

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6741		Fine amount reduced by 35% to \$2,437.50 on February 12, 2018 pursuant to Iowa Code Section 135C.43A	Date: January 19, 2018	
Facility Name: Methodist Manor Retirement Community		Survey Dates: December 15, 19, 20, 21, 27		
Facility Address/City/State/Zip West Fourth Street Storm Lake, IA 50588		HL		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.28(3)e	<p>481-58.28(3) Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) [ARC 1398C, IAB 4/2/14, effective 5/7/14]</p> <p>DESCRIPTION: Based on observation, record review and staff interviews, the facility failed to ensure that -(1) The resident environment remained as free from accident hazards as possible; and (2) Each resident received adequate supervision and assistance devices to prevent accidents for 6 of 7 residents reviewed. The facility failed to fully investigate accidents and failed to implement adequate interventions for 4 residents following falls. The facility did not always ensure care planned interventions were in place or functional. (Resident #11, Resident # 3, Resident #10, Resident #12.) Two residents fell from EZ stands when they did not have the proper number or properly trained staff assisting (Resident #14 and Resident #15). Facility census was fifty-eight (58) residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A Minimum Data Set (MDS) with assessment reference date of 9/18/17, assessed Resident # 11 with a BIMS score of "10" (moderate cognitive impairment). The resident required extensive staff assistance with bed mobility, transfers, dressing, 	I	\$3,750.00	Upon Receipt
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	<p>toileting, personal hygiene and bathing. The resident had an indwelling Foley catheter and was continent of bowel. A "balance during transitions and walking" test revealed the resident was not steady and only able to stabilize with staff assistance when moving from seated to standing position and surface to surface transfers (transfers between bed and chair).</p> <p>Hospital discharge information dated 9/7/17 revealed the resident discharged from the hospital on that date following admission for weakness and hypokalemia related to lung cancer and metastasis disease. The resident admitted to the nursing facility for hospice care.</p> <p>A hospital fall risk assessment flow sheet, included with hospital discharge information revealed the resident was a high risk for injury and identified the fall risk interventions implemented which included: ambulate with assistance device, bed/chair exit alarms/personal alarm, close to nurses station, family at bedside, fall risk alerts and gait belt.</p> <p>A facility fall risk assessment form, dated 9/7/17, revealed the resident scored "8". A score of 10 or more indicated high risk for falls.</p> <p>Progress notes dated 9/27/17 at 6:54 a.m. and documented by Staff E LPN (licensed practical nurse) revealed at 3:30 a.m. the resident sustained an unwitnessed fall. The entry identified the resident's</p>			

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	<p>bathroom light was on and all other room lights were off. Staff observed the resident on the floor up against the bed laying on her left side with knees to the resident's chest and head on the floor. The resident hit her head. The resident stated her nose hurt and staff observed a 0.5 centimeter (cm.) by 0.5 cm. skin tear on the bridge of the nose with bruising. The resident had some bleeding from the area that subsided quickly. The resident stated she didn't know what happened. The call light was within reach clipped to the side rail.</p> <p>A hospice note regarding the incident dated 9/27/17 at 9:06 a.m. revealed the resident fell out of bed around 3 a.m. and landed on her face. The hospice nurse observed swelling and faint bruising over the left eye, redness and swelling over the left cheekbone, upper lip and nose. There were 2 steri strips in place over the a 1 cm. by 0.25 cm. skin tear. Hospice documented the resident had trouble reaching the bedside stand due to difficulty moving arms (not new) to get water, tissues, etc. Hospice asked the facility to get the resident an overbed table the day before the fall on 9/27/17. On 9/28/17, the room did not have the overbed table. Staff F RN (registered nurse) told hospice that she put one in the room yesterday but later shifts must have removed it. Staff F would get one and put it back in the room. Hospice also spoke with the care coordinator to add the following to the care plan: 'call light over resident's stomach area within easy reach" and "over bed table at bedside at all</p>			

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	<p>times."</p> <p>A fall committee review undated revealed the resident informed the Hospice nurse that she couldn't find the call light attached to the bed. The fall report did not identify when staff last saw the resident.</p> <p>On 12/18/17 at 12:18 p.m. Staff E LPN stated she didn't recall the fall. She stated staff did rounds around 2 a.m. so that would have been the last check on the resident. When asked if the resident could reach the call light prior to the fall, Staff E stated the resident was able to let staff know what she needed. The standard is that the call light is in reach so she assumes it was in reach. The siderails were up at the top of the bed. The resident used them to get out of bed.</p> <p>A care plan dated 9/20/17 identified the resident with a risk for injury. The care plan contained the following interventions prior to the fall which included: assist of 1 to 2 for transfers, glasses on as she allows, maxifloat mattress to bed, use wheelchair for locomotion in hallway- staff propels, walks with walker and assist of 1 in room. Following the 9/27/17 incident the care plan contained an addendum to place call light across abdomen so resident can easily get to it when in bed. The care plan did not contain the intervention of overbed table.</p> <p>On 12/13/17 at 2:05 p.m. Staff F RN stated she got the resident an overbed table and then replaced it the day</p>			

