

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

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|---------------------------------------------------------------------------------------|---------------------|-----------------------------------------------|-------------|-----------------|
| Citation Number: 7099 | | Date: 02/05/2020 | | |
| Facility Name: Rowley Memorial Masonic Home | | Survey Dates: 12/24/19 to 1/23/2020 | | |
| Facility Address/City/State/Zip 3000 East Willis Avenue Perry, IA 50220 | | SB | | |
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| 56.1(1) | <p>481—56.6(135C) Treble and double fines. 56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.</p> | I | <p>\$30,000 (treble) (held in suspension)</p> | <p>Upon receipt</p> |
| 58.28(3)e | <p>481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)</p> <p>58.28(3) Resident safety.</p> <p>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on observations, record review, facility policy, resident, family and staff interviews, the facility failed to equip 1 independently mobile</p> | | | |

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| | <p>resident with diminished cognition with a functional Wanderguard bracelet (device intended to lock exit doors when the wearer gets too close to the door) and failed to protect residents from elopement by failure to maintain a functional alarm system on the exit doors leading outside. Resident #1 eloped from the facility when the Wanderguard failed to sound and the exit door was not alarmed with a secondary alarm. The facility also failed to adequately supervise 3 residents at risk for falls; which resulted in falls with injuries. (Resident #2, Resident #3 and Resident #4) The facility reported a census of 43 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated 8/12/19 noted Resident #1's diagnoses included: Alzheimer's disease, depression, difficulty walking and muscle weakness. The MDS assessed Resident #1's Brief Interview for Mental Status (BIMS) score as 3 out of 15, severe cognitive impairment. The MDS also identified the resident with inattention and disorganized thinking. Resident #1 required limited assistance of one staff for most activities of daily living (ADLs) and required supervision to walk with a walker in the corridors on her living unit. The MDS identified the resident with one fall without injury</p> | | | |
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| | <p>since the previous assessment. The MDS did not identify the resident with wandering behavior. The MDS identified the resident as using a wander/elopement alarm daily. The resident admitted to the facility 8/1/19.</p> <p>The 8/16/19 Care Plan noted Resident #1 at risk for falls related to dementia. The care plan directed staff to anticipate and meet her needs. The care plan also identified the resident with a need for a safe environment. The Care Plan noted that Resident #1 had an ADL self-care performance deficit related to dementia. The Care Plan indicated she required assist of one with her 4 wheeled walker for ambulation and transfers and a wheelchair with staff assist for longer distances. According to the Care Plan, staff should monitor/document for physical/non-verbal indicators of discomfort or distress and follow up as needed (see progress note related to Resident #1's statement after moving from the Memory Unit to A Hall; "I don't like change").</p> <p>A document titled ROWL-Wandering Risk Scale dated 8/1/19 noted Resident #1 with a score of 9. A score of 9 identified the resident as at risk to wander. According to the document, Resident #1 had a diagnosis of dementia/cognitive impairment and a diagnosis impacting gait/mobility or strength.</p> | | | |
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| | <p>The document titled Elopement Monitoring of Door Alarms dated June 2014 noted its policy as follows:</p> <p>A specific system to notify staff that an external door opened in an area accessible to residents. Door alarms are tested each shift at least once a month and the results of the tests are then recorded. Only the Executive Director may authorize disabling the alarm system and is responsible for the method of monitoring for resident safety and resetting the alarm.</p> <p>The April 2009 revised document titled Elopement/Missing Resident noted the facility policy was to implement all possible measures to protect/minimize any resident who attempts to elope.</p> <p>Procedure directives included:</p> <p>a. Upon admission, all residents will be assessed for risk of elopement and reassessed after any attempts to elope and/or as needed.</p> <p>b. When the Resident is found, an in-depth physical assessment is completed by the charge nurse or designee.</p> | | | |
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| | <p>c. Care Plan interventions are documented and/or revised.</p> <p>d. An immediate intervention is implemented to prevent further elopement. This may include 15 to 30 minute checks for at least 8 hours or more, placement to a secured unit or use of a wander-guard.</p> <p>e. The facility completes an incident report. The investigation of the incident includes a timeline of the resident's whereabouts and staff interactions prior to elopement.</p> <p>f. The Director of Nursing (DON) completes an investigation of the elopement that includes possible causes, witness statements, immediate interventions any permanent interventions or prevention measures.</p> <p>A Social Service Note dated 10/23/19 at 11:44 a.m. noted Resident #1's son requested the resident move off the Memory Unit. The document also noted that Resident #1 and her husband would move to a room on A Hall.</p> <p>A Nurses Note dated 10/23/19 at 3:51 p.m. revealed Resident #1 moved to a room on A hall at her husband's request. According to the nurse, Resident #1 stated she did not like change.</p> | | | |
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| | <p>An Activity Progress Note dated 10/24/19 at 5:23 p.m. noted that Resident #1 said the room change made her a bit anxious.</p> <p>A document titled #1307 Elopement and dated 10/25/19 at 6:55 p.m. revealed 2 staff members saw Resident #1 ambulating with her walker outside of A Hall. According to the author (DON), Resident #1 wore a pink button up shirt, black pants and black shoes. The DON also noted the resident ambulated independently with a wheeled walker. The document identified predisposing physiological factors for the elopement as confusion and impaired memory boxes. The DON noted she checked the call light system and the door did not alarm; therefore she changed the Resident's Wanderguard and verified it worked. The DON identified no witnesses to the incident..</p> <p>A Nurses Note authored by the DON and dated 10/25/19 at 9:10 p.m. noted she discussed whether Resident #1 should remain on the Memory Unit (locked unit) with the Interdisciplinary Team (IDT) at the morning meeting on 10/23/19. After review of Nurses Notes and dialogue with the IDT, they concluded nobody witnessed Resident #1 ever trying to exit the building. As a result, the IDT decided they</p> | | | |
