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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165188	A. BUILDING _____ B. WING _____	C 10/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BRIDGE CARE & REHABILITATION	1015 WEST SUMMIT WINTERSET, IA 50273

(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 11/8/19 The following deficiencies resulted from investigation of complaints #84883-C and #85849-C. Both complaints were substantiated. Investigation of facility reported incident #85850-M also resulted in a deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, family interview, and staff interview, the facility failed to ensure staff did not leave medications unattended for 2 of 5 residents reviewed for medication administration (Resident #3, #6). The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 9/6/19 for Resident #3 identified a Brief Interview for Mental Status (BIMS) score of 05, which meant the resident displayed severely impaired cognitive skills. The MDS documented diagnoses that included non-Alzheimer's dementia and generalized edema.	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/6/19

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 658	Continued From page 1 Review of the care plan revealed Resident #3 was not care planned to self-administer medications. The care plan focus area dated 12/11/18 identified an alteration in cognitive status related to confusion secondary to change in environment. On 10/2/19 at 10:16 a.m., a family member reported nurses gave medications to Resident #3 in the dining room and did not wait for the resident to take the medications before they walked away. The family member commented they had found pills on the floor in the resident's room in the past. In a follow up interview at 7:32 p.m., the family member reported they again found a pill on the resident's floor that evening. The family member stated they took the pill to the night nurse who identified the pill as Lasix pill (diuretic medication). Review of the October 2019 Medication Administration Record (MAR) revealed Resident #3 received Furosemide (also known as Lasix) 20 mg by mouth 1 time a day in the AM for generalized edema (swelling). 2. The MDS assessment dated 8/7/19 for Resident #6 identified a BIMS score of 05 (severely impaired cognitive skills). The MDS documented diagnoses that included non-Alzheimer's dementia. Review of the care plan revealed Resident #6 not care planned to self-administer medications. The care plan focus area dated 4/30/19 identified impaired cognitive function/dementia or impaired thought processes related to dementia.	F 658		

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F 658	Continued From page 2 Observation on 10/2/19 at 1:32 p.m. revealed Staff I, Dietary Aide, cleaned the tables in the main dining room. When asked if they had ever cleared tables and found empty pill cups or pill cups with medications in them, Staff I answered in the affirmative. When asked if the cups were empty of had pills in them, Staff I reported no cups found with pills in the main dining room, but added she had found medications in therapy room before and given them to the nurse. Observation on 10/3/19 at 9:30 a.m. revealed Staff J, Dietary Cook, cleared tables in the main dining room. Staff J responded she had found pills left on the table at times. Staff J said the day before she had found 3 pills on a plate and gave them to the nurse. Staff J estimated she found pill cups with medications in them occurred approximately once a week. On 10/3/19 at 9:34 a.m., Staff K, Licensed Practical Nurse (LPN), responded there were times she left medications at the dining room table. Staff K stated sometimes she handed the pills to a resident to take and would need to leave to give the resident time to take the pills. Staff K reported Resident #6 was a resident she left pills with; she would check back, and if they didn't take them, she collected and destroyed them. Staff K responded she did not know what the surveyor meant by asking if residents were care planned to self-administer medications, but the residents took the meds themselves when she handed them to the residents. Staff K clarified yes she would leave meds, continue working, check back to see if a resident took the meds, and if not, picked up the meds.	F 658		

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F 658	Continued From page 3 Observation on 10/3/19 at 9:36 a.m. revealed 2 clear, empty pill cups and 1 pill cup with applesauce/crushed pill residue with a spoon in it on the tables in the front dining room. No residents sat at the place settings where the empty pill cups were observed. On 10/3/19 at 12:45 p.m., Staff F, LPN, responded nurses were not supposed to leave medications without observing the resident take meds. Staff F reported yes, dietary aides had returned empty pill cups before, but never any with meds in them. Staff F denied hearing complaints from residents or families about finding medications unattended. On 10/3/19 at 2:13 p.m. Staff H verified she had found Resident #6's (2) pills in a pill cup that morning at breakfast time. Staff H said call lights were going off, so she gave them to Staff L, CNA, to give to the nurse assigned to Resident #6's hall. Staff H responded she had found pills before, but did not find pills in cups often. Staff H stated Resident #6 was aware of what was going on and said if the resident didn't want to do something like take pills or eat, then the resident wouldn't. On 10/3/19 at 4:45 p.m. the DON stated the facility had only 1 resident care planned as allowed to self-administer medication and it was not Resident #6 not that resident. The DON acknowledged she expected nurses to observe residents take medications. The Order Summary Report printed 10/15/19 documented orders for the resident to take the following medications during the day:	F 658		

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F 658	Continued From page 4 a. Docusate sodium (stool softener) capsule 100 mg (milligrams); 1 capsule by mouth 2 times a day for constipation b. ferrousul tablet 325 (65 fe) (iron) mg; give 1 tablet by mouth 1 times a day related to anemia c. Furosemide tablet 20 mg; give 2 tablets by mouth 1 time a day for CHF (Congestive Heart Failure)/essential hypertension (high blood pressure) d. omeprazole (used to treat stomach problems) tablet delayed release 20 mg; give 1 tablet by mouth 1 time a day related to gastroesophageal reflux disease without esophagitis (a digestive disease in which stomach acid or bile irritates the food pipe lining) e. vitamin D3 tablet 1,000 Unit; give 1 tablet by mouth 1 time a day for supplement	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in	F 676		

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F 676	Continued From page 5 accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, resident interview, family interview, and staff interview, the facility failed to encourage and assist a resident to complete a walk to dine program 2 times a day according to the care plan old or to document refusals to participate in the program for 1 of 4 residents reviewed (Resident #3) for meeting resident needs with ADL's (Activities of Daily Living). The facility reported a census of 61 residents. Findings include: The Minimum Data Set (MDS) assessment dated 9/5/19 for Resident #3 identified a Brief Interview for Mental Status (BIMS) score of 05. A score of 05 indicated severe cognitive impairment. The MDS revealed the resident required: extensive physical assistance of 1 person for bed mobility,	F 676		

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F 676	Continued From page 6 transfers; limited physical assistance of 1 person for walking in room/corridor; and extensive physical assistance of 2 persons for toilet use. The MDS coded the use of a walker and wheelchair for mobility devices. The MDS identified the resident exhibited no behaviors during the 7 day look-back period. The MDS documented diagnoses that included non-Alzheimer's dementia, Multiple Sclerosis (MS), and weakness. The prior quarterly MDS assessment dated 6/5/19 revealed the resident required limited physical assistance of 1 person for bed mobility, transfers, walk in room, toilet use, and extensive physical assistance of 2 persons for walk in corridor. When compared to the 9/5/19 MDS assessment, the resident demonstrated an increased physical need in assistance level with bed mobility, transfers, and toilet use while walk in corridor did show some improvement. The care plan focus area dated 12/11/18 identified an increased risk for actual/potential limitation in the resident's ability to perform ADLs. The care plan informed staff the resident frequently transferred herself to her room and instructed staff to attempt assistance with transfer encouraging the resident to call for help. The care plan revision dated 6//8/19 instructed staff to encourage the resident to ambulate (walk) to lunch and supper. The care plan informed staff the resident required reminders the activity increased her strength and the resident needed encouragement due to frequent refusals. The care plan directed staff to assist the resident with 1 staff and a walker for ambulation.	F 676		

