STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165161	A. BUILDING _____ B. WING _____ 12·8·2015	C 10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

(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 Correction date 11/18/15 Investigation of complaint #55500-C and facility-reported incident #55644-I resulted in deficiency See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide adequate supervision to protect two (2) of five (5) residents from hazards (including environmental hazards) during transfers. On 10/3/15 staff transferred Resident #1 and let go of his/her gait belt to pull on the resident's oxygen tubing. Resident #1 fell forward and sustained pelvic fractures.Record review revealed Resident #1 required one staff to assist with transfers. The staff working with Resident #1 at the time of the fall revealed the resident's oxygen tubing was stuck at the door, too short, thus she let go of the resident's gait belt when the resident fell face forward. Observations showed staff did not follow	F 323		

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

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.

POC accepted 12/4/15

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F 323	Continued From page 1 Resident #2's care plan to maintain his/her safety. The facility reported a census of 103 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated 9/1/15 Resident #1 had diagnoses that included osteoporosis and chronic obstructive pulmonary disease. The MDS identified the resident required extensive assistance with bed mobility, transfers and toilet use. According to the MDS the resident required the use of a walker and wheelchair. The resident demonstrated moderate cognitive impairments with a score of 12 on the Brief Interview for Mental Status (BIMS). Review of the fall risk evaluation dated 8/5/15 revealed the resident had a score of 10. A total score of 10 or above represented a high risk. The fall assessment identified the following which put him/her at risk for falls: the assessment describe Resident #1 as incontinent, took medication(s) that could cause lethargy/confusion, and an infection as a predisposing disease. The care plan dated 9/2/15 directed staff to provide one person assistance with transferring and ambulation to the bathroom with a walker. The care plan identified the resident can become short of breath and used oxygen. The care plan identified Resident #1 as in need of assistance with all ADL's (activities of daily living) due to being so weak. The care plan describe the resident as incontinent of bladder at times. The resident took medications that may increase his/her risks for falls, and the resident used a wheelchair for long distances.	F 323		

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F 323	Continued From page 2 Record review identified an incident of Resident #1 being lowered to the floor on 9/21/15. According to the Review of the Change in Condition Report-Post Fall/Trauma form dated 9/21/15 at 1:15 a.m., revealed staff assisted the resident to the bathroom with the front wheeled walker and gait belt. The resident suddenly stopped stepping his/her feet and turned pale and leaned into staff. The resident responded verbally but struggled saying words for less than 1 minute. The resident's speech slurred and staff called for another staff member who came and staff lowered the resident carefully to sit on the floor. A progress note dated 9/22/15 documented the physician suggested to notify the cardiologist regarding the syncope that he/she has been having. A progress noted dated 10/2/15 at 11:30 a.m., identified the resident had returned from a doctor appointment due to complaint of urgency and urge incontinence. Review of the Change in Condition Report-Post Fall/Trauma dated 10/3/15 revealed the nurse called to the room and entered and found the resident on the floor. The resident's feet out in front of him/her and he/she hit his/her bottom lip with slight bleeding noted. The resident alert and Nero's had been regular. Range of motion done with complaints of pain in the right hip. No external rotation of the hip noted. The resident had a gait belt on when the nurse entered the room and the walker had been in the bathroom. A Hoyer lift used to lift the resident off of the floor with the assistance of the nurse and 2 CNAs (certified nursing assistant). The resident transferred to the emergency room.	F 323		

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F 323	Continued From page 3 Review of the Diagnostic Radiology Report dated 10/3/15 revealed the resident had a fracture of the superior and inferior rami of the right pubic bone with minimal displacement. Review of the progress notes dated 10/3/15 at 6:03 p.m. revealed the nurse had been called to the resident's room at 1:45 p.m. The nurse entered the room and the resident laid with his/her feet in front of him/her and the head against the floorboard in the bathroom. Staff had stated that she had been assisting the resident to the bathroom and he/she went down hitting their face. The resident had not been laying in a prone position (face down) when the nurse entered the room. The resident had a cut on the lower lip. An assessment had been done and the resident complained of right hip pain. No external rotation of the right foot had been noted. The resident did not complain of groin pain. Neurological checks started and had been in the normal range. The nurse asked the resident if staff had been holding onto him/her went toileting and the resident stated no. A gait belt was around the resident's waste. The resident had socks on without shoes. The staff transferred Resident #1 [up from the floor] using a Hoyer lift. An order received to transport the resident by ambulance to the hospital. At 2:45 p.m., the resident transported to the hospital. The progress notes revealed the resident had been readmitted to the facility per ambulance on 10/5/15. Progress Notes dated 10/6/15 revealed the resident admitted to skilled for PT/OT (physical therapy/occupational therapy) following a pelvic fracture. The progress note identified the resident had not been out of bed since he/she	F 323		

