

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

<b>Citation Number:</b> <b>6935</b>		<b>Date:</b> <b>March 27, 2019</b>		
<b>Facility Name:</b> <b>Carlisle Center for Wellness and Rehabilitation</b>		<b>Survey Dates:</b> <b>February 25 to March 7, 2019</b>		
<b>Facility Address/City/State/Zip:</b> <b>680 Cole Street</b> <b>Carlisle, IA 50047</b>	<b>MW/SS</b>			
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction date</b>

<b>58.28(3)e</b>	<b>481—58.28(135C) Safety.</b> The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) <b>58.28(3) Resident safety.</b> e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)	<b>I</b>	<b>\$8500.00 (Held in Suspension)</b>	<b>Upon Receipt</b>
	<b>DESCRIPTION:</b>  Based on clinical record review, observation, resident interview, staff interviews, and facility record review, the facility failed to increase nursing supervision on the CCDI (Chronic Confusion Dementing Illness) unit after several incidents involving resident to resident interactions to prevent potential for abuse for 5 of 6 residents reviewed for abuse (Residents #2, #47, #55, #36 and #33). The facility failed to identify the need for increased supervision housing multiple residents, with the potential for physical and verbal behaviors directed towards others, on the same unit. The facility failure resulted in an Immediate Jeopardy situation identified on 12/8/18 and abated on 2/27/19. Fourteen residents resided on the CCDI unit. In addition, based on clinical record review and staff interviews, the facility failed to provide adequate transfer assistance during a resident transfer that resulted in a fall with fracture for one of 23 residents reviewed (#25). The facility reported a total census of 67 residents.			

Page 1 of 48

Facility Administrator

Date

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	<p>Findings include:</p> <p>1. The admission Minimum Data Set (MDS) assessment dated 11/2/18 for Resident #2 documented an admit date of 10/22/18. The MDS identified a BIMS score of 3 with sign/symptom of delirium with fluctuating presence of inattention; a score of 3 indicated severe memory and cognitive impairment. The MDS documented the resident exhibited physical and verbal behavioral symptoms directed toward others and wandering on 1 to 3 days of the 7-day look back period. The MDS recorded the resident's behaviors impacted others putting others at significant risk for physical injury and significantly disrupted care or the living environment. The MDS recorded he was independent with transfers, walking in the room and corridor, and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, depression, delirium due to known physiological condition, unspecified/uncomplicated nicotine dependence, other uncomplicated psychoactive substance abuse, and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood).</p> <p>The MDS dated 1/4/19 for Resident #2 documented a Discharge Return Not Anticipated.</p> <p>The MDS dated 2/19/19 for Resident #2 documented the resident re-entered the facility.</p> <p>The care plan focus area dated 11/1/18 identified</p>			

Page 2 of 48

Facility Administrator

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	<p>Resident #2 was independent with ADLs (activities of daily living) and transferred independently. The care plan focus area dated 11/5/18 identified an elopement risk/wanderer with behaviors of exit seeking, kicking exit doors, pacing, and going into other residents' rooms related to increased agitation when he did not have cigarettes and could not go out to smoke when he wanted. The care plan informed staff the resident resided on the CCDI (or dementia) unit. The care plan focus area dated 11/5/18 identified a behavior deficit related to physical and verbal behaviors towards others, hitting other residents, shoving another resident; increased agitation when out of cigarettes or couldn't go out to smoke when he wanted or get into the fridge when he wanted and throwing items off nurses cart and throwing nurses tablet breaking it. The care plan informed staff the resident with a history of: yelling/cursing at others; getting upset because the fridge locked; threw juice at staff; took items off med cart, shook drawers on med cart and tried to open them; threatened staff; lifted up a chair and threatened to break window; rammed his shoulder into nurses station door causing damage to facility property; kicked exit door and damaged facility property; and broke locks on cupboard doors in dining area. The care plan identified the resident diagnosed with vascular dementia, delusional disorder, depression, metabolic encephalopathy, and had a long history of substance abuse with nicotine dependence. An intervention dated 11/5/18 directed staff to intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention;</p>			

Page 3 of 48

Facility Administrator

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	<p>and remove from situation and take to alternate location as needed. An intervention dated 11/7/18 directed staff to monitor behavior episodes and attempt to determine underlying cause; consider location, time of day, persons involved, and situations; and document behavior and potential causes. The care plan intervention dated 12/28/18 directed staff to educate the resident expectations of keeping his hands to himself and on successful coping, interaction strategies. The care plan instructed when Resident #2 became agitated, staff should attempt to intervene and redirect him before agitation escalated, guide him away from the source of distress, engage calmly in conversation and if he had an aggressive response, staff should walk calmly away and approach later. The care plan focus area dated 11/9/18 identified a mood deficit related to diagnosis of depression and placement in facility. The care plan directed staff to monitor, record, report to physician as needed risk for harming others (increased anger, labile mood or agitation), if he feels threatened by others or thoughts of harming someone and possession of weapons or objects that could be used as weapons.</p> <p>The Progress Notes dated 10/26/18 at 7:23 a.m. documented the nurse asked to go to the CCDI unit at 2:45 a.m. to help watch Resident #2 along with another nurse because of behaviors. The entry recorded Resident #2 complained/cussed because of a cold room, upset the refrigerator locked, and he wanted something to drink and when staff gave drinks the resident threw the juice at the nurse as not the kind</p>			

Page 4 of 48

Facility Administrator

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	<p>he wanted.</p> <p>The Progress Notes dated 10/27/18 at 1:22 a.m. documented Resident #2 was upset at 3:00 a.m. and the nurse called back to the unit. At 9:52 a.m., at 6:15 a.m. Resident #2 acted agitated due to wanting to smoke and the refrigerator being locked. The entry recorded Resident # 2 threatened staff with foul language, took items off the med cart, shook the drawers to try to open them, tried to go in others' rooms and the office, then got more agitated when told he couldn't go out to smoke because no staff were available to go with him.</p> <p>The Progress Notes dated 10/28/18 at 3:46 a.m. documented Resident #2 became agitated due to the lack of a lighter, cursed, stated someone stole his lighter and threatened assault. The nurse attempted to redirect the resident 3 times and he continued to make comments regarding the lighter. Staff assisted the resident to smoke and he demanded staff return his lighters or he would leave after breaking a window. He then picked up a chair and headed towards the window. Staff removed residents and Resident #2 put the chair down then rammed his shoulder against the outside door. Staff then called the police and Resident #2 transferred to the ER (Emergency Room). Resident #2 said he would rather be on the streets. ER called the facility, stated Resident #2 was alert and oriented in the ER, without signs/symptoms of violence, and they needed to send Resident #2 back as he was a frequent flyer with too many visits too</p>			

Page 5 of 48

Facility Administrator

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	<p>count and this was the best they had ever seen him.</p> <p>The Progress Notes dated 11/2/18 at 2:28 p.m. documented the resident upset and demanding after assisted with smoke breaks at 6:10 a.m., 7:30 a.m., 10:00 a.m., 11:45 a.m., and 12:30 p.m. The entry recorded Resident # 2 agitated the nurse did not go out right that minute for a cigarette and demanded the supervisor be called; while waiting Resident # 2 kicked the doors so staff paged for help and the resident taken out to smoke.</p> <p>The Progress Notes dated 11/2/18 at 4:46 p.m. documented a Plan of Care Note and documented staff reported Resident # 2 had verbal behaviors and would curse/yell at staff when agitated/upset. Staff reported physical behaviors. Resident #2 would threaten staff, threw juice at the nurse, threatened to break a window with a chair, rammed his shoulder into a door of the nurses' station, kicked a door, took items off nurses cart, and shook drawers on the nurses cart to try to open them. Resident # 2 got easily agitated and upset related to the refrigerator in the CCDI unit being locked with increased behaviors when he didn't have cigarettes or couldn't go out to smoke whenever he wanted. The entry recorded Resident # 2 wandered on occasion, paced, and would go into other residents' rooms.</p> <p>The Progress Notes dated 11/15/18 at 2:28 p.m. documented the resident kicked the CCDI unit door open and broke all the cupboard locks in the dining</p>			

