| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165386 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Manor of Elma | 407 9th Street<br>Elma, IA 50628 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133<br><br>Based on observation, clinical record review, document review, policy review, resident and staff interviews, the facility failed to provide a full assessment for 1 of 4 residents sampled for falls (Resident #2). Resident #2 fell on [DATE] at 9:50 PM. Resident #2 exhibited left hip pain and an externally rotated left leg. Staff A, Assistant Director of Nursing (ADON) failed to assess the resident and assisted Resident #2 from the floor to standing position where Resident #2 could not bear weight on his left leg. Staff A called for help and Staff B, Certified Nursing Assistant (CNA) assisted her to transfer Resident #2 into a wheelchair and then they transferred him to lay in bed. Resident #2 was transferred to the emergency room department on 10/13/24. Resident #2 was diagnosed with a left hip fracture on 10/14/24. The facility mitigated the situation through staff education on falls from 10/14/24 - 10/17/24 for nursing staff. The facility identified a census of 30 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating intact cognition. The MDS documented Resident #2 had a functional impairment on both lower sides of the body (hip, knee, ankle, foot) and utilized a walker for walking. The MDS showed Resident #2 required substantial to maximum assistance (a helper does more than half the effort. The helper lifts or holds trunk or limbs and provides more than half the effort) with toileting and supervision/touch assistance (a helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for chair to bed/bed to chair transfers, toilet transfers, and walking 10, 50, and 150 feet. The MDS further documented Resident #2 was frequently incontinent of bowel and bladder. The MDS listed diagnoses of neurogenic bladder, anemia, hypertension, and anxiety disorder. The MDS identified Resident #2 without pain, no falls since the prior assessment; utilized alarms of the bed, chair, and wander guard on a daily basis.<br><br>A 9/02/24 Alarm Review Monthly Assessment documented Resident #2 utilized a bed alarm when in bed and a chair alarm when up in the chair to alert staff when Resident #2 changed positions independently. The Alarm Review Monthly Assessment further documented no plan to reduce the use of the alarms as the resident continued to transfer independently and the devices alerted staff for assistance.<br><br>(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 |
|---|---|---|---|
| | 165386 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Manor of Elma | 407 9th Street<br>Elma, IA 50628 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A 9/27/2024 8:15 AM Communication with Family/Related Party Progress Note written by Staff A (LPN/ADON), documented she received a phone call from Resident #2 family member to discuss the discontinuation of bed/chair alarms. She reported to the family it was a company-wide policy fall alarms would no longer be used and the alarms would be removed some time next week. The family member voiced understanding but had concerns Resident #2 would fall and break a hip if the fall alarms were removed. She reassured the family member Resident #2 would still be assisted as needed and that he does use his call light/doorbell when he needs assistance.<br><br>A Progress Note titled Incident Report dated 10/13/2024 at 9:50 PM documented by Staff A (LPN/ADON) showed a Late Entry into Resident #2 Medical Record containing the following information:<br><br>a. Describe the Situation: banging noise heard down the hallway; upon investigation, found resident banging into door of wardrobe; resident leaning forward and holding on to walker with arms stretched out; in order to prevent resident from falling forward, nurse quickly wrapped arms around resident's waist and pulled him to my knee to attempt to hold him steady; propped resident on knee while holding onto waist and applied gait belt as nurse called out for help and CNAs came to hold/stand resident up and walk to bed; noticed resident not putting weight on left leg; encouraged resident to advance left leg but resident was unable to move it; CNAs got wheelchair to assist the resident to sit and then transported the resident into bed; once in bed the left leg noted to be externally rotated and painful; nurse attempted to inspect leg without rolling resident to side and determined leg was injured.<br><br>b. Assessment of Resident including Range of Motion (ROM) and Pain: left leg externally rotated; pain in the left leg.<br><br>c. Vital Signs - if a fall, include orthostatic blood pressures: not applicable.<br><br>d. Describe Any Injury Noted: left leg externally rotated; transfer to emergency department, per family request.<br><br>e. List Any Treatment Provided: assisted to standing position and transferred into the wheelchair and then into the bed with two staff assist and gait belt.<br><br>f. List Relevant Interventions That Were In Place at the Time of the Incident: resident call light in reach, not utilized; doorbell on his walker, not utilized.<br><br>g. Preliminary Recommendations, if any, for Consideration as Further Preventative Measures: night-light/hall-light/over-the-bed-light in room to be turned on while in bed.<br><br>h. List Responsible Party Notified: family notified.<br><br>i. The Incident Note detailed the Director of Nursing (DON) and the Administrator had been notified and the Provider was notified via facsimile (fax).<br><br>The original Incident Report Progress Note was lined through in Resident #2 Medical Record to indicate to omit the entry.<br><br>(continued on next page) |

