STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165446	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westbrook Acres	605 Garfield Street Gladbrook, IA 50635

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** Based on clinical and hospital record review, observation, resident and staff interviews, and facility policy review, the facility failed to ensure a safe transfer and ambulation with the use of a gait belt as determined necessary by the care plan during Resident #1's staff-assisted transfer and ambulation on 3/13/26 for one of three residents reviewed for falls (Resident #1). Resident #1 fell to the floor, sustained a hip fracture with 7 out of 10 pain level, and required hospitalization with surgical repair. The facility reported a census of 44 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented the resident scored 10 out of 15 on a Brief Interview for Mental Status (BIMS) exam. which indicated the resident had moderately impaired cognition. Per this assessment, the resident required partial/moderate assistance to walk 10 feet, and for chair/bed to chair transfer. The MDS assessment further revealed the resident used a walker and wheelchair. The MDS assessment dated [DATE] for Resident #1 documented a 3/17/26 readmission date to the facility from an acute hospital stay. Her diagnoses included a primary medical condition of a hip replacement, a fracture of unspecified part of neck of right femur (the longest, heaviest, and strongest bone in the human body, running from the hip to the knee), and a subsequent encounter with routine healing, personal history of a traumatic fracture, Alzheimer's Disease, and diabetes mellitus. The MDS identified a BIMS score of 10 out of 15. The MDS coded a functional limitation in range of motion (ROM) with impairment present on one side of the resident's body in the lower extremity, and coded the use of a walker and wheelchair. Resident #1's Pain Assessment Interview revealed she had experienced pain which occasionally limited her participation in her rehabilitation therapy and day-to-day activities. The MDS recorded the resident reported she had experienced pain and rated her pain at 6 on a 00 to 10 pain scale with 10 being the worst pain imaginable. The MDS documented the resident's medications included antipsychotic, antianxiety, antidepressant, antibiotic, opioid, and antiplatelet medications. The MDS documented the resident had received physical and occupational therapy services. The Care Plan initiated 3/12/25 for Resident #1 identified the resident at risk for falls. The Update 3/13/26 revealed, Fall in room with turning and losing balance noted shortening of right (R)/leg. The Intervention dated 3/12/25 directed staff to provide the assistance of one to two staff persons and walker with transfers and ambulation. Another Intervention dated 3/12/25 revealed, Discourage independent ambulation/transfer and educate on risk of falls/injury PRN (as needed). The undated Mini Care Plan for Resident #1, informed staff the resident required a walker and the assist of 1 to 2 staff persons with a gait belt for transfers. Per the Mini Care Plan for Resident #1, the resident was ambulatory with the assistance of 1 of 2 staff persons and a walker, or used wheelchair with foot pedals. The undated paper Cheat Sheet developed by the facility for use by new staff and temporary agency staff directed staff assisting Resident #1 to provide 1 or 2 staff persons and a gait belt when assisting the resident with transfers, and noted walker and/or a wheelchair use. Resident #1's Incident Report for Fall During Staff Assist dated 3/13/26 at 2:30 p.m. authored by Staff B, Licensed Practical Nurse (LPN) revealed the resident was ambulating back to her recliner after using the bathroom with agency staff member (Staff A, CNA). (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Agency staff (Staff A) yelled out of room [Resident #1] fell. Upon entering the room, resident was sitting in an upright position with back to door and legs on ground in front of resident body When writer (Staff B, LPN) asked agency CNA (Staff A, CNA) where the gait belt was, agency CNA (Staff A, CNA) said she did not use one. After Staff B, LPN assessed Resident #1 on the floor, a gait belt was placed around the resident and three staff members assisted Resident #1 to her recliner and then to her bed Resident then told writer (Staff B, LPN) this area right here hurts and the resident pointed to at her right hip area Residents rights leg appeared shorter than the left leg, however resident was unable to completely straighten her right leg. Per the Nurse's Note dated 3/13/26 at 5:25 PM, Staff B then called Resident #1's representative and arranged for Resident #1 to be transferred to the local