Page **6** of **48**

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	<p>area by pulling the doors apart until they broke.</p> <p>The Progress Notes dated 11/15/18 at 10:36 p.m. documented Resident #2 was found in a female resident's room with his head towards her groin area. Staff removed the resident from the area, and called to the DON (Director of Nursing) to ask if they needed to report the event. At 10:57 p.m. staff placed the resident on 15 minute observation checks and then found the resident back in the female resident's room, sitting on the end of her bed.</p> <p>The Progress Notes dated 11/16/18 at 10:51 a.m. documented Resident #2 wanted a razor and therefore he kicked open the locked supply door when staff did not respond to his request fast enough. At 11:30 a.m. the notes recorded staff informed the physician Resident # 2's behaviors involved staff members, other residents, as well as damage of property; an order received to send the resident to the ER due to high risk of injury to self and others. At 12:30 p.m. the notes documented the resident sent to the ER and at 4:50 p.m. noted the resident returned to the facility.</p> <p>The Progress Notes dated 12/3/18 at 3:24 p.m. documented Resident #2 approached another male resident to request salt and pepper and when that resident did not understand, Resident #2 became verbally aggressive and grabbed the salt/pepper from that resident. Resident #2 said told that resident to not act stupid. At 5:57 p.m. Resident #2 refused medication, stating he felt like a prisoner and after</p>			

Page 7 of 48

Facility Administrator

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	<p>being served a plain hamburger. Resident #2 threatened to go to his room to get his boots in order to kick in the door and he told staff he could smoke anytime he wanted, he did not care what the nurse said. Staff responded they needed Resident #2 to wait a bit because they did not have a second person in the unit at the time to take him out.</p> <p>The Progress Notes dated 12/5/18 at 6:32 a.m. documented Resident # 2 had paced since 4:00 a.m. waiting for a cigarette as no staff available to take the resident out to smoke.</p> <p>The Progress Notes dated 12/7/18 at 3:01 p.m. documented the CCDI unit nurse paged to the unit and the ADON (Assistant DON) found another resident lying on the floor with spilled coffee around him and a skin tear. Resident # 2 made contact with the other resident, resulting in a fall. Resident # 2 said he wanted in to the other room to make a phone call and the other resident stood in the doorway so he asked him to move but he didn't move. Resident # 2 said he didn't push him, he moved him, and would never push another man. The entry documented Resident # 2 placed on 15 minute checks. At 3:06 p.m., another nurse documented Resident # 2 had approached the nurses station, shoved another resident at the doorway at the same time he told that resident to get out of his way as he wanted to call his sister.</p> <p>The Progress Notes dated 12/7/18 at 11:06 p.m. documented Resident # 2 yelled at another resident</p>			

Page 8 of 48

Facility Administrator

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	<p>about the TV remote.</p> <p>The Progress Notes dated 12/11/18 at 5:47 p.m. documented Resident # 2 left the dining room stating he wanted the boss called to get some decent food. When staff informed him the boss had gone for the day, Resident # 2 said he would kick the door in and pack his stuff up to go back to the streets. Staff called the Administrator at home and instructed kitchen staff to cook what Resident # 2 agreed to. Resident # 2 responded that he didn't want that, yelled, appeared threatening in his approach in the dining room and upsetting other residents, so staff asked Resident # 2 to leave the room with the writer, which he did.</p> <p>The late entry Progress Notes dated 12/14/18 at 8:10 a.m., created by the MDS Coordinator, documented upon the MDS Coordinator's arrival to the facility at 5:00 p.m. Resident # 2 was found standing in front of the TV in the West dining area of the facility yelling about the food being the same for 4 days. The MDS Coordinator approached the aide standing next to Resident # 2 to ask why he was out of the unit to which the CNA responded to ask his nurse. The charge nurse in the CCDI unit attempted to call the on-call staff. The MDS Coordinator walked the resident back to the CCDI unit and Resident # 2 stated he would pack his bags to get out of the place. The MDS Coordinator went back to the Assisted Living (AL) side of the facility and 20 minutes later, staff called to inform her Resident # 2 refused his medications and wanted to smoke; she instructed them to take the</p>			

Page **9** of **48**

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	<p>resident to smoke. Twenty minutes after that, staff reported Resident # 2 kicked open the CCDI door again and headed out the front door with a CNA following behind. Staff called the police to assist in redirecting Resident # 2 back to the facility and into the CCDI unit.</p> <p>The Progress Notes dated 12/14/18 at 1:27 p.m. recorded Resident # 2 with increased agitation when another resident wore his socks and with increased anxiety when another resident wandered into his bathroom. At 5:31 p.m. Resident # 2 went to the dining area and wanted some 'real food'. Resident # 2 cursed and walked straight to the CCDI unit door, kicked it open and stated staff couldn't keep him there, he was leaving. Resident #2 went and told the kitchen staff they had served that food for 4 days but he refused any substitutes. Management staff walked him back to the unit where he packed his belongings. At 9:53 p.m. the notes documented that at 6:05 p.m. Resident # 2 knocked open the CCDI unit door again and a CNA escorted him to the main entrance of the building and called police.</p> <p>The Progress Notes dated 12/16/18 at 5:30 a.m. documented Resident # 2 yelled at another resident who watched TV in the activity room. Resident #2 complained that resident didn't know what he was doing and needed to stop messing with the TV. Resident # 2's behaviors came out of nowhere; he scolded a wandering resident and had unpredictable behavior, hard to redirect. At 9:17 p.m. Resident # 2</p>			

Page 10 of 48

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	<p>told the night nurse he would kick the door in that night so she would have paperwork. The entry recorded Resident #2 then calmed to take his medications but escalated within a few seconds to yell at a resident watching TV. The felt anxious and afraid of Resident # 2's unpredictability and potential for violence, so she called the DON to report and the DON reshuffled staff to ensure the nurse was not alone with Resident # 2 after 8:30 pm.</p> <p>The Progress Notes dated 12/19/18 at 7:19 a.m. documented Resident # 2 wanted to smoke at 6:30 but staff informed him they had no lighter as the resident had it in his room from another staff member. The note recorded the resident laughed at staff and denied having the lighter but when he realized he couldn't go to smoke he obtained the lighter from his room.</p> <p>The Progress Notes dated 12/21/18 at 8:53 p.m. documented Resident # 2 ran out of his room into the commons area and yelled at 2 residents in the TV room; the nurse noted Resident # 2's behavior as very unpredictable. At 9:23 p.m. Resident # 2 again yelled at 2 residents watching TV telling them they should be in bed and stop messing with the TV.</p> <p>The Progress Notes dated 12/22/18 at 9:26 p.m. documented Resident # 2 screamed at another resident who accidentally entered his room then he wanted to go smoke. When staff couldn't go right away, Resident # 2 became upset and screamed at the ladies sitting in the hallway and upon returning</p>			

Page 11 of 48

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	<p>from a smoke break went to a room looking for 'that idiot'.</p> <p>The Progress Notes dated 12/23/18 at 3:40 p.m. documented Resident # 2 walked in the hallway when another resident with an episode of increased agitation yelled inappropriate language to him at which time Resident # 2 called the resident a crazy b**** and staff redirected him away. At 7:47 p.m. Resident # 2 appeared cocky and strutted arrogantly in the hallway scaring female residents (#47 and #33), by saying 'Boo' in their faces and then yelled at another resident (#24) for messing with the TV.</p> <p>The Progress Notes dated 12/26/18 at 9:59 p.m. documented Resident # 2 exhibited increased agitation toward another resident yelling and getting in the other resident's face to tell him to stay out of his room and to stop messing with the TV.</p> <p>The Progress Notes dated 12/28/18 at 2:42 p.m. documented a late entry for 12/22/18. The entry recorded a CNA reported after breakfast Resident # 2 walked past another resident and smacked them on the bottom. The other resident swung at Resident # 2 and hit him in the left shoulder. Staff separated both residents immediately and noted no injuries.</p> <p>The Progress Notes dated 12/29/18 at 2:50 a.m. documented Resident # 2 had 2 unpleasant interactions with Resident #24 about the TV. The entry recorded Resident # 2 as difficult to redirect.</p>			

