STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165591	A. BUILDING _____ B. WING _____	C 12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPURGEON MANOR	1204 LINDEN STREET DALLAS CENTER, IA 50063

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F 000	INITIAL COMMENTS Correction date 12-26-2017 Investigation of facility-reported incidents #69023-I and #72511-I and mandatory report #70812-M resulted in deficiency. Investigation of facility-reported incident #72266-I did not result in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	As a result of the deficiency cited during the inspection of Spurgeon Manor ending December 1, 2017, the facility has prepared and submitted a Plan of Correction and credible allegation of compliance to your office. Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusion set forth on the statement of deficiency. This Plan of Correction is prepared and submitted solely because of requirements under state and federal law. This Plan of Correction constitutes my credible allegation of compliance. Spurgeon Manor respectfully requests that it be certified as having achieved substantial compliance as of December 26, 2017.	
F 223 SS=D	FREE FROM ABUSE/INVOLUNTARY SECLUSION CFR(s): 483.12(a)(1) 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to ensure the residents was free from abuse. The facility staff must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion for 2 of 6 residents. Staff B had alleged interactions with Resident #1 and	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cahill, Administrator — TITLE — (X6) DATE: 12-26-2017

POC accepted 12/27/17 VS. minnesota

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F 223	Continued From page 1 Resident #9 . The facility identified a census of fifty-four (54) residents. Findings include: 1. A Minimum Data Set (MDS) with a reference date of 5/12/17, assessed Resident #9 with a brief interview for mental status (BIMS) score of 9. A score of 9 identified the resident with moderate cognitive impairment. The MDS identified a behavior of wandering 4 to 6 days out of 7. The MDS did not identify verbal or physical behaviors or rejection of care. The resident required supervision with bed mobility, transfers, and ambulation. The resident required limited staff assistance with dressing, toileting and personal hygiene. The resident was frequently incontinent of bladder and occasionally incontinent of bowel. The resident had diagnoses that included dementia. A Care Plan with an onset date of 11/25/15 and in place on 4/27/17, identified the resident had trouble finding her room. The Care Plan directed staff to validate resident's thoughts and feelings when she gets confused or anxious, approach resident from the front in a calm unhurried manner and alert staff if resident wanders. Review of the Pocket Care Plan for CNAs (undated), revealed staff should give the resident verbal cues to help prompt the resident and validate the resident's thoughts and feelings when the resident gets confused or anxious. On 11/16/17 at 10:42 a.m. Staff C CNA (certified nurse aide) stated awhile back Resident #9 and Staff B CNA were in the resident's room before breakfast. When the resident came out of the	F 223	F223 Free from abuse Residents #1, Resident #9 and all residents will receive care with dignity and respect, free from abuse. The staff member who reported that another staff yelled at a resident was counseled and reeducated on resident abuse reporting on November 20, 2017. On December 21, 2017 during an all staff in-service, resident rights, abuse and mandatory reporting were reviewed with all staff. In addition, staff are provided with this information upon hire and annually at minimum. To ensure ongoing compliance, a new position has been created, Nursing Services Coordinator, to audit competencies and adherence to policies.	

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F 223	Continued From page 2	F 223		

room, she appeared agitated and identified Staff B as mean and hurt her. About 10 minutes later, Staff C took the resident to the bathroom and noticed blood on the resident's sweater. There was a skin tear on the resident's right arm. Later that day, the resident's hand looked bruised. Staff C reported the incident immediately to Staff D LPN (licensed practical nurse). Staff B and Staff C wrote statements regarding the incident at that time.

