

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2019
NAME OF PROVIDER OR SUPPLIER WEST RIDGE SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1904 WEST HOWARD STREET KNOXVILLE, IA 50138		
(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 The following information relates to the investigation of facility reported incident #82717-I, abuse allegation #83374-M and complaint 83635-C. The facility reported incident #82717 was substantiated. Complaint #83635 was substantiated. See the Code of Federal Code of Regulations (42-CFR) Part 483, Subpart B-C. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 000	Please see attached Plan of Correction		
F 584 SS=F		F 584			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Michelle Kershner

Administrator

7-3-2019

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.

John Schulte

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaints 83635-C: Based on observation and staff interviews, the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly and comfortable interior. The facility reported a census of 72. Findings include: During an observation and interview on 6/13/19 at 8:10 a.m., Staff F (Housekeeping Supervisor) reported the nursing staff remove the bed linens every week. Staff F reported on Monday the nursing staff remove the linens on 100 and 300 Hall even numbered rooms, on Tuesday remove the linens on 100 and 300 Hall odd numbered rooms, on Wednesday remove the linens on 200 and 400 hall odd numbered rooms and	F 584			

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F 584	Continued From page 2 Thursdays remove the linens on 200 and 400 hall even numbered rooms. The Surveyor observed Staff F applying bed linens. Staff F reported the housekeeping staff cleans the mattresses with 256Q (sanitizer) and allow to dry before making the beds. Staff F reported Staff J had already sprayed the mattress with sanitizer. During an interview on 6/13/19 at 8:00 a.m., Staff J (Housekeeping/Maintenance) reported a shortage of housekeeping staff and he helped by delivering linens and cleaning rooms. Staff J stated the housekeeping staff swept, dusted, mopped, cleaned and sanitized the toilets and sinks, cleaned the mirrors and removed the trash in the resident's rooms every day. Staff J stated the nursing staff removed the bed linens according to the schedule, housekeeping staff sprayed the beds with 256Q, allowed it to dry and then made the beds. Staff J stated he sprayed bed 206-1 this morning, but no others, noting Staff F sprayed the other beds. During an observation on 6/13/19 at 7:00 a.m. to 1:25 p.m. revealed the bed linens removed from 405-1's bed. The toilet had smeared fecal matter. The toilet remained in this condition throughout the day. The beds in rooms 204-1, 204-2, 206-1, 206-2, 208-1 and 210-2 had the linens removed. At 7:45 a.m., Staff F and Staff J delivered linens. Staff F made beds but failed to sanitize the mattresses per protocol. Staff J cleaned dusted and mopped rooms 108, 206, 208 and 100. However, failed to clean any other rooms. The staff cleaned 4 of the 48 resident rooms from 6:45 a.m. to 1:25 p.m. During an interview on 6/13/19 at 1:15 p.m. Staff F (Housekeeping Supervisor) stated she had been	F 584			

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F 584	Continued From page 3 unable to get to any rooms to clean today and her day ends at 2:30 p.m. Staff F admitted the rooms are not getting routinely cleaned, but hopes it will change with new hires. During an interview on 6/13/19 at 10:40 a.m., the Administrator stated the facility had a difficult time retaining housekeeping staff. Staff F officially started today as the housekeeping supervisor and another housekeeper was on vacation. The Administrator reported an expectation of the housekeeping staff to clean the resident's rooms every day and sanitize the beds once a week and as needed. The Administrator was aware cleaning was not completed and had other staff help when available.	F 584			
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: The following deficiency relates to complaint #83635 and abuse allegation #83374. Based on clinical record review and interviews, the facility failed to follow the plan of care and failed to implement interventions to prevent falls for 2 of 2 sampled (Residents #2, #7). Resident #2 sustained a fractured right femur during an improper transfer. Resident #7 had repeated falls	F 689			

