

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Friendship Village Retirement		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Park Lane Waterloo, IA 50702	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126</p> <p>Based on clinical record review, observations, staff, resident, and family interviews the facility failed to provide adequate supervision for 1 of 3 residents reviewed with falls (Resident #1). On 1/25/24, Resident #1 fell while receiving assistance from a Certified Nurse Aide (CNA). As the CNA assisted Resident #1 she failed to apply a gait belt. The fall resulted in a hip fracture to Resident #1's right hip that required surgical repair. The facility reported a census of 63.</p> <p>Findings include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified a staff assessment for mental status. The assessment reflected Resident #1 had an ok short-term memory and could make independent decisions. Resident #1 required partial to moderate assistance with walking 10 - 150 feet. She used a wheelchair for mobility. The MDS included diagnoses of stroke, hemiplegia (complete paralysis on one side of the body), major depressive disorder, edema, and reduced mobility.</p> <p>The Care Plan Problem dated 1/18/24 reflected Resident #1 had a potential for injury related to a stroke with right sided residual (long lasting) weakness and a history of falls. The Interventions directed the following:</p> <p>a. 8/12/23: Use proper footwear with any stand, pivot, transfer and a gait belt.</p> <p>b. 1/25/24: Informed the staff Resident #1 experienced a fall and went to the emergency room for evaluation with right hip pain. The new fall intervention indicated the staff received education that all residents who require assistance from 1 staff for transfers or ambulation must have on a gait belt.</p> <p>Review of an interdisciplinary note dated 1/25/24 reflected Resident #1 experienced a fall at approximately 9:05 PM. Staff A, Licensed Practical Nurse (LPN), reported being outside Resident #1's room when she heard a loud crash and a scream coming from there. Staff A entered the room and found Resident #1 on her right side in front of her chair. She screamed, My hip, my hip hurts. The nurse assessed her for injuries, and called the physician for an order to transfer her to a local hospital for evaluation. The note indicated the nurse asked Staff B what occurred. Staff B, Certified Nurse Aide (CNA) stated as they walked Resident #1 to bed with her walker, the walker caught on the tray table, causing her to trip, and fall.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The local hospital's History and Physical dated 1/25/24 indicated Resident #1 arrived at the emergency room after she fell on her right side, resulting in excruciating right hip pain. The physician ordered x rays revealing a femoral neck fracture. The surgical consult team recommended admitted Resident #1 for surgical correction. The Assessment and Plan listed Resident #1 had a right hip fracture.</p> <p>The X-Ray Results dated 1/25/24 at 10:28 PM reflected Resident #1 had an impacted fracture of the right femoral neck.</p> <p>The Gait Belt Policy and Procedure dated May 2023 indicated the staff must use a gait belt at all times when transferring and/or walking residents that are not independent. All direct care workers receive a gait belt upon employment. They should place the gait belt around the resident's waistline when transferring or walking them. Ensure the gait belt is secure and but not creating discomfort. Staff need to grasp the sides of the gait belt during pivot transfers or grasp the back of the belt while ambulating the resident. Failure to use a gait belt may result in disciplinary action up to and including termination.</p> <p>The Investigation Summary of the Self-Report dated 1/26/24 identified Resident #1 had a fall with an injury, resulting in a transfer to a local emergency room . The conclusion of the investigation summary indicated the CNA assisting Resident #1 when she fell , failed to use a gait belt while transferring her.</p> <p>On 7/16/24 at 9:02 AM Staff A, Licensed Practical Nurse (LPN), reported she worked the evening shift on 1/25/24 when Resident #1 experienced a fall in her room. Staff A explained she responded to a crashing noise followed by screaming. Upon entering Resident #1's room she found her on the floor laying on her right side. Staff A assessed Resident #1 and sent her to a local emergency room . Staff A indicated when she entered Resident #1's room and saw her on the floor she didn't have a gait belt on. Staff A interviewed Staff B, CNA, who assisted Resident #1 in her room, Staff B stated she forgot to put a gait belt on Resident #1 prior to walking her.