Citation Numb					Date:	
	#8094				Septe	ember 9, 2020
Facility Name: Accura Health	care of Pleasantville		Survey Dates:			
Facility Addres	ss/City/State/Zip		August 4 – 24, 2020			2020
	rth State Street ntville, IA 50225	VW, HL, JS				
Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
58.28(3)e	facility shall be responsimaintenance of a safe opersonnel. (III)  58.28(3) Resident safette.  e. Each resident shall reprotect against hazards in the environment. (I, III)  DESCRIPTION:  Based on clinical record observations, the facility of 6 sampled (Resident raised in a total mechan striking her head on the sustained a traumatic bedeath. The lift failed to hanger bar to prevent the lift. The facility faile proper use of the lift and	deceive adequate supervision to from self, others, or elements, III)  I review, staff interviews, and a staff failed to safely transfer 1 #2). Resident #2 moved while sical lift and fell from the lift base of the lift. Resident #2 rain injury which resulted in contain safety clips on the ne lift sling from detaching from detaching from detaching from detaching train to do in the event a the lift. The facility reported total mechanical lift for		\$8,500 (Held i Suspe		Upon Receipt

Facility Administrator	Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to lowa Code section 135C.43A (2013).

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	ncare of Pleasantville		Survey Dates:  August 4 – 24, 2020			2020
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	Alzheimer's dementia, posteoarthritis. Resident impairments and display directed towards others disruptive sounds). Rest the assistance of two st wheelchair for mobility.  The Care Plan revised unable to transfer effect impaired cognition. The assist Resident #2 to transfer demechanical lift, to offer throughout the transfer provide clear instruction.  The Order Summary R orders to administer Clean antiplatelet medication day. Resident #2's MAI Record) dated 7/1 - 7/3 Plavix every morning.  The Incident Report dat authored by Staff A (Re Nurse Aide notified her #2's room and the residentered the room and n	/20, Resident #2 had Alzheimer's disease, Non- post-polio syndrome and the #2 had severe cognitive yed behavioral symptoms (like verbal symptoms or sident #2 did not walk, required aff for transfers and used a  1/16/20 revealed Resident #2 tively related to weakness and the Care Plan instructed staff to the ansfer with two staff with a total treassurance and talk with her to ease fears/anxiety and the in regard to tasks.  The port dated 7/1/20 documented to pidogrel Bisulfate (or Plavix, ton) 75 mg (milligrams) once a the port dated of the pidogrel Bisulfate (or Plavix, the port dated of the pidogrel Bisulfate (or Plavix, the pidogrel Bisulfate (or Plavix) (or				Page <b>2</b> of <b>1</b>

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Rule or Code Section	Natur	e of Violation	Class	Fine A	Amount	Correction date
	between the legs of the partially on the leg of the documented Staff B (No Aide) witnessed the fall.  The Health Status Note revealed Staff A (Regist loops were intact. Staff bleeding, moved the lift bleeding at the resident instructed a Nurse Aide wound and summoned signs and assessed the emesis and bowel move started to move Resident more emesis and anoth cervical collar and trans board and gurney. The had not been lowered to documented Resident #right temple, a hematon her head and skin tears of her right elbow and ri left hand near the thuml Resident #2's blood pre of 89, respirations at 18 93% on room air.	Resident #2 lay on her side lift with her head laying e Hoyer. The Incident Report arse Aide) and Staff C (Nurse dated 7/31/20 8:27 p.m., tered Nurse) noted all lift sling A observed the resident and assessed the site of sright temple. Staff A to apply pressure to the 911. Staff A then obtained vital resident. Resident #2 had an ement. Medics arrived and ht #2. Resident #2 had two er BM. Medics applied a ferred Resident #2 on a back note documented Resident #2 of floor. The note also for the right shoulder, the sides ght knee and the back of her besure (BP) at 198/92, a pulse and an oxygen saturation of				Page <b>3</b> of <b>1</b>