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	<p>after the fall. She thought the overbed table would be closer so the resident could use it instead of reaching for the night stand.</p> <p>Progress notes dated 9/28/17 at 12:21 p.m. revealed the resident got up in the recliner for 5 minutes and then wanted to lay back down due to pain.</p> <p>Progress notes dated 10/1/17 at 11:44 a.m. revealed the resident attempted to get out of bed but staff reoriented the resident to use the call light to make needs known.</p> <p>Progress notes dated 10/8/17 at 12:40 p.m. and documented by Staff G RN revealed staff observed the resident on the floor in front of the recliner laying on her right side at 11:45 a.m. Prior to the fall, the resident sat in the recliner and didn't feel well sitting and wanted to go back to bed so she got up. The resident wore nonskid socks and the call light was in the chair. Lighting was appropriate. The resident complained of shoulder pain and right sided head pain. The resident requested to go to the emergency room (ER). The resident's right side of the head bulged and was painful. The resident was alert but not oriented to time or place. The resident transported to ER for evaluation.</p> <p>A fall committee report not dated identified the call light was not on at the time of the fall. Following the incident the resident moved to a different hall to a room closer</p>			

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	<p>to the nurses station. Prior to the 10/8/17 fall, the resident resided on "C" hall in a room farthest distance from the nurses station.</p> <p>On 12/13/17 at 2:48 p.m. Staff G RN stated she didn't know how long the resident sat in the recliner prior to the fall. She stated she thought she gave the resident's roommate a medication about 15 minutes before the fall. She stated she didn't check if the recliner controller or call light was available to the resident after the fall. She stated she did not know who the CNA was that alerted her the resident fell. She stated someone told her they needed her down the hall and she went to the resident's room and the resident was face down on the floor on her right side. The resident was confused and thought she was at the bank. Staff D RN stayed with the resident while Staff G called the resident's family and the hospital. Staff G stated the resident was conscious.</p> <p>On 12/18/17 at 2:49 p.m. the hospice nurse stated she got to the facility about 10 minutes after the fall and the resident's recliner was not reclined and was raised way up. She stated the resident may have pushed the controller to elevate the chair.</p> <p>On 12/12/17 at 4 p.m. Staff D RN stated she was in the resident's room sitting with the resident after the fall. The resident's call light was in the recliner right next to the arm rest. The resident had a huge hematoma on the head. She stated the resident's</p>			

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	<p>recliner was raised all the way up and the resident was at the bottom of the chair on the floor. She wasn't sure where the chair controller was. On 12/18/17 at 3:06 p.m. Staff D stated she saw the resident attempt to get up per self occasionally. She didn't recall seeing her in the recliner much. She stated the resident made the recliner go up and down but never saw her make it go all the way up.</p> <p>On 12/14/17 at 12:12 p.m. Staff H CNA (certified nurse aide) stated she was working the resident's hall that day. The resident was in the recliner with feet elevated. She placed the resident in the recliner around 10:15 a.m. and most likely saw the resident sometime between 11 and 11:30 a.m. The last time she saw the resident would have been when she offered the resident a snack at that time. The resident didn't say anything about wanting to lay down at that time. Staff I CNA came in at 11 a.m. but Staff H didn't think he did anything with the resident. She was across the hall when she heard the resident's roommate call for help. Staff H entered the room and saw the resident on the floor and on her right side. She didn't recall the position of the recliner. She stated she usually placed the controller in the side pocket of the recliner. The resident could still reach it. Staff H called for the nurse who took over the situation and Staff H went back to her duties. Staff D RN helped the other nurse. On 12/18/17 at 10:52 a.m. Staff H stated she did not ask the resident if she wanted to lay down. She stated she did know the resident would try and get up per self a</p>			

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	<p>lot and was not reliable about using the call light.</p> <p>The surveyor attempted to reach Staff I during the investigation but was unable to reach him.</p> <p>A hospital admission history and discharge dated 10/8/17 identified the resident with a head injury (large contusion to right side due to fall) and back pain-new (related to fall). The report identified the resident slipped out of her recliner chair which was in the upright position and hit the right side of her head. She rated her pain a "8" on a scale of 0 to 10 (with 10 being the worst pain) when the ambulance picked her up. On her arrival to the ER the resident rated her pain a "4". The resident had low back and coccyx pain with movement. The resident had a large hematoma on the right side of the head from the fall. She also fell a few weeks ago and had bruising to the left eye area since then. The report identified the resident was admitted to hospice inpatient for observation and treatment. They would control the resident's pain with IV (intravenous) morphine (narcotic).</p> <p>A hospital discharge summary dated 10/9/17 revealed a CT of the head was done with a questionable subarachnoid hemorrhage. Repeat imaging was not done given her end of life and would not change management. The resident discharged with active diagnoses that included : small cell lung cancer, sacral contusion and subarachnoid hemorrhage. The resident was comfortable and released back to the facility on</p>			