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| | <p>would initiate a trial living with the resident another hall at the family's request.</p> <p>A Social Service Note dated 10/25/19 at 10:51 p.m. revealed the author notified the resident's son regarding the resident returned back into the building after ambulating with her walker outside.</p> <p>A Nurses Note dated 10/25/19 at 11:27 p.m. documented the nurse notified the physician about Resident #1 getting outside the building unattended.</p> <p>A statement dated 10/25/19 an handwritten by Staff D, Certified Medication Aide (CMA), noted how she and another employee (Staff E, Transportation) took a break at the picnic table outside the facility on 10/25/19 at approximately 6:50 p.m. when they noticed Resident #1 on the sidewalk outside the A hall door. According to the CMA, they could not open the A hall door while outside so Staff E went into the building and got a wheelchair and returned the resident inside the building. The CMA also noted that they replaced Resident #1's Wanderguard bracelet with a new one because hers did not work.</p> <p>A statement dated 10/25/19 handwritten by Staff E noted how he and another employee took a break at the picnic table outside the facility on</p> | | | |
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| | <p>10/25/19 at approximately 6:50 p.m. when they noticed Resident #1 walking with her walker on the sidewalk outside the A hall door. According to Staff E, Staff D assisted Resident #1 while he went into the building and got the resident's wheelchair and returned her inside the building.</p> <p>A statement dated 10/26/19 and handwritten by Staff A, RN revealed she began her shift on 10/25/19 at 6:00 p.m. and never saw Resident #1 prior to staff discovering the resident outside the building.</p> <p>A statement handwritten by the Activity Director on 10/25/19 revealed that Resident #1 wore a pink button up shirt, black slacks and black shoes the night of 10/25/19.</p> <p>A statement handwritten by Staff F, RN on 10/28/19 revealed that she worked on A Hall as an aide and a medication passer on 10/25/19. According to the RN, she assisted Resident #1 to the bathroom around 4:00 p.m. The RN said she last saw the Resident when she delivered her supper tray around 5:00 p.m.</p> <p>A Resident List Report dated 1/8/20 revealed Resident #1 and 3 other Residents identified as independently mobile, cognitively impaired and/or required Wanderguard protection on 10/25/19.</p> | | | |
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| | <p>According to the list, those 4 Residents and another newly identified Resident required Wanderguard protection after 10/25/19.</p> <p>Observation on 12/30/19 at 3:50 p.m. during a tour with the Maintenance Supervisor revealed the A Hall lounge/TV area exit door appropriately locked with a Wanderguard bracelet present, but did not alarm when the surveyor opened the door without the Wanderguard bracelet nearby. Further observation revealed the same findings at the C Hall lounge/TV area exit door and the main front door. The doors locked appropriately with the Wanderguard bracelets present, but they did not alarm when the surveyor opened the doors without the Wanderguard bracelet nearby.</p> <p>Observation on 1/8/20 at 1:15 p.m. during a tour with the Maintenance Supervisor revealed that all the exit doors on A, B and C Halls were locked. According to the Maintenance Supervisor, the facility would lock those doors at all times beginning that morning. He stated the facility made the change to provide for a safer and more reliable system. Further observation revealed the exit door closest to the DON office in the main dining area, the main front doors and both exit doors on S (service) Hall did not alarm when opened by this surveyor. Observation also revealed the unlocked door at the end of S Hall</p> | | | |
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| | <p>that led into the old building did not alarm when opened. Other unlocked doors just inside the old building led in 2 directions; either towards the chapel or towards the old long term care (LTC) residential housing area. Both of those doors did not contain alarms. Two other unlocked exit doors in the chapel area; one exiting from the hallway and the other exiting from the chapel to the outside did not alarm when opened.</p> <p>On 12/31/19 at 8:10 a.m. the DON revealed Resident #1 wore a Wanderguard bracelet at the time she eloped. The DON said it seemed like the doors were malfunctioning when it first happened. She said with the exception of the Memory Unit, all the exit doors were unlocked to the outdoors. The DON said they could not open the outside door at the end of A Hall to return the Resident inside the building.</p> <p>The DON explained the exit doors were supposed to lock when an active Wanderguard bracelet got within a certain distance of the door. The DON also explained that the Wanderguard bracelet Resident #1 wore had never been activated; therefore it would not lock the door for her protection as intended. According to the DON, although they check Wanderguard bracelets every shift now, they were not checked at the time of the elopement. The DON said she</p> | | | |
