STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165286	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE HILL CARE CENTER	909 6TH STREET TRAER, IA 50675

(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		
OK/TAG ✓	Correction Date: 4/27/23			
	A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on April 4, 2023 to April 10, 2023. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. The following deficiency resulted from an investigation of Complaint #110461-C and Facility Self-Reported Incidents #108020-I and #111585-I conducted April 4, 2023 to April 10, 2023. Facility Self-Reported Incidents #108020-I and #111585-I were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.			
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 facility and Hospital records review, staff interviews and facility policy review, the facility failed to provide adequate supervision for	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/17/2023

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.

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

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F 689	Continued From page 1 residents to avoid falls with injuries to occur for 2 out of 3 residents reviewed for falls (Resident #1 and #2). Staff A, Certified Nurse Aide (CNA), let go of Resident #1's gait belt, which resulted in Resident #1 tripping over her walker, falling, and sustaining a fractured hip. Staff B, CNA, stepped out of Resident #2's room to grab an EZ Stand Lift (transferring device) and did not lower Resident #2's bed, which resulted in Resident #2 falling out of a bed that was not in it's lowest position, thus resulting in a fractured leg and rib/s for the resident. The facility reported a census of 53. Findings Include: 1. A Minimum Data Set (MDS) dated 9/15/23, documented diagnoses for Resident #1 included unspecified fracture of left femur. A Brief Interview for Mental Status (BIMS) documented a score of 15 out of 15, indicating Resident #1's cognition intact. This resident identified required limited assist of 1 for transfers and ambulation and an extensive assist of 1 for toileting and dressing. A Care Plan initiated on 6/30/22, showed a self care deficit focus area on it, which included a rationale for this problem as a fall with fracture. An intervention directed staff the resident was an assist of one with a walker and a gait belt. A Progress Note dated 9/25/22 at 8:25 p.m., documented Staff A, CNA requested the Nurse to go to Resident #1's room. The Staff A stated the resident was returning from the bathroom using a walker and gait belt. CNA stated the resident stopped and CNA turned to get sleep pants for the resident and heard the sound of the resident	F 689		

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F 689	Continued From page 2	F 689		

falling and yelling. The Nurse entered the room and found the resident behind the door by the night stand on her left side. The Nurse asked this resident how it happened and the resident answered that she did not know but she was still here. Vital signs were blood pressure (BP)190/100, pulse oxygenation (O2 Sat) 97%, Pulse (P)94, temperature (T) 97.9 Fahrenheit (F), and respirations (R) 22. Assisted resident up with 2 staff and a gait belt and the resident immediately had increased pain and discomfort. The resident placed into a wheelchair and transferred to bed where resident was laying flat. Noted the resident's left hip had external rotation, her left heel was shorter and she displayed continued discomfort. The resident given scheduled Tylenol and insulin with snack.

A Progress Note on 9/25/22 at 8:50 p.m., documented that the ambulance was at the facility to transport Resident #1 to the hospital.

A Progress Note on 9/26/22 at 3:32 p.m., documented that Resident #1 was admitted to the hospital for a left hip fracture.

A Progress Note on 9/27/22, documented the Social Worker from the Hospital reported the resident had surgery on her left hip on 9/26/22 and was to return to the facility.

A Hospital History and Physical (H&P) showed an admission date of 9/26/22 and documented Resident #1 had a past history of knee replacement, CVA (stroke), atrial fibrillation (A-Fib, irregular rapid heart rate) on Eliquis (blood thinner), diabetes and presented from nursing home facility for evaluation. The H&P documented the resident stated she was

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F 689	Continued From page 3	F 689		

ambulating with help of a walker and tripped landing on the left side of her body. The patient was unable to bear any weight on affected extremity and hence the facility called 911. The H&P documented that upon arrival the resident's left lower extremity was seen externally rotated with excruciating pain. The resident underwent x-ray which showed left intertrochanteric femur fracture (hip fracture). The resident was also found to have A-fib with RVR (rapid ventricular (heart chambers) rate) upon presentation for which she was placed on a Cardizem (medication for ventricular rate control in A. fib) drip. In the Emergency Room (ER) the patient received Fentanyl (synthetic opioid for pain control). Upon further history taking the resident's daughter mentioned that on 6/6 this resident had left knee replacement and transiently had to stop her anticoagulation medication (blood thinner). The resident apparently developed left sided hemiparesis after stopping her anticoagulation and a MRI (imaging test for soft tissues) of her brain indicated ischemic (reduced or blocked supply of blood) stroke. The resident's sensorimotor deficit is back to her baseline as far as stroke was concerned.