Page 12 of 48

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	<p>The Progress Notes dated 12/30/18 at 4:14 a.m. documented Resident # 2 had 3 episodes of using abusive language towards Resident #24 early in the shift when Resident # 2 called Resident #24 names and told him to stop messing with the TV. The nurse intervened with limited success.</p> <p>The Progress Notes dated 1/2/19 at 2:03 a.m. documented Resident # 2 called Resident #24 an idiot at snack time and said the resident would have a bowel movement (BM) all over the place.</p> <p>The late entry Progress Notes dated 1/2/19 at 8:14 a.m. documented Resident # 2 refused his meds and wanted to smoke. Resident # 2 pushed past the nurse cursing and stating, he could do whatever he wanted at the facility, could smoke whenever he wanted and staff couldn't stop him or tell him what to do. Resident # 2 went into the nurses office, threw a side table down the hall and grabbed his cigarettes and lighter. Staff I, CNA, took him out to smoke. Resident # 2 refused to return the lighter and stated he didn't mind going back to jail because the food better and he hadn't eaten in 3 days, and that he could do what he wanted because the state paid for him to stay at the facility. The nurse contacted the Administrator who informed staff the resident was no longer allowed to light his own cigarettes and staff must maintain possession of the lighter and keep the nursing office door closed at all times.</p>			

Page 13 of 48

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	<p>The Progress Notes dated 1/4/19 at 10:45 p.m., created by the MDS Coordinator, documented at approximately 8:15 p.m. she spoke with another staff member on the phone while Resident # 2 stood 2.5 feet behind her asking to go smoke in a loud voice. The MDS Coordinator informed Resident # 2 she was the only staff member in the unit and no one could take him outside. Resident # 2 yelled he wanted to go f***ing smoke and they better get staff back here to take me. The MDS Coordinator locked the medication cart, went into the nurses station, and shut the door. The MDS Coordinator documented she was not going to cater to Resident # 2's temper tantrum. The MDS Coordinator documented Resident # 2 ripped the computer from the wall plug, threw it down the hallway, and cleared the medication cart of every single item on it. The MDS Coordinator called 911 then a code red for help and a nurse from the west side of the facility arrived within a few minutes to find Resident # 2 standing up against the railing and within 2 more minutes, the police arrived. The MDS Coordinator informed the Administrator and then police and EMS (Emergency Medical Services) who escorted the resident from the premises.</p> <p>The Progress Notes dated 2/19/19 at 2:05 p.m. documented Resident # 2 returned to the facility via a taxi service, he recognized staff and greeted them accordingly. At 3:25 p.m. the resident recognized all management staff and made jokes about the gang being back together and he already broke the rules.</p>			

Page 14 of 48

Facility Administrator

Date

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**Health Facilities Division**  
**Citation**

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	<p>The Progress Notes dated 2/21/19 at 5:03 a.m. documented Resident # 2 wanted a smoke and repeated 4 times he needed a smoke to go back to sleep. The nurse re-educated Resident # 2 of the signed rules to which Resident # 2 started to pace the halls stating, take me back to the hospital, you better call somebody. The nurse attempted to give as needed anxiety medication but Resident # 2 refused and pulled on the main door. The note documented after an inability to open the door, Resident # 2 sat down and finally relented.</p> <p>The Progress Notes dated 2/24/19 at 1:00 a.m. documented staff educated Resident # 2 after he jumped around in hallway in front of others yelling, Hi-Ya, and kicking his leg and waving his arms. Resident # 2 said he was just showing them his karate moves and repeated his actions in front of the nurse. They educated Resident # 2 on inappropriate behavior. At 12:57 p.m. Resident # 2 continued 15 with minute checks and he had been very demanding that day. Resident # 2 waved a paper in a female resident's face and antagonizing her. When staff attempted to redirect him, Resident # 2 was slow to respond and stared at that person in a defiant manner.</p> <p>The Progress Notes dated 2/25/19 at 6:49 p.m., created by Staff G, LPN (Licensed Practical Nurse) documented she received report Resident # 2 sought out staff to take him to smoke and was agitated he couldn't go; he had a smoking schedule to follow. Staff G documented Resident # 2 was in the TV lounge,</p>			

Page 15 of 48

Facility Administrator

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	<p>smacked a resident in the left temple of face, then went down CCDI hallway, smacked another resident on the buttocks and then ducked aside in another residents room. The nurse immediately notified the management team of the behavior/incidents, police arrived at 1:15 p.m. and Resident #2 transferred to the hospital.</p> <p>Review of the clinical record revealed Resident #2 on continual 15 minute observation checks from 10/29/18 through 2/25/19.</p> <p>Observations:</p> <p>Observation on 2/25/19 at 11:57 a.m. revealed Resident # 2 requested Staff K, Certified Nurse Aide (CNA) to take him out to smoke then shower. Staff K informed Resident # 2 the next smoke break would be at 1:00 p.m., asked him to shower and have lunch and then it would be almost time for his smoke break. Resident # 2 demanded Staff K call the director to report he couldn't go out to smoke. Staff K informed the resident she would call but had something to do right that moment. Resident # 2 became angry and stated he was going out to smoke and Staff K better call the director right then. Staff K responded she would call but the director in a meeting at that time and would just tell him the same thing.</p> <p>Observation on 2/25/19 at 12:04 p.m. revealed Staff C, Certified Medication Aide (CMA) took 3 other residents out the CCDI unit doors to the East hallway. Resident</p>			

Page 16 of 48

Facility Administrator

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	<p># 2 stood at the medication cart by the door and got in line behind the others to leave. Staff K blocked the entrance when Resident # 2 attempted to walk through with the others. Staff K held onto both doors as Resident # 2 pushed against her. Staff K continued to hold the doors and Resident # 2 increased his agitation. The Admissions Coordinator intervened at the door and told Staff K to let Resident #2 through and then walked with Resident # 2 hand in hand to the front offices. The DON and the Admissions Coordinator walked with the resident back to the CCDI unit. The DON was able to keep the resident calm and approached him gently; joking lightly with the resident. Resident # 2 allowed the DON to tie his shoes once on the unit and discussed smoking times. Resident # 2 interacted well with the DON. Resident #2 agreed to the 1:00 p.m. smoke time and shower and the DON encouraged him to take off his coat. As Resident # 2 took off his coat, he repeated shower-smoke, shower-smoke, then Resident # 2 said he wanted to smoke now. The DON had to continue to interact with the resident to redirect him away from the topic of smoking. The Admissions Coordinator accompanied the DON and Resident # 2 back to his room with encouragement to lay down for a while.</p> <p>Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV room by the nurse's station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch; I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20.</p>			

Page 17 of 48

Facility Administrator

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	<p>Resident #47 turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management help in the unit immediately.</p> <p>Staff Interviews revealed the following information:</p> <p>On 2/25/19 at 11:53 a.m., the Activities Assistant stated Resident #2's current condition was about the same as before he left the unit to the hospital. The Activities Assistant confirmed the resident lived in the facility since approximately October of 2018. The Activities Assistant commented that residents seemed intimidated by Resident # 2.</p> <p>On 2/25/19 at 11:59 a.m., Staff K stated she did not know the resident's previous level of functioning as she was new to the facility and only worked her third orientation day. Staff K was not working on her own yet.</p> <p>On 2/25/19 at 2:11 p.m., the Administrator and the owner reported a police officer was in the building and would be escorting Resident # 2 to the hospital as they were actively initiating an involuntary discharge related to resident safety. The Administrator and owner reported they were forced by the Administrative Law Judge (ALJ) to take the resident back from the hospital</p>			