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| | <p>checked the bracelet and it did not lock either of A Hall's exit doors. The DON said she also pushed the button on the bracelet and it did not appear on the computer; therefore it did not function as a call light or Wanderguard protection. The DON did not know if the Resident wore the inactive Wanderguard bracelet since admission or if someone changed it at some point and did not activate it then. Either way, the DON said it allowed Resident #1 to exit the door without supervision.</p> <p>According to the DON, another Resident said he saw Resident #1 go out A Hall's lounge area door. The DON said that door led her into an ungated courtyard and employees sitting in the designated outdoor break area saw Resident #1 walking on the sidewalk outside the door at the end of A Hall (approximately 100 feet away).</p> <p>An interview on 12/31/19 at 9:25 a.m. with Staff E, Transportation, revealed he and Staff D were outside under the shelter when they saw Resident #1 outside the exit door at the end of A Hall. Staff E said he did not see which direction the Resident came from. Staff E said Resident #1 made an abrupt turn which would have led her off the sidewalk, down a ditch and into a grassy area if they did not intervene. Staff E said he did not remember the time, but remembered it as just</p> | | | |
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| | <p>about dark. He also remembered it as cool outside but not cold; probably in the 50s. Staff E said Resident #1 had a pink zip up "sweater thing" on.</p> <p>Staff E said they informed the nurse immediately and they started checking to see why the bracelet did not cause the door to lock. Although he did not know for sure, he thought the bracelet may have been defective or had a bad battery. According to Staff E, they changed the bracelet and did not had any more problems since.</p> <p>An interview on 12/31/19 10:35 a.m. with Staff D, CMA revealed she and another employee were on break at the outdoor picnic table when they saw Resident #1 walking with her walker on the sidewalk about 20 feet from the exit door at the end of A Hall. Staff D said she did not know which door the resident exited the building from. According to the CMA, it was chilly outside. The resident wore a shirt, sweater, pants, shoes and socks. Staff D said she did not know how the resident got outside without someone knowing it because she wore a Wanderguard bracelet. Staff D stated nobody knew Resident #1 got out until they discovered her. The CMA said "thank God I happened to be outside; I don't know if they would have found her or not". Staff D described it as a very stressful situation.</p> | | | |
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| | <p>A subsequent interview on 12/31/19 at 11:35 a.m. with the DON clarified the Nurse Consultant's comment that Resident #1 did not need Wanderguard protection at the time of the elopement. The DON clarified that they intended for Resident #1 to wear the bracelet for Wanderguard protection in addition to its call light function. The DON said they just moved the resident off the dementia unit; which automatically qualified her as a candidate to wear a Wanderguard bracelet. The DON said Resident #1 needed it due to her dementia and during an adjustment/trial period to determine if she should continue to wear it since she no longer resided on the locked Memory Unit. The DON further explained that Resident #1's bracelet did not appear in the computer system; which identified it as inactive and enabled the Resident to get out without setting off an alarm. The Nurse Consultant apologized to the surveyor and said she did not know they intended for the resident to wear a Wanderguard bracelet.</p> <p>An interview on 1/7/19 at 2:30 p.m. with Staff A, RN revealed she just started working for the facility 4 days before Resident #1 eloped. Staff A believed Staff D notified her about the elopement as she worked in the Memory Unit. Staff A wondered how the resident got out without setting</p> | | | |
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| | <p>off an alarm because she wore a Wanderguard bracelet; which she replaced with a new one. The RN said she notified the DON.</p> <p>An interview on 1/8/20 at 2:45 p.m. with the Maintenance Supervisor revealed that each door contained a reader, a computer and a sensor. With all that technology, the door and/or alarm can malfunction any time one of those components does not work like it should. The Maintenance Supervisor said he received calls about malfunctioning doors; which work fine when he checks them. He said the system should work all the time.</p> <p>An interview on 1/13/20 at 12:30 p.m. with the State Climatologist revealed that the sun set at 6:20 p.m. on 10/25/19. According to the Climatologist, that evening had fair weather, 6 mph winds and a temperature of 41 F at 6:35 p.m.</p> <p>An interview on 1/14/2020 at 8:55 a.m. with Staff F revealed that she worked as the charge nurse from 6:00 a.m. to 6:00 p.m. on 10/25/19. According to Staff F, she "pretty much" stayed on A Hall after 2:00 p.m. unless she had to go and administer insulin elsewhere in the building. The RN said she last saw Resident #1 in her room eating supper with her husband about 5:00 p.m.</p> | | | |
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| | <p>Immediate Jeopardy Abatement</p> <p>Abatement Plan prepared 1/13/2020 and immediate jeopardy abated 1/14/2020:</p> <p>The following doors: front door, door near DON office, exit doors on service hall and wood door on service hall Front doors now locked and key pad with code required for entry Wood door on service door locked Exit doors alarmed/locked education immediately started with staff on 1/13/2020. education ongoing to capture each staff person prior to next working shift. Discussions with residents and families so they are educated. Discussions started 1/13/20 and ongoing. Policy amended to include updates. New policy to QAPI for approval. Door checks daily for 30 days and then weekly ongoing. Door audits to QAPI for review and further recommendations.</p> <p>Observation revealed on 1/13/2020 at 7:45 a.m. the doors from the main dining room down south hall and into old area unlocked and not alarmed to the outside. The door in the main dining room near the DON office unlocked and not alarmed as well as the doors down south hall.</p> | | | |
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| | <p>Observation revealed on 1/14/2020 at 9:42 a.m. all doors locked and alarmed except door to old building was open and unalarmed from entry into old building. The maintenance person locked the door after the observation.</p> <p>2. The MDS assessment dated 11/22/19 noted Resident #2's diagnoses as Alzheimer's disease, dementia, depression, difficulty walking, lack of coordination, muscle weakness, restlessness and agitation. According to the MDS, Resident #2's BIMS score of 7 out of 15, severe cognitive impairment. The MDS also noted Resident #2 wandered. Resident #2 required extensive assistance of 2 staff members for most ADLs and required supervision of one person physical assist to move in her room and adjacent corridors on her living unit. The MDS identified Resident #2 as unsteady and only able to stabilize with staff assistance. The MDS identified Resident #2 with frequent episodes of bowel and bladder incontinence. According to the MDS, Resident #2 had 2 falls without injuries and 2 with non-major injuries since she admitted to the facility or since her prior assessment. The resident admitted to the facility 7/19/17.</p> <p>The 11/30/16 Care Plan identified Resident #2 at risk for falls related to dementia, gait and balance</p> | | | |
