Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#5231	**Fine amount reduced by 35% to $3575 on November 26, 2013, pursuant to Iowa Code section 135C.43A(2013).**	**Date: October 1, 2013**
Barthell OES Home		**Survey dates: September 3-5,2013**
911 Ridgewood Drive	**Surveyor: Joe saddler RN, Marcia Lashbrook RN**	
Decorah, Iowa 52101		

		Class	Fine Amount	Correction Date
58.18(2) **+** **58.19(1)i**	**481-58.18(135C) Nursing Care.** **58.18(2) Residents shall be protected against hazards to themselves and others or the environment. (II,III)** **481.58.19(135c) Required nursing services for residents.** The program plan for nursing facilities shall have the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules. **58.19(1)** *Activities of daily living.* **i.** Mobility (assistance with wheelchair, mechanical lift, or other means of locomotion) (I, II, III). **DESCRIPTION:** Based on observation, record review and staff interviews, the facility failed to protect a resident from hazards from themselves and failed to use a mechanical lift properly in order to prevent accidents (Resident #1). The facility reported a census of 42 residents. Findings include: The admission record for Resident #1 documented an admission date of 9/17/10. A problem list dated 9/12/12, documented diagnoses which included degenerative joint disease, osteoarthritis and osteoporosis. A Report of Incident/Accident dated 8/3/13 at 9:20 p.m., documented the Certified Nurse Aides (CNA) were assisting the resident to bed using a stand up lift, CNAs stated resident was fastened with waist belt and feet on	**I**	**$5,000**	**Upon Receipt**

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	metal foot platform. When CNAs were pulling resident away with lift from chair, the resident's hands dropped and the resident began slowly sliding down to knees onto the floor. The resident's left and right legs rested underneath the resident and turned feet to left side. The CNA was standing behind the resident and noticed the resident slowly dropping down and the [CNA] began pulling at the harness to try to pull the resident back into the chair. This was ineffective as the resident continued to lower to her/her knees. Person operating [the lift] called for help and began to assist CNA with resident and hoist resident onto knee. The report made no indication the leg strap had been secured on the stand lift used to transfer the resident. An assessment on the reverse side of the form dated 8/3/13 at 9:20 p.m., documented the resident's left knee had been red from pressure. The resident stated there was some pain when the leg extended straight and an ice pack was applied to the knee. After thirty minutes, the resident denied any more pain in the left hip. No other lacerations, observable bruises or bumps. An entry in the Nurses' Progress Notes dated 8/3/13 at 10:50 p.m., documented at 9:20 p.m., the CNA called from the resident's room for help from the nurse. Upon entering the room, the resident was on knees directly behind stand up lift. Resident down on knees with legs turned towards left side. Staff stated they were assisting resident to bed [and] using the stand-up lift. The CNAs stated resident's feet were on metal foot platform, waist harness strapped and appropriately buckled. As they were pulling the lift away from chair, the resident's arms dropped and resident slowly started falling to knees. One			

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	CNA that was behind the resident, tried to pull up on the harness behind the resident to get the resident back on to the wheel chair. This was ineffective. The other CNA had gone around to where the resident was and propped the resident on to their own leg and had the other CNA go to hall and call for the nurse. The resident stated they had pain rated at a 5-6 (scale of 1-10 with 10 severe) at left hip and pain with movement of the left knee. Left knee red in color. Noticeable moaning with movement of left knee. A 24 hour update dated 8/4/13 at 4:00 a.m., documented the resident had no new founded bumps or lacerations, however, 2 bruises: a. 5 centimeter (cm) by 1 cm bruise, purple in color, no drainage/blister-anterior right arm. b. 2 cm by 1 cm bruise purple in color, no drainage/blister-anterior right arm. Denies pain, no treatment needed. An entry on 8/4/13 at 6:15 a.m., documented the resident complained of left hip pain with morning cares, family called and wished for the resident to be seen in the ER (hospital Emergency Room), ambulance called and arrived at the facility. An ER report dated 8/4/13, documented the resident had an x-ray of the left hip and pelvis for a fall with hip pain, with no acute fracture seen. At 8:40 a.m., an entry in the Nurses' Progress Notes documented x-rays of the left hip and pelvis were			

