Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6720	**Amended Citation – Fine amount reduced by 35% to $1,625.00on December 23, 2017. Pursuant to Iowa Code Section 135C.43A**		**Date: December 15, 2017**
QHC Winterset North		**Survey Dates: October 19-November 30, 2017**	
411 East Lane Winterset, Iowa 50273			
	DS		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.43	**481-58.43(135C) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows; When authorized in writing by a physician for a specific period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II) **DESCRIPTION:** Based on record review, observation, staff, resident and interviews, the facility failed to keep Resident #14 free from verbal abuse and confinement by Staff R (certified nursing assistant). The sample size consisted of 24 residents and the facility reported a census of 61	**II**	**$500**	**Upon Receipt**

Facility Administrator _____ Date _____

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	residents. Findings include: 1. Resident #14 had a MDS (Minimum Data Set) assessment with a reference date of 8/26/17. The MDS identified the resident's diagnosis included dementia. The BIMS (Brief Interview for Mental Status) test scored 0 out of 15. A 0 identified the resident had severe cognitive impairment for decision making. The MDS indicated the resident usually understood others and others usually understood him. The MDS also noted Resident #14 had inattention and disorganized thinking that fluctuated. According to the MDS, Resident #14 depended on extensive assistance of at least one person for all ADLs. The MDS indicated Resident #14 had occasional episodes of bowel and bladder incontinence. The Care Plan dated 2/24/17 directed the staff to speak slowly and clearly to ensure effective communication. The Care Plan also instructed staff to redirect/reproach/reorient Resident #14 as needed every day. The Care Plan dated 3/1/17 directed the staff to take extra time to listen and understand Resident #14. The Care Plan also instructed staff to assist Resident #14 to clearly understand, and if confusion or misinterpretation occurred, staff should approach slowly and kindly			

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	to redirect him. The Care Plan dated 3/31/17 noted Krio as Resident #14's first language; not English. A Nursing Note dated 10/17/17 at 11:28 a.m. by Staff F, RN, noted she heard and responded to a page, calling a nurse to the Memory Unit. The RN documented she heard a female voice yelling "Listen here you mother f..... [Expletive]" upon entering the unit. Staff F noted she proceeded to where she heard the voice. Staff F also noted that she encountered Staff Q, CNA in the hallway saying "We need you in Resident #14's room". Staff F noted upon entering Resident #14's room, she saw him seated on the bed and Staff R, CNA standing above him holding both of his wrists tightly with her hands. Staff F noted she asked Staff R to release Resident #14's hands and asked Staff R if she was the one she heard screaming "Listen here mother f.....(expletive)." Staff F noted the CNA admitted it was her yelling. Staff F documented she asked Staff R to leave the room, at which time she walked to the front lobby and sat in a chair. Staff F also noted Resident #14 allowed her to assist him with putting his pants on. Staff F noted that due to the resident's dark skin color, no bruising or redness had been noted at the time. Staff F noted she immediately informed the previous Administrator about the incident, and then the previous			

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	Administrator went to the Memory Unit to speak with Staff R. On 11/1/17 at 11:10 a.m. Staff O, CNA (certified nursing assistant) was interviewed and stated she knew Resident #14 could be a handful, but only when people got pushy with him. According to Staff O, Resident #14 needed his space when he was resistant. Staff O stated the resident is cooperative if you re-approach him. On 11/1/17 1:50 p.m. Staff I, CNA, was interviewed and stated she had been off work during the incident that involved Staff R, CNA and Resident #14. According to Staff I, Staff R worked there for about 6 months and then left. Staff I recalled that Staff R had only been rehired a few weeks before the alleged incident occurred. According to the CNA, Staff R always hollered at the residents. Staff I stated that Staff R spoke to another resident like "sit down", in a gruff and demanding voice. Staff I stated Staff R did not show any respect to the residents. According to Staff I, Staff R treated another resident (Resident #10) like that too. The CNA stated Staff R "was just mean to the residents." Staff I said it seemed like Staff R seemed to be that way to residents that could not speak for themselves. According to Staff I, other residents that were more assertive stood up to Staff R and just walked away from her			

