

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

Citation Number: 6731		Date: January 4, 2018		
Salem Lutheran Home		Survey Dates: December 13-21, 2017		
207 College Ave. Elk Horn, Iowa 51531		DS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.19(1)n(1)	<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.</p> <p>58.19(1) Activities of daily living. n. Nutrition and meal service. (1) Regular, therapeutic, modified diets, and snacks; (I, II, III).</p> <p>DESCRIPTION:</p> <p>Based on observation, record review, resident, family and staff interviews and review of the facility video footage and policy and procedures, the facility failed to provide Resident #2 with the required therapeutic and modified diet, resulting in the resident choking and died. The sample consisted of 7 residents and the facility reported a census of 67 residents.</p> <p>Findings include:</p> <p>A Certificate of Death form dated 9/1/17 indicated Resident #2 passed away 8/24/17 at 12:28 a.m. related to an injury that occurred on 8/17/17 at 1 p.m. when the patient aspirated a large piece of hot dog and some other food while he/she had been eating lunch. The hot dog occluded 80% of</p>	I	\$10,000 (Held in suspension)	Upon Receipt
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Facility Administrator

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	<p>the distal trachea (wind pipe) and fully occluded the left main stem bronchus. The identified cause of death were the following:</p> <p>Acute hypoxemic Respiratory Failure. Aspiration Pneumonitis. Aspiration of food.</p> <p>Resident #2 had a MDS (Minimum Data Set) assessment with a reference date of 8/1/17. The MDS identified the resident had diagnoses that included non-Alzheimer's dementia, Parkinson's disease and a seizure disorder. The assessment indicated the resident had a Brief Interview or Mental Status (BIMS) score of 3 out of 15. A score of 3 represented the resident had a severe cognitively impairment. The MDS identified the resident had fluctuating disorganized thinking, required supervision while eating and required a mechanically altered diet.</p> <p>A Care Plan with a focus area initiated on 6/3/16 indicated the resident had activities of daily living (ADL) self-care performance deficit related to Parkinson's disease and dementia as evidenced by an inability to care for self. The approaches directed the staff to do the following:</p> <p>Resident requires set up and reminders to eat slowly. Notify the nurse if staff observed trouble</p>			
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	<p>swallowing. Review of the Progress Notes revealed the following documentation as dated:</p> <p>On 3/12/17 at 10:49 p.m., the resident ate popcorn and apple slices at the center television lounge when a resident's family member noticed the resident experienced difficulty breathing, color red/purple, lips cyanotic and unable to speak initially first. The resident coughed up pieces of apple and popcorn, his voice cleared and color returned to normal after an effective cough. The resident denied pain, lungs clear and he had a temperature of 98.1 Fahrenheit (normal 98.6), blood pressure of 131/70 (normal), pulse 74 (normal 60-100), respirations 20 (normal 16-20) and an oxygen saturation rate of 95 percent (normal 97-100 percent).</p> <p>On 3/13/17 at 1:15 p.m. the physician changed the diet order to all ground foods. The nurse returned the order to the physician for clarification.</p> <p>On 3/21/17 at 12:04 a.m. the new physician orders as follows: Speech therapy to evaluate and treat as indicated, diet clarification - small portions, ground meat, no raw fruits or veggies not including bananas, moisten food if possible, may have had a regular hamburger instead of</p>			
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	<p>loose meat.</p> <p>A Fax Communication form signed by a Physician (not dated) directed staff on the above stated diet directives.</p> <p>The Speech Therapy Plan of Care, dated 3/21/17, identified the resident had previous therapy on November 2016 for dysphagia. The Speech Therapy Progress and Discharge Summary dated 3/31/17 indicated the resident had a medical diagnosis of dysphagia (difficulty swallowing) and oropharyngeal phase (difficulty during act of swallowing).</p> <p>An August 2017 activity calendar identified a State Fair Day at 10:30 a.m. on 8/17/17.</p> <p>A form titled <u>Choking</u> dated 8/17/17 at 6:19 p.m. identified the following incident: Staff F (licensed practical nurse) called to the chapel via the intercom system at 10:00 a.m. and she responded immediately. Resident #2 sat in a wheelchair with his face purple/blue, not breathing with visible vomit on his shirt and visibly choking. Staff F was told the resident at been eating a corn dog. The form indicated no other nurse present. Staff F sent the Activity Director to get the Director of Nursing Services (DNS) and Staff F called 911. Staff F attempted the Heimlich</p>			
