DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	960169	A. BUILDING: Dcon 0123 B. WING _____ OCT 23 2013	09/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARTHELL OES HOME	911 RIDGEWOOD DRIVE DECORAH, IA 52101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments	L 000		

Correction Date 9.15.2013

The following defciencies are the result of the facility's state annual licensure survey.

9m, RN 10-23-13

L 252	58.11(3)a Personnel	L 252	Please see attached Sheet for Corrections.	9/5/13

481-58.11(135C) Personnel.
58.11(3) Personnel histories.
a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility shall submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, " employed in a facility " shall be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. Direct treatment or services include those provided through person-to-person contact. Indirect treatment or services include those provided without person-to person contact such as those provided by administration, dietary, laundry, and maintenance. Specifically excluded from the requirements of this subrule are individuals such as building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and do not provide any treatment or services to the residents of the health care facility. (I, II, III) AC 12/8/06

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L 252	Continued From page 1	L 252		

This Statute is not met as evidenced by:
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

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L 252	Continued From page 2 of the criminal background check which identified Staff F did not have a criminal record.	L 252		
L 372	58.18(2) Nursing care 481-58.18(135C) Nursing care. 58.18(2) Residents shall be protected against hazards to themselves and others or the environment. (II, III) This Statute is not met as evidenced by: 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 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	L 372	Please see attached Sheet for corrections 10/14/13	

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L 372	Continued From page 3	L 372		

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 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

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L 372	Continued From page 4	L 372		

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 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

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L 372	Continued From page 5	L 372		

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 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 some swelling above

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L 372	Continued From page 6	L 372		

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 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

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L 372	Continued From page 7 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 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	L 372		

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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 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

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L 372	Continued From page 9	L 372		

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 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.

II Based on observation and interview, the facility failed to store hazardous chemicals in a locked storage area. The facility reported a census of 42 residents.
Findings include:
1. Observation during the environmental tour on 9/4/13 at 10:05 a.m. revealed an unlocked cabinet under the sink in the Activity Room/Kitchenette containing a spray bottle labeled Clorox " Green Works " cleaner and a box of Miracle Grow plant food/fertilizer. Both items contained warnings on the label to keep out of reach of children.
During an interview on 9/4/13 at 10:20 a.m. the facility Assistant Administrator stated that the cleaning items and plant food were to have been in a locked cabinet. The Assistant Administrator then stated those items have now been placed in

Please see attached sheet for corrections 9/4/13

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L 372	Continued From page 10 the locked cabinet of the Activity Room/Kitchenette.	L 372		
L 632	58.24(6)j Dietary 481-58.24(135C) Dietary. 58.24(6) Dietary ordering, receiving, and storage. j. Foods held in refrigerated or other storage areas shall be appropriately covered. Food that was prepared and not served shall be stored appropriately, clearly identifiable and dated. (III) This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to ensure refrigerated and dry foods were properly covered, dated and labeled. The facility reported a census of 42. Findings include: During the initial tour of the facility kitchen on 9/3/13 at 9:25 a.m., observation revealed the following in a 3 door refrigerator: a. A bowl of what appeared to be scrambled eggs with a plastic wrap over it and no date or label. b. A bowl of what appeared to be prepared hot cereal with a plastic wrap over it and no date or label. c. Two opened packages of salami, not resealed and with no date opened. d. An opened package of sliced chees with no date opened. e. A clear plastic bag of what appeared to be sliced ham with no date or label. f. An uncovered bowl of what appeared to be mandarin oranges. g. A small uncovered container of what appeared to be peanut butter. h. A small uncovered container of what	L 632	Please see attached Sheet for corrections 10/8/13	