Page 18 of 48

Facility Administrator

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	<p>2/19/19. They stated the ALJ informed them they provided the wrong language in the Emergency Involuntary Discharge notice they gave upon discharge in January (1/4/19). They didn't want to take the resident back but they had to follow the judge's order.</p> <p>In an interview on 2/25/19 at 2:55 p.m., Staff G, LPN, responded she assessed Resident #47 and she did not have any marks (2/25/19). Staff G responded Resident # 47 recalled what happened and stated feeling scared of Resident #2. Staff G didn't think Resident #2 had been gone long enough for the residents to get him out of their heads (when he left 1/4/19). Staff G said Resident #47 stated she always walked on the far side of the hall because she had to look out for Resident #2. At 3:25 p.m., Staff G stated she thought Resident # 2's behaviors for that day were set off by his desire to go out and smoke. Staff G stated she was a rule follower and told Resident # 2 he had to wait until the scheduled smoke time of 1:00 p.m. to go out. When the resident first came to the facility he was more aware of the exits and of the other residents' disabilities which frustrated him. Staff G felt Resident # 2 did not understand mentally why the other residents were confused due to their cognitive declines. Staff G gave the example when a resident would be exit seeking, Resident # 2 informed the exit seeker there was a back door and he would take them to the door to try to help them out. On 2/26/19 at 7:46 a.m., Staff G reported the residents were much calmer than the day before. Their anxiety level were way down since Resident #2 left the night before versus</p>			

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	<p>when Resident #2 resided on the unit. Staff G thought the residents were aware Resident #2 had gone and thought they had been hesitant to even sit next to Resident #2 for fear he would bully them.</p> <p>On 2/26/19 at 8:00 a.m., Staff L, CNA, stated she had worked for the facility for 3 years. The residents acted more calm that day and she felt they knew when Resident # 2 was on and off the unit. Staff L stated Resident #33 acted scared of Resident # 2; she felt Resident # 2 knew it and focused in on Resident #33's fear. Resident #2 always had behaviors since his admission in October 2018. Staff tried to redirect Resident # 2 to the TV room or to play checkers but activities did not divert Resident # 2. Resident # 2 would get into the residents' personal spaces, especially Resident #33. Resident # 2 would get into Resident #33's face, wave his arms around, and when Resident #33 tried to walk away with staff, Resident # 2 followed them and continued to antagonize the residents. Staff L thought Resident # 2 knew what he was doing when he intimidated the other residents and it was possible the resident did things to other residents that staff were unaware of when they weren't looking due to being a full watch hall. Staff L explained a full watch hall meant they were constantly going up and down the halls to observe everything going on, so if they went down the hall one way and Resident # 2 went the other way, it would be possible for Resident # 2 to have interactions with other residents without her being aware of it.</p>			

Page **20** of **48**

Facility Administrator

Date

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	<p>In an interview on 2/26/19 at 8:45 a.m., the Activities Assistant responded she was in charge of activities in the CCDI unit and out in the main facility. The Activities Assistant stated she did some activities on the unit but tried to gather residents from the CCDI unit and take them out to the main facility to join activities. The Activities Assistant stated she provided some supervision when present on the unit but she had no set times scheduled there.</p> <p>On 2/26/19 at 2:25 p.m., the DON discussed her summary of what the facility did to increase supervision of Resident #2 after signs of aggression and resident-to-resident altercations occurred. The DON said for the incident of resident-to-resident contact between Resident # 2 and Resident # 55 that occurred on 12/7/18, they increased to 15 minute checks, the doctor evaluated Resident # 2 on 12/13/19 and changed medications. The DON stated for the incident of resident-to-resident contact between Resident # 2 and Resident # 47 that occurred on 12/22/18, they did not become aware of the incident until 12/28/18. The DON said at that time they notified the DIA (Department of Inspections and Appeals), disciplined a charge nurse for not reporting immediately and placed Resident #2 on 15 minute checks; when 15 minute observation checks were initiated, they conducted them for 72 hours, but if the behaviors continued they would put a resident back on the checks. The DON had Resident #2 sign a contract agreement to acknowledge the expectation that all residents keep their hands to themselves, residents</p>			

Page 21 of 48

Facility Administrator

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	<p>cannot pinch, slap, grab, or make contact with another resident in any other manner, it was not a joke, it was not funny, and it was not allowed. The DON confirmed the resident a BIMS score of 3 but they still presented the contract as they felt he was aware of his actions. When the facility accepted Resident # 2 back the second time 2/19/19, they did not get any information about him needing to be held down in the hospital for injections or that he had been moved units due to some sexual interactions. The DON stated they did not receive that information until approximately 2 days after the resident returned to the facility. The DON stated when Administrative Law Judge (ALJ) ruled they must take Resident # 2 back on 2/19/19, they decided to place him on 15 minute checks indefinitely. The DON reported the facility called the police who witnessed the resident's sister receiving notification of an Emergency Involuntary Discharge notice and then the police officer escorted the ambulance to the hospital to deliver the paperwork to the hospital 2/25/19.</p> <p>In an interview on 2/26/19 at 4:00 p.m., the DON responded the staff on the unit responsible for completing the 15 minute observation checks and confirmed no additional staff had been put back in the unit to assist with 15 minute checks.</p> <p>In an interview on 2/27/19 at 11:00 a.m., Staff N, CNA/Scheduler stated she knew of 2 residents on the unit who showed they were bothered by Resident # 2: Resident #47 and Resident #33. Staff N stated she</p>			

Page 22 of 48

Facility Administrator

Date

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	<p>had not received a directive to staff 2 staff members on the CCDI unit until Resident # 2 returned to the facility on 2/19/19. Staff N said she received instruction to start staffing 2 staff persons on the CCDI unit during the waking hours of 6:00 a.m. to 9:00 p.m. when Resident # 2 returned. Staff N confirmed she had not made any staffing changes to the amount of help assigned to the unit at any time before 2/19. If the facility had a float on the overnight shift, the float staff would go back to unit to give staff a break or supervise a resident to smoke. In reference to the previous months, Staff N stated they sometimes staffed a nurse or CNA, or both on the 6:00 a.m. to 2:00 p.m. (dayshift) and the 2:00 p.m. to 10:00 p.m. (afternoon shift), but always staffed just one staff member 10:00 p.m. to 6:00 a.m. (overnight shift). There were times Resident # 2 did well on the unit and she was not made by the DON to staff 2 during the second shifts. Staff N acknowledged difficulties filling the shifts as they only had 3 regular full time CNAs for the second shift; the facility did not use temporary staffing agencies. Staff N stated she was also on the on-call schedule and worked the floor as a CNA.</p> <p>In an interview on 2/27/19 at 11:30 a.m., Staff E, LPN, stated she worked for the facility for 5 years but did not work back on the unit often. At the time of the interview, Staff E worked as the charge nurse on the CCDI unit. Staff E had only worked with Resident # 2 one time but she had heard staff report every day that Resident # 2 tried to intimidate staff and residents with weird noises, kicking doors, and hitting people. Staff E</p>			

