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	165507	A. BUILDING _____ B. WING _____	C 08/24/2018

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VALLEY VIEW VILLAGE	2555 GUTHRIE AVENUE BUILDING C DES MOINES, IA 50317

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F 000	INITIAL COMMENTS 9/10/18 KK Correction date 8/30/18 The following deficiency relates to the investigation of facility reported incident #76844 & #77292 and complaint #77099. (See code of Federal Regulations (42 CFR), Part 483, Subpart B-C) Complaint #77291 was not 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 §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 clinical record review, facility policy review and staff interviews, the facility failed to ensure fall interventions planned were implemented in order to prevent accidents for two of five residents reviewed. (Resident #1 & #2) The facility census was 69 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/17/18, documented Resident #1 had diagnoses that included anemia, coronary artery disease and non-Alzheimer's dementia and required extensive assistance of one staff for bed	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/10/2018

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 689	Continued From page 1 mobility, transfers, ambulation, dressing, toilet use and personal hygiene needs. The MDS documented the resident used mobility devices of a wheelchair and walker. The care plan dated 5/3/18, identified the resident at risk for falls and safety risk related to falls. The care plan included the following approaches/interventions: a. 5/03/18 staff to use orthostatic hypotension precautions. b. 5/03/18 staff to place resident's personal belongings within easy reach. c. 5/03/18 staff to keep resident's room free of clutter. d. 5/03/18 staff to keep call light within reach for resident and encourage use of call light. e. 5/3/18 staff to assure the resident has proper fit and non-skid soles. f. After fall of 5/13/18 staff to place Dycem in resident's wheelchair. g. After fall of 5/16/18 staff to ensure resident is wearing gripper socks at bedtime. h. After fall of 7/17/18 staff to have physician do a medication review. i. After fall of 7/21/18 staff obtained x-ray's and resident sent to the hospital. An Event Report form dated 5/13/18 at 3:10 p.m., indicated the resident was found on the floor in front of the wheel chair when attempting to get up and slid out of the wheel chair. No sign or symptoms of injury. Fall was not witnessed. An Event Report form dated 5/16/18 at 12:30 a.m., indicated the resident was found sitting on the floor next to the bed and was incontinent of stool. No apparent injury observed. Fall was not	F 689		

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F 689	Continued From page 2 witnessed. Resident noted to have socks on and last time resident toileted at 10:30 p.m. Initial interventions to prevent another fall: gripper socks placed on resident. An Event Report form dated 5/23/18 at 5:40 a.m., indicated the resident was found lying on the floor in her room, fall was unwitnessed. Progress Notes dated 5/23/18 at 5:44 a.m., indicated the nurse overheard falling sound in resident's room, went immediately and found the resident lying on right lateral side on the floor with bleeding on the forehead. Nurse applied pressure using gauze and notify nursing staff for assistance. The physician was notified and ordered the resident to be transported to the emergency room for evaluation and treatment. At 2:35 p.m., facility received call from the emergency room reporting the resident would be transported back to the facility with stitches to the forehead and antibiotics prophylactic. Initial interventions to prevent another fall: will consult physician regarding edema in bilateral feet. An Event Report form dated 6/1/2018 at 8:58 p.m., indicated the resident was sitting on the edge of her wheel chair and slid out and fell to the floor in the dining room, fall was witnessed by staff. No injury noted. Initial interventions to prevent another fall: Dycem applied to the seat of resident's wheel chair and would have therapy for proper wheel chair. An Event Report form dated 7/17/18 at 11:00 a.m., indicated the resident was in the activity area and attempted to stand up and reach for an object when she fell to the floor, hitting her head on the table, fall was witnessed.	F 689		