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	instead of being targeted by her. On 11/13/17 at 11:00 a.m. Staff Q, CNA was interviewed and stated she relieved Staff S, CNA, so she could go on break. According to Staff Q, she and Staff R noticed Resident #14 brief was soiled. Staff Q stated Staff R went with Resident #14 to his room to change him. Staff Q stated she heard a noise and went down the hall to investigate. Staff G stated that Staff R asked her if she could assist her, so she went into to Resident #14's room. Staff Q stated Resident #14 stood in the doorway of his bathroom and she approached him. Staff Q stated she attempted to touch his waistband to pull his pants down and he said "no, no, no, no". Staff Q stated he seemed a little agitated and it was apparent he didn't want to be "messed with" at that time. Staff Q stated she suggested leaving Resident #14 alone and re-approaching him after a while. According to Staff Q, Staff R said "We can't leave him wet". Staff Q stated she had never worked with Staff R before. According to Staff Q, she looked at Staff R and said "OK"; basically agreeing to proceed with changing him. Staff Q said she told Staff R to hold Resident #14's hands as she assisted him to walk over to his bed. Staff Q stated Staff R still had a hold of Resident #14 hands as she got his pants pulled down and sat him on the edge of the bed. Staff Q recalled Staff R saying "He's hitting", so			

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	she told Staff R to continue holding onto him. Staff Q said she bent down in front of Resident #14 just off to the side of him as she put his pants on him. Staff Q said he had his pants on up to his knees and she kept feeling him moving around. Staff Q said she looked up and saw Staff R pinning his hands/arms to his chest as she leaned into him holding his arms crossed at the wrists. Stated the resident became more agitated. Staff Q stated she told Staff R "I'm going to get the nurse". According to Staff Q, Staff R and Resident #14 were in the same position when she returned as they were when she left to go page the nurse. Staff Q said she told Resident #14 "we have to put another one on you" (he had ripped it off while Staff Q found a nurse). Staff Q said she got another brief on Resident #14 as Staff R continued holding his wrists. According to Staff Q, she stepped out into the hallway and saw Staff F and the CMS (Corporate Maintenance Supervisor) approaching Resident #14 room. Staff Q stated they heard Staff R say "You mother f.... [Expletive]". According to Staff Q, the 3 of them entered Resident #14's room and Staff F said "Tell me I didn't just hear you say that; and let go of him now". Staff Q stated Staff R responded by saying "Well he head butted me". Staff Q said Staff F repeated that Staff R should let go of Resident #14, which she did. According to Staff Q, Resident #14 stood up and took off the			

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	plaid pants he had on. According to Staff Q, Staff F said "It's alright, you both can leave now". Staff Q stated she and Staff R went and sat in the lounge area in the memory unit. Staff Q stated Staff F and the CMS person left the memory unit about 10 minutes later. Staff Q stated Resident #14 was still in his room looking out into the hallway. Staff Q stated Staff R had still been sitting there with them. Staff Q stated about the time Staff R prepared to leave, the previous Administrator entered and said "I need to talk to you [Staff R]." Staff Q stated they both [Administrator and Staff R] left and she stayed on the unit with Staff S [Staff S returned]. Staff Q stated Staff R never returned. On 11/13/17 at 12:30 p.m. with Staff F, Licensed Practical Nurse, LPN was interviewed and stated she heard a page summoning a nurse to the memory unit on 10/17/17. Staff F stated she responded to the call and entered the unit when she heard a female voice saying "Listen here mother f.... [Expletive]" Staff F stated she wondered which resident was so upset because it did not dawn on her that it was a staff member saying that. Staff F stated she saw Staff Q standing with the door open at the opposite end of the hall. According to Staff F, it appeared like Staff Q looked for assistance from someone outside of the memory unit. Staff F stated Staff Q			

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	told her they needed her in Resident #14's room due to the resident being combative. Staff F stated she had seen Resident #14 angry before and it could be pretty scary. Staff F stated she saw Staff R standing over Resident #14 as the resident sat on the bed. Staff R used both of her hands to pin Resident #14 hands/arms to his body. Staff F stated she looked at Resident #14 and he looked at her. Staff F stated he looked kind of scared, not the aggressive look she had seen in his eyes on multiple other occasions prior to then. Staff F stated she asked "What is going on here?" and Staff R said "He won't let us put these pants on him". The RN said she told Staff R to let go of his arms. Staff F said she asked Staff R if she had been the one saying "Listen here mother f.... [Expletive)]"? Staff R said "Yes, but he was fighting with me", as if to justify her behavior. Staff F stated she explained to Staff R she should have left him alone and re-approached him if he had been refusing help. Staff F stated Resident #14 calmly sat there once Staff R let go of him. She said he had not exhibited any signs of aggression. Staff F stated she asked Staff R to leave the room and Staff Q followed her to the great room where they sat waiting. Staff F stated she assessed Resident #14's arms and did not see any redness or injuries. Staff F stated Resident #14 stood up with his pants in his hands and looked down the			

