



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

<b>Number</b> FC 6455		<b>Fine amount reduced by 35% to \$650.00 on February 28, 2017 pursuant to Iowa Code Section 135C.43A</b>	<b>Report Date</b> February 15, 2017		
<b>Facility Name</b> Glenwood Resource Center			<b>Survey Dates</b> January 11, 2017- February 3, 2017		
<b>Facility Address</b> 711 South Vine St		65074-C, 65079-I, 65215-C, and 65216-I.			
<b>City</b> Glenwood, IA. 51534		HL/CC/LK			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
<b>W 288</b>	<p><b>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</b> Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.</p> <p><b>DESCRIPTION:</b> Based on interviews and record review, the facility failed to ensure staff consistently and correctly utilized approved interventions to address inappropriate client behavior. Staff utilized unapproved techniques to address inappropriate client behavior not addressed in the individual program plan. This affected 1 of 1 client (Client #2) identified during the investigation of 65074-C and 65079-I.</p> <p>Finding follows:</p> <p>Record review on 1/11/17 revealed an incident report, dated 1/10/17, completed by Resident Treatment Supervisor (RTS) A at 2:45 p.m. The RTS documented Client #2 grabbed and pulled a Psych Assistant's (PA) hair with both hands. The staff assigned to Client #2, Resident Treatment Worker (RTW) C intervened along with RTS A. Additional staff present were RTW D and PA B. According to the report, staff held the client's hands close to the staff's head and waited for the client to let go. While the group continued to wait, RTW E walked toward the group and stated, "I can help with this." Immediately he took his forefinger and thumb and placed them on the client's nose. His fingers were placed in front of the client's mouth. He stated, "If (he/she) can't breathe, (he/she) will let go." The RTS intervened and explained that he could not do that and removed him from the situation and the house.</p>				

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	<p>When interviewed on 1/11/17 at 1:35 p.m. RTW E admitted he saw Client #2 pulling PA A's hair. He walked to the group from the front and put his thumb and first finger on the client's nose. He pinched the client's nose. He said his hands were not tightly on the client's nose. He explained he did this to distract the client. RTS A told him, "Don't do that." and he let go. Within a minute Client #2 released his hands from, PA A's hair. He confirmed he had done this about a week prior when Client #2 had RTW F's hair. He said that time he held the client's nose about 10 seconds. As soon as the client released, RTW E released. He denied being shown this technique and just did it himself the two times. RTW E confirmed training on Mandt techniques and explained when clients pull hair, staff should hold their hand to the head until they tire out.</p> <p>Interview with RTW D on 1/12/17 at 2:15 p.m. via phone, confirmed she was present at the incident on 1/10/17. She explained the situation as RTW E stated he thought he could help. She stated RTW E put hands on nose and over the client's mouth. The supervisor told him he could not do that and he let go. Also, RTW E said "it worked last time." She reported RTW C also stated that it only took 20 seconds last time and (he/she) let go. RTW D had not seen this technique used in the past.</p> <p>During an interview with PA A, she explained Client #2 pulled her hair on 1/10/17. She held the client's hands close to her own head and conveyed to the staff helping that the client was not hurting her. She stated she saw RTW E walk up and put his hands and fingers over Client #2's nose and lips. RTW E commented about if (he/she) can't breathe (he/she) will let go. She noted he pinched the nose for a couple seconds and was told to stop and he did.</p> <p>When interviewed on 1/12/17 at 1:05 p.m. RTS A</p>				

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	<p>confirmed she assisted with the incident. She held the client's hands to PA A's head and also blocked the client from head butting her. She observed RTW E walk towards them saying he could help with this. He put the palm of his hand over Client #2's mouth and his thumb and first finger on the client's nose and commented that if (he/she) can't breathe (he/she) will let go. Immediately the RTS told him he could not do that and he let go. She then had him leave the area and informed him he needed to go to the supervisor's office and she notified management.</p> <p>When interviewed on 1/12/17 at 2:40 p.m. RTW F explained Client #2 pulled her hair the week prior-approximately 1/3/17. She stated RTW E was present during the hair pulling incident, however she did not see where any staff's hands were. She was bent forward and could not see what was going on. She did hear a rumor that day or the next that they plugged the client's nose to get him/her to release her hair. She could not remember who told her this information. She denied informing any supervisors or management about this information.</p> <p>Record review revealed Client #2's behavior support plan, started 12/5/16, included target behaviors of: aggression, property destruction, self-injurious behavior (SIB), stripping, inappropriate social behavior, and inappropriate sexual behavior. The BSP did not include hair pulling. When staff saw target behaviors, the BSP instructed staff to: give one verbal prompt to stop using a firm voice, back away if aggression directed at staff. If you cannot back away when aggression is displayed towards staff, if aggression is directed at a peer, or for any other target behaviors, use GRC approved techniques to interrupt the behavior.</p> <p><b>FACILITY RESPONSE:</b></p>				