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	<p>hospice care.</p> <p>Staff Interviews:</p> <p>On 12/19/17 at 11:14 a.m. Staff B CNA stated the resident would get confused and try and get up per self.</p> <p>On 12/14/17 at 12:33 p.m. Staff J CNA stated the resident would sit in the recliner and would raise herself up and down.</p> <p>On 12/13/17 at 1:50 p.m. Staff K CNA stated the resident would not stay up long in the recliner. If the controller was in her reach, she would mess with it and rise it up. She would also try and get out of it. On 12/18/17 at 11:08 a.m. Staff K stated the resident would try and get up per self a lot. She needed constant reminders and when reminded, the resident would say "oh that's right". Staff K stated she reported it.</p> <p>On 12/18/17 at 1:08 p.m. Staff L CNA stated she heard that the resident did occasionally try and get up per self.</p> <p>On 12/18/17 at 1:32 p.m. Staff M RN stated the resident would try and get up per self. Staff M caught her several times. The resident said she would go wherever she wanted to go. She was that way on both halls.</p>			

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	<p>On 12/18/17 at 1:48 p.m. Staff N stated the resident would try and get out of bed per self. When the resident sat in the recliner, she would not sit very long. She stated she told the nurses about the resident's self transfers.</p> <p>On 12/18/17 at 4:10 a.m. Staff O CNA stated the resident would manipulate the controller. She would raise herself up high enough to where staff knew she did it herself. The resident also self transferred earlier in her stay at the facility.</p> <p>On 12/18/17 at 4:48 p.m. Staff P CNA stated the resident attempted self transfers. She also messed with the recliner controller making it go way up sometimes and almost coming out of the chair.</p> <p>The care plan did not identify interventions to increase supervision for the resident knowing she self transferred and manipulated the controller to raise the recliner until after the falls with injury when they moved the resident to another hall closer to the nurses station.</p> <p>2. A MDS with assessment reference date of 8/14/17, assessed Resident #3 with impaired long and short term memory and moderately impaired decision making skills. The MDS did not identify behaviors or wandering. The resident required extensive staff assistance with bed mobility, transfers, ambulation in room, dressing, toileting, personal hygiene and</p>			

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	<p>bathing. The resident was occasionally incontinent of bladder. A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize in all but 2 areas of testing that included: moving from seated to standing position and walking. The resident had 2 or more falls without injury since the prior assessment and 1 fall with injury since the prior assessment.</p> <p>A care plan dated 6/10/16 identified the resident with an injury risk. The care plan directed staff to implement the following measures in place : body pillow in bed, left leg protector, restorative exercise program, ensure room door remains open during the day, bathroom light in at night, assist to get ready for bed, gripper socks as he allows, bed alarm at night, floor alarm at night by bed.</p> <p>A resident fall assessment sheet dated 7/17/17 at 1:25 p.m. revealed an unwitnessed fall in the resident room. Staff documented the resident fell by the bed side table. Staff identified the resident with an internal risk factor of unsteady gait. A progress note dated 7/17/17 at 12:29 p.m. identified the resident with a 2 cm. by 2 cm. skin tear on the left leg that was previously present but reopened when the fall occurred. Staff also identified a red area above it. The care plan identified the intervention following the incident dated 7/18/17 as "left arm protector".</p> <p>A resident fall assessment dated 7/25/17 at 11 a.m.</p>			

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	<p>revealed a witnessed fall at the nurses station. The resident attempted to stand up from the wheelchair and slid out. The resident did not sustain injury. A care plan intervention dated 7/25/17 identified "dycem in the wheelchair" as the intervention following the incident.</p> <p>A resident fall assessment dated 7/27/17 at 9:50 p.m. revealed staff found the resident in the floor against the bed on his bottom with alarms sounding. The resident sustained a 4 cm. by 2 cm. skin tear to the left forearm underneath an arm protector. The intervention following the incident was dated 7/27/17 that directed staff to place bed alarm under shoulders.</p> <p>A care plan intervention dated 8/1/17 directed staff to assist the resident with ambulation and transfers.</p> <p>A resident fall assessment dated 8/22/17 at 7 a.m. revealed the resident was on "d" hall by the dining room and staff heard a thump. The resident hit his head on the lower trim of the hallway. The intervention following the incident on the care plan was dated 8/22/17 and was "chair alarm" and "ambulate resident as tolerated with 4 wheeled walker or front wheeled walker with the assistance of one".</p> <p>A resident fall assessment dated 8/29/17 at 9:45 p.m. revealed the resident was confused and frequently attempted to self transfer. The resident also did not lock his wheelchair brakes before getting up. A progress note identified staff observed the resident</p>			

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	<p>lying on the floor near the nurses station on his right side with right elbow against the floor and head resting in his hands. The alarm failed to sound when the fall occurred. When asked what he was trying to do, he stated he was laying down. The care plan contained an addendum dated 8/30/17 that identified the intervention following the fall as "recheck alarm and replace as needed".</p> <p>A resident fall assessment dated 9/3/17 at 7 p.m. identified the resident attempted to self transfer and fell to the floor. Progress notes dated 9/3/17 at 9:15 p.m. revealed an unwitnessed fall in A hall. The resident was face down on his stomach. The resident was in the wheelchair prior to the fall. The resident did not sustain injury. The care plan identified an intervention dated 9/5/17 to "keep in line of vision while in wheelchair". Documentation did not identify of the alarm sounded or if dycem was in place.</p> <p>A resident fall assessment dated 9/5/17 at 7:40 p.m. revealed the resident was confused and known to self transfer. Progress notes dated 9/5/17 at 8:19 p.m. revealed the alarm sounded and staff witnessed the resident losing his balance and falling backwards on bottom in a sitting position near the nurses station. The resident did not sustain injury. A fall committee review dated 9/6/17 revealed the intervention following the incident was "medication adjustment-lexapro (antidepressant) started".</p>			