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| | <p>disturbances, poor safety recognition and impulsivity that sometimes kept her from calling or waiting for staff assistance. The care plan directed staff to review information from falls and attempt to determine a cause. Staff should toilet Resident #2 before and after meals and at bedtime. An intervention implemented on that date noted that staff should maintain a safe environment for Resident #2. The 12/2/16 Care Plan noted altered thought affecting cognitive functioning, mood, behavior and psychosocial well-being and implemented an intervention on 12/8/16 instructing staff to be attentive to her needs; observe for signs or symptoms of discomfort, anxiety being overwhelmed etc. According to the 3/20/17 intervention, Resident #2 should not be left unattended in the bathroom. They included Resident #2's risk of elopement and wandering on 4/17/19 and instructed staff to distract her from wandering. On 11/5/19; staff should offer toileting after they identified standing and self-transferring attempts as a fall indicator.</p> <p>A document titled Fall Risk Assessment dated 10/26/19 noted Resident #2 with 3 or more falls in the last 6 months. Along with additional factors, the facility identified her at risk for falls related to cognitive impairment, mobility status, poor safety awareness and multiple medications.</p> | | | |
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| | <p>A document titled #1318 dated 11/4/19 at 8:20 p.m. identified an unwitnessed fall in the resident's room. Staff found Resident #2 on the floor at the end of her bed. The resident laid on her stomach and was incontinent of urine. The resident bled from the mouth from possibly biting her tongue during the fall. Both of her knees were "skinned up". Staff got the resident off the floor via hoist lift. The resident could not give a description of the incident. Following the fall, the resident expressed occasional moans/groans and had a sad, frightened expression on her face. The document identified the resident's mobility as wheelchair bound. Predisposing physiological factors listed: incontinence, weakness, gait imbalance and impaired memory. The resident ambulated without assistance. A care plan revealed a new intervention dated 11/7/19 for 11/4/19 Mattress on floor by bed until floor mat available. The document did not identify when staff last saw or toileted the resident.</p> <p>A document titled #1319 identified a witnessed fall in the resident's room dated 11/5/19 at 7:00 a.m. Staff reported the resident maneuvered herself off her bed into a kneeling position on the fall mat. The CMA reported the resident previously sat at the edge of the bed. The CMA left the room to get somebody else to help with ADLs and found the resident lying on the fall mat</p> | | | |
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| | <p>when she returned. The fall document identified predisposing factors for the fall as confusion, impaired memory and side rails up. The resident did not sustain injury. There were no new interventions identified on the care plan following the incident. The document did not identify when staff last toileted the resident.</p> <p>A document titled #1330 identified an unwitnessed fall in the resident room dated 11/15/19 at 9:20 p.m. A CNA . found the resident on the floor in her room beside the bed laying on her left side. When asked what happened, the resident stated she was going to look for her mother. There were no apparent injuries. Confusion and impaired memory were considered Predisposing Physiological Factors. The document did not identify when staff last saw or toileted the resident. The care plan did not contain a corresponding intervention following the incident.</p> <p>A document titled #1332 Fall dated 11/16/19 at 7:38 p.m. identified a fall in the lounge. The document revealed a nurse aide lowered Resident #2 to the floor when she noticed the resident's wheelchair pushed back while the resident sat down after attempting to self-transfer. Confusion and impaired memory were considered Predisposing Physiological Factors.</p> | | | |
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| | <p>There were no apparent injuries. The document did not identify when staff last toileted the resident. The intervention following the incident was to ensure wheelchair brakes are locked before transfers.</p> <p>A document titled #1334 identified a witnessed fall in the hallway dated 11/19/19 at 7:15 p.m. Staff observed the resident standing up by grabbing the bars on the wall in the hallway. The Resident missed the seat of her wheelchair as she attempted to sit back down and sat herself down on the floor. There were no apparent injuries. Predisposing Physiological Factors were noted as confusion, incontinence, gait imbalance and impaired memory. The nurse and CNA assisted Resident #2 to a shower chair and cleaned her up in the shower following bowel incontinence. The document did not identify when staff last toileted the resident. The care plan did not identify an intervention following the incident.</p> <p>A document titled #1351 identified a witnessed fall in the hallway dated 12/2/19 at 6:20 p.m. Staff observed the resident sitting on the floor in front of her wheelchair. Staff lifted the resident from the floor with the hoyer lift and placed her back in the wheelchair. There were no apparent injuries. Predisposing Physiological Factors were noted as</p> | | | |
