovascular accident (CVA), macular degeneration and legally blind. The assessment indicated the resident had a Brief Interview for	F 689	Past noncompliance: no plan of correction required.	

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

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Mental Status (BIMS) score of 14 out of 15 (no cognitive impairment), required limited assistance of one (1) staff with transfers and ambulation in her room and in the corridor and 1 fall with a minor injury.

An Observation Detail List Report dated 9/3/18 at 2:44 p.m. indicated the resident had a history of falls, difficulty walking, muscle weakness and an altered mental status. The form indicated the resident as at risk for falls.

A Care Plan dated 6/21/18 indicated the resident had a problem with mobility and safety and fall and injury. The interventions included the following:

a. The resident ambulated and transferred with a walker, gait belt and and 1 or two (2) staff assist. (dated 6/23/18)
b. A personal body alarm at all times due to attempted self transfers, weakness and confusion. (dated 6/23/18)
c. Used a wheel chair to meals and activities due to fatigue and shortness of breath (SOB).
d. The staff propelled her wheel chair daily per her request and the resident propelled herself short distances also.
e. The resident fell having transferred self from the wheel chair to the lift chair which resulted in a bruise to her right upper arm (dated 6/23/18)
f. Found the resident on the floor in her room with the personal body alarm not activated. Staff added pressure alarms to the bed, wheel chair and the recliner due to her having disabled the personal body alarm. (dated 9/6/18)

An Incident Report Follow-Up form dated 9/6/18

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at 7:45 p.m. and written by Staff E RN (registered nurse) indicated the resident had been found on the floor in front of a chest in her room without the alarm having sounded which resulted in a fractured right femur.

A Incident Investigation Form dated 9/6/18 at 7:45 p.m. reviewed by the Director of Nursing (DON) documented what happened, how it happened and why did it happened as follows:

A certified nurse aide called the writer to the resident's room by a certified nursing assistant (CNA) and found the resident laying on her right side on the floor in front of a big chest. The right leg appeared bent at the knee with the foot under the left leg. The resident was alert and oriented to reality but could not recall what she was doing when the fall occurred. The personal body alarm did not activate. The writer rolled the resident onto her back and slowly moved the resident's right leg to a straight position. The resident complained of pain when staff palpated the hip area. The resident denied having hit her head and denied pain anywhere else on the body. Observation revealed a large bump that protruded from the right hip and no redness or bruising noted. Staff positioned pillows under the resident's head and knees for support. The resident moved her toes on both of her feet and denied pain. The resident's vitals signs at 8:45 p.m. were: blood pressure (B/P) of 165/82, pulse (P) 89 a temperature (T) of 97.6 degrees Fahrenheit and and oxygen (O2) saturation level of 97% at room air. The staff sent the resident to the hospital for evaluation and treatment. The resident sustained a fractured right femur. Staff interviewed felt the resident unhooked the personal body alarm from herself and transferred

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herself to the recliner on her own after supper and then attempted to self transfer again prior to staff finding her on the floor. The CNA stated she put a personal body alarm on the resident after she helped her to the bathroom before supper. The nurse reported the resident had been in her recliner at 6:30 p.m. The personal body alarm was still attached to the wheel chair when staff found her on the floor, indicating staff did not transfer it to the recliner when they saw the resident at 6:30 p.m. The call light had been in reach.

A Follow-up on the fall written by the DON on 9/13/18 continued as follows:

The DON spoke to the resident about the fall. When asked if the resident transferred herself from one spot to another within her room without assistance, the resident revealed she did self transfer at times. When asked if she transferred by herself the day she fell she stated she moved on her own from the recliner and fell when she tried to moved things on her bed. The resident stated she sometimes did not call for help and self transferred.

The resident was able to get around in her wheel chair through the facility and wheeled herself in the wheel chair to and from activities and meals prior to the fall. The resident brought herself back from the dining room that evening per usual. Nursing reported confusion improved at the time of the fall and also reported the resident usually used the call light when she wanted to get ready for bed.

On the resident's return from the hospital her alarms changed to pressure pads to decrease the

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probability of self removal and staff placed a camera in the resident's room for closer monitoring of the resident.

The facility educated staff on 9/7/18 to ensure personal alarms are connected to all residents care planned for alarm use when going from different locations. Staff should double check alarms when assisting residents with cares, snacks, medications and etc. Management reviewed with staff the residents care planned to use alarms and started personal alarm audits. Maintenance staff checked functionality of alarms two times a month and the facility updated CNA toileting sheets to show residents who used personal body alarms.

A Hospitalist History and Physical Note dated 9/7/18 documented the resident as admitted to the hospital on 9/6/18 with an acute right proximal femur fracture following a low impact fall at the nursing home.

An X-ray report from dated 9/6/18 documented the resident sustained a comminuted proximal right femur fracture which involved the intertrochanteric and subtrochanteric femur with overlap and varus angulation at the fracture site. Mildly displaced lesser trochanteric fracture fragment. No bone mass identified. Osteopenia and scattered degenerative changes noted.

A resident progress note dated 9/11/18 at 11 a.m. revealed the facility received an update from the hospital. The resident right hip nailing done on 9/7/18. The resident received 1 unit of packed red blood cells due to low hemoglobin, required an indwelling foley catheter due to urinary retention and had 3 hip incisions. The resident will

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discharge from the hospital needing physical and occupational therapy and Tylenol (analgesic) and Tramadol (narcotic) for pain control. Resident progress notes revealed the resident returned to the facility on 9/12/18 at 2:25 p.m. Resident progress notes dated 9/13/18 at 1:46 p.m. identified the resident with 6 small incisions on the right leg due to surgery with sutures in place and a dressing to cover. Staff observed purple and yellow bruising to the mid and side if the abdomen, periarea, hip and down to the knee.