Staff C's written statement dated 4/27/17, revealed Staff C documented the resident was very combative before breakfast when Staff B tried to dress the resident. Staff C observed the resident wandering and trying to find her room so Staff C took the resident to her room and the resident said she needed the rest room. As they left the room, the resident told Staff C a girl was being mean and pulled her clothes away from her and hurt her. The resident then pulled up her sleeve and Staff C noticed a bleeding skin tear. The resident identified Staff B as causing the skin tear and stated Staff B hurt her and the resident didn't like her and keep her away from me. The resident kept repeating this information. Staff C then told Staff D who applied a bandage. On 11/21/17 at 1:23 p.m. Staff C confirmed the resident pointed at Staff B and identified Staff B as the one that hurt her and caused the skin tear. Staff C immediately reported what the resident said to Staff D who had staff write statements.

Staff B's written statement dated 4/27/17, revealed Staff B entered the resident's room around 7:25 a.m. and found the resident on the toilet without clothes on. The resident stated she did not want clothes on. Staff B got clothes from the closet and walked to the bathroom and began

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F 223	Continued From page 3 trying to dress the resident. The resident became combative telling Staff B to stop tearing at her clothes and she was hurting her. The resident then tried to leave the room without clothes on so Staff B stopped the resident and told her she would have to get dressed. The resident slapped Staff B's arm and told her to go away. Staff B got clothes from the bathroom and the resident kept running from Staff B. Staff B then put the resident's top on by placing the resident's top over her head and the resident put her arms through the sleeves. Staff B followed the resident pulling up her pants. Staff B documented she did not notice the skin tear during that time. Ten minutes later, Staff C CNA noticed the skin tear when she assisted the resident to the bathroom. Staff B stated the only thing she could think of that may have caused a skin tear was when the resident sat on the toilet and tried to hit Staff B. The resident's arm may have hit the bar by the toilet. Departmental notes dated 4/27/17 at 11:15 a.m. and documented by Staff D LPN (licensed practical nurse), revealed during morning care at 7:30 a.m. the resident stood in the middle of the bedroom without clothes on. As the nurse aide assisted the resident to get dressed, the resident yelled she didn't want to get dressed and slapped at the nurse aide. The resident needed the bathroom and was resistive to the bathroom. Once the resident got dressed, staff assisted her to the breakfast table. Departmental notes dated 4/27/17 at 11:18 a.m., revealed the resident did not sit at the breakfast table long, when she needed to use the bathroom (a little after 8 a.m.) Staff observed a 1.2 centimeter (cm.) linear superficial skin tear with a small amount of clear red drainage. Staff cleansed the area and applied	F 223		

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F 223	Continued From page 4 steri- strips. Review of Departmental notes did not identify any other skin tears from 1/1/17 to 11/16/17. On 11/21/17 at 8:37 a.m. the Administrator said they did not report the incident to the State agency because Staff D LPN stated anyone that took care of the resident at that time was the "bad guy" so no one ever suspected anything. 2. A MDS with a reference date of 7/28/17 assessed Resident #1 with a brief interview for mental status (BIMS) score of "1" (severe cognitive impairment). The resident could only recall one of 3 words spoken to her. The resident had verbal and physical behaviors and rejection of care 4 to 6 days out of 7. The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The resident was frequently incontinent of bladder. The resident had diagnoses that included: Alzheimer's disease and anxiety. A Care Plan dated 3/9/17 identified the resident with advanced dementia with behaviors and the need for staff assistance with ADLs (activities of daily living), grooming, bathing and all other cares. The Care Plan directed staff to: encourage to do as much as she can for herself, approach in a calm unhurried manner using a calm tone of voice and using slow simple speech and movements, offer the resident choices, reassurance and praise to enhance mood and affect. The Care Plan also identified the resident with a problem of late onset Alzheimer's and behaviors. The resident had no long or short term memory and needed staff assistance/direction to	F 223		

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F 223	Continued From page 5	F 223		

manage cares and routines. The resident also had problems at times effectively communicating needs. The Care Plan directed staff to: approach the resident warmly and positively from the front to address her or assist her with cares or conversation, refocus resident behaviors/conversation when resident had anxiety or aggression, reapproach at a later time if resident cannot focus, explain in simple language each activity/care procedure prior to beginning it and allow resident time to do as much as possible for self, praise resident for appropriate verbal response and behaviors, try to keep routine simple and consistent as is possible.

