Department of Inspections and Appeals
Health Facilities Division
Citation

Number 5819			Report date August 4, 2022
Facility name Edgewater, A Wesleylife Community		Survey dates July 17, 2022- July 27, 2022	
Facility address 9225 Cascade Avenue			
City West Des Moines	JB		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.28(3)e	**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) **DESCRIPTION:** Based on review of documents, observations, resident, and staff interviews, the facility did not ensure: 1. Assistance for safe ambulation 2. Implementation of safe transfer techniques after a fall 3. Supervision during the use of restorative equipment, for 1 of 4 residents (Resident #11) in the sample reviewed for accidents. 4. In addition, the facility did not consistently investigate fall incidents to determine root causes, in order to develop appropriate interventions to prevent or minimize potential occurrences, the facility did not consistently reflect assessments data, and interventions implemented related to falls in the clinical records for 1 of 4 residents (Resident #11) in the sample reviewed for accidents. The facility reported a census of 38 residents at the time of the survey.	I	$ 9500 Collected	Upon Receipt

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	Findings include: Resident #11's electronic medical records identified an admission date of 11/16/21. Resident #11's medical diagnoses included hemiplegia and hemiparesis (weakness, stiffness, and lack of control on one side of the body) following a cerebral infarction affecting her right dominant side, and low back pain. Resident #11's Minimum Data Set (MDS) assessment dated 12/22/21 indicated his active diagnoses included hemiplegia, acute respiratory failure, and depression. The MDS documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate impaired cognition. The MDS identified Resident #11 needed extensive assistance of one person for bed mobility, transfers, ambulation, personal hygiene, dressing, and toilet use. Resident #11 needed supervision with set up help to eat. The MDS also indicated Resident #11 as being unsteady and could only stabilize with staff assistance for balance during transitions, transfers, and walking. The MDS further indicated that Resident #11's used a 4 ww (wheeled-walker) and wheelchair as mobility devices. The section related to restorative nursing programs indicated Resident #11 had 0 to less than 15 minutes of restorative programs in the previous seven calendar days.			

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	Resident #11's MDS assessment dated 5/31/22 identified a BIMS score of 11, indicating moderate cognitive impairment. The MDS indicated that Resident #11 required extensive assistance of two persons for bed mobility, transfers, dressing, and toilet use. Resident #11 used extensive assistance of one person for locomotion on the unit and personal hygiene. verified facility report about having 3 falls since admission On 7/18/22 at 10:16 AM, observed Resident #11 sitting in his wheelchair in his room, alert, and signifying permission for the surveyor to enter for a routine survey interview. Resident #11 affirmatively replied to the inquiry regarding falls, and reported he sustained injury as a result of a fall. When asked of any changes in his cares related to the falls, Resident #11 said that the staff members now used a device to help him stand and transfer. On 7/20/22 at 10:05 AM, watched Staff C, CNA (Certified Nurse Aide), push an EZ stand (Standing mechanical lift) in the hallway towards Resident #11's room. Staff C explained that she was waiting for a Hospice staff member to assist with Resident #11. Staff C corroborated Resident #11's statement about needing to use an EZ stand and always with assistance of two people for all transfers. On 7/20/22 at 10:16 AM, Resident #11 verified that he fell three times since admitting to the facility.			

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	Resident #11 reported that he fell while using an exercise machine. Resident #11 said that he wanted to get off but no staff were there to help. Resident #11 also said during another one of his falls, he went walking with a staff member but could not remember if they used a gait belt. Resident #11 explained another fall when he slid down (pointing at the brown chair), saying he had to go to the bathroom. When asked if he used his call light when he needed to go to the bathroom, Resident #11 replied, "Got to have called and nobody was coming." Care Plan review The resolved Care Plan Focus area initiated on 1/12/22 and resolved on 3/23/22 directed that Resident #11 had limited physical mobility. The connected goal indicated that Resident #11 would maintain his current level of mobility of one assist with activities of daily living (ADLs) and be able to walk with 4 ww short distances through review date. The Care Plan included the following interventions initiated on 1/12/22 and got resolved on 3/23/22 a. Nursing rehab/restorative: active range of motion (ROM) Program bilateral upper extremities (BUE) strengthening exercises weight as Resident #51 could tolerate up to two pounds, three times a week.			