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	<p>A resident fall assessment dated 9/21/17 at 7:05 a.m. revealed the resident slipped out of bed. Progress notes dated 9/21/17 at 7:05 a.m. revealed staff found the resident kneeling by his bed after trying to get up. The resident had regular socks on when the fall occurred. The resident did not sustain injury. A fall committee review dated 9/21/17 identified the resident's door was shut. Documentation did not identify if the body pillow was in place or if the alarm sounded. The care plan did not identify a new intervention. The form identified an intervention dated 9/21/17 of "gripper socks" (already in place).</p> <p>A resident fall assessment dated 9/25/17 at 5 a.m. revealed the resident fell. Progress notes dated 9/25/17 at 5:01 a.m. revealed around 4:50 a.m. the resident sustained an unwitnessed fall in the resident room. The alarm sounded. The resident was on the floor next to the bed with the body pillow behind him. The bed was in low. The resident needed the bathroom. The resident did not sustain injury. Documentation did not identify when the resident last used the toilet. The care plan contained an addendum dated 9/25/17 that stated "floor mat".</p> <p>A resident fall assessment dated 9/28/17 at 8:45 p.m. revealed the resident was confused and had a history of self transfers. The resident self propelled the wheelchair in the hall prior to the fall. Progress notes dated 9/28/17 at 9:08 p.m. revealed staff found the resident in the ice making room on the floor with pants</p>			

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	<p>unzipped. The alarm did not sound. The fall was not unwitnessed. The care plan did not contain a new intervention following the incident. Documentation did not reveal why the alarm failed to sound, when staff last saw the resident (since the resident was to be within staff's line of vision when in wheelchair) or when staff last toileted the resident or if the wheelchair contained dycem.</p> <p>A resident fall assessment dated 10/11/17 at 5 a.m. revealed the resident fell. Progress notes dated 10/11/17 at 5:40 a.m. revealed at 5:08 a.m. staff informed the nurse that the resident was on the floor. The alarm sounded. The fall was unwitnessed. Staff observed the resident in the floor against bed laying on his left side with knees drawn to chest and head on the floor. The resident hit his head which resulted in an abrasion on the top of the head that measured 5 cm. by 2 cm. Staff did not observe other bruising. The fall committee review dated 10/11/17 identified the alarms sounded and the body pillow was in place. The bed was in low. The review did not identify if the floor mat was in place or when staff last saw or toileted the resident. The review form identified staff would get the resident up at 5 a.m. as the intervention following the incident. The care plan did not reflect a new intervention.</p> <p>A resident fall assessment dated 11/11/17 at 1:38 p.m. revealed staff observed the resident sitting on the floor against the bed with alarms sounding. The</p>			

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Facility Name: Methodist Manor Retirement Community	Survey Dates: December 15, 19, 20, 21, 27			
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	<p>assessment identified the resident was in the wheelchair prior to the fall. Progress notes dated 11/11/17 at 1:44 p.m. revealed no injury from the fall. The notes did not identify when staff last saw/toileted the resident or if the dycem in the wheelchair was in place. The resident was not in the line of vision as directed per care plan. The care plan contained an intervention dated 11/11/17 that identified the new intervention as "encourage to lay down in bed after lunch".</p> <p>A resident fall assessment dated 11/20/17 at 2:30 p.m. revealed a fall. Staff found the resident in another resident's room on the floor next to the bed. Prior to the fall, the resident propelled self in the wheelchair. The resident said he was trying to lay down. Progress notes revealed staff called the charge nurse to a resident room after hearing an alarm. The resident laid on the floor next to the other resident's bed with his head near the foot and legs outstretched in front of him. Staff did not observe injury. The resident was not in the line of vision as directed per care plan. It is not known if dycem was in place or when staff last saw/toileted the resident. A fall committee review dated 11/21/17 identified the new intervention as "all staff to direct resident to his hall as he allows".</p> <p>A resident fall assessment dated 12/6/17 at 6 a.m. revealed a fall. The resident was in a wheelchair prior to the fall. Progress notes dated 12/6/17 at 5:21 a.m. revealed staff called for help at 4:45 a.m. Staff found</p>			

