STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165350	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Acres Rehabilitation and Care Center	1501 Office Park Road West Des Moines, IA 50265

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on observations, clinical record review, hospital documentation, staff interviews and facility policy review the facility failed to ensure 1 of 3 residents reviewed (Resident #2) was free from accidents. Resident #2 experienced a fall on 6/26/24 and staff were to ensure he had gripper socks on per his care plan. On 6/27/24 Resident #2 experienced another fall and was found to have regular socks on, not gripper socks. Resident #2 complained of right hip pain and the nurse noted the resident's right foot to be rotated externally. The resident was sent to the hospital for evaluation and found to have a right hip fracture. The facility reported a census of 68 residents. Findings include: According to Resident #2's Admission Minimum Data Set (MDS) assessment tool with a reference date of 6/14/24 documented he had a Brief Interview of Mental Status score (BIMS) of 4. A BIMS score of 4 suggested severe cognitive impairment. Resident #2 exhibited wandering behavior daily. The MDS documented Resident #2 was independent for indoor mobility and required supervision or touching assistance for lying to sitting, sit to stand, chair/bed to chair transfer, toilet transfer, walk 10 feet, walk 50 feet with two turns. Resident #2 utilized a wheelchair and had no impairments to his upper and lower extremities. The MDS documented the following diagnoses for Resident #2: end stage renal disease, atrial fibrillation, benign prostatic hyperplasia, obstructive uropathy, UTI) last 30 days), thyroid disease, malnutrition, cognitive communication deficit. The Care Plan focus area with an initiated date of 6/24/24 documented Resident #2 was at high risk for falls due to weakness, end stage renal disease and poor safety awareness. The following interventions were put in place: staff were instructed to anticipate and meet his needs (initiated 6/24/24), be sure his call light is within reach (initiated 6/25/24), encourage him to use the call light for assistance, ensure he is wearing appropriate footwear, shoes or gripper socks when ambulating or mobilizing in his wheelchair (initiated 6/26/24) and his wheelchair foot pedals are to be removed unless he is being assisted in his wheelchair (initiated 6/26/24). On 10/10/24 at 8:50 AM Resident #2 sat in his wheelchair with yellow gripper socks on. The Progress Notes documented the following: (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a) On 6/26/24 at 9:28 AM Certified Nursing Assistants (CNA) called this nurse to the dining room due to Resident #2 falling. Staff in the dining room reported resident was standing up from his wheelchair to ambulate and fell . When the resident was asked what happened, he stated he tripped over the wheelchair peddles. Resident #2 had regular socks on and no shoes on. b) On 6/26/24 at 2:25 PM the interdisciplinary team (IDT) discussed resident and 2 falls in less than 24 hours. Resident did not have shoes on but had socks on. Intervention: no foot pedals on his wheelchair unless resident is being pushed. Staff will continue to monitor the resident. c) On 6/27/24 at 5:10 PM the Registered Nurse (RN) was called to the resident's room by the CNA. Resident #2 was in the supine position when the nurse arrived. He complained of pain to his right hip that worsened with leg movement. His right foot rotated externally, pain with palpation but denied hitting his head. The nurse noted no other visible injuries and was able to move his upper extremities, with normal left leg movement. Order received to send to the emergency room (ER) and left the facility at 6:00 PM. d) On 6/27/24 at 11:58 PM Resident #2 has a right hip fracture per his wife. e) On 6/28/24 at 8:15 AM the IDT reviewed resident's fall. Resident continues to self-transfer himself has had 3 falls in 3 days. Resident does not use his call light to call for assistance. With this fall he was wearing regular socks and when he got up to transfer himself from the bed to the chair he slipped and fell . Resident is currently in the hospital, already in therapy. f) On 7/3/24 at 10:17 PM resident readmitted from the hospital at approximately 7:00 PM. Resident had a fracture on his right acetabular (socket of the ball and socket hip joint). The facility provided the following document titled Witnessed Fall: a) Dated 6/26/24 at 8:50 AM CNAs called this nurse to the dining room due to Resident #2 falling. Staff in the dining room reported resident was standing up from his wheelchair to ambulate and fell . Resident reported he tripped over his wheelchair peddles. Resident #2 had regular socks on and no shoes. Resident as oriented to person and the form had a check mark next to socks in the predisposing environmental factors. In the predisposing physiological factors section there were check marks next to confused and impaired mobility. A check mark was next to ambulating without assistance in the predisposing situation factors section. The facility provided the following documents titled Un-witnessed Fall: a) Dated 6/25/24 at 3:00 PM staff noted resident kneeling on the floor next to the bed. Resident stated he was attempting to self-transfer to bed and the bed pushed to the side. No injuries noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b) Dated 6/27/24 at 5:42 PM Resident #2 was in the supine position when the nurse arrived. Noted pain to right hip what worsened with leg movement. Resident #2 denied hitting his head. Resident's call light was on his bed and he stated he slipped getting up to sit on the chair. In the predisposing environmental factors section there was a check mark next to socks. Gripper socks and shoes were not checked. In the predisposing physiological factors section there was a check mark next to impaired memory. There were no predisposing situation factors checked. In the other information section staff documented resident self-transferred himself. He is an assistance of 1 staff with a front wheeled walker. Resident is non-compliant with this and self-transfers often. This is the resident's third fall in three days. Clinical record review revealed a Trauma Admission History and Physical (H&P) with a performed or dictated date of 6/28/24 at 12:39 AM. The H&P documented it was reported that Resident #2 has had a few falls at the facility and now has right hip pain. He was evaluated in the Emergency Department and was found to have a right acetabulum fracture. A CT scan of his abdomen and pelvis showed comminuted fracture of the right acetabulum. Orthopedics recommended non-surgical management. On 10/10/24 at 1:25 PM the Director of Nursing (DON) stated when Resident #2 first came to the facility he was there for rehab and was doing really well. He has had a few falls because he self-transfers a lot and they have tried all kinds of things to help prevent them. The day they sent him to the emergency room , she was in the vicinity so she assessed him. She was pretty sure his hip was broken because his foot was externally rotated. He told her he was getting up because he wanted to leave. When asked what interventions were in place at that time she stated the changed his push call light to a pad one, then wrapped it in bright tape to encourage him to use it. They made sure his bed was in the lowest position, fall mat on the floor, made sure his bed was against the wall. After he fell on [DATE] they noted he had regular socks on so they added that he needed to have gripper socks on. He would just get up on his own and fall; he just could not bare his weight. The DON stated he most likely should have had his gripper socks on while in bed given his 3 falls in 3 days and him self-transferring. On 10/10/24 at 2:03 PM the Administrator stated after Resident #2's fall on 6/26/24 they added grippy socks to his care plan, signs in his room to use his call light and bright tape on the call light. For the 6/27/24 fall the Administrator indicated the note stated socks when she was informed he was not wearing gripper socks before that fall. She was informed the unwitnessed fall document had checked socks with gripper socks being an option, she acknowledged she saw that. She was also informed the IDT note documented he wore regular socks when he got up to transfer himself from the bed to the chair, he slipped and fell . She acknowledged that's what the note read. When asked since Resident #2 had had 3 falls in 3 days, with reports of self-transferring without using a call light, should his gripper socks been worn on 6/27/24, she stated if it was an intervention that was put in place, they should have been on. The facility provided a document titled Fall Prevention Program with a revised/reviewed date of 7/2023 indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.