hospital. The Nurse's Note dated 3/13/26 at 8:15 p.m. revealed the local hospital's emergency room (ER) nurse called to confirm that Resident #1 had broken her right hip. The Nurse's Note dated 3/13/26 at 9:23 p.m. revealed The ER nurse called back to inform Staff B, LPN that Resident #1 would be transferred to another hospital for the surgical repair of her hip fracture. Further review of Resident #1's Electronic Medical Record (EMR) revealed her documented Pain Level Summary was between 0-3 prior to her fall on 3/13/26. After her fall on 3/13/26 at 2:30 p.m. Resident #1's pain level was documented on her incident report at a level 7. Further review of Resident #1's 3/13/26 Incident Report documented the resident's gait imbalance as a predisposing factor and documented, Agency CNA [Staff A, CNA] transferred resident with a walker and shoes but without a gait belt. Agency staff member was educated on the importance of using a gait belt during transfers after the incident occurred. The Incident Report also documented Staff A, CNA's statement she had provided on 3/13/26, which revealed the following: We [Staff A and Resident #1] were coming from the bathroom, going to the recliner. Resident was walking fast and realized she was past her recliner. She [Resident #1] went to turn towards the recliner and turned to fast, loosing her balance while turning, she started to fall. I [Staff A, CNA] was standing behind her and as she lost her balance she began falling. I put my arm behind her and tried to ease her to the ground. She twisted so fast that the momentum of her fall was fast. Her butt hit the floor first and then she laid her head back and hit her head on the leg of the chair next to her doorway. And then I yelled for help out the door. The local hospital's emergency department (ED) report with an initial patient evaluation time of 3/13/26 at 4:17 p.m. revealed the patient (Resident #1) stated she had a fall that day, stated that while trying to turn left with her walker she fell onto her right side. She presented with right elbow pain and an abrasion over the right elbow. She endorsed right knee pain and pain on the right side of the head. She reported she was unable to walk after the fall due to the severity of her pain. Further review of the local hospital records revealed a 3/13/26 at 6:38 p.m. CT (computed tomography) scan (a non-invasive medical imaging test that combined a series of X-ray views taken from various angles with computer processing to create cross-sectional images of bones, blood vessels, and soft tissues inside the body) that documented an acute displaced fracture of the right femoral neck (break in the right thigh bone near the hip joint, where the fractured bone pieces have shifted out of alignment). The local hospital records documented on Friday, 3/13/26 at 7:11 p.m. there was no orthopedic coverage over the weekend at that hospital, and Resident #1 needed to be transferred to another hospital. Later that evening at 8:38 p.m., another hospital was located that accepted the resident for the orthopedic surgery. Review of hospital records from the hospital Resident #1 transferred to documented an inpatient consultation on 3/13/26 at 9:18 p.m Records detailed Resident #1 was found to have acute displaced fracture of the right femoral neck, and was transferred to [Hospital Name Redacted] for orthopedic surgery. Further review of the hospital records revealed an Operative Note dated 3/14/26 at 10:22 a.m. during which the Physician documented that he had discussed with Resident #1 her medical findings and treatment options, including the risks, benefits, complications, and alternatives. Per the Operative Note, the resident understood and requested to proceed with hemiarthroplasty [partial joint replacement, a surgical procedure that replaces only one half of a damaged joint. Most commonly performed on the hip, it replaces the ball of the joint (the femoral head) while leaving the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	natural socket (acetabulum) intact). The admission Summary Note dated 3/17/26 at 1:00 p.m. revealed the resident was readmitted back to the facility. In an interview on 6/1/26 at 1:40 p.m. Resident #1 stated she had lived at the facility over a year. She recalled the fall she had on the afternoon of 3/13/26 when she used her walker, turned to quick, lost her balance and fell. She stated her pain was at a 7 or 8 at the time of the fall accident. She said she was taken to the local hospital by an ambulance and then transferred to a [City Redacted] hospital for surgery, stayed at the hospital for one week and then returned to the facility. She stated she had received therapy services at the facility when she returned. Observation on 6/2/26 at 1:03 p.m. revealed Staff D, CNA