

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

Citation Number: <b>#6480</b>		Date: <b>March 15, 2016</b>		
Facility Name: <b>Trinity Center at Luther Park</b>		Survey Dates: <b>February 6–9, 15-16, &amp; March 2, 2017</b>		
Facility Address/City/State/Zip  <b>1555 Hull Ave Des Moines, IA 50316</b>				
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction date</b>

<b>58.28(3)e,f</b>	<p><b>481—58.28(135C) Safety.</b> The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)</p> <p><b>58.28(3) Resident safety.</b></p> <p>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p>f. Residents shall be protected against physical or environmental hazards to themselves. (I, II, III) [ARC 1398C, IAB 4/2/14, effective 5/7/14]</p> <p><b>DESCRIPTION:</b></p> <p>Based on record review and staff interviews, the facility failed to provide adequate nursing supervision to protect residents against hazards from themselves, others, or the physical environment for 2 of 8 residents reviewed (Resident #1 &amp; Resident #7). The facility identified a census of 110 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) assessment tool dated 6/5/16, Resident #1 had diagnoses of diabetes mellitus and Alzheimer's dementia. The MDS documented the resident experienced severe cognitive impairment and displayed verbal behavioral disturbances toward</p>	<b>I</b>	<b>\$7,000</b>	<b>On Receipt</b>
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Facility Administrator

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	<p>others. The MDS also documented Resident #1 required extensive assist of 1 staff for transfers, but could ambulate (walk) independently.</p> <p>A fall assessment dated 9/4/16 revealed a score of 16. A fall assessment dated 1/18/17 revealed a score of 14. The assessment form indicated a score of 10 or greater meant the resident was at high risk for falls.</p> <p>An MDS dated 11/13/16 revealed the resident displayed severe cognitive impairment and verbal aggression. The MDS documented Resident #1 rejected cares and did not ambulate in his/her room or off unit during the assessment period. The MDS also documented the resident as totally dependent on 2 staff for surface to surface transfers.</p> <p>A care plan with a problem/onset date of 6/15/16 identified the resident as at risk for falls related to diagnoses of weakness, limited safety awareness, confusion and dementia. The care plan directed staff to provide 1 staff assist with ambulation during the night and provide standby assistance when the resident attempted to sit due to decreased depth perception. A problem/onset dated 6/15/16 revealed the resident experienced a self-care deficit due to a diagnosis of dementia and intermittent confusion. The care plan directed staff to assist with transfers as needed (prn).</p> <p>A care plan with a problem/onset date of 11/23/16 revealed the resident was at risk for altered thought, communication related diagnoses of dementia and</p>			
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	<p>intermittent confusion. The care plan directed staff to remain aware of the resident's confusion and verbal behaviors with cares and transfers. A problem onset dated 11/23/16 revealed the resident was at risk for falls related to previous injuries, limited safety awareness, confusion related to dementia, and a previous right hip fracture. The care plan directed staff to provide assist of 2 staff for transfer by Hoyer (a mechanical device used to transfer a resident by placing them in a sling, lifting them and physically taking them from one surface to another.)</p> <p>Departmental notes dated 8/13/16 at 1:33 p.m. documented Resident #1 became weak when he/she ambulated for long distances and had depth perception problems when aligning to sit in a chair. The notes revealed the resident required assist of 2 staff for both situations.</p> <p>An incident report dated 8/14/16 at 11:44 p.m. revealed the resident got up independently to go to the bathroom and staff found him/her on the floor.</p> <p>Departmental notes dated 8/14/16 at 10:05 p.m. revealed at 9:33 p.m. the resident got up independently to go to the bathroom and fell. The resident complained of hip, back, and neck pain. The facility notified the resident's family and they gave consent for staff to transfer Resident #1 to a local hospital emergency room for evaluation and treatment</p> <p>Departmental notes dated 8/15/16 at 4:05 a.m. revealed hospital staff notified the facility the resident</p>			