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	hallway from the doorway of his room. The resident pointed to the great room where the CNAs were and said "mean, mean." Staff F said although Resident #14 can be very hard to understand, he can relay information. Staff F stated the resident let her help him put his pants on. On 11/13/17 at 1:40 p.m. with Staff S, CNA, revealed that Staff Q, CNA had been the person that relieved Staff R and her for their breaks. According to Staff S, Staff R just returned from her break and then she left for hers. Staff S said Resident #14 had not been agitated before she left. Staff S said Resident #14 did not act like himself after she returned from her break. According to Staff S, Resident #14 seemed leery of her and Staff Q and did not want either one of them to take him to his room to be toileted and/or changed. According to Staff S, they left him alone and re-approached him later. Staff S stated she did not know Staff R very well. Staff S said she liked her as a person, but did not like working with her. Staff S said Staff R was not exactly a team player. Staff S said Staff R liked to do everything her way, even if it was not right. Staff S said she told Staff R later "If you're going to hang onto a resident, you're supposed to hang onto their hands, not restrain them." Staff S said she had never heard of Staff R restraining anyone prior to			

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	that. Staff S said her observations of Staff R interacting with residents prior to that were not positive because she is pushy and because of her attitude. On 11/14/17 at 11:30 a.m. the Administrator was interviewed and stated the incident between Staff R, CNA and Resident #14 occurred on the previous Administrator's last day. According to the Administrator, Staff R basically admitted to cursing at the resident and holding the resident's arms down. The Administrator stated Staff R asked "Wouldn't you have said the same thing to Resident #14 if you were in that situation"? The Administrator stated she informed Staff R "No, we do not swear in my household." On 11/15/17 at 9:30 a.m. Staff R, CNA, was interviewed and stated she worked with Staff S in the memory unit that day. According to Staff R, she always worked "up front" so it was her first time working in the Memory Unit. According to the CNA, Staff S stated "I can't change Resident #14 because he doesn't like me". Staff R stated she told Staff S she did not know the residents back there [in unit]. In an effort to familiarize herself with the residents Staff R said she asked Staff S about the residents and their behaviors. Staff R, Staff S stated she told her "we don't really have any behaviors back here". Staff R stated Staff S			

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	told her she would help her since she did not know anyone. According to Staff R, she asked Staff S where the pocket care plans were and Staff S said she should not bother with them because they are never current. Staff R said Staff Q entered the unit about 10:30 or 10:45 a.m.; at which time Staff S left for her half hour break. According to Staff R, Staff Q sat in the common area with Resident #14. Staff R said Staff Q pointed to Resident #14 and said he needed to be changed because of his brief being saturated (incontinent of urine). Staff R stated Staff S told her sometimes only one person had to assist Resident #14, but other times two people were required. Staff R stated she asked her why and Staff Q told her Resident #14 gets aggressive with people he does not like. Staff R stated she walked over to Resident #14 and said "Let's go for a walk". According to the CNA, Staff Q said "Don't tell him that you're taking him to the bathroom to be changed." Staff R stated she and Resident #14 walked to his room, entered it, and shut the door behind them. Staff R said she had a hold of Resident #14 hand and started to take him into the bathroom. According to Staff R, Resident #14 started to pull back when he realized they were going into the bathroom. Staff R stated Staff Q knocked on the door at that time and asked if she needed help, and she replied yes. Staff R recalled that Resident #14 demeanor changed			

