STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165530	A. Building B. Wing	09/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Haven Village	133 Indian Hills Drive Glenwood, IA 51534

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. 49628 Based on observations, clinical record review, staff interviews, and policy review the facility failed to transfer a resident with a gait belt and the resident fell resulting in an injury for 1 of 10 residents (Resident #1) reviewed for falls and safe transfers. The facility reported a census of 67 residents. Findings include: The Minimum Data Set (MDS) assessment of Resident #1 dated 7/2/24 reflected the Brief Interview for Mental Status (BIMS) score of 14/15, indicating intact cognition. The resident required partial/moderate assistance for transfers, ambulation, and lower body dressing. In the past 7 days of the assessment period the resident used a walker and wheelchair. During the previous 5 days of the assessment period Resident #1 received scheduled pain medication and as needed (PRN) pain medication. The resident was frequently incontinent of bladder and occasional incontinence of bowel. The resident had diagnoses of heart failure and renal insufficiency. The document further revealed the resident took an anticoagulant medication. Resident #1's Care Plan had an identified problem area of risk for falls related to incontinence, need for staff assistance for transfers, pain and weakness. Approaches for staff to utilize included ensuring call light and frequently needed items were within reach, and placement of the lift recliner remote in the side pocket. Resident #1's pocket care plan at the time of the fall reflected the resident required staff assist x1 for activities of daily living (ADLs), and transfers with assistance x1. The Care Plan also identified the resident at risk for complications related to anticoagulant (blood thinner) therapy. It directed staff to assess for episodes of excessive bleeding/bruising and to notify the physician. The Active Orders for Resident #1 revealed the resident was on warfarin (blood thinner) 3mg oral every day. The email dated 7/24/24 to the staff of Resident #1's cottage, nursing department, and Staff G, Registered Nurse (RN), Care Coordinator from the therapy department provided instructions to staff that the resident required assistance of 1 staff for ambulation with a front wheeled walker and left (L) knee brace to and from the bathroom (room only). (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	The electronic health record (EHR) revealed on 8/13/24 at 11:02 AM Staff G, RN, Care Coordinator, responded to a nurse stat call. The document revealed Resident #1 was seated on the floor with her backside to the toilet, legs in front of her, and a laceration to the back of her head. Staff H, Certified Nursing Assistant (CNA), was seated on the floor next to the resident. The document revealed the resident was responding at baseline; however, due to the resident taking an anticoagulant medication was sent to the emergency room via 911 services and admitted to the hospital. The Event Report document within the EHR dated 8/13/24 at 11:34 AM revealed Resident #1 sustained a ground level fall in the bathroom. The document indicated the resident had no complaints of pain post fall and sustained a laceration to the back of the head. Assessment of Resident #1 included vitals, range of motion, neurological check, facial muscle movement, upper extremity movements/grasps, lower extremity range of motion, pupil size/response/shape, and speech. The document revealed the resident's walker was in the bathroom, and the resident was wearing tennis shoes. The document indicated the primary care provider was called and a phone order was received for sending the resident to the hospital. The resident's son and daughter were called and notified of the fall, and the resident was transferred to the hospital. Resident #1's hospital record dated 8/13/24 to 8/16/24 revealed diagnoses of intraventricular hemorrhage, scalp laceration and closed head injury without loss of consciousness. An observation on 9/20/24 at 12:07 PM revealed Staff A, CNA, utilized an EZ Way Lift (weight bearing mechanical lift) for transferring Resident #1 from the wheelchair (w/c) in her bedroom to the bathroom/toilet and from the toilet to the resident's recliner. On 9/20/24 at 10:57 AM Staff I, Physical Therapist Assistant (PTA) stated Resident #1 prior to the fall on 8/13/24 required minimum to moderate assistance for sit to stand sequence, and once standing the resident required contact guard assist for ambulation using a front wheeled walker (FWW). Staff I stated the cottage staff were instructed to ambulate the resident using a FWW and L knee brace for bathroom/bedroom distances. The staff stated the resident had decreased compliance with use of the knee brace before the fall. Staff I stated staff should have had at least 1 hand on Resident #1 at all times. Staff I stated the use of gait belt is a facility requirement for all transfers. The staff stated since returning from the hospital, therapy had assessed the resident and recommended the use of an EZ Way Lift for all transfers as the resident was no longer safe for stand pivot transfers or ambulation due to knee pain and crepitus. Staff stated an email was sent to the cottage staff in July with instructions for room distance ambulation with the resident. On 9/20/24 at 12:15 PM Staff A stated prior to the fall in August, Resident #1 was able to ambulate to the bathroom with a gait belt and FWW. The staff stated a gait belt was required for all transfers. On 9/20/24 at 12:24 PM Resident #1 stated she did fall in the bathroom and cut the back of her head. The resident stated her feet just started sliding and she fell . The resident stated she did not like to wear her knee brace and was not wearing a gait belt at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/20/24 at 12:43 PM Staff G, RN, Care Coordinator, stated on 8/13/24 she assessed Resident #1 post fall. The staff stated the resident did not have a gait belt or the knee brace on. Staff G stated the resident had a laceration on the back of her head, was conscious, and at baseline cognitively. The staff stated the resident had complaints of pain in her knees prior to the fall and would not consistently wear her knee brace. Staff G stated that since returning from the hospital the resident was changed to the use of the EZ Way Lift due to decreased strength and safety. The staff stated all staff were to use a gait belt with all residents when completing transfers. Staff G stated the gait belt was required to be on the staff at all times when working. The staff stated the facility provided gait belts for staff to use while at work, and the cottages had extra gait belts if needed. On 9/20/24 at 2:34 PM Staff H, CNA, stated she assisted Resident #1 to the bathroom. The staff could not recall whether a gait belt was utilized walking to the bathroom. Staff H stated she did not use a gait belt following toileting and when starting to walk back to the resident's bedroom. The staff stated Resident #1 lost her balance, and she was not prepared for that and could not stop the fall. Staff H stated the resident had her FWW with her. Staff H stated she had turned her attention to obtain the resident's glasses from the counter when the resident lost her balance and fell . Staff H stated she was aware of the facility policy requiring the use of gait belt when transferring residents, but at the time was not thinking the steps through as clearly as she should have. The staff did recall receiving the email regarding the resident's assistance needs for transfers and ambulation. On 9/20/24 at 4:36 PM Staff E, CNA, stated staff should always use a gait belt when transferring a resident, and they had recent re-training on the use of gait belts and transfers. On 9/21/24 at 8:25 AM Staff F, CNA, stated staff should always use a gait belt when transferring residents and that she had recent training on transfers and gait belts. On 9/20/24 at 9:45 AM the Administrator stated the facility policy required staff to utilize gait belts for all transfers. The Administrator stated the facility had implemented competency checks during nurse manager rounds, and did a re-training on gait belt use following the fall. The facility provided document, Glen Haven Village Safe Lifting/Transfers, revised 2/21, revealed all non-mechanical transfers require gait belt usage. The document further revealed that staff should wear a gait belt on their person at all times to ensure they were readily available.