STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165580	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Urbandale Health Care Center	4614 NW 84th Street Urbandale, IA 50322

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on observation, clinical record review, staff and resident interviews and policy review, the facility failed to provide assessment and intervention for the necessary care and services for 1 of 3 residents reviewed (Resident #1). The facility lacked assessments of the resident following a fall and an assessment prior to the resident being transferred to a higher level of care for evaluation and treatment. The facility reported a census of 77 residents. Findings include: The Admission Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated the resident carried diagnoses that included: atrial fibrillation, end stage renal disease, diabetes mellitus, seizure disorder, fractured tibia and fibula, liver and kidney transplant status, and hemiplegia. Resident #1 required set-up assistance for eating, substantial assistance for bathing and personal hygiene and was dependent on staff for toileting and transfers. Per a facility provided incident report dated 9/8/24 at 10:07 PM the resident was being transferred from the wheelchair to bed with the sliding board and lost his balance and slid to the floor on his buttocks. At 9:30 PM the call light was on and the nurse went to answer the light and witnessed the resident being lowered to the floor. The resident was able to move the right upper and lower extremities without any complaints. The resident had known left sided weakness. No injuries were noted. Vital signs were within normal limits at: 120/62-66-18-98.2- and 98% on room air. The wheelchair brakes were on and the resident had proper footwear on. The resident stated I was transferring with the sliding board and slipped. The resident was assisted off the floor utilizing 2 staff and a gait belt and placed back in his wheelchair. The resident's daughter and the Assistant Director of Nursing (ADON) were made aware. No injuries were observed at the time of the incident. The resident was oriented x 3. Predisposing physiological factors included weakness and gait imbalance. Review of the facility progress notes revealed the following: (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/8/24 at 21:47 [9:47 PM]: Resident was being transferred from w/c [wheelchair] to bed with the sliding board and lost his balance and slid to the floor at 2130 [9:30 PM]. Call light was on and this writer went to answer light and witnessed resident being lowered to the floor. Resident was 2 assisted off the floor using the gait belt and back into his w/c. Able to move RUE [right upper extremity] RLE [right lower extremity] without any complaints. Resident has left sided weakness. No injuries noted. W/c brakes on, proper footwear on. VS WNL [within normal limits]: 120/62-66-18-98.2- 98% RA [room air]. Daughter/ADON [Assistant Director of Nursing] notified. 9/10/24 at 18:00 [6:00 PM]: [AGE] year old male returned to facility on hospital gurney via ambulance transport team after having been sent to ER [emergency room] for evaluation of AMS and family request on 9/9/24 pm. Resident met at front door by writer and escorted back to own room by writer. Alert and oriented x 3 - voiced gratefulness to being back and not to be in the hospital. Assisted slide transfer back to bed from gurney with x 4 assist. Denied c/o [complaints of] prior to/during and after transfer. 0/10 pain scale. Skin W/D/P [warm/dry/pink]. Alert and speech clear. Mucous membranes pink and moist. PEARLA [pupils equal and reactive to light and accommodation] bilaterally - facial symmetry is equal - hand grips equal with known loss/weakness to LUE/LLE [left upper extremity/left lower extremity] secondary to CVA/DX [cardiovascular accident/diagnosis]. Resp [respirations] ENL[even and non-labored]/purposeful . LSCTA [lung sounds clear to auscultation] all fields. Denies cough/wheeze or SOB [shortness of breath]. Able to answer questions appropriately. ABD [abdomen] soft BLE [bilateral lower extremities] (LLE > RLE) [left lower extremity greater than right lower extremity]. Homan's negative bilaterally. PPP [pedal pulse present] x 2 - Cap [capillary} refill less than 3 seconds. Able to demonstrate AROM/PROM [active range of motion/passive range of motion] unlimited in RLE/RUE - is weaker in LLE/LUE. Continues to wear immobilizing brace to LLE - dry flaky ski9n [skin] observed when Non skid socks removed for exam. Noted area on Lt [left] heel - tender to touch and deep purple fluid filled blister to Lt heel - area cleaned and patted dry - Soft PROFO boots placed for support and comfort - after settled in bed heels floated with positioning devices. Set up dinner tray and reoriented to room/call light/tv and bed controllers. Assisted in calling wife to notify