Department of Inspections and Appeals
Health Facilities Division
Citation

Number **6456**			**Report date** **Corrected 2/20/17** **February 16, 2017**
Facility name **United Presbyterian Home**		**Survey dates** **January 30, 2017 to February 2, 2017**	
Facility address **1203 E. Washington Street**			
City **Washington, IA.** **52352**	**JM**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.28(3)e	**481- 58.28(3) *Resident safety.*** ***e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)**	**I**	**$2,000.00** **Held in Suspension**	**Upon Receipt**
58.20(4)a, b	**481-58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:** **58.20(4) Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident's family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:** **a. The written health care plan, based on the assessment and reassessment of the resident's health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)** ***b.* The health service supervisor is responsible for preparing, reviewing, supervising the implementation**, and revising the written health care plan; (III) **DESCRIPTION:** Based on record review and staff interviews, the facility failed to provide adequate nursing supervision to protect against hazards from self, others or hazards in the environment for 1 of 3 residents reviewed who experienced falls (Resident #11). The resident sustained injuries which included right and left cerebral hemorrhages, multiple rib fractures, and a right clavicle fracture. The facility reported a census of 52 residents. Findings include:			

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	1. According to the Minimum Data Set (MDS) assessment tool dated 1/11/17, Resident #11 had diagnoses of: non-Aizheimer's dementia, other fracture, and Parkinson's disease. It also identified the resident displayed severe cognitive impairment and required staff assistance with all Activities of Daily Living (ADLs). The resident's care plan initiated on 1/10/16 identified the resident experienced impaired cognitive function and thought processes related to impaired decision making with a goal that indicated the resident would remain oriented to self and spouse. The care plan also identified the resident displayed an Activities of Daily Living (ADL) deficit and was at risk for falls. The care plan directed staff: a. Anticipate and meet the resident's needs. b. Resident #11 utilized a walker for ambulation (walking). c. Provide standby assist of one staff with use of walker for ambulation when he/she is seen up. d. Provide standby assist of one staff for transfers when seen up. e. Provide extensive assist of one staff for toilet use. f. Cue, reorient and supervise as needed. g. Present just one thought, idea, question, or command at a time. h. Be sure the call light is in reach and encourage the resident to use it. i. Apply bed alarm at bedtime and throughout the night to alert staff when he/she is up so staff may check on and assist the resident (added 1/22/16).			

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	j. Falls are expected as Resident #11 is not aware of his/her deficits. The resident is able to get down on the floor and he/she often does this to clean floors, baseboards, organize closets and pick up items from the floor (revised 2/11/16). A Fall/Injury Monitor- Suspected Head Injury form dated 12/31/16 at 6:05p.m. revealed the resident's roommate called for help. Staff entered the room and found the resident on the floor on the roommate's side of the room in front of the roommate's recliner with the left side of his/her face against the floor and the rest of the body in the prone position. The resident's feet pointed toward the head of the bed and the rest of his/her body angled toward the doorway of the room. Staff documented the resident's right lower leg lay over the bottom of the resident's tray table with water from the cup on the tray on the floor. The nurse called the resident's name with no response. Vitals signs as follows: Temperature 97.5, P 63. Respirations 16. Blood Pressure 160/100 and Oxygen Saturation 95% on room air. The staff documented the resident began to open their eyes and was able to provide the nurse with their daughter's name. The resident sustained a quarter-sized hematoma to the forehead and when the nurse slid a hand under the resident's head on the left side blood was noted. Another staff member had been directed to notify the physician and the writer of the report stayed with Resident #11 until the ambulance arrived. At that time, the resident's roommate reported the resident stood on the bed to hang a picture and fell and hit his/her head. Progress Notes dated 12/31/16 at 6:08a.m. revealed staff documented they notified the physician of the resident's fall and obtained an order to transfer. Progress Notes dated 1/4/17 at 2:11 p.m., revealed the resident returned from an admission to the hospital			

