Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#6458				**Date: February 20, 2017**
Maple Heights		**Survey dates: January 23, 31,2017**		
2 Sunrise Ave.				
Mapleton, Iowa 51034	**DS/kk**			
		Class	**Fine Amount**	**Correction date**
58.28(3)e	**481—58.28 (135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to ensure against hazard from self, others, or elements in the environment. (I,II, III) **DESCRIPTION:** Based on observation, record review and staff interviews, the facility failed to provide adequate supervision and planned active assistive devices to ensure against hazards from self (Resident #1, #3). The sample consisted of 4 residents and the facility reported a census of 56 residents. Resident #1 fell twice without alarms sounding. The second fall resulted in a right hip fracture that required surgical repair. It is unknown who shut the resident's room door prior to the fall. Another resident, Resident #3, care plan, identified he/she used an alarm. During the investigation, the surveyor observed the alarm box in the off position. It is unknown who deactivated the alarm. Findings include: 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 12/14/16. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 1. A score of 1 represent the resident as severely cognitively impaired. The MDS indicated the resident	**I**	**$3,000** **Held in suspension**	**Upon Receipt**

Facility Administrator Date

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	displayed inattention and disorganized thinking. The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The resident required limited assistance of one staff with ambulation. A "balance during transfers and ambulation" test identified the resident with the score of "2" in all areas of testing other than turning around while walking which was not tested. A score of "2" identified the resident as unsteady and only able to stabilize with staff assistance. The resident was frequently incontinent of bladder and occasionally incontinent of bowel. The resident had diagnoses that included Parkinson's disease. The resident did not experience falls since the previous assessment. A care plan with a problem onset date of 12/15/16, identified the resident with a self-care deficit in ADL's (activities of daily living) related to requiring physical help with activities of daily living. Regarding alarms, the care plan identified the following interventions: seat alarm with hallway alert when in recliner, seat alarm when in dining room chair, motion alarm with hallway alert when in bed or recliner. Fall with bruises and skin tear: A resident incident report dated 12/17/16 at 4:16 p.m. indicated the resident tried to self-ambulate to the bathroom and fell. The staff found the resident in the bathroom doorway lying on his/her			

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	right side. The resident sustained a bruise to the right shoulder which measured 9 centimeters (cm.) by 3 cm. and a skin tear and bruise to the left knee measuring 1 cm. by 2 cm. The immediate post incident action was to replace the battery in the motion alarm. The report identified the battery in the alarm was dead. A fall description detail sheet identified the alarm did not sound but the seat alarm did sound. Staff Interviews: On 1/31/17 at 12:40 p.m. Staff A CNA (certified nurse aide) stated she came up the hall to use the rest room and a resident notified her that Resident #1 needed help. Staff A did not hear an alarm and she was the first one to arrive to the room. On 1/31/17 at 4:19 p.m. Staff B CNA stated the resident appeared agitated the day of the fall. Another CNA (Staff A) came down the hall and found the resident. Staff B stated she didn't hear any alarms. She was in a room with another resident. She was the second one to the room and when she arrived, Staff A was with the resident and there was no alarm sounding then. She stated she heard Staff A call on the walkie talkie and at that time Staff A was the only one with the resident. Staff B stated when she arrived, she didn't hear any alarms but she didn't know if Staff A may have shut them off. The DON (Director of Nursing) was not there yet. Staff B stated she checked the resident's alarms at shift			