</p> <p>On 7/16/24 at 7:20 AM Staff D, Registered Nurse (RN)/Assistant Director of Nursing (ADON) stated through her investigation of Resident #1's fall, they determined Staff B failed to use a gait belt when assisting Resident #1 with walking in her room. Staff D stated they did extensive re education with Staff B on the proper use of a gait belt. Staff D stated the aide would have known how to transfer Resident as each aide received an aide sheet at beginning of each shift. The aide sheet informs the staff how each resident transfer, the use of assistance devices, and personal hygiene needs.</p> <p>Review of the personal file for Staff B identified a hire date of 1/3/24. She began her facility training on 1/8/24 and completed on 1/14/24. The file contained a form titled Use of the Gait Belt, which directed the aide they must use a gait belt at all times when transferring or walking a resident. Staff B signed the policy on 1/13/24, indicating she read the policy and understood her responsibility in the use of a gait belt.</p> <p>The Corrective Action Plan dated 1/26/24 indicated the facility reviewed and educated Staff B on the Gait Belt/Transfer Policy. The facility provided additional information on when to use a gait belt.</p> <p>The facility corrected the deficiency by implementing the following:</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. The untitled form dated 1/26/24 reflected all facility staff read and understood the Gait Belt Policy & Procedure. b. The facility completed a Skills Fair on 3/19/24 that included education on the proper use of gait belts.		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126</p> <p>Based on clinical record review, observations, staff, and resident interviews the facility failed to ensure their call light system properly functioned for 2 of 4 resident neighborhoods observed (Community and Excellence) affecting 3 of 63 resident rooms (room [ROOM NUMBER], 4001 and 4010). The facility reported a census of 63.</p> <p>Findings include:</p> <p>On 7/15/24 at 11:45 AM observed Resident #3's family member attempt to activate the residents paddle call light in room [ROOM NUMBER] on the Community Neighborhood. Staff E, Certified Nurse Aide (CNA), present in the room at the time stated the call light didn't activate and come across her pager. The family member pushed the call light several times in attempts to summon staff but the light remained off.</p> <p>On 7/15/24 at 12:23 PM - 1:00 PM an observational tour with Staff F, Maintenance, revealed 2 call lights on the Community Neighborhood failed to work properly, room [ROOM NUMBER] and room [ROOM NUMBER]. Staff F stated nursing is responsible for the call light audits and will notify the Maintenance Department when there are malfunctioning call lights. He stated they have had occasional problems with the call lights and have had to reset/repair them.</p> <p>On 7/15/24 at 1:02 PM, Staff G, Administrator, stated the nursing staff completed call light audits on the remaining 3 neighborhoods that day and found 1 malfunctioning call light in room [ROOM NUMBER]. Staff G reported they asked the maintenance staff to fix the call lights.</p> <p>On 7/15/24, Staff H, Licensed Practical Nurse (LPN), denied knowing of any current malfunctioning call lights but stated they had issues in the past. Staff H reported she didn't get Resident #3's call light page at 11:45 AM that day. Staff H stated the only way to shut off the call lights after staff respond is to physically go into the resident's room and push the reset button. They can't shut them off any other way.</p> <p>On 7/15/24 at 1:30 PM Staff H explained she didn't get the page from room [ROOM NUMBER] at 11:45 AM that day. Staff H added it seemed like the call light system malfunctioned, the staff gave the residents either bells or air [NAME] to use until the completion of the call light system repair. She stated they fixed the system until the next time it malfunctions. Staff H indicated the staff put in a work order to Maintenance each time the call lights malfunction.</p> <p>Review of the Smart Call Resident Call Light System policy and procedure dated 1/5/23 revealed the Smart Call system is a wireless call light system that utilized pagers carried by nursing personnel each shift. Its the goal of the nursing department to answer resident's call lights, when activated, within 15 minutes.</p>