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	where he/she had been since 12/31/16 after sustaining a fall with loss of consciousness. The resident sustained right and left cerebral hemorrhages, multiple right sided fractures and a right clavicle fracture. Resident #11 had an order for a Miami J (neck) collar to wear at all times, and physical and occupational therapy. Staff documented the resident transferred from the wheelchair to the toilet with the assist of one staff. A review of the discharge summary revealed the resident was admitted to the emergency department on 12/31/16, admitted to the local hospital, later transferred to the university hospital and discharged on 1/4/17 with the reason for admission - trauma and principal diagnosis of subarachnoid hemorrhage (bleeding in the area between the brain and the tissues that cover the brain). The hospital course included orthopedic and neurosurgery consults. The care plan with the target date of 2/8/17 failed to contain any information related to the resident's fall which occurred on 12/31/16, the Miami J collar, or the need for physical and occupational therapy services. The Progress Notes contained the following entries: a. On 1/10/17 at 9:30p.m. staff found the resident crawling out of bed. Staff assisted him/her to the wheelchair, took the resident to the dining room and gave him/her a snack. b. On 1/15/17 at 12:25 a.m. the Resident #11 stood up from his/her low bed and walked into neighbor's room where staff provided care. The alarm did not sound. Staff documented the resident walked with no problems and staff escorted the resident back to his/her own room. Staff then took the resident to the bathroom. c. On 1/15/17 at 2:21 p.m., the CNA found the resident			

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	standing in his her room with the chair alarm in the recliner with his/her lunch tray. The staff attempted to remove the lunch tray and the resident grabbed the tray and would not let go. The RN documented the CNA called for help and RN responded and witnessed the resident with one hand on the tray and water pitcher and another on the walker. The resident poured water on the tray and floor and staff assisted him/her to the recliner and cleaned up the water. Staff then assisted Resident #11 to the wheelchair with the chair alarm and took him/her to the common area by the nurse's station. d. On 1/16/17 at 5:45a.m., Staff found the resident's alarm sounding without the resident in the room. They found the resident under the table in main dining room wiping the floor. Staff brought the resident his/her walker and the resident stood up without help, returned to his/her room and went to sleep. f. On 1/20/17 at 5:17a.m., Staff documented they found the resident under the table in main dining room. The resident stood up alone with the walker and staff assisted him/her back to bed. g. On 1/21/17 at 12:15 a.m. the resident sat at the nurse's station in the wheelchair eating a snack and reading the paper. The resident stood up and began to walk without his/her walker. Staff attempted to assist the resident to their room, but the resident was non-compliant and resisted. Staff attempted 3 more times and the resident went back to bed. A review of an incident report (fall/injury monitor) revealed the resident fell again on 1/17/17 at 6:15p.m. which resulted in a 3 centimeter hematoma to the left posterior part of the resident's head. In an interview on 2/1/17 at 3:14p.m., Staff G, CNA reported on 12/31/16 the resident's roommate called out for help and reported the resident had attempted to			

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	hang a picture on the wall while standing on the bed and fell on the floor. Prior to the fall, the resident had a bed alarm at night and could be up ad lib in the room, however, if out in the hallway required standby assistance. The resident had been found on the floor, unresponsive, sent to the hospital by ambulance and in the hospital for a few days. Staff G reported the resident fell a few more times after returning from the hospital and required the assistance of one person for transfers and ambulation, low bed and now a chair alarm. During an interview on 2/1/17 at 3:26 p.m., Staff I, RN reported prior to the fall on 12/31/16 the resident required the assistance of one staff member with walker when the resident had been seen up. On 12/31/16, staff found the resident on the floor with a small amount of blood noted to the back of the head and unresponsive. Staff sent the resident to the hospital by ambulance. When the resident returned to the facility he/she received skilled services and continued to do so. Staff I stated now the resident is care planned to transfer with assist of one with gait belt and walker and has a bed and a chair alarm. The resident had some falls after he/she returned from the hospital. As a result of one of the falls, Resident #11 sustained a hematoma to the back of the head. Staff G reported the resident now required a lot of one-on-one assistance. A review of the undated facility policy titled: fall prevention directed staff to: a. Interview the resident and family upon admission to determine if there is a history of falls. Attempt to identify times, locations and what the resident was attempting to do when they fell. b. Establish interventions based on the RAP information to eliminate or decrease the resident's risk and/or causative factors. Identify these on the resident's plan			

