

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6594		Date: July 28, 2017		
Facility Name: Blair House		Survey Dates: July 17-20, 2017		
Facility Address/City/State/Zip 1212 Indian Hill Drive Burlington, IA, 52601		HL		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.28(3)e	<p>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)</p>	I	\$8000.00	Upon Receipt
58.19(1)g	<p>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:</p> <p>58.19(1) Activities of daily living.</p> <p>g. Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on record review and staff interview, the facility failed to provide adequate nursing supervision for one of eight residents reviewed who required assistance with transfers. (Resident #12). Staff interviews and the facility investigation revealed staff failed to transfer Resident #12 to a safe position before leaving the room to get assistance. The facility reported a census of 45 residents.</p> <p>Findings include:</p> <p>1. Resident #12's Minimum Data Set quarterly assessment completed 4/23/17 had documentation of the following diagnoses: hypertension and chronic atrial fibrillation (an abnormal heart rhythm). It also</p>			

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	<p>identified the resident to be cognitive impaired and required extensive staff assistance with most activities of daily living.</p> <p>The care plan with the target date of 7/28/17 identified the resident with impaired mobility. The care plan directed staff to assist with toileting before and after meals, at bedtime and as needed. The care plan directed staff to transfer Resident #12 with the assist of one staff member using a walker. Resident #12 received Coumadin as ordered and staff were directed to monitor for abnormal bleeding or bruising.</p> <p>A review of the incident report revealed on 4/28/17 at 5:45 a.m., the CNA placed a gait belt on the resident who used a walker to attempt to walk to the bathroom. The resident stated his/her left knee gave out and the CNA lowered the resident to the floor and the resident hit his/her head on the CNA's stomach.</p> <p>The resident developed an 11 centimeter hematoma to the back of the head. An ice pack had been applied to the back of the head.</p> <p>A review of the neurological assessment flow sheet had documentation that assessments began on 4/28/17 at 5:50 a.m.. The resident's level of consciousness at 8:00 a.m., became stuporous and his/her pupil responses were pinpoint and sluggish. The resident was not able to follow commands. Staff sent the resident to the hospital.</p> <p>A review of the witness statement dated 4/28/17 and written by Staff C, CNA who assisted the resident</p>			

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	<p>during the above incident revealed she placed a gait belt around the resident, placed the walker in front of the resident. Staff C assisted the resident to stand when the resident's knees buckled, she lowered the resident to the floor. Staff C left the resident to get help to assist the resident back to bed.</p> <p>A review of the nurse's notes revealed the following entries:</p> <p>On 4/28/17 at 7:01 a.m. the CNA reported she assisted the resident to ambulate. The resident had a gait belt and had been using a wheeled walker when the resident's knees became weak. The CNA lowered the resident to the floor. Upon arrival to the room, the resident sat on the floor beside the lower half of the bed. The resident reported he/she hit head. The nurse completed a neurological assessment (Neuro checks) and initiated vital signs. When the day nurse arrived to check on the resident she found an 11 centimeter sized hematoma.</p> <p>On 4/28/17 at 9:00 a.m. at approximately 8:00 a.m. the resident stated "I don't feel well, what am I supposed to be doing; I don't know." The resident then became very drowsy then stuporous, pupils sluggish and pinpoint. Vital signs were stable. The nurse called the physician and received orders to send the resident to the hospital and notified the family.</p> <p>On 4/28/17 at 1:09 p.m. the resident returned from the hospital via ambulance. Four staff transferred the resident to bed. Resident #12 was unresponsive and hospice would be attending to the resident.</p> <p>On 4/30/17 at 11:23 p.m. time of death 10:25 p.m. assessment showed absence of blood pressure, apical</p>			

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	<p>pulse and respirations.</p> <p>According to the ED (emergency department) Note Physician summary dated 4/28/17 at 9:40 a.m. the resident present with a head injury with onset prior to arrival. The resident fell at the nursing home with loss of consciousness and still unconscious. The occipital (bottom back part of the brain) was identified as the location with the course of the symptoms was constant [no change]. The resident was at the nursing home when his/her knees gave out and the aide lowered him/her to the floor. The head CT dated 4/28/17 at 10:36 a.m. showed and intracranial bleeding with closed head injury.</p> <p>A review of a facsimile from the physician dated 5/2/17 had documentation the resident had an intracranial hemorrhage due to head trauma.</p> <p>A typed summary by the Director of Nursing dated 4/28/17 revealed she investigated the incident and conducted a demonstration with Staff C, another nurse and the DON. The summary included the following information: Staff C allowed Resident #12 to get his/her bearing by sitting on the side of the bed as they conversed, which was the usual routine. Resident #12 stood at bedside with gait belt and wheeled walker, CNA demonstrated that she put her foot in front of the resident's left foot to support his/her leg as it would often slip/give out. Once Resident #12 stood he/she then turned towards the bathroom (to the right) then his/her left knee gave out.</p>			

