Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#5205	**Fine amount reduced by 35% to $325 on October 25, 2013, pursuant to Iowa Code section 135C.43A (2013).**		**Date: September 4, 2013**
Manorcare Health Services		**Survey Dates:** **August 12-15, 2013**	
201 W. Ridgeway Ave.	**Surveyors: Marcia Lashbrook, Deb Nebel RN, Becky Colby RN**		
Waterloo, Iowa 50701	**Ds/jm/kk**		

		Class	Fine Amount	Correction date
50.7(1)a(2)	**481-50.7(10A, 135C) Additional notification**. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III). **50.7(1)** Of any accident causing major injury. a. "Major injury" shall be defined as any injury which; (2) Requires admission to a higher level of care for treatment, other than for observation. **DESCRIPTION:** Based on clinical record review, physician assistant (PA) and staff interview, the facility failed to notify the Department of Inspection and Appeals of an accident causing major injury which required a higher level of care for one of two residents reviewed. (Resident #13). The facility census was 77 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/23/13; documented Resident #13 had diagnoses that included hip fracture, osteoarthrosis and syncope with collapse. The MDS documented the resident required extensive assistance of two staff with bed mobility and transfer. An incident report dated 7/9/13 at 3:00 a.m., documented the resident was lowered to the floor on knees after an unsuccessful transfer from the bed to the wheel chair per staff, no injury sustained, range of motion within normal limits. The form documented the resident had an urgency to void and had been rushing to get into a wheel chair. An undated statement by the Certified Nurse Aide present during the 7/9/13 fall documented the aide answered the resident's call light and the resident stated	**II**	**$500**	**Upon Receipt**

Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (Supp. 2009).

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	they needed to use the bedpan. The resident was wet and the sheets were wet. The resident had sat on the edge of the bed. The resident was told not to get up. The aide applied a gait belt and went to get sheets and went into the resident's bathroom to get a brief. When coming back from the bathroom the resident was observed to stand up and shake the brief off and went down with bent left knee and the right knee was behind the resident on the floor. The aide was unable to get to the resident in time as the resident went down. The resident was instructed to stay put while the aide got the nurse. The resident was assisted to the chair and said 'ooh ooh', but did not have increased indication of pain than usual. The nurse gave the resident a pain pill after evaluating him/her. On 8/14/13 at 1:21 p.m. the Director of Nursing (DON) was interviewed and stated the resident was attempting to transfer self when a staff person entered the room and attempted to get to the resident and then lowered the resident to the floor. The DON stated the resident's assessment appeared normal and the resident's physician had even seen the resident after the fall and had no assessment concerns. The DON stated the resident had gradually started having more pain so had been sent to a pain clinic at which time the fracture was discovered. The DON stated that even though the resident's injury resulted in surgery and the resident had experienced a condition change the physician felt the resident would eventually return to a normal level of function and that had been the reason for not reporting the fracture. A physician note dated 7/26/13, documented the resident was status post fall on July 9 which likely resulted in a newly discovered periprosthetic fracture found on July 19. The report documented the resident was in significant pain and would be admitted from their			

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	clinic appointment on 7/23/13 to the hospital for pain control. A major injury determination form dated 7/23/13, documented the resident had an oblique fracture at the distal end of a prosthesis, hip fracture with repair. A physician signed the form on 7/24/13, and indicated after reviewing the circumstances, injury and prognosis of the patient, the injury sustained had not been a major injury and to the best of their knowledge, barring any complications, the resident would return to their previous functional status. **FACILITY RESPONSE:**			

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