An X-ray of the resident's hip 2-3 views done on 9/25/22 at 11:42 p.m., revealed an intertrochanteric fracture on the left femur and no dislocation noted.

On 4/5/23 at 1:50 p.m., Staff A, CNA Agency, stated she had worked at the facility before the incident but had not worked down Resident #1's hall. When asked how she knew what each resident's Plan of Care was, she stated she knew what the needs of the resident were because staff had given her a list of residents and what they

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F 689	Continued From page 4 needed for Activities of Daily Living (ADL's) . Staff A stated that day she had taken Resident #1 to the toilet. Staff A reported on the way back from the toilet, she had a gait belt on Resident #1 and Resident #1 was using her walker. Staff A explained Resident #1 wanted her sleep pants and Staff A asked if Resident #1 would sit down first. Resident #1 said she didn't want to sit down and Staff A stated she let go of Resident #1 for just a second. Staff A felt that Resident #1 had been pretty steady on her feet. Staff A stated she had taken 2 steps toward the closet to grab the resident's pants and Resident #1 fell. Staff A stated she felt so horribly bad. She repeated this and also said that she shouldn't have let go of Resident #1. Staff A said it was her fault the resident fell because she should not have let go of the gait belt. Staff A stated she felt bad to this day. Staff A added if she could do it over again, she would not have let go of the gait belt and would have insisted that Resident #1 sit down first prior to going to getting her sleep pants. On 4/6/23 at 2:13 p.m., Staff C, Licensed Practical Nurse (LPN), stated that Resident #1 was pleasantly confused but also can remember your name. Staff C stated she asked Resident #1 what had happened but Resident #1 could not say that she had stumbled over her feet. Staff C stated they assisted her up and she immediately complained of pain, so Staff C assessed her and then sent her up to the ER at the Hospital. Staff C reported Staff A was a CNA from an agency. When Staff A turned around that's when the resident must have done something and she couldn't relay what it was but it resulted in the fall. Staff A didn't say anything about letting go of the gait belt, but she would have had to let go of the gait belt because Staff A was getting things out of	F 689		

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F 689	Continued From page 5 the dresser and it was far enough away that she would not have been able to keep a hold of the gait belt. 2. A MDS dated 2/16/23, documented that Resident #2's diagnoses included Alzheimer's, anxiety and depression. A BIMS documented a score of 11 out of 15, indicated the resident with moderately impaired cognition. Resident #2 required extensive assist of 2 for bed mobility and transfers. A Care Plan initiated on 9/1/22, had a self care deficit focus area with interventions that directed staff the resident was assist of 2 staff for bed mobility and was an assist of 2 staff for transfers with the EZ Stand. A Progress Note on 3/10/23 at 10:56 a.m., documented Staff B, CNA was assisting the resident with morning cares and as she turned her back to get the EZ stand and another CNA to assist, the resident rolled out of bed. The resident was found lying on her back in her room with her head up against the nightstand at 6:45 a.m. The Staff B called for help. The resident's leg was bent at the knee and tucked under her left leg. This resident did state that her leg hurt when asked. Staff D, Registered Nurse (RN) documented they did not attempt to move resident related to unknown injury. A call was placed for an ambulance. Assessment, neurological checks and vital signs were completed and were within normal limits (WNL). The paramedics and staff assisted to get this resident on to the cart and this resident was brought to the hospital. Vital signs were BP 140/84, P-90, R-20, O2 sat 97%, T 97.8 (F).	F 689		

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F 689	Continued From page 6 A Progress Note dated 3/10/23 at 2:17 p.m., documented that a call was received from the ER Nurse who stated that the resident had a right femur fracture and was being transferred to another hospital. A Progress Note dated 3/11/23 at 2:51 p.m., documented the writer spoke with the Hospital Staff, whom stated the resident had a full leg brace on at that time and was planning on having surgery for the right femur fracture the following day. A Discharge (DC) Summary (from the 2nd hospital) dated 3/16/23, documented the resident was admitted on 3/10/23 after a witnessed fall at her Care Facility. Her injuries were documented as right displaced 6 rib and possible 7-8 ribs, and right periprosthetic midshaft femur fracture (fracture of large leg bone above a knee replacement). The DC Summary documented Resident #2 had an open reduction internal fixation of the femoral shaft (surgery to fix severely broken bones). The DC Summary documented the resident was trying to get out of bed and fell to the ground resulting in the above fractures. The DC Summary also documented Resident #2 was initially evaluated at an outside hospital where a local Orthopedics Doctor was not comfortable managing, so Resident #2 was transferred to this hospital. On 4/5/23 at 2:21 p.m., Staff B, CNA, stated she was getting Resident #2 ready and dressed her in the bed. Staff B had the bed up to her waist level so that Staff B wasn't bending over or hurting her back or anything. The EZ Stand Lift was right outside the room. Staff B stated she probably	F 689		