of return to facility. Message left with residents message. Call light attached to chest. Complete skin assessment to be completed after supper meal completed per resident request. ARNP [Advanced Registered Nurse Practitioner] notified of return to facility. Hot charting updated - 97.6-78-18-123/68-94% RA [room air] The facility lacked any follow-up documentation relating to the fall or the request to send the resident to the hospital for evaluation and treatment status post fall. The Care Plan dated 9/6/24 for Resident #1 included a focus area for the resident having an actual fall and being at high risk for falls related to poor balance. The goal was that the resident would have no injuries from falls through the rating period. Interventions included ensuring the call light was in reach as allowed, ensuring proper footwear was in place during transfers as allowed, resident had a weak left side from previous cardiovascular accident and staff education was provided for safe slider board transfers. The Care Plan also included a focus area related to alteration in activities of daily living functioning and transfers requiring the assistance of staff with a goal that the resident would increase functioning with activities of daily living and transfers through the review date. Interventions included the resident was to utilize 2 staff for transfers using the slider board. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/15/24 at 11:18 AM, the Interim Director of Nursing (DON) stated it was the expectation with all falls that staff complete an assessment for pain and injury and document their finding every shift for 72 hours. The fall should be placed on Hot Charting at the nurses station and documentation placed in the electronic health record. The Interim DON stated she would further expect an assessment to be completed and documentation put in the electronic health record if a resident was being transferred out of the facility along with how and when they left the facility. In a facility provided policy titled Change in a Resident's Condition or Status with a revision dated of 12/16/21, it stated the nurse was to record in the resident ' s medical record information relative to changes in the resident's medical/mental condition or status. In a facility provided policy titled Falls Management System last revised 9/2022, it stated when a resident sustained a fall an evaluation for injury by a licensed nurse was to be completed and the results documented in the medical record. Follow-up assessments and documentation were to be conducted for a minimum of every shift for 72 hours.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on observation, clinical record review, staff and resident interview and policy review, the facility failed to provide treatment and services to promote the healing of a pressure ulcer for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 77 residents. Findings include: The Admission Minimum Data Set (MDS) dated [DATE] documented the resident admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated the resident carried diagnoses that included: atrial fibrillation, end stage renal disease, diabetes mellitus, seizure disorder, fractured tibia and fibula, liver and kidney transplant status, and hemiplegia. Resident #1 required set-up assistance for eating, substantial assistance for bathing and personal hygiene and was dependent on staff for toileting and transfers. Resident was at risk for developing a pressure ulcer, and received dialysis. The Medication and Treatment Administration Record for Resident #1 dated 9/1/24 to 9/30/24 documented the following physician orders: a. Braden Assessment weekly x 4 every day shift every 7 days. On admission then weekly x 3. Scheduled for 9/7/24, 9/14/24 and 9/21/24. (signed for on 9/14/24 and 9/21/24 but only the 9/21/24 was actually completed per documentation) Start dated 9/7/24. b. Skin Prep Wipes - Apply to left heel blister topically every shift for blister care related to difficulty walking. Start date 9/11/24. c. Weekly skin assessment every shift every Monday. Start date 9/9/24. discontinued on 9/23/24. (Signed for on 9/16/24 only. Not completed on 9/9/24) d. Weekly skin assessment every shift every Tuesday. Start date 9/24/24. A Braden Scale for Predicting Pressure Sore Risk was completed on 9/21/24 at 5:06 PM with a score of 17 indicating Resident #1 was at risk for development of a pressure sore. A Weekly Non-pressure Injury Evaluation completed on 9/13/24 revealed: Right anterior wrist hematoma - not resolved and buttock redness. Both were first noted on 9/6/24 (on admission). Physician and family notified 9/6/24. No mention of the left heel wound. A Weekly Skin Review completed on 9/16/24 indicated Resident #1's skin was intact and dry. The fistula to the right inner bicep and the left heel purple blister continues to heal- skin prep