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	<p>maneuver at 10 a.m. multiple times while the resident remained in the wheel chair. The DNS entered and they slid the patient out of the wheel-chair and on to the floor. The resident's code status verified as a full code (requested to have CPR (cardio-pulmonary resuscitation) if should stop breathing and no heart beat). The staff continued the Heimlich maneuver with suctioning until 2 pieces of hot dog became dislodged and swept out of the resident's mouth. With additional suctioning, Resident #2 started moving air and his color turned from purple/blue to red. Resident #2 began to respond to the nurses. The resident did not lose consciousness and continued with a heart rate. The nurse placed oxygen at 10 liters by mask device and the resident's saturation registered at 80%. The resident's blood pressure and heart rate stable. The lung sounds were wet and diminished. The medics arrived and transported the resident to a local hospital. The resident left the facility in a stable condition with the airway patent, vital signs stable and alert and oriented.</p> <p>A facility Investigation form dated 8/17/17 indicated the choking episode occurred at 10:03 a.m. The summarization of factors that may have contributed to the incident included the following:</p> <p>The resident to receive a ground meat diet except</p>			
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	<p>for a hamburger patty and instead given a corn dog. The resident known to eat fast. A Choking Incident timeline signed by the DNS (not dated) and review of the video timeline identified the following events:</p> <p>At 9:57 a.m. - Each resident in the chapel received a cup of corn dogs and a napkin from a cart being pushed by a family member or volunteer and Activity Director.</p> <p>At 9:58 a.m. – Resident #2 received a cup of corn dogs by the volunteer.</p> <p>At 9:59 - The resident poured 4 corn dogs into his mouth.</p> <p>At 10:00 a.m. - The Activity Director left the chapel.</p> <p>At 10:01 - Questioned choking.</p> <p>At 10:02 - The resident placed another corn dog in his mouth.</p> <p>At 10:03 - Resident #6 sat beside the resident and looked at Resident #2.</p> <p>At 10:04:23 - Nurse called and Heimlich initiated.</p>			
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	<p>At 10:04:56 - The DNS was called.</p> <p>At 10:04:56 - The DNS entered the chapel.</p> <p>At 10:05:17 – Staff positioned the resident on the floor and continued abdominal thrusts.</p> <p>At 10:06 - Called CNA's for removal of the residents.</p> <p>At 10:06 - Switched from Staff F to the DNS for abdominal thrusts and a call placed for the crash cart.</p> <p>At 10:07 - Abdominal thrusts continued the resident remained alert.</p> <p>At 10:07 - 2 hot dogs removed and his airway been suctioned.</p> <p>At 10:07:52 - All food removed.</p> <p>At 10:08 - Recovery.</p> <p>At 10:08:41 - Mouth suctioned and oxygen on.</p> <p>At 10:09 - Mouth suctioned and oxygen on.</p> <p>At 10:09 - The Administrator entered the chapel.</p>			
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	<p>At 10:10 - Recovery position while awaited the ambulance crew arrival.</p> <p>At 10:12 - Vitals (pulse, blood pressure, pulse) taken.</p> <p>At 10:14 - More suction [given].</p> <p>At 10:15 - An Emergency Medical Tech (EMT) arrived.</p> <p>At 10:17 – Staff sat the resident up.</p> <p>At 10:19 - The resident positioned in the wheel chair and suctioned again.</p> <p>At 10:21 – The DNS left the chapel with the resident stable.</p> <p>At 10:23 - Oxygen taken again.</p> <p>At 10:23-The ambulance crew arrived.</p> <p>At 10:28 - The resident left the facility with the facilities vitals in hand.</p> <p>On 12/14/17 at 9:02 a.m. the Activity Director was interviewed and stated the facility celebrated the State Fair that week and served all types of food pertaining to what food served at the fair. The staff member finished the last tray of corn dogs</p>			
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	<p>when another resident's family member/volunteer asked to pass them out to the residents. The volunteer gave another resident that required a pureed diet, a cup with 4 pieces of corn dog in it. The Activity Director knew the resident required a pureed diet so she took the corn dogs and took the resident to the center nurse's station in an attempt to get the corn dogs changed to the appropriate consistency. There had been no nurse present so she gave the corn dogs to another resident present and on a known regular diet. The Activity Director stated she then returned to the chapel and told the volunteer she would return but she had to let another family member out of the West doorway of the facility. The Activity Director stated when she returned to the chapel a couple of the residents said Resident #2 had not looked well and noticed vomit on his chest. The Activity Director stated when she returned with Kleenex, she noticed the resident had been choking. The Activity Director stated she proceeded around the back of the wheelchair and attempted the Heimlich but because of his stature, she could not get hands around the residents so paged for a nurse to the chapel but failed to page "stat". The Activity Director then went to get the DNS who followed her immediately into the chapel. The DON yelled for staff to call 911 and to remove all residents from the chapel. The Activity Director called 911 and</p>			