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| | <p>incontinence, weakness, gait imbalance and impaired memory. The document did not identify when staff last toileted the resident. Following the incident, staff placed anti roll backs to the wheelchair.</p> <p>A document titled #1364 identified an unwitnessed fall in the resident room dated 12/12/19 at 7:51 a.m. Staff observed the resident sleeping on the fall mat next to her bed. The resident rolled out of bed onto the mat. There were no apparent injuries. The document did not identify when staff last saw or toileted the resident. Following the incident staff placed pool noodles on each side of the mattress under the fitted sheet.</p> <p>A document titled #1389 revealed an unwitnessed fall in the resident room dated 12/31/19 at 7:45 p.m. Staff found the resident laying on a mattress on the floor. There were no apparent injuries. Predisposing Physiological Factors were noted as incontinence, confusion, drowsiness and impaired memory. The document did not identify when staff last saw or toileted the resident. An intervention following the incident was to offer/provide animated cat when resident anxious or self transferring.</p> | | | |
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| | <p>A document titled #1397 identified a witnessed fall in the lounge dated 1/5/20 at 12:33 p.m. Resident #2 stated she "was putting herself" on the floor and did. According to the report, Resident #2 refused staff attempts to help her up; saying "I'm living a little, you should try it. I'm not getting up". The nurse noted that the Resident had scrapes on her left side and lower back from the wheelchair pedals. The document did not identify when staff last toileted the resident. The care plan did not contain a new intervention following the incident.</p> <p>A document titled #1400 revealed an unwitnessed fall in the resident room dated 1/7/20 at 7:45 p.m. Staff discovered Resident #2 lying on her left side; half on a bedside mat and half off. The Resident bled from an open area on the left side of her forehead. She had a 2.0 cm x 1.0 cm laceration at her left eyebrow and a 9.0 cm x 8 cm bruise on her shoulder. The document did not identify when staff last saw or toileted the resident. Following the incident a care plan identified staff ordered a tranquility blanket and essential oil necklace</p> <p>An Incident Note dated 1/7/20 at 10:44 p.m. noted that they discovered Resident #2 lying half on the bedside mat and half off. Assessment included observations of bleeding from an open area on</p> | | | |
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| | <p>left side of forehead and reddened and slightly swollen left shoulder. Orders obtained to send to ER and daughter notified.</p> <p>A Major Injury Determination Form dated 1/7/20 noted that the facility informed the physician that Resident #2 sustained a laceration to her face after she rolled out of bed onto a fall mat. (Staff found Resident #2 in another Resident's room on the floor according to interviews with 2 CNAs).</p> <p>A Nurses Note dated 1/8/20 at 1:05 a.m. revealed the resident returned to the facility with a dressing on the right side of her forehead. A new order for antibiotics accompanied the Resident and an appointment needed to be scheduled for suture removal.</p> <p>An interview on 1/9/20 at 12:18 p.m. with Staff H, CNA, revealed that she and Staff G, CNA worked on the Memory Unit the night of Resident #2's 1/7/20 fall. According to Staff H, she and Staff G worked in another resident's room getting them ready for bed. Staff H said she "ran to the restroom" while Staff G picked up linen and garbage in that resident's room. Staff H said she heard Staff G yell "oh no, Resident #2 is on the floor". The CNA observed Staff G and Resident #2 in another Residents room that she wandered into.</p> | | | |
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| | <p>Staff H said that although Resident #2 should not walk by herself; she will frequently try. The CNA said Resident #2 previously fell before. According to Staff H, Resident #2 wanders into anybody's room to use their bathroom; she does not care where she goes.</p> <p>Staff H said that although they have to leave the Great Room unsupervised at times, it puts the Residents at risk. When asked, Staff H said the facility tells them to check on the other Residents frequently when they are in other Resident's rooms.</p> <p>An interview on 1/9/19 at 1:23 p.m. with the Director of Nursing (DON) revealed that that they do not have a policy related to supervising the halls/units where residents reside. The DON said she expected someone to be back in the Memory unit at all times, but did not expect someone to monitor the Great Room at all times.</p> <p>An interview on 1/13/19 at 9:10 a.m. with Staff G revealed that she and the other nurse aide worked in another room helping 2 Residents. Once they finished, Staff G said she found Resident #2 in another resident's room. She "pulled" Resident #2 from the other resident's room at about 6:30 p.m. before she went into</p> | | | |
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| | <p>another resident's room to help them. Staff G said the other CNA went to the bathroom instead of assisting her with the next resident. According to Staff G, the CNA spent quite a bit of time in the bathroom because she had not been feeling well.</p> <p>Staff G said she heard Resident #2 yelling for help between 7:00 and 7:30 p.m. The CNA said she found Resident #2 in the same Resident's room she found her in earlier. Half of her body on a fall mat and the other half on the tile floor. Staff G ran to the bathroom to inform the other CNA. According to Staff G, that CNA ran to notify the nurse. Staff G said she saw blood on Resident #2's hand and on the floor. Staff G said the Resident ended up with stitches above her left eyebrow.</p> <p>According to the CNA, nobody supervised the Great Room as she helped another resident and the other CNA spent time in the bathroom. Staff G explained that she "pulled" Resident #2 out of the other resident's room earlier so she didn't get hurt. Staff G said Resident #2 spent a significant amount of time in the other resident's room that night.</p> <p>3. The MDS assessment dated 11/17/19 noted Resident #3's diagnoses as arthritis, Alzheimer's disease and dementia. According to the MDS,</p> | | | |