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F 689	Continued From page 7 took 3 to 4 steps away from the bed to get to the EZ Stand. Staff B didn't want to bring all the equipment into the room so she left the EZ Stand out in the hall while Staff B did Resident #2's cares. When Staff B was getting Resident #2 dressed, Resident #2 was lying flat on her back in her bed. Staff B stated Resident #2 would roll pretty well in bed, it depended on the day. Staff B stated that Resident #2 would roll but you have to give her assistance or a little bit of a push to have her roll on to her side. Staff B stated that when using the EZ Stand Resident #2 could grab the bar with 1 hand. Staff B stated this resident was not a fall risk at the time. Staff B stated that Resident #2 sat up and flipped around and landed on the floor (when Staff B stepped away from the bed). Staff B stated she watched it happened but she couldn't do anything because Staff B had the EZ stand right in front of her (the EZ stand was between Staff B and the bed as she was pushing it into the room). Staff B stated the Nurse was right out there in the hall and asked what was that? In hind sight, Staff B stated she would have lowered the bed and/or she would have brought the EZ stand into the room instead of leaving it out in the hall. Staff B stated that anytime you are not at the bed the bed needs to be in low position. Staff B stated she had worked with Resident #2 quite a few times as having worked at the facility about a year and a half. Staff B stated that never would she have thought the resident would fall out of bed. On 4/6/23 at 2:24 p.m., Staff D, RN, stated that was her hall for the morning, so she knew the CNA's were getting Resident #2 ready for the day. Staff D stated she was 2 doors down (from Resident #2's room) and 1 CNA was in there (Staff B) and Staff D knew that the other CNA	F 689		

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F 689	Continued From page 8 was across the hall. Staff D stated she did not know where the EZ Stand was as Staff D wasn't with Staff B. Staff D stated the bed was up in a higher position and she heard the boom. Staff D stated she then heard Staff B yell for help. Staff D stated that it was obvious that something was wrong with Resident #2's right leg, just the way it was positioned, I didn't want to move her. Staff D stated she didn't know if the leg was dislocated or if there was a break in her hip or leg. Staff D knew Resident #2 required 2 staff for transfer, but did not know how many staff Resident #2 required while in bed. (per MDS Resident #2 required extensive assist of 2 for bed mobility). On 4/6/23 at 10:30, the Director of Nursing (DON), concurred residents' beds in low position before leaving the room, and keeping hold of the gait belt are standards of care and should be followed. She agreed that leaving the bed up further than the lowest position would need to be Care Planned specifically for a resident. The DON stated Staff B had stated that part of the reason Staff B left the EZ Stand out in the hallway was that Resident #2 liked to reach for the stand and Staff B did not want the resident to reach for the EZ Stand while Staff B was providing cares and getting resident ready in bed. Review of the Gait Belt policy updated on 10/2021, directed staff that gait belts were to be used on residents who could not ambulate or transfer independently for the purpose of safety. Review of the Fall Policy updated on 8/2022, directed staff that a Fall Assessment Review will be done with each MDS Assessment with interventions added at that time.	F 689		

Tag Cited: F-689
§483.25(d)(1)(2) – Accidents and Supervision

Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.

1. **Immediate action(s) taken for the resident(s) found to have been affected include:**

   Assessments and care plans for Resident(s) #1 and 2 were reviewed. If needed, revisions were made to reflect all current supervision and safety interventions. Any revised assessments and care plans were reviewed with staff involved in the care of each resident.

2. **Identification of other residents having the potential to be affected was accomplished by:**

   The facility has determined that all residents have the potential to be affected.

3. **Actions taken/systems put into place to reduce the risk of future occurrence include:**

   All staff will be in-serviced on keeping the resident environment as free of accident hazards as possible and ensuring each resident receives adequate supervision and assistance devices to prevent accidents.

   Nursing staff will observe residents to ensure appropriate supervision and implementation of safety interventions as documented on the plans of care.

4. **How the corrective action(s) will be monitored to ensure the practice will not recur:**

   The nursing management team will oversee assigned caregivers and residents to ensure appropriate supervision and interventions are implemented and that plans of care are followed. The Director of Nursing Services (DON), or designee, will complete random weekly chart audits for four (4) consecutive weeks. Care plans for residents will be reviewed to ensure that appropriate interventions have been put in place to reduce the risk of accidents.

   Findings of this audit will be discussed with the Resident Council.

   This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.

Corrective action completion date: 4/2/23.