STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. BUILDING _____ B. WING _____	C 01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY CENTER AT LUTHER PARK	1555 HULL AVENUE DES MOINES, IA 50316

(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 2.13.20 The following information is related to the investigation of facility reported incidents #87555 and #87943, incident #87943 is substantiated. (See Code of Federal Regulation (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 and resident interviews and observations the facility failed to provide adequate supervision for 1 of 3 open sampled residents (Resident #1). The facility reported a census of 118. Findings include: According to the Minimum Data Set (MDS) dated 12/15/19 Resident #1 had diagnoses which included diabetes mellitus, fracture, Alzheimer's disease, anxiety, depression and repeated falls. The resident had a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive ability. Resident #1 required extensive assistance of 1 staff for transfers, walking with assistance of walker, dressing, toilet use and personal hygiene. The resident utilized a	F 689		

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

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 wheelchair to move about the facility. Resident #1 had frequent urinary incontinence and occasional bowel incontinence. The staff utilized a bed alarm, chair alarm and a floor mat alarm daily to alert the staff when movement is detected. Review of Resident #1's Care Plan dated 2/16/19, indicated the resident had a risk for falls due to vision problems and poor safety awareness. The Care Plan directed the staff to check resident after 10 p.m. to 6 a.m. shift change and offer toileting, place a fall mat next to bed, floor and pressure alarm in bed and chair, keep walker within reach and staff directed not to leave resident un-attended in the bathroom. The Care Plan dated 1/8/20, directed staff to transfer the resident with the assistance of a mechanical lift and 2 staff. Review of a fall investigation report dated 1/7/20, revealed a nursing assistant assisted Resident #1 to the toilet, the staff stepped outside of the resident's room to grab a brief, the aide returned to the room and found the resident on the floor. The staff sent the resident to a local hospital, the resident sustained a displaced transverse fracture through the medial melleolus and distal fibula. The facility suspended the responsible staff pending an investigation. The facility camera's revealed the following time line: a. At 15:58 Staff A-C.N.A assists Resident #1 from the common area to her room. b. At 1600:45 Staff A exits the resident's room. c. At 16:03:51 Staff A re-enters the resident's room with a brief in hand. d. At 16:04:19 Staff A calls for Staff B-C.M.A. to the resident's room. e. At 16:04:57 Staff B summons Staff C-LPN to	F 689		

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F 689	Continued From page 2	F 689		

the resident's room.
f. At 21:36 a portable x-ray completed.
g. At 22:16 results return with a possible fracture and physician gave order to transfer the resident to a local emergency room.
h. At 4:49 (1/8/19) the resident returns from the emergency room with a boot to the left foot and a follow up appointment scheduled for 1/19/20.
The investigation revealed the root cause of the fall is determined to be the result of leaving the resident unattended on the toilet by staff. The resident is considered a high risk for falls due to having alarms and has had a history of previous falls.

Review of a X-ray Report dated 1/7/20, revealed the resident had a x-ray due to a fall. The results revealed a displaced transverse fracture through the medial melleolus and displace oblique fracture thru the distal fibula. The surrounding tissue noted to have swelling.

During an interview with Staff A-C.N.A on 1/28/20, the aide stated she assisted the resident to the toilet in her room. Staff A completed personal cares and when she looked for a fresh brief in the resident's bathroom closet, finding the board empty. Staff A told the resident to stay sitting on the toilet as she goes to the next room to get a brief for the resident. Staff A entered the next room and retrieved a brief, at this time she noted the other resident in the bed with her feet dangling out of bed, Staff A stopped and assisted the resident. She stated when she returned to Resident #1's bathroom, she found the resident on the floor, yelling for help. Staff A summoned help at this time from other staff members. Staff A stated she and 2 other staff lifted the resident off the floor and sat her in the wheelchair. The