Review of the Pocket Care Plan for CNAs (undated) revealed the resident did better with fewer people for cares if possible; the resident liked singing with cares sometimes and staff should approach in a calm unhurried manner.

On 11/16/17 at 3:05 p.m. Staff A, CNA (certified nurse aide) stated she heard Staff B CNA tell Resident #1 to shut up about a month before Staff B CNA left employment at the facility. After Staff B told the resident to shut up, the resident just kept on being verbally and physically combative. Staff A did not report the incident.

On 11/12/17 at 2:05 p.m. Staff I CNA stated she worked the evening shift on 8/2/17 with Staff B and after supper they assisted Resident #1 get ready for bed. The resident was verbally combative and irritated. Staff B worked a double shift that day. They hooked the resident to the EZ stand and the resident screamed. They removed the resident's shirt and Staff B held a handful of the resident's shirt over the resident's nose and mouth with the other hand behind the resident's

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head holding it so the resident could not get away. The resident continued screaming in the shirt. While Staff B held the shirt over the resident's nose and mouth, the resident tried to get away and bite the shirt. Staff B held the shirt over the resident's nose and mouth for 30 seconds or less but Staff I stated it "felt like 15 minutes" . The resident's face was red, not due to suffocation but to muffled screaming. The resident's face became less red when Staff B removed the shirt. The resident continued to scream. Staff I identified Staff B as irritated and told the resident to "Shut up", "You should not be screaming" and "Why do you always yell". Staff I thought the incident was abuse. She stated she did not report it until about 4 hours later when she called the DON (Director of Nursing) at home about the incident. Prior to the incident, Staff I said Staff B would sometimes egg the resident on. When asked how staff should care for the resident if the resident appeared agitated, Staff I stated the resident would sometimes respond to music if staff sang to the resident or if staff turned the radio on. Staff would also try to talk to the resident. If staff left and came back later, the resident would become more agitated the longer she was up so reapproach was not effective.

Resident progress notes dated 8/2/17 at 7:29 p.m. revealed Staff J LPN documented the resident did not have behaviors that shift.

On 11/20/17 at 2:55 p.m. Staff J LPN stated she worked on another wing on 8/2/17 and she documented no behaviors because she spoke with the CMA (certified medication aide) that evening and the CMA informed her the resident did not have behaviors that shift.

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F 223	Continued From page 7 On 11/20/17 at 11:13 a.m. Staff K CMA stated no one reported anything to her about the incident or behaviors that night. She stated she had no idea she worked the evening of the incident. No one asked her about it. Observation and conversing with the resident on 11/15/17 at 11:25 a.m. the resident denied having trouble with anyone at the facility. The resident denied anyone placed anything over her mouth and nose. The resident identified the month as "Sunday", the year as "Monday" She stated she did not know the president's name or the town she was living in. On 11/20/17 at 1:12 p.m. observation identified 3 staff members assist the resident to the toilet. The resident became loud and verbally abusive during cares. Staff attempted redirection but it was not effective. The resident told staff to "Go to hell and get their ass out of here and leave the resident alone right now". The resident was quiet after staff completed cares. On 11/20/17 at 11:06 a.m., the Administrator stated Staff B's last day of work was 8/2/17. The facility's abuse policy identified the residents had the right to be free from verbal, sexual, physical and mental abuse neglect and mistreatment; corporal punishment; involuntary seclusion and misappropriation of property. Any allegation will be investigated promptly and thoroughly in order to protect the well-being of the residents.	F 223	F 323 Free of accidents Resident #12, Resident #10 and all residents have individual care plans addressing their care. Staff were educated immediately following the incident and again on December 21, 2017 during an all staff in-service, regarding the gait belt policy, use of the pocket care plan information and the need to document interventions that have been attempted or implemented onto the care plan. The Multidisciplinary Rounding (MDR) system was reevaluated to now include documentation of any additional interventions discussed during MDR.	
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3)	F 323		