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| | <p>Resident #3's BIMS score of 3 out of 15 indicated he had severely impaired cognition with inattention and disorganized thinking. The MDS also noted that Resident #3 either depended on staff completely or required extensive assistance of 2 staff members for most ADLs. According to the MDS, they considered Resident #3 unsteady. The MDS noted that Resident #3 frequently had episodes of bowel and bladder incontinence. According to the MDS, Resident #3 had 2 falls without injuries since he admitted to the facility or since his prior assessment. The resident admitted to the facility 11/15/18.</p> <p>The 11/27/18 Care Plan noted Resident #3's ADL self-care deficit related to dementia. The care plan indicated Resident #3 did not ambulate at the time and required 2 staff to assist him with a gait belt to stand, pivot, toilet and transfer. The 11/29/18 Care Plan indicated Resident #3's thoughts were altered by dementia and therefore staff should provide cues, supervise as needed and anticipate and meet his needs. The Care Plan also instructed staff to promptly respond to all the Resident's requests related to his risk for falls due to confusion and wandering. The care plan did not identify the resident frequently self transferred or failed to use a call light. The care plan failed to contain a scheduled toileting plan.</p> | | | |
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| | <p>A document titled Fall Risk Assessment dated 11/21/19 noted that Resident #3 had 1 to 3 falls in 3 months. Along with neuromuscular/functional loss and additional factors, the facility identified him being at risk for falls related to his memory, mobility status, and poor safety awareness.</p> <p>A document titled #1217 revealed an unwitnessed fall in the resident room dated 8/18/19 at 7:15 p.m. Staff found Resident #3 on the floor against the bed in a seated position with his legs extended towards the entry of the bathroom door. There were no apparent injuries. Predisposing Physiological Factors were confusion, gait imbalance and impaired memory. The nurse also identified Resident #3 being a wanderer as a Predisposing Situational Factor. The resident did not sustain injury. The document did not identify when staff last saw or toileted the resident. The care plan did not contain a new intervention following the incident. The care plan did not contain a scheduled toilet plan.</p> <p>A document titled #1360 revealed a fall in the lounge dated 12/9/19 at 6:20 p.m. Staff called the nurse to the Memory Unit after an unwitnessed fall. Observation revealed Resident #3 on his back on the floor near the couch and table in the day hall saying "it's broken, it's broken". The nurse noted that Resident #3 complained of pain</p> | | | |
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| | <p>when he bent his right leg. According to the nurse, he also complained of right hip/leg pain as 2 people assisted the Resident to a standing position. They also assisted the Resident to his room to clean him up due to an episode of incontinence. The nurse obtained an order to have ER evaluate Resident #3's complaint of right hip pain. As Other Info, the nurse included that the resident fell when he attempted to self-transfer while sitting in the common area. Predisposing Physiological Factors were confusion and incontinence. The nurse also identified Resident #3 as a wanderer and ambulating without assistance as a Predisposing Situational Factors. The DON noted that ER identified a fracture. The document did not identify when staff last saw or toileted the resident. The care plan did not contain a new intervention following the incident. The care plan did not contain a scheduled toilet plan.</p> <p>A Major Injury Determination Form dated 12/10/19 at 6:25 a.m. noted that the facility informed the physician that Resident #3 sustained a right hip fracture when he fell on the floor in the day hall on 12/9/19 at 6:30 p.m. The physician noted on 12/10/19 at 10:00 a.m. that he considered the injury a major injury.</p> | | | |
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| | <p>An interview on 12/30/19 at 12:40 p.m. with Staff J, CNA, revealed Resident #3 could walk on his own before he broke his hip, but one person assisted him for his safety due to his age and being so unsteady. According to Staff J, he had a history of self-transfers. She said he probably needed to go to the bathroom; which she described as a factor that precedes his self-transfer attempts. Staff J said he will not wait. He will get up right away. According to the CNA, Resident #3 wore a call light bracelet which he did not know how to use.</p> <p>The CNA identified the Memory Unit as usually staffed with a CMA and a CNA. She said the common area is usually left unsupervised when both workers have to help residents that require the assistance of 2 people; Resident #2 and Resident #3. Staff J described leaving the common area unsupervised as unsafe and thinks falls have occurred as a result; like what happened with Resident #3. The CNA said she heard Staff H left Resident #3 unsupervised while toileting someone else.</p> <p>An interview on 12/30/19 at 1:15 p.m. with Staff I, CMA, revealed that Resident #3 had a history of self-transferring on "a whim"; it does not matter if he is in his room or the common area. According to Staff I, Resident #3 used his call light/bracelet</p> | | | |
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| | <p>occasionally if he remembers to use it. She said the resident will get up on his own if someone does not get to him right away.</p> <p>The CMA said typically they are staffed with a CMA and a CNA on the Memory Unit. Staff I said Resident #2 and Resident #3 both require assistance of 2 people along with 2 other Residents that need those same accommodations on an as needed basis. Staff I said the Activity Director will supervise the room when both staff members have to help a Resident at the same time. The CMA said that is "hit and miss"; they do not recruit her help if she does not happen to be there.</p> <p>An interview on 12/30/19 at 1:55 p.m. with Staff G revealed that she worked on the Memory Unit a couple times a week. According to the CNA, Resident #3 had a history of self-transferring even before his 12/9/19 fall. Although Staff G could not identify a pattern; she said Resident #3 would self-transfer at any given time.</p> <p>The CNA said they usually staffed the Memory Unit with a Medication Aid (CMA) and a CNA; depending on the census. She said they tried to use 2 CNAs with a higher census; which did not happen very often. According to the CNA, approximately 4 Residents required the</p> | | | |
