STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A002	A. BUILDING _____ B. WING _____	C 05/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA VETERANS HOME	1301 SUMMIT MARSHALLTOWN, IA 50158

(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 The following deficiency relates to the investigation of incident #82306. (See code of federal regulations (42CFR) Part 483, Subpart B-C) Complaint #82070 and Complaint # 81911 was not substantiated. The deficiency cited under F689 will be considered past non-compliance as the facility corrected the deficiency on April 18, 2019, prior to surveyor entrance.	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 staff interviews and clinical record review the facility failed to implement measures to ensure adequate supervision to prevent falls and major injury for one of three residents reviewed. (Resident # 1) Record review and staff interview revealed Resident #1 required a condom catheter (external urine collection device) at bedtime to prevent the resident from getting out of bed unassisted. On 3/21/19 facility staff failed to place the condom catheter, which resulted in the resident standing unassisted and voiding on the floor. Resident #1 fell and sustained a fracture of	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/28/2019

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F 689	Continued From page 1	F 689		

the right hip. The facility reported a census of 437 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 2/26/19 for Resident #1 identified a Brief Interview for Mental Status (BIMS) score of 9 indicative of moderately impaired cognition. According to the MDS, the resident required the extensive assistance of two staff for transfers, toilet use, dressing, personal hygiene, and bed mobility. A balance during transition and walking test identified the resident as not steady and only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around, moving on and off toilet and surface to surface transfer. The MDS further identified functional limitation in range of motion on one side for lower extremities. The resident had diagnosis that included arthritis, chronic pain due to trauma, and non-Alzheimer's dementia. The resident had experienced two falls with no injury and two falls with injury (not major injury) since admission or prior assessment.

Review of the Fall Risk Assessment, dated 3/6/2019 identified the resident scored a total score of 13 which indicated the resident should be considered at high risk for potential falls.

The Resident Care Plan, dated as printed on 3/21/19 directed staff: moon boots (soft pillowed boots that provide heel protection) on both feet as HS, staff to apply non-skid socks on both feet when in bed, and assist of one staff with transfers.

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F 689	Continued From page 2	F 689		

An incident report dated 3/21/19 at 12:15 AM documented the resident was found on the floor with moon boots on, near his walker, urine on the floor, resident complained of right hip pain. The document further documented an adverse event occurred resulting in a need for transfer to a higher level of care.

A progress note, titled Initial Fall Documentation dated 3/21/19 at 12:15 AM documented the resident was found by staff in his room on the floor, the resident had no incontinence brief on and had urinated on the floor, had moon boots on with slipper socks under, and was laying on his right hip. The resident was assessed as having right hip pain with external rotation and was transferred to local emergency room for evaluation and treatment. Contributing factors were identified as resident ambulatory with moon boots on and no incontinence brief.

An order requisition form dated 3/21/19 documented the resident was inpatient for a closed fracture of the right hip. Nursing progress note dated 3/21/19 at 12:54 PM documented the resident had surgery to repair hip at a local hospital.

In an interview on 5/8/19 at 10:15 AM the Administrator of Nursing (AON) provided an overview of the investigation of the incident and revealed the evening shift failed to put on the condom catheter, and the night shift failed to check if the condom catheter was on when put on the moon boots. Further stated, the residents care plan directed staff to have moon boots over gripper socks when in bed. The AON explained that accountability rounds are shared rounds between the current shift and the oncoming shift

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F 689	Continued From page 3	F 689		

to assure safety measures are in place and exchange information. Further explained that the investigation and video surveillance review revealed staff failed to assure all safety measures were in place and failed to exchange information during accountability rounds. A document provided by the AON documented a timeline of events as observed when reviewed surveillance recording. Stated would have expected staff to check that condom catheter was in place when completed rounds.

In an interview on 5/8/19 at 2:50 PM the evening supervisor stated the investigation revealed Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA failed to communicate who had cared for resident during the evening shift. Each had assumed the other had provided care, and neither had. The investigation further identified Staff C, CNA failed to check for incontinence brief or condom catheter when put on moon boots. Additionally confirmed the condom catheter had been effective in keeping the resident from standing unassisted when in bed.

In an interview on 5/13/19 at 1:38 PM Staff C, CNA confirmed Staff A and Staff B had not gone into the residents room during accountability rounds. Stated would have expected evening staff to report no incontinence brief, and no condom catheter as the resident was in bed. Confirmed the resident had underwear on when fell. Additionally stated, the care plan directed moon boots over slipper socks when in bed.

In an interview on 5/13/19 at 4:05 PM Staff D, Registered Nurse (RN) confirmed care plan directed staff condom catheter at bedtime. Explained the resident often felt he had to go to

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F 689	Continued From page 4 the bathroom at night. Stated the resident had not been consistent in using the call light, and had previously tried to go himself. However, with the condom catheter in place, he would stay in bed. Staff D, RN confirmed the condom catheter was a fall precaution strategy. The facility corrected the deficient practice on April 18, 2019 by conducting inservice training regarding safety strategies and resident room checks. Because the facility corrected the deficient practice prior to the complaint and incident investigation, the situation was identified as past non-compliance.	F 689		