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F 689	Continued From page 4 and sustained a fractured jaw and broken teeth. The facility made a therapy referral for wheelchair positioning but failed to implement interventions to keep Resident #7 safe in the interim. The facility reported a census of 72. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 2/27/19, Resident #2 had a diagnosis of Alzheimer's disease. Resident #2 had moderately impaired decision-making. The MDS dated 2/27/19 documented Resident #2 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. The Care Plan identified Resident #2 had decreased mobility secondary to spinal stenosis and status post fractured left femur repair. The Care Plan directed the staff to transfer Resident #2 with a total mechanical lift with two staff for safety. During an interview on 6/10/19 at 12:29 p.m., Staff A (Nurse Aide) reported the morning of 5/16/19 Resident #2 required two staff to roll her over in bed and had increased pain with her leg turned inward. Staff A summoned the Staff B (Charge Nurse) to assess Resident #2. Staff A stated Resident #2 often had pain related to arthritis but didn't recall her having any pain issues on 5/13/19 or 5/14/19. Staff A stated she worked the day shifts on 5/13/19 to 5/16/19 and Resident #2 had complained of leg and right knee pain with transfers. During an interview on 6/10/19 at 3:10 p.m., Staff	F 689			

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F 689	Continued From page 5 B (Licensed Practical Nurse) stated on the morning of 5/16/19 Staff A asked her to look at Resident #2. Staff B noticed Resident #2's right leg and knee had internally rotated. Resident #2 yelled out in pain when she touched the right knee. Staff B arranged for an x-ray outside of the facility. Resident #2's roommate (Resident #3) told Staff B a male nurse aide assisted Resident #2 into bed a couple of nights ago and the roommate heard Resident #2 yelled out "ow, that hurts". Resident #3 as not able to identify the aide by name, but later that day identified Staff C, as the aide that assisted Resident #2 into bed when she yelled out in pain. The radiology report dated 5/16/19 revealed Resident #2 sustained a markedly displaced/impacted supracondylar fracture of the right distal femur with resultant valgus angulation and severe degenerative change in the knee joint. Resident #2 had severe bony demineralization in her pelvis. According to the MDS assessment dated of 3/27/19, Resident #3 had no cognitive impairments. During an interview on 6/10/19 at 1:55 p.m., Resident #3 reported Staff C transferred Resident #2 by himself from the wheelchair to the bed with a total mechanical lift. Resident #3 reported Staff C had the privacy curtain pulled between them, but she heard Resident #2 yell "oh no, oh no, oh no". Resident #3 asked what was going on and Staff C stated Resident #2's foot slipped. During an interview on 6/13/19 at 12:00 p.m., Staff C (Nurse aide) stated he transferred Resident #2 into bed on the evening of 5/11/19	F 689			

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F 689	Continued From page 6 and Staff D (Agency Aide) assisted with the total mechanical lift transfer. Staff C stated the transfer was uneventful and recalled Resident #2 asking about his kids. Staff C stated Resident #2 never complained of any pain or discomfort. The Surveyor informed Staff C the other staff denied being involved in Resident #2's transfer the evening of 5/11/19. Staff C reiterated Staff D (Agency Aide) helped with the transfer. During an interview on 6/10/19 at 2:43 p.m., Staff D (Agency Aide) stated she worked the evening shift on 5/11/19. Staff D stated she assisted Staff C with a total mechanical lift transfer of Resident #2 around supertime. Resident #2 had no complaints. Staff D reported she had no further contact with Resident #2 after 6:00 p.m. During an interview on 6/11/19 at 2:09 p.m., Staff E (Nurse Aide) stated she worked the overnight shift on 5/11/19. Staff E stated she assisted Staff C with some two-person transfers, but never with Resident #2. Staff E stated she went into Resident #2's room around 9:30 p.m. to help transfer Resident #2 into bed but Resident #2 was already in bed. Staff E stated she was not involved with transferring Resident #2 into bed and did not know who may have helped Staff C with the transfer. During an interview on 6/11/19 at 9:43 a.m., Resident #2's son stated he and other family visited his mother on 5/12/19. Resident #2 complained of right knee pain but he did not think much of it because she had arthritis. He visited again on 5/13/19 and she complained again of right knee pain. Her daughter attempted to place a rolled towel underneath her knee she cried out in pain. Resident #2's son stated the surgeon	F 689			