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64.60	<p><b>481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.</b></p> <p><b>Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility.</b></p> <p><b>This rule is intended to implement Iowa Code Section 135C.2(3).</b></p>	II	\$500.00	Upon Receipt	
W318	<p><b>483.460 Heath Care Services</b> <b>The facility must ensure that specific health care services requirements are met.</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to be in minimal compliance with the Condition of Participation (COP) - Health Care Services. The facility failed to ensure all clients were consistently provided appropriate health care services in accordance with their needs; including failure to adequately assess an injury and provide Client #1 pain medication to alleviate the severe pain from a fractured thumb.</p> <p>Findings follow:</p> <p>Cross-reference W322: Based on interviews, and record reviews, the facility failed to ensure clients consistently received appropriate medical care to address acute health concerns. Staff failed to adequately assess client injury,</p>				

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<b>W322</b>	<p>ensure timely follow up, and provide adequate pain management.</p> <p><b>483.460(a)(3) Physician Services</b> <b>The facility must provide or obtain preventive and general medical care.</b></p> <p>Based on interviews, and record reviews, the facility failed to ensure clients consistently received appropriate medical care to address acute health concerns. Staff failed to adequately assess client injury, ensure timely follow up, and provide adequate pain management. This affected 1 of 1 client (Clients #1) identified as a result of investigation #62515-C and 62516-I.</p> <p>Findings follow:</p> <p>Record review on 1/16/17 revealed an Incident Report, dated 1/13/17 at 6:45 a.m., completed by Resident Treatment Worker (RTW) A. The report detailed staff assisted Client #1 with a brief change. When rolling towards and resting against staff, the staff's knee gave out and Client #1 slid off the bed. Staff had a hold of Client #1 and prevented his/her head and body from reaching the floor; Client #1's knees hit the floor and his/her body landed on staff's knee. RTW A had their arms under the client and lifted/rolled the client back to the bed, when he noticed the client's thumb bled. RTW A did not know how Client #1 hurt his/her thumb, but thought it may have possibly gotten caught on the bed brake lever. Staff examined the thumb and immediately called for other staff to call nurse.</p> <p>The report further documented the fall and head injury assessment that occurred. Registered Nurse (RN) A documented upon arrival at approximately 6:59 a.m. she observed a dime sized scrape, no broken skin, to the</p>				

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	<p>client's left knee and a pink mark, approximately 0.7 centimeters (cm) by 0.4 cm on his/her right knee; no bruises or edema were noted to either knee. The RN further documented, "...rt (right) hand rt thumb on visual examination appears very much out of alignment, bruised and swollen, nail bed is raised up off nail bed nail seems to split near base of nail and bleeding slightly. Nail bed bluish tinged strong radial pulse..." The report further noted the Advanced Registered Nurse Practitioner (ARNP) asked that the thumb be stabilized as much as possible and she would order an x-ray. The ARNP arrived at 7:31 a.m. to see Client #1 and instructed administration of Tylenol. The report documented, "...7:35 a.m. hold off administering (his/her) routine meds to be sure (he/she) can keep (his/her) PRN Tylenol down in case of stomach upset as (Client #1) is [moaning and] yelling out..." RN A documented instruction from the ARNP to put a "stat" order on the x-ray to include Client #1's right thumb, wrist and hand. A gentle splint was applied per instruction from the ARNP and his/her right hand elevated on a pillow as they awaited x-ray to rule out fracture.</p> <p>Additional record review revealed Client #1's clinical notes. Review revealed the following timeline regarding Client #1's injury:</p> <p>a. 1/13/17 at 9:17 a.m., RN B documented nursing assessment: "near fall this am (morning) during routine cares, knees scraped floor, small abrasion, right thumb w/(with) swelling, bruising, injury to nail, and unnatural appearing alignment per (RN A)... x-ray order in place, awaiting mobile x (x-ray) arrival, thumb splinted, Tylenol given also, (Physician A) aware."</p> <p>b. 1/13/17 at 10:45 a.m., Licensed Practical Nurse (LPN) A documented nursing assessment: "(Client #1) has been making vocal sounds [on a regular basis]... Right thumb</p>				