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Rule or Code Section	Nature	e of Violation	Class	Fine A	mount	Correction date
	and she fell on her head as about three to four fereported the resident was to Emergency Medical Stresident did not normally to her dementia; she must any complaints. EMS stresident's forehead to copious amounts of box Resident # 2 transported to copious amounts of box Resident # 2 transported During interview on 8/13 Emergency Medical Ser 7/31/20) stated she saw entering Resident #2's rothree to four feet in the attraction to the head with risk fact and with associated synvomiting. The records at experienced a hypertensime asurement of 158/11 for hypertension via intraction.	sferring the resident with the lift d. The report described the lift d. The report described the lift det off the floor. Staff also as unresponsive for a time prior Services (EMS) arrival. The y talk or obey commands due umbled but did not verbalize taff documented a laceration to that was difficult to access due blood flowing from the wound. It directly to the hospital.  8/20 at 8:00 a.m., the roice staff (dispatched on the height of the lift when dom and it must have been air.  In ment (ED) Physician Notes m. documented Resident #2  Il just prior to arrival. The fall feet out of a Hoyer lift at the dent had swelling and bleeding tors of age and anticoagulation aptoms of nausea and also documented Resident #2				Page <b>4</b> of <b>16</b>
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Rule or Code Nature	e of Violation	Class	Fine A	mount	Correction date
head on 7/31/20 at 8:58 large subdural hematom convexity. The hemator (cm) in the maximal dim a marked associated maparenchyma (the brain's approximate 1.2 cm mid showed effacement (nail ventricle. The impression associated mass effect and resultant acute hydroin the brain).  The hospital Discharge 3:20 p.m. recorded Resist the facility with Hospice  A Health Status Note day documented Resident # assessed the resident a groan to a firm sternal run attempt to pull away. Reference (with her hands). Staff oplanned to discontinue to medications and begin of the control of the planned to her namaright frontal/temporal broadens.	rrowing) of the right lateral on of the CT documented an on the adjacent parenchyma rocephalus (fluid accumulation)  Face Sheet dated 8/1/20 at ident #2 discharged back to and comfort cares.  ated 8/1/20 at 4:04 p.m.  22 returned to the facility. Staff is nonresponsive; she would ub (painful stimuli) but did not esident #2 did not grip or pull contacted Hospice who				Page <b>5</b> of <b>1</b>
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		ated 8/9/20 at 10:30 p.m. 2 expired at the facility at 6:45					
	#2's Physician on 7/31/2 the circumstances, injur	nation Form signed by Resident 20 revealed that after reviewing ry and prognosis of Resident ed Resident #2 sustained a					
	Resident #2's immediat traumatic head injury.	The manner of death, otion of the injury as the patient					
	A remembered the incide when she entered Resident laying on the right side of leg of the lift and blood Resident #2's head, obstignificant and asked State dialed 911. Staff A aides what happened at the lift sling was not corre-position the sling whi wheelchair, but the resident. Staff A stated it was	w on 8/6/20 at 10:57 a.m., Staff dent on 7/31/20. Staff A stated dent #2's room, she saw her with her head partially on the on the floor. Staff A lifted served the laceration was a taff C to apply pressure while stated that she asked the fterwards. The aides reported nected correctly. They tried to the resident sat in the dent was positioned badly and is like they tried to blame ent's fall. When asked about					
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Rule or Code Section	Nature	e of Violation	Class	Fine A	mount	Correction date
	bottom would have been Staff A stated she took a lift had not been lowered she could care for the revia text and asked to sp Staff A stated she is an not want to get anyone had very pronounced he Staff A thought the loop completely on the lift ho #2, her body weight cau hooks, causing the fall. photo she took on 7/31/Nursing (DON).  A review of the photograrevealed a total mechan revealed and loop hung the resident sat) and op the lift arms. The lift sea approximately three fee The facility reported Res Department of Inspection 8/7/20. The Incident Resident #2 moved her shifted her weight, during resident's weight shifted knee lifted off the loops	oks. When staff lifted Resident used the sling to come off the Staff A stated she sent the 20 to the facility's Director of aph received from Staff A nical lift. The photograph free from the lift (lower right as en-ended hooks at the end of at appeared to hang t from the floor.				Page <b>7</b> of 1