treatment to be completed twice a day. Left lower extremity skin was dry and lotion was applied. Hematoma to right wrist present and slight redness to inner buttocks. A Weekly Skin Review completed on 9/24/24 indicated Resident #1's skin was dry. Left heel blister continued to heal. Left elbow had a red area from rubbing on the wheelchair - 3 centimeter (cm) x 3 cm and was left open to air. Resident could benefit from sling to flaccid left arm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress notes for resident #1 revealed the following: a. Date: 09/06/2024 15:39 [3:39 PM] Admission assessment - Abnormalities noted with skin assessment: Redness to buttocks; intact. Dry skin throughout, L [left] forearm is darkened in color-end stage renal failure. R [right] anterior wrist has a hematoma present, R [right] post FA [forearm] bruise-1 Fistula to R [right] inner bicep, L [left] heel purple blister- 3.5cmx3cm intact. b .Date: 09/08/2024 12:11 [12:11 PM] -Daily Skilled Charting. skin is C/D/I [clean/dry/intact]. c. Date: 09/10/2024 18:00 [6:00 PM] Alert Note - Noted area on Lt [left] heel - tender to touch and deep purple fluid filled blister to Lt [left] heel - area cleaned and patted dry- Soft PROFO boots placed for support and comfort- after settled in bed heels floated with positioning devices. Complete skin assessment to be completed after supper meal completed per resident request. ARNP [Advanced Registered Nurse Practitioner] notified of return to facility . Hot charting updated - 97.6-78-18-123/68-94% RA [Room Air] d. Date: 09/11/2024 11:00 [11:00 AM] Nursing Note Note Text : New order for skin prep to left heel blister BID [bis in die] (twice a day). Resident notified. e. Date: 09/12/2024 14:15 [2:15 PM] *Skilled Nursing Note - Blister to L [left] heel- skin prep BID [bis in die] (twice a day) currently intact, float heels when in bed x2 f. Date: 09/14/2024 13:15 [1:15 PM] *Skilled Nursing Note- Skin/Dressing Changes/Repositioning : No skin issues noted g. Date: 09/16/2024 22:21 [10:21 PM] *Skilled Nursing Note. : No new skin issues noted. h. Date: 09/18/2024 18:43 [6:43 PM] *Skilled Nursing Note. skin dry and intact , skin prep to the left heel, Res able to propel self in chair and in bed. i. Date: 09/20/2024 03:41 [3:41 AM] *Skilled Nursing Not [Note]. wound care provided to left heel. blackened area intact to left heel. heel protectors on bilaterally. no new skin issues noted, reported. j. Date: 09/21/2024 13:38 [1:38 PM] *Skilled Nursing Note. : Left heel skin prep applied. k. Date: 09/24/2024 08:06 [8:06 AM] *Skilled Nursing Note. Res has a necrotic area to the left heel, treatment in place. l. Date: 09/25/2024 19:30 [7:30 PM] *Skilled Nursing Note. Skin W/D/ [warm/dry] with necrotic left heel, treatment in place. Resident #1's Care Plan dated 9/6/24 included a focus area for the resident being at risk for skin breakdown related to decreased mobility with a goal the resident would maintain skin integrity through the review period. Interventions included completing a Braden Scale weekly x 4, then quarterly, to keep the residents' skin clean and dry and to complete weekly skin assessments. The MDS nurse added the left heel blister to the care plan on 9/16/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The left heel blister was noted on admission on 9/6/24 and measured 3.5 cm x 3 cm. The facility failed to report or set up assessments/monitoring or a treatment to the area. The skin prep treatment was not initiated until 9/11/24. The facility failed to complete the weekly skin assessment as ordered on 9/9/24. The assessment was completed on 9/16/24 and 9/24/24 but was not complete as ordered on 9/9/24. The facility failed to complete the Braden Scale on admission and weekly x 3 as ordered on 9/7/24. The only one completed was on 9/21/24. The facility Care Plan failed to address the left heel blister being present on admission and was not noted on the care plan until 9/16/24. In an interview on 10/15/24 at 1:18 PM, the Interim Director of Nursing (DON) stated it was the expectation that a skin assessment be completed weekly and when a wound was identified. The physician was to be notified the same day a wound was identified, and an assessment completed and a treatment and interventions set up. A Braden Scale was also to be done on admission and weekly x 3 and as needed with any new skin issues. In a facility provided policy titled Pressure Injury Surveillance with no date noted, it stated the licensed nurses were to participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of new or worsened pressure injuries. All pressure injuries were to be tracked. Data to be used in the surveillance activities may include, but were not limited to: 24-hour shift reports, incident reports, focused incident reviews, pressure injury/wound assessments, medication and treatment records, and rounding observation data.