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	<p>the resident on his knees in front of his wheelchair by the public restroom. The resident received skin tears on the webbing between thumb and index finger. The notes did not identify which hand. The left hand skin tear contained a 5 cm. moon shape skin tear. The resident received the skin tears by attempting to pull self up into the wheelchair after the fall. Staff did not observe bumps or bruises to the resident's head. The resident's alarm did not sound. The fall committee review dated 12/6/17 identified the fall as unwitnessed. After the incident, staff toileted the resident and the resident had a large bowel movement. The review identified skin tears to both right and left hands. After the incident, staff replaced the alarm. The review did not identify when staff last toileted the resident or if there was dycem in the chair. The review did not indicate if staff redirected the resident to his hall prior to the fall.</p> <p>On 12/17/17 at 11 a.m. the surveyor asked Staff C unit manager about the resident's falls and what interventions were in place since the information was not always available on the resident fall assessment, progress notes or fall committee review. She stated she would have to ask staff and get back to the surveyor.</p> <p>On 12/18/17 10:37 a.m. Staff C unit manager stated she called the nurses who worked to find out what interventions were in place when falls occurred: Regarding 9/3/17 fall Staff C called the charge nurse</p>			

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	<p>who stated the alarm sounded. Regarding the 9/21/17 fall she stated Staff A said yes the alarm sounded and the resident crawled over the body pillow. Regarding the 9/25/17 fall, Staff C called Staff E who stated he was last seen at 4 a.m. rounds. The resident is not incontinent so he is not toileted regularly. Staff toilets when he gets up or is restless. Regarding the 9/28/17 fall, Staff C spoke with Staff D who said the resident was toileted right after supper and she wasn't sure why the alarm didn't sound. It was checked earlier and sounded. Staff D replaced the alarm. On the 10/11/17 fall Staff E stated they toilet the resident when he's anxious and they visualize the resident every 1.5 to 2 hours. On 12/8/17 at 2 p.m. Staff C stated the resident got up and was using a bed alarm all night. That worked but the chair alarm did not sound.</p> <p>Observation showed on 12/12/17 at 1:08 p.m. 2 staff toileted the resident. The resident's chair alarm did not sound until after the staff had the resident seated on the toilet. The surveyor questioned if the placement of the alarm which laid on top of a wheelchair cushion resulted in the delay in the alarm sounding. Staff V CNA then moved the alarm pad under the cushion. When tested the alarm sounded immediately after staff placed it under the cushion.</p> <p>Progress note documentation of self transfer attempts:</p> <p>10/3/17 at 10 a.m. Resident propelled into another resident's room and transferred into other resident's</p>			

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	<p>bed.</p> <p>10/14/17 at 11:32 a.m. Resident at the desk and attempted to self transfer</p> <p>10/21/17 at 6:38 p.m. The resident self transferred from wheelchair to bed</p> <p>10/23/17 6:41 p.m. The resident sits by nurses station in wheelchair and attempted to self transfer twice</p> <p>11/13/17 at 1:40 a.m. Resident entered a resident's room on another hall and stood in an attempt to self transfer to bed</p> <p>11/16/17 at 1:01 p.m. Resident attempted to self transfer in the dining room</p> <p>11/28/17 at 9:49 a.m. Staff found the resident in another resident room trying to self transfer into another resident's bed</p> <p>12/3/17 at 4:19 p.m. The resident attempted to self transfer to another resident's toilet. Staff took the resident back to his room to use the rest room</p> <p>12/4/17 11:21 a.m. Resident wandering into other resident rooms. Staff took resident to rest room.</p> <p>12/5/17 at 1:36 p.m. The resident made one attempt to self transfer into another resident's bed.</p>			

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	<p>12/11/17 at 9:46 p.m. Staff found the resident self transferring to another resident's toilet. Staff took the resident back to his room to use the toilet.</p> <p>The care plan did not identify self transfer attempts or interventions that increased supervision based on knowledge of the resident self transferring. The care plan intervention for toileting was dated 5/18/17 and stated "assist to toilet" with no frequency identified.</p> <p>3. A Minimum Data Set (MDS) with assessment reference date of 8/14/17, assessed Resident #10 with a brief interview for mental status (BIMS) score of "5" (severe cognitive impairment). The resident required extensive staff assistance with bathing, transfers, ambulation, dressing, toileting, personal hygiene and bathing. A "balance during transitions and walking" test revealed the resident was unsteady and only able to stabilize with staff assistance in all areas of testing except for walking. The balance test revealed the resident as unsteady and able to stabilize without staff assistance. Progress notes dated 8/7/17 at 3:08 p.m. revealed the resident admitted to the facility on 8/7/17 from the hospital for skilled services.</p> <p>A physician progress note dated 8/30/17 revealed the resident returned for a 1 month follow up of hypertension, compression fracture T12, depression and other medical issues. The progress note documented that the physician saw the resident</p>			

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	<p>6/28/17 with low back pain and diagnosed the resident with a compression fracture of T12 at that time.</p> <p>A fall risk assessment dated 8/7/17 identified the resident with a score of "12". A score of 10 or above represented high risk.</p> <p>A temporary care plan dated 8/7/17 identified the resident as assist of one or 2 and full weight bearing.</p> <p>Progress notes dated 8/20/17 at 9:59 a.m. revealed the resident fell in the activity room. The resident stated he attempted to assist another resident over the door threshold. The resident did not sustain injury. A fall committee review dated 8/21/17 identified the intervention following the fall as "resident education not to assist other residents". (not effective-resident had BIMS of "5"). A resident fall assessment form dated 8/20/17 at 9:30 a.m. revealed the resident had the following internal fall risk factors: unsteady gait, impaired vision and incontinence. On 12/19/17 at 2:44 p.m. Staff C RN (registered nurse unit manager) stated the incident occurred on a Sunday morning. The church group gathers together and activity staff are not present. The only staff that would have been around were staff in the hall that day.</p> <p>Progress notes dated 8/28/17 at 10:35 p.m. revealed an unwitnessed fall in the resident room. Staff found the resident on the floor when the resident put a shirt on a hanger and lost his footing. The resident received</p>			

