STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165548	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARBOR SPRINGS OF WEST DES MOINES L L C	**7951 E P TRUE PARKWAY WEST DES MOINES, IA 50266**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility staff failed to report an incident of neglect and immediately segregate the alleged perpetrator for one of five residents reviewed (Resident #2 and Staff A). On 6/16/20, Staff A ambulated Resident #2 without the use of a gait belt, contact guard assistance or with a wheelchair following the resident which resulted in the resident falling and suffering injuries related to the fall. Staff conducted an internal investigation but did not report the allegation to the state agency or segregate the staff member from residents, as directed by their Abuse Prevention policy. The facility identified a census of 42 current residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 had [DIAGNOSES REDACTED]. The assessment documented she required the assistance of one staff during transfers and while walking. Resident #2 showed unsteady balance while walking, could stabilize only with the assistance of staff and used a walker and a wheelchair as mobility devices. The MDS also documented she had a fracture related to a fall within the last 6 months, but no falls since the prior MDS assessment. Resident #2's Care Plan, updated on 4/15/20, instructed she required the assistance of one staff for transfers and ambulation, using a front-wheeled walker. The resident should have a wheelchair for transport for longer distances and staff must push it. On 4/15/20, staff added the intervention to follow Resident #2 with a wheelchair for all ambulation. On 6/16/20, staff updated the care plan to instruct the assistance of 2 with a stand/pivot transfer and not walk the resident at this time per therapy. On 7/1/20, staff were directed to use a gait belt at all times and provide the assistance of one to stand/pivot transfers from the wheelchair, recliner, toilet and bed only. A Fall Scene Investigation form dated 6/16/20 at 8 am documented Resident #2 had an intercepted fall, she lost strength and appeared to get weak while walking. The investigation form documented staff lowered the resident to the floor and the care plan was being followed. The form documented she suffered no injuries. A Fall Summary dated 6/17/20 documented Resident #2 was careplanned to have a wheelchair follow with all ambulation. Staff A, CNA/CMA (certified nursing assistant/certified medication aide) ambulated the resident with no wheelchair follow and no gait belt. The resident's legs gave out and she fell face forward onto the floor. The resident had no initial complaints. However, later in the shift she had significant [MEDICAL CONDITION] and bruising to the left knee. An X-ray was done without fracture or injury noted. The CNA was given a written immediate education regarding following the care plans. The Assistant Director of Nursing (ADON) completed the Fall Summary and also obtained witness statements related to the fall. The witness statements obtained at the time revealed Staff A did not place a gait belt on the resident during ambulation nor did she use a wheelchair to follow behind the resident. Witnessing staff included Staff C, CNA and Staff D, CNA. The Fall Scene Investigation form documented the resident had no injuries following the fall. However, Resident #2's Skin Condition Forms documented the following injuries noted on 6/17/20: a. A dark purple bruise to her left thumb, measuring 2 x 2 centimeters (cm) documented as healed on 6/3/20. b. Two dark purple bruises to her left bicep, one measuring 6 x 8 cm and the second measuring 2 x 3 cm. Both bruises were documented as healed on 7/8/20. c. A light reddish purple bruise to the left shin, measuring 4 x 4 cm, documented as healed on 7/8/20. d. A dark purple bruise to her right elbow, measuring 6 x 3 cm, documented as healed on 7/8/20. A Skin Condition Report dated 6/30/20 documented the resident's left knee now had a dark hard scab measuring 5 x 4 cm. On 7/6/20, staff documented the presence of 3 eschar/dry scab open areas measuring 4 x 5.5 cm, 1.5 x 2 cm and 2.5 x 3 cm. On 7/13/20, staff documented the areas measured 3.5 x 5.5 cm, 1 x 2 cm and 1.5 x 2.5 cm with a dark brown wound bed and no redness. The facility's Abuse Prevention policy revised 4/1/17 defined neglect of dependent adult as deprivation of the minimum food, shelter, clothes, supervision, physical or mental care or other care necessary to maintain a dependent adult's life or physical or mental health. The policy also directed that upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee this will be accomplished by separating the employee accused of abuse from all residents, either through suspension, segregation or separation. The policy also instructed that allegations of resident abuse shall be reported to the Department of Inspections and Appeals no later than two hours after the allegation is made (the facility did not report the allegation to the Department). During interview on 7/15/20 at 3 pm, the ADON stated when doing Resident #2's fall investigation, did not think it to be a possible abuse case. The ADON stated Staff A made a really bad decision without intent to hurt the resident. During interview on 7/22/20 at 1:20 pm, Staff C stated she did not think Resident #2's fall was a case of abuse. The fall was public and Staff C did not see Staff A push the resident. During interview on 7/22/20 at 1:30 pm, Staff D stated she had no thoughts that Resident #2's fall was abuse, just a bad accident. Review of Staff A's time records revealed she worked on 6/16/20 from 6:05 am until 8:44 pm. On 6/17/20, Staff A worked from 6:05 pm until 2:20 pm. Review of Staff A's personnel file revealed a Disciplinary Action Form dated 6/17/20 documenting termination from facility employment as a result of absenteeism/tardiness.