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	<p>had been admitted with a right hip fracture. Notes dated 8/18/16 at 9:50 p.m. revealed the resident returned to the facility at 3:00 p.m.</p> <p>Departmental notes dated 9/30/16 at 2:49 p.m. revealed during an occupational therapy assessment, Resident #1 was unable to bear weight.</p> <p>Departmental notes dated 1/12/17 at 12:01 a.m. revealed a late entry dated 1/11/17. During the 2:00 p.m.-10:00 p.m. shift an aide had called a nurse into the shower room to help because Resident #1 was combative with cares.</p> <p>Departmental notes dated 1/13/17 at 2:45 p.m. revealed the occupational therapy staff notified the nurse that a certified nursing assistant (CNA) needed staff assistance because the resident was on the floor. The nurse went to the resident's room and the CNA reported she attempted to place a Hoyer pad (sling) under the resident, but he/she displayed resistive behaviors and slid around the CNA feet first. The CNA then lowered the resident to the floor. The notes revealed during a nursing assessment, the resident's range of motion was within indicated normal limits. Three staff then assisted the resident to bed.</p> <p>Departmental notes dated 1/13/17 at 9:14 p.m. revealed the resident complained of severe pain to the right leg when staff transferred him/her from bed to wheelchair. During assessment, the resident complained of pain to the right upper leg. The nurse documented the right leg looked swollen compared to</p>			
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	<p>the other. Staff notified the resident's physician ,who gave an order to transfer the resident to a local hospital emergency room for evaluation and treatment.</p> <p>Departmental notes dated 1/14/17 at 1:05 p.m. revealed hospital staff notified facility staff Resident #1 had been admitted due to right femur fracture.</p> <p>Notes dated 1/17/17 at 9:53 p.m. documented the resident returned from the hospital via ambulance at 3:00 p.m. and remained totally dependent on staff for all care needs.</p> <p>A Follow-up/Conclusion to the resident's the fall on 1/13/17 completed by the director of nursing revealed the resident had a fall on 4/8/16. The report indicated the resident had more weakness during ambulation at times in the last few weeks and staff monitored for possible physical therapy involvement. The resident required more help with ambulation at night because he/she had not been fully awake when getting up to the toilet. Staff documented they had been monitoring the resident because the resident had become weaker with ambulation.</p> <p>During an interview dated 2/8/17 at 8:25 a.m. and at another at 2:15 p.m., Staff H, CNA reported had cared for the resident for the past 4 months; during the last 2 months, the resident had been physically combative during cares and he/she had tried to strike staff when cares were given. Two days before the fall on 1/13/17, the resident had been physically combative. Staff H stated on 1/13/17 at approximately 12:00 p.m., she</p>			
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	<p>went to the resident's room to assist him/her to get up for lunch. Once in the room, she activated the call light, completed incontinence care, dressed the resident and placed the Hoyer sling under him/her as she rolled the resident toward her. At the same time, the resident became combative and his/her legs slipped off the bed and hit the floor. Staff H reported the resident was unable to bear weight and she tried to keep the resident from hitting his/her head. She reported 30 minutes went by from the time she activated the call light. Then, therapy staff came into the room to see the resident's roommate and saw her on the floor with the resident. Staff H stated there is not enough staff to assist with transferring residents.</p> <p>During an interview dated 2/8/17 at 8:59 a.m. Staff G, CNA reported on 1/13/17 she went to lunch from 11:00 a.m.-11:30 a.m. When she returned, occupational therapy staff told her she needed to go to the resident's room because staff needed help. When she arrived, she saw Staff H sitting on the floor with the resident. Staff F, RN had completed an assessment and the resident screamed for help. Staff G reported the resident's combative behavior had escalated during the last 3 - 4 months; Resident #1 flailed his/her arms, slapped staff and rejected cares. Staff G stated the resident needed 2 staff to assist with transfers and positioning the Hoyer sling under the resident. Staff G reported it is not safe for 1 staff to provide cares.</p> <p>During an interview dated 2/8/17 at 9:37 a.m. Staff F, RN reported she knew the resident well and he/she yelled constantly and was combative, i.e. pushed,</p>			
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	<p>shoved, and attempted to strike staff. Staff F reported at the time of the incident she knew the resident's call light had been on between 15 minutes to 30 minutes, but she couldn't leave the commons area because there were residents in the common area and they could not be left alone. She reported it would have been appropriate to have 2 staff assist with placement of the Hoyer sling and added staff knew they could call for additional assistance if the resident became combative or resisted cares.</p> <p>During an interview dated 2/8/17 at 12:10 p.m., the Director of Nursing (DON) stated the resident had a history of combative behaviors such as striking out and being verbally aggressive toward staff. The DON reported staff have been directed to seek additional staff when needed. Two staff are needed when preparing the resident for a Hoyer transfer; including placement.</p> <p>2. According to the MDS dated 12/11/16, Resident #7 had a diagnosis of non-Alzheimer's dementia and displayed severely impaired cognition. The MDS documented the resident required limited assist of one staff for bed mobility and required oversight, encouragement or cueing with ambulation during the assessment period.</p> <p>A Fall Assessment dated 10/2/16 documented a score of 14. A score of 10 or greater meant the resident was at high risk for falls.</p> <p>A care plan with a problem/onset dated 12/21/16</p>			