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F 689	Continued From page 3 Progress Note dated 7/17/18 at 9:55 a.m., indicated bleeding noted from the residents forehead where bruise noted from previous fall, band aide applied, assessment completed and physician notified. Initial intervention to prevent another fall: would have resident's physician do a medication review. Contributing factors to help identify root cause of fall: staff reported to nurse of resident attempting to get up on own more frequently and being agitated towards staff and spouse. An Event Report form dated 7/21/18 at 2:00 p.m., indicated the resident was found on the floor in the common area, unwitnessed fall, resident at that time was all alone and unattended. No injury noted after fall. Resident had lunch and assisted with toileting after lunch and placed in the common area watching television What appears to be root cause of fall? Resident displaying increased fidgety behavior. Initial interventions to prevent another fall: x-ray obtained and sent to the hospital due to x-ray results. Progress Note dated 7/21/18 at 3:15 p.m., on call physician notified and received new order for x-ray. At 10:56 p.m., received order from physician to send emergency room. At 11:18 p.m., resident transferred to emergency room. A History of Physical dated 7/22/18, indicated assessment and plan for the resident included diagnoses of closed displaced fracture of right femoral neck, resident was not ready for surgery today, may be in a couple days to stabilize her medically.	F 689		

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F 689	Continued From page 4 Orthopaedic Progress Note dated 7/23/18, indicated the resident was not cleared for surgery and may never be a surgical candidate. Plan was for palliative care consult. Progress Note dated 7/24/18, indicated the resident was readmitted to the facility with Hospice care. The resident had a fracture that will not be surgically corrected. During interview on 8/7/18 at 9:35 a.m., Staff A, Certified Nurse Aide, CNA stated she worked 7 a.m. to 7 p.m. and was assigned to care for the resident. Staff A stated the night shift reported the resident was anxious most of the night and required 1 to 1 supervision to keep her from falling. Staff A indicated the resident was anxious and attempting several times to get up on her own throughout the day. Staff A reported the resident had been more anxious and attempting to get up on her own over the last couple weeks. Staff A stated she toileted the resident before lunch and around 2 p.m., took the resident to the common area and placed her at the table with another resident and they were watching television. Staff A stated the other CNA was on break at that time and Staff B, licensed practical nurse, LPN, was at the nurses station. Staff A indicated Staff B was aware the resident was sitting in the common area but did not recall if she said anything to her. Staff A stated the resident usually does better if she was sitting with other residents or staff in common area, less anxious. Staff A stated another resident needed assist to go to the bathroom right away and she left the common area and to assist resident. Staff A stated she was gone 3 to 4 minutes when she heard Staff B yell out and Staff A responded and observed the resident on the floor in the common	F 689		

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F 689	Continued From page 5 area about 2 feet away from her wheelchair. Staff A indicated after Staff B assessed the resident they assisted the resident up to her wheelchair. Staff A stated it was obvious the resident had pain as she was not bearing weight very well. Staff A stated she felt it would have been helpful if the resident was on one to one supervision. During interview on 8/16/17 at 8:37 a.m., Staff B, Licensed Practical Nurse, LPN indicated she worked 7 a.m. to 3 p.m., on 7/21/18 and was assigned to care for the resident. Staff B stated the resident was on one to one supervision most of the day and they kept the resident in sight. Staff B stated they try to have 3 CNA's and one nurse in the memory unit but were short and they pulled one of the CNA's to another area of the facility to work. Staff B stated she called her nurse manager and asked for additional staff due to resident's behaviors that day but was told they had no other staff to send to memory unit. Staff B indicated with only 3 staff members in memory unit it was hard to monitor the residents. Staff B stated around 2:00 p.m., the resident was sitting in the wheel chair in the common area, one CNA was on break, Staff A was assisting another resident and Staff B was at the nurses station. Staff B stated you cannot see the common area at the nurses station. Staff B stated she heard a resident yell out from the common area and immediately responded and found the resident lying on the floor of the common area. Staff B indicated she assessed the resident and initially did not note any injury, but after toileting the resident she noted the resident was having difficulty walking. Staff B stated she called the physician and received new orders for x-rays. During interview on 8/22/18 at 9:38 a.m., Staff E,	F 689		

