STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165346	A. BUILDING _____ B. WING _____	C 03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR VILLAGE	345 PARROTT ST APLINGTON, IA 50604

(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	F 000		
VKK 4/18/17	Correction date 4/6/17			
	The following deficiencies relate to the investigation of incident #67080. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).			
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to prevent the development of a pressure sore and failed to promote the healing of the sore for 1 of 2 residents reviewed (Resident #1). The facility reported a census of 29 residents. Findings included:	F 314		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/06/2017

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 314	Continued From page 1 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 11/11/16. The MDS identified the resident had short and long term memory loss and severely impaired cognition. Resident #1 required the extensive assistance of two or more persons with bed mobility, and totally dependent for transfer, toilet use, and bathing. The MDS identified the resident had bilateral upper and lower extremity range of motion impairments and used a wheelchair for mobility. The resident's diagnoses included anemia, non-Alzheimer's dementia, anxiety, depression and low back pain. The MDS identified the resident to be at risk for the development of pressure ulcers. The Care Plan with a target date of 3/7/17 identified a focus area of having a pressure ulcer [sore] related to the disease process, history of ulcers, immobility. The Care Plan indicated the resident was receiving treatment for a pressure ulcer located on the coccyx area on 12/7/16. The approaches directed staff to apply Calmoseptine to the buttocks twice a day, lay the resident down after breakfast and lunch to get off bottom. The approaches directed the staff the resident needed monitoring to turn/reposition approximately every 2 hours, more often as needed, The approach directed the staff the resident used device cushion in wheelchair and pressure relieving device on bed and to off load feet when in bed. A form titled Weekly Pressure Ulcer Progress Report identified a coccyx pressure ulcer found on 12/1/16. The pressure ulcer was identified as Stage II and measured 0.5 by 0.3 by 0.1 cm with a depth of 0.1 cm. The wound color was dark pink with no odor. The preventive measures included to turn every 2 hours, pressure relieving	F 314		

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F 314	Continued From page 2 cushion device in the wheelchair and provide nutritional supplement. The MDS identifies the following definitions of pressure ulcers: Stage I is intact skin with non-blancable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (yellow stringy substance). May also present as an intact or open/ruptured blister. Stage III is a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling. Stage IV is a full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The MDS assessment with a reference date of 2/10/17 identified Resident #1 with short and long term memory impairments and severely impaired daily decision making abilities, required extensive assistance of two staff for bed mobility, and total dependence with staff for transfers, toilet use and personal hygiene. The MDS documented the resident with functional limitations in range of	F 314		

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F 314	Continued From page 3 motion to upper and lower extremity on both sides, and a wheelchair used for mobility, incontinent of bladder and bowel and had a Stage II pressure ulcer. A Braden Scale for Predicting Pressure Sore Risk completed on 3/29/17, documented the resident at a high risk (score of 10) with a problem with friction and shearing that required moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, required frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction. The Weekly Pressure Ulcer Progress notes included and indicated: On 2/22/17, the area measured 0.4 by .3 cm by 0.1 cm and a Stage II. On 3/1/17, the area measured 0.4 by 0.3 by 0.1 cm and Stage II. On 3/8/17, the area measured 0.4 by 0.3 cm by 0.1 cm and a Stage II. On 3/15/17, the area measured 0.4 by 2 centimeters and a Stage II. On 3/22/17, the area measured 0.4 cm by .2 cm by .1 cm Stage II. On 3/29/17, the area measured 0.4 cm by 0.4 cm by 0.1 cm Stage II. Observation identified the following:	F 314		

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F 314	Continued From page 4 On 3/29/17 at 11:45 a.m. the resident was observed in his/her room, transferred from bed to wheelchair via EZ way lift by Staff A, CNA (Certified Nursing Assistant) and Staff B, CNA. Observation identified a pressure relieving cushion in the wheelchair. Staff A and Staff B positioned the resident on the edge of the pressure relieving cushion at the front edge of the wheelchair. On 3/29/17 at 12:50 p.m., the resident sat at the dining room table with buttocks on the edge of the blue pressure relieving cushion and not positioned back in the seat. The resident's back of the head rested against the back of the wheelchair. On 3/29/17 at 1:16 p.m., the resident continued to sit with buttocks on the edge of the blue pressure relieving cushion and back of head resting against the back of the wheelchair. On 2/29/17 at 10:00 a.m. the Assistant Director of Nursing was interviewed and stated the staff leave the sling underneath the resident while seated in the wheelchair. On 3/29/17 at 12:20 p.m., Staff C (certified nursing assistant) was interviewed and stated the resident likes to lean forward out of the wheelchair and will slide down and sit on the edge of the blue pressure relieving cushion. On 3/29/17 at 1:16 p.m., Staff A (certified nursing assistant) was interviewed and stated the resident liked to slide forward out of the wheelchair and the bottom sits on the edge of the blue pressure relieving cushion. Staff A stated the resident had been doing this a long time.	F 314		