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	<p>Staff C attempted to support resident. Staff C stated the resident "Hold on a minute" as the resident was trying to regain a standing position. Staff C stated resident was not able to regain standing position therefore CNA began to step backwards to lower resident to the floor. As CNA stepped back she came in contact with the 3 drawer bedside stand therefore she braced herself to assist in lowering resident since resident was heavy (body weight was 219 pounds). While lowering resident, the resident fell back into Staff C's body (torso area) causing Staff C to push back against bedside table. Staff C continued to lower resident to floor. Staff C was seated on the floor next to bed. Staff C reports the resident leaned his/her head on the mattress holding onto bedframe, remaining in a seated position. CNA reports she then exited the room to get assistance.</p> <p>Staff J stated Staff C came to find her for assistance and when they returned Resident #12 was sitting on his/her buttocks toward lower half of bed holding onto the bed frame. Staff J then instructed Staff C to stay with resident left to get the nurse.</p> <p>After demonstration completed, the DON took the placement of how the resident was sitting in the positon that Staff C stated resident was left in, the DON let go of the bed frame and fell backwards sticking the right posterior side of her head on the bed frame/bed rail (where the two meet).</p> <p>The DON re-educated Staff C that when a resident is lowered or had fallen to ensure safety, as in this instance, Staff C should have assisted Resident #12 to lie down and placed a pillow under his/her head if she needed to exit the room. Staff C was also instructed to</p>			

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	<p>not leave the area but to use the phone to call other areas or page for assistance. The nurses were re-educated of when to inform a physician of a change in condition.</p> <p>In an interview on 7/19/17 at 12:31 p.m., Staff C reported on 4/28/17 at the end of working 3rd shift, she helped the resident sit at the edge of the bed. Staff C placed a gait belt around the resident and placed the walker in front of him/her and began to help the resident stand beside the bed. When the resident stated his/her knees started to give out, Staff C lowered the resident to sit on the floor next to the bed without any support behind the resident's back. Staff gave the resident the call light and left the room to get the nurse. Staff B, LPN helped Staff C transfer the resident back to bed and both filled out the incident report and turned over care to the day shift staff.</p> <p>During an interview on 7/19/17 at 10:52 a.m., Staff A, Registered Nurse (RN) reported she came to work (day shift) at 6:00 a.m. and overheard Staff C, CNA reported to day shift Staff I, CNA that she had assisted the resident to stand when the resident's knees buckled, and she lowered the resident to the floor. Staff A did not witness the incident. Staff I later asked Staff A to check the resident as she felt a bump on the back of the resident's head. Staff A assessed the resident and discovered an 11 centimeter hematoma to the back of the resident's head. The resident became unresponsive later and sent to the hospital. She also reported she would have expected Staff C to stay in the room with the resident and pull the</p>			

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	<p>emergency call light for help.</p> <p>In an interview on 7/19/17 at 11:14 a.m., Staff I, CNA reported on 4/28/17 she received report from Staff C, CNA of Resident #12 being lowered to the floor at 5:45 a.m.</p> <p>At 7:45 a.m., when Staff I checked the resident she found a bump in the back of the resident's head and asked the nurse to assess the resident. After the resident had been taken to the dining room and became responsive, paramedics took the resident to the hospital. The resident returned to the facility that same day and expired 2 days later.</p> <p>During an interview on 7/19/17 at 11:44 a.m., Staff B, License Practical Nurse (LPN) reported she had been the only nurse on duty during third shift on 4/28/17 before 6:00 a.m. when Staff A asked for her assistance. Upon arrival to the resident's room, Resident #12 sat on the floor beside the bed and stated he/she hit his/her head. Staff B completed an assessment and did not find a hematoma to the back of the resident's head at that time.</p> <p>She completed the incident report and turned the care over to the day shift staff.</p> <p>During an interview on 7/19/17 at 12:08 p.m., the Director of Nursing reported she would have expected the CNA to use the emergency call light and stay with the resident until help arrived.</p> <p>FACILITY RESPONSE:</p>			

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58.11(3)	<p>481—58.11(135C) Personnel.</p> <p>58.11(3) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III) [ARC 0903C, IAB 8/7/13, effective 9/11/13]</p>	II	\$500.00	Upon Receipt
50.9(3)b,c	<p>481-50.9(135C) Criminal, dependent adult abuse, and child abuse record checks.</p> <p>50.9(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a facility, the facility shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.</p> <p>c. If a person being considered for employment has been convicted of a crime. If a person being considered for employment in a facility has been convicted of a crime under a law of any state, the department of public safety shall notify the facility that upon the request of the facility the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the facility (I, II, III)</p>			

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	<p>DESCRIPTION: Based on personnel file review, policy review and staff interview, the facility failed to obtain timely criminal and abuse background checks prior to hire for 1 of 5 new employee personnel records reviewed (Staff D). The facility identified a census of 45 residents.</p> <p>Findings include:</p> <p>A review of the personnel file for Staff D, Certified Nurse Aide (CNA) revealed a hire date of 7/19/16. The Single Contact License & Background Check (SING) reflected a the criminal/abuse background check had been completed on 8/10/16 with a possible hit on the criminal history background check. Staff D's Iowa record check request form for criminal history had documentation of a waiver signature on file dated 8/12/16. The Record Check Evaluation showed Staff D's evaluation to work dated 8/19/16 approving her to work in the health care facility.</p> <p>The hiring checklist, identified Staff D's start date as 7/19/16 had documentation that the nurse aide registry check had been completed, the criminal check had been left blank.</p> <p>A review of the facility procedure for hiring steps dated 6/12/17 had documentation of the following:</p> <ul style="list-style-type: none"> a. Complete a SING check and if it states "further research" is required, need to await Department of Criminal Investigation (DCI) final response for criminal history, must wait until the person is cleared b. Check Direct Care Worker Site 			

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	<p>c. No job is to be offered until all the above steps have been completed</p> <p>During an interview on 7/19/17 at 8:20 a.m., the Administrator reported the administrative assistant had been responsible for completing the hiring process when Staff D had been hired. The Administrator stated she could not explain why the SING check had not been completed prior to Staff's D's hire date.</p> <p>FACILITY RESPONSE:</p>			