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F 323	Continued From page 8 (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 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 observation, record review and staff interview, the facility failed to ensure the resident environment remained as free from accident hazards as possible; and each resident received adequate supervision and assistance devices to prevent accidents for 2 of 5 residents reviewed for supervision concerns. Resident #10 required staff assistance for ambulation. Prior to falling and sustaining injury on 11/17/17, staff observed the resident fail to use the call light and self-transferred. The facility failed to implement interventions to increase supervision based on	F 323		

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their knowledge that the resident failed to use the call light and made self-transfer attempts. Resident #12 fell and fractured her femur while staff failed to use a gait belt. The facility identified the facility census as fifty-four (54) residents. Findings include:

1. A Minimum Data Set (MDS) with assessment reference date of 9/15/17 assessed Resident # 10 with a brief interview for mental status (BIMS) score of 7. A score of 7 reflected the resident had a severe cognitive impairment. The resident had no behaviors identified including rejection of care. The resident required extensive staff assistance with bed mobility, transfers, ambulation, dressing and toileting. The resident had functional range of motion limitations in both lower extremities. The resident used a walker and wheelchair for mobility. The resident was frequently incontinent of bowel and bladder. The resident had diagnoses that included: dementia and stroke. The MDS indicated the resident had one fall without major injury since the prior assessment. A CAA (care area assessment) worksheet for falls identified the resident had no recent falls. The resident was at risk for falls related to generalized weakness, obesity and fluid retention causing heaviness and clumsiness of limbs. The resident also had some behaviors and resistance to care at times. The resident drug his feet during ambulation with FWW (front wheeled walker). The resident needed a lot of encouragement to walk and mobilize. The resident required extensive staff assistance of one to ambulate and a wheelchair for long distances.
A Care Plan dated 6/27/16 identified the resident with problem of a risk for falls. The Care Plan directed staff to wear nonslip soled shoes for

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F 323	Continued From page 10 transfers and ambulation, assistance of 1 for transfers and ambulation using gait belt and FWW (front wheel walker), remind the resident to use the pendant for assistance and not to try to get up on his own, monitor closely for episodes of weakness or lethargy and report to doctor and bring resident to the common area when he is yelling out in his room. Addendums dated 11/15/17 identified the physician reviewed and adjusted the resident's medications and 11/17/17 to keep walker in reach at all times when in room. A Pocket Care Plan for the certified nurse aides (CNAs) (undated) included the directive to bring the resident to the common area when the resident yelled out in his room. The Pocket Care Plan did not contain directive to increase supervision of the resident or interventions for self-transfers. Neither Care Plan identified a night time toilet plan. A fall occurrence report dated 11/17/17 at 5:15 a.m. revealed an unwitnessed fall in the resident room. The resident received the following skin injuries from the fall: Skin tear: right forehead above right eyebrow measuring 0.5 centimeters (cm.) with a dark purple bruise surrounding the skin tear and a 4 cm. by 3 cm. abrasion surrounding the skin tear. Skin tear: of the 5th finger of the right hand with purple bruise and 0.5 cm. skin tear at the base of the right 5th finger. Skin tear: of the 4th finger of the right hand with purple bruise and 0.5 cm. skin tear at the base of the right 4th finger and also bruising to the upper knuckle. Skin tear: of the 3rd finger of the right hand	F 323		