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F 314	Continued From page 5 On 3/29/17 at 1:17 p.m., Staff B (certified nursing assistant) was interviewed and stated the resident liked to lean forward out of the wheelchair and sits with their bottom on the edge of the blue pressure relieving cushion. Staff B stated the resident did this for a long time. On 3/29/17 at 3:40 p.m., Staff D (licensed practical nurse) was interviewed and stated the resident will be positioned correctly in the wheelchair and the resident likes to slide forward to the edge of the pressure relieving cushion. On 3/30/17 at 8:55 a.m., Staff E (certified nursing assistant) was interviewed and stated the resident would slide forward while in the wheelchair and their buttocks are on the edge of the pressure relieving cushion. Staff E stated the resident was in the wheelchair with the green sling underneath their buttock. (Leaving the sling under the resident while seated in the wheelchair can make the cushion ineffective). On 3/30/17 at 9:50 a.m., Staff F (assistant director of nursing) was interviewed, acknowledged and observed the resident sliding forward in the wheelchair on occasion, but was not aware of the consistent frequency for which it was occurring. Staff F confirmed the clinical record lacked an assessment for wheelchair positioning and the expectation would be for the floor nurse to report to the charge nurse and then to the Occupational Therapist for a referral. Staff F also acknowledged the resident's incontinence and nutritional decline are precipitating factors for the development of the facility acquired pressure ulcer, but since becoming aware of the resident sliding forward in the wheelchair this is also a contributing factor of the ulcer.	F 314		

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F 314	Continued From page 6 On 3/30/17 at 10:40 a.m., Staff D, LPN, was interviewed and stated the resident has a facility acquired pressure ulcer and acknowledged the resident does slide forward in the wheelchair and that could be a contributing factor to the pressure ulcer. Staff D stated they failed to notify Occupational Therapy for a referral due to the resident sliding forward. On 3/30/17 at 11:36 a.m., Staff G (Occupational Therapy Assistant) stated the last time the resident had been seen according to their notes happened to be 2 years ago with the change of transfer to the Hoyer lift. Staff G stated the expectation of the facility would be to contact them and have a referral done with the resident due to sliding forward out of the wheelchair.	F 314		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		

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F 323	Continued From page 7 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide adequate supervision during an inappropriate transfer with a mechanical lift in order to prevent accidents and injury to Resident #1. The sample consisted of 4 residents and the facility reported a census of 29 residents. Findings include: 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 2/10/17. The MDS indicated Resident #1 had short and long term memory impairments and severely impaired decision making abilities. The MDS indicated the resident required total dependence for assistance of two staff members for transfers, dressing, personal hygiene, and toileting, locomotion on and off the unit and extensive assist or two staff for bed mobility. A balance during transition and walking test identified the resident as not steady and only able to stabilize with staff assistance when surface to surface transfers. The MDS documented Resident #1 had limitations in range of motion on both sides of his/her upper and lower extremity. The MDS identified the resident had diagnoses that included intervertebral disc degeneration of the lumbar region, osteoarthritis of the knee and low back pain. The MDS indicated the resident had	F 323		

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F 323	Continued From page 8 no falls since the prior assessment and no restorative programs. An Admission/Readmission Fall Risk Assessment and Interventions dated 8/26/12, documented potential fall risk factors included, assistance required with transfers, cardiovascular disease, cognitive impairment and decline in functional status, dementia diagnosis, hypertension, incontinence, psychotropic medications, use of assistive devices, unsteady gait, use of 9 or more medications, vision disturbances and wheelchair use. The Interdisciplinary Working Plan of Care, with a target dated 3/7/17, directed staff to see therapy alert for changes and details, assist of two with use of the mechanical lift (3/12/15), size small or medium. An intervention dated 3/22/17, directed staff to transfer with mechanical lift using sling that crisscrosses between the legs to prevent sliding. A record review of the Progress notes dated 3/22/17 at 10:27 a.m. (late entry) reflected the nurse called to the resident's room by staff to find the resident lying on the floor with head facing the doorway and feet facing the foot of the bed. The resident was lying in between the legs of the Hoyer (mechanical lift) with head towards the main/base end of the Hoyer. The floor was dry and uncluttered. All 4 straps to the Hoyer sling still intact correctly to the machines hooks. The staff stated the resident slipped out of the sling feet first and then once on the ground, rolled onto the left leg of the Hoyer lift and onto the left hip and left arm. The resident had severe contractions and unable to verbalize any acute pain at the time. This nurse noted some swelling	F 323		