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F 676	Continued From page 7 The Progress Notes dated 7/2/19 at 6:37 a.m. documented the resident's care plan reviewed with no changes made at that time. The entry recorded the resident's daughter wanted the resident to walk at least twice a day. The entry documented the resident had been known to refuse ambulation so staff would encourage her. The Task Documentation for Walk to Dine, printed 10/3/19, recorded a response history for the previous 30 days and directed staff to record instances when the resident walked to breakfast or lunch with 4WW/CGA (4 wheeled walker with contact guard assist) with 1 person assist as tolerated. The directions instructed staff to document the amount of minutes spent training and skill practice in walking. The response history showed task not ever completed, but documented only 4 refusals in the 30 days: 9/5, 9/9, 9/18, 9/21. The Task Documentation for ADL - Walk in corridor, printed 10/3/19, recorded a response history for the previous 30 days and directed staff to record the resident's "self-performance," or how the resident walked in corridor on the unit. The response history lacked documentation the activity occurred on the following days: 9/4, 9/5, 9/6, 9/7, 9/10, 9/11, 9/12, 9/15, 9/17, 9/22, 9/24, 9/25. On 10/2/19 at 10:16 a.m., a family member reported the facility staff were not sticking to the care plan. The family member voiced the resident should be walking every day to lunch and supper and the staff were not doing that. The family member felt the resident hardly walked and their ability to walk going down hill. The family	F 676		

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F 676	Continued From page 8	F 676		

member acknowledged the resident would refuse at times, but the family member had asked the facility to document the refusals. The family member commented she wanted the staff to entice the resident to walk rather than ask her, because the resident could be stubborn.

Observation on 10/2/19 at 12:08 p.m. revealed a staff aide exited the resident's room with Resident #3 in a wheelchair and transported the resident to the dining room. At 1:11 p.m., Resident #3 self-propelled her wheelchair from the dining room back toward her room.

On 10/2/19 at 2:00 p.m. Staff D, Registered Nurse (RN), entered the resident's room to encourage the use of the bathroom. Staff D informed the resident of the plan and showed the steps they would take to go to the bathroom. Staff D applied a gait belt around the resident's waist and placed a front wheeled walker in front of the resident. Staff D provided contact guard assist with limited assist (merely have 1 or 2 hands on the body but provides no other assistance to perform the functional task to help steady the body or help with balance) to ambulate to the bathroom. Resident #3 had been able to turn/pivot so Staff D could lower her pants. When finished, Staff D assisted the resident to pull up her brief and pants, then the resident ambulated to the sink. Resident #3 responded it depended on how she felt for the day on whether or not she walked to dine. Resident #3 stated there were times she preferred to be taken in the wheelchair and not walk to the dining room.

After cares, at 2:23 p.m., Staff D reported the resident could have behaviors if she were pushed to do something she didn't want to do. Staff D

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said the resident would yell and scream and tell a person to get out. Staff D said the resident's daughter would get really upset with them when she would come and find out the resident didn't walk to dine or do other things she had concerns about, but the resident would be adamant about refusing.

Observation on 10/3/19 at 1:13 p.m. revealed Resident #3 self-propelled her wheelchair from the dining room towards her room and able to move at a fast rate.

On 10/3/19 at 2:16 p.m. Staff E, Certified Nurse Aide (CNA), reported she had been the float for the day shift. Staff E stated she got the resident up that morning but she did not want breakfast. Staff E stated she did take the resident to lunch but did not ask or offer to walk the resident to lunch. Staff E commented she was not the float often so she had not ever offered to walk the resident to lunch. Staff E said the resident would not be able to walk far. Staff E stated when the resident got confused it lead to frustrations and the resident would yell at staff.

On 10/3/19 at 2:18 p.m. Staff F, Licensed Practical Nurse (LPN), responded Resident #3 refused to do anything. Staff F stated she had not offered for the resident to walk to dine as the CNA's did that. Staff F reported the resident was not able to walk far at all, only to the next room. She commented most times the resident would not want to go for a walk.

On 10/3/19 at 2:20 p.m. Staff G, CNA, responded she did not offer to walk Resident #3 as she was not the float that day. Staff G stated most generally the resident would refuse to walk and

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F 676	Continued From page 10 not walk far and Staff G would just let the nurse know. On 10/3/19 at 2:23 p.m. Staff H, CNA, stated she had taken Resident #3 to walk to dine before but it took all the resident's effort just to walk to the bathroom and back to her chair. Staff H said the resident usually became worn out and not want to walk. She stated sometimes the resident would be in a good mood and she would try, but it would be rare. Staff H responded she did not document refusals as she thought their documentation didn't have a place to do so. Staff H commented it had been approximately 3 months since Resident #3 walked with her and she gave that information to therapy. Staff H said other than that, she hadn't been able to walk with the resident. On 10/3/19 at 4:45 p.m. the Director of Nursing, (DON), stated she could only go back 30 days for task documentation in POC/PCC (electronic record) and therefore could not provide information or documentation regarding the resident's participation in walk to dine or walking in corridor more than 30 days prior. On 10/15/19 at 1:15 p.m., the DON confirmed she found no additional information related to documentation to show Resident #3 assisted by staff twice a day to walk to dine. The DON said she put the activity on the MAR (Medication Administration Record) to have nurses verify completion of the activity going forward.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 11 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview, and facility record review, the facility failed to assess a resident's lack of bowel movements, provide timely intervention with bowel regimen medications to stimulate/promote a bowel movement per facility protocol and nursing professional standards, and notify the physician of the lack of bowel movements, for 1 of 4 residents reviewed for assessment and intervention (Resident #4). The facility reported a census of 61 residents. Findings include: The quarterly Minimum Data Set (MDS) assessment dated 7/10/19 for Resident #4 identified severely impaired cognitive skills for daily decision making and documented the resident displayed with constant inattention, constant disorganized thinking, and fluctuating altered level of consciousness. The MDS revealed the resident remained totally dependent upon 2 persons for toilet use and almost always experienced urinary and bowel incontinence. The MDS documented diagnoses that included non-Alzheimer's dementia and generalized muscle weakness. The MDS recorded the resident received opioid medications (a side effect of these meds can be constipation) on 3 of 7 days of the look-back period.	F 684		

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F 684	Continued From page 12 The care plan focus area initiated 5/23/17 and revised 8/20/19 identified bladder incontinence related to dementia and reoccurring history of UTIs (Urinary Tract Infections) and in an intervention dated 5/23/17 instructed staff to monitor/document/report PRN (as needed) any possible causes of incontinence that included constipation. The Look Back Report for Bowel documented the resident's bowel elimination record for August 2019. The report showed the resident had the following bowel movements: a. 8/10 - medium formed stool at 4:11 a.m. and medium loose stool at 5:59 p.m. b. 8/11 - small formed stool at 1:53 a.m. c. 8/12, 8/13, 8/14, 8/15 - no bowel movements (8/15 day 5 without a significant bowel movement) d. 8/16 - medium formed stool at 2:19 a.m. e. 8/17 - medium loose stool at 1:21 a.m. f. 8/18 - medium formed stool at 12:38 a.m. and small formed stool at 11:56 p.m. g. 8/19, 8/20, 8/21, 8/22, 8/23 - no bowel movements h. 8/24 - small loose stool at 2:59 p.m. (8/24 day 6 without a significant bowel movement) i. 8/25 - medium loose stool at 1:38 a.m. The August 2019 Medication Administration Record (MAR) documented PRN medications available to give the resident to promote bowel movements and recorded whether or not the medication was effective. The MAR showed the resident received:	F 684		