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	<p>swollen and red and bruise in color. Limited ROM (range of motion) to extremity of thumb. Nail is pushing outward with edema under nail bed and bleeding around nail. Area cleansed and ice applied with ace wrap applied. [Mobile x-ray] was here with [x-ray] completed... Trauma to right thumb... To be seen by OD (on duty physician)."</p> <p>c. 1/13/17 at 11:10 a.m., RN B documented nursing assessment: "right thumb, distal section with significant swelling, bleeding from the thumb nail site, blue in color" Assessment: "trauma to right thumb... seen by Physician A [at] GRC's (Glenwood Resource Center) clinical wing... x-ray report available now, multiple fractures reported, ER (emergency room) evaluation pending..."</p> <p>d. 1/13/17 at 12:00 p.m., LPN A documented nursing assessment: "To JEMH (Jennie Edmundson Methodist Hospital) by state van with a departure time of 12:30 p.m..."</p> <p>e. 1/13/17 at 4:19 p.m., RN C documented ER communication: "...client is being admitted... Client will be taken to surgery sometime dx (diagnosis) fracture..."</p> <p>f. 1/13/17 at 8:00 p.m., RN C documented JEMH communication: "...Client had ORIF (open reduction internal fixation) of the Right thumb and has a splint and 1/2 cast along with ace wrap..."</p> <p>When interviewed on 1/18/17 at 1:15 p.m., Resident Treatment Worker (RTW) A confirmed Client #1 fell out of bed while he provided cares. He explained he rolled the client towards him while changing his/her brief, and leaned the client against him. RTW A's knee gave out and the client fell, partially on RTW A and partially on the floor. RTW A lifted Client #1 back to his/her bed and put up the bed rail. He looked at the client's knees and they</p>				

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	<p>appeared fine, but noticed his/her hand had "a significant injury." He described Client #1's right thumb as "purple and disfigured, turning blue to purple." RTW A stated Client #1 did not begin moaning right away, but began about 10 -15 minutes later and continued to cry out. RTW A stated he placed cool packs on the injury and called for a co-worker to call the nurse right away. RTW A recalled the nurse arrived within five minutes to assess the injury, and stated medical treatment was needed. The nurse called for mobile x-rays and they took two hours to get there. RTW A stated the nurse could tell it was broken and did not understand why Client #1 wasn't taken to the emergency room. RTW A stated it took two more hours to see Physician A, and they finally just took him/her to Physician A's office. As soon as Physician A saw Client #1, he immediately sent him/her to the emergency room. RTW A stated Client #1 showed significant pain within 15 minutes of the injury and the nurses wanted to send him/her to the emergency room, but they required physician approval.</p> <p>When interviewed on 1/24/17 at 12:30 p.m. RTW B stated she came from the hallway when the injury first occurred and RTW A asked for help. RTW B stated she saw Client #1's injury and it immediately began swelling and turning purple, the nail bed was popped up and it bled. She stated it appeared as a bad injury and it was "very obvious it was broken." RTW B stated she called Licensed Practical Nurse (LPN) A and he came to the home immediately. Registered Nurse (RN) A then arrived to assess. RTW B stated she took Client #1's vitals: Client #1 had a higher blood pressure (BP), but he/she has a little high BP; his/her heartrate was "a little elevated." RTW B stated she thought Client #1's thumb was broken, as did RTW A and LPN A. The ARNP came to the home shortly after 7:00 a.m. RN A had made a makeshift bandage/splint for Client #1's thumb. The ARNP did not</p>				

