

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/24/2017
NAME OF PROVIDER OR SUPPLIER WEST RIDGE SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1904 WEST HOWARD STREET KNOXVILLE, IA 50138		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Correction Date: _____ The following deficiencies result from the investigation of facility self report #66672-I. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 000			
F 241 SS=D	(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to display respect to Resident #1 when speaking with or during a transfer with a mechanical lift. The sample consisted of 6 residents and the facility reported a census of 72 residents. Findings include: 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 2/22/17. The resident scored 14 out of 15 on the BIMS (Brief Interview for Mental Status) test. A score of 15 identified the resident had no problems with cognitive status. The MDS indicated the resident required total assistance of 2 staff persons with transfers, bed mobility and dressing and extensive assist of one staff member for toilet use	F 241			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/31/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 and personal hygiene. Resident #1's diagnoses included heart failure, hypertension, multiple sclerosis, depression and anxiety disorder. Review of the facility's Incident Occurrences Form dated 2/27/17 indicated in room with two staff members who were assisting the resident to transfer from bed to wheel chair to go to dining room for supper. During the transfer one staff member got into an argument with the resident and left the room with resident suspended in air, via Hoyer lift, above the bed. The other staff member remained in the room with the resident. On 3/23/17 at 3:30 p.m. the resident was interviewed. The resident lay in bed and had worked on a crossword puzzle. The resident stated not too long ago, a female staff person said something derogatory to her/him. The resident stated she/he said it right back to the worker. The resident stated she recalled the incident because it was when she remained up in a Hoyer lift for some time and longer than usual. The staff person just called her/him a name. On 3/23/17 at 2:17 p.m. Staff A, Environmental Aide (EA) was interviewed and stated on 2/27/17 around 4:45 p.m. she assisted Staff B, Certified Nurse Aide (CNA), with a transfer for Resident #1 from the bed to the wheelchair using the Hoyer lift. Staff A stated they hooked the sling (placed under the resident) up to the Hoyer lift and Staff B operating the controls of the Hoyer, lifted the resident up above the bed and stopped. Then Staff B stated "I need to get the resident's wheel-chair" and left the room leaving the resident suspended above the bed. Staff A stated the resident became upset and started to cry due to being up in the Hoyer sling and having to wait.	F 241			

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F 241	Continued From page 2 Staff A stated Staff B returned to the room approximately 25 minutes later with the wheel-chair. Staff A stated they then transferred the resident to the wheelchair and lowered the resident into the chair incorrectly. The resident sat at a slope with buttocks half off the chair seat and head resting on the back of the wheelchair. Staff A reported the resident upset and the resident stated she/he was falling out of the chair. Staff A stated Staff B spoke in a loud voice telling the resident you are fine, you are in the chair correctly. Staff A stated Staff B then told the resident "We don't have time for this" and then threw her hands in the air said "(Fu. Explicit) it, I can't do this", than the resident asked Staff B why are you doing this job if you can't do this? Staff A stated then Staff B became increasingly upset and said to the resident "What the hell did you just say to me" and threw her hands up in the air again and said "I'm sorry to Staff A, (Fu. Explicit) it I can't do this" and left the resident's room. Staff A stated the resident was upset and wanted to return to her bed, stating he/she felt like they were falling out of the wheelchair, Staff A called to Staff C, CNA to help her put the resident back to bed. On 3/24/17 at 11:44 Staff B, CNA, was interviewed and stated she and Staff A transferred the resident with a Hoyer lift to the wheelchair. The resident stated 1 time she/he was not in the chair correctly. Staff B stated the resident sat back as far as possible in the wheelchair. Staff B reported the resident started saying really hurtful things to her, like, why do I work here and I was terrible, and I started to cry. Staff B stated after the resident was sitting correctly in the wheelchair, she told Staff A that she is sorry she can't do this and left the resident's room.	F 241			

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F 241	Continued From page 3 Staff B stated she then assisted another resident, When she returned to Resident #1's room and saw Staff A and Staff C assisting the resident back to bed, Staff B stated she then said "this was a waste of time" and went out to her car to smoke a cigarette to calm her nerves as she is crying and upset. Staff B reported while she was outside, a nurse suspended her from work and told her to gather her belongings. Interview was conducted on 3/24/17 at 9:03 am with Staff C, CNA. Staff C stated she is in the hallway and saw Staff B walk out of Resident 1's room visibly upset. Staff C reported Staff A then opened the resident's room door and asked her for help. Staff C stated when she entered the resident's room, the resident was in a wheelchair hooked up to the Hoyer sling and crying. Staff C stated the resident slid out of the wheelchair and had his/her buttocks half off the chair seat with resident's head on back of chair close to the seat of the wheel chair. Staff C stated they repositioned the resident in the wheelchair using the Hoyer lift. The resident remained upset and requested to go back to bed.	F 241			
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use	F 323			

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F 323	Continued From page 4 appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interviews and review of the policy and procedures, the facility failed to provide adequate and appropriate supervision when using a mechanical in order to ensure against hazards in the environment (Resident #1). The sample consisted of 6 residents and the facility reported a census of 72 residents. Findings include: 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 02/22/17. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) test score of 14 out of 15. A score of 14 identified the resident had no cognitive problems. The MDS indicated the resident required two staff member assistance with bed mobility, transfers, dressing and extensive assist of one staff member for toilet use and personal hygiene. Resident #1's diagnoses included heart failure, hypertension,	F 323			