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F 684	Continued From page 13 a. Milk of Magnesia (MOM) 400 mg/5 ml (milligrams per milliliter), 30 mls by mouth as needed for constipation everyday on: 8/4 at 12:01 a.m., ineffective; 8/23 at 7:25 p.m., ineffective b. Bisacodyl suppository 10 mg, insert 1 suppository rectally as needed for constipation everyday: 8/15 at 5:51 a.m., effective; 8/24 at 5:21 a.m., ineffective c. Fleet enema 7-19 g (grams)/118 ml, insert 118 mls rectally 1 time only for constipation on 8/25/19 at 5:32 a.m. The August 2019 MAR lacked entries for PRN medication administration to promote bowel movements on 8/13, 8/14, 8/21, 8/22. The Daily Bowel Management Checklist dated 8/21/19 documented Resident #4's last bowel movement as a small on 8/18/19 and MOM administered. No results recorded. No checklist available for 8/22/19. The 8/23/19 checklist documented Resident #4's last bowel movement as a small on 8/18/19 and Bisacodyl suppository administered with no results. The 8/24/19 checklist documented Resident #4's last bowel movement as a small on 8/18/19 and Bisacodyl suppository administered with no results. The 8/25/19 checklist documented Resident #4's last bowel movement as a small on 8/18/19 and Fleets enema administered. No results recorded. The Progress Notes lacked documentation from 8/5/19 thru 8/14/19 and therefore no documented assessments of the abdomen or lack of significant bowel movements 8/11 thru 8/14.	F 684		

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F 684	Continued From page 14 On 8/15/19 at 5:51 a.m. the notes recorded a Bisacodyl suppository given to promote bowel movement and at 1:20 p.m. noted it was effective. On 8/19/19 at 3:45 a.m. the notes recorded the resident looked sluggish and tired. The entry included no loose stools that shift. On 8/22/19 at 12:07 a.m. the notes documented the resident treated with an antibiotic for UTI, the resident tired and sluggish, and observed to be sleeping more. The Progress Notes lacked documentation from 8/19 thru 8/22 pertaining to bowel assessments or interventions for lack of bowel movements. On 8/23/19 at 7:25 p.m., the notes recorded the resident received a dose of MOM to promote a bowel movement; no assessment of the resident documented. On 8/24/19 at 5:21 a.m. the notes recorded the resident received Bisacodyl suppository to promote a bowel movement; no assessment of the resident documented. At 3:51 p.m. the notes recorded the MOM and suppository ineffective. At 5:39 p.m., the notes recorded the resident had not had a bowel movement that day, was very lethargic (lacking energy/weak), up in wheelchair that morning and afternoon, and continued on an antibiotic for UTI with no adverse reactions. The entry lacked an assessment of the resident's bowel status/abdomen or vitals. On 8/25/19 at 2:30 a.m., the notes recorded the resident refused supper and fluids. The entry documented the resident's abdomen: distended	F 684		

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F 684	Continued From page 15 (occurs when substances, such as gas or fluid, accumulate in the abdomen causing its expansion); firm; and bowel sounds hyperactive times 4 quadrants (increased sound indicator of increased bowel activity). Staff gave a Bisacodyl suppository rectally. At 5:26 a.m. the notes recorded the resident expelled 2 small emesis (vomiting) of brownish/black substance, no odor, and small liquid bowel movement; a call placed to the primary care physician (PCP). The physician ordered a Fleets enema to given at that time. At 2:19 p.m. the notes recorded the resident: moaned and ground her teeth that morning; abdomen hard and extended; bowel sounds hypoactive (decreased sound can be indicator of obstruction); and had brown emesis that morning. The entry documented a call placed to the physician to report, order given to send the resident to the ER (Emergency Room), and the resident admitted to the hospital for fecal impaction. On 8/27/19 at 8:45 a.m. the notes recorded the resident remained hospitalized for bowel obstruction. On 9/2/19 at 1:45 p.m. the notes recorded the resident readmitted to the facility after hospitalization for UTI and constipation. The hospital H&P (History & Physical) dated 8/26/19 documented the resident admitted for observation of constipation and UTI with an x-ray showing significant fecal burden. On 8/30/19 the care plan updated to address	F 684		

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F 684	Continued From page 16 constipation. The care plan identified an actual/potential alteration in elimination pattern due to history of constipation, decreased mobility, diminished appetite, use/side effects of medication, and recent history of inability to self evacuate bowels. The interventions added on 8/30/19 included: a. administer medication as ordered b. follow facility bowel protocol for bowel management c. monitor/document/report PRN signs/symptoms of complications related to constipation such as: change in mental status, new onset; confusion, sleepiness, inability to maintain posture, agitation, bradycardia (slow,low pulse); abdominal distension; vomiting; small loose stools or fecal smearing; bowel sounds; diaphoresis (sweating); abdomen tenderness, guarding, rigidity; or fecal impaction. d. record bowel movement pattern each day On 9/24/19 intervention added to report to daughter if resident had not had a bowel movement in 3 days or showed signs/symptoms of constipation. Observation on 10/2/19 at 4:29 p.m. revealed Staff L, Certified Nurse Aide (CNA), and Staff M, CNA, entered the resident's room to provide incontinence care. Resident #4 experienced an episode of urinary incontinence and required total assistance of 2 staff for transfer into the bed and provision of incontinence care. On 10/3/19 at 2:10 p.m. the Director of Nursing (DON) provided copies of the Daily Bowel Management Checklist the night nurses filled out when a resident had no bowel movement within 3 days. The DON was not able to find the sheet for	F 684		

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F 684	Continued From page 17 8/22/19. On 10/15/19 at 1:15 p.m., the DON confirmed she found no additional information related to documentation to show Resident #4 received PRN medications for bowel movement stimulation per the facility bowel protocol. The Daily Bowel Management Checklist instructed the following facility bowel protocol: a. Each shift signs off for report given, every shift change. b. When BM resolved,delete from clinical alerts. c. Assure staff filling out BM records, including asking independent residents. dl Aides should not leave shift without completing BM sheet. Yes or No must be filled out every shift for every resident. e. Physically check to see when last BM was, through paper BM sheet, and from PCC (electronic) clinical alerts. f. Sign out on PCC - PRN used and document. g. Day 3, administer MOM. Day 4+, administer suppository or doctor orders. h. Day 4 or 5 (depending upon the residents usual status) if no BM, doctor should be notified of lack of results despite meds given and include: bowel sounds, distention, stool characteristics if noted pain, etc., for further orders needed. According to the bowel protocol, nurses should have: a. administered MOM medication on 8/13 b. administered Bisacodyl suppository on 8/14 c. notified the physician of no bowel movement on 8/15 d. administered Bisacodyl suppository on 8/22	F 684		