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	<p>a 5 centimeter (cm.) by 0.5 c.m. skin tear to the left elbow. The resident complained of hip pain and transferred to the ER (emergency room) for examination at 5:40 a.m. on 8/29/17. The resident returned to the facility at 9:40 a.m. on 8/29/17 with diagnosis of hip contusion. A fall committee review dated 8/29/17 revealed the resident received a bump/bruise to the right hip and a skin tear to the left elbow. The intervention following the incident was "mobility alarm after supper". A dermal flow sheet dated 8/30/17 identified a painful 12 cm. by 7.5 cm. bruise to the right hip and pelvis. On 10/5/17 the bruise resolved</p> <p>A facsimile to the physician dated 9/5/17 revealed the resident had a sudden increase of blue/purple bruising to the right hip from the previous fall. The area was almost resolved and now increased with a semi hard easily movable mass above the right hip. The physician responded saying he would see the resident today. At the physician visit that day, the physician measured a 36 cm. by 15 cm. with 23 cm. by 7 cm. hematoma of the area.</p> <p>A physician note of the 9/5/17 visit revealed the resident returned to the physician for a follow up of hypertension and due to a history of right lateral abdomen and lower chest bruising and mass. The physician documented the resident had a fall a few weeks ago and the bruising was nearly resolved. The staff noticed bruising again over the past few days. A</p>			

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	<p>physician order dated 9/5/17 revealed the physician ordered a physical therapy consultation (PT) for possible ultrasound treatment of right lower chest and abdomen hematoma.</p> <p>A PT discharge summary dated 9/7/17 revealed the resident achieved all goals and could be independent in the facility. The care plan contained a directive dated 8/27/17 that the resident could be independent with transfers and gait using walker (supervise for direction as needed) and assist when unsteady. A therapy communication form dated 8/25/17 revealed the PTA (physical therapy aide) identified the resident could ambulate independently with front wheel walker. Staff should supervise for direction secondary to confusion</p> <p>Progress notes dated 9/12/17 at 12 p.m. revealed the resident fell while using the rest room by the nurses station. On 12/19/17 at 10 a.m. Staff A RN (registered nurse) stated she worked the day of the incident. The resident was independent during the day at the time and fell coming out of the bathroom by nurses station. A fall committee review dated 9/13/17 identified the resident complained of dizziness when the fall occurred. The intervention was "updating cardiologist on dizziness and irregular heart rate".</p> <p>Progress notes dated 9/20/17 revealed the resident saw the cardiologist and received a diagnosis of "chronic atrial fibrillation". The physician prescribed</p>			

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	<p>Warfarin (blood thinner).</p> <p>A physical therapy assistant (PTA) recommended on 10/3/17 for the resident to be independent during the day and assist of one after supper.</p> <p>Progress notes dated 11/10/17 at 5:10 p.m. revealed an unwitnessed fall in the resident room. Staff observed the resident sitting on the floor of the resident's room. The resident complained of coccyx pain and stated he laid in bed prior to the fall. The resident's pants were lowered to the thighs. The resident denied a need for the bathroom. The intervention on the care plan dated 11/10/17 (following the incident) was to "move the time of the alarm placement to midafternoon due to sundowning". There were lines through the intervention and "changed" beside it with no date.</p> <p>Progress notes dated 11/15/17 at 6:26 p.m. revealed an unwitnessed fall in the bathroom by the nurses station at 5:10 p.m. Staff found the resident sitting on his bottom with both legs extended in front of him. The walker was on the left side of the resident. The resident stated he slipped. Staff observed blood on the resident's jeans and on the entrance of the door from a pinpoint open area on the left hand. The intervention was "staff write up". Review of the staff write up dated 11/17/17 showed the staff did not follow the care plan resulting in a fall.</p>			

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	<p>A therapy recommendation dated 11/28/17 from the PTA directed staff to ambulate the resident with assist of one at all times and alarm at all times.</p> <p>Progress notes dated 12/9/17 at 10:51 a.m. revealed the resident ambulated with staff and walker when he reached out for his chair and lost his balance and fell backwards on his bottom. The entry did not identify if staff used a gait belt. The fall committee investigation dated 12/11/17 did not identify if staff used a gait belt when the fall occurred. On 12/19/17 at 11:14 a.m. Staff B CNA (certified nurse aide) stated she used a gait belt when the incident occurred. The intervention following the incident was "PT screen".</p> <p>Progress notes dated 12/11/17 at 4:14 p.m. revealed at approximately 3:55 p.m. staff observed the resident sitting in his bottom in his room. The resident sat at the entrance of the bathroom and stated he needed the bathroom. A fall committee review dated 12/12/17 revealed prior to the fall the resident sat in the recliner and alarms sounded.. The report did not identify when staff last toileted or saw the resident. The intervention following the incident was to "keep wheelchair out of reach".</p> <p>Progress notes dated 12/14/17 at 11:17 p.m. revealed an unwitnessed fall in the resident room. Staff observed the resident seated on the edge of the bed around 10:10 p.m. The alarm cord disconnected from the box causing it to sound. The resident stated he must have</p>			