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F 323	Continued From page 5 multiple sclerosis, depression and anxiety disorder. The Care Plan identified a problem, dated 4/21/03, with the resident needing assistance due to decreased mobility, joint rigidity secondary to diagnosis of multiple sclerosis. The Care Plan approaches included and directed 2 staff members to transfer the resident with a Hoyer (mechanical lift). A form titled Incident/Accident/Unusual Occurrences identified an incident event on 2/27/17. The incident occurred in the resident's room when getting the resident up for supper and bingo. The 2 staff members had an argument while transferring the resident from the bed to the wheelchair at 6:18 p.m. The 2 staff members got into an argument and the CNA left the room. The CNA left the resident suspended in the Hoyer lift sling above the bed. The other member (environmental aide) remained with the resident. The policy and procedures titled Lift-Mechanical, revised date of 4/8/15, directed the staff that two staff members are to be present for transfers, a Licensed Nurse and Nurse's Aide. Staff are to gather equipment and bring to the bedside, position wheel chair and lock the wheels. Review of the facility's interview with Resident #1, indicated the resident reported two staff members transferred the resident from the bed by a Hoyer lift. When the staff had him/her up in the air above the bed in the Hoyer sling, one staff member left the room to go get help and the other remained in the room. Resident reported being in this position for 3 to 4 minutes and that resulted in a little pain to his/her legs.	F 323			

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F 323	Continued From page 6 On 3/23/17 at 2:17 pm Staff A, Environmental Aide (EA) was interviewed and stated on 2/27/17 around 4:45 pm she and Staff B, Certified Nurse Aide, went to Resident #1's room to assist the resident from the bed to the wheelchair via a Hoyer lift. Staff A stated they hooked the sling (placed under resident) up to the Hoyer lift and Staff B, operated the controls of the Hoyer; lifted the resident up above the bed and stopped. Staff A stated at that time, Staff B made a comment "I need to get the resident's wheelchair" and left the room leaving the resident suspended above the bed. Staff A stated she remained at the bedside. Staff A stated she is an EA (environmental aide) and not sure if she could lower the resident back to the bed. Staff A stated the resident asked her to turn on the bathroom call light to get help of another staff member. Staff A stated the resident became upset and started crying due to being up in the Hoyer sling and having to wait. Staff A stated Staff B returned to the room approximately 25 minutes later with the wheelchair. Staff A stated they then transferred the resident to a wheelchair. They lowered the resident into the chair incorrectly and the resident sat at a slope with buttocks half off the chair seat and head resting on the back of the wheelchair. Staff A reported the resident got mad and said he/she was falling out of the wheelchair. Staff A stated Staff B screamed in a loud voice telling resident he/she is fine, you're in the chair correctly several times. Staff A stated she unhooked the resident from the Hoyer lift and resident told her that he/she felt like he/she is going to fall out of the wheel chair. Staff A stated she then saw Staff C, CNA, in the hallway and she asked her to come in and assist her with positioning the resident. Staff A stated the resident was upset and	F 323			

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F 323	Continued From page 7 requested to go back to bed. Staff A stated they hooked the resident back up to the Hoyer lift and transferred the resident back to bed. On 3/24/17 at 11:44 am Staff B, CNA was interviewed. Staff B stated she and Staff A went on a 30 minute break around 4:45 pm. Staff B stated when she returned from break there were several call lights on in her hallway and Resident #1 to be still in bed. Staff B stated she was upset at that time and things just went downhill for after that time. Staff B stated she and Staff A went to the resident's room with the Hoyer lift to assist the resident out of bed. Staff B stated they placed the Hoyer sling under the resident and hooked up the Hoyer lift to the sling. Staff B stated she instructed Staff A not to lift resident up and that she is going to get the resident's wheel- chair. Staff B stated when she left to get the wheelchair she noted resident's call lights on and she proceeded to assist other residents. Staff B stated she returned to the resident's room about 25 minutes later and resident was in the Hoyer sling up in the air above the bed. On 3/24/17 at 9:03 am with Staff C, CNA. Staff C stated she is in hallway and saw Staff B walk out of Resident #1's room visibly upset. Staff C reported then Staff A opened resident's room door and asked her for help. Staff C stated when entering the room, the resident sat in the wheel chair hooked up to the Hoyer sling and crying. Staff C stated the resident slid out of wheelchair and had buttocks half off the chair seat with the resident's head on the back of the chair close to the seat of the wheel chair. Staff C stated they repositioned the resident in the wheel- chair using the Hoyer lift and the resident seemed upset and requested to be returned to bed. Staff C stated	F 323			

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F 323	Continued From page 8 she and Staff A transferred the resident to bed . On 3/24/17 at 12:12 pm with the Assistant Director of Nursing (ADON) was interviewed and stated the staff are expected to have a wheel chair in position before transferring and lifting a resident with a Hoyer lift transfer. The ADON stated Staff A passed her written test to become a CNA but will be taking her skills test over again as she did not pass them the first time. The ADON stated Staff B had not received Hoyer lift transfer training. The ADON stated Staff A had only received testing for hand washing.	F 323			