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F 323	Continued From page 4 went to the hospital. Staff D's nursing assistant orientation checklist reveal she had been educated on 8/13/15 regarding ambulating and transfers with one assist/transfer belt [gait belt]. An interview with the Administrator on 10/27/15 at 1:30 p.m., revealed she Staff D was no longer employed at the facility. During an interview with Staff D, CNA on 10/28/15 at 9:20 a.m., she stated that she assisted the resident to the bathroom. Staff D reported it was a crazy day. The resident had a gait belt and the walker. The resident ambulated to the bathroom and the oxygen tubing was stuck right at the door. The residence head bobbed and had resistance with the oxygen tubing. Staff T had her left hand on the resident's left hip. She took her right hand and pulled at the oxygen tubing. Staff T reported she did not think the resident could be without the oxygen, and ever time she saw the resident, he/she had oxygen on. The oxygen tubing had been too short and the concentrator came towards her when she pulled on the tubing. The resident then fell face forward to the floor. Staff T also stated that she had been trained and had always used the gait belt. She could not say why she used the same hand to move the tubing. Staff D reported she could not say why her hand had not been on the gait belt. Review of the document identified as the policy for gait belt usage (not dated) directed staff that it is the policy and expectation that a gait belt be used when transferring or ambulating residents who are care planned to be assisted.	F 323		

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F 323	Continued From page 5 2. According to the MDS dated 8/2/15 Resident #2 had diagnoses that included osteoarthrosis, cerebral vascular accident and dementia. The MDS identified the resident required extensive assistance with bed mobility, transfers and toilet use. According to the MDS the resident not steady and only able to stabilize with staff assistance when moving from a seated to standing position, moving on and off the toilet and surface to surface transfer. Review of the fall risk dated 8/3/15 revealed the resident had a score of 12. A total score of 10 or above represented a high risk. The care plan dated 1/9/15 directed staff to provide assistance with toileting. On 4/1/15 the care plan updated to direct staff to not leave the resident alone in the bathroom and for staff to stay with the resident until done. Observation on 10/28/15 at 9:10 AM revealed Staff B, CNA assisted the resident to the bathroom for toilet use. Staff B moved away from the bathroom and bathroom door. She went to the sink area and moved a few items in the room. She had not been in visual contact of the resident during that time. Staff B then moved to the bathroom door and assisted the resident with cares. Staff B removed her hands from the resident's gait belt and pulled up the resident's brief and pants. Observation on 10/28/15 at 11:55 a.m. revealed Staff F, CNA assisted the resident to the bathroom. Staff remained in the door way of the bathroom. Staff assisted the resident with cares and removed her hands from the gait belt and	F 323		

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F 323	Continued From page 6 removed her gloves. She then pulled the resident's brief and pants up without hands on the gait belt. Observation on 10/28/15 at 4:45 p.m. revealed Staff G, LPN (Licensed Practical Nurse) assisted the resident to the bathroom for toilet use. Staff left the bathroom and remained in the residence personal room. Staff completely shut the door and had not been able to visualize the resident. Staff then assisted the resident with cares and then removed her hands from the gait belt to pull up the resident's brief and pants. During an interview with Staff E, LPN, Unit Manager, on 10/29/15 at 8:45 AM she stated that if a resident had been care planned to not be left alone while toileting she would expect staff to be able to see the resident. Staff should not shut the door to the bathroom. She also stated that she expected staff to have one hand remain holding the gait belt on the resident. Staff may use the other hand to replace the resident's brief and pants. If the resident able, they may be able to assist pulling up their brief and pants or staff may need to have another staff member's assistance.	F 323		

F 323—Free of Accidents

Correct Deficiency as they relate to the individual
Resident #1 care plan changed to be assist of 2 for toileting transfer.
Resident #2 care plan changed to be assist of 2 for toileting transfer.

Protect Residents in Similar Situations
All residents requiring assistance with toileting will be assessed for assistance needed with clothing article and personal hygiene during toileting task. Also residents will be assessed for bed side donning of pants.

Systems we will alter to assure the problem does not recur
Education is provided to all nursing staff regarding proper use of gait belt with transfers.

Plan to monitor performance to make sure that solutions are permanent
The DON or designee will audit proper use of gait belt with transfers and toileting according to this schedule:
8 Gait Belt Transfers a week for 2 weeks and then
4 Gait Belt Transfers a week for 4 weeks and then
4 Random Gait Belt Transfers every month x 90 days

Audits will be shared with the facility's QAPI committee for input on the need to increase, decrease, or discontinue the audits.

Date of Correction: 11/18/2015