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	<p>responded they usually just staffed 2 people on the CCDI unit even when a resident exhibited behaviors.</p> <p>In an interview on 2/27/19 at 11:40 a.m., Staff J, CNA, responded she did not work back on the CCDI unit often. Staff J acknowledged she was familiar with Resident # 2 and he had always displayed behaviors.</p> <p>2. The MDS assessment dated 11/9/18 for Resident #47 identified BIMS score of 3 without signs/symptoms of delirium. The MDS documented the resident exhibited no behavioral symptoms during the 7-day look back period. The Resident #47 transferred and walked in her room independently and required supervision while walking in the corridor and with locomotion on her living unit. The MDS documented diagnoses that included Alzheimer's disease, Non-Alzheimer's dementia, depression, and schizoaffective disorder.</p> <p>The care plan focus area dated 11/12/18 identified an ADL (Activities of Daily Living) self-care deficit related to diagnoses of dementia, schizoaffective disorder, depression, and debility. The care plan intervention revised 11/12/18 informed staff the resident transferred independently.</p> <p>The care plan focus area dated 11/12/18 identified the resident wandered and resided on the CCDI (Chronic Confusion Dementing Illness) unit related to dementia. The care plan identified impaired cognitive function/impaired thought processes and the resident usually understood related to diagnosis of dementia.</p>			

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	<p>Incident 1:</p> <p>The Progress Notes dated 11/15/18 at 10:30 p.m., written by Staff H, Licensed Practical Nurse (LPN), documented an incident at 10:20 p.m. another resident was not seated in the TV room and not found in their own room. Staff searched for the resident (#2) and found him in Resident #47's room, sitting at the end of her bed and leaning over towards her groin area. Staff reported Resident #47 did not have any blankets on her, but was clothed as when put to bed. Staff removed the other resident from Resident #47's room and Staff H contacted the DON to report the incident. Staff H put both residents on 15 minutes checks and the DON planned to call the Administrator and call Staff H back. At 10:50 p.m. Staff H received a call from the DON who instructed her to monitor both residents and talk with Resident #47 to see if the other resident had touched her inappropriately and then call the DON back if the resident stated she was touched inappropriately. At 10:55 p.m. as soon as the call ended with the DON, staff called from the CCDI unit to report to Staff H the other resident had entered Resident #47's room a second time when staff went into another resident's room to provide assistance. Staff called the DON who instructed they put a second staff member in the CCDI unit and continue 15 minute checks on both residents. Staff H and another staff member asked Resident #47 if she had been touched inappropriately or if she remembered another resident entering her room twice; Resident #47 said she knew</p>			

Page 25 of 48

Facility Administrator

Date

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	<p>the other resident came in twice, she told him to get out of there, and he did not touch her inappropriately but did rub her arms to wake her up. The entry documented staff visually assessed Resident #47 visually assessed and no injuries or issues noted.</p> <p>The Progress Notes dated 11/15/18 at 11:00 p.m. documented 2 staff members in the CCDI unit and monitoring residents and 15 minute checks would continue on Resident #47 and the other resident for safety precautions.</p> <p>The clinical record lacked documentation of an incident report for the occurrence.</p> <p>On 2/28/19 at 12:50 p.m., the Administrator provided a summary of the resident-to-resident interaction that occurred on 11/15/18 between Resident #2 and Resident #47. The Administrator confirmed the facility did not conduct or document any staff interviews or formal investigation of the incident. The Administrator confirmed the term 'other resident' in Resident #47's progress notes dated 11/15/18 referred to Resident #2. They concluded that no inappropriate contact had been made between the residents based on a verbal, informal, undocumented investigation with staff members.</p> <p>The undated, unsigned facility investigation titled, Investigation of Incident on 11/15/18 regarding Resident #2 and Resident #47 documented the following:</p>			

Page **26** of **48**

Facility Administrator

Date

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	<p>On 11/15/18 at approximately 10:20 p.m., Resident #2 and Resident #47 seen sitting at the end of Resident #47's bed. It was reported that Resident #2's head was in the direction of Resident #47's groin area. Staff H reported the observation to the DON at 10:30 p.m. and the DON reported the observation to the Administrator. Both residents were fully clothed and Resident #2 seen in the TV room at approximately 10:10 p.m. according to staff. Resident #47 denied Resident #2 touched her inappropriately or in a sexual manner. Resident #47 stated Resident #2 just rubbed her arms to wake her up. Both residents placed on 15 minute checks and an additional staff member brought to the CCDI unit for supervision. It was determined that no inappropriate or sexual touching occurred.</p> <p>In an interview on 3/4/19 at 8:50 a.m., the Administrator confirmed no incident report had been created for the contact made between Resident #47 and Resident #2 on 11/15/18.</p> <p>On 3/4/19 at 9:00 a.m., Staff H stated she had worked for the facility approximately a year before quitting in 11/18. Staff H recalled working the night of 11/15/18 and assigned to the East hall with also covering the CCDI unit if they needed help. Staff H reported the unit only staffed with a med aide or CNA usually. Staff H stated Staff M, CNA, reported to her Resident #2 was found in Resident #47's room in a compromising position; Staff M reported Resident #47 laid in bed dressed with her legs spread open, Resident #2 sat on the end of the bed leaning down towards Resident</p>			

Page **27** of **48**

Facility Administrator

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**Health Facilities Division**  
**Citation**

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Facility Address/City/State/Zip: <b>680 Cole Street Carlisle, IA 50047</b>		<b>MW/SS</b>		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	<p>#47's groin but not touching. Staff H said she called the DON immediately to report and she quit partly due to not feeling management responded appropriately. Staff H felt management did not take the report seriously as she felt it should be reported to the state within 2 hours. Staff H felt they needed extra staff in the unit due to Resident #2's unpredictable and violent behaviors. Staff H reported to the management they needed more staff and their response would be they would put 2 staff members on the unit, but they never followed through with 2 staff members on the unit. When Staff H worked in the unit she felt very nervous and scared of Resident #2. Staff H stated she did not feel educated on how to deal with Resident #2's violent behaviors and did not feel his placement appropriate in the dementia unit. Staff H knew of another incident where the staff had to yell at all other residents to get back to their rooms and out of the hallway while Resident #2 threw chairs; she feared for the safety of the residents. Staff H wrote a statement about the incident that occurred 11/15/18 as did Staff M and they slid the statements under the DON's office door that night. Staff H said after that, she never heard back from management and no one asked her for an interview about the incident.</p> <p>On 3/4/19 at 9:20 a.m., the DON confirmed both Staff H and Staff M no longer worked for the facility. The DON acknowledged both Staff H and Staff M wrote witness statements from the night of 11/15/18 but she could not locate them.</p>			

Page **28** of **48**

Facility Administrator

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	<p>Incident 2:</p> <p>The Progress Notes dated 12/22/18 at 8:10 p.m. and 11:22 p.m. documented Resident #47 received acetaminophen (Tylenol) for right arm pain, noted as effective on follow-up. The Progress Notes contained no other entries for the date of 12/22/18.</p> <p>The Progress Notes dated 12/28/18 at 2:35 p.m. documented a late entry created by Staff G, LPN. On 12/22/18 a CNA (Certified Nurse Aide) reported Resident #47 in the hallway after breakfast and another resident walked by smacking Resident #47 on the bottom, who in turn, swung at the other resident, hitting them in the left shoulder. Staff separated both residents, noted no injuries and completed skin assessments with no skin issues found.</p> <p>The Progress Notes dated 12/28/18 at 3:32 p.m. documented staff placed a call to Resident #47's guardian to inform them of the incident.</p> <p>The unsigned, typed facility investigation dated 12/28/18, titled Self-Report, documented: On 12/22/18 at approximately 10:00 a.m., Staff I, CNA observed Resident #2 swatted Resident #47 on the backside. Resident #47 slapped Resident #2 on the shoulder and told him not to touch her ever again. Staff I immediately separated the residents. Resident #2 thought his actions were funny and Staff I educated Resident #2 that it was not funny and never appropriate to touch another resident. There was no injury to either resident in relation to this incident. Staff</p>			