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| | <p>assistance of 2 staff members; including Resident #3. Staff G said nobody typically supervised the common area when both workers were in a resident's room. She said self-transfers are common on a Memory Unit and leaving them unsupervised increases their risk of falling.</p> <p>An interview on 12/31/19 at 1:45 p.m. with Resident #3's daughter revealed her input regarding her Father's 12/9/19 fall. She wondered how it happened; "he's just confused enough where he thinks he can get up on his own". According to his daughter, she redirected him in the past when she saw him trying to get up on his own at times. She said her Father fell at home now and then; which accounted for one of the reasons they admitted him to the Nursing Home. She said he could not use his phone anymore. She said he also lacked the cognition to use his call light.</p> <p>Resident #3's Daughter said she visits 2 or 3 times a week and 2 other sisters visit at least once a week. She recalled Staff H working alone some evenings. The family member said she asked Staff H 2 evenings in a row if anyone else would help her. She did not remember the date; either late November or early December. She said Staff H told her someone did not show up for work. Resident #3's Daughter said you cannot</p> | | | |
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| | <p>predict when he might decide to get up on his own.</p> <p>An interview on 1/9/20 at 12:18 p.m. with Staff H revealed she discovered Resident #3 when he fell on 12/9/19. Staff H said she worked alone on the Memory Unit that evening because her partner went home sick at 2:00 p.m. Depending on scheduling, Staff H said they work alone back there 2 or 3 times a week.</p> <p>An interview on 1/13/19 at 9:10 a.m. with Staff G revealed that she went home sick at 2:00 p.m. the day Resident #3 broke his hip. The CNA could not remember how he acted that day. She identified the resident with a history of self-transferring and revealed staff could never tell when he might attempt it; it could be at any given time.</p> <p>Staff G CNA said the nurse would come to the Memory Unit when she needed help with residents that required the assistance of 2 people. Staff H said Resident #3 acted normal; he seemed fine when she left him unattended in the dining area. According to Staff H, she heard Resident #3 yell for help as she toileted another resident in their room. Staff G said she called the nurse back to the Unit when she discovered the Resident had fallen.</p> | | | |
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| | <p>4. The MDS assessment dated 11/19/19 noted Resident #4's diagnoses as hip fracture, depression, difficulty walking and lack of coordination. According to the MDS, Resident #4 required extensive assistance of one staff member for most activities of daily living (ADLs). The MDS identified the resident with a brief interview for mental status (BIMS) score of "15 no cognitive impairment.</p> <p>The 12/21/18 Care Plan noted that Resident #4 had impaired thought processes related to dementia and impaired decision making related to short term memory loss. Staff should cue, reorient and supervise Resident #4 as needed. The 1/3/19 Care Plan noted that Resident #4 has an ADL self-care performance deficit related to recent fall with hip fracture. As of 12/6/19, Resident #4 could bear full weight to her left leg; transferring and ambulating with assistance of one with a gait belt and walker. The care plan revealed, the resident started 15 minute checks 8/31/19 and ended 11/19/19. The care plan did not contain a toilet schedule until 12/16/19 when it directed staff to "check at shift change and offer toilet".</p> <p>According to the 8/30/19 intervention, staff were to administer pain medication as ordered. The</p> | | | |
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| | <p>9/2/19 Care Plan instructed staff to keep Resident within visual sight when not sleeping.</p> <p>A document titled #1231 revealed a fall in the resident room dated 8/25/19 at 10:26 p.m. A nurse aide heard a noise coming from Resident #4's bedroom and found her on the floor in front of the recliner with her left leg extended and externally rotated. The Resident said she stood up to go to the bathroom and "just went right over". The nurse indicated that Resident #4 waved her hand over her left hip as she said "it hurts here". The nurse called 911. The nurse noted poor lighting as a Predisposing Environmental Factor, incontinence, gait imbalance and impaired memory as Predisposing Physiological Factors and improper footwear and ambulating without assistance as Predisposing Situational Factors.</p> <p>A document titled #1243 revealed an unwitnessed fall in the resident room dated 9/2/19 at 7:50 p.m. Staff found Resident #4 sitting on the floor beside her bed at 2:45 p.m. According to the nurse, the Resident could move all extremities, but guarded her left leg. They sent the resident to ER for x-rays; which proved negative. Predisposing Physiological Factors were identified as confusion, impaired memory and a recent change in condition. "Other Info" noted that after a</p> | | | |
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| | <p>previous fracture, the resident did not remember that she could not walk, stand or bear weight. Staff conducted 15 minute checks since 8/31/19. The care plan contained an intervention dated 9/2/19 that directed staff to keep the resident within visual sight when not sleeping. The intervention was discontinued on 12/18/19.</p> <p>An Infection Note dated 12/5/19 at 7:26 p.m. noted that antibiotic use and Resident #4's confusion continued and staff made attempts to reorient her.</p> <p>A Nurses Note dated 12/7/19 at 12:16 a.m. noted that Resident #4 showed signs and symptoms of more confusion. The nurse also noted that the Resident currently received antibiotics for a urinary tract infection (UTI).</p> <p>A document titled #1358 revealed an unwitnessed fall dated 12/7/19 at 8:20 p.m. Staff revealed the nurse found Resident #4 sitting on the floor of her room. According to the report, Resident #4 said she fell out of her wheelchair in her room as she tried to put her pajamas on while getting herself ready for bed. According to the report, Resident #4 had increased confusion related to a UTI. The document did not identify when staff last saw or toileted the resident.</p> | | | |