A Major Injury Determination Form signed by a physician 9/6/18 at 10:22 p.m. indicated the physician reviewed the circumstances of the fall and felt the injury was a major injury.

Resident Progress Note forms included the following entries as dated and timed:

a. 8/4/18 at 4:30 a.m. - The resident had set off the personal body alarm several times tonight rather than utilizing the call light. One time the resident set off the alarm and staff directly entered the room in response to the alarm. The resident was getting up with the walker when staff entered the room. The resident did not wait for staff assistance.

b. 8/4/18 at 11:06 a.m. - The personal body alarm had been in place and the resident set it off for bathroom use.

c. 8/4/18 at 11:42 p.m. - The resident set off the personal body alarm several times that evening and one time got up per self without having waited for staff assistance.

d. 8/11/18 at 4 p.m. - The resident's personal

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body alarm activated so staff entered the resident's room and found the resident seated on the edge of the lift chair and the resident attempted to stand by herself. Staff asked the resident what she wanted but the resident could not verbalize what she wanted.

An All -Call form dated 9/28/18 documented the resident activated her call light at the following times that correlated with the interviews below:

a. on 9/6/18 at 4:17:33 p.m. activated and answered at 4:19:01 p.m.
b. on 9/6/18 at 4:23:32 p.m. activated and answered at 4:24:30 p.m.
a. on 9/6/18 at 6:27:58 p.m. and answered at 6:29:30 p.m.

A typed statement dated 9/7/18 revealed Staff A, Administrator documented the following entries:

a. Staff B, CNA assigned to the 200 hallway reported she assisted the resident to the bathroom when she came in around 4 p.m. but someone else assisted the resident off of the toilet. The resident had her alarm on at that time. Staff B stated she went to the resident's room at 7:45 p.m. when she found her on the floor by the dresser. Staff B stated she did not assist the resident since 4 p.m.

b. Staff C, CNA reported she helped the resident off the toilet and into the wheel chair at 4:30 p.m. She stated she knew she put the personal body alarm on her because earlier that day the resident attempted to self transfer into the bathroom without calling for staff assistance. Staff C reported the resident went to the dining room for supper. Staff C did not assist the

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resident after 4:30 p.m.

c. Staff D, CNA reported she last observed the resident around 6:45 p.m. when she passed the snack cart and the resident sat in her recliner at that time. The staff member stated she had not helped the resident after supper.

d. Staff E, Registered Nurse (RN) reported she was in the resident's room at 6:30 p.m. to 6:45 p.m. and administered medications. At that time, the resident sat in the recliner. Staff E indicated she did not assist the resident with transfers that night.

During an interview 4/4/19 at 1 p.m. Staff B indicated she positioned the resident on the toilet before supper with alarms in place. She did not assist the resident from the toilet, another staff assisted the resident. At 8 p.m. Staff B heard yelling and found the resident on the floor next to the dresser and parallel to the dresser. The alarm did not activate. Staff B then went to get a nurse.

During an interview 4/4/19 at 12:16 p.m. Staff C confirmed she worked when the resident fell but she could not recall if she observed the resident in the dining room prior to the fall. Staff C indicated the nurse asked for her assistance as the resident fell but she could not recall the position of the resident, if she had been alert and oriented and if she self propelled her wheel chair at the time. All the staff member recalled is she held the door open for the ambulance crew and the resident was known to have removed her alarm at times.

During an interview 4/4/19 at 11:39 a.m. Staff D confirmed she worked as a float when the

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resident fell. Staff D gave the resident a snack that evening at which time the resident sat in the recliner but she did not recall if the alarm was in place. The staff member indicated when the resident was first admitted to the facility she was independent with ambulation. The resident's status then changed to needing assistance with ambulation and using an alarm at all times because the resident attempted to self transfer/ambulate. Staff D indicated she did not observe the resident on the floor that night and stated the resident was alert and oriented at the time.

During an interview 4/4/19 at 11:55 a.m. Staff E confirmed she worked the night of the resident's fall but it was "a long time ago". The staff member stated the resident fell in the evening as Staff E administered medications. Staff E found the resident on the floor with her leg under her but she could not recall which leg had been under the other. Staff E recalled assessing range of motion. She positioned the leg for comfort as the resident denied pain. Staff E indicated she observed a deformity in the affected leg area. The resident appeared alert and oriented at the time. Staff E left the resident on the floor, performed vitals, called the ambulance and sent her to the hospital. Staff E stated the fall was so long ago she would have needed to review the chart to know specifics of the fall and the situation. Part of Staff E's 9/7/19 at 4:30 p.m. entry in the chart identified the resident's personal alarm was still in the wheelchair when staff found her on the floor. When Staff E administered medications at 6:30 p.m. to 6:45 p.m. she did not check the placement of the resident's personal body alarm. Staff E indicated the resident removed the alarm at the time because she

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disliked it so staff would place the clip on the resident's back out of reach.

On 4/4/19 at 1:27 p.m. Staff F, CNA confirmed the resident was known to self transfer prior to the fall with a fracture

On 4/4/19 at 1:35 p.m. Staff G, CNA confirmed the resident attempted to self transfer prior to the fall with a fracture

A Personal Alarms policy dated 9/18 revealed the facility used personal alarms to potentially reduce the event of falls and injury. To help alert or remind the resident to use the call light and wait for assistance and alert staff when a resident arose without assistance. The policy included the following procedure:

a. Each personal alarm would have been attached to the resident and the bed, wheel chair or recliner as ordered.

Observation:

On 4/4/19 at 10:45 a.m. observation showed the resident in a wheelchair at the nurses station with a pressure alarm in place. The alarm functioned when checked.