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	negative. An entry at 9:30 documented the resident denied pain. An entry in the Nurses' Progress Notes dated 8/6/13 at 2:30 p.m., documented when CNAs were turning in the morning heard a "pop ". Legs were equal. An entry dated 8/7/13 at 10:00 a.m., documented it came through report left leg shorter than right. Having discomfort, needs assist with meals. Ambulance present to send for follow-up at emergency room. A continued entry at that time documented the physician had been notified of left leg change and complaint of pain with touch. An emergency room (ER) report dated 8/7/13, documented the resident came to the ER with persistent left hip pain, slipped and was slowly lowered to the ground while being transported by a Hoyer on August 4th, 2013, intermittent discomfort since. Seems to be worse between lying and standing. The report documented diagnoses which included previous left hip fracture and significant dementia, with current x-rays of the hip, pelvis and sacrum negative for acute fracture. An entry in the Nurses' Progress Notes at 1:45 p.m. documented a report from the emergency room was the left hip and pelvis were OK [alright]. An entry in the nurses notes on 8/8/13 at 11:30 p.m., documented the resident denied having any pain while napping at 4:00 p.m., and at supper at 6:30 p.m. An entry on 8/14/13 at 10:00 p.m., documented the			

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	resident denied pain. An entry on 8/19/13 at 10:10 a.m., documented a call had been made to the physician to question the use of pain medication for continued complaints of pain in the left leg/hip area with movement and again to report the left leg shorter that right. An entry on 8/22/13 at 2:00 p.m., documented the resident complained of discomfort with transfers from bed to wheel chair with Hoyer (mechanical) lift, complained of pain in left lower extremity, with swelling in the left thigh. An entry on 8/27/13 at 10:50 a.m., documented a message had been left for the physician updating them on left leg/hip discomfort with transferring and repositioning. An entry on 8/30/13 at 3:20 p.m., documented the resident went to a local clinic for an appointment with the physician due to left leg/knee pain. The entry documented the resident returned and the daughter reported the resident had a fracture above the left knee. A physician progress note dated 8/30/13, documented the resident had been seen 3 to 3 ½ weeks prior in the local emergency room after having slid down to a fall at the nursing home when they had been trying to transfer the resident. While in the local emergency room the resident had x-rays of the pelvis and hip. This did not reveal any fracture and the resident went back to the nursing home. Since going back to the nursing home, the resident had persistent pain in the left leg as well as			

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	some swelling above the knee. An x-ray report dated 8/30/13, documented the resident had an acute comminuted left distal femoral (above knee) diaphyseal fracture with apex posterior angulation. The resident care plan documented a problem of potential for injury related to arthritis, dementia, poor balance and history of left hip fracture 2012. The problem had an initial date of 7/29/13, and included an entry dated 8/6/13, which documented the resident's legs gave out with a transfer using the E-Z stand, slid to base, returned to bed with no injury. An entry under the same problem dated 8/30/13, documented the resident's daughter had been informed of swelling in the left thigh and continued pain, appointment made and seen by the physician with orders for an immobilizer on left leg always except for changing cloths and bathing due to a fracture above the left knee. Continue Lortab (pain medication) as needed, Hoyer lift transfer, activity as tolerated, alright to be up in wheel chair, alright to have shower but need to cover left leg immobilizer with plastic bag to keep dry, orthopedist to schedule consult. An update to the care plan dated 9/3/13, documented the resident had an appointment scheduled in a specialty clinic on 9/5/13. The problem included the following interventions: a. Place call light within resident reach. b. Place bed in low position to floor, may surround bed			

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	with soft mat. c. Frequent staff monitoring with reminders to use call light and/or ask for help d. Provide meaningful activities. e. Assist with toileting, transfers, and positioning as needed. f. Keep personal items frequently used within reach and keep room free of clutter. g. Environmental devices to assist with mobility h. Medications per order. i. Physical therapy per order. j. Alarms per order. The care plan included no information about the use or safety devices to be used during transfers. On 9/4/13 at 8:10 a.m., the facility Director of Nursing stated they reviewed the incident report and were not sure if the leg straps had been used when the incident occurred. They stated staff did not necessarily have to use the legs straps on the E-Z stand lift for all residents and stated it would depend on the individual resident and how they [the resident] were doing at the time. During an interview on 9/4/13 at 10:30 a.m., the Assistant Administrator stated the facility investigation would be the incident report. At that time they stated the resident had been transferred with a lift that did not have			