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	<p>I immediately reported the incident to Staff G. Staff G reported she thought Resident #47 had a delusion and the incident did not really occur. Resident #2 had a BIMS score of 3, expressive aphasia (difficulty communicating) and difficulty responding to the questions on the BIMS. Resident #2 could address and ask for staff members by name and the BIMS score not a reliable method of determining Resident #2's cognitive status. Staff I reported the incident to the DON and the Administrator at approximately 3:00 p.m. on 12/27/18. The DPOA (Durable Power of Attorney) and physicians for both residents received notice of the incident. Resident #2 continued 15 minute checks and staff observed both residents to keep them separated. Both residents lived in the CCDI unit. Staff G received a written warning on 12/28/18 regarding the reporting of all resident-to-resident contact to the DON or Administrator so that an investigation could be carried out in a timely manner to avoid further incidents. Resident #2 received education that it was not permissible to ever place his hands on another resident. Both resident care plans were reviewed and updated to address this situation.</p> <p>Staff I's witness statement, signed 12/28/18, documented on 12/22/18 after breakfast, she stood outside the dining room in the hallway. Resident #2 leaned up against the wall with his hands behind his back waiting to go smoke and talking to another resident. When Resident #47 walked by Resident #2, he smacked Resident #47's bottom open handed. Resident #47 turned around and smacked Resident #2</p>			

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	<p>on the shoulder open handed and told him not to touch her again. Staff I went down the hall and told Resident #2 he could not do that, to which Resident #2 laughed and replied 'you seen, she hit me'. Staff I took Resident #47 to tell the charge nurse, Staff G. Staff I told Staff G everything that happened as did Resident #47.</p> <p>Incident 3:  Observation on 2/25/19 at 12:45 p.m. revealed Resident #2 walked up the hallway from the TV room by the nurse's station passing Resident #47. A loud slap could be heard and Resident #47 yelled "Ouch, I'm tired of you hitting me". Resident #2 made eye contact with surveyor and quickly walked into room 20. Resident #47 turned and walked back down to the TV room. Another resident (#36) walked up the hall to the nurses station from the TV room at the same time and informed Staff K that Resident #2 just slapped him. The surveyor reported the slap on Resident #47's buttocks immediately to Staff J, CNA, and Staff K. Staff J called for management help in the unit immediately.</p> <p>In an interview on 2/25/19 at 2:55 p.m., Staff G responded she assessed Resident #47 that day and she did not have any marks. Staff G responded Resident #47 did recall what happened and did state being scared of Resident #2. Staff G said she didn't think Resident #2 gone to the hospital long enough for the residents to get him out of their heads. Staff G said Resident #47 stated she always walked on the far</p>			

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	<p>side of the hall because she had to look out for Resident #2.</p> <p>On 2/25/19 at 3:07 p.m. an interview attempted with Resident #47. When asked if she recalled the incident from earlier that day, Resident # 47 said no one had touched her that day, then responded that he comes out of nowhere so she watches where she's going, then she changed topics.</p> <p>The Progress Notes dated 2/25/19 at 4:00 p.m., created by Staff G, recorded the following:</p> <p>It was reported to this nurse that resident ambulated in hallway of CCDI when she let out a yell and said ouch, I'm sick of you touching me, while a loud smack heard. Another resident noted to walk up to this resident and smack her on the buttock. The resident immediately taken to her room, other resident left the hallway entering room 220, and skin assessment completed with no injury noted. Doctor in facility at the time of the incident and made aware with call placed to the DON.</p> <p>3. The admission MDS assessment dated 11/21/18 for Resident #55 documented an admission date of 11/12/18. The MDS identified he had BIMS score of 3 and signs of delirium with fluctuating behavior of disorganized thinking. The MDS recorded the resident exhibited behaviors of delusions and physical and verbal behavioral symptoms directed toward others on 1 to 3 days of the 7-day look back period. The MDS recorded the resident wandered on 4 to 6 days of the 7-day look back period. The MDS revealed the</p>			

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	<p>resident as independent with transfer, walk in his room, and required supervision with walking in corridor and locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia, schizophrenia, and unspecified altered mental status. The MDS coded the use of antipsychotic, antianxiety, and antidepressant medication all on 7 out of 7 days of the assessment reference period.</p> <p>The care plan focus area dated 11/14/18 identified the potential for an ADL (Activities of Daily Living) self-care deficit related to diagnoses of dementia with behavioral disturbances and schizoaffective disorder. The care plan informed staff the resident ambulated independently on the CCDI (dementia) unit.</p> <p>Incident 4:  The Progress Notes dated 12/7/18 at 2:39 p.m., by Staff R, LPN documented as Resident #55 waited for Staff R to take him for a walk, another resident shoved him and he fell backward hitting his right elbow on the wall. Resident #55 sustained a 3 cm (centimeter) U-shaped skin tear to his right elbow. Resident #55 landed on his buttock and spilled his milk, his upper torso went back resting flat on the floor but did not hit his head.</p> <p>The Progress Notes dated 12/7/18 at 2:49 p.m. documented the CCDI nurse paged for assistance with the ADON responding to find Resident #55 on the floor, on his back with legs stretched out, empty coffee cup with spill around him. The entry recorded the</p>			

Page 33 of 48

Facility Administrator

Date

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	<p>resident as very calm, not upset, and stating he must have ran into the wrong one, he guessed. Resident #55 could not voice details of what occurred, but the nurse witnessed another resident push Resident #55 from the doorway, and Resident #55 fell backwards to ground landing on his buttocks. Staff assessed Resident #55's skin tear to the right elbow and provided treatment of steri-strip in place.</p> <p>The undated, unsigned, typed facility investigation titled, Self Report Incident Date 12/7/18 documented that on 12/7/18 at 2:39 p.m. a situation occurred between Resident #55 and Resident #2. Resident #55 stood in front of the nurses station door in the CCDI unit waiting for the nurse to take him for a walk. Resident #2 approached the nurses station door and shoved Resident #55 telling him to get out of his way. Resident #55 lost his balance, fell to the floor, and sustained a 3 cm skin tear to his right elbow.</p> <p>The Progress Notes dated 11/18/18 at 1:39 p.m. documented the resident paced up and down hallway pushing on front door attempting to get out as well as pushing the numbers on the keypad. The resident required redirection to leave another resident's room and although visibly upset, could be redirected to the hallway. A family member of another resident reported they redirected the resident out of their room 4 times in order to visit with their loved one. Resident #55 then went back to front door and attempted to push on it and when the nurse tried to redirect, he started to get loud telling the nurse to, shut up and cursed at her.</p>			

Page 34 of 48

Facility Administrator

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	<p>The nurse attempted to redirect the resident back to his room as other residents present but he refused stating he would go where he pleased. Another charge nurse spoke to him about calling his wife, walked him to the TV room to talk to him about his phone call, and engaged him in conversation. At 3:12 p.m. the resident paced the halls, hit doors, packed his suitcase, and carried it around. Staff attempted to redirect and distract with TV, food, fluids, cards, picture albums, conversation, and phoned his wife, but escalated and started to get physical. The note recorded the resident received as needed Ativan and he slowly started to calm down.</p> <p>4. The admission MDS assessment dated 1/16/19 for Resident #36 identified a BIMS score of 4 without signs/symptoms of delirium; a score of 4 indicated severe cognitive impairment. The MDS documented the resident exhibited wandering behavior on 1 to 3 days of the 7-day look back assessment reference period. The MDS revealed the resident independent with bed mobility, transfers and walking in his room, and required supervision to walk in the corridor and during locomotion on the unit. The MDS documented diagnoses that included Non-Alzheimer's dementia and unspecified dementia without behavioral disturbance.</p> <p>The care plan focus area dated 1/17/19 identified the resident wandered into other residents' rooms and resided on the CCDI unit related to diagnosis of dementia. The care plan identified a behavior deficit</p>			