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	when Staff S walked into the room. Staff R stated he did not want Staff S touching him. Staff R said Resident #14 changed from a relaxed posture to a very stiff and aggressive posture when Staff S touched him. The CNA said Staff Q held one of Resident #14 hands. Staff R said Staff Q had been very nice at first until Resident #14 struck out at her. Staff R stated she stepped back when Resident #14 hit Staff Q in the ribs because she did not know Resident #14. According to the CNA, Staff Q grabbed Resident #14's wrist to stop him from hitting her again. Staff R said Staff Q got close to his face and said repeatedly (about 3 times) "Resident #14, you don't hit" while pointing her finger within inches of his face. Staff R stated Staff Q looked at her and said "He does this all the time on the night shift". Staff R stated it bothered her when Staff Q suggested that they should leave him wet in order to give him a chance to calm down. Staff R stated she insisted on changing him [the soiled brief]. Staff R stated Staff Q held one of his hands and she held his other hand as they walked him over to his bed. Staff R said Resident #14 was somewhat agitated, but willingly walked with them. According to Staff R, Resident #14 sat on the side of the bed without either one of them touching him. Staff R said she stood in front and off to the side of Resident #14 while facing him. Staff R stated Staff Q stood directly in front of him while			

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	facing him. Staff R said she asked Staff Q how they should proceed and Staff Q told her she would try and get his brief off of him. Staff R said she ripped one side of his brief and Staff Q ripped the other side while he sat on the bed. Staff R stated Resident #14 would not stand up but proceeded to beat "the crap" out of Staff Q by pounding on her back. In response, Staff R said she grabbed both of Resident #14's wrists. Staff R stated Staff Q got the new pull up above Resident #14's knees when he jerked his arms free and started ripping the new pull up and his pajama pants. Staff R said they got another new brief up to his knees while he continued sitting on the side of his bed. Staff R said she and Staff Q agreed that they needed to go and page for a nurse. Staff R said Staff Q ran down the hall to where the phone was because they did not have walkie talkies. Staff R stated she continued to hold Resident #14's wrists after Staff Q left because he was hitting her. Staff R explained that she thought it was OK to continue holding his wrists to protect herself. Staff R recalled a similar incident when another resident hit her and bruised her ribs. According to Staff R, management told her she should have attempted to protect herself to avoid being injured. Staff R said they never really trained any of the CNAs to deal with aggressive residents. Staff R said she left the door open when Staff Q left the room. She			

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	said she could hear the page go across the intercom. Staff R said she glanced away from Resident #14 and he reared back and head butted her in the ribs. Staff R said the impact knocked the wind out of her and pushed her back two steps. According to Staff R, she yelled "mother f… [Expletive]" as a reaction to being head butted; not a name she called Resident #14. Staff R said she would never speak to a resident that way. Staff R said that although she yelled it loud enough that it echoed down the hallway, nobody else had been in the room to witness everything that happened. Staff R stated Resident #14 started hitting her again so she grabbed his wrists again. At that time, Staff R said Staff Q, Staff F walked into the room because they heard her say "mother f..... [Expletive]". According to Staff R, they saw her holding Resident #14's wrists. Staff R recalled that Staff F said "OK, you can stop physically restraining him now." Staff R stated she said "Oh, I didn't know." When asked what she meant by "I didn't know", Staff R said did not know that grabbing and holding a resident's wrists had been considered a physical restraint. Staff R stated she felt like the facility was partially to blame because of the lack of training. Staff R said there the hand book did not have anything in it about dealing with aggressive residents in those situations. Staff R stated that Staff F told her and Staff Q to leave Resident			

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	#14's room. **FACILITY RESPONSE:**			

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56.6(1)	**481-56.6 (135C) Treble and double fines. 56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481-56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.**	**II**	**$1500 (Trebled $500 x3)**	**Upon Receipt**
235E.2 3a +	**235E.2 Dependent adult abuse reports in facilities and programs. 3. a.** If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within twenty-four hours.			
52.2(2)a	**481-52.2 (235E) Persons who must report dependent adult abuse and the reporting procedure for those persons. 52.2(2)** Reporting suspected dependent adult abuse in facilities or programs. a. If a staff member or employee is required to			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
+	make a report pursuant to this rule, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within 24 hours of such notification or the next business day.			
58.43(9)	**481-58.43(135C) Resident abuse prohibited.** Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows; When authorized in writing by a physician for a specific period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II) **58.43(9)** Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be			