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	b. Nursing rehab/restorative: active rom Program NuStep (exercise bike that works upper and lower body) exercise for all extremities, time, and resistance to Resident #11's tolerance of three times per week. The Care Plan Focus area revised 12/16/21 identified Resident #11 as a high risk for falls related to deconditioning, unaware of his safety needs, hemiplegia from a previous cardiovascular accident (CVA). The attached goal initiated 12/16/21 documented that Resident #11 would have no serious injuries due to falls through the next review date. The Care Plan Focus included the following interventions a. Revised 2/24/22: Fall intervention: x-rays, emergency room (ER) evaluation, gait belt education for Certified Nurse Aides (CNA's). b. Initiated: 2/24/22: Anticipate and meet the resident's needs. c. Revised 12/16/21: Assist with toileting needs d. Initiated 12/16/21: Assist with toileting needs as needed (PRN). e. Initiated 1/20/22: Resident #11 is not to be left unattended on the NuStep. f. Revised 1/22/22 Intervention - urinalysis (UA) with culture and sensitivity (C&S). g. Initiated 1/25/22, Resolved 2/26/22: Keep Resident #11's walker close to him regardless of his location in his room.			

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	Initiated 12/16/21: Resident #11 would like to be encouraged and assisted with wearing non-skid footwear for all mobility attempts Initiated 12/16/21: Resident #11 would like to keep his room clutter-free. Resident #11's Restorative Nursing document dated 1/7/22, identified therapy recommendations from Physical Therapy (PT). The Restorative Identified Needs indicated the following programs a. NuStep exercise for BUE and lower extremities (LE) at time and resistance to the patient's tolerance. b. Ambulate patient with contact guard assist (CGA) with 4 ww distance to patient's tolerance. c. Upper extremity (UE) strengthening up to two pounds gross motor coordination (GMC) activities three times per week. Despite the care plan above, Resident #11 incurred fall incidents, as follows: The facility's records of incidents showed that Resident #11 had fall incidents related to failure to follow care plan, as follows: a. 1/20/22 at 1:30 PM: Unwitnessed fall from the NuStep in the Loden Living Room. i. The January 2022 Documentation Survey Report lacked documentation of Resident #11's ADLs indicating completion for the 6 AM to 2 PM shift on 1/20/22 or during the time of his fall.			

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	ii. In addition, despite Resident #11 having used the NuStep and falling from it, Resident #11's record lacked documentation of his performance of the NuStep activity on the same date. 1. FALL 1/20/22 (Unwitnessed). The Incident Report dated 1/20/22 at 1:30 PM labeled unwitnessed documented that the nurse got a call to the Loden living room area of the facility. The CNA reported that Resident #11 on the floor near the NuStep. When the nurse entered the living room, she observed the resident sitting parallel to the NuStep. Resident #11 sat upright with his feet outstretched in front of him with his hands on either side of his body holding him upright. The nurse assessed no injuries and his vitals were within stable. Two staff assisted Resident #11 up with a Hoyer Lift. Resident #11 denied pain, discomfort, or that he hit his head. When the nurse asked Resident #11 what happened, he responded that he decided to get off the machine and he slid off the edge of the seat. The Immediate Action Taken included an intervention for Resident #11 to not be left unattended while using the NuStep. The January 2022 Documentation Survey Report recorded that on 1/20/22, Resident #11's ADLs were not signed from 6 AM to 2 PM, which covered			

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	the time of the incident. The report lacked documentation regarding Resident #11's performance on the NuStep for his restorative plan and who assisted Resident #11 during the activity. Additionally the progress notes lacked entries to show Resident #11's incident on 1/20/22, including pertinent assessments and interventions. Resident #11's clinical records lacked evidence regarding a follow-up investigation after his fall regarding a root cause analysis, the staff involved, and the appropriateness of the intervention. On 7/25/22 at 11:39 AM, Staff C showed the NuStep equipment used by residents on a restorative at Loden Unit. Staff C said she got trained to not leave residents while in there (pointing at the NuStep). When asked if residents using the NuStep could call for help if they needed to get off, Staff C replied, "No call button on the NuStep because staff should be present all the time." Staff C showed a portable call system, but said that residents who sat in the living room and watched television used it. Staff C added that they should assist residents that fell with the Hoyer lift, and not stand them up. On 7/25/22 at 11:44 AM, Staff D, CNA, verified that she worked on the Loden Unit when Resident #11 fell from the NuStep machine. Staff D denied knowing who put him there and left him			

