

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165613	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Northridge Village		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 George Washington Carver Avenue Ames, IA 50010	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858</p> <p>Based on clinical record review, staff interviews, and review of the facility's self-report, the facility failed to ensure the safety of a resident in the environment for 1 of 3 residents reviewed (Resident #1). The record review revealed Resident #1 required assistance of one staff with a gait belt for ambulation and transfer. On 4/3/24 at approximated 8:15 AM, as Staff A, Certified Nursing Assistant (CNA), assisted Resident #1 to ambulate with a gait belt, they said they needed to sit down in a wheelchair. When Staff A let go of the gait belt, Resident #1 lost their balance and fell down on the floor on their left side, resulting in a hip fracture. The facility reported a census of 35 residents.</p> <p>The facility corrected the deficiency on 4/30/24 by educating all staff regarding the proper transfer technique. The facility provided the training in person and online for the ones who couldn't attend the in person training.</p> <p>Findings include:</p> <p>1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] indicated they could understand others and others could understand them. The MDS identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Resident #1 required substantial to moderate assistance with ambulation with walker. The MDS included diagnoses of hypertension (high blood pressure), pneumonia, urinary tract infection (UTI), arthritis, osteoporosis, chronic pain, hip fracture following a recent fall, and recent hip replacement.</p> <p>A Baseline Care Plan dated as 3/29/24 identified Resident #1 required assistance from one staff with transfers, ambulation with a four wheeled walker (FWW), and toilet use. In addition, the Care Plan identified Resident #1 had a recent fall with a fracture of their left hip that required a hip replacement.</p> <p>The Care Plan Focus created 4/1/24, identified Resident #1 as a high risk for falls related to gait and balance problems. The Interventions included the following:</p> <p>a. Anticipate and meet their needs</p> <p>b. Be sure their call light is within their reach and encourage them to use it for assistance as needed.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 165613
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>c. Provide a prompt response to all requests for assistance</p> <p>d. Ensure Resident #1 wore appropriate footwear, tennis shoes or gripper socks with transfer.</p> <p>e. Physical therapy evaluation and treatment as ordered as needed.</p> <p>A Fall Risk assessment dated [DATE], documented Resident #1 fell 1 2 times in the past 3 months. In addition, they had a recent hospitalization in the last 30 days, and a fall with left hip fracture.</p> <p>The Progress Notes dated 4/1/24 at 8:07 PM, documented, therapy recommended Resident #1 had assistance from 1 staff with transfers with their FWW, ambulation to the bathroom, and up in their wheelchair for meals to increase mobility.</p> <p>The Progress Notes dated 4/3/24 at 9:33 AM indicated at 8:15 AM, a CNA called the nurse to Resident #1's room due to an observed fall to the floor. Upon entering the room, the nurse observed Resident #1 on the floor in the entry way of their room. Her head pointed towards her roommates' side of the room with feet pointing towards her room. She laid on left side with a pillow under her head and her walker next to her. The CNA reported as she assisted Resident #1 with the walker and gait belt, she reached out to get a wheelchair for Resident #1 when she lost balance. The nurse assessed Resident #1 who report she did hit her head in back area. The assessment revealed no bumps, bruises, or knots noted, and no observed injuries. The nurse completed Resident #1's range of motion (ROM) to her upper extremities with no complaints of pain, ROM to right leg had no complaints of pain. Resident #1 could move their left leg but is post hip precautions at the time from a previous hip surgery. Resident #1 reported she felt pressure in the area she never felt before. The staff assisted Resident #1 to chair with assistance of a gait belt, therapy, and 2 staff members. The nurse initiated neurological (neuro) checks. Resident #1 reported to the nurse she didn't want to go to hospital. The nurse received orders to get a 2-view complete X ray of her left hip, may use portable X ray. Resident #1's Daughter stated she respected her mother's wishes to not go to hospital and appreciated the call.