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F 684	Continued From page 18 e. notified the physician of no bowel movement on 8/23 f. notified the physician of no bowel movement on 8/24	F 684		
F 689 SS=J	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, fire department reports, hospital records, police reports, restraint information card instructions, employee file review, and facility record review, the facility failed to provide adequate nursing supervision and assistance devices to prevent accidents for 1 of 11 residents reviewed for adequate nursing supervision (Resident #1). On 9/11/19, during transport from a doctor appointment, the facility van driver failed to attach all 4 floor restraint straps/hooks to the wheelchair frame and buckle a shoulder-lap seat belt in the facility wheelchair transport van. As a result, Resident #1 tipped over in the van and fell out of her wheelchair, lay with her head in contact with the metal floor and blood present in her mouth, and went into cardiac/respiratory arrest requiring initiation of CPR (cardiopulmonary resuscitation) at the scene of the accident. Emergency personnel transported her to the hospital via ambulance, and she died in the	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 19 hospital ER (Emergency Room). This constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility reported a census of 61 residents. Findings include: The admission Minimum Data Set (MDS) assessment dated 9/6/19 for Resident #1 documented an admit date of 8/30/19. The MDS identified a Brief Interview for Mental Status (BIMS) score of 13 without signs/symptoms of delirium. A score of 13 indicated the resident demonstrated intact cognition. The MDS revealed the resident was totally dependent upon 2 persons for transfers, did not walk in the room/corridor during the 7 day look back period, and required extensive physical assistance of 1 person for locomotion on/off the unit. The MDS coded the use of a wheelchair as a mobility device and impairment on 1 side of the resident's lower body. The MDS documented diagnoses that included atrial fibrillation (irregular heartbeat), CAD (Coronary Artery Disease - narrowing of the arteries), heart failure, hypertension (high blood pressure), renal insufficiency, diabetes mellitus, and pathological fracture of the left ankle. The MDS recorded the resident received anticoagulant medication (blood thinners) on 7 out of 7 days of the look back period. The care plan focus areas dated 8/30/19 identified the resident: a. took an anticoagulant medication to manage her medical condition. b. had a potential/actual functional status limitation in ability to transfer and ambulate (walk) due to her left lower extremity non-weight bearing	F 689		

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F 689	Continued From page 20 status related to her left ankle fracture. - required a mechanical lift (Hoyer) and assist by 2 staff to transfer - used a wheelchair and a walker - required the assistance of 2 staff for locomotion using a wheelchair - wore a cast on her left lower extremity c. had a potential/actual alteration in cardiovascular status specific to circulatory and hemodynamic (blood flow) balance. d. had an alteration in cardiovascular status requiring placement of a pacemaker or AICD (cardioverter) [a device designed to monitor the heartbeat that can deliver an electrical impulse or shock to the heart when it senses a life-threatening change in the heart's rhythm]. e. at a risk for falls. - educate the resident/family/caregivers about safety reminders and what to do if a fall occurs The Medication Administration Record recorded the resident received the anticoagulant apixaban (also known as Eliquis) 2.5 mg (milligrams) by mouth 2 times a day for HTN (hypertension). The Progress Notes dated 9/11/19 at 3:22 p.m. documented the resident went to a heart appointment that morning with a family member there. The entry recorded the facility received word of a medical incident when the resident left the appointment and later received word of the resident passing away. The City of Des Moines EMS (Emergency Medical Services) firehouse report dated 9/11/19 recorded the alarm sounded at 10:59 a.m.; the responders arrived on scene at 11:07 a.m., and the actions taken included advanced life support (ALS) and transport.	F 689		

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F 689	Continued From page 21 The City of Des Moines fire department Patient Care Record, with assessment time of 9/11/19 at 11:12 a.m., recorded emergency response dispatched to 7th & Laurel street intersection for a fall in a white van. The report documented primary impression injury of head with secondary impression respiratory arrest with cardiac arrest protocol used. The report described the injury as fall from wheelchair 2 feet. The report included the following documentation: When the responders arrived on scene, the driver of the facility van stood outside at that rear of the wheelchair van and stated the patient fell out of the wheelchair when he turned from Laurel onto 7th. The driver said the wheelchair was secured but the patient was not. When the responders entered the wheelchair van, they found the patient prone (face down) with her head in the right rear corner, head hypo-extended (indicating head tipped down), and turned toward her left shoulder. The driver alleged the patient just talked to him prior to responders' arrival and at the time of responders' arrival the patient not responsive and possibly not breathing; responders called for cardiac arrest response. The responders rolled the patient to place a backboard; they noted the patient breathing on her own but breaths slow and shallow with blood in her mouth and on her teeth. At that time, the patient still unresponsive but had a weak carotid pulse. The responders loaded the patient into the squad and another crew of responders arrived on scene to start assisting with patient care. Initial vitals obtained but noted patient breathing rate more agonal (abnormal gasping for air considered inadequate breathing) and the monitor showed bradycardic rate (slow heart	F 689		

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F 689	Continued From page 22 rate). The responders notified the hospital ER they were en route with cardiac arrest possible trauma. The hospital History and Physical Consultation report, signed 9/11/19 at 1:32 p.m., documented under impression and plan, injuries of cardiac and respiratory arrest, right temple laceration, and abrasion/bruising to bridge of nose. The hospital Trauma Services Discharge Summary dated 9/11/19 at 2:17 p.m. included the following documentation: The patient admitted 9/11/19 at 12:13 p.m. The history of present illness recorded the patient being transported in a wheelchair van when she fell out of the wheelchair as the van went around a corner and EMS called. Upon arrival of EMS, the patient reportedly laid in the corner of the van face down with her neck bent, pulseless, and apneic (not breathing). CPR initiated and a King LT airway placed (device used to secure the airway for mechanical ventilation); the patient arrived initially as a medical code but after the entire story obtained a trauma code called. The hospital course included: CPR in progress upon arrival; 2 doses of Epi (epinephrine medication used in emergencies to act quickly to improve breathing and stimulate the heart) used by EMS prior to arrival; paced rhythm with pulse upon arrival; and intubated with attempts to place central line which during that time the patient again went into cardiac arrest. After discussion with physicians and family, the resuscitation attempt was stopped. Time of death noted at 12:44 p.m. The body cam video of the 1st City of Des Moines Police Officer to arrive at the scene of the	F 689		