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	<p>remove the bandage to assess Client #1's injury, she just said they would get x-rays. When asked to clarify, RTW B stated it did not appear the ARNP assessed Client #1's injury. RTW B reported Client #1 in pain the entire time he waited to go to ER. She stated they waited to see Physician A after the mobile x-rays were taken. She stated they told every supervisor and every nurse that Client #1 needed to immediately to the ER and it did not happen. RTW B accompanied Client #1 to the emergency room. She stated they left campus around 12:10 p.m. and arrived at 12:40 p.m. When they arrived to the hospital, she stated they asked "what took so long to get (him/her) here?" She stated Client #1 was clearly in pain and let out "gut wrenching" cries. She stated he/she had been in pain since 7:00 a.m. and had received Tylenol, but he/she needed more. She requested pain medication for Client #1 while in triage at the ER, and they gave him/her Lortab. They took Client #1 back to take x-rays, again. Client #1 was still in pain, and was given morphine.</p> <p>When interviewed on 1/25/17 at 9:30 a.m. LPN A recalled he received a call from RTW A and went to the house. RTW A and RTW B were at Client #1's bedside and it was apparent he/she had an injury. RTW A told him what happened. At that point the thumb appeared swollen and the thumb nail appeared "pushed up." LPN A attempted to immobilize the thumb. He reported Client #1 appeared to "be in a little bit of pain." He thought they would be getting him/her something for the pain. RN A arrived to the home, and he figured Client #1 would be "sent out." He explained Client #1's thumb appeared to be fractured. He talked with RN A and she stated she had not yet spoken with the on-call physician. He stated he asked if they were "okay" and she said yes, so he left and thought they would send Client #1 out. He stated he returned to the home around 8:45 - 9:00 a.m. and saw Client #1 still there. He stated Client #1 had a splint on the injury and</p>				

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	<p>appeared to be in discomfort. LPN A reported he cut away some of the dressing and checked the circulation. He stated the injury appeared red and swollen. He believed x-ray arrived before 10:00 a.m. He contacted the clinic (on campus) right after x-ray left and told RN B the thumb appeared swollen. She reported the x-ray came back with a fracture. She told him they wanted to see Client #1 in the clinic. LPN A reported Physician A never refused to come out to the home to see Client #1, they just bypassed him and sent the client to the clinic. LPN A reported he was not in the home when the ARNP came to assess, but he was with Client #1 when Physician A assessed him/her. Physician A realized Client #1's thumb was fractured. He cleaned his/her injury and prepared to send him/her out to the emergency room. LPN A reported Client #1 in pain "more often than not," but did not show pain the entire time. He stated Client #1 would act like the injury hurt, and cry out in pain. LPN A stated he felt they did an "okay job," except for Client #1's pain and he felt he/she should have been sent out right away. He stated it was a very painful injury Client #1 sustained, with the injury to the nail bed and the severe fracture.</p> <p>When interviewed on 1/19/17 at 12:30 Registered Nurse A (RN A) stated LPN A called her to the house around 6:45 a.m. and she arrived at 6:50 a.m. LPN A told her he thought Client #1 had a fractured finger. RN A reported she assessed the injury and noted the thumb to be bruised, and out of alignment. She reported Client #1 yelled and it was apparent he/she was in pain. Staff working in the home, who knew the client, reported he/she was in pain and she knew it to be true. RN A reported she felt the client should have gone to the ER right away. RN A called Physician A and was told the ARNP was on-call. She called the on-call physician, the ARNP, and told her Client #1's thumb was probably fractured. The ARNP asked RN A to stabilize the thumb, which she did using a</p>				

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Health Facilities Division  
Citation**

<b>Number</b> FC 6455		<b>Fine amount reduced by 35% to \$650.00 on February 28, 2017 pursuant to Iowa Code Section 135C.43A</b>	<b>Report Date</b> February 15, 2017		
<b>Facility Name</b> Glenwood Resource Center			<b>Survey Dates</b> January 11, 2017- February 3, 2017		
<b>Facility Address</b> 711 South Vine St		65074-C, 65079-I, 65215-C, and 65216-I.			
<b>City</b> Glenwood, IA. 51534		HL/CC/LK			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
	<p>tongue depressor, gauze, and tape. She reported the thumb bled from the nail, through the gauze. RN A asked the ARNP if she wanted an x-ray and told her she would order it "stat." Around 7:30 a.m., the ARNP arrived at the house to assess the injury. RN A offered to remove the bandage/splint for ARNP A to assess Client#1's thumb, but she said "No." Client #1 received Tylenol around 7:40 a.m. for pain.</p> <p>When interviewed on 1/18/17 at 2:45 p.m. ARNP A stated she went out to the house to see Client #1. He/she sat in a wheelchair. She reported the injury was bandaged, so she did not see that it was an open fracture. She stated she asked the nurse to get x-rays of the client's right hand fingers/thumb. ARNP A reported the nurse informed her of an open area with some bleeding, but no deformity. When asked if Client #1 was in pain, ARNP A reported the client was "a little loud," but she did not find it out of normal. ARNP A confirmed she never observed Client #1's injury with the bandage off.</p> <p>When interviewed on 1/18/17 at 2:30 p.m. Physician A stated ARNP A went to the home to see Client #1, prior to 8:00 a.m. ARNP A then came to a meeting and notified Physician A she ordered x-rays. He asked to be notified when Mobile-X arrived to complete the x-rays. Physician A reported he received an email from the Health Care Coordinator informing him Client #1's thumb was swollen. He asked if it was a soft tissue injury. ARNP A was unclear whether it was torn skin, laceration, or open wound, she just ordered x-ray, so Physician A requested they bring Client #1 to clinic to look at it. Within 5-10 minutes they called to report Client #1 had a fracture. Client #1 arrived to the clinic and he assessed. Physician A reported the thumb was swollen. There was no laceration or torn skin. The nail was displaced. He reported no open fracture and no soft tissue injury.</p>				