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	<p>when the Assistant Director of Nursing (ADON) arrived she took over the telephone call and the Activity Director took the residents out of the chapel while the other staff members kept working with the resident. After she removed a couple of residents, she did not return to the chapel. The Activity Director confirmed she was aware the resident required a special diet of ground meat.</p> <p>On 12/14/17 at 4:08 p.m. the Activity Director was interviewed and stated she questioned her inconsistencies with her above statement following a viewing of the video footage revealed she stood next to the resident when the family member/volunteer gave the resident the mini corn dogs. The Activity Director stated at the time she was more focused on the resident who also received the mini corn dogs, when that resident required a pureed diet. The 2nd inconsistency she identified was her failure to perform the Heimlich as she stated above. The Activity Director stated she thought she had performed the maneuver but videos do not lie.</p> <p>On 12/14/17 at 2:08 p.m. the family member/volunteer was interviewed and stated she visited her spouse the day of the incident, however, she could not recall what had been served and stated she had not assisted in the</p>			
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	<p>serving process.</p> <p>On 12/14/17 at 2:17 p.m. Staff F, Licensed Practical Nurse (LPN) stated a "calm" page requested a nurse in the chapel. Staff F stated as she walked to the chapel, the Activity Director informed her in a casual manner Resident #2 was choking. Staff F stated she then ran to the chapel as the Activity Director informed her that she tried the Heimlich maneuver. Staff F stated when she entered the chapel, she could tell the resident had been choking awhile as the resident's color had been purple and saliva had shot from his mouth. The staff member attempted the Heimlich in the wheelchair but could not perform the maneuver as the resident had been too big. The staff member instructed the staff present to get the DNS who immediately responded. The staff positioned the resident on the floor and the Heimlich was performed until the staff removed 3 pieces of corn dog. This was further described as 3 pieces that would have equaled one mini-corn dog but just the hot dog not the corn portion. When the pieces were removed, the resident began to exchange air so staff applied oxygen. Staff F stated the resident voiced he had his shoes on. Staff F stated 911 was called and the resident suctioned. The resident's vital signs remained stable with an oxygen saturation rate in the 70's ad 80's and climbing. The resident was</p>			
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	<p>talking when the ambulance crew arrived.</p> <p>On 12/14/17 at 12 p.m. the resident's spouse confirmed the facility staff told her the resident choked on a corn dog, turned blue, was given CPR (cardio pulmonary resuscitation) and the staff planned to send him to the emergency room. When the resident went to the local hospital the staff put a tube down his throat to get the hot dog out and they could not believe his oxygen level was at a 70 percent. The staff then put the resident on a ventilator and sent him to a hospital in Nebraska because of the aspiration of the corn dog into the lungs. When the resident went to a hospital in Nebraska, the staff could not dislodge the hot dog so they had to pluck it and pluck it little by little and they finally put in a balloon type device to remove the hot dog. The family member stated she was told the resident's oxygen levels to be at a 30-40 percent for hours. The next day the staff checked the resident's gag reflux and eventually removed the ventilator.</p> <p>Review of a typed statement by the DNS and titled <u>Choking Incident</u> of the resident on 8/17/17 identified the following information:</p> <p>The DNS was in a meeting in her office with a family member. The Activity Director interrupted and stated the resident choking in the chapel and</p>			