Facility Administrator _____ Date _____

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6720	**Amended Citation – Fine amount reduced by 35% to $1,625.00 on December 23, 2017. Pursuant to Iowa Code Section 135C.43A**	**Date: December 15, 2017**
QHC Winterset North		**Survey Dates: October 19-November 30, 2017**
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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	reported and investigated pursuant to Iowa Code chapter 235E and 481-Chapter 52. (I, II, III). **DESCRIPTION:** Based on record review, staff and family member interviews and review of the policy and procedures, the facility failed to report to the Iowa Department of Inspections and Appeals of 2 incidents of resident to resident physical altercations involving four residents (#1, #8, #10 and #12) and failed to investigate and report one allegation of staff physically assaulting one resident (#18) of 24 total residents reviewed. The facility reported a census of 61 residents. Findings include: 1. Resident #1 had a MDS assessment with a reference date of 5/9/17. Resident #1 had a BIMS (brief interview for mental status) score of 10 out of 15, which indicated moderate cognitive and memory impairment. According to the MDS, Resident #1 could make herself understood and usually had the ability to understand others. Resident #1 walked with supervision only and displayed no behavioral symptoms during the assessment period. An interview on 11/15/17 at 3:00 p.m. with			

Facility Administrator _____ Date _____

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	Resident #1's granddaughter revealed she and her mother went and spoke with the previous administrator on 7/5/17. The resident's daughter visited Resident #1 the day before and learned about a physical altercation between Resident #1 and Resident #10. The family member said they went to speak with the past administrator to let her know what happened and find out if it had been documented but the past administrator said she had not been informed. An interview on 11/22/17 at 10:00 a.m. with Resident #1's daughter revealed that she visited her mother on 7/4/17 at about lunch time. Her mother was shaking and visibly agitated and she went to speak with a nurse. The resident's daughter asked Staff I, CNA (certified nursing assistant) what happened and Staff I told her she saw Resident #10 in Resident #1's room and they had their hands on each other. The resident's daughter said Resident #1 complained about her shoulder hurting and she noticed her mother's hands and forearms were reddened as if someone had grabbed her. The daughter said she went into the facility the next morning with her daughter to speak with the past administrator, who had no knowledge or record of the incident between Resident #1 and Resident #10. On 11/27/17 at 8:15 a.m. Staff I (acting CNA)			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	revealed that Resident #10 had gone into Resident #1's room on 7/4/17. According to Staff I, Resident #1 attacked Resident #10 as evidenced by Resident #1 pushing Resident #10 out the door. Staff I stated she told the family Resident #10 was in Resident #1's room and she saw Resident #1 push Resident #10 out the door. Staff I stated she exited another resident's room when she saw Resident #1 push and strike Resident #10 in the hallway by Resident #1's room. Staff I stated she reported the incident to the nurse on duty, but could not recall which nurse. Resident #1's medical record contained no documentation regarding the 7/4/17 physical altercation between Resident #1 and Resident #10. Review of the DIA reporting records, identified no facility report of the incidents. On 11/20/17 at 3:00 p.m. the Administrator was interviewed and stated she could not find incident reports or other evidence the 7/4/17 incident between Resident #1 and Resident #10 and the incident between Resident #8 and Resident #12 (incident around 9/11/17) were reported to administration. 2. The MDS assessment dated 6/1/17 for Resident #10 listed diagnoses that included dementia and Alzheimer's disease. The assessment documented the resident had			

Facility Administrator _____ Date _____

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	severely impaired cognitive skills for daily decision making. The MDS noted Resident #10 had memory problems, inattention, disorganized thinking, physical and verbal behavioral symptoms directed towards others and a history of wandering every day. The MDS documented she walked with supervision and received daily antipsychotic and antianxiety medications. 3. Resident #8 had a MDS assessment with a reference date of 7/31/17. The MDS indicated Resident #8 had a BIMS score of 0 out of 15. A score of 0 identified the resident had severe cognitive impairment with daily decision making skills. According to the MDS, other people sometimes understood Resident #8 and he sometimes understood others. The assessment indicated Resident #8 required limited assistance of two people to walk in his room or in the hall and required supervision only to self-propel his wheelchair throughout the facility. According to the MDS, Resident #8 received daily antipsychotic and antianxiety medication and displayed no behavioral symptoms. An interview on 11/2/17 at 10:35 a.m. with Staff V, Housekeeping, identified Resident #8 assaulted Resident #12 in the dining room. Staff V saw Resident #8 standing over Resident #12 hitting him at least twice with an open hand in the			