</p> <p>In an interview on 6/19/24 at 2:00 PM, Staff A, Registered Nurse (RN), stated she worked on 4/3/24. At approximately 8:15 AM the headphone walkie talkie alerted of a fall in Resident #1's room. Staff A went to Resident #1's room and found her on the floor on her left side with a pillow under her head. She had the walker next to her and the wheelchair in the room by her bed, a gait belt around Resident #1's waist. Resident #1 said that her left hip hurt, as they had 4 of staff in the room, they assisted getting her up and put her in a wheelchair to transfer her to bed. Resident #1 refused to go to the hospital, but agreed to have a portable x ray done at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/19/24 at 2:30 PM, Staff B, Certified Nursing Assistant (CNA), said she worked on 4/3/24 when Resident #1 fell . Staff B said she never worked on the east hall before, and never worked with Resident #1 before. She knew Resident #1 was fairly new to the facility. Staff B explained that Resident #1 stated she wanted to walk to the dining room for breakfast. Around 8:00 AM Staff B put a gait belt around Resident #1, assisted her to stand with the four wheeled walker and started to walk her to the dining room. When they got to the door of the bathroom, Resident #1 stated that she felt weak and needed to sit down in the wheelchair, which was in the bathroom. Staff B let go of Resident #1's gait belt to grab the handle of the wheelchair and as she reached for the handles on the wheelchair, Resident #1 laid on the floor on her left side. Staff B said that it is standard procedure to make sure that a staff member also holds onto the gait belt at all times and that the expectation of the staff is to make sure that they never let go of the gait belt at all times. If they need assistance, use the headphones to call other staff to come and help as needed.</p> <p>In an interview on 6/19/24 at 3:15 PM, Staff C, RN, said the facility expected the staff to always use a gait belt with all transfers and to never let go of the gait belt when it is around a resident.</p> <p>In an interview on 6/19/24 at 4:00 PM, The facility Administrator and Director of Nursing both confirmed that staff knew to never let go of the gait belt when it is around a resident. They did was education to make sure staff knew that they need to always hang onto the gait belt when around a resident and it is common practice to keep one hand on the gait belt at all times.</p> <p>In a Self-Report Injury Form dated 4/3/24 at 8:15 AM, documented Resident #1 fell . At 8:15 AM, a CNA called the nurse to Resident #1's room due to an observed fall to the floor. Upon entering the room, the nurse observed Resident #1 on the floor in the entry way of their room. Her head pointed towards her roommates' side of the room with feet pointing towards her room. She laid on left side with a pillow under her head and her walker next to her. The CNA reported as she assisted Resident #1 with the walker and gait belt, she reached out to get a wheelchair for Resident #1 when she lost balance. The nurse assessed Resident #1 who report she did hit her head in back area. The assessment revealed no bumps, bruises, or knots noted, and no observed injuries. The nurse completed Resident #1's range of motion (ROM) to her upper extremities with no complaints of pain, ROM to right leg had no complaints of pain. Resident #1 could move their left leg but is post hip precautions at the time from a previous hip surgery. Resident #1 reported she felt pressure in the area she never felt before. The staff assisted Resident #1 to chair with assistance of a gait belt, therapy, and 2 staff members. The nurse initiated neurological (neuro) checks. Resident #1 reported to the nurse she didn't want to go to hospital. The nurse received orders to get a 2-view complete X ray of her left hip, may use portable X ray. Resident #1's Daughter stated she respected her mother's wishes to not go to hospital and appreciated the call.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An investigation self report amendment submitted to the Department by the facility included the following: Resident received an injury after she fell on [DATE]. As the CNA assisted Resident #1 to breakfast with her walker using gait belt, she requested to have the wheelchair to follow in case she got tired. The CNA reached back for the wheelchair, releasing her hold on the gait belt, and then Resident #1 lost her balance and fell . The nurse immediately responded and completed an assessment. Resident #1 refused to go to the hospital, electing for a mobile X Ray. The provider ordered a mobile X Ray STAT (immediately), however it didn't arrive until late in the day. At 5:11 PM, Resident #1 received the results of a mildly displaced greater trochanteric fracture. The facility indicated their corrective action as the facility educated the CNA involved about the proper use of gait belts. The facility would complete training for all of the staff on proper use of gait belts.</p> <p>The Biotech X Ray dated 4/3/24 at 5:53 PM, documented, Findings/Impression: There is a mildly displaced left greater trochanteric fracture. Hip hemiarthroplasty there appears properly positioned.</p>		