Page 35 of 48

Facility Administrator

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	<p>related to making inappropriate comments towards others.</p> <p>Incident 5: Observation on 2/25/19 at 12:45 p.m. revealed Resident # 2 walked up the hallway from the TV room by the nurses station and quickly into room 20 after hitting Resident #47. Resident #36 walked up the hall to the nurses station from the TV room at the same time and reported to Staff K that Resident #2 just slapped him. Staff J, CNA, and Staff K called for management help to the unit immediately.</p> <p>The Progress Notes created 2/25/19 at 6:06 p.m. by Staff G, LPN, documented the nurse notified at 12:40 p.m. Resident #36 reported sitting in TV lounge on couch when another resident come up to him and hit him in the left side of the face Resident #36 stated he didn't do anything and had never seen the other resident before. Initial assessment revealed Resident #36 had a red mark on the left temple and the area faded and was no longer present at the time she wrote the entry: 6:06 p.m.</p> <p>5. The MDS assessment dated 1/11/19 for Resident #33 identified a BIMS score of 6 without signs/symptoms of delirium, indicating severe cognitive impairment. The resident exhibited wandering behavior during 1 to 3 days of the assessment reference period. The resident was independent with transfers and required supervision while walking in her room, in the corridor, and during locomotion on the</p>			

Page 36 of 48

Facility Administrator

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	<p>unit.</p> <p>The care plan focus area dated 1/14/19 identified an elopement risk/wanderer and informed the resident resided on the CCDI unit.</p> <p>In an interview on 2/26/19 at 8:00 a.m., Staff L, CNA, stated Resident #33 was scared of Resident # 2 and she felt Resident # 2 knew it and focused in on Resident #33's fear. Resident # 2 would get into the residents' personal spaces, especially Resident #33. Resident # 2 would get into Resident #33's face, wave his arms around, and when Resident #33 tried to walk away with staff, Resident # 2 followed them and continued to antagonize the residents.</p> <p>In an interview on 2/26/19 at 2:25 p.m., the DON confirmed Resident # 2 antagonized Resident # 33.</p> <p>In an interview on 2/27/19 at 11:00 a.m., Staff N, CNA/Scheduler, responded she knew of 2 residents on the unit who showed they were bothered by Resident # 2; Resident #47 and Resident #33. Staff N stated she had not been given a directive to staff 2 staff members on the CCDI unit until Resident # 2 returned to the facility on 2/19/19.</p> <p>The above situations resulted in an Immediate Jeopardy (IJ) situation for facility residents from 12/7/18 until 2/27/19 when staff abated the IJ situation. The facility abated the IJ situation through system changes and education which included:</p> <p>a. Immediate identification of resident aggressive</p>			

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	<p>behaviors and implementation of direct supervision.</p> <p>b. Continued direct supervision until aggressive resident(s) are no longer a threat to other residents.</p> <p>c. Continued observation and assessment of affected residents.</p> <p>d. Communication with the affected residents' primary care providers.</p> <p>e. Behavior resolution meetings by facility staff to develop interventions for future actions.</p> <p>f. All staff education of the actions listed above.</p> <p>6. The MDS assessment dated 1/1/19 for Resident #25 identified a BIMS score of 15 without signs/symptoms of delirium; a score of 15 indicated intact memory and cognition. The resident required the assistance of 2 with bed mobility, transfers and personal hygiene, and did not walk in room or corridor during the assessment reference period. During surface to surface transfers, the resident was unsteady and able to stabilize only with staff assistance. The MDS documented diagnoses that included diabetes mellitus, cerebrovascular accident (CVA), hemiplegia (weakness on 1/2 of the body), and acute kidney failure. The MDS recorded the resident weighed 296 pounds.</p> <p>The care plan focus area dated 1/6/19 identified an ADL self-performance deficit related to diagnoses of left cerebral with right hemiplegia, OA (osteoarthritis), and amputation of the right great toe. The care plan directed staff to provide assistance of 2 persons with lateral scoot transfer to get into the wheelchair; may</p>			

Page 38 of 48

Facility Administrator

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	<p>use the mechanical lift (Hoyer) for dialysis. The care plan revision dated 3/6/19 identified the resident's transfer status had changed to a mechanical lift with assistance of 2 persons. The care plan focus area dated 1/6/19 identified a potential for falls related to left cerebral stroke with right hemiplegia, debility, poor balance, and need for assistive devices. The care revision dated 3/5/19 identified a current fracture of the right distal femur. The care plan focus area initiated 3/5/19 identified acute pain related to recent fracture of the right distal femur and informed staff the resident used as needed narcotic pain medication.</p> <p>The Care Card updated 9/12/18 documented under Transfer: Lateral scoot support with assist times 2 (persons), may use mechanical lift with assist x2 for dialysis.</p> <p>The Progress Notes dated 2/22/19 at 6:16 p.m., created by Staff B, LPN, documented a CNA called Staff B to the resident's room and Resident # 25 was found on the floor. Staff B documented Resident # 25 laid on his side on the floor between his bed and dresser and denied hitting his head but stated he hit his right knee. Staff B assessed the resident, who had intact skin to his right knee with no bruising present and ROM (range of motion) WNL (within normal limits). Staff B documented the CNA reported the resident told him he could stand up by himself while the CNA made his bed and Resident # 25 admitted saying that. Staff B educated the resident and CNA on the resident's transfer needs of the Hoyer at all times and both</p>			

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	<p>voiced understanding. Staff B recorded education given to the resident to not tell staff he could stand and to the CNA on following the care plan.</p> <p>The Progress Notes dated 2/22/19 at 10:24 p.m. documented acetaminophen (Tylenol) pain medication 650 mg (milligrams) given as needed for knee pain rated a 10 out of 10. At 10:57 p.m. documented the resident refused all scheduled medications, complained of knee pain from recent fall, offered as needed Tylenol, but first refused as he wanted a pain pill. The note recorded the nurse informed him Tylenol was all they had available to give and the resident accepted the Tylenol. At 10:59 p.m. staff documented the Tylenol as effective with a follow up pain rating of 1 (on a scale of 10).</p> <p>The Progress Notes dated 2/23/19 at 1:34 p.m. documented Resident # 25 complained of tenderness to the right knee, ROM WNL, just slow to move the right knee, and with no discolored areas or swelling found. At 8:44 p.m. Resident # 25 received Tylenol 650 mg as needed for pain rated 10 out of 10. At 9:30 p.m. staff documented the Tylenol as effective with a follow up rating of 6 out of 10. At 10:31 p.m. Resident # 25 complained of right knee pain and requested Tylenol with little effect.</p> <p>The Progress Notes dated 2/24/19 at 1:01 p.m. documented Resident # 25 requested help to sit up on the edge of the bed and reported his knee felt tender from the fall. Resident # 25 stated he had arthritis in</p>			

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	<p>that knee and it gave him fits. Staff noted no increased swelling or discoloration to the knee.</p> <p>The Progress Notes dated 2/25/19 at 6:15 a.m. documented staff sent a fax (facsimile) to the physician to request an order for a right knee X-ray due to the resident's fall and complaints of pain and discomfort. At 1:03 p.m. the fax returned with no new orders but direction to continue to monitor per fall protocol. At 5:57 p.m. the notes documented Resident # 25 complained of knee discomfort with no swelling or discoloration present.</p> <p>The fax dated 3/3/19 documented the resident had a fall approximately 2 weeks prior during cares and that night complained of terrible right knee pain, stating he had pain for 2 weeks and not getting any better and asked for physician to advise. The signed physician response ordered an X-ray of the right knee and PT/OT (Physical Therapy/Occupational Therapy) evaluation.</p> <p>The Patient Report dated 3/4/19 documented the results of the right knee X-ray with recorded findings of an impacted mildly displaced transversely (diagonally) oriented fracture through the distal femoral metaphysis (area of the leg just above the knee joint).</p> <p>The Progress Notes dated 3/5/19 at 1:20 p.m. documented the results of the X-ray received with possible fracture found, the physician contacted, and staff to follow up with the physician in the morning.</p>			