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, facility document review and staff and physician interviews, facility staff failed to ensure a resident received transfer assistance as directed by her care plan and facility directives for one of five residents reviewed (Resident #2). On 6/16/20, Staff A ambulated Resident #2 without the use of a gait belt, contact guard assistance or with a wheelchair following the resident which resulted in the resident falling and suffering injuries related to the fall. The facility identified a census of 42 current residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 had [DIAGNOSES REDACTED]. The assessment documented she required the assistance of one staff during transfers and while walking. Resident #2 showed unsteady balance while walking, could stabilize only with the assistance of staff and used a walker and a wheelchair as mobility devices. The MDS also documented she had a fracture related to a fall within the last 6 months, but no falls since the prior MDS assessment. Resident #2's Care Plan, updated on 4/15/20, instructed she required the assistance of one staff for transfers and ambulation, using a front-wheeled walker. The resident should have a wheelchair for transport for longer distances and staff must push it. On 4/15/20, staff added the intervention to follow Resident #2 with a wheelchair for all ambulation. On 6/16/20, staff updated the care plan to instruct 2 staff to assist the resident with a stand/pivot transfers and not walk the resident at this time per therapy. On 7/1/20, staff were directed to use a gait belt at all times and provide the assistance of one to stand/pivot transfers from the wheelchair, recliner, toilet and bed only. A Fall Scene Investigation form dated 6/16/20 at 8 am documented Resident #2 had an intercepted fall, she lost strength and appeared to get weak while walking. The investigation form documented staff lowered the resident to the floor and staff followed the care plan. The form documented

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.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) she suffered no injuries. A Fall Summary dated 6/17/20 revealed Resident #2 careplanned to have a wheelchair follow with all ambulation. Staff A, CNA/CMA (certified nursing assistant/certified medication aide) ambulated the resident with no wheelchair follow and no gait belt. The resident's legs gave out and she fell face forward onto the floor. The resident voiced no initial complaints. However, later in the shift she had significant [MEDICAL CONDITION] and bruising to the left knee. An X-ray was done without fracture or injury noted. The CNA received a written immediate education regarding not following the care plans. The Assistant Director of Nursing (ADON) completed the Fall Summary and also obtained witness statements related to the fall. The witness statements obtained at the time revealed Staff A did not place a gait belt on Resident #2 during ambulation nor did she use a wheelchair to follow behind the resident. The Immediate Education and Correction Required form contained in the fall investigation documented Staff E, LPN (licensed practical nurse) educated Staff A the resident needed a wheelchair follow for all ambulation, Staff A did not follow the care plan and this resulted in the resident falling. The Fall Scene Investigation form documented the resident had no injuries following the fall. However, Resident #2's Skin Condition Forms documented the following injuries noted on 6/17/20: a. A dark purple bruise to her left thumb, measuring 2 x 2 centimeters (cm) documented as healed on 6/30/20. b. Two dark purple bruises to her left bicep, one measuring 6 x 8 cm and the second measuring 2 x 3 cm. Both bruises, documented as healed on 7/8/20. c. A light reddish purple bruise to the left shin, measuring 4 x 4 cm, documented as healed on 7/8/20. d. A dark purple bruise to her right elbow, measuring 6 x 3 cm, documented as healed on 7/8/20. Resident #2's Health Status Notes documented the following: a. 6/16/20 at 3:55 pm - She had no visible signs of discomfort at the time. Her left knee to upper thigh showed swelling and discoloration. She could move the knee and staff applied ice. b. 6/16/20 at 4:32 p.m. - Staff spoke with the resident's physician who ordered a 3-view X-Ray to her left knee. c. 6/17/20 at 6:16 am - Resident #2 had increased swelling to her left knee and it remained bruised from the fall. d. 6/18/20 at 6:13 - The resident's left knee remained swollen and bruised and painful to touch per the resident. e. 6/18/20 at 9:41 pm - Her left knee/thigh remained at various stages of healing. The knee remained