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	<p>revealed the resident's potential for injury related to falls due to unsteady gait at times. Interventions directed staff to observe the resident when he/she ambulated around the unit and observe when he/she ambulated around obstacles</p> <p>Departmental notes dated 11/21/16 at 2:26 p.m. revealed the resident limped on the right lower extremity and leaned toward the right side.</p> <p>Notes dated 11/23/16 at 1:55 p.m. documented the resident limped slightly throughout the evening shift.</p> <p>Notes dated 12/2/16 at 2:01 p.m. documented staff saw the resident sitting on the floor. Two staff with a gait belt assisted the resident with ambulating in the hallway. Notes dated 12/7/16 at 9:34 a.m. documented the resident ambulating independently but unsteady.</p> <p>Notes dated 12/9/16 at 1:38 p.m. documented the resident as unable to make his/her needs known as the resident did not speak.</p> <p>Departmental notes dated 12/19/16 at 3:04 p.m. documented the resident as severely impaired cognitively and unable to locate his/her room.</p> <p>Departmental notes dated 1/10/17 at 9:08 a.m. documented a CNA reported she found the resident on the floor lying on top of his/her side rail. The resident sustained a skin tear to the right upper arm near the elbow.</p>			
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	<p>Departmental notes dated 2/9/17 at 9:57 p.m. documented a nurse sitting at the nurse's station noted the janitor vacuuming the floor in the unit. At 7:50 p.m., she heard the vacuum turn off and heard a thump. The nurse looked up and saw the resident on the floor between the nurse's station and the medication cart lay on his/her right side. A nurse and a certified nursing assistant (CNA) assisted the resident up and to a chair. The nurse assessed the resident and didn't find any bruises or bumps. The nurse noticed the resident's right foot pointed outward so staff took the resident to his/her bed by wheelchair and called the resident's physician, who ordered staff to send him/her to the local hospital emergency room for evaluation. At 11:50 p.m. an entry documented hospital staff notified the facility Resident #7 sustained a left femur fracture and would be admitted for treatment.</p> <p>A radiology "Final Report" dated 2/9/17 at 10:57 a.m. documented the resident sustained a "subcapital fracture (a fracture line that extended through the junction of the head and neck of the right femur (long bone of the leg).</p> <p>A facility investigation dated 2/9/17 documented the resident as alert to self and unable to make needs known due to an inability to verbally communicate. The investigation revealed the resident had abnormal involuntary movements, ambulated with a slouch, and leaned to the right causing falls due to the loss of balance. The resident at times walked throughout the</p>			
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	<p>unit during a 16 hour shift at a fast pace, but looked and understood when to step over objects. The investigation documented the resident's speed and leaning to the right side caused one foot to step in front of the other and made the resident trip.</p> <p>Surveillance video of the event showed Staff M, housekeeping vacuumed the commons area as the resident walked up to the vacuum cord, stopped, looked, saw the cord, and started to lift one foot at a time to cross the cord. The video revealed as the resident crossed the cord, his/her toe caught it. The resident then took two more steps, regained his/her balance, took another step, stepped on the interior side of the left foot, and fell.</p> <p>A witness statement from Staff M reported as he vacuumed the commons area near the table close to the nurse's station, he heard the vacuum shut off, turned around and saw the resident on the floor about 12 feet away. He yelled to the nurse who came and assessed the resident. Staff M received a one day suspension because staff is to keep the walking path for residents clear.</p> <p>During an interview dated 2/14/17 at 3:05 p.m., Staff M reported he failed to erect a hazard sign when he vacuumed. He reported he tried to watch the residents because the power cord is a tripping hazard. He reported he hadn't told anyone to watch for residents if they come close to the power cord.</p> <p>During an interview dated 2/14/17 at 3:15 p.m. the</p>			
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	facility's Housekeeping Supervisor reported staff are not to string electrical cords when they can't keep an eye on the cord at all times.  <b>FACILITY RESPONSE:</b>			
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