Page 41 of 48

Facility Administrator

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	<p>With assessment, the resident made no complaints of pain but he complained of tenderness to both knees and denied the need for pain medication. The note documented no edema, redness, or bruising observed.</p> <p>The Progress Notes dated 3/5/19 at 6:18 a.m. documented the resident left for dialysis.</p> <p>At 9:53 a.m. the physician reviewed the X-ray results and ordered the resident be sent immediately to the orthopedic urgent care. At 4:00 p.m. staff documented the resident returned to the facility with a knee brace and orders to recheck and X-ray in 2 weeks and follow up with the physician in 4 weeks. At 4:41 p.m. staff documented the resident wore a right knee brace, transferred to bed via Hoyer, complained of pain with transfer, and after settled in bed the CNAs reported the resident complained of discomfort. At 5:08 p.m. the notes recorded a new order received for narcotic pain medication. At 5:26 p.m. notes documented the resident reported pain when moving, and the nurse administered an as-needed dose of the narcotic pain medication Norco.</p> <p>On 3/5/19 at 3:45 p.m., Staff T, LPN, reported the resident was out of the facility being seen in the orthopedic urgent care. Staff T stated an X-ray came back the night before and it confirmed a fracture in the resident's leg. Staff T stated early in the morning the resident went to his dialysis appointment and then the physician ordered transfer from the dialysis appointment to urgent care. Staff T said the resident's transfer status had been the assist of 2 with a slide</p>			

Page 42 of 48

Facility Administrator

Date

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	<p>board.</p> <p>In an interview on 3/5/19 at 3:50 p.m., the DON reported Resident # 25 was in his room on 2/22/19 with Staff S, CNA assisting the resident. The DON stated Resident # 25 sat on his bed while Staff S made the bed. The DON said Resident # 25 offered to stand to make it easier for Staff S to make the bed and Staff S handed Resident # 25 his walker. The DON stated Staff S knew he should follow the care card which listed Resident # 25 as an assist of 2 persons for transfers and Staff S should not have offered the resident his walker. Staff S did not discourage the resident from standing and as Staff S turned his back to continue making the bed, Resident # 25 attempted to stand and fell. The DON stated she awaited the resident's return from orthopedic urgent care to complete an interview about the fall. The DON reported the resident did not have a history of falls or attempts to get up. The DON said the resident did have the cognitive ability to follow commands and make decisions. The DON reported after the fall, the resident did complain of pain but described it as arthritic pain. The DON stated the original request for an X-ray denied by the physician citing no evidence to support the need for one. Nursing staff continued to monitor the resident's pain and as he continued to voice pain, they requested again for an X-ray and the physician able to order it. The DON reported the faxed results from X-ray received on the evening of 3/4/19. The DON reported they had enough staff that day with 3 CNAs scheduled up on West side of building on</p>			

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	<p>2/22/19.</p> <p>Observation on 3/5/19 at 4:00 p.m. revealed Resident #25 returned from the hospital accompanied by a family member and wore a brace to right leg. The family member reported to Staff T the urgent care ordered a brace to the leg and to follow up with X-ray in 2 weeks and the physician in 4 weeks.</p> <p>On 3/6/19 at 11:05 a.m., the DON reported the resident recalled the incident of the fall on 2/22/19. The resident reported Staff S planned to change the bed linens due to the linens being soaked with urine, the resident then told Staff S to hand him his walker and he thought he could stand. Staff S was on the opposite side of the bed and raised the bed up. The DON stated Staff S had worked for the facility for a while and primarily worked on the West side of the facility so Staff S was familiar with Resident # 25. The DON stated the care cards for each resident hung on the back of residents' room doors and Resident # 25's care card had been in place on 2/22/19 listing the transfer status as lateral scoot with assist of 2 staff but that staff may use Hoyer lift as needed for dialysis related to fatigue. The DON stated a lateral scoot the same as a slide board and Hoyer lift same as the mechanical lift listed on the care plan. The DON stated they would be completing a transfer audit with Staff S when he arrived for work that afternoon.</p> <p>In an interview on 3/6/19 at 11:15 a.m., the Physical Therapist (PT), stated he had worked with Resident #</p>			

Page 44 of 48

Facility Administrator

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	<p>25 on and off in the past. Resident # 25 would have occasions where he requested PT to attempt to walk again but then a day or two later, refused and did not want to complete exercises. The PT said the walker would not be used with the lateral scoot transfer. At the time of the fall 2/22/19, Resident # 25 should have been a lateral scoot transfer. The PT demonstrated that staff would use the slid board from the bed to the wheelchair by scooting his bottom across the board. The PT had worked with Resident # 25 on the use of a brace to attempt to stretch out his leg as the resident could not fully extend his right knee. The PT knew of times the resident transferred himself when he did not want to wait for help; staff would find him in bed after he had been in the wheelchair.</p> <p>In an interview on 3/6/19 at 11:20 a.m., Resident # 25 recalled the fall that occurred on 2/22/19. Resident # 25 reported the fall occurred in the evening before his supper and Staff S was the only aide in the room assisting him. Staff S informed him he needed to assist him to change the incontinence brief and the bed since they were wet with urine. Staff S told him to stand up as he handed him the walker. Resident # 25 stated he responded 'I'll try'. Resident # 25 did not even get stood up because he could not fully extend either leg and he fell right to the floor. Resident # 25 said Staff S had assisted him several times before and knew he was a Hoyer transfer. Resident # 25 acknowledged the care card hung on the back of the bathroom door at the time of the fall and accessible to Staff S. Resident # 25 stated immediately pain</p>			

Page 45 of 48

Facility Administrator

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	<p>present in his right knee and he did report it to the nurses. Resident # 25 said all the staff could give him was Tylenol but that was not very effective. Resident # 25 had a brace he was supposed to wear prior to the fall each day but only for a couple hours. Resident # 25 did not have the brace on at the time of the fall and stated he could remove the brace himself when he wanted; the brace got uncomfortable when he slept so he would take it off in bed. Resident # 25 reported it had been a year and 2 months since he last stood and walked. Resident # 25 stated Staff S immediately sought help and staff got him off the floor with the Hoyer machine. Resident # 25 rated his pain a 10 on a scale of 0 to 10 with 10 being the worst pain ever felt. Resident # 25 said the nurse Staff T was aware of his pain and he had told her he would take a pain pill after he had his lunch. Resident # 25 stated he thought the fall probably could have been preventable if Staff S would have assisted him to transfer to his wheelchair first. Resident # 25 responded he would have waited for Staff S if he had left to get help to transfer him.</p> <p>In an interview on 3/6/19 at 2:00 p.m., Staff S reported he had worked for the facility for approximately 3 months. Staff S responded he was familiar with Resident #25 and his cares. Staff S recalled working 2/22/19 and stated he went in to assist Resident #25 with incontinence cares and a bed linen change. Staff S stated he just needed to do the corner on the right lower side of the bed and went to raise the bed then the resident stood up and fell. Staff S clarified that</p>			

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	<p>Resident #25 called for help because his whole bed needed to be changed, Staff S got most of the bed changed, then just needed the resident to stand to complete the corner. Staff S stated Resident #25 said he could use his walker to stand so Staff S gave him the walker. Staff S said the resident was on the side of bed facing the door, holding the bed rail and Staff S was on the other side to reach across the bed to hold up Resident #25. Staff S did not place a gait belt on the resident. Staff S stated when he raised the bed a little the resident went down to the floor without hitting his head. Resident #25 yelled about his leg and Staff S went to get the nurse. When Staff S returned, he found the resident had vomited. Staff S voiced he messed up by not following the resident's care plan that was in the bathroom and didn't know the resident needed a 2 person assist, he just went by the resident's word and he shouldn't have done that. Staff S had assisted Resident #25 to transfer twice before the fall and denied using the lateral scoot saying he just took the handle off the wheelchair and scooched him over. Staff S stated the facility told him about the care cards during orientation; he just didn't look at his.</p> <p><b>FACILITY RESPONSE:</b></p>			

Page 47 of 48

Facility Administrator

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