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F 323	Continued From page 11 measuring 1 cm. Bruise: of the right forearm reddish/purple bruise to the right upper forearm measuring 8 cm. in diameter. The fall occurrence report identified the intervention following the incident was "walker in reach at all times when in room." Departmental notes dated 11/17/17 at 7:44 a.m. and documented by Staff E LPN (licensed practical nurse) revealed identified at approximately 4 a.m. the resident rested quietly in his chair. At 5:15 a.m. a nurse aide called Staff E to the resident's room. Staff observed the resident lying face down on the floor in front of his chair. The resident stated he tried to stand up by self and fell. Staff rolled the resident to his side and then to his back and placed the Hoyer lift sling under the resident and then used the Hoyer lift to lift the resident into the wheelchair. Staff E checked the resident and found multiple bruises and skin tears. The resident sat with the nurse in his wheelchair for the rest of the shift. Departmental notes dated 11/20/17 at 3:40 a.m. revealed staff heard hollering and went to the resident's room. The resident had his legs kicked out of bed and the resident attempted to sit up on the side of the bed per self. Staff assisted the resident back to bed. The resident stated he was "peeing his pants" and wanted to go to the bathroom. Staff instructed the resident not to try and get up per self. Observation showed, on 11/20/17 at 12:50 p.m. the resident in a wheelchair assisted by staff. The resident stated he fell and hit the floor. The resident stated he hit his head and hand during the fall. Observation revealed a bandage to the	F 323		

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right hand/wrist area and a large bruise on the right forehead and eye. Steri strips covered a gash on the forehead. At that time, 2 staff transferred the resident with a gait belt to a recliner in the common area.

Prior self transfer attempts:

Departmental notes dated 11/12/17 at 6:24 a.m. and documented by Staff F LPN revealed staff observed the resident ambulating with his walker last night at 11 p.m. and staff attended to the resident stat [immediately] and redirected the resident to his room.

Departmental notes dated 11/15/17 at 10:54 p.m. and documented by Staff G RN (registered nurse) revealed the resident yelled on and off throughout the shift and got up from the recliner per self. Staff assisted the resident back to the recliner.

On 11/20/17 at 4:40 p.m. Staff G RN stated the resident did try and get up a couple times last week prior to the fall. Staff G also stated the resident did not reliably use the call light. Staff G stated she also found the resident in bed with his feet on the floor so she put the resident back to bed. When asked, the resident didn't know what he needed.

On 11/21/17 at 8:35 a.m. Staff F LPN (licensed practical nurse) stated she knew of one self transfer prior to the fall incident. The resident walked up the corridor to the dining room with a walker. Staff walked the resident back to his room. Staff F stated she charted the incident. She stated staff checked the resident every 2 hours and if the resident wants to use the toilet, they take him at that time.

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F 323	Continued From page 13 On 11/21/17 at 10:56 a.m. Staff E LPN stated the resident did get up on his own prior to the fall incident. On the night the resident fell, Staff E last saw the resident at 4 a.m. The night before Staff E caught the resident sitting on the side of the bed. Staff E stated she made frequent checks on residents by making minimum hourly checks. Staff E stated she always did this even before the resident got up on his own. The resident informed Staff E that he stood up and fell. She stated she didn't know when staff last toileted the resident but they generally take the resident a couple times through night at no particular time. On 11/21/17 at Staff H, CNA stated the resident tried to get up all week without using the call light. The resident also yelled at night that past week. Staff H stated he worked when the resident fell on 11/17/17. He stated he found the resident at 4:54 a.m. when staff was going to do last rounds. The resident started yelling and he found the resident on the floor in front of the recliner. He observed the recliner all the way up when he found the resident. The resident didn't know why he tried to get up. The resident also did not use the call light. He stated staff checks the resident every 2 hours. Information provided to the surveyor from the Administrator on 11/28/17 at 9:31 a.m., revealed a discussion in MDR (multidisciplinary rounds) on 11/20/17. The resident was in the recliner prior to the fall and attempted to take self to the restroom without pushing the call pendant. Staff felt the resident would benefit from having a walker available if he attempted to self-transfer without using a call light. Review of the Pocket Care Plan for Resident #10 from 11/21/17 to 11/27/17 did not reveal any	F 323		