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	of care and the CNA care guide. c. After each fall, complete the falls assessment record. Look for trending. Identify the possible reason for the fall and make appropriate changes to the plan of care. **FACILITY RESPONSE:**			

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58.19(2)b	**481-58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:** **58.19(2) *Medication and treatment.*** ***b.* Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (1, II)** **DESCRIPTION:** Based on observation, record review, and interview, the facility failed to provide appropriate care and treatment to prevent new sores from developing 1 of 2 residents reviewed with pressure ulcers (Resident #4). The facility reported a census of 52 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 12/20/16, listed diagnoses for Resident #4 included diabetes, neuropathy (a condition causing pain, numbness, and reduced sensation), and non-pressure chronic ulcer of other part of unspecified foot with unspecified severity. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended totally on 2 staff for bathing. The MDS stated the resident was at risk of developing pressure ulcers and had 1 unstageable pressure ulcer with suspected deep tissue injury. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.	**I**	**2,000.00** **Held in Suspension**	**Upon Receipt**

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	The resident's Admission Record listed an admit date of 12/13/16 with admission diagnoses included Type 2 diabetes, neuropathy, and non-pressure chronic ulcer of other part of unspecified foot with unspecified severity. The Skin Risk Assessment, dated 12/13/16 (the resident's admission date), revealed the resident had a chronic ulcer under the right great toe and listed the resident's skin risk as low. The document contained no other information related to additional skin concerns upon admission. Skilled charting for 12/14/16 documented the resident had no open skin areas on the left or right foot/toes, protecting area on left outer metatarsal (top middle portion of the foot). a. A Skin Observation Tool, dated 12/20/16, revealed staff noted a blood blister on the left heel, blister intact, Tegaderm(a transparent film dressing) applied for protection, heels floated in bed, staff informed to avoid all pressure, including shoes and socks and to float heels at all times. Measurements (in length x width x depth) = 2 cm (centimeters) x 3.4 cm x "unmeas". The stage was listed as "suspected deep tissue injury" defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. A Skilled Charting entry, dated 12/20/16, documented the resident's heels were flat on the bed, blood blister noted to left heel 2 cm x 3.4 cm, heels floated at this time. The resident's January MAR (Medication Administration Record) displayed a 12/21/16 order for Tegaderm for			

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	protection to blister on left heel, check every shift for placement. A Skin Observation Tool, dated 12/27/16, listed the left heel measurements as 3.3 cm x 4.8 cm x "unease". A Skin Observation Tool, dated 1/3/17, listed 2 measurements for the left heel: 1.6 cm x 1.6 cm x "unmeas" and 2.8 cm x 3.6 cm x 0.1 cm. The document stated the left heel blister was broken and the top skin came off, no inflammation or drainage, center of blistered area darkened, not black at this time, floating heels and no shoes when in recliner/room. A Skilled Charting entry, dated 1/4/17, identified the dark area on the left heel was larger and the resident had no dressing covering the wound. A Skin Observation Tool, dated 1/4/17, listed measurements for the center of the left heel as 2.6 cm x 1.8 cm x "unmeas" and described the center as "black". The document listed the left heel measurement as 3 cm x 2 cm x 0.1 cm. The document stated the center of the left heel changed since 1/3/17, area black and firm. A 1/4/17 physician's order sheet listed the following orders: a. Strict pressure precautions b. Blue boot cushion or similar c. Pad foot of recliner d. Egg crate to bed e. No shoes, daily dressing changes to left foot f. Keep wound clean and dry The MDS assessment tool, dated 1/10/17, revealed the resident was at risk of developing pressure ulcers and had 2 unstageable pressure ulcers with suspected deep tissue injury. A Skin Observation Tool, dated 1/11/17 listed			