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F 689	Continued From page 6 Registered Nurse, RN stated on 7/21/18 she pulled a CNA from the memory unit to cover another area of the facility due to a call in and it did leave the memory unit short staffed. 2. The MDS assessment dated 6/29/18, documented Resident #2 had diagnoses that included osteoarthritis, non-Alzheimer's dementia and delusional disorders, had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition and required limited assistance of one staff for bed mobility, dressing, toilet use and personal hygiene needs and required the assistance of two staff for transfers. Ambulation did not occur during the assessment period. The MDS documented the resident used mobility devices of a wheelchair and walker. The care plan dated 10/10/16, identified the resident had injuries related to falls, non-compliant at times with waiting for staff assistance and will transfer self. Approaches/interventions included: a. Staff to keep call light in reach at all times and personal items close within reach, and keep room free of clutter. b. Staff to educate me to use call light for staff assistance when need to go to bathroom; verbalize understanding. c. Staff to encourage me to use call light or bell for staff to pick up items on the floor. d. Staff to check bed to ensure appropriate height. e. Staff to assist with cares in am. f. Staff to assess footwear to ensure that they are	F 689		

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F 689	Continued From page 7 appropriate. g. Staff to ensure resident is wearing gripper socks at bedtime. h. Staff to ask resident when she prefers to get up in the morning and educate staff to get up when she wants to. i. After fall of 6/21/18 staff to transfer resident to shower and resident to have non-skid socks on, do not place a towel under feet. j. Staff to transfer resident with Hoyer lift and assist of two staff members until seen by physician. A Physical Therapy Note dated 3/7/18, indicated the resident was assessed to be at prior level of function consistent. Resident was safe to perform transfers with assistance of one. Resident can ambulate short distances with four wheeled walker and with assistance of one. Recommending wheelchair for other mobility, no physical therapy treatment not indicated at this time. An Event Report form dated 6/21/18 at 2:45 p.m., indicated the resident was found on the floor of the shower stall sitting on their buttocks with legs extended out and feet up against the shower stall wall and back resting on shower seat with towel on it which also slid down behind the resident preventing her back from getting scraped by the shower seat. A certified nurse aide, CNA was in the shower room with the resident and reported the resident's feet slid slowly out from underneath her, but the resident did not hit her head. Resident had been standing on a towel bare footed getting ready for a shower. Root cause of this fall: footwear. Initial intervention to prevent another fall: not to use towel underneath feet during shower, transfer resident with shoes on	F 689		

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F 689	Continued From page 8 then take shoes off when resident is sitting on shower chair. Progress Notes dated 6/21/18 at 2:45 p.m., indicated the resident was found on the floor in the shower stall in the room, CNA assisting the resident to take a shower, had towel underneath the resident's feet and feet started to slide out from underneath her, floor dry had not started shower, feet were up against the shower wall, did not hit head per CNA, resident denies dizziness/lightheadedness, resident assessed and head to toe assessment completed. Assist of 4 staff and gait belt to stand resident up on her feet, staff put tennis shoes on resident before standing resident, able to bear full weight with no problem, then assisted resident to wheel chair as resident no longer wanted to take a shower, assisted resident to dress. At 3:10 p.m., resident's family and physician notified. At 3:50 p.m., resident complained of pain to right ankle, slight swelling noted to area and slightly tender upon touch, Tylenol given as ordered for discomfort. At 4:05 p.m., new order received for x-ray of right ankle. Review of x-ray results dated 6/21/18, indicated the resident with an acute oblique distal fibula metadiaphysis fracture with one third shaft width lateral displacement the distal fibula. Progress Notes dated 6/21/18 at 9:10 p.m., indicated staff notified on call physician of the residents x-ray results and orders received to keep resident non-weight bearing and to call resident's physician in am to collaborate with orthopedics treatment plan.	F 689		