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	<p>Physician A reported Client #1 showed no signs of pain and appeared calm at this point, and he thought the Tylenol was working.</p> <p>When interviewed on 1/24/17 at 2:15 p.m. the Director of Nursing (DON) stated nurses use two different pain scales to assess client pain. She said they need clinical evidence the client is in pain in order to document this.</p> <p>Record review on 1/17/17 revealed Adult Nonverbal Pain Scale (ANVPS). The scale provided the following areas: face, activity, guarding, physiologic I (vital signs), and physiologic II, and required scoring from 0-2. The cumulative score then provided the level of pain from "no pain" to "worst imaginable." The document directed, "Score of 0-2 indicates no pain, 3-6 moderate pain, and 7-10 severe pain."</p> <p>Record review on 1/17/17 revealed nurses assessments for Client #1 from 1/13/17. The assessments documented the following:</p> <p>a. At 8:12 a.m., assessment completed by RN A documented: BP 132/ 88 and a pulse rate of 90, respirations 18. RN A utilized "faces (Adult Nonverbal Pain Scale)" pain assessment tool, and rated Client #1's pain at 5 [out of 10]. The assessment also revealed a pain scale (faces) of a level 5. RN A documented, RTW B reported while giving personal cares to Client #1, he rolled the client toward him and the side of the bed and the client began to fall. RTW B reported he did break most of the fall and only Client #1's knees touched the floor. The assessment further noted, "left knee has dime sized scrape no broken skin, and no edema noted, Rt (right) knee has only a pink mark approx. 0.7cm (centimeters) by 0.4cm no bruises or edema at either knee cap no other injury noted except rt hand rt thumb on visual assessment</p>				

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	<p>appears to be very much out of alignment, bruised and swollen, nail bed is raised up off nail bed nail seems to be split near base of nail and bleeding slightly. Nail bed bluish tinged strong radial pulse. Nail bed cleansed gently with saline was and On call (ARNP A) called at 7:05 am She asked that the thumb be stabilized as much as possible and she will order a x-ray (ARNP A) here on unit at 7:31 a.m. to see (Client #1) CMA (certified medication aide) instructed to administer PRN (as needed) Tylenol... (Client #1) is moaning and yelling out. (ARNP A) instructed (RN A) to put a 'stat' order for x-ray to include (his/her) Right thumb, wrist and hand this was done at 7:46 a.m. Gentle splint was applied as instructed by (ARNP A)."</p> <p>b. At 10:45 a.m. assessment completed by LPN A documented: pulse rate of 90 and respirations 18. Subjective documented: "Staff reports bleeding from dressing." Objective documented: "(Client #1) has been making vocal sounds at regular bases [sic]... Right thumb swollen and ruse and bruise in color... Limited ROM to extremity of thumb. Nail is pushing outward with edema under nail bed and bleeding around nail... Mobil X Ray [sic] was here with (x-ray) completed."</p> <p>c. At 11:10 a.m. assessment completed by RN B documented: BP 138/82, pulse 82, respirations 18. Assessment did not include a pain rating, but noted, "significant pain this morning, has been crying out continually, even after Tylenol per staff, seems to have settled down in past 30 minutes or so." Objective documented: "right thumb, distal section w/significant swelling, bleeding from thumb nail site, blue in color." Assessment documented: "trauma to right thumb" Plan documented: " seen by (Physician A)... x-ray report available now, multiple fractures reported, ER evaluation pending..."</p>				

