STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165610	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Vista Village	2785 1st Avenue S Altoona, IA 50009

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 - 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** 34817 Based on clinical record review, staff interviews, and policy review, the facility staff failed to follow the Care Plan to properly transfer a resident as directed in the resident's care plan for 1 of 4 residents sampled for transfers and falls (Resident #22). The facility reported a census of 39 residents. Findings include: The Quarterly Minimum Date Set (MDS) assessment dated [DATE] revealed Resident #22 had diagnoses of orthostatic hypotension, non-Alzheimer's dementia, and tremors. The resident had a Brief Interview for Mental Status score of 4, which indicated severely impaired cognition. The MDS revealed the resident required partial to moderate assistance for transfers. The MDS recorded the resident had no falls. The Quarterly MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 4, indicating severely impaired cognition. The resident required substantial to maximum assistance for transfers. The MDS indicated the resident had a fall without injury since the prior assessment. The Care Plan revised 9/1/22 revealed the resident at risk for major injury related to falls due to weakness and impaired gait and balance. The staff directives included to transfer the resident with assistance of one and a gait belt, and ensure the resident wore proper footwear. The Care Plan revised 2/29/24 revealed staff directives to use an EZ stand lift and assistance of two staff for all transfers except toileting. Use a front wheeled walker and assistance of one staff and a gait belt as tolerated for toileting, and use the EZ stand to toilet PRN (as needed). A Fall Risk assessment dated [DATE] revealed the resident at risk for falls. Incident Reports revealed the following: (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 - Minimal harm or potential for actual harm Residents Affected - Few	a. On 1/9/24 at 6:20 AM, resident on floor on his knees and bent at waist with torso and head on his mattress. Certified Nursing Assistant (CNA) stated the resident's legs buckled while she transferred the resident from the bed to his wheelchair. Resident #22 reported the same story. Gait belt not in use. Resident only had socks on, no shoes on. No injuries. Resident assisted into wheelchair by two staff. Education provided to CNA on proper footwear during transfers and to use a gait belt. b. On 3/20/24 at 4:20 PM, CNA stated resident lowered to the floor during a stand pivot transfer (SPT) from the recliner to his wheelchair. The recliner moved during the transfer. Staff did not use the EZ stand lift or two staff for transfer. The Progress Notes revealed the following: a. On 1/9/24 at 6:20 AM, resident on floor on his knees and bent at waist with torso and head on his mattress. CNA stated the resident's legs buckled while she transferred the resident from the bed to his wheelchair. Resident #22 reported the same story. Gait belt not in use. Resident only had socks on, no shoes on. No injuries. Resident assisted into wheelchair by two staff. Education provided to CNA on proper footwear during transfers and to use a gait belt. b. On 3/20/24 at 8:16 PM, called to resident's room at approximately 4:20 PM. The resident sat on floor in front of his recliner. CNA in room at time of the incident. CNA reported the resident slid out of recliner onto the floor. The Physical Therapy (PT) discharge summary dated 2/23/24 revealed PT recommended EZ-stand and assistance of two staff for transfers to improve ease of transfers on the resident and staff. Resident able to transfer using grab bars in the bathroom with assistance of one staff as he tolerated. In an interview 5/16/24 at 9:55 AM, the Director of Nursing (DON) reported a fall packet filled out by the nurse whenever a resident had a fall. A risk watch put in place and an intervention added to prevent further falls. The DON completed investigation on how and why the fall occurred. Information shared at staff huddle held daily to go over new information and things the staff needed to know. The DON confirmed Resident #22 had falls. Therapy got involved to help with strengthening and to determine best transfer status. Resident #22 used a SPT for toileting otherwise staff used an EZ stand lift for transfers (to/from bed, chair. wheelchair). The DON checked the resident's Care Plan in the electronic health record and confirmed Resident #22 transfer status changed to using an EZ stand started on 2/24/24. The DON reported a pocket care plan for staff to use kept in a binder at the nurse's station. The MDS nurse updated the pocket care plan. The DON stated she expected staff used a gait belt for all transfers on residents who required assistance of one staff. In an interview 5/16/24 at 9:45 AM, Staff C, CNA, and Certified Medication Aide (CMA) reported she obtained a pocket care plan from the nurse's station and used the pocket care plan to know how a resident transferred. In an interview 5/16/24 at 10:33 AM, Staff D, MDS nurse stated she updated the pocket care plan as soon as she got notification for updates. Staff D stated the EHR care plan updated weekly. She only kept the current pocket care plans. Former pocket care plans not kept. The pocket care plan included information such as how a resident transferred. Resident #22 transfer status changed 2 weeks ago and he now used an EZ stand lift for all transfers, but prior to this time staff used an EZ stand lift PRN. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 5/16/24 at 10:50 AM, the DON reported Staff E was the CNA involved when Resident #22 had a fall on 3/20/24. In an interview 5/16/24 at 10:52 AM, Staff F, CNA, reported she used a pocket care plan to know how a resident transferred. She recalled Resident #22 transferred with assistance of one staff but it depended on the day. A gait belt used if a resident required assistance of one staff. Staff F reported she believed the pocket care plan showed Resident #22 required assistance of one staff. On the day of his fall (1/9/24) she assisted resident and his knees buckled, he went down on his knees by the bed. She called for the nurse. Staff F stated she believed she used a gait belt when she transferred the resident, but the incident happened awhile ago. In an interview 5/16/24 at 11:10 AM, Staff G, Licensed Practical Nurse (LPN) reported Resident #22 had falls. Interventions in place included to ensure his bed in lowest position and a mat on the floor by the bed. Therapy did an evaluation on him. When Resident #22 had a fall (1/9/24) he was not wearing gripper socks or shoes. She gave the CNA education at that time to use a gait belt whenever she transferred the resident and ensure he had proper footwear on. Resident #22 currently used an EZ stand and assistance of two staff for transfers. Previously he required assistance of one staff and use of a gait belt. In an interview 5/16/24 at 11:20 AM, Staff E, CNA, reported she looked at the pocket care plan to know how a resident transferred. The pocket care plan included the number of staff needed for transfers and any equipment needed. Staff E stated Resident #22 used a walker and assistance of two staff. They used an EZ stand PRN. Staff E reported the resident use to walk but he hadn't walked in awhile. On the day when he had a fall and she worked (3/20/24), the resident was a SPT. She placed his wheelchair by him and locked the brakes. She was transferring him from his chair to the wheelchair. His feet started sliding after he stood up. She lowered him to the floor and called for the nurse. He didn't have any injuries. She didn't realize his transfer status had changed. She didn't check the care plan or she would have had two staff assistance during this transfer. Staff E reported she worked agency for 8 months at the facility, then signed on as an employee. She had 1 hour of orientation when she first started working at the facility as agency. When she was hired to work at the facility as an employee she completed paperwork but did not receive any formal training. In an interview 5/16/24 at 12:25 PM, the DON reported they have done audits on falls and if staff are following the care plan as to how they are supposed to transfer a resident. A comprehensive person-centered care plan policy revealed the care plan included measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs, and implemented for each resident. Care plans are revised as information about the residents and the residents ' conditions change.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49990 Based on observation, staff interview, and policy review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility reported a census of 39. Findings include: 1. Observation of the kitchen on 05/13/24 at 10:01 AM revealed the refrigerator contained the following items; a bag of open to the air, unsealed, undated ham slices sitting in a pool of what appeared to be its own juices. A container of whipping cream that was open to the air, with no label to indicate when it had been opened. A Sealed, unlabeled, undated bag of an unknown food product. Observation on 05/13/24 at 10:09 AM revealed the walk-in freezer contained the following items: Two bags of what appeared to be hamburger patties that lacked labels, dates, and were not sealed. One bag of what appeared to be meat chunks that lacked labels, dates, and was not sealed. One bag of sealed meat products that lacked a label. Observation on 05/14/24 at 12:08 PM of Staff A, dietary aide, preparing and serving food without performing hand hygiene, while wearing gloves, and without using serving utensils or changing gloves. In an interview on 05/15/24 at 10:13 AM with Staff B, who indicated gloves should not be worn during food service, staff should avoid direct contact with a person's food, and staff should perform hand hygiene before and after dining service, and as needed during service. In an interview on 05/15/24 at 03:09 PM the Culinary Director stated her expectations are that staff should wash their hands before service, after service, and if their hands are visibly soiled. Staff should avoid direct contact with food by using serving utensils such as spoons and tongs. Review of policy titled Food Receiving and Storage, revised in 2018, stated All foods stored in the refrigerator or freezer will be covered, labeled, and dated. Opened containers must be dated and sealed or covered during storage. 34817 2. Observations of the breakfast meal service on 5/14/24 revealed the following: At 08:13 AM , Staff A, dietary aide, wore gloves as she checked the temperature of food in the warming table in the Rehab dining room. Staff A opened a cabinet, then picked up serving utensils and scooped food into a bowl and onto a plate. Staff A continued to wear the same gloves as she picked up a donut, then placed the donut on the plate. Staff A then picked up menu slips that dropped off the counter, and placed the menu slips back on the counter. Staff A removed her gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 08:17 AM, Staff A continued to scoop food onto plates, donned a pair of gloves, and reached into a bread sack with her gloved hand and removed a slice of bread. Staff A touched multiple surfaces with her gloved hand including menu slips, plates, and utensils for serving food, as well as touched donuts with the same gloves during meal service. The food was delivered to a residents in the dining room.