

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

<b>Citation Number:</b> 6713					<b>Date:</b> December 8, 2017
<b>Facility Name:</b> Sunrise Hill Care Center		<b>Survey Dates:</b> November 16, 21, and 22, 2017			
<b>Facility Address/City/State/Zip</b> 909 6th Street Traer, IA 50675					
		HL			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date	

<b>58.28(3)e</b>	<p><b>481—58.28(135C) Safety.</b>  <b>58.28(3) Resident safety.</b>  <b>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</b></p>	<b>I</b>	<b>\$5000.00</b> <b>Held In</b> <b>Suspension</b>	<b>Upon Receipt</b>	
<b>58.19(2)g</b>	<p><b>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:</b>  <b>58.19(1) Activities of daily living.</b>  <b>g. Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)</b></p> <p><b>DESCRIPTION:</b></p> <p>Based on clinical record review and staff interviews, the facility staff failed to provide adequate supervision and a safe transfer for 1 of 6 residents reviewed (Resident #1). Resident #1 sustained an injury to his head when staff failed to secure him in the whirlpool tub during a bath. The facility reported a census of 72 residents.</p> <p>Findings include:</p> <p>1. According to Resident #1's Minimum Data Set (MDS) dated 8/10/17 the resident had diagnoses which included Peripheral Arterial Disease, Alzheimer's Disease, cardiac arrhythmia's</p>				

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	<p>and idiopathic scoliosis. The resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive ability. Resident #1 required extensive assistance of 2 staff for bed mobility, transfers, toilet use and personal hygiene and required physical help with bathing. The resident could stabilize with staff assistance only when standing or transferring between bed and chair.</p> <p>Review of the Care Plan updated on 8/17/17 Resident #1 utilized an EZ Stand as needed for transfers and has a history of leaning forward in the wheelchair. The care plan informed the staff the resident experiences chronic back pain due to scoliosis and back weakness. The care plan directed staff to provide physical assistance with bathing.</p> <p>Review of the Fall Risk Evaluation dated 8/17/17 Resident #1 had a fall risk score of 16, which indicated a high risk for falls.</p> <p>Review of a Fall/Incident Report dated 10/11/17 at 8:40 p.m. Resident #1 had a fall from a raised whirlpool chair after a bath. The resident fell from the whirlpool chair and landed face down on the floor with his head wedged under the open door of the whirlpool. The staff who assisted the resident with the bath indicated she did have the safety belt on but it wasn't tight around the resident's trunk. The staff summoned the local ambulance who transferred the resident to a local</p>				
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	<p>hospital for an evaluation and treatment.</p> <p>According to the Progress Notes dated 10/11/17 at 8:40 p.m. Staff A CNA called Staff B LPN into the whirlpool room. Staff A explained to Staff B when she transferred Resident #1 out of the whirlpool, the resident held one hand on the side of the whirlpool and one hand on the whirlpool door. As the staff pulled the resident back the resident fell forward hitting his head on the side of the whirlpool and then fell onto the floor. Staff A indicated the resident sustained a large laceration to the left forehead and had discomfort with movement. Staff B summoned the local ambulance for transport to the hospital.</p> <p>Review of a Progress Note dated 10/12/17 at 2:30 a.m. the facility received an update from the local hospital, Resident #1 required 29 sutures to the head and his heart rate in the 30's. Resident #1 admitted to the local hospital for bradycardia.</p> <p>Review of a Progress Note dated 10/14/17 at 6:00 p.m., revealed Resident #1 returned to the facility via ambulance.</p> <p>During an interview with Staff A on 11/21/17 at 2:00 p.m., Staff A stated she gave Resident #1 a whirlpool bath on the evening of 10/11/17. Resident #1 required assistance of 2 staff to sit in the whirlpool chair, he was transferred to the whirlpool room and bath completed. Staff A stated when she and another staff member placed him in the</p>			
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	<p>chair she applied the safety belt but it wasn't tight. Staff A stated she could put 2 hands between the belt and the resident's abdomen, indicating she kept the belt loose because it's the way the resident liked it. After she completed the bath, Staff A lifted the mechanical chair up into the air, approximately 28 inches, just enough to clear the resident's feet from the bottom of the whirlpool door. Staff A stated when she lifted the resident up and moved him out of the tub, the resident leaned forward and grabbed the door of the whirlpool and the edge of the tub. Resident #1 fell forward out of the whirlpool chair, struck his face on the tub and landed face down on the floor. The resident struck his head on the floor. Staff A stated she initially thought the chair strap broke but she admitted she had the strap on incorrectly and the belt became unfastened, causing the resident to fall.</p> <p>During an interview with Staff B on 11/21/17 at 1:35 p.m. Staff B stated staff called her to the whirlpool room. Staff B stated she witnessed Resident #1 laying on the floor of the shower room, next to the whirlpool tub with his head wedged under the open whirlpool door. The resident found to be bleeding from the head. The staff called 911, upon arrival to the facility, EMS staff removed his head from under the whirlpool tub and transported the resident to a local hospital. Staff A initially told Staff B the whirlpool belt broke and the resident fell from the whirlpool chair. Staff B stated Resident #1 had a</p>				
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	<p>history of leaning forward in his wheelchair.</p> <p>A review of the Tub Bath Whirlpool Bathing System (Sitting Tub) instructed staff to follow the precautions to maintain the safety of residents. The instructions (#15) directed staff to position the resident in the tub chair designed for the system and ensure the resident is safety secure in the chair.</p> <p>During an interview with Director of Nurses (DON) on 11/21/17 at 10:05 a.m., the DON stated during her investigation it was determined the whirlpool seat belt was not on as tight as it should have been and it was applied incorrectly. The DON stated the facility did re-education with staff on the proper application of the whirlpool seat belt after the resident fall.</p> <p><b>FACILITY RESPONSE:</b></p>				
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