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F 323	Continued From page 9	F 323		

starting to the resident's right ankle. Resident was then assisted with 4 staff members to bed using a crisscross sling and the sling lift machine. The Care Plan was updated following a fall to direct staff to only use the Hoyer slings that crisscross through the legs. Staff transferred the resident to the hospital Emergency Room for an evaluation and treatment.

The x-ray report dated 3/22/17 documented Resident #1 with a right ankle fracture. The impression included: an oblique nondisplaced fracture involved the posterior malleolus (ankle) of the tibia (lower leg bone), subtle linear lucency in the distal metadiaphysis of the fibula (lower leg bone) could represent nondisplaced fracture and subtle linear lucency of the proximal shaft of the fifth metatarsal (fifth long bone in foot), could be due to technique or nondisplaced fracture. The resident returned back to the facility the same day with physician's orders that directed staff to keep the boot on and to please avoid falls.

On 3/29/17 at 9:44 a.m. the Administrator was interviewed and stated the staff used the correct lift and sling. Due to the fact the resident had lost some weight; the facility should have had the resident re-evaluated for a different lift and different size of sling. The Administrator stated since the incident, the resident is using the EZ Way lift and sling now. At the time of the fall, the staff used the Hoyer lift with a medium sling.

Date submitted:04/17/17

Preparation and execution of this plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under State or Federal law.

F000 – Correction Date 04/06/2017

F 314 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The facility is disputing this deficiency, and is submitting a response with additional information in a separate document. However, for the required Plan of Correction, the facility submits the following:

1. Resident #1 was evaluated by occupational therapy on 4/3/17 for wheelchair placement. The wheelchair was modified by the therapist to help prevent sliding which could contribute to shear/friction of the skin. Resident #1's schedule was adjusted on 4/5/17 to further minimize amount of time spent in wheelchair versus time in bed.
2. The Braden Scale for Predicting Pressure Sore Risk is performed upon admission, annually and with any significant change in condition, and this will continue to be our practice. The facility will place appropriate preventive interventions on the care plan in an attempt to reduce the risk of developing pressure injury.
3. The facility has policies and procedures in place for pressure injury risk assessment and documentation. Nursing staff will receive additional training regarding recognition of risk factors for pressure injury and interventions for prevention beginning on 4/6/2017. Nursing staff will review risk factors and interventions for prevention of pressure injury at hire and yearly.
4. Assessment of pressure injury and interventions occurs weekly. These will be reviewed by an interdisciplinary team weekly to ensure compliance.
5. The Director of Nursing, or her designee, will complete weekly audits of the pressure ulcer progress reports. This will continue weekly x 2 months to ensure appropriate treatments and interventions are utilized. The results of the audits will be reviewed through the quality assurance process and system weaknesses will be identified and interventions will be initiated to improve resident outcomes. The frequency of the audits thereafter will be based on outcomes.

323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
ıe facility must ensure that the resident environment remains as free of accident hazards as is possible;
ıd each resident receives adequate supervision and assistance devices to prevent accidents

ıe facility is disputing this deficiency, and is submitting a response with additional information in a eparate document. However, for the required Plan of Correction, the facility submits the following:

1. Physical therapy evaluated Resident #1 on 3/24/17 to ensure safe handling during transfers and that appropriate mechanical lift equipment was in use.
2. Caregiver staff were re-educated on safe mechanical transfers and facility policy of the same completed on 4/6/2017.
3. Staff receives education and training to ensure competency of use of lift equipment upon hire and this will continue to be our practice. The facility will provide education and training yearly, to include a demonstration of competence by staff of the use of mechanical lifts.
4. Occupational and/or physical therapy will evaluate resident transfers and mobility when there has been a determination by nursing staff that a mechanical lift will be used, including sling type and size.
5. Audits of transfers of residents who utilize mechanical lifts will be completed at least quarterly for a year. The results of the audits will be reviewed as part of our on-going quality assurance process and the frequency of the audits thereafter will be based on outcomes and subsequent recommendations.