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F 689	Continued From page 23 accident captured the following visual and audio documentation: *Minute 1:58 to 2:44 of the video Staff A, facility bus driver, stated the following to the officer: It's easier to show you. When Staff A transported he had to get them in 3 point harness, (indicated Resident #1's wheelchair in place to the far left of the back of bus behind the row of seats on the driver's side) this one here (physically demonstrated the floor latch on the left front of wheelchair) came loose from the floor and she leaned at the same time and ended up like this (showed the wheelchair tipped over to the right side to the floor) as turned the corner. She did not yell or nothing, Staff A thought like what the hell, pulled twice (indicated the left front floor latch) seemed to be there and came loose. The way the seat belts are can't seat belt anyone in that's behind the seats. Staff A had another patient he was picking up and he sits right here (indicated the spot in front of the ramp behind the passenger side row of seats). *Minute 4:05 to 4:18: Staff A stated he picked up (the resident) at Iowa Heart right here and Staff A checked that thing (pointed to the latch on the left front floor) and it was hooked. Staff A turned on 7th and heard a crash Minute 11:59: Resident #1's grandson arrived on scene. Minute 12:40 to 13:05 = Staff A stated to the grandson, made her fall this way so we don't know what's going on why it didn't, when Staff A had the Fire Chief in he did it then (indicated pulling out the left front floor latch/strap repeatedly) and it just came all the way out. The grandson asked, is she badly hurt, to which Staff A responded, she hit her jaw but they said she	F 689		

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F 689	Continued From page 24 was okay other than that, that they could tell, but they wanted to take her over to get checked out due to her age. *Minute 15:43 to 15:55: Staff A stated (unintelligible vocalization) when the Fire Chief out Staff A pointed out (unintelligible vocalization) and all of sudden it just came loose, Staff A never had anything like that happen before. Minute 18:25 to 18:48: Staff A stated, like he said he never had that happen. Staff A couldn't believe it like he said he pulled on it and it just shot right out of there and not supposed to, supposed to lock. Staff A said his boss was freaking out because the maintenance guy and he both inspected the thing and he never had one do that. Minute 38:35 to 38:49: The 1st Police Officer stated, obviously he wasn't there when it happened so (the report) going to be pretty basic. Staff A responded, well it just came loose again while he (Crime Scene Investigation photographer) was in there photographing. Staff A reported the photographer asked, so it's supposed to catch and stay locked? Staff A said yes. *Minute 40:40 to 41:00: After the 1st Police Officer informed Staff A it was not criminal, report being made for injured person, Staff A clarified nothing going against the vehicle (no tickets), then stated, like he said that thing had never done that. *Minute 41:11: Staff A mentioned the grandson there when he strapped Resident #1 in and seen he did it right.	F 689		

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

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F 689	Continued From page 25 Facility Investigation A written statement by Staff A dated 9/11/19 documented the following: Staff A picked up Resident #1 at Iowa Heart following her appointment where her grandson watched Staff A load and strap Resident #1 in the bus. Staff A left and went 2 blocks to the stop light at 7th & Laurel. As Staff A made the turn, he heard a loud crash, pulled over immediately, and found the resident on the floor. The left front strap had come lose allowing the resident to tip sideways. Staff A immediately called 911 for ambulance, stayed with the resident, and talked to her. Resident #1 bleeding from her mouth, breathing ok. Staff A called the facility to inform the Administrator of the event and waited for the ambulance to arrive. Once they got there, Resident #1 wasn't breathing very well. Staff A helped the 2 ambulance people get the resident loaded then waited for police to arrive. They checked the straps, it wasn't catching every time, took pictures, and released Staff A from the scene. No tickets were written or reports filed against Staff A or the facility. Staff A wrote a separate paper on how to secure passengers in the bus. Staff A wrote: If in a wheelchair and possible, a person should use 4 tie straps hooked to the steel frame of the wheelchair and once hooked, try to move the wheelchair to insure tie straps secured. Then set wheelchair brakes and place seat belt around the arms of the wheelchair, not the person. Make sure all the slack removed and the wheelchair then secured for transport.	F 689		

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F 689	Continued From page 26 Facility Driver/Witness Interview On 10/3/19 at 11:00 a.m. Staff A replied he was hired for transport as a PRN (as needed) position in June 2019 and recently worked 3 days a week. Staff A stated Staff B trained him when he first started. Staff A explained Staff B took him out for a driving test. Staff A commented he rode the facility bus before helping to volunteer so knew how to seat belt in residents. Staff A stated when he put someone on the bus, it was a different situation for everyone due to their size and where he had to place them. Staff A stated there was not a set standard or procedure that worked for every single person and no book on how to put residents in. Staff A said when he took people with full size geri-chairs (type of reclining wheelchair), he had to hook the resident all different because of all the plastic parts and it would not hold if hooked to plastic. Staff A commented that was an example of why he said every situation different. Staff A reported Staff B verbally trained him by walking him thru how to secure a resident, they did not have anyone on the bus for that training, and Staff B reminded him how to use all the restraints. Staff A clarified reminded meant when he helped to volunteer prior to hire; like going to the zoo when the facility needed to have 1 person for each resident. Staff A commented under the old administrator he could push residents around the zoo, just making sure a body with each resident, but no cares provided by him. Staff A stated when he volunteered he watched the staff connect the residents. Staff A said it was pretty simple and if a resident was in a seat, he just connected the lap belt. Staff A stated he would demonstrate once out in the bus, but there were not too many ways to hook up in the back. He said pretty much	F 689		

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only thing is to hook to the structural spot of the chair, because PVC breaks. Staff A stated the biggest thing Staff B pushed was don't hook it to the person, hook it to the chair. Staff A denied he received any checklists on how to strap in a resident, only the checklist for driving the bus. Staff A said he took time on his own to look on the Internet on how to strap in residents, but it wasn't accurate. Staff A agreed his employee file only showed the checklist, nothing on procedures or policies for driving the bus. Staff A reported he looked the bus up on the internet, but it was not 100% accurate, and it depended on type of wheelchair and how big a wheelchair was; there were so many variables. Staff A stated he had to do what fit the person to make them feel comfortable and safe. Staff A denied ever seeing the paper/information card for the Q'Straint floor latch. Staff A responded, like he said every situation different. Staff A commented he had transported a resident who had a seatbelt in his own chair so all Staff A had to do was secure that wheelchair. Staff A clarified he completed just 1 driving test and 1 walk thru with Staff B then was allowed to drive. Staff A said the facility asked him to drive because he had driven a semi and another list of vehicles; anything with wheels on it.

Staff A then relayed what happened on 9/11/19 when Resident #1 tipped over in the transport bus. Staff A reported he picked Resident #1 up from her appointment. Staff A stated he went in to get the resident and her grandson stood outside of the lift gate. Staff A commented it was the 3rd time he transported the resident and had to put Resident #1 in the corner as another resident would board the bus later and needed to walk through. Staff A recalled he hooked the front 2 floor restraints and 1 floor restraint in the back.