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165386 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/05/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Colonial Manor of Elma | | STREET ADDRESS, CITY, STATE, ZIP CODE 407 9th Street Elma, IA 50628 | |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A Second 10/13/2024 9:50 PM Incident Report Progress Note documented by Staff A included a corrected late entry entered 10/15/24 at 2:35 AM which included the following information:<br><br>a. Describe Situation: heard some tapping coming from north hall; upon inspection, resident noted to be on the floor with his back against the outside bathroom wall and right foot tapping on the door to get staff attention; nurse put gait belt on and wrapped arms around resident to stand him up and called for CNAs to help. The nurse propped up resident on her knee to steady him while waiting for CNAs to help get resident into bed. When the CNAs came to help stand him, noted that his leg was externally rotated. The CNAs retrieved a wheelchair and got resident into the wheelchair; he was then assisted into bed.<br><br>b. Assessment of Resident including range of motion (ROM) and Pain: resident complained of pain in the left leg and noted external rotation of his left leg.<br><br>c. Vital Signs - If fall, include orthostatic blood pressure: within normal limits (WNL).<br><br>d. Describe Any Injury Noted: left leg externally rotated.<br><br>e. List Any Treatment Provided: resident assisted off floor and into bed; family called.<br><br>f. List Relevant Interventions That Were In Place At The Time of The Incident: call light within reach, not utilized; doorbell attached to walker, not utilized; proper footwear on.<br><br>g. Preliminary Recommendations, if any, for Consideration as Further Preventative Measures: bed alarm<br><br>h. List Responsible Party Notified: family notified.<br><br>The Incident Note also detailed the Director of Nursing and the Administrator had been notified and the Provider was notified via facsimile (fax).<br><br>The amended 10/13/24 Incident Note failed to document Staff A provided documentation of actual vital signs (temperature, pulse, respirations, blood pressure and oxygen saturation, pain) and assessment of ROM of the upper and lower extremities prior to assisting Resident #2 up off the floor. The original lined through documentation had vital signs documented as not applicable. The amended Incident Report documented vital signs as WNL.<br><br>A 10/14/24 Emergency/Urgent Care Report documented Resident #2 with a diagnosis of a left hip fracture. The 10/14/24 Hospital History and Physical documented the Chief Complaint as left hip pain. The History of Present Illness further documented the patient had an unwitnessed fall at the facility earlier this morning. He was unable to stand on his own and was transferred to the hospital for definitive management. Radiographs were obtained demonstrating a left hip fracture. The patient reported pain in the left hip. The Assessment/Plan noted a hip fracture on the left; hip injury major.<br><br>Resident #2 Care Plan revised 10/15/24 noted Resident #2 at a risk for falls and (fall) alarms had been removed due to the resident removing the alarms on his own and shutting the alarms off. The Activities of Daily Living (ADL) Care Plan directed Resident #2 required the assistance of one staff member with a gait belt and a two-wheeled walker for walking and transferring.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165386 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/05/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Manor of Elma | 407 9th Street Elma, IA 50628 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A 10/15/24 document from Staff A's Employee Record documented by the Director of Nursing (DON) documented Staff A approached her in her office and started crying. Staff A stated she had lied. Resident #2 fell on [DATE]. Staff A stated she was afraid to tell the family he fell and didn't know what to do. The DON informed her they needed to report this to the administrator. Staff A verbalized she messed up and was sorry. The Document was signed by the DON.<br><br>A 10/15/24 document retrieved from Staff A's Employee File documented by the DON documented after the conversation with Staff A and the Administrator regarding Resident #2 incident, Staff A came back into the DON's office and stated, Am I going to get fired? What is going to happen? The DON informed her she didn't know. Staff A replied, I should not have told you guys and kept my mouth shut, and this wouldn't be happening. The DON stated she did the right thing in telling the truth. Staff A stated, I don't think so. The document was signed by the DON.<br><br>A Facility Self-Report to the Department of Inspection, Appeals and Licensing (DIAL) showed the Facility submitted a 10/15/24 11:44 AM report to the State Agency regarding an Accident with Major Injury for Resident #2. The Incident Summary documented on 10/13/24 at 10:26 PM, it was reported Resident #2 was sent out to the emergency room . Staff A found the resident standing outside the bathroom and non-weight bearing on the left leg. Following assessment of the left leg, Staff A found the hip to be displaced. The Facility was notified on 10/14/24 at 8:20 AM that Resident #2 had a confirmed hip fracture. Staff A arrived to work 10/15/24 at 8:45 AM and reported to the DON and the Administrator, she incorrectly documented her statement and original incident report in Point Click Care (PCC, electronic medical records system). Staff A reported she came into the facility at 2:00 AM 10/15/24 and generated a second incident report to show Resident #2 was found on the floor at shift change on 10/13/24 at 9:50 PM. She entered Resident #2 resident room to find him on the floor tapping his foot against his closet. Staff A proceeded to assist Resident #2 off the floor and then called for the aides to help her. The Self-Report identified Staff A was placed on suspension immediately as of 10/15/24 at 10:17 AM. Further investigation submitted to the State Agency revealed Staff A, after entering Resident #2 room, asked him what happened and he stated, fall. Staff A put the gait belt on him while looking over the situation. His legs were bent at the knee and his arms were at his sides with his hands on the floor. Staff A panicked as his bed alarm had just been taken away per company policy. Staff A stood Resident #2 part-way up and propped/stabilized him with her knee under his buttocks while yelling for help from the CNAs as Resident #2 could not bear weight on his left leg. Staff B grabbed the gait belt on the left side to help fully stand the resident. Upon fully standing, resident's left leg was turned outward and noted that he could not advance his leg. Staff A and Staff B transferred the resident into a wheelchair and then transferred him into bed in a lying position. Staff A informed Resident #2 she thought his leg was hurt and asked if he wanted to go to the hospital and he state, yeah. The Report further detailed an emailed statement from Staff A on 10/17/24 at 8:45 AM, Resident #2 did complaint of pain in his left leg when assisted to a full standing position. In response to was there deformation seen, heard, cracking, popping, moving before getting up, Staff A responded yes to an extent. His legs were bent and unable to fully straighten them.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165386 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/05/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Manor of Elma | 407 9th Street Elma, IA 50628 |