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F 689	Continued From page 9 Progress Notes dated 6/22/18 at 4:59 p.m., indicated the resident returned from orthopedic appointment. Resident to be non-weight bearing of right leg, cast in place to right lower leg, return for follow-up in 3 weeks. During interview on 8/16/18 at 11:07 a.m., Staff C, Certified Nurse Aide, CNA stated on 6/21/18 around 2:00 to 3:00 p.m., she was assisting the resident to take a shower. Staff C stated she took the resident to the shower room and resident always requested a towel to be placed on the floor for her to stand on. Staff C stated she placed the towel on the dry floor and assisted the resident to stand, using a gait belt and resident holding on to the safety rail in the shower, removed her clothing, when the resident started to slip on the towel. Staff C stated she lowered the resident to the floor and called the nurse for help. Staff C stated the nurse responded immediately and assessed resident and we assisted resident up and into wheel chair. Staff C stated the resident complained of a little pain, assisted resident to dress as she did not want to take shower. During interview on 8/16 & 8/22/18, Staff D, Registered Nurse, RN stated she was assigned to the resident on 6/21/18. Staff D stated she was summoned and found resident sitting on the shower floor with her back against the built in shower bench and feet out in front of her with feet up against the shower wall. Staff D stated the resident had no clothes on, no shoes on and no gait belt on. Staff D indicated the floor was dry as the shower was not started. Staff D indicated Staff C should have had shoes on resident and a gait belt before transfer. Staff D stated they had	F 689		

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F 689	Continued From page 10 to apply a gait belt to the resident to assist her up off the floor with assistance of 4 staff member. Staff D stated she assessed the resident prior to assisting her up off the floor and noted no injury initially until shortly after she complained of right ankle pain, tender to touch, and some swelling noted. Staff D reported she called physician and received order for x-rays. During interview on 8/22/18 at 9:38 a.m., Staff E, RN stated when staff transfer a resident that was an assist of one to two staff they are to always use a gait belt, even to transfer in shower. During interview on 8/22/18 at 9:51 a.m., Staff F, CNA stated she has given showers to the resident before and she always requested to have a towel placed on the floor for her to stand and transfer on and she would do this for the resident. Staff F stated the resident would refuse to wear her shoes to the shower room. Review of the facility's Transfer assist using transfer belt dated 8/14/18 indicated transfer belts will be used for all residents who require physical support for mobility or safety in transfers.	F 689		

F689-G

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.

It is the policy of Valley View Village to ensure that the Facility meets professional standards of care for our Residents, by following the comprehensive care plan.

To assure continued compliance, the following plan has been put into place:

1. Regarding cited resident: For Residents #2 and all similar residents' nonskid bath strips are to be added to all resident in room showers. Shower gait belts were added to resident's bathrooms that shower in their room. Nurses and CNA's were reeducated to ensure residents have appropriate footwear while transferring to the shower for resident's safety and to not place a towel on the ground when showering residents. For resident #1 and all similar residents the IDT falls team reviewed residents and determined if additional person centered care planning needed to be completed to fulfill all the resident's needs.

2. Actions taken to identify other potential residents having similar occurrences: Audit completed to determine which residents shower in their room vs the spa room. Will add additional shower gait belts and placed nonskid bath strips in all resident bathrooms.
   Reviewed care plans and care planned impulsiveness on each resident with person centered care interventions with appropriate interventions.
   Education provided to staff via in-service on August 26th and 28th.

3. Measures put in place to ensure deficient practice does not recur:
   Reeducation and continuing education to staff on proper transfers and interventions.

4. Effective implementation of actions will be monitored by:
   Director of Nursing or designees will audit resident showers bi-weekly for one month and then monthly to ensure that proper transfers are occurring. Care plans will be reviewed quarterly or at significant change to ensure proper and quality care is being provided.

5. Those responsible to maintain compliance will be:
   The Director of Nursing or designee is responsible for maintaining compliance in care plan The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time, the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued.

Completion date for certification purposes only is: 8/30/2018