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F 689	Continued From page 7 who repaired the fracture questioned how she sustained the fracture as she was nonweight bearing, and unlikely to fracture during a lift. In an interview on 6/10/19 at 11:45 a.m., Staff F (Nurse Aide) stated she worked during the day on 5/12/19 and Resident #2 complained of leg pain that morning. Staff F recalled Staff E (Nurse Aide) reported Resident #2 yelled out in pain when transferred the prior evening. During an interview on 6/10/19 at 12:55 a.m., Staff G (Nurse Aide) reported she worked the afternoon and overnight of 5/12/19 and recalled the off going staff reported Resident #2 had knee pain and the staff informed the charge nurse. Staff G stated the staff used a total mechanical lift to transfer Resident #2 for as long as she could recall. Staff G reported Resident #2 had stiff legs, unable to bear weight and unwilling to move legs apart during cares. During an interview on 6/10/19 at 2:20 p.m., Staff H (Nurse Aide) stated she worked the evening shift on 5/13/19, 5/14/19 and 5/15/19 and cared for Resident #2. On 5/14/19, Staff H and Staff I transferred Resident #2 with the total mechanical lift. Resident #2 complained of right knee pain. Staff H reported this was new and she reported this to the charge nurse. Staff H reported the nurse looked at Resident #2's knee and it had swelling. During an interview on 6/10/19 at 11:05 a.m., Staff I (Nurse Aide) reported she helped transfer Resident #2 into bed the evening of 5/14/19. Resident #2 complained of right knee pain. Staff H reported the complaint to the charge nurse. Staff I stated a couple days earlier, Resident #2	F 689			

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F 689	Continued From page 8 complained of right knee pain and the staff informed the charge nurse. Staff I reported Resident #2 required a total mechanical lift for transfers, which required the use of two staff. Staff I reported after Resident #2's fracture the staff switched to a from a cross leg sling to a full body sling to decrease the pressure around her knees. During an interview on 6/11/19 at 12:37 p.m., Resident #2's Primary Care Physician (PCP) stated Resident #2 had severe bony demineralization and inactivity, which made her susceptible to fractures. The PCP reviewed the radiology report and stated the fracture and deformity Resident #2 sustained was likely due to trauma, possibly a fall or some torsion at the knee. 2. According to the MDS assessment dated 5/8/19 Resident #7 had diagnoses of Alzheimer's disease and Parkinson's disease. Resident #7 had severe cognitive impairments. The MDS dated 5/8/19 revealed Resident #7 required limited assistance with transfers and dressing and extensive assistance with mobility, toilet use and personal hygiene needs. The Care Plan revealed Resident #7 had a potential for injury from falls and had six falls in two months. The Care Plan directed the staff to place dycem above and below wheelchair cushion, do not leave alone in room when in wheelchair, gripper socks, sign in room to remind resident to use call light, ensure wheelchair next to bed at night with brakes locked, remove wheelchair pedals to allow safe self-propelling before and after meals. The Care Plan revealed	F 689			