and Staff E, CNA assisted Resident #1 in her room while she was seated in her wheelchair. Staff D, CNA placed a gait belt around Resident #1's waist and Staff E, CNA placed the resident's walker in front of her. With a staff member on each side of the resident holding on to the gait belt, Resident #1 was assisted to a standing position on both of her legs. Once standing, Resident #1 used her walker and walked a few steps to her recliner with the two staff members grasping the gait belt with both of their hands. Resident #1 then turned slightly to position herself in front of her recliner and with both the staff members assistance sat down in her recliner. Staff D, CNA and Staff E, CNA were asked about the resident's transfer and walking ability and assistance required and they stated Resident #1's ability to transfer and walk had returned to the same level she had prior to her fall on 3/13/26. In an interview on 6/2/26 at 2:52 p.m., Staff F, CNA, revealed that she had worked at the facility as an agency CNA before she was hired by the facility as a CNA in November 2025. Staff F, CNA recalled that when she started working as an agency CNA at the facility, she was shown the paper Mini Care Plans her first day. Staff F, CNA was asked how the CNAs knew what interventions or assistance was needed for each resident, and she stated there was a three-ring binder at the nurses station that contained a hand-written, one-page Mini Care Plan for each resident. Staff F, CNA, stated she had not worked Friday, 3/13/26, but had worked the next day on Saturday, 3/14/26 and heard about Resident #1's fall that day. Per Staff F, there was always a gait belt on Resident #1's chair in her room.When asked regarding agency CNA staff, Staff F stated for agency CNA staff that were new to the facility, she oriented them by going over where the Mini Care Plans are located and we provide them a paper Cheat Sheet that the new agency CNA staff could carry with them to refer to when caring for the residents. She stated she had never worked with Staff A, CNA. In an interview on 6/2/26 at 3:56 p.m., Staff B, LPN, stated she had worked the second shift on 3/13/26 from 2:00 p.m. to 10:00 p.m., and that when Resident #1 had fallen she was getting the nursing report from the first shift nurse. Staff B recalled that when she entered Resident #1's room, the resident was sitting on the floor with her back against the wall and appeared razzled. Staff B stated she recalled the CNA (Staff A) in Resident #1's room was an agency staff member, but could not recall her name. Staff B stated she had asked the agency CNA (Staff A) where the gait belt was and Staff A replied that she had not used a gait belt. Staff B stated she assessed Resident #1 while the resident was on the floor and Resident #1 had stated my butt hurts. Staff B stated she and other staff moved the resident to her recliner and then to her bed. Resident #1 would not extend her right leg fully and Staff B stated she had called for an ambulance to transfer the resident to the local hospital. After the incident, Staff B recalled asking Staff A why she was not using a gait belt when she assisted Resident #1 with her transfer and ambulation (walking) and Staff B recalled seeing two gait belts in Resident #1's room at that time. Staff B stated she had said to Staff A there was no excuse not to use a gait belt, especially when ambulating a resident. Staff B explained Staff A, CNA had apologized for not using a gait belt. Staff B recalled provided education to Staff A after the incident. In an interview on 6/2/26 at 11:58 a.m. with the Director of Nursing (DON), when asked about the orientation provided for staff members working at the facility, the DON stated that no orientation checklist was completed with agency staff on their first assignment to the facility. The DON explained the facility had not done that with agency staff as the agency was responsible to send staff that were qualified to fill the positions that had been requested. The DON stated that on the first assignment of a CNA from a staffing agency to the facility, a CNA (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	employed directly by the facility would provide a facility tour, show the new CNA where the gait belts, supplies, and Mini Care Plans for the residents were located, and provided a Cheat Sheet to the new CNA that they could carry with them to refer to during the shift. On 6/2/26 at 12:51 p.m., the DON explained after the incident on 3/13/26, she had posted a note for one month at the nurses' station that reminded staff to use gait belts and to review the resident care plan if they were unsure of that resident's transfer or ambulation status. Signatures were not collected. On 6/2/26 at 3:09 p.m., the DON stated the