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F 323	Continued From page 14 changes. Observation identified on 11/29/17 at 9:20 a.m. and 10:15 a.m. the resident asleep in a recliner in the common area. 2. A MDS with a reference date of 8/18/17, assessed Resident #12 with a brief interview for mental status (BIMS) score of "8" (moderate cognitive impairment). The resident had no behaviors including rejection of care. The resident required extensive staff assistance with transfers, ambulation, dressing, toileting and personal hygiene. A balance test during transitions and walking revealed the resident scored "2" in all areas of testing. A score of "2" identified the resident as not steady and only able to stabilize with staff assistance. A physical therapist (PT) discharge plan dated 3/13/17 identified the resident required assistance of one [staff person] for all functional mobility for safety. A Care Plan dated 2/15/17 identified the resident needed help with all areas of care. The Care Plan directed staff to ambulate the resident with assistance of one staff with walker and a gait belt in place. A Pocket Care Plan dated 11/26/17 identified the resident's transfer and mobility status as "1 assist". The Pocket Care Plan did not identify the use of a gait belt. A gait belt policy and procedures (undated) revealed gait belts should be used for all weight bearing and non-weight bearing residents who require:	F 323		

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F 323	Continued From page 15 Assistance with ambulation Assistance when getting in and out of bed Assistance with transfer to chair or toilet Assistance in repositioning resident already sitting in chair. Gait belts are to be used for ambulating residents who need assistance and for support during transfers. On 11/28/17 at 10:17 a.m. the Director of Nursing (DON) stated staff needed to use a gait belt when assisting residents unless it is care planned otherwise. On 11/29/17 at 12:37 p.m. the DON identified the gait belt policy as in place for at least 3 years. Departmental notes dated 11/27/17 at 6:50 a.m. and documented by Staff F LPN identified a nurse aide summoned her to the resident's bathroom at approximately 5:20 a.m. When Staff F arrived at the room, she observed the resident lying in the supine position on the floor with her back against the bathroom wall and a CNA with her. The CNA lowered the resident to the floor. Assessment revealed inner and outer rotation. The resident tolerated range of motion and said "ouch" once. The resident stated she was Ok and requested staff assist her up. Staff F and 2 CNAs transferred the resident with a gait belt from the floor to a standing position. The resident did not bear weight well. The resident sat in the wheelchair without difficulty. The facility notified the physician who directed staff to send the resident to the emergency room (ER) for an evaluation. The CNA informed Staff F that she assisted the resident to the toilet and the resident ambulated prior with the walker without difficulty. The resident fell forward during toileting when the resident attempted to pull up her night gown. She	F 323		

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F 323	Continued From page 16 then lost her balance and the CNA lowered her to the floor for safety. Staff Working the Night of the Incident: On 11/28/17 at 11:02 a.m. Staff F stated Staff L CNA lowered the resident to the floor because the resident lost her balance lifting her gown for toileting. When initially assessed, the resident did not have complaints. Upon further assessment, shortening and rotation was observed and the extremity appeared broken. The resident took some Tylenol (analgesic) and went to ER. Staff F stated she was not aware Staff L did not use a gait belt at the time of the fall until this morning. Staff F stated she didn't know why Staff L did not use the gait belt. She stated the resident does not refuse the gait belt. On 11/27/17 at 4:43 p.m. Staff L, CNA stated she worked 2 a.m. to 6 a.m. on the night of the incident. Other than peeking in the resident room, she stated she didn't see the resident that night until she got the resident up at 5:20 a.m. to use the toilet. The resident wore nonskid socks. Staff L helped the resident get up and walked with her to the toilet with her hands near the resident's hips. Staff L did not use a gait belt. She stated she never used one with the resident. She was not sure the resident was care planned for it. She stated she had access to Pocket Care Plans but she did not carry one that night. She stated when a Care plan says "1 assist" that means staff should use a gait belt. She stated the resident positioned herself in front of the toilet and started to pull up the night gown. She started leaning forward and Staff L tried to steady the resident but she kept going forward into the walker. The resident landed on the walker. The resident's	F 323		

