

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

Citation Number: 6636				Date: August 31, 2017	
Facility Name: Premier Estates		Fine amount reduced by 35% to \$325.00 on September 14, 2017 pursuant to Iowa Code Section 135C.43A		Survey Dates: July 27-28, August 1-3, 2017	
Facility Address/City/State/Zip 3440 Mulberry Avenue Muscatine, Iowa 52761					
		DS			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date	

58.18(4)	<p>481-58.18(135C) Nursing care. 58.18(4) The facility shall provide prompt response from qualified staff for the resident's use of the nurse call system. (II,III) (Prompt response being considered as no longer than 15 minutes.) [ARC 1398C, IAB 4/2/14, effective 5/7/14].</p> <p>DESCRIPTION:</p> <p>Based on observation, record review and staff and resident interviews, the facility failed to respond to call lights in a timely manner for 3 of 5 residents (Residents #1, #3 and #5). The facility reported a census of 69 residents.</p> <p>Findings include:</p> <p>1. Resident #1 had a Minimum Data Set (MDS) assessment with a reference date of 7/3/17. The MDS indicated Resident #1 had diagnoses of traumatic subdural (bleeding on the brain) hemorrhage, stroke, depression, anxiety and hemiplegia (paralysis of arm and leg)</p> <p>The Roster Sample Matrix document, provided by the facility on 7/28/17, identified Resident #1 as able to be interviewed. The MDS indicated Resident #1 required extensive assistance of two staff for bed mobility, transfers and toilet use. Resident #1 had frequent bladder incontinence.</p>	II	\$500	Upon Receipt	
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Facility Administrator

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	<p>The current Care Plan initiated a problem with the resident at risk for falls due to gait and balance problems. The approaches directed the staff to be sure the resident's call light is within reach and encourage the resident to use the call light for assistance as needed. The approach directed the staff that the resident needed prompt response to all requests for assistance.</p> <p>Observation of Resident #1's room identified a Therapy Communication -Teaching - Training sheet, attached to the wall. The sheet dated 7/6/17 directed the staff to transfer/ambulate Resident #1 with assistance of one staff and a platform rolling walker.</p> <p>On 8/1/17 at 3:45 p.m. Resident #1 was interviewed and reported 2 weeks ago he/she asked the staff for assistance to go to the restroom. Resident #1 stated a staff person told him/her they would be back and then didn't return for almost an hour. Resident #1 stated she/he had an accident (urinated) in his/her pants. Resident #1 reported he/she felt a feeling of disgust and embarrassment and had to walk down the hallway with wet pants. Resident #1 stated she/he is in the common area most of the day and even sleeps in the common area.</p> <p>On 8/3/17 at 10:40 a.m. Staff B reported Resident</p>			
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	<p>#1 tells the staff when he/she needs to use the restroom. Staff B reported the residents may have to wait over 15 minutes for assistance if one of the staff is on break.</p> <p>2. Resident #3 had a MDS assessment with a reference date of 6/16/17. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 13. A score of 13 represented no cognitive problems. The MDS identified the resident had diagnoses of diabetes, aphasia (inability to speak), hemiplegia (paralysis of arm and leg) and anxiety. The MDS indicated the resident had no urinary or bowel incontinence problems.</p> <p>The Care Plan directed the staff to provide assistance of two staff for transfers with a gait belt, place call light in reach and encourage use.</p> <p>On 8/1/17 at 3:00 p.m. Resident #3 was interviewed and reported he/she turned the call light on and waited up to 30 minutes every day for the last two weeks. Resident #3 stated he/she knows when needs to go and can make it there if the staff respond timely. Resident #3 stated he/she times the response on his/her wristwatch.</p> <p>An interview on 8/3/17 at 10:35 a.m. Staff A reported residents had accidents waiting for the</p>			
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	<p>staff to use the restroom. The residents reported to Staff A that they waited 20 minutes for the staff to respond to the call lights. (A reasonable person does not like to urinate in their personal clothing).</p> <p>3. According to the Admission Record dated 8/1/17, Resident #5 had diagnoses of heart failure, anxiety and oxygen dependence.</p> <p>The MDS with a reference date of 7/13/17 indicated Resident #3 dated 7/13/17 identified Resident #5 required limited assistance of 1 staff person for transfers and toilet use. The MDS identified the resident had no cognitive problems and had a BIMS score of 15.</p> <p>The Care Plan directed the staff to keep the call light in reach, encourage to use it for assistance as needed and provide a prompt response to all requests for assistance.</p> <p>The Progress Notes dated 7/23/17 at 10:04 p.m. indicated Resident #5 called 911 [emergency number] because of chest pain. The note indicated when medics arrived; Resident #5 stated the chest pain had gone away.</p> <p>On 8/1/17 at 12:06 p.m. Resident #5 was interviewed and stated he/she had chest pain and put the call light on [activated]. Resident #5</p>			
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	<p>stated when the staff didn't respond after 30 minutes, he/she called 911. Resident #5 described the experience as scary.</p> <p>On 8/2/17 at 3:46 p.m. Staff D (licensed practical nurse) was interviewed and stated Staff E (Nurse) informed him/her someone called and reported Resident #5 called 911 and an ambulance was dispatched. Staff D went to Resident #5's room. Staff D did not recall if the call light was activated. Resident #5 reported the chest pain subsided. Staff D reported she was in Resident #5's room 15 minutes prior to this and administered medications to Resident #5.</p> <p>According to the Medication Administration Audit dated 7/23/17, staff signed out Resident #5's medications from 4:52 p.m. to 5:01 p.m.</p> <p>A phone interview on 5/2/17 at 4:10 p.m. identified the emergency services received Resident #5's call at 5:34 p.m.</p> <p>On 8/3/17 at 10:55 a.m. Staff C (certified nursing assistant) was interviewed and stated she reported the residents have complained about the staff's response to the call lights. Staff C stated she reported the residents had accidents in their pants while waiting for the staff to respond. Staff C stated the longest wait is when one of the staff</p>				
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	<p>is on break. Staff C stated the staffing is based on the census. Staff C reported the 500/600 Hall had 3 nurse aides instead of 4 for about a month because of the census. Staff C stated it is hard to answer the lights within 15 minutes. Staff C reported the staff is spread too thin.</p> <p>The CNA Orientation checklist, received on 8/3/17, identified a goal to respond to call lights in 10 minutes. The checklist directed the staff to never shut the call light off unless able to meet the resident's needs at that time. If the resident is the assistance of two staff, leave the light on and go ask for help.</p> <p>FACILITY RESPONSE:</p>				
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