STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165342	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW DALE WELLNESS VILLAGE	404 FIRST STREET BATTLE CREEK, IA 51006

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to follow care plan interventions for one of one resident reviewed (Resident #1). Resident #1 did not have a urinal in their room. The care plan directed a urinal at the bedside. The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 6/24/20 showed the resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The resident required extensive assistance of one staff member with toileting and transfers during the seven day lookback period. The MDS identified the resident as not steady and only able to stabilize with staff assistance for walking, the surface to surface transfer, toileting, and going from a seated to a standing position. The resident received opioids for seven days in the lookback period. The resident was frequently incontinent with urine. The resident did not have falls since the previous assessment. On 8/10/20 at 12:33 PM, observed revealed the resident in bed with curtains pulled around the bed to provide privacy in the isolation area. The floor next to the bed was clear, with no floor pad. On 8/3/20 at 6:20, the Incident Report labeled as a Late Entry completed by Staff A RN (registered nurse) said the housekeeper heard an alarm sounding while cleaning the railings. When the housekeeper opened the door, she observed the resident on the ground. The nurse arrived at the resident's room and upon entering, noted resident's door only open a little bit. The resident laid on the ground in front of the roommate's recliner with legs extended. The resident was leaning on the left elbow with his right hand, gripping the walker. The walker hovered over the resident's body. The nurse noted blood on the floor and, upon inspection, noted blood running down the back of the resident's head. The nurse applied a washrag to the resident's head. The resident was last checked on at 6:05 AM by a Certified Nurses' Aide (CNA). The CNA stated that the resident had their eyes closed and appeared to be sleeping. The resident's pendant call light was not activated, and the pendant was on the left wrist. The alarm was sounding and noted the door was only open a smidge (small amount). The resident attempted to go to the bathroom due to the urinal not on the walker. The resident was incontinent of urine due to not making it to the toilet on time. The resident was continent of bowel at the time of the fall. The resident was barefoot at the time of fall. The resident ambulated to the bathroom without any assistance. The resident usually required assistance from one staff with a gait belt and a front wheeled walker (FWW). The floor was dry and free of clutter before fall. After the resident fell , the floor was wet with the resident's blood from two skin tears on the right arm and a head injury. Two staff and a gait belt with the FWW assisted the resident in a standing position. The staff then sat the resident into the wheelchair, taking the resident to the bathroom. Upon standing the resident, the nurse noted one skin tear on the right elbow and another skin tear to the back of the right upper arm. The resident's gait was steady per usual. The resident did not have any additional as needed medication before the fall. The resident's assessment showed a range of motion (ROM) within normal limits (WNL). The resident did hit their head. The resident's roommate's chair was upright tilted forward. It appeared that the resident hit the head, right elbow, and the back of the upper right arm on the metal frame of the back of the roommate's chair-the description of the injuries 1. The top middle of the resident's head noted to have an open area measuring 1 centimeter (cm) x 0.1 cm x 0.1 cm with a moderate amount of sanguineous drainage. 2. The resident's right elbow measured an open area of 3 cm x 3 cm x 0.1 cm with a moderate amount of sanguineous drainage. 3. The resident's upper right arm on the posterior side showed a skin tear with a scant amount of sanguineous drainage measuring 1 cm x 3 cm x 0.1 cm. Treatment provided to the areas was areas 1. The resident's head was cleaned with normal saline and left open to the air. 2. The skin tears to the right elbow, and the back of the upper right arm cleaned with normal saline, padded dry with a four by four (4x4) gauze. 3. Steri strips applied to the resident's elbow with the skin tear. An oil [MEDICATION NAME] dressing applied covered with a 4x4 gauze and then wrapped with conforming wrap. The dressings were to be changed on bath days and as needed (PRN) until healed. The list of relevant interventions that were in place at the time of the incident included: Toileting: The resident likes to use a urinal at night for toileting, and kept at the bedside. Please offer to help the resident to go to the toilet when assisting the roommate in the bathroom. Floor pad next to the bed when in bed. The preliminary recommendations for consideration for further preventative measures were to ensure the urinal is in the resident's room and on the walker. After the incident, the nurse identified placing a urinal on the walker in the resident's room. Care plan review The care plan problem dated 1/28/20 identified the resident at risk for falls related to psychoactive drug use and pain at times, as evidenced by requiring the assistance of one staff with a gait belt and a walker to safely ambulate as the resident had a history of [REDACTED]. The toileting intervention said the resident liked to use a urinal at night for toileting and keeps it at the bedside. Please off to help the resident with the toilet as the roommate assisted with toileting. (Created 9/24/19) Interview: On 8/11/20 at 9:50 AM, Staff A, Registered Nurse (RN), stated staff that went to check on the resident the morning of the fall reported the resident's eyes were closed and staff did not want to wake them. Staff reported that the resident did not have a urinal in their room when the fall occurred. Follow-up interview On 8/11/20 at 12:25 PM, the Director of Nursing said the expectation was that if the care plan said the resident was to have a urinal at the bedside, the resident should have a urinal. After the surveyor exited the facility, they faxed a note from the ARNP (advanced registered nurse practitioner) that stated the resident most likely sustained a pathological fracture causing the 8/3/20 fall.

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