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	change (2 p.m.) and found the alarm functional. They also went off several times prior to the fall. Staff did not document the checks. On 1/31/17 at 12:38 p.m. when asked about the alarms, the DON stated her report says the alarm sounded. She stated when she entered the room, she heard the alarm sounding. Fall with Fracture: A resident incident report dated 1/3/17 at 1:55 p.m., revealed the resident got up to open his/her door and fell. After the fall, the resident complained of right thigh/hip pain. A fall scene investigation report revealed the alarm was not in use when the fall occurred. The OTA (occupational therapy aide) did not activate the alarm after returning the resident to his/her room. A fall huddle also identified the alarm not in place at the time of the fall. Staff Interviews: On 1/31/17 at 10:33 a.m., Staff C RN (registered nurse) stated Staff D CNA came to her and said the resident's room door was shut. They went through the adjoining bathroom door and observed the resident on the floor. At that time, the resident stated he/she got up to shut the room door. Staff C stated she did not know how the door got shut. She stated she last observed the resident after lunch seated in a recliner in the resident's room resting quietly. Staff C stated she			

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	did not pay attention to how many alarm boxes the resident used. On 1/31/17 at 10:07 a.m. Staff D CNA stated she took the resident to the bathroom at 10:30 a.m. and the resident voided. The resident sat in his/her recliner and Staff D activated the alarms. Staff D stated the resident had one alarm box fastened to the wall outside the room that contained the alarm for the motion and seat alarm that the resident used in the room. Staff D stated the resident also had a blue box alarm that went with the resident in the wheelchair. Staff D stated the next time she saw the resident; he/she was in the dining room having lunch. Staff D did not notice anything unusual. As lunch cleared, Staff E CNA said the OTA would take the resident back to his/her room. The next time Staff D saw the resident after that was when they found the resident on the floor in front of his/her sink. She went to check the resident because the room door was shut and that was unusual. Staff D did not know how the room door got closed. The resident's leg hurt so the ambulance came. Staff D stated no alarms sounded when the fall occurred. Staff D stated therapy is usually pretty good about resetting the alarms. On 1/31/17 at 9:25 a.m. Staff E CNA stated she observed the resident in the recliner around 1 p.m. with his/her feet up. The resident sat quietly. Staff E left the room door open. She stated she didn't notice if the motion and chair alarm were on. She stated Staff F OTA took the resident from			

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	the dining room table because she wanted to walk the resident. Staff E told Staff F that she did not need to take the alarm out of the wheelchair and put it in the recliner because the recliner already had an alarm. On the same date at 11:15 a.m. Staff E stated she didn't know anything about the resident no longer using a seat alarm on the day of the incident but stated she only worked part time. On 1/31/17 at 4:09 p.m. Staff G CNA stated she took the seat alarm out of the recliner on 12/16/16. Initially staff removed the floor alarm on that date. The floor alarm and seat alarm were synched to the same hall box so when she took the floor alarm away the seat alarm in the recliner did not work. They took the hall box leaving one hall box instead of 2. She stated she asked the DON about taking the seat alarm out of the recliner and just switching the blue wheelchair alarm box between wheelchair and recliner. The DON said yes so Staff G took the seat alarm away. Staff G stated the only alarm in place then was the motion alarm and then the blue wheelchair box alarm that staff transferred from wheelchair to recliner. She stated that is what the resident used from then (12/16/16) up to the time of the fracture On 1/31/17 at 11:30 a.m. the surveyor asked the DON about Staff G saying the facility discontinued the seat alarm prior to the two falls. The DON stated if changes like that are made they usually change the care plan and the care plan said the			

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	resident still used the seat alarm. On 1/31/17 at 9:38 a.m. Staff F OTA stated she placed the resident in the recliner after lunch and an hour later, the resident fell. She stated she could not recall if she placed or activated the alarm but she didn't know why she wouldn't have. She stated prior to leaving the dining room, she asked a staff about putting the wheelchair alarm in the recliner and they told her 'no' the resident used a seat alarm in the recliner so she didn't need to. She stated there was only one alarm box in the hall (confirming what Staff G said) When asked how she knew what alarms residents used, Staff F stated there was nothing to go by. She just asked staff or else it was "just by knowing". When asked what "just by knowing" meant, she stated it was by working at the facility long enough to know if there is a box outside the room door in the hall then staff needed to activate an alarm. Staff F stated the facility has books now and care plans available. On 1/31/17 at 9:56 a.m. the DON stated the alarm books and care plans have always been available at each nurse's station. The DON stated it was the head of the therapy department's responsibility to educate their staff. She stated she was sure Staff F knew but evidently she didn't because she didn't do it. On 1/31/17 at 2:38 p.m. the Director of Therapy was interviewed and stated the therapy aides are educated verbally about alarms. There was no			