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	a leg strap which would have needed to be secured. The Assistant Administrator and Administrator then showed the surveyor a similar lift in the hallway. The lift had a strap to secure the legs and the Assistant Administrator stated it does have a strap, and then told the Administrator the staff should have had the leg strap secured. During an interview on 9/4/13 at 8:20 a.m., Staff B (CNA) stated they had been present during the incident when the resident had been lowered to the floor. Staff B stated they did not think the residents legs had been strapped in to the E-Z stand because as the resident had been raised Staff E (CNA) had noted the residents feet had not been on the metal platform. Staff B stated the residents feet had been on the platform before raising the resident. Staff B stated the resident had let go of the hand rails and began to slump down. Staff B stated they really felt it would have made a difference if the residents 'legs had been strapped in. The surveyor then asked Staff B what the facility policy stated regarding the use of leg straps and the lift and they stated it depended on the resident and how they were doing that would determine if you would strap the legs in the lift or not. At 11:35 a.m., Staff C (CNA) stated using the leg strap depended on whether a resident being transferred is coherent and if they could hold their own weight, if not then a strap would be used. At 11:43 a.m., Staff D (CNA) stated you would use the leg strap if a resident is not coherent or is not able to bear weight. At that time the surveyor asked what you would do if the resident became weak during a transfer			

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	and Staff D stated you would hurry up and put the strap on or get them to the chair. Staff E (CNA) stated during interview on 9/4/13 at 12:05 p.m., they were caring for the resident when the incident occurred with the E-Z stand lift. Staff E stated they were not sure if the resident kicked their feet back behind them but when the resident had been lifted they realized their feet were not on the metal platform of the lift. Staff E stated the person who they had been working with had been pulling the resident away at the waist, and the leg strap had not been used. Staff E stated they did not know when to use the leg straps and did not even know the lift had one until they saw it used on another resident. Staff E stated they had not been told and did not know it had been there until after the incident. The resident's primary Physician was interviewed on 9/4/13 at 3:12 p.m., and stated the resident had been seen 3 weeks earlier and had an x-ray which showed no fracture. They stated the x-ray had been of the pelvis and hip but the resident's fracture had been just below the view taken so it had not been seen. The physician stated the resident had still been having pain and swelling above the knee and the resident stated the whole leg hurt so a decision had been made to x-ray the whole leg. The physician stated the presumption would be probable that the fracture had occurred when the resident had been lowered from the lift, but did not know for sure. The resident had a previous repair and a rod in the femur already so the treatment options were now limited. The physician stated that his/her best guess would be the fracture had occurred at that time due to			

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	the resident having been very osteoporotic. A facility policy titled Transfers, Proper use of EZ Stand (no date), included a directive to place the residents feet in foot platform, strap and secure lower leg straps in place. During an interview on 9/5 13 at 8:30 a.m., the facility Director of Nursing stated that staff should have had the leg straps on during the transfer and an in-service would be completed that day to instruct all staff on the use of safety devices during a lift transfer. The DON stated the leg straps were to be used for all stand lift transfers. **FACILITY RESPONSE**:			

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	481—50.9(135C) Criminal, dependent adult abuse,			

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50.9(3)	**and child abuse record checks.** **50.9(3)** *Requirements for employer prior to employing an individual.* Prior to employment of a person in a facility, the facility shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. *a. Informing the prospective employee.* A facility shall ask each person seeking employment by the facility, "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under Iowa Code chapter 321 or equivalent provisions, in this state or any other state?" In addition, the person shall be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted. (I, II, III) *b. Conducting a background check.* The facility may access the single contact repository (SING) to perform the required background check. If the SING is used, the facility shall submit the person's maiden name, if applicable, with the background check request. If the SING is not used, the facility must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services. (I, II, III)	**II**	**$500**	**Upon Receipt**
58.11(3)	**58.11(3)** *Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse.* The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse			

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	checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III) [**ARC 0903C**, IAB 8/7/13, effective 9/11/13] **DESCRIPTION:** Based on review of a personnel record for Staff F and staff interviews, the facility failed to obtain a completed criminal history background check prior to employment. The sample consisted of 4 personnel records. Findings include: 1. The personnel file for Staff F (Registered Nurse) documented a hire date of 5/6/13, with current active employment with the facility. The criminal background check completed on 4/18/13, identified further research was required. The check directed staff to please note: there may be multiple individuals with similar search criteria, requiring more research. This required the facility to await the Department of Criminal Investigations (DCI) final response for criminal history clearance. The personnel file for Staff F lacked evidence the facility obtained a final response from the DCI for a criminal history and had not obtained approval from DHS for the individual to work in the facility if needed. On 9/4/13 at 2:15 p.m., the facility Administrator stated since the form documented the background check had been complete as of 4/18/13, they had been under the impression everything had been satisfactory. At that time, the Assistant Administrator stated they had not noticed the statement that further research was required on the criminal check. On 9/9/2013, the facility obtained final clearance of the			

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	criminal background check which identified Staff F did not have a record. **FACILITY RESPONSE:**			

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