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

An undated, unsigned Facility Investigation entailed the above information, including the Facility was notified on 10/21/2024, following radiology tests obtained on 10/19/2024, Resident #2 had fractured 3rd and 4th ribs on his right side. The Investigation further detailed Resident #2 shut his room door at approximately 9:28 PM and was attempting to re-open the door at 9:49 PM. Staff A entered his room at approximately 9:20 PM and exited his room at approximately 9:22 PM. Resident #2 was assisted to bed by a CNA at approximately 7:24 PM. The Facility Investigation concluded there was no staff culpability related to the fall. Staff were following his Care Plan, supervising, and meeting his needs appropriately. It was an unavoidable fall.

A Witness Statement dated 10/13/24 at 3:11 PM for Staff B documented when she entered Resident #2 room to see he was at the front door of the room with a gait belt on. They wanted him to go back to bed, but he couldn't move his leg. She could see that his leg was not right and he couldn't move it. The Witness Statement contained documentation Staff B was aware not to try get a resident up off the floor after a fall and wait for a nurse to come.

A Witness Statement dated 10/17/24 at 3:30 PM Staff D, CNA documented she worked 2:30 - 10:00 PM on 10/13/24. She had last seen Resident #2 after supper sitting in the recliner in the lounge area. She had walked him out to supper and he didn't seem out of character. The Witness Statement documented Staff D observed Staff A on the right side of Resident #2 holding him up (in the room). It kind of looked like Staff A was holding the resident up with her knee. Staff B was on the other side of Resident #2 holding him with her arm. Staff D brought the wheelchair into the room. Staff D Witness Statement identified she knew to call for a nurse and not get a resident up off the floor if they fall.

A Witness Statement dated 10/17/24 at 3:38 PM Staff E, CNA documented she worked 10/13/24 2:30 PM to 10:00 PM. She had last seen Resident #2 sitting his recliner in the lounge area. The Witness Statement identified Staff E was aware to make sure a resident is safe and never move them. Call for the nurse, never leave the room, and wait for the nurse to come in.

Observation on 12/03/24 at 12:22 PM Staff G, CMA and Staff H, CNA assisted Resident #2 via the standing lift from his wheelchair to the bathroom for cares, then to transfer into bed. Resident #2 stood upright in the standing lift without complaints of pain. The DON reported Resident #2 was just evaluated by therapy on 11/27/24 and moved from a full mechanical lift to the standing lift.

Interview on 12/03/24 at 12:37 PM Resident #2 when asked if he remembered his last fall when he broke his hip stated, yes. When asked if he recalled where he fell , he stated and pointed, front door of room. When asked if he had pain while on the floor he responded, yes. When asked if the nurse moved his legs to see if he was injured before getting him up off the floor he responded, No.

