

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

Number FC 6207	Fine amount reduced by 35% to \$1,300.00 on July 27, 2016 pursuant to Iowa Code Section 135C.43A	Report date July 20, 2016		
Facility name Ravenwood Specialty Care		Survey dates April 21-25-26 2016 & July 7, 2016		
Facility address 2651 St. Francis Drive				
City Waterloo, IA 50702	HL			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.19(2)j	481- 58.19(2) Medication and treatment. j. Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III) [ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 2560C, IAB 6/8/16, effective 7/13/16] DESCRIPTION: Based on record review and staff interviews, the facility did not always provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care. Concerns were noted for one resident (#7) in which facility staff failed to complete on going physical assessments and intervention. The facility reported a census of 156 residents. Findings include: According to documentation in the Minimum Data Set (MDS) assessment form dated 04-05-16 Resident #7 scored 10 (of 15) on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive decline. The assessment form also described Resident #7 as requiring staff assistance with completing activities of daily living such as transfers, ambulation, dressing, bathing and toilet assistance. Review of the clinical record revealed that Resident #7 had diagnoses which included recent history of pneumonia, hypertension and chronic obstructive pulmonary disease, on two liters of oxygen at bedtime. The care plan dated 12/28/15 documented Resident #7 staff would monitor the resident's health status including but not limited to oxygen saturation, blood pressure, pulse, lung sounds, signs/symptoms of shortness of breath and notify the physician of significant changes in	I	\$2000.00	Upon Receipt

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	any of the prior. According to documentation the clinical record, Resident #7 was hospitalized for 23 hour out patient observation from 04-10-16 to 04-11-16. Resident #7 returned to the facility on skilled care on 04-11-16. Review of the nurse's notes revealed staff completed skilled assessment documentation via flow sheet on 04-12-16, 04-13-16, 04-14-16, 04-15-16 and 04-16-16. Review of the clinical record revealed staff did not complete the skilled assessment documentation for 04-17-16 or 04-18-16. Documentation in the nurse's notes dated 04-17-16 at 1:50 a.m. indicated Resident #7 had no complaints of pain and had an oxygen saturation level of 92 % and refused oxygen. Documentation in the nurse's notes dated 04-17-16 at 8:00 a.m. indicated Resident #7 refused morning cares, the morning meal, weight, vitals and meals after numerous attempts. The notation indicated Resident #7 swung at staff and told staff to get out of the room. The next documentation in the nurse's notes at 10: 30 p.m. indicated Resident #7 refused a pain medication at 8:30 p.m. but requested a pain medication at 10:10 p.m. Documentation in the nurse's notes dated 04-18-16 at 6:05 a.m. included vital signs and an oxygen saturation level of 88 % on room air. The notation addressed Resident #7's behaviors and refusal to take medications. Staff indicated a facsimile was sent to Resident #7's physician addressing vital signs, refusal of oxygen, nebulizer treatments and medications. The notation also indicated Resident #7 had no edema to lower legs, lung sounds posterior decreased, lobes with crackles to lower right bases, combative and rude to staff. Documentation on 04-18-16 at 1:45 p.m. indicated staff received a return order from Resident #7 physician with direction to hold Lasix for today (04-18-16).			

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	The next documentation on 04-18-16 at 8:30 p.m. indicated staff received a physician's order to send Resident #7 to the emergency room for evaluation due to an elevated temperature. Review of the clinical record for Resident #7 indicated staff completed a SBAR (Situation Background Assessment Recommendation) form on 04-18-16 at 7:50 p.m. At this time the summary of observations and evaluation documented, "Resident appears to be acutely ill with respiratory illness". Resident #7's condition, symptom had worsened since it started. The description identified Resident #7 a primary diagnosis of sepsis, with pulse oximetry at 84% room air Documentation in the emergency room chart dated 04-18-2016 at 8:52 p.m. indicated Resident #7 was "dropped off at the ER (emergency room) registration desk by Dolly's Taxi", patient was unaware of why he/she was brought to ER. Triage nurse was told by the facility registered nurse, "patient is septic". Review of the emergency room chart dated 04-18-16 at 8:52 p.m. triage is documented as "urgent". Additional assessment indicated Resident #7 arrived by taxi. Resident #7's family stated the resident has a decreased amount of fluid intake and fever today. Resident has audible wheezing and oxygen saturation initially at 89%. "Nurse states patient was sent by taxi with instruction by unit manager". Resident was at 85% (oxygen saturation) at the facility on 2 liters of oxygen per nasal cannula. Upon arrival Resident #7 was at 88% (oxygen saturation) on 2 liters of oxygen. Resident states he/she "hurts all over". During an interview on 04-26-16 at 3:45 p.m. Nurse Manager, Staff D indicated the nursing staff were to complete daily flow sheet skilled charting. Staff D also			

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	indicated he completed an assessment of Resident #7 the evening of 04-18-16 and stated he did had tried to keep Resident #7 at the facility. Staff D stated he saw Resident #7 as "sick", non-emergent, but not acutely ill. Staff D stated Resident #7's lungs sounded "nasty" but added not a lot different, and not remarkably different from day to day. Staff D did state he was concerned with Resident #7's (elevated) temperature. Staff D stated the change in Resident #7's mental status seemed to alarm the resident's family member most, and perhaps Resident #7 had a little dehydration due to no urine output. Staff D went on to add one can get pneumonia "just like that". Staff D stated he set up a ride through Dolly's Taxi as a non-emergent transfer. Staff D stated there was about a 20 minute wait, but the taxi service was encouraged verses an ambulance transfer due to the cost involved. During an interview on 06-21-16 the emergency room physician stated Resident #7 had been dropped off at the emergency room by a taxi. No phone call to the emergency room preceded the resident's appearance and Resident #7 was not competent enough to be dropped off and left alone in the emergency room. The emergency room physician also stated the emergency room nurses were horrified that Resident #7 had been transferred by a taxi. The physician stated Resident #7 had a low oxygen saturation level, a fever and a cough. He stated that Resident #7 was quite ill/sick and a transfer by taxi rather than by ambulance was not appropriate. According to documentation in the hospital history and physical, dated 04-19-16, Resident #7 was admitted to the hospital with severe lethargy, somnolence, UTI (urinary track infection) and pneumonia. The general observation described Resident #7 as very frail looking, and currently in respiratory distress. The laboratory results showed a urinalysis which showed greater than			

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	900 WBC's (white blood cells), positive for bacteria and RBC's (red blood cells). The CBC (complete blood count) showed a WBC (white blood count) of 19.7 X10**3/ul (Normal = 4.3 - 11.3) On 04-26-16 at 11:47 a.m. the facility assistant Director of Nursing indicated skilled nursing flow sheet records for Resident # 7 for 04-17-16 and 04-18-16 could not be located. At 11:57 a.m. the facility director of nursing indicated that if no skilled flow sheets could be located, then the only assessments completed for Resident #7 was the documentation in the nurse's notes. FACILITY RESPONSE				

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