STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G011	A. BUILDING _____ B. WING _____	C 11/21/2017

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CHRISTIAN OPPORTUNITY CENTER	1554 BROADWAY ST PELLA, IA 50219

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W 000	INITIAL COMMENTS	W 000		
W 331	As the result of the investigation of #72307-I a deficiency was cited at W331. NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure timely nursing assessment and intervention as warranted for an individual showing signs of an injury. This affected 1 of 1 client injured in the investigation of #72307-I (Client #1). Findings follow: Record review on 11/20/17 revealed a General Event Report (GER) for Client #1, last updated 11/07/17. According to the GER, another client pushed Client #1 to the ground on the evening of 11/06/17 at approximately 8:10 p.m. Client #1 fell onto his/her right leg. The client's right knee had a small abrasion. Client #1 also indicated his/her right arm was "very painful." According the the GER, Client #1 "broke down into tears and was inconsolable." The client continued to cry off and on for at least one and a half hours before going to bed. About 30 minutes after the injury, staff again assessed Client #1's arm and noted a "clicking noise" when staff extended the right arm. The clicking sound was not present in the left arm. The Training Facilitator (TF) wrote the GER and was present at the time of the incident. The Health Services Coordinator (HSC) added a note to the GER on 11/07/17 at 8:53 a.m.	W 331	POC 12/6/17 Health Services will come on site to assess in person all reports of falls with any type of resulting injury. In person assessment will be completed within one hour after being made aware of the injury. In addition, all potential injuries (whether caused by a fall or not) will be assessed by Health Services in person within 24 hours. When notified of any potential injury, Health Services will ask the reporting staff thorough and clarifying questions so they are able to determine the potential severity of any possible injuries. They will then make a determination based on their nursing skills as to whether an immediate in person assessment is needed (immediate meaning within one hour) or whether the injury appears to be minor and assessment can be completed within 24 hours. Health Services will document their assessment and their reason for deciding whether it needed to be done within one or 24 hours. The Regional Director will monitor on-going compliance by reviewing the timeliness of injury assessments.	12/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ICF/IDAdministrator	12/14/17

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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W 331	Continued From page 1	W 331		

According to her entry, staff notified the HSC at 8:15 p.m. on 11/06/17 Client #1 was consolable, but upset about the fall. The HSC instructed staff to give Client #1 Naproxen for pain and possible edema and to call her back if the client could not sleep after being given the medication. The HSC further noted she received a call from staff at 2:30 a.m., informing her bruising had increased to include a large amount of Client #1's inner arm. The HSC instructed staff to apply ice to the area 20 minutes on and 20 minutes off, as tolerated. Staff reported Client #1 slept prior to being woken by staff for a routine blood sugar check. The HSC noted staff called again at 6:15 a.m. At that time, Client #1 dropped to the floor, instead of walking to the bathroom. The HSC instructed staff to use a wheelchair and to check Client #1's blood sugar, which was 495 (very high). The client's blood pressure was 122/65 and pulse was 65. Client #1 dropped to the floor in the past when his/her blood sugar was high. The HSC arrived at the facility at 6:45 a.m. to assess Client #1. Client #1 was asleep when the HSC arrived. She noted "bruising to the inner aspect of (his/her) right deltoid with swelling noted." The area was tender to the touch, but Client #1 was vague on amount of pain. The HSC took Client #1 to the emergency room later in the morning.

Additional record review revealed a "T-Log" written by LSA C on 11/07/17 at 2:41 a.m. LSA C documented Client #1 "in obvious pain" and winced every time he/she moved his/her right arm when LSA C checked the client's blood sugar. LSA C checked Client #1's right arm and noted a "very large swollen purple bruise covering (Client #1's) whole bicep." LSA C called the on-call nurse (the HSC) "to see if (Client #1) needed immediate attention." The HSC called back and

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instructed LSAC to apply ice to the client's arm, as tolerated. LSA C documented the HSC told her Client #1 might need to be taken to the hospital in the morning.

The HSC documented in a "T-Log," dated 10/07/17 at 8:45 a.m,. she arrived at the facility at 6:45 a.m. and woke Client #1 to check his/her arm. She noted bruising to the inner aspect of right deltoid with swelling. Client #1 would not lift the right arm, unless lifting it with left hand. The HSC left a message at the local clinic for an appointment. A "T-Log" written by Work Skills Supervisor on 11/07/17 at 9:50 a.m. noted the HSC and another staff took Client #1 to the emergency room at 9:15 a.m.

The Emergency Department record for Client #1 dated 11/07/17 noted Client #1 seen at 10:01 a.m. According to the report, Client #1 complained of persistent pain in right upper arm since an altercation with another client the night before. The right upper arm had notable bruising and swelling that morning. X-rays were done and the diagnosis was a closed displaced comminuted humeral head fracture extending into the humeral neck. Prescription pain medication was prescribed and an appointment was made with an orthopedist for follow up care regarding the arm fracture.

A review of Client #1's November 2017 Medication Administration Record (MAR) revealed Client #1 had a PRN (as needed) order for Acetaminophen 325 mg to be given every 4-6 hours as needed for pain/fever. The November MAR documented Client #1 did not receive Acetaminophen on or around 11/06/17 or 11/07/17. Client #1 also had a physician's order

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for Naproxen Sodium 220 mg, one tablet twice a day PRN for knee pain. According to the November MAR, the Naproxen was not routinely given. It was given three times in November as of 11/21/17: on 11/06/17 at 8:23 p.m.; on 11/07/17 at 8:23 a.m. and on 11/16/17 at 12:00 p.m. Client #1 got an order for a prescription strength pain reliever on the afternoon of 11/01/17, after the fractured humerus was diagnosed.