On 12/03/24 at 1:23 PM Staff D reported she didn't actually see the 10/13/24 incident happen. Staff A and Staff B were already in the room. They yelled to bring a wheelchair. When she brought the wheelchair to the room she saw Staff A had her knee under Resident #2 thigh area, next to his butt holding him up. She dropped off the wheelchair and she left the room.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165386 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/05/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Manor of Elma | 407 9th Street Elma, IA 50628 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 12/03/24 at 1:39 PM Staff E verbalized Resident #2 needed a hand on the gait belt to keep him steady and verbal cues to take big steps, when it came to walking. He used a two wheeled walker with the front wheels and tennis balls on the back. He had a door bell on his walker to call for help. He used the doorbell anytime he needed something, if people were not around. If people were around he would say something or just raise his hand. They were told they couldn't use fall alarms anymore. They were told to do more frequent checks on the residents that had the fall alarms discontinued. They tried to walk up and down the hallways as much as possible. She didn't really see Resident #2 the night of the incident.<br><br>Interview on 12/03/24 1:51 PM Staff B explained they were almost done in another resident's room. She heard the nurse calling for help from Resident #2 room. Staff A and Resident #2 were standing between the room doorway and the bathroom door with Resident #2 facing the closet. She didn't know what happened, but Resident #2 foot was turned in a weird way. He couldn't get his foot straight and he couldn't move. It was painful for him to stand. They assisted him to sit in the wheelchair. Put the wheelchair by his bed and did a two-person manual transfer from the wheelchair to the bed. The nurse decided they needed to move him to his bed.<br><br>Interview on 12/04/24 at 7:20 AM, Staff F, Registered Nurse (RN) reported when a resident falls, they keep them on the floor, get a set of vital signs and move their arms and legs (ROM) to assess if they are injured before assisting them up off the floor. She voiced if a resident exhibits a change in ROM, she is to keep the resident immobilized on the floor and call 911 to send the resident out to the hospital. The facility provided fall education to the nursing staff after Resident #2 fall on keeping the resident on the floor if injured and completing an assessment. Staff F explained the fall alarms were discontinued about 4-6 weeks ago. They started by notifying the family of the alarm reduction to see if the family had any concerns with the fall alarms being removed. If the family had concerns with the fall alarms being removed, then DON would follow up with the family on their concerns.<br><br>During an interview on 12/04/24 at 8:10 AM the DON reported Staff A did not do an assessment before standing Resident #2 up off the floor. The DON voiced she wouldn't lie and Staff A did not do an assessment before she tried to stand Resident #2 from the floor. She further explained she thought Resident #2 leg was bent when he was sitting on the floor and he couldn't stand on the leg when Staff A lifted him up off the floor, but that the Administrator had watched the camera footage and she could talk more about that. She voiced she expects the nursing staff to complete a full assessment including vital signs (temperature, pulse, respirations, blood pressure and pulse oximetry), range of motion (ROM) and a pain assessment. A resident should not be moved if there are signs of injury. She explained documenting vitals signs WNL is not acceptable as part of the facility fall documentation. She explained they provided staff education on falls to the nursing staff after Resident #2 fall. They have a fall care path that they educated on and that they use.<br><br>Interview on 12/04/24 at 9:20 AM the DON reported Resident #2 does have garbled speech but he is able to communicate his needs. The DON voiced in her professional opinion the actions taken by Staff A to not assess Resident #2 and move him from the floor may have worsened his condition.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165386 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Manor of Elma | 407 9th Street<br>Elma, IA 50628 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview completed with the Administrator on 12/04/24 at 9:32 AM revealed she confirmed they did have camera footage that she was able to review. By the time they completed the investigation, the camera footage had recorded over the video. She viewed the camera that was positioned at the entrance to Resident #2 hallway by his room. She observed Staff A entered Resident #2 room at 9:20 PM and exited the room at 9:22 PM. At 9:28 PM the room door started to close. The Resident was the only one in the room. She believed Resident #2 walked from the bed to the door and closed the door. At 9:49 PM the door begins to open. She assumed Resident #2 tried to open the door himself. At 9:58 PM Staff A entered the room herself. She couldn't see Resident #2 on the camera. She could see Staff A grab the gait belt with two hands on each side of Resident #2 back as she tried to pull him up off the floor. At 10:00 PM Staff B entered the room. Staff D brought the wheelchair to the room. Only Staff A and Staff B remained in the room. The Administrator verbalized she did not see Staff A