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Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
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	ends of the lift's hanger clips to close the end of loops connected. The il the clips were present of Page 26 of the manual is patient if the sling was rehooks of the hanger bare. Observation on 8/5/20 as safety clips in place on hanger bars on either the lifts.  During interview on 8/10 stated after supper on 7 #2 to her room and put Staff C obtained the lift. lift, Staff B noticed the rethe lift sling, so she straustated she ran the lift. Staff C staff B staff B staff C staff D s	at 10:40 a.m. revealed no the hooks at the end of the ne facility's total mechanical 0/20 at 10:00 a.m., Staff B 7/31/20, she assisted Resident the resident's pajamas on while When Staff C arrived with the esident positioned crooked in ightened her out. Staff B				
	her leg and Staff B thou out; Resident #2 fell to t	the lift. Resident #2 swung ght the right lower hook came the floor. During the interview, re supposed to have safety				
	Staff B had never seen	safety clips on the lifts. Staff B er phone, which contained				
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Facility Name: Accura Healthcare of Pleasantville  Facility Address/City/State/Zip  909 North State Street Pleasantville, IA 50225    WW, HL, JS	Citation Numb					Date:	
Accura Healthcare of Pleasantville  Facility Address/City/State/Zip 909 North State Street Pleasantville, IA 50225    VW, HL, JS		#8094				Septe	mber 9, 2020
Rule or Code Section    Photos of the hooks without safety clips at the end of the Invacare hanger bar. Staff B stated she received the photos from another staff member (Staff D).    During interview on 8/10/20 at 3:57 p.m., Staff C (Nurse Aide) stated the night of 7/31/20, Resident #2 had been kicking her legs over the edge of the chair more than once, beginning at 6 pm. The resident also kept trying to sit forward and she got more fidgety. About 6:30 or 7:00 p.m., she and Staff B assisted Resident #2 to her room. They noticed the resident curled sideways in her chair and the sling appeared crooked; they tried to reposition the sling multiple times. They started the lift; Staff B worked the controls and Staff C pulled the chair away. The next thing she knew, Staff C observed Resident #2 turned right in the sling, her right and left legs crossed over each other. Staff C originally thought the loop snapped. Staff C stated she had never seen any safety clips at the hook ends of the lift thanger bar. She also had photos of the lift on her phone which showed no safety clips at the hook ends of the lops had been on the lift on 7/31/20, they might have prevented Resident #2's fall.    During interview on 8/12/20 at 5:15 p.m., Staff D	Accura Health	care of Pleasantville					2020
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(Certified Medication Aide) stated she had photos of the lift on 8/5/20 and provided the photos. Staff D stated she had worked at the facility for more than two years and the lifts failed to contain safety clips.		the Invacare hanger bar the photos from another the photos from another During interview on 8/10 (Nurse Aide) stated the had been kicking her leg more than once, beginn kept trying to sit forward About 6:30 or 7:00 p.m. Resident #2 to her room curled sideways in her cooked; they tried to retimes. They started the and Staff C pulled the cknew, Staff C observed happened fast. Residen her right and left legs croriginally thought the lock had never seen any safthe lift hanger bars. She her phone which showed ends of the hanger bars the clips had been on the have prevented Resider During interview on 8/12 (Certified Medication Aid the lift on 8/5/20 and prostated she had worked in the lift on 8/5/20 and prostated sh	r. Staff B stated she received r staff member (Staff D).  D/20 at 3:57 p.m., Staff C night of 7/31/20, Resident #2 gs over the edge of the chair ing at 6 pm. The resident also d and she got more fidgety.  I she and Staff B assisted in. They noticed the resident chair and the sling appeared position the sling multiple lift; Staff B worked the controls hair away. The next thing she Resident #2 on the floor. It in the sling, cossed over each other. Staff C pp snapped. Staff C stated she ety clips at the hook ends of also had photos of the lift on id no safety clips at the hook in Staff C stated she wished he lift on 7/31/20; they might in the 2/20 at 5:15 p.m., Staff D de) stated she had photos of by by ded the photos. Staff D at the facility for more than two				

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Review of the photogra the hook ends of the had Observation on 8/10/20 mechanical lift 600 had the hooks at the end of 3:00 p.m. revealed the had safety clips in place of the hanger bar.  During observation and a.m., Staff E (Nurse Aid 600 and stated the safe not see the safety clips and she thought they we buring observation and a.m., Staff F (Nurse Aid mechanical 450 lift and floor on 8/7/20 and did Invacare lifts then; toda them.  On 8/10/20 at 10:10 a.m. stated he had worked a does monthly checks the clips, pulls hair out of the batteries. Observation occurred shortly after the	at 1:50 p.m., revealed the total safety clips in place to close the hanger bar. Observation at total mechanical lift 450 lift also to close the hooks at the end interview on 8/12/20 at 10 le) observed the mechanical lift try clips were new. Staff E did on the lifts the previous week ere placed on 8/10/20.				
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	contained instruction to hanger bar connected) is swivel bar supports and bolts/hooks for damage, bends or deflection.  During an additional into Director of 8/13/20 at 10 he mentioned on 8/12/2 with. He reviewed the L stated he looked at all li of the lifts after the intersure the safety clips we not listed on the checkli Maintenance Director the lifts at another facility armay be the other facility the safety clips in place.  During interview on 8/12 Administrator reviewed of the fall and stated he The Administrator stated the hook ends of the lifts the clip's purpose would lift's hooks, he stated he unreasonable to think so An invoice from the facil	8/20, 7/2/20 and 8/12/20 inspect the boom (where the to check its hardware and linspect the swivel bar /wear and the sling hooks for erview with the Maintenance 0:00 a.m., he stated the items 0 were items he had problems logbook documentation and sted items. Upon observation view, he stated he was pretty re on the end of the hooks, but st he maintains. The nen stated he maintained three and two lifts at this facility and it it is lifts he remembered seeing 1.  2/20 at 10:45 am, the the photograph taken the night had seen the photo before. It is on 8/10/20. When asked if it be to keep the loops on the end did not really know but it's not				Page 11 of 16