facility had developed the Cheat Sheets for new staff who needed something to refer to on the floor until they became comfortable with the residents' care needs. It was noted the Cheat Sheet listed the assistance level (independent, assist of 1 or 2 staff) needed for each residents' transfer, the assistive devices needed (walker, wheelchair, gait belt, type of mechanical lift), the residents' care information (glasses, dentures, hearing aids, and continence status), and products used (type and size of incontinent product, braces, compression wear, and protectors). In an interview on 6/3/2026 at 1:16 PM Staff G, Physical Therapist (PT) revealed Resident #1 had received therapy services prior to the 3/13/26 incident, from 1/19/26 to 3/13/26 three times a week. Therapy was working with Resident #1 on bed mobility, functional transfers, and ambulation for longer distances, 150-200 feet. Resident #1 was being discharged from her therapy services on 3/13/26 and Staff G stated she had met her bed mobility goal. Resident #1's functional transfer goal was to be able to transfer with stand-by assistance and clarified that meant the resident's goal was to be able to stand with staff standing beside her, but with no hands-on contact. Staff G stated she had not achieved that goal and for transfers Resident #1 was to be assisted with contact guard which she stated meant staff were to use a gait belt around the resident's waist and have their hands on that gait belt while she transferred. Resident #1's ambulation goal was not met which was for the resident to be independent walking on her own. Staff G confirmed that on 3/13/26 Resident #1's transfer and ambulation status was contact guard assist. On 6/3/26 at 1:59 p.m. Staff E, CNA, stated he had worked full time at the facility the past four years. Staff E stated he was familiar with Resident #1. He stated Resident #1 was able to walk short distances with the use of a walker while staff used a gait belt around her waist. Staff E explained he had always used a gait belt when he had assisted Resident #1 with transfers and walking and he had always seen other staff use a gait belt with Resident #1. Staff E pointed to the facility's Cheat Sheet which was in a binder at the nurses' station and to Resident #1's care information which indicated that she was a one to two staff assist with gait belt. On 6/1/26 at 4:52 p.m., the Administrator explained, in part, the following regarding the 3/13/26 incident: The Administrator revealed that the facility had not kept any Cheat Sheets from the time of the incident, but provided a current Cheat Sheet. The Administrator confirmed for Resident #1, one to two staff were needed to assist the resident with her transfers and ambulation, with staff use of a gait belt. When the Administrator was asked where the gait belts were located, she stated they were at the nurses station and in the resident rooms. On 6/3/26 at 3:17 p.m., the Administrator explained the root cause of the incident was that Staff A, CNA, had failed to use a gait belt as indicated on Resident #1's Mini Care Plan. Attempts to contact Staff A, CNA on 6/2/26 and 6/3/26 were unreturned prior to the exit of the survey. Review of the facility's Gait Belt policy reviewed on March 2011 revealed the standard directed, All employees providing direct resident care are required to utilize a gait belt whenever hand on assistance is needed for resident transfer and/or ambulation. The policy's rationale documented, In effort to ensure that residents and employees safety is protected during transfer and ambulation. The policy stated that the gait belt would be provided by the facility, was considered part of the employee's uniform, and was to remain in the facility. The policy further directed, All direct care staff are required to wear gait belt while on duty, and prior to transfer of a resident, staff member is to remove his/her gait belt and place it around the resident's waist, securing it with approximately one finger's space between the belt and the resident. The policy further directed staff to, Place any needed devices (walker, wheelchair, etc.) in proper position, and if transferring to a walker, make sure the resident is safely secured. The policy instructed staff that the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	gait belt be used to assist with walking a resident. It [the gait belt] can serve as a handle to grasp if the resident begins to fall. This can prevent a fall or control the resident's descent. Review of the facility Plan of Care Policy revised 2024 revealed, Plans of care, referred to a Mini Careplans, are to assure staff has the appropriate information to provide care. The policy informed staff all mini careplans were available in binders at both nurses desks.