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	formal training. She stated therapy notes contained information about alarms and staff are also instructed to speak with nursing if they have a question. On 1/31/17 at 1:07 p.m. the surveyor double checked with Staff F if she knew about the alarm books and care plans. At that time, Staff F stated she must have forgotten. She stated the information was also located on therapy notes on the computer and IPad. On 1/31/17 at 11:30 a.m. the administrative support person stated she saw the resident resting in the recliner around 1:45 p.m. She observed the resident's room door open. The Administrative support person thought the resident had one alarm box outside the room in the hall at the time of the observation. On 1/31/17 at 1:50 p.m. the social worker stated around 1:45 p.m. she saw the resident's room door open. Departmental notes dated 1/3/17 at 2:29 p.m. revealed a nurse aide called Staff C to the resident's room at 1:55 p.m. Staff found the resident on the floor lying on the left side. The alarm did not sound and OT was the last staff in the room with the resident. The resident complained of right thigh pain. The facility notified the physician and the resident transported to the emergency room (ER) for evaluation at 2:25 p.m. of the same date.			

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	Hospital discharge instructions dated 1/13/17 identified the resident was admitted to the hospital 1/3/17 after a fall that resulted in a right hip fracture. On 1/4/17 the resident underwent surgery-a right intertrochanteric hip ORIF (open reduction and internal fixation). The resident returned to the facility with orders for skilled care for physical/occupational therapy for strengthening and gait training. The resident was partial weight bearing when he/she returned to the facility. A major injury determination form dated 1/3/17 revealed the right fractured hip as a major injury. On 1/31/17 at 11:45 a.m. observation identified 2 staff transfer the resident from the bed to the wheelchair. The resident had a motion alarm by the bed and blue box alarm for the wheelchair. 2. Resident #3 had a MDS with a reference date of 1/3/17. The MDS identified the resident had a BIMS score of 9. A score of 9 represented the resident with a moderate cognitive impairment. The resident had an admission date into the facility as 12/27/16. The resident required extensive staff assistance with transfers and ambulation. A "balance during transfers and ambulation" test identified the resident with the score of "2" in all areas of testing other than turning a round while walking which was not tested. A score of "2" identified the resident as unsteady and only able to stabilize with staff assistance. The resident had diagnoses that			

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	included dementia. The MDS identified the resident with a history of falls prior to admission to the facility. A care plan with problem onset date of 1/6/17 identified the resident with a history of falls. The care plan directed the resident should utilize a motion alarm when in bed or recliner. On 1/31/17 at 10:50 a.m. observation identified the resident sitting in the recliner in her/his room. Observation revealed a motion alarm at the foot of the recliner. However the alarm box did not blink, which indicated the alarm not turned on. The surveyor summoned Staff H LPN (licensed practical nurse) to have her look at the alarm box. Staff H confirmed the alarm box not on and should be on. Staff H flipped a switch on the side so the alarm box was "on". Staff H stated the last person she saw in the room was Staff I RN about 20 minutes ago. At 11 a.m. Staff I stated she went in the room but stated she hit the silence button and then reset the motion alarm and it beeped. She stated she did not touch the on/off switch. On 1/31/17 at 4:45 p.m. the DON stated she was unable to determine who turned the alarm box off. On 1/31/17 at 1:15 p.m. observation identified the resident in a recliner in his/her room with motion alarm in place. At that time, the resident put his/her feet down and the alarm sounded. It could not be determined who shut the alarm box			

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	off. **FACILITY RESPONSE:**			

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