slightly swollen. f. 6/22/20 at 8:05 am - Resident #2's left knee had a water filled blister measuring 3 x 3 cm. The knee was swollen, red and painful to touch. Staff contacted her physician who ordered a second portable X-ray. A Skin Condition Report dated 6/30/20 documented the resident's left knee now had a dark hard scab measuring 5 x 4 cm. On 7/6/20, staff documented the presence of 3 eschar/dry scab open areas measuring 4 x 5.5 cm, 1.5 x 2 cm and 2.5 x 3 cm. On 7/13/20, staff documented the areas measured 3.5 x 5.5 cm, 1 x 2 cm and 1.5 x 2.5 cm with a dark brown wound bed and no redness. X-ray reports dated 6/16/20 and 6/22/20 documented no evidence of fracture. Review of Resident #2's Medication Administration form for 6/20 documented she received as needed [MEDICATION NAME] medications on 6/20/20 (Tylenol and [MEDICATION NAME]) and 6/30/20 (Tylenol). The resident received routine administration of Tylenol, a [MEDICATION NAME], [MEDICATION NAME] and [MEDICATION NAME] for chronic pain per physician's orders [REDACTED]. The resident had a history of [REDACTED]. She likely had [MEDICAL CONDITION] disease on top of the trauma, which caused a significant eschar. The physician documented resolving ecchymoses (bruising) below the left knee. The wound is now significantly smaller with healing in the central aspect, dry eschar that is unstageable and with the edges dramatically improved in terms of turgor and skin growth. Assessment revealed left knee presumptive [MEDICAL CONDITION] and family requests to go to a wound center. Interview with the physician on 7/22/20 at 10:25 am revealed he did not know if the open area to the resident's left knee would have occurred without the trauma. She had a left knee replacement and COVID-19 three - four months prior. It was likely the knee would have had less swelling without the coagulopathy from COVID-19. The resident had a remarkable amount of swelling. The physician did not think the wound was a deep tissue injury. A wound consult report dated 7/14/20 documented the resident was seen for a wound on the left knee which had been present since a fall 6/16/20. She had Covid 5/9/20. The wound originally started as a blister and stayed about the same. treatment for [REDACTED]. She had a X-ray, but notes from nursing home indicate it was negative for fracture and she saw the PCP the next day. Wound care included application of [MEDICATION NAME] paint. The clinician did not recommend debridement at the time. On 7/22/20 at 10:25 a.m. the resident's physician stated he did not agree with the 7/14/20 [MEDICATION NAME] order. Review of physician orders [REDACTED]. Review of the July 2020 treatment administration record revealed the facility implemented the orders as the physician directed. Observation on 7/14/20 at 9:55 at the facility revealed Resident #2 sat in the recliner in her room with wound care beginning by a CMA. The resident's left knee showed 3 areas of black eschar measuring approximately 4 x 2 cm. The entire knee appeared swollen and greenish in color. On 7/14/20 at 9:35 am, Staff B, Cook stated on 6/16/20 during breakfast, she saw the resident on the floor after she fell . Staff B stated the resident was not wearing a gait belt when she saw her laying on the floor. Staff A then ran and got a gait belt and placed it on the resident while she lay on the floor. Staff B then saw and heard Staff A call the nurse for help on the walkie-talkie and Staff B returned to her duties. During an interview at the facility on 7/14/20 at 11:15 a.m., Staff C, CNA stated on 6/16/20 she worked in the kitchen during the resident's fall and it was the first time she'd worked on Resident #2's neighborhood. Staff C stated Staff A insisted on getting the resident up. She saw Staff A walk the resident out of her room without use of a gait belt and without a wheelchair following behind the resident. Resident #2 fell while Staff A walked beside her; she did not see Staff A touching the resident while the resident ambulated. The resident went face down, hit her face and glasses but did not have injury to her face. The resident complained of pain to her left knee later and the knee appeared swollen and bruised up; Staff A told Staff C later in the shift that the resident might have hit her knee, but Staff C did not see that. During the interview, Staff C wore a gait belt draped over her shoulder; she stated she uses a gait belt whenever she walked with any resident. Staff C concluded that she didn't know Resident #2 could walk as she sat in the wheelchair the times she had seen her. During a re-enactment of the fall with Staff C on 7/16/20 at 10:30 am, she stated and demonstrated she saw the fall from the kitchen window. Staff C saw Staff A walk to the right of the resident, without touching her, without use of a gait belt and without a wheelchair following behind. The resident pushed a walker; her legs gave out, she fell straight down and did not hit the walker. Staff C repeated she saw Staff A put a gait belt on the resident before the nurse arrived. Staff C concluded that she normally worked on the Evergreen neighborhood and she's been trained to always use a gait belt while walking with a resident During a phone interview on 7/14/20 at 5:50 pm, Staff D, CNA stated she made breakfast in the kitchen on 6/16/20 when