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| | <p>An Incident Note authored by Staff A, RN and dated 12/7/19 at 8:20 p.m. noted she found Resident #4 in her room sitting on the floor in front of her wheelchair. The nurse identified no apparent injuries on the initial assessment.</p> <p>According to the nurse, she notified the physician by fax but the resident's family would be notified in the morning.</p> <p>A Nurses Note authored by Staff B, LPN and dated 12/8/19 at 8:48 a.m. revealed that Resident #4 complained of left flank pain and burning with urination that morning. The nurse noted Resident #4 continued on antibiotics. She also noted that she sent a fax to the physician requesting a consultation with a urologist or kidney specialist for symptoms of a recurring UTI. The nurse wrote "daughter aware".</p> <p>An Infection Note dated 12/8/19 at 8:59 p.m. revealed the nurse's charting for her 6:00 p.m. to 6:00 a.m. shift. Resident #4 continued to receive an antibiotic for a UTI and continued very confused and anxious. The nurse described the resident's urine as yellow with a very concentrated smell. The nurse encouraged fluids, but Resident #4 only took small sips.</p> | | | |
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| | <p>A Health Status Note authored by Staff C and dated 12/9/19 at 1:29 p.m. revealed that Resident #4 continued to complain of left rib pain after the fall on 12/7/19. The nurse also documented that confusion and hallucinations continued. The resident requested an x-ray to rule out left rib fractures.</p> <p>An Order Note authored by Staff C, RN and dated 12/9/19 at 2:45 p.m. revealed she received an order to refer Resident #4 to a Physician for frequent UTIs. The nurse wrote that she received notification that Resident #4 fell and she obtained an order to send the Resident to ER to be evaluated for left rib pain. The RN also noted that she informed Resident #4's family.</p> <p>A Nurses Note dated 12/9/19 at 6:52 p.m. revealed that ER notified them that Resident #4 had fractures of the 7th, 8th, 9th and 10th ribs on the left.</p> <p>A document titled Half Hour Checks note intermittent ½ hour checks of Resident #4 completed from 12/20/19 thru 1/15/20.</p> <p>An interview on 1/6/2020 at 11:20 p.m. with Staff L, CNA revealed that Resident #4 did not need help to transfer when she first admitted to their facility. Staff L said her transfer status changed</p> | | | |
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| | <p>where she needed 2 people to help her once she broke her hip. The CNA believed Resident #4's most recent fall on 12/7/19 happened when she self-transferred because a UTI caused her to be anxious and hallucinate. The CNA said she also had a history of self-transfers prior to that fall. Staff L said the Resident told her after her first fall that she thought she was capable of doing things for herself and did not want to bother them. Staff L said Resident #4's patience depends the day and her mood; she may or may not wait for help after calling out.</p> <p>An interview on 1/6/2020 at 12:25 p.m. with Staff C, RN, revealed that Resident #4 had a history of self-transferring. The RN said they keep her out in the common area when restless or hallucinating. According to the RN, Resident #4 has had "sundowners" (effects of dementia) since she admitted to their facility which caused the resident to experience paranoia and see things. Staff C said the Resident also gets frequent UTIs.</p> <p>An interview on 1/6/2020 at 1:15 p.m. with Staff B, LPN, revealed that Resident #4 gets really confused at times. According to Staff B, the Resident "skootches" towards the foot rest of her recliner and calls out for help when she is confused. The LPN said Resident #4 knows how to use her call light but calls out for help instead</p> | | | |
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| | <p>of using it when at certain times of the day when dementia affects her the most.</p> <p>An interview on 1/7/2020 at 9:45 a.m. with Staff K, CMA, revealed they caught Resident #4 sliding to the foot of her recliner a couple of times in the days before her 12/7/19 fall. The CMA said she did not fall those times but probably would have if they did not get to her in time. Staff K said she told other people to keep an eye on her because of those observations. Staff K said Resident #4 had a history of self-transferring; especially when she is confused. The CMA said she also had a history of hallucinating but did not know whether to attribute that to UTIs or dementia.</p> <p>An interview on 1/7/19 at 2:30 p.m. with Staff A, RN, revealed that she did not remember if a nurse aide told her they found Resident #4 on the floor or if she walked in and found her on 12/7/19. The nurse believed Resident #4 received antibiotics for a UTI at the time, which caused her to be more confused than normal.</p> <p>An interview on 1/9/19 at 9:45 a.m. with the DON revealed her response when asked what they have done to help prevent Resident #4 from falling again in light of previous falls and tendency to self-transfer, the DON said they performed frequent checks for a period of time. When asked,</p> | | | |
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| | <p>she assumed they discontinued the frequent checks because the resident did not fall for quite a while. The DON said it would not be reasonable to do the checks indefinitely. When asked about other interventions listed on the Resident's Care Plan, the DON said she also wondered why bed alarms were listed because they do not use them in the facility.</p> <p>An interview on 1/15/20 at 9:15 a.m. with Staff D, CMA revealed that Resident #4 with a history of self-transferring. The CMA said they try and remind her to push her call lite and she says "oh that's right honey". According to the CMA, the resident knew how to use the call light, but forgetfulness and confusion prevented her from using it. Staff D said they can hear her say "is anybody out there" at times when they are near her room. Staff D said being forgetful and confused caused Resident #4 to fall when she self-transfers. The CMA said she checked on her every 15 or 30 minutes. The CMA said she will bring her out to the nurse's station if she cannot figure out what the Resident wants/needs. Staff D said she knows Resident #4 thinks she can get up and walk by herself so she reminds her to call for help.</p> <p>A subsequent interview on 1/15/20 at 12:07 p.m. with Staff K revealed how she considered</p> | | | |
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| | <p>Resident #4 to be very unpredictable; even more so since last July. According to Staff K, they recently started frequent checks (documented since 12/20/19 to the time of interview) on her again because of being so unpredictable. Staff K said frequent checks are not on the care plan; therefore not everyone does frequent checks. She said some of them do it to keep a closer eye on her.</p> | | | |
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