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F 689	Continued From page 28 Staff A said he couldn't reach the other 1 (back floor restraint) as the resident was big with a broken foot and his arms were not long enough. Staff A commented with those 3 restraints, the wheelchair couldn't go anywhere. Staff A stated he showed the fire chief sat in the bus and rocked back and forth but couldn't go anywhere as 3 quarters of an X couldn't go anywhere. Staff A stated when he turned the corner at the stop light all he heard was a thud and he thought someone had hit him. As Staff A turned the corner with a left hand turn, he heard a big thud and immediately went to the side of the road as he thought someone hit him at the intersection of 7th and Laurel (in Des Moines). Staff A said he looked in the side mirrors, seen everyone still at the stop light except for him, he looked in the rearview mirror and the resident was gone, he couldn't see her. Staff A stated he immediately put the bus in park and saw the resident lay on the floor. Staff A said he called 911. Staff A reported a little pool of blood had been present by Resident #1's head, about the size of a large tomato spot and it looked as if it dripped out of the resident's mouth. Staff A stated the resident lay totally on her right side and he didn't move the resident; just let the blood drip out of her. Staff A said 911 told him they were sending an ambulance to him and asked if resident responded, said no still breathing. Staff A recalled Resident #1 was the type of lady who never talked anyway, and was not talking then, but was still there. Staff A stated he then called the Administrator to inform her what happened while it took forever for EMS to get there. Staff A stated just 2 ambulance people and he helped get the resident onto the back board and slid onto the gurney so they could do something with her. Staff A reported Resident #1 stopped breathing	F 689		

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F 689	Continued From page 29 when she got on the gurney. Staff A said when they took the resident out of the bus her lips and nose were blue. Staff A reported the fire truck had not yet arrived. Staff A stated he did move the resident's wheelchair by sitting it up so EMS could get to her; the resident wasn't in the chair at that point and he knew he had to move it for them to get to her. Staff A responded he moved the wheelchair right before the ambulance got there and he waited until the last minute to do so. Staff A commented he thought he had to move it as she wasn't in it anymore. Staff A recalled Resident #1 lay on her side and when she breathed in she moaned; not in the chair at all. Staff A responded he did not have to unhook anything to set up the wheelchair because the 1 strap that came loose, the left front floor latch, and it allowed the wheelchair to be put back up. Staff A stated when he left the appointment, he shook the wheelchair back and forth to make sure it couldn't go anywhere. Once secured, Staff A reported he locked the wheelchair brakes, but where the wheelchair sat, he couldn't put on the back shoulder-lap belt (a safety belt fixed on the back wall of the bus that attached to a floor restraint/buckle). Staff A stated he couldn't put the shoulder-lap belt on because it was right in the middle of (the resident's) head and it would have been around her head. Staff A responded the shoulder-lap belt could be adjusted down but the strap still went right across the neck if he went across the resident. Staff A commented he showed all that to the Des Moines Fire Department and CSI (Crime Scene Investigations) and each time he showed them, the latch gave way and they said it was faulty equipment. Staff A stated, with those 3 straps he	F 689		

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F 689	Continued From page 30 put on the wheelchair couldn't go anywhere. Staff A clarified the hook was still hooked to the wheelchair, but the ratchet part was broken. Staff A further clarified he had 3 straps on the wheelchair and was able to set it upright. Staff A explained the floor latch/restraint spring loaded to go back in but the stop that let it pull back out wasn't working. Staff A recalled the fire chief asked him if he hooked it and he said yes it was hooked. Staff A clarified he connected the left front floor, right front floor, and right rear floor latches; the left rear floor and the seat belt on the wall was not utilized as he couldn't get to them and the resident had a broken foot and was a good size. Staff A clarified Resident #1 never said anything. Staff A said he was legally deaf and couldn't hear what was said in the back of the bus. Staff A stated from the time of the thud on, Resident #1 never said anything that he could hear. Staff A reported the only way he watched what went on back in the bus was by the small rear view mirror. Staff A said it took quite a while for the fire chief to come as the ambulance needed to call and send the fire truck; about 10 minutes before the ambulance then called fire to be dispatched. Staff A responded he knew it was the fire chief he talked to, but did not know his name, he said he was there to control traffic, and said to walk him through what happened as he was standing there. Staff A stated he spoke to the police officer and the police sergeant and they called to see how to handle the situation, then waited for crime scene to come and photograph everything. Staff A responded Staff B taught him to use the belt strap on the wall attaching on the wheelchair not the person because when it went down the	F 689		

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road it bounced and would keep tightening and cinching in until a resident couldn't breathe-there was no way to stop the cinching. Staff A stated Staff B taught him the floor latches were to be put in 4 point and always try 4 points, to the structure of the wheelchair; not plastic, not wheels, the wheelchair frame. Staff A again stated he did not use the 4 points on Resident #1's wheelchair as he couldn't reach. Staff A explained the problem was getting the belt unhooked (the left back floor latch). Staff A said he had to get the pin down to release the belt, he was a big guy, and couldn't get there to release. Staff A said he tried getting on the floor but if he couldn't later get it to release he couldn't hook it up. Staff A stated the only way he could see getting it hooked up and released would be to get a cane to push in there to release the belt. Staff A commented he never had any problems and he hauled a lot of people. Staff A confirmed Resident #1 had a cast on the left lower extremity that had been applied a week to 10 days prior to the accident. Staff A reported the resident could mover her legs very little and a lot of times she sat still when with him.
Staff A responded it was not possible Resident #1's foot slipped off onto the red button (release) as the size she was she couldn't move. Staff A commented Resident #1 had been tall enough and big enough her feet were under the seat in front of her. Staff A stated he did not see it happen as his eyes were on the traffic when turning.

On 10/3/19 at 11:40 a.m., Staff A re-enacted Resident #1's position before and after the accident in the facility bus and pictures were taken of the re-enactment. Staff A said as he walked to the back of the bus he couldn't see the resident's head. Staff A recalled the resident lay

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completely on her right side on the floor, head against the back wall between the floor lift vertical joist and the back door. Staff A said the pool of blood coming out of the resident's mouth was by the bottom of the vertical seat belt mounted on the back wall on the passenger side of the van. Staff A reported there had been no blood on the ramp at that time; the blood on the ramp was there later there from being smeared when paramedics moved her. Staff A said 3 straps were still hooked and 1 like this (indicated the left front floor strap still on wheelchair and should not have been extended). When asked if he thought the wheelchair would have stayed up with all 4 straps on and then the left front floor latch faulted, Staff A responded, yes but as long as 3 floor latches on it would have stayed upright. Staff A demonstrated being in the chair, rocked back and forth being hooked with the 3 floor latches, and he could not tip it over, then showed it could tip when he put his foot down on the latch (red button release). Staff A showed he couldn't use the wall seat belt on the back rear wall because it sat behind the resident. Staff A said the resident was in the corner with her arm against the window, and said he couldn't reach the left back floor latch with her wheelchair all the way back against the wall. Staff A showed with the wheelchair positioned all the way towards the left side of the vehicle, he couldn't even see that latch. Staff A stated Resident #1's wheelchair had been wider than the chair used for demonstration and wider than his arm. When asked, Staff A responded no, he never let anyone from the facility know that he couldn't reach that back and could only connect 3 straps. Staff A said he even got down on hands and knees but he couldn't reach that back corner to release the hook. Staff A again stated 3 points connection