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	measurements for the black center of the left heel as 3 cm x 2.5 cm x "unmeas" and listed the left heel measurements as 4 cm x 3 cm x "unmeas". A 1/13/17 physician's order sheet listed an order for Levaquin (an antibiotic) 500 mg (milligrams) x 10 days, monitor left heel for infection. A Skin Observation Tool, dated 1/18/17, listed 1 set of measurements for the left heel described as "black eschar (dead tissue)": 2.2 cm x 3 cm x" unmeas". The document stated the left heel pressure round center was blackened, dry, and firm. A Skin Observation Tool, dated 1/25/17, listed measurements for the left heel as 2.2 cm x 3 cm x "unmeas". During an observation on 1/31/17 at 10:40 a.m., Staff H, Licensed Practical Nurse (LPN) measured an area of black eschar on the resident's heel at 3 cm x 2 cm. The surveyor noted an odor coming from the wound. The facility lacked any documentation of the odor coming from the wound during the surveyor observation. b. A Skin Observation Tool, dated 12/27/16, identified the facility noted a small scratch to the top of the left great toe measuring 0.2 cm x 0.4 cm x 0.1 cm and listed the stage as N/A(Not available). A Skin Observation Tool, dated 1/3/17, described the area to the top left great toe as a scratch/pressure and categorized the area as a Stage 2 described as partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red pink wound bed. The document listed the measurements as 0.2 cm x 0.2 cm x 0.1 cm.			

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	A Skin Observation Tool, dated 1/4/17, listed measurements for the top left great toe as 0.2 cm x 0.2 cm x 0.1 cm. A Skin Observation Tool, dated 1/11/17, listed measurements for the top left great toe as 0.3 cm x 0.3 cm x "unmeas". A Skin Observation Tool, dated 1/18/17, listed measurements for the top left great toe as 0 cm x 0 cm x 0 cm and described the area as a dry open scab with slight indentation. A Skin Observation Tool, dated 1/25/17, stated the pressure area on the left great toe resolved, dry flaky skin present. During an observation on 1/31/17 at 10:40 a.m., Staff H LPN measured a pink/red area on the resident's left great toe at 3 cm x 2 cm. The facility lacked documentation of the wound worsening between the 1/25/17 note stating the wound had resolved and the surveyor observation on 1/31/17 with measurements of 3 cm x 2 cm. The initial resident care plan, dated 12/13/16, directed staff to reposition the resident every 2 hours and provide treatment per physician's orders. The care plan lacked documentation of additional specific interventions to prevent the development of pressure ulcers including floating the heels. A care plan entry, dated 12/23/16, stated the resident had actual impairment to skin integrity of the left heel related to suspected deep tissue injury. Care plan entries, dated 1/2/17 stated the resident required the following interventions: a. Assistance of staff to turn and reposition in bed			

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	every 2 hours and as necessary. b. Skin inspection during bathing and as needed, observe for redness, open areas, scratches, cuts, bruises, report changes to the nurse. Care plan entries, dated 1/3/17, stated the resident required the following interventions: a. A pressure relieving/reducing mattress on the bed to protect the skin while in bed b. Float heels while in bed Care plan entries, dated 1/4/17, stated the resident required the following interventions: a. Provide 1 ounce liquid protein twice per day b. Resident is not to wear shoes at this time c. Pressure reducing boots while in bed A care plan entry, dated 1/31/17, stated the resident required an air flow pressure reduction mattress. The care plan lacked documentation of interventions implemented related to the prevention and treatment of the resident's pressure ulcer prior to 1/3/17. The care plan did not identify any problems related to the resident's refusing to wear the boot or refusing to float heels. During an interview on 2/1/17 at 10:30 a.m., the Assistant Director of Nursing stated she found the blister on the resident's heel. She stated when she found the blister the resident had his/her heel dug into the mattress. She said it looked like his/her heel was floated but he/she pushed the pillow away. During an interview on 2/1/17 at 4:20 p.m. the Director of Nursing stated the resident was "absolutely" at risk for skin breakdown upon admission. She stated staff were to float the resident's heels but is "questioning" whether that was done consistently. She stated she would have expected interventions on the care plan			