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	back of the head. Staff V said she and another staff person approached them at the same time and got Resident #8 to sit right down and separated them. An interview on 11/1/17 at 11:10 a.m. with Staff O, CNA revealed she witnessed Resident #8 hitting Resident #12 in the dining room. Staff O stated staff were getting everybody into the dining room for lunch and she sat at one of the back tables getting a resident ready for lunch. Resident #12 sat in his wheelchair when Resident #8 wheeled himself towards Resident #12. Staff O said Resident #8's alarm started sounding so she turned to see Resident #8 pulling himself up by hanging on to Resident #12's wheelchair. Staff O said Resident #8 stood above Resident #12 and hit him with karate chop motions on Resident #12's shoulder about 2 or 3 times. On 11/16/17 at 9:15 a.m. Staff O stated she witnessed Resident #8 hitting Resident #12 in the dining room on about 9/13/17. Resident #8's record lacked documentation of the physical altercation between Resident #8 and Resident #12 in the dining room on or about 9/13/17 as reported per staff interviews. 4. The MDS assessment with a reference date of 8/18/17 identified Resident #12 had diagnosis of dementia, Parkinson's disease, difficulty walking,			

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	muscle weakness and lack of coordination. The BIMS score of 2 out of 15 rated Resident #12 with a severe cognitive impairment. According to the MDS, other people usually understood Resident #12 and he sometimes understood them. The assessment indicated Resident #12 depended on extensive assistance of one person to transfer and to walk in his room and in the halls. The MDS noted Resident #12 utilized a walker and wheelchair and depended on staff to be propelled in his wheelchair throughout the facility. Resident #12's medical record lacked documentation regarding the physical altercation between Resident #8 and Resident #12 in the dining room on or about 9/13/17 and identified per staff interviews. Review of DIA records revealed no report of this resident to resident assault. 5. Resident #18 had a MDS assessment with a reference date of 8/31/17. The MDS identified the resident had diagnoses that included heart failure, diabetes, fracture, anxiety disorder, depression, obesity and chronic pain syndrome. The resident had a BIMS score of 15, indicating intact memory and cognition. The assessment indicated Resident #18 required the extensive assistance of two people for all activities of daily			

Facility Administrator _____ Date _____

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	living A Resident Concern Form with a date range of 10/7/17 through 10/13/17 and written by Resident #18 described her concerns as: Improper cares by Staff Y, CNA. Resident #18 alleged that Staff Y physically and mentally abused her on her back top rib, shoulder blade and her left side causing pain. Staff Y had also grabbed both of her wrists as she tried to sit up. Resident #18 documented Staff Y told her you're not my mother, with an ugly face and an angry tone. According to Resident #18's documentation, Staff Y attempted to mislead her by saying she was someone else, despite the resident being able to read her nametag. On 10/23/17 at 10:05 a.m. Resident #18 stated she sat in her wheelchair the week before and Staff Y grabbed her left wrist. Resident #18 stated Staff Y's friend and co-worker (Staff M, CNA) had been with her when it happened that afternoon on the second shift. Resident #18 stated Staff Z grabbed her wrist because she's mean and doesn't like the resident. Resident #18 said she has told other aids, but not the previous Administrator. The resident stated Staff M saw it happen twice and just stood by and watched Staff Y do it without saying something or telling anyone. Resident #18 stated she told Staff Y to			

Facility Administrator _____ Date _____

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	stay away from her, but that has not happened. On 10/19/17 at 12:45 p.m. Staff Z, CNA, was interviewed and stated after dinner on Saturday 10/7/17, Resident #18 informed her that Staff Y had been verbally aggressive and physically restrained her by holding her wrists. According to the CNA, Staff Y walked into Resident #18's room at that time and Resident #18 said she did not want Staff Y there as she was not nice and b ...ch [Expletive]. Staff Z heard Staff Y reply she was proud to be a b ....ch [Expletive]. Although she did not witness Staff Y restraining Resident #18, Staff Z said there were red marks on the bottom sides of Resident #18's wrists. Staff Z said she told Staff C, LPN (licensed practical nurse) and Staff C told Resident #18 to submit a written complaint. On 10/24/17 at 2:30 p.m. Staff C was interviewed and stated she did not give Resident #18 a complaint form to fill out. Staff C remembered telling Resident #18 to write her complaint down on a piece of paper, but she never submitted it as far as she knew. Staff C also said the resident told her a couple weeks ago that someone hurt her shoulder. According to Staff C, Resident #18 accused Staff Y of hurting her left shoulder when she [Staff Y] put her to bed. Staff C stated she went in and put Bio freeze (topical pain reliever)			

