

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

Citation Number: #5503				
Facility Name: Accura Healthcare of Lemars		Date: December 29, 2021		
Facility Address/City/State/Zip 954 7 th Ave SE LeMars, IA 51031		Survey Dates: December 13-16, 2021		
		MW/DC		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

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: Based on record review, interviews and observation the facility failed to provide adequate nursing supervision resulting in a fractured hip due to a fall for 1 out of 3 residents reviewed, (Resident #125). The facility reported a census of 25 residents.</p> <p>Findings Include:</p> <p>The Minimum Data (MDS) with an Assessment Reference Date of (ARD) of 11/11/20 for Resident #125 showed a Brief Interview Status Score (BIMS) of 08 which indicated moderately impaired cognitive skills. The MDS showed the resident had diagnoses of dementia, disorientation, weakness, chronic kidney disease, and anxiety. The resident required limited assistance with one staff for transfers, dressing and ambulation.</p> <p>Review of Progress Note dated 9/6/2020 at 10:26 PM</p>	I	\$9500.00	UPON RECEIPT
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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 Iowa Code section 135C.43A (2013).

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	<p>stated Resident #125 was found sitting in the hallway in front of room 45 sitting on buttocks holding on to side rail in hallway. The Resident stated, I just wanted to get out of bed. I wasn't tired yet. Intervention at time of fall was to educate staff on alarm use.</p> <p>Review of the Incident Report dated 9/6/20 stated the immediate action taken was staff to ambulate resident with walker and gait belt, lay resident back down in bed, alarm activated. Certified Nurse's Aides (CNA) educated on making sure alarm box is turned on.</p> <p>Review of the Progress Note dated 11/29/20 at 3:45 PM noted the resident was resting in a recliner in the lounge area of the commons room. The Nurse had seen the resident about 30 minutes prior to the incident. The two CNA's were down a hall helping another resident when they heard a thump from the commons room and found the resident lying on the floor on her right side. The Progress Note stated it appeared the resident got up on her own and started waking to the piano in the dining room. There was a chair alarm placed in the recliner but it was not turned on. The resident was complaining of pain in her right leg and was sent to the emergency room for evaluation.</p> <p>On 12/14/21 at 10:22 AM observation made of the area with Director of Nursing (DON). The DON showed the resident was sitting in the commons area with the recliners and TV and was found on the floor by a piano which was located about 50 feet from where she was seated.</p>			
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	<p>Review of the Incident Report dated 11/29/20 prepared by Staff C, Registered Nurse (RN) stated the resident was sitting in a recliner in the front lounge area, got up unassisted and fell on her right side. Alarm was in place but was not turned on.</p> <p>Review of the facilities investigation stated at approximately 3:15 PM Staff C RN conducted vitals on the resident while in the recliner and then went on to obtain other residents vital signs. At approximately 3:30 PM Staff D CNA noticed the resident laying on the floor from a distance after hearing a noise. Staff D CNA noted the pad alarm was not sounding. Staff C RN then called the emergency room and Emergency Medical Team arrived on site at 3:40 PM. Plan of action taken was to reeducate all nursing staff to ensure proper alarm utilization by the end of day 12/2/20.</p> <p>Review of the Progress Note dated 11/29/20 at 5:27 PM showed the facility was notified by the hospital Resident #125 sustained a dislocated trochanter and a fractured hip.</p> <p>Review of the Progress Note dated 12/1/20 at 1:51 PM stated the facility was informed by the hospital Resident #125 had surgery on 11/30/20.</p> <p>Review of the Respiratory Surveillance Form showed Resident #125 tested positive for Covid-19 on 11/29/20 at the hospital.</p>			
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	<p>Review of the Progress Note 12/2/20 at 12:54 PM showed the resident returned to the facility</p> <p>Review of Progress Note dated 12/11/20 at 5:18 PM Resident #125 was admitted to hospice with diagnosis of Covid-19 and comorbidities of right hip fracture repair.</p> <p>The Progress Note dated 12/12/20 at 6:00 PM noted the resident had passed away.</p> <p>Review of the Care Plan stated a personal alarm was to be on at all time with an initiation date of 6/10/20.</p> <p>Review of the Fall Risk Assessment dated 11/13/20 stated resident was a high risk for falls with a high fall risk score of 18.</p> <p>Interview on 12/14/21 at 1:50 PM the DON stated the facility does not have personal alarms any more, it has been about a year since they have used alarms, she stated she does not like to use alarms and expects staff to observe residents.</p> <p>FACILITY RESPONSE:</p>			
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