she saw Staff A walk Resident #2 out of her room. Staff D stated she knew the resident should walk with a gait belt and with a wheelchair following. Staff A did not use a gait belt or a following wheelchair while walking with the resident. Staff D stated she did not see the fall because it happened so fast; the resident was just on the floor. Staff D concluded that staff uses gait belts whenever staff walk residents. During a phone interview on 7/14/20 at 6:30 p.m., Staff E LPN stated on 6/16/20, she remembered Resident #2 assisted with a gait belt and lowered to the floor. However, her injuries were not consistent with being lowered to the floor. Then other witnesses came forward. They learned that Staff A did not lower the resident to the floor and she landed pretty hard on her left knee. Resident #2 did not have swelling or open areas to the left knee and no complaints of pain initially. The resident complained of left knee pain near the shift change from days to evenings; the evening shift nurse assessed the knee further and an X-Ray was done. Staff E stated the resident walked with physical therapy after the fall and her knee seemed to get worse as time went on. Staff A informed Staff E at the time of the fall the resident was really strong during care that morning, so Staff A decided to walk her. When Staff E saw the resident, she wore a gait belt, a walker nearby and no wheelchair. Residents, including Resident #2, should wear a gait belt with all transfers. The next day, Staff E stated she learned that others saw Staff A get a gait belt and put it on Resident #2 while she lay on the floor. Staff E stated she educated Staff A on following care plan direction for transfers after the fall on 6/16/20. During interviews at the facility with the Administrator and Director of Nursing on 7/15/20 beginning at 11:30 am, both stated they did not know of staff statements that Staff A put a gait belt on Resident #2 while the resident lay on the floor. The Administrator stated she talked with Staff A after the fall, who described how she held the resident (contrary to witness statements). The Administrator stated the facility did not have a policy on resident ambulation, but used a check list instead. It is the facility's policy for all resident to wear a gait belt during transfers and ambulation unless a resident walked independently or became agitated or refused gait belt placement. The facility's Competency: Ambulation skills checklist directed that placement of and contact with a gait belt is required during resident ambulation. The facility's Competency: Ambulation skills checklist directed that placement of and contact with a gait belt is required during resident ambulation. During a phone interview on 7/15/20 at 9:15 am, Staff A stated on 6/16/20, she walked Resident #2 to breakfast and she used a gait belt on the resident, and it seemed like her legs gave out. The resident did fine and then just got weak. Staff A stated Resident #2 usually required the assistance of one staff to transfer and walk. Staff A stated she used care plans and therapy recommendations to learn how to walk and transfer residents, she did not use a wheel chair to follow the resident on 6/16 and did not remember receiving any additional education on transfers and ambulation following the

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) resident's fall. Staff A was then informed that other staff remembered the resident did not wear a gait belt when she fell and they saw Staff A place one while the resident lay on the floor. When asked why their recollections differed from hers, Staff A stated she did not know why. During an in-person interview on 7/21/20 at 3:05 pm, Staff A stated she walked right behind the resident, holding on the waist of her pants. She did not hold onto a gait belt and did not use a wheelchair to follow behind the resident. Staff A stated she did not know of the care-planned intervention to have a wheelchair behind the resident while she walked. Staff A stated the resident walked to the bathroom before that without problems and seemed strong. When asked if the resident wore a gait belt at the time, Staff A stated she did not work the floor often and usually worked as a CMA. She thought she placed a gait belt on the resident, but maybe she took it off once she seated the resident in the bathroom. Staff A stated she knew the resident did not walk much and needed a heavier gait belt to support her. It was possible Staff A forgot to put the gait belt back on. Staff A did not remember the last skills day she had and no longer worked at the facility. Review of Staff A's personnel file revealed a hire date of 4/3/13 and a position title of CNA/CMA. The file showed a Competency Form for Ambulation dated 2/12/20, in which she successfully demonstrated step #4 (placing a gait belt properly around a resident's waist) and step #9 (which included to never let go of the gait belt when walking the resident). Observation on 7/15/20 at 1 p.m. revealed Staff F, OT (Occupational Therapist) in Resident #2's room. Staff F placed a gait belt and walked the resident using a walker 4 steps from a straight chair to a recliner. Staff F stated Resident #2 could only ambulate with OT and Physical Therapy oversight. CNA's could pivot transfer the resident only.