Department of Inspections and Appeals
Health Facilities Division
Citation

Number **FC#6779**	**Amended Citation – Fine amount reduced by 35% to $3,412.50 on April 30, 2018. Pursuant to Iowa Code Section 135C.43A**	**Report date** **April 6, 2018**
Facility name **Accura Healthcare of Knoxville**		**Survey dates: Feb. 26 – 28 and March 1, 2018**
Facility address **606 N 7th St.**		
City **Bloomfield, Iowa 52537**	**JM**	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.28(3)e	**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)** **DESCRIPTION:** Based on observation, record review and interview, the facility failed to provide adequate supervision to protect against hazards from self, others or elements in the environment, and also failed to consistently develop interventions to prevent an injury for 1 of 3 residents reviewed with falls (Resident #43). The facility reported a census of 41 residents. Findings: 1. According to the MDS (Minimum Data Set) assessment tool dated 11/4/17, Resident #43 had diagnoses that included weakness, symptoms and signs with cognitive functions and awareness, and personal history of transient ischemic attacks (mini-strokes). The MDS documented the resident required extensive assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, personal hygiene, and bathing, and listed the resident as not steady and only able to	**I**	**$5250**	**Upon Receipt**

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	stabilize with staff assistance when moving from a seated to standing position, walking, turning around, moving on and off the toilet, and transferring between the bed and chair or wheelchair. The MDS stated the resident had 2 falls without injury since the prior assessment and listed the resident's BIMS (Brief Interview for Mental Status) score as 10 of 15, which indicated a moderately impaired cognitive status. During an observation on 2/27/18 at 7:09 a.m., the resident lay in bed with a pressure pad under him connected wirelessly to an alarm in the hallway. The resident's bed was in a low position and a floor mat lay beside the bed. The resident's 11/26/17 Morse Fall Scale listed the resident's score as 80 with a score of 45 or higher indicating a high risk for falls. Facility Quality Assurance Monitoring Tools (incident reports) for the resident during the survey year revealed the following: a. On 1/13/17, the resident went to the bathroom by himself, fell at the foot of the bed, landed on his back, and sustained an abrasion to the back. b. On 1/18/17, a CNA (Certified Nursing Assistant) found the resident on the floor in front of the recliner. The resident stated he stood up to get into his chair. c. On 4/21/17, staff found the resident on the floor in the closet. d. On 8/3/17, the resident slid out of his recliner and sat on the floor. e. On 10/10/17, the resident transferred himself from bed to toilet and on the way back from the toilet went down on one knee. f. On 10/17/17, staff found the resident sitting in front of			

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	the recliner. g. On 12/28/17, the resident transferred himself and fell. h. On 1/15/18, a CNA found the resident lying on the floor. The resident had turned off the personal alarm. The facility sent the resident to the hospital due to hip pain. A 12/29/17 9:50 a.m. nursing note documented the resident continued to attempt self transfers after many reminders to wait for staff assistance. A 12/30/17 1:28 p.m. nursing note documented the resident continued to attempt self transfers after many attempts to educate; the personal alarm in place and functioning. A 1/5/18 6:30 p.m. nursing note documented the resident attempted to transfer himself prior to supper. A 1/6/18 11:15 a.m. nursing note documented the resident was noncompliant with assistance with walking and transfers and shut off the alarm and/or placed it in crevice of chair to muffle the sound so staff couldn't hear it. A 1/7/18 10:21 a.m. nursing note documented the resident continued to attempt self-transfers and shut off or hid the alarm. A 1/8/18 3:59 p.m. nursing note documented the resident continued to self-transfer and hid or turned off the alarm. A 1/10/18 3:20 p.m. nursing note documented the resident continued to self transfer and hid or shut off the alarm.			

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	A 1/15/18 hospital report documented the resident sustained a right hip fracture after a fall. A 1/19/18 10:50 a.m. nursing note documented the resident admitted to the hospital on 1/15/18 with a left hip fracture and had surgery on 1/16/18. A 1/19/18 12:20 p.m. nursing note documented the resident readmitted to the facility to a room closer to the nurse's station. The resident's care plan included the following entries/interventions: a. 10/28/16 Encourage the resident to wear gripper socks at night. b. 11/16/16 Keep call light in reach and remind to use. c. 10/10/17 Physical therapy/Occupational therapy evaluation/treatment. d. 1/4/18 Place alarm box out of reach. The facility lacked documentation of an additional intervention initiated completed between the dates of 1/4/18 and the resident's fall with fracture on 1/15/18. Nursing notes during this period revealed staff documented the resident continued to turn his/her alarm off. A care plan entry dated 1/19/18 (the resident's readmission date) listed the following interventions: a floor mat, low bed, and cordless pressure alarm. The facility's undated policy "Falls Management" directed staff for residents at risk for falls, the nurse would review the resident's condition, put an appropriate intervention into place, and update the care plan. The policy also directed staff to monitor the care plan,			

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	monitor for effectiveness of interventions, and make changes as deemed necessary or when reviewed and updated. During an interview on 2/27/18 at 12:44 p.m., Staff C CNA stated on the night the resident fell, he tried to get up and down and the alarm sounded multiple times prior to the incident. When she completed rounds she saw the resident lying on the floor with his feet pointing toward the bathroom. The resident's alarm had been turned off and the resident told Staff C he shut it off. Staff C stated she thought he had already been to the bathroom because of the way he was positioned, and reported it didn't matter where one placed the alarm, the resident could get to it. She stated the resident currently had an alarm which was wireless and couldn't be disabled. During an interview on 2/27/18 at 1:27 p.m., Staff D CNA stated the resident currently used a wireless alarm and confirmed the resident knew how to turn off the old alarm. During an interview on 2/27/18 at 2:28 p.m., the DON (Director of Nursing) stated staff should have made sure the alarm was under the bed. She reported the resident went to the bathroom and fell on the way back to bed; the facility added a low bed and a fall mat after the resident sustained a fracture. During an interview on 2/27/18 at 2:39 p.m., Staff A LPN (Licensed Practical Nurse) reported on the night of the fall, one of the CNAs alerted her the resident was on the floor. When she entered the room, the resident lay on his left side. She stated the alarm was within reach on the bedside table and Resident #43 could have easily reached it, and reported if it was placed under the			

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	bed, he could not have reached it. She reported the resident told her he turned off the alarm and reported she had seen him do this in the past. She stated after the fall, she called an ambulance for the resident. During an interview on 2/28/18 at 1:06 p.m., the ADON (Assistant Director of Nursing) reported if a care plan intervention was ineffective they would attempt something else. She stated the resident was able to turn off his alarm and added staff should have made sure it was out of his reach. During an interview on 2/28/18 at 1:42 p.m., the MDS Coordinator stated if an intervention didn't work, they would try to come up with something else. She verified she did not see another intervention added to the care plan after the intervention of placing the alarm out of the resident's reach. **FACILITY RESPONSE:**			

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