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	unattended. Staff D said that "no one" is supposed to be left alone on the NuStep machine. On 7/26/22 at 11:14 AM, when asked about supervision for residents who used the NuStep machine, the Director of Nursing (DON) reported that residents could be left unattended if they ask to use the NuStep machines because they have that right. The DON stated that they have a restorative aide but if she's not here, and a resident asks to be put on the machine, that request could be honored. The DON said, "it maybe what happened" with Resident #11 because prior to the fall on 1/20/22, Resident #11 had intact cognition. The DON said that Resident #11 could be left unattended using the NuStep machine. The DON added that she completed the investigation from Resident #11's fall, and discovered that an agency staff member signed the restorative nursing documentation. The DON explained with that documentation she determined who put Resident #11 on the NuStep machine, and that she (the Agency staff) could do that if Resident #11 requested. The DON said she completed the investigation regarding the fall but she didn't know if at that time, Resident #11 requested to use the NuStep by himself. The DON further said that the ADON (Assistant Director of Nursing) was still "digging" to look for investigation notes about the incident because those "were filed separately." The DON stated she would not expect witnesses for fall incidents with use of restorative			

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	equipment for residents who use or request these equipment on their own because "nobody is there." The DON also stated that the facility properly implemented interventions in handling/addressing fall incidents such as Resident #11's fall on 2/22/22 because the CNA who was with Resident #11 at the time had been coached and educated. On 7/27/22 at 12:30 PM, the DON provided the January 2022 Restorative Nursing Documentation, which lacked documentation for Resident #11's Restorative Nursing activities on the date of his fall (1/20/22). 2. FALL 1/22/22 (Unwitnessed). The Incident Report dated 1/22/22 at 10:45 AM labeled unwitnessed indicated a CNA notified the nurse of Resident #11 on the floor in his room in front of his closet with his head close to the closet and his body parallel with the dresser with his feet outstretched. Resident #11 explained that he woke up from a nap in his recliner. He thought that he could get up and go to the bathroom, so he attempted to get out of the recliner to get his walker. The nurse noted Resident #11's walker across from him as he didn't previously use it on a consistent basis. Resident #11 reported that he lost his balance and fell to the floor. He denied hitting his head. The staff placed Resident #11 into his bed with the use of a hoyer and two staff members.			

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	Two Registered Nurses (RN) assessed him with no injuries noted. The nurse got an order for a urinalysis (UA) with culture and sensitivity (C&S). On 7/25/22 at 11:59 AM, Staff E, RN (Registered Nurse), reported that she was on orientation when the incident happened, however, she verified that she documented about Resident #11's incident. Staff E verified that Resident #11's clinical progress notes lacked documentation about the fall but said "there is another place" where they document about it, and showed her own documentation in the computer. Staff E verified that the contents of her documentation in the computer are the same as the ones provided to the surveyor in hard copy (incident record), that contained the label Privileged and Confidential - Not part of the Medical Record - Do not copy. During an inquiry about the process for handling resident falls, Staff E replied that it would be to assess the resident before moving them and then assist the resident up from the floor with a Hoyer lift. If the resident complained of pain, or had any signs of injury, they should send the resident to hospital immediately for evaluation. Staff E said that she would not wait for a Portable X-ray. Staff E added that in regards to notifying a physician about an acute or emergency event, she said that she would call the physician's office and she wouldn't stop until she got an answer.			

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	Resident #11's clinical records lack entries pertinent to the fall, including assessments and interventions with regard to the fall when it happened on 1/22/22. The records also lack evidence of follow-up investigation regarding the surrounding circumstances of the incident. 3. FALL 2/22/22 (Witnessed). The Incident Report dated 2/22/22 at 7:30 AM labeled Unwitnessed Fall documented that while ambulating (walking) to the bathroom with his 4 ww, staff observed Resident #11 falling to the floor on his left side. Resident #11 didn't hit his head but did get a skin tear to his right hand. Resident #11 described that he complained of weakness and lost his balance. The nurse got an order to do an x-ray to his lower back and left hip. The report indicated that Resident #11 didn't go to the hospital. Resident #11 complained of pain at a 5 out of 10, indicating moderate pain. The Incident Report listed Resident #11's mobility as ambulatory with assistance. The Predisposing Physiological Factors listed weakness/fainted and gait imbalance. The Predisposing Situation Factors listed ambulating with assistance and using a wheeled walker. The form documented no witnesses found. On 7/18/22 at 10:16 AM, Resident #11's interview indicated he had a fall with injury.			

