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**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Citation**

<b>Number</b> 4486					<b>Report Date</b> January 7, 2011
<b>Facility Name</b> Ridgecrest Village					<b>Survey Dates</b> December 8, 9, 10, 14, 21 and 22, 2010
<b>Facility Address</b> 4130 Northwest Boulevard		<b>Surveyor</b> Pam Diveney, RN			
<b>City</b> Davenport, IA. 52806		HL			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
56.12	<b>481-56.12(135C) Class I violation as a result of multiple lesser violations.</b> The director of the Department of Inspections and Appeals may issue a citation for a Class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.	I	10,000.00	Upon Receipt	
58.28 (3)e	<b>481—58.28(135C) Safety.</b> The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)				
+	<b>58.28(3) Resident safety.</b> e. Each resident shall receive adequate supervision to ensure against hazard from self, others, or elements in the environment. (II, III)				
58.18 (2)	<b>481—58.18(135C) Nursing care.</b> <b>58.18(2)</b> Residents shall be protected against hazards to themselves and others or the environment. (II, III)				
	<b>DESCRIPTION:</b>  Based on record review, resident and staff interview, the facility failed to provide the necessary provisions to ensure Resident #3 and Resident #4 received adequate supervision from hazards in the environment. Four residents and three facility staff were traveling in the facility vehicle for a community outing when the vehicle stopped abruptly forcing two residents seated in wheelchairs without any safety devices in-place to fall out from their wheelchairs. Resident #3 received injuries and subsequently died after the incident and Resident #4				

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	<p>sustained a fractured pelvis. Concerns were identified for two out of five residents with reported census of 88 residents.</p> <p>Findings Include:</p> <p>The facility used the Q'Straint system to secure residents and their wheelchairs in the facility vehicle for transportation. The Q'Straint manufacture's handbook identified the lap/shoulder belt should always be used on your passenger's to keep them safely in their wheelchairs, should you need to stop quickly or make a sudden diving maneuver or experience an impact.</p> <p>The Q'Straint manufacture's handbook explained to begin by threading the lap belt around the passenger and through the opening in the chair; and the lap belt should take a direct path from the passenger to the rear tie-down anchorage.</p> <p>A document signed by the Administrator summarized an incident that occurred on 11/19/10. The summary identified four residents and three staff were traveling in the facility vehicle/van on a community outing when the van driver suddenly stopped to prevent hitting the car in front of them. The report documented two residents seated in wheelchairs were not secured with the lap belts and sustained fractures.</p> <p>1. According to the Minimum Data Set (MDS) assessment dated 10/11/10 Resident #3's required the assistance of one staff member for bed mobility, transfer, dressing and assist of two staff members for toileting. A physician's order revealed diagnoses including depression, high blood pressure, and glaucoma.</p> <p>The Care Plan dated 10/13/10 for Resident #3 indicated the resident required assist of two staff members for</p>			

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	<p>transfers to and from the wheelchair and assistance of one staff member for wheelchair mobility.</p> <p>A hospital consultation reports dated 11/19/10 identified Resident #3 admitted to the hospital following the motor vehicle incident and sustained trauma to both knees when s(he) slid out of the wheelchair. The resident had been hypotensive and resuscitated in the emergency room with fluid and blood. The X-ray findings showed Resident #3 sustained both a right and left femur fracture, fracture of the right wrist, fracture of the right long finger, a possible neck fracture and acute blood loss (anemia) and hypotension. The resident had been admitted to the intensive care unit with the orthopedic physician discouraging surgery due to his/her clinical condition.</p> <p>According to the hospice care interdisciplinary team notes, on 11/24/10 Resident #3 returned to the nursing home. The resident responded with nonverbal communication and shook his/her head "yes" when asked if in pain.</p> <p>Nurse's notes dated 11/30/10 at 2:20 a.m., revealed the resident moaning in pain; and at 11:30 a.m. the hospice nurse visited Resident #3 and increased the resident's pain medication. The notes documented the resident yelling with movements.</p> <p>A facsimile (FAX) transmission dated 12/13/10 identified the resident's cause of death [on 12/1/10] as coronary arterial disease causing congestive heart failure as a result of bilateral femur fracture and anemia.</p> <p>2. According to the Minimum Data Set (MDS) dated 9/27/10 indicated Resident #4 had diagnoses that included osteoporosis. According to the MDS Resident #4's exhibited short and long term memory impairments and severely impaired skills for daily decision making.</p>			

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	<p>The Care Plan dated 10/13/10 for Resident #3 indicated the resident required assist of two staff members for transfers to and from the wheel chair and assist of one staff member for wheel chair mobility and assist with bed mobility every two hours.</p> <p>Review of the Radiology Report dated 11/19/10 revealed Resident #4 admitted following a motor vehicle accident. The results of the pelvis examination identified the resident sustained a right a pubic symphysis fracture.</p> <p>Interview on 12/8/10 at 3:22 a.m., Resident #4 revealed s(he) did recall the van outing and stated s(he) had fallen out of the wheelchair while in the van. Resident #4 stated staff had not used the lap belt to secure him/her when in the van.</p> <p><b>Staff interviews:</b></p> <p>Interview with Staff F on 12/8/10 at 12:34 a.m. revealed Resident #3 wanted to participate on the activity on 11/19/10. Staff F stated Staff E and Staff D were also on the van when they left the facility around 9:30 a.m. Staff F indicated the staff assisted the residents out of van and into the activity for approximately one hour until Staff D returned to pick them up around 11:00 a.m.. Staff F stated Resident #3's wheelchair had been positioned behind Resident #4's wheelchair. Staff F indicated he/she had been seated in the passenger front seat. Staff F stated two additional residents occupied the seats behind her/him and they had their seats belts applied. Staff F stated the wheelchairs were secured in the van, but he/she never checked to see if the two residents seated in wheelchairs had their lap belts applied. Staff F reported after they were on the van Staff D started driving north when he/she slammed on the van brakes causing Resident #4 to come out of wheelchair landing in the front floor of the van; and</p>			

