STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 9/2/19 Complaint # 79913-C was not substantiated. Investigation of facility-reported incidents # 79937-I and # 84111-I did not result in deficiency. Investigation of facility-reported incident # 84077-I resulted in the following deficiency. See the 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 clinical record review, staff interview, observation and facility policy review, the facility failed to ensure staff provided adequate nursing supervision and assistance devices to prevent accidents for 1 of 6 residents reviewed. On 7/2/19, Staff A assisted Resident #3 to the bathroom without using a gait belt as required. The resident tripped, fell, and sustained a right femur fracture which required surgical repair. The facility identified a census of 26 residents.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/23/2019

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.

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F 689	Continued From page 1 Findings include: 1. According to the Minimum Data Set (MDS) assessment of 5/1/19, Resident #3 had diagnoses that included a heart arrhythmia, arthropathy, edema (swelling) and high blood pressure. The assessment documented she had unsteady balance with all assessed activities and could stabilize only with staff assistance. Resident #3 had impaired range of motion in one lower extremity and no history of falls; she required the assistance of one staff member to transfer and to walk in her room. The resident's Care Plan revised on 4/26/19 documented she needed extensive assistance of one staff person with bed mobility, transfers and ambulation (walking). Resident #3 used a wheeled walker and a wheelchair. The Witnessed Fall report dated 7/2/19 at 6:49 am documented the resident was on the floor. Upon entering the room, the nurse observed Resident #3 sitting on the bathroom floor with her back against the wall, her right leg bent and her right foot under the left knee. The resident wore shoes and pants, with the pants around her ankles. The resident complained of pain to her right hip, rating it at 10 (the worst) of 10 possible points. The witness to the fall, Staff A CNA (certified nursing assistant) stated the resident and aide walked to the bathroom. The resident had her shoes and walker. Staff A looked away for second and the resident suddenly went down to the floor. Staff A stated she could not lower Resident #3 to the floor as she (Staff A) was a little person trying to catch a bigger (Resident #3) person. Staff A stated the resident tripped on her walker. Staff A suggested to make gait belts more	F 689		

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F 689	Continued From page 2	F 689		

visible or to let aides wear them.

The resident's After Visit Summary identified she received treatment at the hospital 7/2 to 7/8/19 following surgical repair of a broken leg. The Summary also documented a follow-up appointment with the Physician Assistant on 7/11/19 for urinary tract infection and right femur fracture.

Email from the facility Administrator to the Department of Inspections and Appeals (DIA) on 7/3/19 communicated that after further interview, Staff A informed them Resident #3 was not wearing a gait belt. Staff A had her hands on the resident's pants. When questioned as to why she did not use a gait belt, Staff A stated she went to get the resident's gait belt, Resident #3 got up and started to walk to the bathroom independently.

The facility's Transferring Residents Policy dated 3/19 instructed that transfer (gait) belts must be used on all residents requiring assistance with pivoting, standing, transferring and walking.

During interview on 7/23/19 at noon with Staff A, she stated she held onto Resident #3's pants while walking her to the bathroom. Staff A stated the gait belt was hidden behind the resident's door and she went down during transfer. She stated the resident tripped over the lip into the bathroom, fell quickly and landed on her hip. She said the resident was too heavy to slow down. Staff A acknowledged she had been told to always put a gait belt on residents for safety reasons. She said she couldn't find it, it was behind a door. Then Staff A stated that gait belts are usually stored behind resident doors and she

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F 689	Continued From page 3 has learned to always look for them. On 7/23/19 at 2:52 pm, the Director of Nursing (DON) stated that after interview with Staff A, she checked Resident #3's room and found her gait belt hanging behind the door. The facility implemented the storage of gait belts behind resident doors two years prior and trained everyone on the location. Staff A told her she did not see the gait belt in the resident's room as an open bathroom door covered it. The DON stated they train all staff at least annually on transfer competencies. In an interview on 7/23/19 at 10:05 am after Staff B transferred another resident safely with a gait belt, Staff B, CNA stated she always uses a gait belt for resident transfers, and added gait belts are stored in each resident's room. On 7/23/19 at 11:35 am, Staff C, CNA stated she always uses a gait belt when transferring residents. If a resident is in a hurry, staff can usually get the gait belt on before a resident gets up. The gait belts are always stored in resident rooms. On 7/23/19 at 2:30 pm, Staff D CNA stated a resident transfer involved placement of a gait belt, a walker if needed and then he would help the resident transfer. Gait belts are usually stored behind the doors in resident rooms. Observations at the time with Staff D showed gait belts hanging behind the entrance doors to rooms 107, 109 and 303. Observation on 7/24/19 at 10:15 am revealed gait belts stored as follows: a. Rooms 103 & 104 - hanging behind each	F 689		

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F 689	Continued From page 4 room's entrance door. b. Room 106 (Resident #3's room) - hanging near the bathroom door; c. Room 306 - on the card table in the room; d. Room 309 - hanging on the towel bar by the sink; e. Room 311 - inside the closet door.	F 689		

Plan of Correction for Self Report Survey

POC date: 9/2/19

F 689 Free of Accident Hazards/Supervision/Devices

Immediate Corrective Action:

Resident #3 sent to hospital for evaluation. DIA notified of fall with major injury. Care plan reviewed for resident #3.

Action as it applies to others:

All nursing staff or staff with the ability to transfer or ambulate resident's reviewed policy on gait belt & transfer/ambulation. Corrective action done with CNA involved in the incident. Verified every room was supplied with a gate belt and extras can be found in the linen closet.

***Date of Completion:* 8/17/19**

Reoccurrence will be prevented by:

Audits of 2-3 staff members weekly x4 weeks of transfers and gait belt use to ensure proper technique and adherence to policy. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.

The corrective action will be monitored by: DON/Designee