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	On 7/20/22 at 10:16 AM, Resident #11 verified that he had three falls since his admission to the facility, including an incident where he was walking with a staff member. Resident #11 could not remember if the staff member used a gait belt or held on to it during his fall. On 7/20/22 at 10:41 AM, Staff G, Registered Nurse (RN), confirmed that she worked as the nurse for Resident #11 during the fall on 2/22/22. Staff G identified Staff H, CNA, as the CNA who "let go of the gait belt" while ambulating Resident #11 to the bathroom. Staff G reported that after her assessment, the three of them, herself with Staff H and Staff F, CNA, lifted Resident #11 from the floor without using the Hoyer lift. Staff G said they should have followed protocol and used a Hoyer lift to transfer Resident #11 from the floor. Staff G said Resident #11 ate breakfast but complained of pain, and asked for pain medication (Tylenol). Staff G said she then obtained an order for X-ray. Staff G reported Resident #11 also vomited after lunch. Staff G further explained that when she notified the physician's office about the X-ray result, they ordered her to send Resident #11 to the hospital. When asked if they followed the facility's fall protocol in handling Resident #11's fall, Staff G answered that they didn’t follow the protocol to use a Hoyer lift.			

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	On 7/20/22 at 2:39 PM, Staff F, CNA, said she worked the day when Resident #11 fell. Staff F said it was Staff H who helped Resident #11 at the time of the fall. Staff F said, she did not know how the fall happened but [Staff H] came and got her. Staff F explained that she told Staff H that she was going to get the nurse. Staff F reported that Staff H left Resident #11 on the floor and went out to get her (Staff F). Staff F added that when she entered the room, Resident #11 laid on the floor halfway to the bathroom, in front of his recliner. Staff F identified Staff G as the nurse who worked that day. Staff F said Staff G assessed Resident #11 and decided that the three of them could pick Resident #11 up from the floor. Staff F reported that they helped Resident #11 from the floor to his wheelchair, then to the bathroom, where they transferred him to use the toilet. While there, they got him dressed and then they took him to his usual dining room for breakfast. When asked if Resident #11 complained of pain during the transfer, Staff F replied Resident #11 was "complaining of a little discomfort but then more after breakfast, and then they got an order for an X-ray. When asked if they did the proper interventions in handling Resident #11's fall, Staff F replied, "No, we should not have picked him up." The excerpt of the Progress Notes dated 2/22/22 below document the timeline of more than 6.5 hours following Resident #11's that he complained			

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	of discomfort and increasing weakness until his hospital transfer: a. At 7:30 AM, staff observed Resident #11 losing balance and falling while walking to the bathroom with a 4 ww. The note indicated that Resident #11 complained of lower back pain. The note continued to record that staff assisted Resident #11 up, as he could bear weight without difficulty. b. At 9:08 AM, the nurse administered a pain reliever (2 tablets of Tylenol 325 milligrams, (MG)). c. At 12:03 PM, the nurse gave another dose of pain reliever (2 tablets of Tylenol 325 MG). d. At 1:00 PM, the facility received the results of the X-ray and notified the physician's office of the results. e. At 1:20 PM, staff noted Resident #11 to have increased weakness, and had a large emesis (vomit) of undigested food after lunch. f. At 2:00 PM, the facility received an order from physician's office to send Resident #11 to the hospital for evaluation. g. At 2:15 PM, the facility transferred Resident #11 to the hospital. The document titled, "Patient Report" dated 2/22/22 contained Resident #11's X-ray results due to pain following a fall. The impression indicated Resident #11 had a probable comminuted fracture deformity noted along the left acetabular roof (the main weight-bearing area of the hip joint).			

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	The Nurses Note dated 2/23/2022 at 6:26 AM, also showed a nurse's follow-up call to the hospital, which confirmed Resident #11 got admitted to the hospital with a diagnosis of a pelvic fracture. Resident #11's decline following his fall a. The Hospital Discharge orders dated 2/25/22, showed Resident #11 discharged to the nursing facility with hospice services. b. The Significant Change MDS dated 3/2/22, identified Resident #11 required extensive assistance of two persons for bed mobility, transfers, personal hygiene, and toilet use; and total dependence for locomotion off the unit of one person. The MDS coded that Resident #11 received hospice services during the lookback period c. The updated Care Plan reflected Resident #11 received hospice services, and increased assistance requirements with his ADLs. d. The follow-up X-ray results dated 5/2/22, indicated that Resident #11's pelvic fractures remain with no convincing evidence of interval healing. e. The Physical Therapy Evaluation documentation dated 5/6/22, showed use of an EZ stand to transfer Resident #11. On 7/25/22 at 12:49 PM, when asked about notifications of change or occurrences, Resident #11's Family Member replied that facility called her about those, including all of Resident #11's falls.			