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L 632	Continued From page 11	L 632		

appeared to be jelly.
i. An uncovered bowl of what appeared to be yogurt.
j. An uncovered bowl of a brown unidentifiable substance.
k. Four small uncovered containers of what appeared to be butter.
During the same tour observation of a freezer in the kitchen revealed the following:
a. Twelve bowls of uncovered ice cream.
b. A clear Ziploc bag with what appeared to be meat patties with no date or label.
c. A clear Ziploc bag of what appeared to be croissants with no date or label.
d. A clear Ziploc bag of what appeared to be French toast with no date or label.
e. An open clear bag of what appeared to be meat balls with no date or label.
f. A clear Ziploc bag with what appeared to be French fries with no date or label.
During the same tour observation in the dry storage area revealed the following:
a. A large brown sack of flour with a large tear in it and flour spilling out.
b. An opened package of Alfredo mix with no date opened.
c. A large plastic container with a dry white powder in it with no date or label.
During the same tour observation of the walk in cooler revealed a clear plastic bag of what appeared to be bratwurst sitting in the same plastic tub as a large cut of thawing red meat.
Observation of the walk in freezer revealed the following:
a. A clear Ziploc bag of ranch potato wedges with no date.
b. A clear Ziploc bag of sweet potato wedges with no date.
c. A large Ziploc bag of what appeared to be frozen chicken breast with no date or label.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 632	Continued From page 12 During an interview on 9/5/13 at 9:00 a.m., the Dietary Manager stated staff would be reminded to cover, date and label foods.	L 632		

Facility Response:

L 252 58.11(3) Personnel: corrective action 9/5/2013

On 9/5/2013 Personnel officer has reviewed all employee files and no other violations have been found relative to criminal background checks. The employee cited was found to have a negative abuse history and both administrator and assistant administrator missed the required follow-up for criminal background checks which the form asked for. The negative report on criminal background check for the employee cited was received on 9/9/2013 from DCI. The P.O.C. is that the Personnel officer will be responsible for assuring each employee required to have a criminal background check, is completed prior to being allowed to work. This will be reviewed with the quality assurance committee on a quarterly basis to assure compliance with any variations reported to the Administrator or Assistant Administrator.

Facility Response:

L372 58.18(2) nursing care: corrective action 10/14/2013

1. The Director of Nursing conducted an In-Service for all staff on 9/5/2013 on safety & resident safety with emphasis on hazards to themselves, others, and or the environment. Nursing staff informed and educated on proper use of mechanical lifts and instructed staff on the use of safety devices during a lift transfer including placing the resident's feet on foot platform, then place strap around lower legs and check to make sure that the strap is secure.

2. Director of Nursing reviewed policy and placed copies of E-Z stand/lift policy on each lift for staff to visualize when using mechanical lift. Copy of E-Z stand lift policy placed in certified nurse aide A & B wing sign off books.

3. Care Plans are updated to address all lifts being used with physician orders obtained to confirm correct lift in use for each resident.(action on care plans "environmental devices to assist with mobility needs to be more specific to allow for safe care").

4. Director of Nursing, who began her duties on August 27th 2013 as DON will monitor compliance.

5. Quality Assurance Committee/Safety Committee will monitor compliance on a quarterly basis and appraise Administrator and Assistant Administrator.

6. Staff reminders for all certified nurse aides and ALL nurse's at shift to shift report on proper use of mechanical lifts using safety devices. (Placing the resident's feet in foot platform and strap & secure lower leg straps in place).

7. Staff informed that not using proper policy & procedure with equipment with resident care will face disciplinary action: 1st verbal warning, 2nd written warning, 3rd suspension and or termination.

L 632 58.24(6)l Dietary: corrective action 10/8/2013

As Food Service Supervisor on October 8th 2013 I informed the dietary department of the State findings at a dietary in-service. All dietary staff has been informed to cover, date & label all food products when opened in the refrigerator, cooler, or freezer. I will be ordering freezer labels that stick to cold items to make this process easier and I will monitor staff to see that they follow this correction according to Iowa code L632-58.24(6) Mary Holthaus, Food Service Supervisor.

L 372 Environmental tour: Chemicals improperly stored: corrective action 9/4/2012

Items in question were locked in closet next to activity room. Activity personnel corrected and will be responsible for making sure items used are all locked up immediately after use. All staff in activity department have been instructed on proper storage and this will be monitored daily by Activity Director and or activity staff to avoid reoccurrence. Mae Schmitt Activity Director.