STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165622	A. BUILDING _____ B. WING _____	C 01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SUITES AT WESTERN HOME COMMUNITIES	5301 CARAWAY LANE CEDAR FALLS, IA 50613

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F 000	INITIAL COMMENTS The Iowa Department of Inspection and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C, and the guidance provided by Centers for Disease Control and Prevention (CDC) conducted this Focused COVID-19 Infection Control Survey. The facility was found to be NOT IN COMPLIANCE. Total residents: 79 Onsite dates: 1/5/2020 - 1/19/2020 During the survey, the following facility reported incidents and complaint were also reviewed: Complaint 88024 - I substantiated without deficiency. Complaint 93885 - C not substantiated. Complaint 95153 - I substantiated.	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	F 689		

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

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§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 record review and staff interview the facility failed to provide adequate supervision to prevent a fall with injury in 1 of 3 residents reviewed (Resident #9). The facility reported a census of 79 residents.

Findings include:

According to the Minimum Data Set (MDS) Assessment dated 10/16/20, Resident #9 diagnoses included coronary artery disease, hypertension, non-Alzheimer's dementia and vertebrae fracture. Resident #9 scored 3 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Resident needed extensive assist to total dependence of 2 staff with transfers, bed mobility, dressing, personal hygiene, and had a history of falls with fracture.

Fall Risk Evaluation dated 10/9/20 on Resident #9 initial admission revealed a score of 12, which indicated the resident at risk for falls.

Incident Report dated 10/16/20 at 9:00 p.m. revealed Resident #9 found on the floor in dining room. Education provided to staff not lock wheels on wheelchair while sitting at table.

Incident Report dated 10/18/20 at 3:20 p.m. revealed Resident #9 slid out of wheelchair onto buttocks while in lounge area. Facility added Dycem (non-slip pad) to the wheelchair.

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Incident Report dated 10/21/20 at 10:00 a.m. stated resident found lying on the floor in dining room. Medication review initiated related to falls.

Incident Report dated 10/22/20 at 2:45 p.m. revealed the nurse heard a crash and saw Resident #9 in the dining room with his back against the television stand. Notes state medication review still continuing order for pain medication brought on board for pain control.

Incident Report dated 10/23/20 at 9:15 p.m. revealed Resident #9 found lying on the floor next to fireplace in lounge area. Staff to offer late bedtime snack.

Incident Report dated 10/27/20 at 5:30 p.m. revealed resident out in lounge area sitting on floor in front of wheelchair. Resident unable to give description of what occurred. Notes directed staff to offer toileting before meals.

Incident Report dated 10/28/20 at 2:00 p.m. revealed Resident #9 found on the floor in the lounge lying on left side. No complaint of pain with passive range of motion. Staff sat resident up on the floor and complaint of pain to left hip. Resident assisted to bed.

Incident Report dated 10/28/20 at 6:50 p.m. revealed #9 was in the dining room and nurse heard someone talking and when looked out resident was laying on the floor on his back.

The Bio Tech X-ray of the left pelvis on 10/29/20 revealed a non-displaced fracture of the left superior pubic ramus.

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Incident Report dated 10/30/20 at 11:05 p.m. documented resident in the dining room sitting on floor in front of the wheelchair. Noted nurse mentor review of incident dated 11/2/20 document staff to transfer to recliner in living room when restless in the wheelchair.

Incident Report dated 10/31/20 at 4:15 p.m. revealed resident found lying on his left side between his wheelchair and his reclining chair in dining room. Notes state nurse mentor review of incident - staff to provide direct supervision and be within reach of resident when extremely restless for safety.

The Care Plan dated 11/1/20 indicates Resident #9 is at risk for falls related to impaired mobility, weakness, dementia, incontinence, diuretic use, impulsive behavior, self-transferring, psychotropic and opioid pain medication use, and history of falls. The Care Plan directed staff to provide hand held assist of one with transfers/ambulation with gait belt. The Care Plan failed to address supervision level or any interventions during periods of increased anxiety and restlessness until after the falls on 10/28/20.

During interview on 1/13/21 at 3:30 p.m., Staff B, Certified Nursing Assistant (CNA) stated Resident #9 would grab tables and attempt to stand up and had behavior that varied greatly.

During interview on 1/13/21 on 3:40 p.m., Staff A, Certified Nursing Assistant (CNA) she stated Resident #9 was the same as every other day on the day he fell and fractured pelvis. Resident would attempt to stand up on his own and he was unable to stand on his own.

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F 689	Continued From page 4	F 689		

During interview on 1/13/21 at 3:50 p.m. Staff C, Licensed Practical Nurse, (LPN) stated Resident #9 had a history of falling frequently and that staff had attempted to keep him at nurses station but nothing formal. Stated still had to care for other residents.

During an interview of Staff D, Certified Nursing Assistant (CNA) on 1/13/21 at 4:00 p.m. stated Resident #9 was always trying to transfer himself, would self-propel down hall, and anxious even after given medications to calm down by nurse. On several occasions, during supper, whenever staff turned their back he was on the floor.

During an interview on 1/13/21 at 4:15 p.m. Staff E, LPN stated the night of Resident #9's fall on 10/28/20 when he fractured his pelvis, staff laid him down but he wouldn't stay in bed. Staff assisted him back into wheelchair and kept him near them but had to do charting in nurses station. Had just checked on him, prior to fall. Nurse station door always kept open, but could not see Resident #9 from where located in nurse station.

During an interview on 1/14/21 at 8:30 a.m. with the Director of Nursing, stated Resident #9 was very anxious since admission. Attempted multiple interventions such as medication reviews and medication changes but not helpful. Attempted to keep by staff as much as possible, due to busy schedule not always possible.

Facility Policy dated August 2019 stated it is the policy of the nursing facility to apply appropriate interventions to attempt to limit and/or prevent the occurrence of falls. The nurse mentor will monitor and update the plan of care to reflect

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F 689	Continued From page 5 current recommendations and interventions.	F 689		