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	<p>Resident #3 had come out of wheelchair and landed on the floor behind Resident #4's wheelchair. Staff F indicated that's when he/she realized Resident #3 and #4 did not have their lap belts applied. Staff F informed Staff D to call 911 and the facility. Staff F reported the ambulance arrived and transported Residents #3 and #4 from the van to the hospital. Staff F further reported it was the van driver's responsibility to ensure all residents had their lap belts on/applied before transporting them.</p> <p>During an interview with Staff E (nurse) on 12/8/10 at 1:30 p.m., he/she identified going on the activity outing on 11/19/10. Staff E indicated they left the facility around 9:30 a.m. and around 11:00 a.m. Staff D returned to transport the residents back to the facility. Staff E indicated he/she was sitting behind Resident #3 in an empty wheelchair and Resident #3 had been positioned behind the wheelchair of Resident #4. Staff E stated while driving that Staff D slammed on the van breaks to avoid hitting a car in front of the van. Resident #4 fell out of his/her wheelchair and Resident #3 flew forward out of his/her wheelchair into Resident #4's wheelchair then fell to the floor underneath Resident #4's wheelchair. Staff E reported that Resident #3's legs were bent in an awkward position and appeared fractured. Staff E stated Resident #3 complained that he/she could not breath and of leg pain. Staff E stated that Resident #3's knee instantly swelled up. Staff E further stated she/he move Resident #3 just slightly to elevate his/her head so the resident could breathe easier. Staff E indicated she/he noted Resident#3's right index finger in a awkward position to the side. Staff E stated apparently Staff D did not put the lap belts onto Resident #3 and Resident #4. Staff E reported the ambulance crew arrived on the sight and they had to remove Resident #4's wheelchair up off of Resident #3 to get the resident out of the van. Staff E reported the other two residents seated in the van were not injured and returned to the facility. Staff</p>			

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	<p>E indicated that it was the van driver's responsibility to ensure the residents were secured in and had their lap belts on/applied. Staff E stated Staff D stated after the accident he/she forgot to put the lap belts on.</p> <p>During an interview with Staff D on 12/8/10 at 1:55 p.m., he/she identified driving the van for the morning activity on 11/19/10. Staff D indicated Resident #3 and Resident #4 were secured in the wheelchairs and he/she applied the safety belt[lap belt] to the residents around 9-9:30 a.m. Staff D stated he/she drove the van from the facility to the community activity and returned to transport residents back to the facility around 11:00 a.m.. Staff D stated he/she secured Resident #3 and Resident #4 wheelchairs in the van but failed to apply the lap belts. Staff D stated he/she was driving when the car in front of the van came to a stop and he/she abruptly applied the van breaks causing Resident #3 and Resident #4 to come out of their wheelchairs and landed on the floor of the van. Staff D stated the van came into contact with the car's back bumper but no damage had been done to either the van or the car. Staff D reported he/she called 911 and the ambulance arrived and took Resident #3 and Resident #4 to the hospital. Staff D stated the other two residents had their seat belts on returned to the facility after the incident. Staff D admitted he/she did not apply or ensure Resident #3's and Resident #4's lap belts were on/applied. Staff D further reported that he/she received training from the facility when he/she started driving the van to secure the wheelchairs in and apply the lap belts. Staff D explained the training focused on spending one week with a trained van driver prior to driving and the facility provided him/her with training of transporting residents in the van, which included applying lap belts. Staff D indicated he/she did receive a traffic ticket from the accident for failure to assure safe driving distance. Staff D stated he/she had worked at the facility for three years.</p>				

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	<p>The interview acknowledged Staff D failed to place the lap belts to secure residents in their wheelchairs.</p> <p>The facility submitted a written affidavit for Staff D which indicated he/she did not have the lap belts on the residents on [November] 19, [2010] because it was hectic, crowded and he/she had forgot.</p> <p>Record Review of Staff D's personnel file revealed no indication of any training completed after date of hire regarding the van transportation of residents.</p> <p>Interview on 12/8/10 at 12:00 noon and 12/10/10 at 2:25 p.m., the Administrator revealed when hired, the van drivers receive one week training with another trained van driver, however the facility did not have documentation of training provided when van drivers are hired.</p> <p>Interview with the Administrator on 12/10/10 at 2:25 p.m., revealed prior to the incident [on 11/19/10] the facility did not have a policy/procedure in place for van driver's training or their procedures. The Administrator stated it was the responsibility of the van driver to ensure residents are secured in the van and the seat belts are applied. The Administrator indicated that after the accident on 11/19/10 the facility has provided training for the van drivers that included demonstration, testing and a completed checklist of areas covered in training. The facility Administrator stated there was no policy/procedure in place and he would begin creating one.</p> <p><b>FACILITY RESPONSE:</b></p>				

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