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	<p>needed now. DNS entered the chapel with the Heimlich in progress on the resident. The DNS requested staff to lower to the floor to receive more proficient abdominal thrusts. Staff F, Staff E, Certified Nursing Assistant (CNA) and the DNS lowered the resident to the floor. Staff F continued abdominal thrusts. The CNAs removed other residents out of the chapel. The DNS checked for a carotid and peripheral pulse during the abdominal thrusts. The resident sustained a pulse during the entire incident. Staff F became tired so the DNS took over the abdominal thrusts. Staff F continued to get the crash cart which allowed staff to apply oxygen and to have suctioned the resident. The abdominal thrusts produced 1 hot dog piece and removed by a finger sweep. No air exchanged noted so abdominal thrusts continued and produced a 2nd piece of hot dog while air exchange noted. The resident moved to a recovery position, suctioned numerous times and vitals taken during the incident. Eventually the resident sat up with assistance and assessed. Vitals and oxygen obtained during the incident. The resident then moved to a wheelchair until the ambulance arrived. The first responder arrived and took over the cares. The DNA left when the resident became stable and the ambulance arrived. The resident then moved to a stretcher with the assistance of multiple staff members. When the</p>			
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	<p>resident moved to the stretcher he stated what now? As the resident left the chapel room he stated I got my shoes on.</p> <p>During an interview 12/14/17 at 2:55 p.m. Resident #6 indicated the choking incident as just horrible. The facility celebrated state fair week and that day they served mini corn dogs and there were 3 in each cup. When the resident received his cup of corn dogs he picked them up as fast as he could, chewed and chewed and then swallowed them in one big gulp. The resident then began to choke, cough, wheeze and turn blue and she could tell the resident was choking to death. The staff got the nurses who laid him down and she left.</p> <p>An Attestation form signed by a Physician 8/17/17 at 6:54 p.m. included the following: The resident was found with a saturation level in the 70's percent. The chest x-ray identified atelectasis (collapse of lung tissue) of the left lung. A bronchoscopy (scope of the lung bronchus) identified a large chunk of hot dog which occluded 80 percent of the distal trachea and lodged in the left main stem bronchus with a small lumen which gave visibility into part of the right main stem bronchus. The patient reportedly spoke with the ambulance to the emergency room with rapid decompensation of the respiratory status.</p>			
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	<p>Oxygen saturation levels remained in the low 60's with an eventual intubation performed. Food particles suctioned from the resident's mouth. A chest x-ray demonstrated near complete opacification (decrease in the ratio of gas to soft tissue in the lung) of the left hemi thorax concerning for obstruction. The resident emergently transported to another hospital for his acute hypoxic respiratory failure due to the aspiration of food.</p> <p>Review of the facility Diet Type Report form dated 12/13/17 identified 13 of 66 residents required a ground diet.</p> <p>A Working with Residents with Special Dietary Needs form (revised 4/16) directed the staff the purpose was to provide guidelines for activity staff members when working with residents with special dietary needs. The procedures included the following:</p> <p>Maintenance a current list of residents on special diets. An updated list should be obtained month or per location practice.</p> <p>Activity staff members and volunteers who distributed food items during activity function should have been made aware of each resident's diet restrictions.</p>			
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	FACILITY RESPONSE:			
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58.28(3)e	<p>481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and Maintenance of a safe environment for residents and personnel. (III) 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> <p>DESCRIPTION:</p> <p>Based on observation, record review, staff and family interviews and review of facility policy and procedures, the facility failed to ensure Resident #5 received adequate supervision to prevent self transferring without staff assistance. The sample consisted of 7 residents and the facility reported a census of 67 residents.</p> <p>Findings include:</p> <p>1. An Admission Record form dated 12/15/17 identified Resident #5 had an admission to the facility on 8/10/15 with diagnosis including: an old myocardial (heart attack) infarction and an acute infarction of the spinal cord.</p> <p>Resident #5 had a Minimum Data Set (MDS) assessment with a reference date of 9/12/17.</p>	I	\$5,000 (Held in suspension)	Upon Receipt
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	<p>The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15. A score of 7 represented a severe cognitive impairment. The MDS identified the resident required extensive assistance of 1 staff person with transfers, limited assistance of 1 staff person with ambulation and experienced 2 falls.</p> <p>A Care Plan with a focus area dated 8/10/15 identified the resident as a fall risk related to severe weakness as evidenced by extensive assistance required with transfers. The focus area revised on 11/13/15 that indicated the resident had activities of daily living (ADL) self-care performance deficit related to spinal ischemia. The Care Plan identified a focus area of limited physical mobility revised on 2/1/17 and a focus area of impaired cognitive function/dementia or impaired thought processes revised on 4/18/17. The approaches directed the staff to do the following:</p> <p>Keep the wheel chair and wheeled walker away from the resident, on the other side of the room or in the bathroom to prevent self-transfers.</p> <p>Transfers with a front wheeled walker and assistance of one staff member.</p> <p>A Falls Tool form dated 11/8/17 at 8:10 p.m.</p>			