According to his/her record, Client #1 was 55 years old with a diagnoses including Moderate Intellectual Disabilities, Down Syndrome, Type 1 Diabetes Mellitus with Hyperglycemia, Peripheral Vascular Disease, Tracheotomy, Osteoarthritis in both Knees, Sleep Apnea and Adjustment Disorder with Depressed Mood. Client #1 was independently ambulatory, with no assistance or adaptive devices needed for ambulation. Client #1 had good verbal skills and generally had the ability to communicate wants and needs.

When interviewed on 11/20/17 at 2:15 p.m. the TF stated he was present when another client pushed Client #1 to the floor. He and the Living Skills Advisor (LSA) A were in the immediate area, but unable to prevent the other client from pushing Client #1. The TF redirected the aggressive client away from the area and then helped attend to Client #1. The TF was a Certified Medication Aide (CMA). There were no nurses on duty at the time of the incident. The only injury the TF initially observed was a small abrasion to Client #1's right knee. Client #1 also held his/her right arm with his/her left hand. The TF assessed Client #1 in the medication room, with his/her shirt removed. He checked Client #1's right arm and saw an older mark around the client's elbow, but no other bruising or swelling. The TF called

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W 331	Continued From page 4 the HSC and informed her of the incident. He told the HSC Client #1 had been pushed to the ground, cried, and seemed to be in pain, but was not specific about injuries/pain. The HSC told the TF to give Client #1 Naproxen and the HSC would check on Client #1 in the morning. The TF checked Client #1's arm again about 1 - 1 1/2 hours after the incident. He heard a "clicking" type of noise when he moved Client #1's right arm, which was not present in the left arm. The arm did not appear to be swollen and there was no bruising at that time. Client #1 pointed to his/her elbow area, but the client was not always reliable with information. Client #1 did not appear to show increased pain when the arm was moved. The TF called the HSC a second time and gave her an update. He told the HSC of the clicking noise when he moved the right arm. He told her Client #1 still winced, even after the Naproxen had been given. They discussed whether the nurse needed to come to the facility to do an assessment. The TF said it was up to the nurse. She said if Client #1 did not showing signs of extreme pain, she would check the client in the morning. The TF said during interview Client #1 continued to cry and wince off and on, but did not scream out in pain. When interviewed on 11/21/17 at 9:35 a.m. LSA B stated she also looked at Client #1's right arm after the client fell to the ground on the evening of 11/06/17. She recalled seeing a small bruise, which might have been an older injury. She did not see any significant injury to Client #1's right arm. LSA B also heard the clicking sound when the right arm was moved. She said it was not a loud sound, and could actually be felt more easily than heard. LSA B said Client #1 cried off and on, but the client did sometimes cry when upset.	W 331		

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W 331	Continued From page 5 Client #1 seemed upset that the other client had pushed him/her. When interviewed on 11/21/17 at 9:30 a.m. LSA C said she was not a nurse or a CMA. LSA C said in her opinion, Client #1 needed immediate medical attention when LSA C checked the client around 2:30 a.m. on 11/07/17. Client #1 was in pain and had a large bruise and swelling on his/her right arm. LSA C called the HSC and told her of the Client #1's symptoms/injuries. The HSC indicated Client #1 overreacted and the staff should apply ice. There was no discussion of pain medication. LSA C was not qualified to pass medications. To her knowledge none of the overnight staff working at South House or North House that night were qualified to administer medications. LSA C said she did not tell the HSC that she thought Client #1 needed immediate medical attention. When interviewed on 11/21/17 at 9:45 a.m. the HSC confirmed she was a Registered Nurse. She got the first call from staff regarding the fall on the evening of 11/06/17 around 8:15 p.m. The TF told her Client #1 cried and indicated pain in right arm. Client #1 could move the arm. The HSC instructed staff to give Client #1 Naproxen. The HSC recalled the TF called her a second time later in the evening and told her of a "clicking sound" when the arm moved, but there was still no obvious sign of injury and Client #1 seemed to be settling down. Overnight staff LSA C called the HSC around 2:30 a.m. and told her Client #1's arm appeared bruised and swollen. The LSA C said Client #1 slept off and on and said his/her arm was sore. The HSC told the staff person to apply ice. When asked why there was no discussion of pain medication, the HSC said she	W 331		

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W 331	Continued From page 6 didn't recall why they didn't discuss it. She was aware the client received Naproxen around 8:30 p.m., which would have lasted about six hours. The HSC said she did not get the impression from LSA C that Client #1 was in a lot of pain, so she didn't think about pain medication. Staff called the HSC again at 6:15 a.m. with concerns and she arrived at the facility around 6:45 a.m. to assess the client. The HSC initially tried to reach the local clinic for an appointment, but based on the client's high blood sugar and the condition of his/her arm, staff took Client #1 to the emergency room. Client #1 was diagnosed with with a fractured humerus at the emergency room. The HSC said it was her understanding the humerus was fractured in four spots.	W 331		