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	prior to 1/3/17 and stated in the future, she would assign the staff members to the same residents for the purpose of consistency of care. **FACILITY RESPONSE:**			

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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 staff interview and record review the facility failed to report a major injury to the Iowa Department of Inspections and Appeals as required for 1 of 3 residents reviewed who experienced falls. (Resident #11). The facility identified a census of 52 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment tool dated 1/11/17, Resident #11 had diagnoses: other fracture, non-Alzheimer's dementia and Parkinson's disease. It also identified the resident as severely cognitively impaired and revealed the resident required staff assistance with all activities of daily living. The care plan dated 11/3/16 identified the resident with the problem of activities of daily living self-care deficit and directed staff to: a. Provide standby assist of one staff with use of walker for ambulation (walking) when he/she is seen up b. Provide standby assist of one staff for transfers when seen up c. Provide extensive assist of one staff for toilet use A review of the nurse's notes revealed the following	**II**	**$500.00** **Held in Suspension**	**Upon Receipt**

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	entries: a. On 12/31/16 at 6:08 a.m. staff documented they notified the physician of the resident's fall and obtained an order to send him/her to the emergency room via ambulance and obtain a head CT b. On 12/31/16 at 6:05 p.m. (late entry), the resident's roommate called for help. Staff entered the room and found the resident on the floor. Resident #11's roommate reported the resident stood on the bed to hang a picture and fell. Staff notified the resident's family member and sent the resident to the hospital by ambulance. c. On 12/31/16 at 8:05 p.m., Staff notified the Director of Nursing (DON) of the fall d. On 1/4/17 at 2:11 p.m., the resident returned from an admission to the hospital where he/she had been since 12/31/16 after sustaining a fall with loss of consciousness. The resident sustained right and left cerebral hemorrhages, multiple right sided fractures and a right clavicle fracture. Resident #11 had an order for a Miami J (neck) collar to wear at all times, and physical and occupational therapy. An interview on 2/1/17 at 2:25 p.m. with the State Agency (SA) revealed the facility last reported a major injury in September of 2016. In an interview on 2/1/17 at 3:26 p.m., Staff I, RN reported she sent the physician the determination of major injury form, but did not follow-up on whether or not the physician had completed and returned the form. She thought the Director of Nursing (DON) was responsible for that. During an interview on 2/1/17 at 3:53 p.m., the DON reported when a resident had a major injury, staff			

Department of Inspections and Appeals
Health Facilities Division
Citation

Number **6456**				**Report date** **Corrected 2/20/17** **February 16, 2017**
Facility name **United Presbyterian Home**		**Survey dates** **January 30, 2017 to February 2, 2017**		
Facility address **1203 E. Washington Street**				
City **Washington, IA.** **52352**	**JM**			

Rule or Code Section	Nature of Violation	**Class**	**Fine Amount**	**Correction Date**
	reported it to her and then sent a major determination to the doctor for completion. She stated the staff needed to follow up and call if the physician did not send the form back in a timely manner. The administrative staff discussed whether or not to self-report it to the SA. The DON reported she did not self-report the injury to the SA because she thought the resident had been independent, but felt the injuries the resident sustained had been major injuries. She stated she had waited to see what the doctor wrote on the determination of major injury form. She also stated she should have followed up on the form. A review of the 7/13/12 facility policy titled Major Injury Definition/Reporting directed staff a major injury is to be defined as an injury which: a. Results in death, or b. Requires admission to a higher level of care for treatment, other than for observation, or c. Requires consultation with the attending physician, designee of the physician, or physician extender who determines in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the resident, and the resident's prognosis. d. The director or the director's designee shall be notified within 24 hours or the next business day by the most expeditious means available. **FACILITY RESPONSE:**			

If, within thirty (30) days of the receipt of the citation, you: (1) do not request a formal hearing or; (2) withdraw your request for formal hearing; and (3) pay the penalty, the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2015).

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