take in a stethoscope, blood pressure cuff, or any equipment in the room. She did not see Staff A go in front of the resident to try to move his arms or legs. The Administrator voiced she absolutely would not expect one nurse to lift a resident up off the floor by herself and she couldn't confirm that Staff A did an assessment on the resident. She expects vital signs, ROM, and pain assessments to be completed and documented within the incident report when a resident falls. She acknowledged and stated she did not see any documentation of any range of motion assessment in the documentation on the actual Incident Report. She responded without vital signs and a full assessment, Resident #2 should not have been assisted up off the floor. She reported she could not make assumptions, but that the lack of assessment did not benefit the resident in regard the resident being transferred out of the facility and a diagnosis of a fractured hip.<br><br>On 12/04/24 at 9:47 AM the DON provided Staff A's Time Card. The Time Card showed Staff A worked 10/15/24 from 7:34 AM to 10:07 AM. The DON further explained that is when Staff A informed her that she had lied about what she charted in Resident #2 chart and that he had fallen. She reported Staff A was working in the office that day and was suspended pending an investigation 10/15/24. She was eventually terminated 10/25/24 due to lying in her documentation.<br><br>During an interview on 12/04/24 10:20 AM Staff A explained they were told by the Nurse Consultant that the new company no longer wanted to use fall alarms. She talked to Resident #2 family about the alarm reduction and the family was not happy. The alarms were discontinued within 1-2 days of the consultant notifying the facility of the alarm reduction. They were given directions to just walk the halls and peek in on residents frequently. The night of the fall (10/13/24) She hadn't seen the resident up until the time of the fall. When she entered his room, he was sitting in the entrance to the room. His back was against the bathroom wall inside his doorway of the room and his legs were facing toward the closet. After her conversation with the daughter on the fall alarms, she panicked. She was petrified. Staff A verbalized she knew his left leg was broken, but she put the gait belt on him and got up off the floor by herself anyway. She had no idea why she got Resident #2 up off the floor when she knew his leg was broken. She panicked. When she had talked with the family prior on the alarm reduction, the family stated they would be waiting for a phone call that Resident #2 broke his hip and that would be the end of him. Staff A reiterated she was scared and that is what drove the events of that night. She shouldn't have gotten the resident up off the floor by herself. Staff A stated, she did not do vital signs or further assessment (ROM, pain assessment) on the resident. She documented WNL on the amended Incident Report as the ambulance responded to the nursing home call and they took vital signs on the resident when they arrived and his vital signs were WNL. Staff A reported she absolutely should not have transferred him up off the floor when she knew his left leg was broken.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165386 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/05/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Manor of Elma | 407 9th Street<br>Elma, IA 50628 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 12/04/24 at 1:59 PM Resident #2 Provider voiced it probably would be best to keep a resident immobilized if a fall occurs and the resident exhibits external rotation of a leg and leg/hip pain.<br><br>The Fall Care Path, utilized for staff education between 10/15/24 - 10/16/24 directed the following:<br><br>a. Take Vital Signs - temperature, blood pressure, pulse, respirations, oxygen saturation and finger stick glucose if diabetic. The Care Path directed a box chart for parameters on vital signs.<br><br>b. Initial Nursing Evaluation for Injury and/or Mental Status Change - do not move off the floor until a complete exam has been performed. Suspected fracture or new bone deformity, head trauma, altered mental status (decreased level of consciousness, suspicion of seizure, new or worsened cognitive impairment), laceration requiring sutures/samples. If yes, Notify the Medical Doctor, Nurse Practitioner or Physician Assistant. If No, evaluate signs and symptoms for immediate notification - abnormal lung sounds, new/irregular pulse, chest pain, acute decline in ADLs, new or worsening incontinence, sign/symptoms suggestive of a stroke (weakness, numbness or tingling), new or worsening pain unrelated to head trauma or a suspected fracture.<br><br>The Fall Occurrence revised 2/24, under Purpose documented it is the policy of the facility to ensure that residents are evaluated for fall risks and implement interventions to minimize risk for falls and/or risk of injury from falls. The Procedure directed residents would be assessed by a licensed nurse prior to being moved after a fall.<br><br>The Guidelines for Charting After a Fall, provided by the facility, directed:<br><br>a. Chart ROM on all extremities with or without discomfort (if severe discomfort noted or shortening of the extremity or external rotation, do not move the resident until emergency medical technicians arrive for transport to the hospital).<br><br>b. Chart a full set of vital signs.<br><br>c. Chart Resident Complaint of pain rated on scale of 1-10 with 10 being the worst pain. |