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F 323	Continued From page 17 torso and arm hung on the walker and the resident's lower extremities were on the floor so Staff L helped the resident the rest of the way down. The walker didn't move. Staff L called for Staff F. The resident's leg was in a funny position. Staff F took the resident's vital signs and gingerly examined the leg. The resident could move the leg but it was angled weird and it looked broken. The resident said ouch. Another staff arrived and put a gait belt on the resident and they got the resident into the wheelchair. The EMTs (emergency medical technicians) came shortly after that. When asked if it would have made a difference if a gait belt was around the resident when the resident leaned forward, Staff L stated she would have been able to slow the resident's fall down a little more with a gait belt. Staff L CNA signed a form that verified she received orientation information on the gait belt policy. The form was undated. On 11/30/17 at 5:29 a.m. Staff N CNA stated she worked the night of the incident but was not in the room at the time of the incident. She stated she assisted Staff L to get the resident up from the ground. The resident's right leg/knee was bent and the resident repeatedly stated she thought it was broken. When the resident sat in the wheelchair she did not have pain. When she got on gurney for transport to the hospital, she did have some pain. On 11/28/17 at 10:30 a.m. Staff N stated she uses a gait belt when she transfers the resident as the resident allows. The need for the gait belt varies as some days the resident is sleepier than other days and the resident leans more. The CNAs carry the pocket care plans. Staff uses a gait belt on all 1 to 2 assist residents unless they don't want it or resist. When that happens, Staff N gets another staff. She knows	F 323		

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F 323	Continued From page 18	F 323		

about using gait belts through her CNA training, orientation and the care plan.

On 11/29/17 at 2:31 p.m. Staff O CNA stated she sat with the resident after the fall when the resident was in the wheelchair. The resident's leg was angled and the resident said she thought it was broken. Staff O stated she used a gait belt when she transferred or walked the resident. She stated the resident didn't refuse when she worked with her but she stated she had not worked with the resident much.

A hospital history and physical dated 11/27/17 at 6:15 p.m. identified the resident with a closed right mid-shaft femur fracture. Notes identified the resident underwent IM nailing of the right femur femoral shaft retrograde (surgery to repair the fracture) on 11/27/17.

Other staff:

On 11/29/17 at 12:01 p.m. the ADON stated she spoke with Resident #12's surgeon. The surgeon informed her there was no way to know if the fracture was from the fall or if the fracture occurred first causing the resident to fall. The surgeon did not return the surveyor's phone call.

On 11/28/17 at 3:25 p.m. Staff A CNA stated they usually use a gait belt when ambulating [walking] the resident. Staff A stated if the Pocket Care Plan says to use a gait belt then they use one. If it just says one assist, then they don't always use one.

On 11/28/17 at 3:20 p.m. Staff M CNA (hired 4/24/17) stated when she first started working at the facility, the resident didn't use a gait belt.

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F 323	Continued From page 19 Lately the resident has used one. Staff M stated she knows when to use a gait belt from the Care Plan. She asked about using a gait belt for a resident that was "so light she could put her arm around her to transfer". The surveyor asked if the resident's Care Plan indicated the resident required one person assistance and Staff M said yes. Staff M was informed it was her understanding that residents that required one assistance needed a gait belt. Past non-use of gait belt: A fax to the physician dated 10/3/17 at 10 a.m. revealed the resident stood holding onto the walker and then decided to sit down with no chair behind the resident. The resident landed on her bottom on the carpet and then rolled onto her back without apparent injury. A fall occurrence report dated 10/3/17 at 7:50 a.m. revealed the resident fell while ambulating with staff. The staff received education. On 11/28/17 at 1:30 p.m. the DON stated Staff P CNA did not use a gait belt and received education regarding the incident.	F 323		