STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165167	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village	1203 North E Street Indianola, IA 50125

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 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. 49990 Based on direct observation, staff interview, facility documentation, and facility policy review, the facility failed to implement measures to ensure safety for each resident identified at risk of injury to themselves for 1 of 4 residents reviewed. The facility reported a census of 49. Findings include: The Quarterly Minimum Data Set (MDS) for Resident#26, dated 10/02/24, documented relevant diagnoses of heart failure, hypertension, history of fractures, Non-Alzheimer's Dementia, seizure disorder, depression, and a history of falling. It documented her brief interview for mental status (BIMS) score as 03, which indicated severely impaired cognition. It further documented a need for a wheelchair or walker for supportive items, and functional ability to walk score of 03, indicating the resident required moderate assistance to walk. The Care plan, last revised on 10/04/24, recorded the resident used a front wheeled walker in her room and a wheelchair for mobility that required longer distances. It documented the resident required an assist of one for ambulation, with the use of a gait belt and front wheeled walker and the resident was an assist of one for wheelchair mobility. It also recorded the resident was an assist of one for transfers. Additionally, it documented fall prevention interventions for Resident #26 included her bed being placed in the standing position, not the low position, to assist the resident in standing from her bed, as well as her wheelchair placed at the foot of her bed to allow her to use it. Review of nursing progress notes dated 08/05/24 revealed Resident #26 fell during the overnight shift at approximately 12:20 am attempting to self-ambulate. She was found by Staff K, Certified Nurse's Aide (CNA), and assessed by Staff L, Registered Nurse (RN). The resident required transportation to the hospital where she was diagnosed with a fractured right wrist. The nursing progress notes do not detail the position of the resident's bed or location of her wheelchair at the time of the incident. Further review of nursing progress notes dated from 07/01/24 until 11/14/24 documented Resident #26 had fallen on at least four documented occasions during the lookback period with the most recent fall having occurred on 10/09/24. Review of hospital discharge records, dated 08/05/24 , confirm Resident #26 sustained a right wrist fracture. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a direct observation on 11/14/24 at 08:32 AM with Staff J, Certified Medication Aide (CMA), Resident #26 was seen sitting in her bed. Her bed was in the low position, as confirmed by Staff J, and her wheelchair was placed in her bathroom behind a closed door. Staff J acknowledged to the surveyor at this time the bed was in the wrong position and that the wheelchair needed to be at the foot of her bed, not in the bathroom. In an interview on 11/14/24 at 09:09 AM with Staff K, CNA he noted he found Resident #26 shortly after midnight on 08/05/24. He was unable to recall what specific care plan interventions the resident had in place to prevent falls, and did not recall the location of her wheelchair at the time of the incident. In an interview on 11/14/24 at 09:50 with Staff L, Registered Nurse she stated she believed the resident was trying to walk to her recliner or the bathroom at the time of the fall. She stated she had been summoned to Resident #26's room shortly after midnight on 08/05/24 by Staff K, who had found her on the floor with an obvious bend in her wrist. She stated she believed the bed was in the low position and the resident's wheelchair was across the room from her bed, placed near the recliner the resident appeared to be attempting to ambulate to. She assessed Resident #26 and found the resident was unable to move the fingers on her right hand, and the resident was complaining of pain in that arm. There was also a clear bend in the arm near her right wrist that led Staff L to believe she had broken her arm. She contacted the Director of Nursing (DON) after having called for an ambulance transport to the emergency room . She could not recall what interventions Resident #26 had in place to prevent falls. In an interview on 11/14/24 at 01:05 PM with Staff I, CNA, she stated she knows the expectation is to follow the documented interventions in the electronic health record (EHR) for all residents. She stated she knows Resident #26 is prone to falling if her care planned interventions aren't followed, and was able to list the care planned interventions from memory. She stated she had seen prior times in the morning when she noted the care planned interventions for Resident #26 had not been followed, though she could not offer exact dates. In an interview on 11/14/24 at 01:14 PM with Staff H, CNA, she was able to accurately state the care planned interventions for Resident #26. She noted Resident #26 is prone to falls and at risk for injury if her care planned interventions are not in place, as she is non-compliant with things like the call lights system, and she has been harmed in the past falling. In an interview on 11/14/24 at 01:32 PM with the Director of Nursing, she stated it was her expectation that staff follow care planned interventions to enhance resident safety. She agreed that not implementing care planned interventions can lead to harm and injury for residents, and she agreed that not following the care planned interventions on the evening of 08/05/24 could have contributed to Resident #26's fracture. In an interview on 11/14/24 at 10:12 AM with the Advanced Registered Nurse Practitioner (ARNP), she stated that while she believes the residents dementia and poor physical condition were the primary factors in the 08/05/24 fracture, she agreed not following care planned interventions could have contributed to her injury. Review of the facility provided document titled CNA Orientation Checklist directs facility staff members to use the Kardex/Care Plan to guide care for residents identified as at risk for falls.