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	<p>d. At 12:00 p.m. assessment completed by LPN A documented no vitals. The assessment rated Client #1's pain at 8, using ANVPS and noted, "Tylenol was given at 7:30 pm and was ineffective [sic]" Plan documented: "To (Jennie Edmundson Methodist Hospital) ER by state van with a departure time of 12:30 p.m.</p> <p>Further record review revealed Emergency Department documentation for Client #1 from JEMH on 1/13/17 revealed the following:</p> <p>a. Client #1 presented with right hand pain, swelling and injury.</p> <p>b. Onset seven hours prior.</p> <p>c. The degree of pain was noted as moderate.</p> <p>d. Vital signs noted on 1/13/17 at 1:38 p.m.: pulse 90 beats per minute (bpm), respirations 16 breaths (br)/minute (min), and BP 148/99.</p> <p>e. Musculoskeletal assessment noted: "Distal upper extremity, Hand, Fingers/toes: Right, first, tenderness, swelling, abrasion, erythema, deformity 1st right digit, deformity, fingernail lifted..."</p> <p>f. Radiology results on 1/13/17 at 12:52 p.m. revealed, "Moderately displaced and comminuted (break or splinter of the bone into more than two fragments) first distal phalanx fracture. Extension of fracture into the articular surface. Oblique mildly displaced fracture of the first proximal phalanx extending from the proximal metaphysis to the distal metaphysis. No dislocation. Moderate soft tissue swelling."</p>				

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	<p>g. Nursing note, dated 1/13/17 2:00 p.m., documented, : thumb intact - fingernail raised and not intact to skin [underneath]. nail dark in color... after IM (intramuscular) morphine given patient had less moaning and didn't seem s as intense/restless."</p> <p>h. At 2:27 p.m. JEMH Physician recommended surgical intervention. Client #1 was admitted.</p> <p>i. The Operate/Surgical Reports documented the following findings: "Right thumb proximal phalanx shift fracture that is mildly displaced... There is a highly comminuted distal phalanx fracture.</p> <p>j. Social Worker/Case Manager daily summary noted, "Pt (patient) crying out in pain. The client's hand had been wrapped.</p> <p>Additional review of Client #1's record revealed the following:</p> <p>a. Client #1's Individual Support Plan (ISP), dated 8/30/16, noted: "(Client #1) does not use words, but does communicate through sounds and expressions.</p> <p>b. Client #1's comprehensive functional assessment (CFA), reviewed 7/26/16, documented Client #1 able to express displeasure (i.e. crying).</p> <p>When interviewed on 1/18/17 at 3:30 p.m., Treatment Program Manager (TPM) A reported Client #1 can and will make noise when he/she is in pain. She explained it is apparent when something is not ok with Client #1.</p> <p>Record review on 1/24/17 revealed an email from Investigator A to the Director of Quality Management, sent 1/24/17. The email noted concerns regarding the</p>				

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	<p>investigation into Client #1's injury. Concerns included:</p> <p>a. "... The record would reflect a considerable period of time elapsed from the time that a witnessed incident occurred resulting in a fracture to the client's right thumb to the time the client received necessary emergency care (surgery) to address the fracture. The record indicates the incident occurred near 6:45 AM, nursing staff were notified quickly, and the doctor on call as notified of a potential for fracture around 7:00 AM. The on call doctor did not physically examine the injury as it had already been stabilized and wrapped at her direction. X-rays were ordered, however, they were not completed until after 10:00 AM, and the client did not leave for emergency treatment until after 12:00 PM..."</p> <p>b. "... There was also concern raised regarding pain management for the client. The trauma and subsequent pain were identified by 7:00 AM and Tylenol was given as of 7:40 AM. At approximately 10:45 AM, nursing had contact with the physician and it was made clear that the client was in pain and that the dressing had 'bled through.' The doctor reported at that point, he did observe the client and observed no signs or symptoms of pain, so he offered no additional pain management. The Psych. Asst. who was present during that examination reported the client did seem to be more comfortable as the original splint dressing had been replaced by an ACE wrap which appeared to support the injury better at the time... (RTW B) reports the client continued to make vocalizations indicating pain during the trip to the hospital and she requested pain relief for the client there which (he/she) received around 1:30 PM. She reports the client continued to show signs and symptoms of pain without relief from the pain medication and requested something further. The record reflects the client was given Morphine at 3:00 PM..."</p>				

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	<b>FACILITY RESPONSE:</b>				

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