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F 689	Continued From page 9 the following updates: a. On 4/22/19, implement a table tent for dining room table to remind staff not leave resident unattended during meals. b. On 5/20/19, continue with occupational therapy to evaluate for wheelchair positioning. c. On 5/25/19, continue with occupational therapy evaluation for positioning. d. On 5/28/19, education review completed. e. On 5/30/19, placed pummel cushion in recliner. The Incident Report dated 4/20/19 at 4:15 a.m., revealed the staff heard someone yell out and found Resident #7 sitting on the floor. Resident #7 attempted to self-transfer from bed to the locked wheelchair and then attempted transfer to the recliner. Resident #7 had no injuries noted. The report revealed no fall interventions. The Incident Report dated 4/22/19 at 1:45 p.m., revealed Resident #7 sitting in wheelchair in dining room following meal. The staff found Resident #7 on her knees next to the dining room table. Resident #7 had injuries noted. The reported revealed an intervention for one on one supervision and table tent on dining room table to remind staff not to leave unattended at the dining room table. The Occupational Therapy note dated 5/15/19, revealed Resident #7 evaluated for wheelchair positioning. The wheelchair had a proper fit but may need a wedge cushion with dycem and positioners on her feet to discourage attempts to	F 689			

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F 689	Continued From page 10 get up and prevent sliding. The Care Plan failed to address the Occupational Therapy recommendations. The Incident Report dated 5/16/19 at 8:25 p.m., revealed the staff found Resident #7 sitting on the dining room floor in front of wheelchair. Resident #7 had no injuries noted. The report had no interventions documented. The Incident Report dated 5/18/19 at 9:10 p.m., revealed the staff observed Resident #7 reaching for clothing protectors and fell out of her wheelchair. Resident #7 had removed her shoes. Resident #7 had redness to her forehead and a superficial abrasion to left elbow. The reported had an intervention to continue with occupational therapy to evaluate for wheelchair positioning. According to Occupational Therapy note dated 5/22/19, the therapist trialed a pommel cushion in the wheelchair. The Care Plan failed to reflect the trial of the pommel cushion. The Incident Report dated 5/25/19 at 3:44 p.m., revealed another resident witnessed Resident #7 leaning forward in her wheelchair. Resident #7 fell forward and struck another resident's wheelchair. Resident #7 had bleeding from her mouth and found on her left side. Resident #7 had an x-ray completed at the hospital. Resident #7 sustained a fractured jaw and had broken teeth. The report revealed an intervention to continue with occupational therapy for positioning.	F 689			

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F 689	Continued From page 11 According to Occupational Therapy note dated 5/28/19, Resident #7 had a pommel cushion in place to help decrease the risk for falls. The Therapist adjusted Resident #7's wheelchair alignment for safety. The Incident Report dated 5/30/19 at 4:08 p.m., revealed Resident #7 sitting in a recliner in the lobby. Resident #7 leaned forward and tipped the recliner. She rolled out of the recliner onto her right side and sustained an abrasion to her right knee. The report revealed an intervention for a pommel cushion in recliner.	F 689			

The facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and/or State law. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provision of federal and/or state law.

Plan of correction date July 7th 2019.
Except for F689 correction of June 27th, 2019

F584

Plan of correction date July 7th, 2019

West Ridge Specialty Care provides housekeeping services necessary to maintain a sanitary, orderly & comfortable interior.

New personnel have been hired.
Maintenance personnel & management staff have been orientated to facility cleaning process for times of low staff availability to maintain facility cleanliness.

All residents with potential to be affected by this are protected thru changes in personnel and facility auditing.

Administrator or designee will conduct routine audits to ensure compliance.

QAPI IDT will review audits to ensure solutions are permanent.

F689

Plan of correction date June 27th, 2019

West Ridge Specialty Care provides an environment where the resident receives adequate supervision and assistance devices to prevent accidents.

Resident #2 receives transfers as directed by plan of care.

Resident #7 receives adequate supervision to prevent accidents.

All resident with potential to be affected are protected thru education, procedural changes and ongoing skill validations.
Staff education occurred on 5/23/2019 related to mechanical lift transfers with return demonstrations.
Procedural changes regarding Agency Staff confirmation of orientation, knowledge of location of resident care & safety information and understanding of operation/navigation of electronic health record was initiated on 6/28/2019.

Fall Prevention Audits were initiated 6/28/19 and are completed routinely.

D.O.N or designee will monitor compliance thru ongoing auditing

QAPI IDT will review audits to ensure solutions are permanent.