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Salem Lutheran Home		Survey Dates: December 13-21, 2017		
2027 College Ave. Elk Horn, Iowa 51531		DS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

	<p>indicated the resident at a medium risk for falls.</p> <p>The Progress Notes form, with an entry dated 11/25/17 at 10:47 a.m. , identified the following documentation from Staff A, Licensed Practical Nurse (LPN):</p> <p>At 6:40 a.m. heard hollering from the resident's room. Entered room and found the resident as he sat on the bathroom floor with his legs out in front as he faced the door and the walker positioned in front of him. The staff member moved the walker to the side and asked him what he had been doing up by himself. The resident stated he tried to get to the wheelchair in the corner but could not get it out so he turned from the wheelchair, lost balance and sat down. The nurse asked him what he had been doing up on his own. The resident stated he told the CNA (certified nursing assistant), as he sat on the edge of bed, he ambulated independently so she left the resident. The resident then ambulated to the door to see if she came back and then ambulated to the bathroom. The LPN (licensed practical nurse) started to perform range of motion (ROM) and the resident voiced it hurt when the left leg had been moved. The LPN noted the leg as rotated out. Two staff with a total lift transferred the resident from the floor to the bed. The LPN asked the resident to stay there until she could get his hip checked out. The LPN called the ED (emergency</p>			
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Facility Administrator

Date

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	<p>department), physician and ambulance. The ambulance crew arrived about 7:45 a.m.</p> <p>An Emergency (ED) Provider Notes form dated 11/25/17 at 8:26 a.m. indicated the resident sustained a mildly distracted intertrochanteric fracture (upper femur bone) of the left hip with mild coxa vara deformity (the angle between the head and the shaft of the femur reduced 120 degrees so the leg had been shortened).</p> <p>A form titled <u>Transition Orders And Information For The Continuation of Patient Care</u> identified the resident as admitted to the hospital on 11/25/17 and discharged back to the facility on 11/29/17 with a left hip pin site wound and a weight bearing status of toe touch only.</p> <p>On 12/15/17 at 10:21 a.m. Staff C, Certified Nursing Assistant (CNA) was interviewed and stated she had worked in the therapy room when she heard a resident yell out for help. Staff C stated she responded and observed the resident on the floor in the bathroom leaning back on a wheelchair in a sitting position. The staff member moved the resident's wheelchair and sat behind him for support. Staff B, CNA entered the room along with Staff A (licensed practical nurse) who came to check vitals. The staff member indicated every time they moved the resident he called out</p>			
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	<p>in pain. The resident then held onto his leg and said the pain ran down his leg. Staff A performed a thorough assessment, then retrieved a Total Lift device and transferred the resident to bed while he continued to call out in pain. The staff member confirmed the resident was known to self-transfer and it had not been appropriate to leave him unattended on the edge of the bed.</p> <p>On 12/15/17 at 10:56 a.m. Staff A was interviewed and stated at about 6:30 a.m., during the time of giving treatments, she heard someone calling for help and observed Staff B and Staff C as they entered the resident's room. Staff A entered the room to check vital signs and observed the resident on the floor in the bathroom. The resident denied hitting his head but when she moved the resident's left leg, he called out in pain and the leg externally rotated so she halted movement and began to assess vital signs. The staff members retrieved a Total Lift device and transferred the resident with 2 staff persons from the floor to the bed. Staff A then began neurological checks. The staff member told the resident she planned to have his hip checked out and proceeded to call the physician, spouse and ambulance crew. The resident also told Staff A he told a CNA he could ambulate independently so she left the room. The resident then stood up and looked in the hallway for the</p>			
