STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165377	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheatland Manor	316 East Lincolnway Wheatland, IA 52777

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. 37072 Based on observation, clinical record review and staff interviews, the facility failed to provide adequate supervision to prevent a fall which resulted in a fracture requiring a surgical repair for 1 out of 2 residents reviewed for falls.(Resident #5). The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 9/25/24, listed diagnoses for Resident #5 which included orthostatic hypotension (a drop in blood pressure that occurs when standing up from a sitting or lying position), right hip fracture, and coronary artery disease. The MDS indicated Resident #5 required partial to moderate assist of staff to sit to stand, chair/bed-to-chair transfer, toilet transfer, and walk 10 feet to 50 feet. The Brief for Mental Status (BIMS) score of 15 out of 15, indicated intact cognition. The Care Plan, revised on 1/15/24 included a Focus Area to address The resident [Resident #5] has an ADL (activities of daily living) self-care performance deficit r/t (related to) R (right) Hip Fracture, Limited Mobility, Muscles Impairment. The Interventions included Mobility: A x1 (assist of 1 staff), GB (gait belt) with WC (wheelchair to follow), as tolerated, as resident requests, revision date 10/9/24. A Health Status Note, transcribed on 11/8/24 at 4:40 PM revealed at 3:10 PM, RCT (Resident Care Technician) alerted nurse that resident [Resident #5] was on the floor. Observed resident lying on L (left) side with feet towards toilet and head near sink. States he was in BR (bathroom) and fell over. Left lower extremity appears to be externally rotated. Reports increased pain to whole LLE (left lower extremity) with slight/movement of extremity. Denies other pain .Phone call placed to 911 for ambulance transport. Resident left facility at 3:30 PM to emergency room . A document titled Wheatland Manor Incident Report, dated 11/8/24 revealed RCT [Staff A] alerted nurse the resident was on the floor. The form indicated the incident witnessed by Staff A, RCT. (continued on next page)

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

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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	A witness statement made by Staff A, RCT dated 11/8/24 revealed she assisted Resident #5 off the toilet to a standing position to assist with toilet hygiene. After assisting with cleaning Resident #5 up, he requested she place his watch on the charger in the room. Staff A left the resident unattended in the bathroom to place the watch on the charger in the window in his room. While at the window she heard the resident fall. A Diagnostic Radiology report dated 11/8/24 at 7:30 PM, revealed Resident #5 sustained a fracture of the left femur including trochanter and proximal femoral shaft (left hip fracture). During an interview on 01/08/25 at 1:12 PM, the Director of Nursing (DON) stated she was the nurse the day Resident #5 fell . The DON stated while at the desk, an RCT came up and stated Resident #5 was on the floor, he was lying on the floor with head towards toilet and feet towards sink resident told her he was standing up and he fell over. The DON stated at the time of the fall she spoke with Staff A and she stated he just fell over. Then another nurse was in the room and he mentioned he wanted to have his watch charged and Staff A admitted that she left him unattended. The DON confirmed Resident # 5 Care Plan at the time of the fall directed staff to provide assist of one with gait belt and walker for transfers and ambulation. The facility policy is to not leave a resident unattended with transfers if they require assistance from staff. During an interview on 01/08/25 at 03:05 PM, the DON stated the expectation of the staff is to follow the gait belt policy and the residents care plan when provide assist with transfers and ambulation. The residents also have a care card in the resident room above the bed and they match the computer care plan. The care card tells them the transfer status of the resident and how they ambulate. The DON stated she would expect the staff to follow the care card. During an observation on 01/09/25 at 8:57 AM, Staff B, RCT and Staff C, RCT provided assistance to Resident #5 with a partial assist mechanical lift to aid in a transfer. With the two staff assisting, Resident #5 gripped the handles of the mechanical lift and able to bear weight on both lower extremities to complete the transfer. During an interview on 01/09/25 at 9:07 AM, Staff AC, RC stated they know how to transfer a resident by the care card in their room. They are expected to follow it and transfer the resident as it is written on the card. If a resident should be a transfer of one with a gait belt and walker she would never leave the resident unattended. A facility policy, dated 12/6/23, titled Transferring/Ambulating Resident With A Gait Belt policy Objective To provide increased security for resident and staff during transfers, and to prevent injury transfer and ambulation of residents. The Procure directed staff to; 1. Use the gait belt during transfer or ambulation of all residents that require hands-on assistance, except for those using a mechanical sit to stand or full body lift. 5. Use the bait belt for duration of transfer and ambulation to stabilize resident, holding gait belt near middle of resident's back. 6. Walk alongside resident and slight behind. The policy did not address leaving a resident unattended during transfer or ambulation.