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F 0689 Level of Harm - Minimal harm or potential for 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** 44972 Based on observation, clinical record review, staff and resident interviews and policy review, the facility failed to provide a safe transfer for 1 of 3 residents reviewed (Resident #1). The facility failed to utilize 2 staff for a sliding board transfer as directed by the care plan resulting in a fall. The facility reported a census of 77 residents. Findings include: The Admission Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated the resident carried diagnoses that included: atrial fibrillation, end stage renal disease, diabetes mellitus, seizure disorder, fractured tibia and fibula, liver and kidney transplant status, and hemiplegia. Resident #1 required set-up assistance for eating, substantial assistance for bathing and personal hygiene and was dependent on staff for toileting and transfers. The resident received antipsychotic, antidepressant, diuretic, opioid, and hypoglycemic medications and was receiving dialysis. Per a facility provided incident report dated 9/8/24 at 10:07 PM the resident was being transferred from the wheelchair to bed with the sliding board and lost his balance and slid to the floor on his buttocks. At 9:30 PM the call light was on and the nurse went to answer the light and witnessed the resident being lowered to the floor. The resident was able to move the right upper and lower extremities without any complaints. The resident had known left sided weakness. No injuries were noted. Vital signs were within normal limits at: 120/62-66-18-98.2- and 98% on room air. The wheelchair brakes were on and the resident had proper footwear on. The resident stated I was transferring with the sliding board and slipped. The resident was assisted off the floor utilizing 2 staff and a gait belt and placed back in his wheelchair. The resident's daughter and the Assistant Director of Nursing (ADON) were made aware. No injuries were observed at the time of the incident. The resident was oriented x 3. Predisposing physiological factors included weakness and gait imbalance. Review of the facility provided Set Sheet dated 9/9/24 revealed Resident #1 was non-weight bearing to the left lower extremity and staff were to use 2 staff assistance with the slider board. Review of the facility progress notes revealed the following: a. Date: 9/8/24 at 21:47 [9:47 PM]: Resident was being transferred from w/c [wheelchair] to bed with the sliding board and lost his balance and slid to the floor at 2130 [9:30 PM]. Call light was on and this writer went to answer light and witnessed resident being lowered to the floor. Resident was 2 assisted off the floor using the gait belt and back into his w/c [wheelchair]. Able to move RUE [right upper extremity] RLE [right lower extremity] without any complaints. Resident has left sided weakness. No injuries noted. W/c [wheelchair]brakes on, proper footwear on. VS [vital signs] WNL [within normal limits]: 120/62-66-18-98.2-98% RA [room air]. Daughter/ADON [Assistant Director of Nursing] notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Date: 09/13/2024 09:25 [9:25 AM] IDT [interdisciplinary team] met to discuss fall 9/8/24. RCA [root cause analysis] performed and resident education completed to utilize call light when transferring. c. Date: 09/15/2024 10:43 [10:42 AM] Res [Resident] is two assist with slide board for transfers. The Care Plan dated 9/6/24 for Resident #1 included a focus area for the resident having an actual fall and being at high risk for falls related to poor balance. The goal was that the resident would have no injuries from falls through the rating period. Interventions included ensuring the call light was in reach as allowed, ensuring proper footwear was in place during transfers as allowed, resident had a weak left side from previous cardiovascular accident and staff education was provided for safe slider board transfers. The Care Plan also included a focus area related to alteration in activities of daily living functioning and transfers requiring the assistance of staff with a goal that the resident would increase functioning with activities of daily living and transfers through the review date. Interventions included the resident was to utilize 2 staff for transfers using the slider board. In an interview on 10/8/24 at 3:30 PM, Staff A, Licensed Practical Nurse (LPN) reported on 9/8/24 during rounds, Staff B, Certified Nursing Assistant (CNA) was putting Resident #1 to bed. The resident was in his wheelchair and was going to transfer into his bed. Staff A, LPN heard Staff B, CNA yelling Help! Help! Staff A, LPN stated when she entered the resident's room she saw Staff, B, CNA lowering the resident to the floor. Staff A, LPN stated the resident had reported to Staff B, CNA that he could transfer using the slide board without assistance. He stated he just lost his balance and fell . Staff A, LPN and Staff B, CNA assisted him off the floor and into bed using a gait belt. Staff A, LPN did state there was only 1 staff present during the attempted sliding board transfer. Staff B, CNA reported to Staff A, LPN that the resident had said they could do it together. No injuries were noted at the time of the incident. Staff A, LPN reported it was care planned for the resident to use the slide board for transfer with the assistance of 2 staff as she checked the care plan after the incident. In an interview on 10/9/24 at 5:20 PM, Staff B, CNA stated she remembered Resident #1's fall on 9/8/24 and she was the staff person assisting him from his wheelchair to his bed. She stated she was aware the sliding board transfer was to be completed with 2 staff assisting but stated the resident acted like he could do it himself. She stated she had planned to get help but once she got the board in place, Resident #1 just started moving. He then told her after the fall that it was not the first time he had fallen while transferring. The resident had indicated that he could do it himself. Staff B, CNA stated it wasn't her fault and she should not be blamed for the incident. Staff B, CNA stated that information on how a resident transfers was found in the resident information book. She stated she did not see it there but knew the transfer should be a 2 person assist. In an interview on 10/15/24 at 1:18 PM, Interim Director of Nursing (DON) stated it was the expectation 2 staff complete all lift transfers and staff follow the care plan for sliding board transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility provided policy titled Falls Management System with a revision date of 9/2022 stated when a resident sustains a fall, an evaluation may include investigation to determine probable causal factors considering environmental factors, resident medical condition, resident behavioral manifestations and medical or assistive devices that may be implicated in the fall. The investigation and appropriate interventions will be evaluated at the time of the fall and reviewed by Nursing Management or the interdisciplinary team. Interventions secondary to the investigation will be documented in the Care Plan, as indicated.