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	<p>CNA and did not see her so he went to the bathroom to get a wheel chair, turned to get out of the bathroom and lost his balance and fell. The staff member confirmed the resident known to self- transfer and not appropriate to leave the resident unattended on the edge of the bed. The staff member indicated when a resident falls it had been normal procedure to transfer them to bed via a Total Lift device however she understood about not moving a resident with an obvious injury because the ambulance crew could have just slid him/her onto a board.</p> <p>During an interview 12/15/17 at 10:43 a.m. Staff B indicated she heard someone as they yelled for help. She asked another resident what had been going on and that resident told her Resident #5 had fallen. The staff member then went to get a vital pole as Staff C went to the resident's room. When the staff member entered the resident's room she observed him/her on the floor in the bathroom with his/her feet located in the entrance of the bathroom and his/her body positioned in the bathroom laying down while Staff C held the resident's head. The wheel chair had been positioned outside of the bathroom with the walker inside. The resident stated he/she had been trying to get his/her machine which she assumed had been the wheel chair. Staff A then entered with her vital pole so Staff B went to get the agency staff member to see where she left</p>			
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	<p>the resident and the agency staff member said on the edge of the bed. When Staff B re-entered the resident's room Staff A said she could handle it from there. Staff B confirmed the resident kept saying he/she had to move his/her left leg because something had been wrong. The staff member also confirmed the resident had been known to self- transfer and it had not been appropriate to leave him/her unattended on the edge of the bed.</p> <p>On 12/15/17 at 11:18 a.m. Staff D, CNA was interviewed and stated she heard a resident call for help and when she responded Staff A, B and C had already been present so she went to retrieve the Total Lift device. Upon return the resident complained of left hip pain when the area moved. The staff members then transferred the resident from the floor to the bed while he moaned and stated it hurt. The staff member confirmed the resident known to self-transfer and it not appropriate to leave the resident unattended on the edge of the bed.</p> <p>The agency staff member provided the following written statement to the facility date 11/25/17: Assisted the resident that morning by helping him switch his catheter bag to a leg bag, put on ted hose, pants and shoes. The resident stood up and she assisted him and pulled up the pants.</p>			
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	<p>The resident sat back down and put on a shirt. The resident seemed alert and oriented as well as able to independently stand. She asked the resident if there had been anything else and he said no and placed his hearing aids. She then made sure the resident's walker was locked and call light in reach. She told the resident as she left the room that she would return to make the bed and the resident said OK, thank you.</p> <p>On 12/20/17 at 2 p.m., the resident was interviewed and stated he could not recall the fall that resulted in a fracture. The resident's family member was present and stated the resident broke his upper leg because a CNA left him setting on the edge of the bed and he walked with a walker to his wheelchair and into the bathroom and fell.</p> <p>According to a typed statement dated 12/22/17 at 2:39 p.m., a physician documented the following information:</p> <p>The physician did not think it was unreasonable to leave the resident at the edge of the bed but the resident did need at least verbal reminders to wait for assistance due to his extremely limited insight into his own physical limitations. The physician thought if someone had been present at the bedside, they could have redirected him more</p>			
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	<p>effectively before he stood, walked and fell. The physician stated he was unsure about the situation enough to know if the Hoyer was appropriate or not. In certain cases, it had been better to get the patient up than leave them down, and the resident would have been a challenging transfer.</p> <p>A form titled Fallen Or Injured Resident Clinical Skill Checklist (not dated) included the following directive to staff: The charge nurse needed to observe the resident and perform a full body exam to determine if there may have been a suspected injury and direct whether to have moved the resident.</p> <p>A form titled Fall Prevention and Management (revised 10/17) directed the staff to do the following: Do not move the resident. Cover the resident and have him/her lay quiet until help arrived. A nurse must have observed the resident and performed a full-body exam to determine if there had been a suspected injury and direct whether to have moved the resident. Do not attempt to move the resident if a spinal or hip fracture had been suspected.</p> <p>FACILITY RESPONSE:</p>			
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