Facility Administrator _____ Date _____

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	on her areas of discomfort and the resident could move her arms normally. Staff C stated she did not report what she knew to the prior administrator or DON. On 10/24/17 at 3:00 p.m. the Director of Nursing (DON) was interviewed and stated no one told her anything lately of Resident #18 voicing someone hurt her. According to the DON, Resident #18 is very accusatory and fabricates things. The DON said it would be taken seriously and investigated if she said staff hurt her. When asked, the DON said their protocol dictates that the DON and Administrator should be notified and they would initiate their investigation (with abuse allegations). The DON stated she would expect staff to follow protocol and relay any information they had about Staff Y allegedly hurting Resident #18. The DON stated she would not have permitted Staff Y to work with Resident #18 anymore if she knew what Resident #18 said about Staff Y. On 10/24/17 at 5:25 p.m. with Staff Y, CNA was interviewed and stated Resident #18 always accuses her of breaking her shoulder and she has never told anyone besides Staff C about the accusations that Resident #18 makes about her. On 10/30/17 at 3:45 p.m. the Administrator was			

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	interviewed and stated Staff C informed her that Resident #18 had a history of making allegations and she just let it go because Resident #18 never said anything to her about it before now. Review of the policy and procedures titled **Abuse Prevention, Identification, Investigation and Reporting** (revised 4/1/17), directed the staff that all allegations of abuse shall be reported to the DIA (Department of Inspections and Appeals) no later than 2 hours after the allegation. All allegations of neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the DIA, not later than two hours if the events result in serious bodily injury, or not later than 24 hours if neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation do not result in serious bodily injury. **FACILITY RESPONSE:**			

Facility Administrator _____ Date _____

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.19(2)j	**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: 58.19(2)** *Medication and treatment.* ***j.*** Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III). **DESCRIPTION:** Based on observations, record review and staff and family interviews, the facility failed to assess residents' skin conditions and failed to provide timely intervention in order to promote healing (Resident #1, #2). The facility reported a census of 61 residents and the sample consisted of 3 residents with skin issues. Findings include: 1. Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 5/9/17. The BIMS (brief interview for mental status) identified a score of 10 out of 15. A score of 10 indicated the resident as moderately cognitively impaired for daily decision making. According to the MDS,	**II**	**$500**	**Upon Receipt**

Facility Administrator _____ Date _____

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	bathing had not occurred during the assessment period and the resident required supervision of one staff person for physical assist with hygiene. The 1/27/17 the Care Plan instructed staff to monitor and provide for changing care needs of Resident #1 on a daily basis and as needed. The 3/27/17 revised Care Plan noted Resident #1 should be bathed/showered weekly and as needed with the assistance of one staff member. The August 2017 ADLs (activities of daily living) report indicated Resident #1 had not received a shower between 8/17/17 and 8/31/17. The August 2017 Order Review Report revealed Nystatin Cream had been ordered and started on 8/31/17. The August 2017 Location of Administration Report documented Nystatin was applied under both of Resident #1's breasts **only** on 8/31/17 throughout the month of August. The Office-Clinic Notes from Adair County Health System dated 8/31/17 identified a physician visit report. The document titled History of Present Illness, Resident #1 lived in the dementia unit until the family removed the resident from the facility.			