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	<p>rolled out of bed. Staff observed a large bump to the resident's right upper forehead with black purple bruising present measuring 6 cm. by 6 cm. The resident denied the need to use the toilet. The resident transported to the ER at 10:30 p.m. for evaluation. On 12/15/17 at 1 a.m. the resident returned to the facility. A CT (computerized tomography) scan was normal. The fall risk committee form dated 12/14/17 intervention following the incident was "body pillow when in bed". The incident report identified a new room for the resident.</p> <p>A care plan dated 8/27/17 identified the resident with "injury risk" and "ADL maintenance" concerns. The care plan revealed the resident could toilet self and staff should assist when unsteady. The care plan did not identify a plan to increase supervision of the resident.</p> <p>On 12/19/17 at 9:50 a.m. observation showed the resident seated in his room in a recliner with alarm on. The right side of the resident's face was completely bruised with a purple bruise. When asked what happened, the resident stated he had "2 to 3 bruises" and they "were coming along". At 10:08 a.m. 2 staff assisted the resident to a standing position with a walker and a gait belt and the alarm sounded.</p> <p>4. A MDS with assessment reference date of 8/7/17, assessed Resident #12 with impaired long and short term memory. The resident required extensive staff</p>			

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	<p>assistance with bed mobility, transfers, dressing, toileting, personal hygiene, eating and bathing. The resident had functional impairments of range of motion of both upper and lower extremities. The MDS identified the resident with two or more falls without injury since the previous assessment. The resident had diagnoses that included: dementia.</p> <p>Progress notes dated 7/1/17 at 9:43 p.m. revealed staff observed the resident on the floor. The resident was in bed prior to the fall. A fall committee review dated 7/3/17 revealed staff found the resident sitting on the floor. The resident said she hit her head. The alarm was not on. The intervention was: husband and staff education. On 12/19/17 at 4:20 p.m. Staff D RN stated the resident's husband just left and the incident occurred. Staff D said the spouse often transferred the resident and did not set the alarm so staff would try and get to the room as soon as the spouse left.</p> <p>Progress notes dated 8/6/17 at 9:37 p.m. revealed an unwitnessed fall at the nurses station. The resident leaned over the right side of the recliner and slid out. Staff found the resident crouching on her knees with her head on the floor. The alarm did not sound. The resident received a 3 cm. by 2 cm. laceration to the forehead and scattered red spots with serosanguinous drainage. A fall committee review dated 8/6/17 revealed the intervention for the incident as: "alarm replaced".</p>			

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	<p>Progress notes dated 8/18/17 at 4:06 p.m. revealed an unwitnessed fall in the resident room. Staff found the resident sitting on her bottom next to the bed at 2:40 p.m. The alarms sounded. A fall committee review dated 8/21/17 did not identify if the body pillow was in place. The intervention was: "bed in low".</p> <p>Progress notes dated 8/24/17 at 8:31 p.m. revealed staff found the resident on the floor next to the bed with alarms sounding. A fall committee review dated 8/25/17 did not identify if the body pillow was in place. The intervention was "Ativan (antianxiety) at 2 p.m. for restlessness".</p> <p>Progress notes dated 9/13/17 at 4:10 p.m. revealed staff found the resident lying on the floor next to the bed. The bed was not in low. There was no alarm present and no body pillow in place. A hospice aide was last seen with the resident. The intervention was "hospice aide education" On 12/19/17 at 4:20 p.m. Staff D RN stated the hospice aide probably left an hour before the incident occurred.</p> <p>5. A MDS with assessment reference date of 6/5/17 assessed Resident #15 with a BIMS score of "15" (no cognitive impairment). The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and bathing. The resident used a wheelchair for mobility.</p> <p>A care plan dated 6/14/16 identified the resident with a</p>			

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	<p>risk for injury. An addendum to the care plan dated 5/16/17 directed staff to use 2 staff with EZ lift transfers.</p> <p>On 12/13/17 at 3:48 p.m. the resident stated in July a girl didn't get the straps on the EZ stand right and one came off and the resident ended up on the floor between the stool and the door. She said she did not sustain injury.</p> <p>A resident fall assessment sheet dated 7/5/17 at 4:20 p.m. revealed staff assisted the resident to the bathroom via EZ stand with upper body left belt in place and secured. While standing to get off the toilet, the left loop came off the EZ stand and the resident fell onto her buttocks in the bathroom. The resident denied injury other than "whole body sore". Staff assisted the resident from the floor to the wheelchair via hoyer lift. The resident fall sheet revealed the facility wrote a CNA up for not following the care plan. There was no documentation the EZ stand or straps were inspected after the incident.</p> <p>On 12/18/17 at 5 p.m. Staff S CNA stated the hoyer lift strap flipped up and over the hook. There was a silver clip to secure the strap and the strap came off the inside of the clip and the resident went to the floor. Staff S stated she knows she put the straps on right but she did not have a second staff with her for the transfer as the care plan directed. Staff S stated before her incident, she heard the same thing happened a</p>			