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F 689	Continued From page 33 should have held. Staff A commented Staff B trained him to always hook on the post of wheelchair frame, not just the lower bar, as it was the strongest part of the chair. Staff A pulled and yanked vigorously on the left front floor strap several times and 2 times out of 5 the belt released tension and extended without depressing the red button. Staff A again yanked 3 more times and it failed once. Staff A then wanted to show how and why he could not use the back seat belt on the wall. Staff A showed pulling the seat belt across from right to left across his body and it went across his neck. When asked if it was adjustable, Staff A said yes it moves up and down to different locations but all locations would have the strap crossing a resident's neck. Staff A said when the strap on the resident each bounce of the road would cinch the belt tighter putting pressure on the neck of a resident. Staff A said the police sergeant had said it was a poor design. Staff A commented he would normally transport a resident in the center of the back of the bus, but he had to push Resident #1 over that day as another resident was to be picked up who used a walker and would need to walk on. Staff A stated in hind sight, he wished he had put Resident #1 in the middle then moved her when he picked the other resident up. Staff A stated the resident did have a cut on her finger so it could have been possible for some of the blood on the ramp to be from the finger. Staff A reported the resident had shallow breathing when the paramedics arrived and they stated it was so shallow she basically wasn't breathing. Additional Staff Interviews On 9/30/19 at 2:30 p.m., the Administrator	F 689		

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F 689	Continued From page 34 reported the bus remained out of service with all keys secured. On 10/1/19 at 9:50 a.m., the Administrator stated the bus had been on was on lock down since the accident so nobody could access it. At 10:15 a.m., the Administrator unlocked the bus for observation. The Administrator said Staff A transported 2 persons that day, but had been at their appointment at the time of the accident so only Staff A and Resident #1 were in the bus at the time. The Administrator did not think the facility had the actual wheelchair used the day of the accident as it had been owned by Resident #1. The Administrator stated the wheelchair fell to the right according to the walk through conducted with Staff A, the Maintenance Director, and the Administrator. The Administrator stated monthly maintenance inspections had been completed prior to the incident and a checklist form completed. The Administrator said formal maintenance in a shop would be for procedures such as oil changes but the monthly inspections were completed by the Maintenance Director in the middle of the month. The last inspection had been completed sometime in mid-August. The Administrator stated in Staff A's account of the incident when the Maintenance Director and she had been present, Staff A did not report attaching the left back floor restraint or the seatbelt that went across the body. Observation revealed a shoulder belt on the back wall of the bus, behind the area where a wheelchair would be placed with the resident facing forward. When asked about documentation of training for Staff A on attachment of the wheelchair, the Administrator said she thought she already provided it. She stated Staff A had been trained	F 689		

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by Staff B, Central Supply Clerk, who had been the former bus driver. The Administrator said the facility investigation included a statement from Staff B regarding how she trained Staff A. The Administrator reported 3 staff members were trained on being able to drive the bus other than Staff A: Staff B (currently only working in Central Supply due to health reasons), Staff C, CNA, and the Maintenance Director.

On 10/1/19 at 11:20 a.m., the Maintenance Director provided a demonstration from start to finish on how to properly load a resident into the facility bus with the surveyor acting as said resident. The Maintenance Director started the bus to be able to lower the lift ramp located on the passenger side towards rear of the bus. The Maintenance Director pulled the wheelchair onto the ramp backwards, locked brakes on wheelchair, connected a belt strap across the ramp approximately at shoulder height, then went into bus, elevated the lift, unlocked the wheelchair brakes, and pulled the chair backwards into the bus. Once in the bus, the Maintenance Director maneuvered the wheelchair to turn toward the left side so the wheelchair and surveyor faced the front of the bus, behind the driver's side, in the back of the bus. The Maintenance Director stated he would connect in that position as Resident #1 in that position per Staff A's report due to 2 residents transported that day. The Maintenance Director showed he connected the floor restraint straps to both sides of the front wheelchair frame and not the wheels. The Maintenance Director said it didn't matter where it connected as long as it was connected onto the frame of the wheelchair. The Maintenance Director then connected the back straps, left and right on the floor underneath the wheelchair to the

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bottom frame bars. The Maintenance Director placed the seat belt that connected from the back wall of the van, thru the arms of the wheelchair, across the surveyor's lap, and to the belt strap connector secured on the floor on the right side of the wheelchair. The Maintenance Director tested the tension on all 4 straps by tugging on them to ensure they were secured and the wheelchair brakes locked as well. The Maintenance Director stated that was the proper way to connect it. The Maintenance Director said Staff A reported he did not connect the back left strap onto the wheelchair as he could not reach it. The Maintenance Director acknowledged the back door of the bus could be opened and a person could reach inside the bus to get to the back connection if needed, but he would expect a driver to get down on hands and knees and reach underneath to connect the strap. The Maintenance Director said Staff A did not mention anything about securing the seat belt onto the resident. The Maintenance Director said on 9/11/19, as soon as Staff A returned with the bus after the accident, Staff A, the Administrator, and himself completed a verbal walk-through and demonstration of what occurred that day. The Maintenance Director and the surveyor tried many scenarios to try to tip the wheelchair. With all 4 straps secured with the seat belt, the chair had been difficult to even budge when empty. Even with an unfastened seatbelt, it had still been difficult, even when pushing on the left side of the bus wall when in the wheelchair to tip over the chair. It did not tip over. The Maintenance Director undid the left back strap and still the chair only leaned approximately 5 to 10 degrees to the right side at most with the entire strength and force of the surveyor tugging on the wheelchair. The only way to tip over the chair 40

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F 689	Continued From page 37 degrees to the right was to undo the left side back and front floor straps. Even with the seat belt connected, the chair could only go so far if attached through the arms of the wheelchair. However, without the seat belt or the left side floor straps front and back, the chair tipped with a lot of effort to pull it over. The Maintenance Director stated Staff A reported the police officer and he identified the left front floor latch as faulty that day, but could not recreate the failure. The Maintenance Director reported Staff A indicated the latch did not catch when the tension released on the belt at the accident site. The Maintenance Director tested it repeatedly and never had the latch fail. The Maintenance Director speculated it would take a big impact to cause a wheelchair or resident to tip over in the bus during transport. The Maintenance Director demonstrated how the mechanism for the latch worked and said the only way the strap would extend further once in place on the frame of the wheelchair would be if something or somehow the red button on the floor latch depressed it. When asked, the Maintenance Director confirmed it would not matter where the floor restraints had been positioned on the floor; what mattered was rather or not tension was put on the belt. He stated once the strap was under tension, it did not go anywhere. The Maintenance Director confirmed the expectation would be for all 4 floor straps to be connected to the wheelchair and verified he would be someone who could provide training on how to transport a resident in the bus. The Maintenance Director reported he had never transported Resident #1 before. On 10/1/19 at 12:00 p.m., Staff B, Central Supply Clerk, responded she worked for the facility for approximately 10 years. Staff B responded the	F 689		

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	165188	A. BUILDING _____ B. WING _____	C 10/15/2019

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WEST BRIDGE CARE & REHABILITATION	1016 WEST SUMMIT WINTERSET, IA 50273