Facility Administrator _____ Date _____

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	The document titled Administration Note, dated 9/1/17 at 10:10 a.m. and written by Staff C, LPN, indicated that Nystatin Cream should be applied under both of Resident #1's breasts every evening, related to a diagnosis of other specified virus infection, characterized by skin and mucous membrane lesions. An interview on 11/15/17 at 3:00 p.m. with a family interview indicated she visited Resident #1 on August 29, 2017. According to the family member, she lifted the breast and noticed the skin as raw with redness, blisters and open lesions that followed the skin creases from her breast around to her back. On 11/21/17 at 8:15 a.m. Staff B (licensed practical nurse) was interviewed and stated she generated the 8/31/17 Skin/Wound Note as a way of bringing it to the wound nurse's attention. Staff B stated she questioned if the initial fax had been sent on 7/26/17 because the physician did not respond until 8/30/17. On 11/21/17 at 12:20 p.m. the Administrator was interviewed and stated she would have expected staff to follow up with the 7/26/17 fax, notifying the physician of Resident #1's skin condition and request for Nystatin. The Administrator stated she expected the shower aides to pay attention for			

Facility Administrator _____ Date _____

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	newly developed skin conditions and report it to the nurses. 2. Resident #2 had a MDS assessment with a reference date of 8/14/17. The MDS identified the resident had diagnosis including, coronary artery disease, diabetes, dementia, muscle weakness, anxiety and depression. The BIMS score of 0 out of 15 scored Resident #2's cognitive status as severely impaired. According to the MDS, Resident #2 required extensive assistance of 2 for most ADLs, including bed mobility and total dependence on staff for bathing. The MDS noted Resident #2 utilized a wheelchair for mobility and always had episodes of bladder and bowel incontinence. The 8/1/17 Care Plan indicated Resident #2 required an EZ stand (mechanical sit to stand device) for all transfers and a wheelchair for mobility. The Care Plan also instructed staff to provide peri care [perineal cleansing] after each episode of incontinence. Because Resident #2 had the potential for impaired skin integrity related to impaired mobility and disease processes, the staff were supposed to assist the resident to reposition frequently, keep skin areas over bony prominences clean, dry, moisturized daily and use lift sheets to move/reposition the resident while in bed to reduce shearing forces. The Care			

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	Plan also instructed staff to provide assistance with ADLs every day and as needed. Observation on 11/7/17 at 2:45 p.m. identified a 1 cm (centimeter) open sore on the resident's inner left buttock. Staff E CNA, assisted the resident with toileting when observation identified the area. According to Staff E, she noticed the sore the day before and reported it to Staff C, LPN. Observation on 11/9/17 at 9:55 a.m. revealed an approximately 0.5 cm sore on Resident #2's left inner buttock as 2 CNAs toileted the resident. No residual cream/ointment or treatment observed on the wound. On 11/8/17 at 11:20 a.m. Staff C (Licensed Practical Nurse) was interviewed and she recalled being informed about the area on the resident's left inner buttock on 11/6/17. Staff C stated a CNA described the sore as being reddened like an abrasion, but the nurse said she did not assess it after being told. According to Staff C, she overheard the off going CNAs telling the oncoming CNA at shift change between the first and second shifts. Staff C stated she asked them if they reported it to the day nurse, Staff A, LPN and they said no. Staff C said Staff A did not tell her anything about it when she reported off to her on 11/6/17.			

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	On 11/9/17 at 8:18 a.m. the DON (director of nursing) was interviewed and stated the facility did not have a policy or procedure once a newly open skin area identified. According to the DON, she expected whoever would find a wound to report it to the nurse so they can follow through appropriately. The DON stated they call the Dr. for orders, notify the family and Staff A (Licensed Practical Nurse) starts a skin sheet. The DON stated she always reads the nurses' notes to stay informed. On 11/9/17 at 11:45 a.m. the DON was again interviewed and stated she did not know about the open area identified on 11/6/17 on Resident #2's left inner buttock. According to the DON, Staff C should have followed through if she knew about it. The DON said "A sore on Resident #2's bottom is a big deal because she's incontinent and it can break down very fast". The DON said it should have been assessed and the physician notified to determine a course of treatment. On 11/21/17 at 4:30 p.m. the Administrator was interviewed and stated she could not find documentation to verify a nursing assessment had been performed or the physician and family notified. **FACILITY RESPONSE:**			

Facility Administrator _____ Date _____

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6720	**Amended Citation – Fine amount reduced by 35% to $1,625.00 on December 23, 2017. Pursuant to Iowa Code Section 135C.43A**	**Date: December 15, 2017**
QHC Winterset North		**Survey Dates: October 19-November 30, 2017**
411 East Lane Winterset, Iowa 50273		
	DS	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

Facility Administrator _____ Date _____

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).