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	8/10/20.  On 8/12/20 at 11:30 a.m provided a list of resider lifts for transfers; the list current residents and di DON stated the facility hall nine residents could mechanical lift 450 or the 2. During interview on (Nurse Aide) stated she trained as A Nurse Aide transfers during that traistaff must be 18 years of lifts. Staff B stated the I had observed transfers training on use of the m 18 in June, 2020 and shecause other staff told now. During further inte Staff B stated she had be mechanical lifts for all retransfers since she turn had transferred Resider stated Resident #2 coul that night was really back.	esidents who required lift ed 18 in June, 2020. She likely nt #2 50 to 100 times. She d be fidgety with transfers but				Page <b>12</b> of <b>16</b>

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		rector of Nurses and the facility had no policy regarding				
		eing prohibited from using				
mechanical lifts; it is the		facility's practice though.				
	On 8/12/20 at 11:10 a.n	n., the Director of Nurses				
		Orientation Checklist - Transfer				
		dated 7/20/19. The Director of is the most recent training Staff				
B had on mechanical lif		t transfers. Staff B had no				
additional training aside the lift.		from watching other staff use				
		oth stated that Resident #2 and attempted to turn				
	sideways during the trai					
	During an interview on 9	3/13/20 at 9:50 a.m., Staff G				
	· ·	Aide) stated she had not				
received training regard		ing resident movement during				
		ated she worked in long-term If a resident moved during a				
mechanical lift transfer,		she would stop the transfer				
	and tell her charge nurs	e and try again later.				
	On 8/13/20 at 10:20 a.n	n., Staff H (Nurse Aide) stated				
		using the total mechanical lifts				
		e. If a resident moved their g a transfer, she would not				
	transfer the resident, wo	ould let them calm and try				
	again later. The Nurse					

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	mechanical lifts prior to  During an interview on 8 (Nurse Aide) stated if a legs or turn during a lift again later. It wouldn't be Staff I knew this based of from training at the facility Page 7 of the Mechanical instructed to use common care must be taken with cannot cooperate while Review of the Staff Edutraining beginning on 8/4 training items:  a. User manuals for each themselves. Please util operation. Shower sling showers only  b. In the event that any removed from operation affixed to the equipment operation. The equipment operation. The equipment operation machine area user.	cal Lift 450 User Manual on sense in all lifts. Special people with disabilities who being lifted.  cation for 8/20 document, with 4/20, identified the following the lift are attached to the lifts ize this as a user's guide to gs should be utilized for equipment fails, it needs to be a. A sign should be securely				

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care as appropriate. The Pocket Care Plans are located at the designated nurse's station. The Staff Education for 8/20 also contained staff audits on safe use of the mechanical lifts.  During interview on 8/13/20 at 10:45 a.m., the Assistant Director of Nurses (ADON) stated she conducted the staff education for 8/20. The ADON stated she went through each item as documented and also went through the User Manual (pages 20-21, 24-28 and 31). She stated she watched as staff read the manual and use the lifts. The ADON stated the training did not specifically address what to do if a resident moved or squirmed during a lift transfer, but it did address the safety and comfort of the resident.  On 8/13/20 at 2:45 p.m. the State Agency informed the facility of the Immediate Jeopardy. The facility abated the Immediate Jeopardy on 8/14/20 by educating staff on the proper use of lifts according to the manufacturer's instructions with return demonstration, educating staff on what to do in the event a resident moves while in the lift, installing clips to the lift hanger bar and implementing checks to ensure the clips are in place prior to use of the lifts. After corrective actions the scope lowered from a "J" to "D".  FACILITY RESPONSE:						
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