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	When asked about the fall with injury that happened on 2/22/22, Resident #11's Family Member replied that she received a call at 7:30 AM that day. Resident #11's Family Member said that the first thing she asked during the call was "was he hurt?". Resident #11's Family Member explained that she got told that Resident #11 already went to breakfast. Resident #11's Family Member said the caller didn't know if Resident #11 got injured but the caller assured Resident #11's Family Member that they would get an order for an X-ray. Resident #11's Family Member said the fall might have happened at around 7:20 AM, because she got notified at 7:30 AM. Resident #11's Family Member explained that by the time she arrived to the facility at 9:00 AM, she noted the X-ray person still in the hallway saying that he just finished working with Resident #11. Resident #11's Family Member said there had been a lot of movement after the fall and before his hospital admission at 2:30 PM. Resident #11's Family Member reported that they did another X-ray that pointed out the fracture all the way across. On 7/25/22 at approximately 11:14 AM, the DOT (Director of Therapy) said residents under therapy services could not be left by themselves while using therapy equipment. The DOT stated expectations that the staff must attend to residents throughout the entire therapy session.			

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Facility Administrator _____ Date _____

Department of Inspections and Appeals
Health Facilities Division
Citation

Number 5819			Report date August 4, 2022
Facility name Edgewater, A Wesleylife Community		Survey dates July 17, 2022- July 27, 2022	
Facility address 9225 Cascade Avenue			
City West Des Moines	JB		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
	On 7/27/22 at 3:20 PM, at the exit conference, the facility continued to not provide any documentation regarding the investigation of Resident #11's fall from the NuStep. The DON again said that Resident #11 requested to use the NuStep that day by an Agency staff who honored his request. The DON added on the recording that the Restorative Aide helped the resident use the NuStep, and the other staff who got interviewed didn't know the process. The DON further explained that Resident #11 asked an Agency CNA to use the NuStep, so the Agency CNA assisted him onto the NuStep. While on the NuStep, he pedaled independently and prior to the Agency CNA's return he decided to get off the machine on his own. The DON said the residents have the right to use the NuStep if they wish, and she was not going to stop them from doing that as it was their right. The DON further said they will have more investigation information regarding the fall to be submitted to the office in two business days from the exit date. Facility Policy Review The Gait Belt Use, revised 7/16, directed the staff person to utilize safe transfer techniques, by moving with the resident, with their knees bent, and a strong grasp on the transfer belt. The form included that if using a wheelchair, place it on the resident's strongest side.			

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	The Accident/incident Prevention Process, revised 6/20, instructed that all nursing staff were required to complete training specific for safe patient handling policy and proper equipment utilization. The form indicated that the Competencies would be completed as follows: a. Upon hire b. After completion of mentor program c. Annually d. After an injury related to transferring, repositioning, or lateral transfers if the investigation determines if improper technique and/or process related to the cause of the incident. e. Competencies must be done with visual return demonstration and be documented in the team members personnel file. f. Any team member off work for 90 or more consecutive days would be required to complete a competency skill check prior to the team member returning to his/her regular duties in the health center. The Restorative Program Procedure, revised 11/20, provides that it refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. The procedure provided that measurable goals and interventions must be documented in the care plan and in the medical record. The procedure also directs staff to write progress notes written by the restorative aid and countersigned by a licensed			

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	nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity, and a nurse must supervise the activities in the restorative nursing program. The Safe Resident/Client Transfer Procedure, revised 4/14, indicated that it is the facility's policy that manual lifting of residents will be minimized or eliminated whenever possible. The policy also provides that it is done for the safety of the residents, clients, participants, and team members during transfer and repositioning tasks. The Procedure directs the following. a. Gait-belt assistance-one person i. The resident can stand for at least 5 seconds, using mobility equipment such as walker ii. The resident requires supervision or contact assistance when ambulating iii. Assistance with sitting to standing may be required by assisting the resident to a standing position. The transfer status will be noted on the care plan, and the change in transfer status will be communicated to other team members at the change of each shift. b. If a resident falls, a medical assessment will be completed by a nurse, and if there is a medical concern, appropriate measures will be taken to			

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	notify emergency personnel, the resident should remain on the floor, made comfortable, and medically monitored until emergency responders arrive. i. If the resident is medically stable, was previously independent, and can get up on his/her own, a gait belt can be placed on the resident to assist with steadying. The staff member should not be using the gait belt to lift the resident from the floor. ii. If the resident is medically stable yet is unable to get off the floor on his/her own, a total body lift will be used regardless of transfer status. c. Training i. All team members will be required to demonstrate competency with transfer, repositioning, and lateral transfers in a controlled environment prior to being permitted to complete these tasks with residents. ii. It is expected that the policy will be followed at all times. d. Additional information i. Any injury resulting from transferring, repositioning, or laterally transferring a resident will go through an injury review process to determine root cause and to define corrective actions which can minimize the risk of another injury of this type from occurring again. **FACILITY RESPONSE:**			

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