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	<p>couple weeks before and the resident slid down onto the toilet and did not fall. She stated she was not working with the resident when that incident occurred. Staff S stated she never received a write up for the incident or signed one. Review of the write up for Staff S revealed the signature area where Staff S should sign to acknowledge she received the write up was blank.</p> <p>On 12/18/17 at 12:30 p.m. the Administrator stated Staff S never worked again after the 7/5/17 incident and that is why she did not sign the discipline form.</p> <p>On 12/20/17 at 10:12 a.m. the human resources (HR) manager stated Staff S did not sign the form because she never worked again after the incident. Review of pay roll records showed Staff S did work on 7 occasions after the incident.</p> <p>Observation on 12/18/17 showed 2 staff transfer the resident with the EZ stand. Staff hooked the straps to the EZ stand bars with the security clips in place. Staff performed the transfer without incident.</p> <p>6. A MDS with assessment reference date of 7/10/17 assessed Resident #14 with a BIMS score of "15" (no cognitive impairment). The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting, personal hygiene and bathing.</p> <p>On 12/14/17 at 1:55 p.m. the resident stated quite</p>			

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Health Facilities Division
Citation

Citation Number: 6741	Fine amount reduced by 35% to \$2,437.50 on February 12, 2018 pursuant to Iowa Code Section 135C.43A	Date: January 19, 2018		
Facility Name: Methodist Manor Retirement Community	Survey Dates: December 15, 19, 20, 21, 27			
Facility Address/City/State/Zip West Fourth Street Storm Lake, IA 50588	HL			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	<p>awhile ago staff didn't have the strap on the hook of the EZ stand and she fell but didn't get hurt.</p> <p>Resident progress notes dated 8/25/17 at 9:59 p.m. revealed staff transferred the resident off the toilet with the EZ stand and the strap came unfastened causing the resident to lean to the side. Staff lowered the resident to the floor. Staff inspected the EZ stand for defects and found none. A resident fall assessment sheet dated 8/25/17 at 9 p.m. revealed the resident had a fall on the EZ lift. A fall committee review undated revealed 2 nurse aides assisted the resident off the toilet with the EZ lift. The strap became unfastened causing the resident to lean sideways and staff lowered the resident to the floor.</p> <p>A care plan dated 5/4/16 revealed the resident had a risk for injury. The care plan dated 5/4/16 directed staff to use 2 staff with EZ Stand lift transfers. Following the incident on 8/25/17 the care plan directed staff to use a hooyer lift with transfers. Staff discontinued the hooyer lift directive on 8/28/17. A typed note revealed the resident voiced concerns about using the hooyer lift after it was implemented. The resident felt the facility implemented the hooyer lift as a punishment for the fall. The facility changed the hooyer lift directive back to EZ lift and 2 staff for transfers on 8/28/17.</p> <p>On 12/14/17 at 3:18 p.m. the surveyor asked Staff T (unit manager) who the staff were that were involved in Resident #14 and Resident #15's incidents. (The</p>			

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	<p>incidents occurred on the same hall on the evening shift and one month apart.) Staff T stated they don't keep track of that. On the same date at 3:55 p.m. the surveyor spoke with the DON about not knowing who the staff were involved in the incidents. At that time, the DON stated Staff S and Staff Q were involved in Resident #15's incident and stated that Staff Q and Staff N were involved in Resident #14's incident.</p> <p>On 12/14/17 at 4:20 p.m. Staff Q CNA denied transferring Resident #15 but informed the surveyor Staff S CNA transferred Resident #15. She stated Staff U CNA assisted her with Resident #14's transfer and not Staff N. Staff Q stated when Resident #14's incident occurred, the EZ stand did not go straight and then the strap came off the hook .</p> <p>On 12/20/17 at 10:08 a.m. Staff U CNA stated he was with Staff Q when Resident #14's incident occurred. He stated the strap just came out from the machine and then he saw the resident falling. He stated all the resident's weight was going to the side. He didn't recall if the device to secure the straps was present. He stated he was underage and he is not supposed to use machines. It was also his first day of work. When asked why his hire date was listed as 7/20/17 he stated he was hired on that day and then took a trip to Mexico and his first day was 8/25/17.</p> <p>On 12/20/17 at 9:33 a.m. Staff T unit manager stated she inspected the lift and everything after Resident</p>			

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	#14's incident and there were no issues. The security clips were there. There were no concerns with the sling condition and the laundry staff inspects them when they are washed. She stated there was no staff retraining following the incidents. On 12/20/17 at 10:19 a.m. Staff T stated the nurse working when Resident #15 fell did not have Staff S show her how she hooked the sling but the nurse did visually inspect everything. FACILITY RESPONSE:			

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 (2015).