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F 689	Continued From page 38 floor latches may need to be moved at times for some wheelchairs. Staff B demonstrated how she would connect a wheelchair. During the demonstration, Staff B connected the left and right front floor straps to the frame of the wheelchair then connected the back 2 floor straps to the underneath frame of wheelchair. Staff B put the seat belt that hung on the back wall of the vehicle thru the arm rests/sides of the wheelchair stating it was to go across the abdomen as a lap band and connected to the floor strap attachment on the right side of the wheelchair. Staff B demonstrated checking the wheelchair brakes locked and tugged on all straps to ensure tension was on them and each was tight. When asked, Staff B stated she would not leave the parking lot if all straps not connected and if she could not reach the back straps, she would find a way and acknowledged she reached over the resident or could open the back door to reach under the wheelchair to secure. Staff B stated most times with elevated foot rests she needed to have them put all the way down, but had never transported Resident #1 before. Staff B demonstrated how to release the floor straps a person would need to press down on the red button on the latch to relieve the tension on the strap. Staff B said when she drove she would keep her ears open to any clicks or movement that may occur from the latch or the resident respectively. Staff B said she had times previously where a resident's foot may come down on the latch/red button and heard the click and she pulled over to make sure everything secured. Staff B commented clutter could land on the red latch button so she always maintained a policy of no clutter allowed on the floor around the wheelchairs, for example something like a shopping bag.	F 689		

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F 689	Continued From page 39 On 10/2/19 at 1:17 p.m., the Administrator confirmed she obtained a copy of the bus manual. The Administrator clarified and confirmed, other than the checklist for driving the vehicle, the facility had no checklists or step-by-step procedure guides for how to latch in a resident's wheelchair into the bus. At 3:30 p.m., the Administrator again said she did not know of any other training material to show the proper way to secure a resident in the vehicle besides the 1 to 1 verbal training provided by Staff B. The Administrator confirmed the vehicle manual also lacked information pertaining to how to secure a wheelchair resident. On 10/3/19 at 4:45 p.m. the Administrator confirmed the facility expectation was and had always been for 4 point floor restraints to be attached to the wheelchair during transport in the facility bus/vehicle. Review of Staff A's personnel record revealed a hire date of 6/17/19. The employee file contained orientation checklist training completed on 6/17/19 related to the facilities overall general policies. The orientation checklist lacked any documentation pertaining to securing residents or residents in wheelchairs into the transport vehicle. The Record of Road Test and Certification completed 6/17/19 recorded Staff A drove 5 miles with the Administrator for testing. The Pre-Trip Inspections and the Motor Vehicle Description checklists lacked any documentation pertaining to securing residents or residents in wheelchairs into the transport vehicle.	F 689		

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F 689	Continued From page 40 The Q'Straint Wheelchair Passenger Safety Solutions QRT Series Use Instructions, revised 10 Aug, included the following documentation: A. Secure Wheelchair 1. Place wheelchair facing forward in securement area; apply wheel locks or turn power off. 2. Attach tie-downs into floor anchorages (Fig. 1) and ensure they are locked in. 3. Attach the four (4) tie down hooks to solid frame members or weldments, near seat level. Ensure tie-downs are fixed at approximately 45 degrees, and are within angles shown in (Fig. 2.). Do not attach hooks to wheels, plastic, or removable parts of wheelchair. 4. Ensure all tie-downs are locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs (if present) to take up additional webbing slack. B. Secure Passenger 1. Attach Lap Belts - Use integrated stiffeners to feed belts through opening between seat backs and bottoms, and/or armrests to ensure proper belt fit around occupant. a. On the aisle side, attach belt with female buckle to rear tie-down pin connector (Fig. 4); ensuring buckle rests on passenger's hip. b. On the window-side, attach belt with male tongue to rear tie down pin connector (Fig. 4) and insert into female buckle. 2. Attach Shoulder Belt - Extend shoulder belt over passenger's shoulder and across upper torso (Fig. #), and fasten pin connector onto lap belt. Note: Combination lap/shoulder belts serve as both window-side lap belt and shoulder belt. 3. Ensure belts are adjusted as firmly as possible, but consistent with user comfort.	F 689		

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F 689	Continued From page 41 Warning: - Lap and shoulder belt should not be held away from passenger's body by wheelchair components or parts such as the wheelchair's wheels, armrests, panels or frame (Fig. 5). - Never rely on wheelchair's lap belt or a postural support belt unless properly approved & crash tested. - Ensure belt webbing not twisted while being worn by passenger. - Occupant belts should always bear upon the bony structure of passenger's body and be worn low across the front of the pelvis with the junction between lap and shoulder belts located near passenger's hip. The facility abated the Immediate Jeopardy detailed above on 9/11/19 by completing the following actions: Immediate Corrective Action: a. Immediately after Staff A returned from the accident on 9/11/19, the Administrator with the Maintenance Director interviewed Staff A and had Staff A re-enact what occurred at the scene of the accident with Resident #1. b. Staff A retrained 9/11/19 he should have connected all 4 floor restraint latches and the back wall shoulder-lap belt. c. The facility bus parked, locked, and remained out of service with all keys kept by the Administrator. d. All pending facility transportation to be completed by contracted company until further notice. Additional corrective measures:	F 689		

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F 689	Continued From page 42 On 10/2/19 at 3:40 p.m., the Administrator and the Director of Operations, informed the manual for the vehicle the base model; it would not include the customizations selected. The Director of Operations said she could obtain the information card for the Q'Straint latches that contained the instructions. The Director of Operations said she was currently working on gathering driver information from all buildings they oversaw and their vehicle information as they were not the owners at the time of the incident. The Director of Operations commented they would be completing new training for the drivers on the Q'Straint information card. On 10/3/19 at 12:50 p.m., the Administrator reported she had ordered all new Q'Straint floor latches for the bus and the Director of Operations was finalizing new training for bus drivers before the bus would be put back into service. On 10/15/19 at 4:15 p.m., the Administrator provided new training materials. The materials included Q'Straint QRT MAX Lesson Plan for Trainers and QRT Max Workbook for Trainees. The Administrator further provided certificates for the Maintenance Director and Staff C to show completion of Wheelchair and Occupant Restraint System Training Program on 10/10/19.	F 689		

This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by state and federal law.

F658 (Professional Standards)

Residents #3 and #6 have been assessed and no negative effects.

All residents have been reviewed for self-administration of medications and care plans updated as needed by MDS Coordinator on or before 10/15/2019.

Nurses have been re-educated on the requirement of medication administration for residents and observation of medications being taken if a resident is not deemed able to self-administer medications.

The Director of Nursing and/ or designee will audit medication administration with nursing staff weekly for 4 weeks and then monthly for 2 months.

Findings of the Audits will be taken to the QA team for review and recommendations.

F676 (ADLs)

Resident #3 has been offered ambulation per their walk to dine program.

An audit was completed to identify residents who are on a walk to dine program to ensure that they are offered ambulation according to their walk to dine program by Director of Nursing on 10/15/2019.

The Nursing staff were re-educated by the DON/designee on completing and charting on the walk to dine program on or before November 8, 2019.

The DON and/or designee will do random audits to monitor the completion and charting of the restorative walk to dine program weekly for 4 weeks and then monthly for 2 months.

Findings of the audits will be taken to the QA team for review and recommendations.

F684 (Quality of care)

Resident #4 has been assessed with interventions and MD notification completed as indicated.

The nursing staff were re-educated by the DON/designee on the appropriate process and documentation of the bowel movement protocol on or before November 8, 2019.

The DON and/or designee will do random audits to monitor the Bowel movement documentation weekly for 4 weeks and then monthly for 2 months.

Findings of the audits will be taken to the QA team for review and recommendations.

F689 (accidents and hazards)

No Plan of correction required.