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F 689	Continued From page 3 resident went to the dining room to eat the evening meal. Staff A stated the resident did not have to bear weight on her foot as the staff lifted her up and into the wheelchair. After the evening meal Staff A asked Staff C-C.N.A for assistance transferring the resident to their bed. At the time of the transfer into bed the resident could not bear weight on left leg and complained of pain to area. Staff A alerted the charge nurse of the complaints. Staff A stated she was suspended after the investigation started for a period of 3 days and received a disciplinary write up for not following the policy regarding leaving a resident who uses alarms unattended on the toilet. Staff A stated she is upset over the fall because she knew she should not have left a resident who uses alarms alone on the toilet. Staff A asked the resident to remain sitting on the toilet while she went next door. During an interview with Staff B-Certified Medication Aide on 1/28/20 at 4:20 p.m., Staff B stated she was passing medications in the common area when Staff A summoned help in Resident #1's room. Staff B entered the room and noted Resident #1 laying on the floor in front of her toilet. Staff B notified Staff D-LPN. Staff B stated the facility policy is to not leave a resident who uses alarms sitting alone on the toilet. Staff B stated Resident #1 uses alarms in their bed and chair. During an interview with Staff C-C.N.A on 1/28/20 at 4:38 p.m., Staff C stated he assisted Staff A to get the resident into bed. Staff C stated the resident did not bear weight on her left leg during that transfer. Staff C stated you are not to leave a resident who uses alarms and is a fall risk alone on the toilet.	F 689		

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F 689	Continued From page 4 During an interview with Staff D-LPN on 1/29/20 at 10:30 a.m., Staff D stated Resident #1 was an assist of 1 staff prior to her fall, she utilized alarms in her bed and chair, is a fall risk and has periods of confusion at times. Staff D stated she got called to the resident's room after she had a fall. Upon initial assessment her left ankle area looked normal but the resident complained of pain with the assessment. Upon asking Staff A about the fall, the staff told her she placed the resident on the toilet and left the room to get a brief. Staff A-LPN stated it is not appropriate to leave a resident who is a fall risk and utilizes alarms alone on the toilet for any length of time. Review of an Incident Report dated 1/7/20 at 4:15 p.m., indicated a C.N.A assisted Resident #1 to the bathroom, the aide left the bathroom to obtain a brief, leaving the resident unattended on the toilet. The staff returned and found the resident on the floor in her bathroom. Review of the Progress Notes dated 1/7/20 at 5:22 p.m., revealed a Certified Nurses Aide assisted the resident to the bathroom, left the resident in the bathroom to get the resident a brief. When the aide returned she noted the resident lying on the floor in bathroom. Review of the Post Fall Progress Note dated 1/7/20 at 6:25 p.m., the notes indicated at 3:00 p.m. the resident experienced an unwitnessed fall in the bathroom due to a self transfer attempt. The nurse documented the staff left the resident unattended in the bathroom. Review of a Resident Toileting Policy dated 1/4/2020, directed staff when assisting a resident	F 689		

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F 689	Continued From page 5 to the toilet who needs physical support/assistance, or who has an alarm due to progressive cognitive decline, you may not leave them unattended in the bathroom. This does not mean you cannot stand outside the bathroom to give them privacy but you may not leave the room. During an interview with Staff E-RN/Director of Nurses on 1/29/20 at 11:20 a.m., Staff E stated when she became aware of the fall and fracture, she began re-education with all staff regarding safety in the bathroom including having the supply cupboard stocked prior to doing cares and to not leave resident's alone in the bathroom who are identified as a fall risk and utilizes alarms.	F 689		

F689: Free of accident hazards/supervision/Devices

- Th facility strives to provide a safe environment where adequate supervision is provided and residents are free from accidents and hazards.

Corrective action taken for resident to have been affected by the deficient practice.

- Resident A. A was sent to the ER, came back with orders to see a podiatrist, Podiatrist saw the resident and scheduled a surgery which was done on 1/20/20. Currently in the healing process. Remains Non-weight bearing to LLE with a Cam boot as tolerated. Resident is care planned for stand pivot transfers as per the doctor's orders and NOT to be left un-attended on the toilet.

How will the center identify other residents having the potential to be affected by the same deficient practice?

- Residents who have alarm devices and have a cognitive impairment have been identified, care plans reviewed and updated to direct that resident is NOT to be left un-attended on the toilet.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- **Staff education on toileting was started on 1/8/20 and is ongoing.**
- Toileting policy was reviewed and updated on 2/15/20
- Random Audits of walking rounds to ensure supplies are in rooms, Overnight stocking rounds and toileting competency are done weekly and as needed.

Quality Assurance Plan to Monitor performance to make sure corrections are achieved and are permanent.

- Identified concerns shall be reviewed by the facilities QAA committee.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when the corrective action will be completed 2/13/20

Violet Arrington RN | DON