Department of Inspections and Appeals
Health Facilities Division
Citation

Number 5951			**Report date** **December 21, 2022**
Facility name Aspire of Gowrie		**Survey dates** **11/28/2022 - 12/08/2022**	
Facility address 1808 Main Street			
City Gowrie	**JB**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.6(1)	**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.	I	**$15,750 ($5250X3)** **Trebled** **Held in Suspension**	**Upon Receipt**
58.28(3)e	**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) **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) **DESCRIPTION** Based on observations, clinical record reviews, policy review, resident, and staff interviews the facility failed to adequately supervise a resident during the administration of eye drops for 1 of 1 resident reviewed (Resident #1) which resulted in fingernail glue being placed in a resident's eye. On 11/11/22, Resident #1 arrived in the dining room with a small bottle he found on his bedside table and asked Staff A, Certified Nurse Aide (CNA), to			

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	assist him with putting in eye drops. Staff A proceeded to administer the drops into Resident #1's right eye without confirming the bottle was eye drops. After Staff A placed a drop into Resident #1's right eye, the resident immediately complained of pain and burning. Staff A then identified the bottle as fingernail glue instead of eye drops. The local EMT's (emergency medical team) arrived at the facility and assisted Resident #1 with flushing his right eye. After 25 minutes of flushing Resident #1's eye, his eyelids broke apart. The facility reported a census of 24 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #1 dated 10/26/22, identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS coded the resident with adequate vision, able to read regular print in newspaper without corrective lenses. The MDS listed diagnoses of anxiety, depression, bipolar, and COPD (chronic obstructive pulmonary disease). The MDS revealed the resident had pain occasionally, that received scheduled pain medications, and he did not receive additional pain medications as needed. The facility incident report titled Unknown dated 11/11/22 at 10:50 PM, revealed:			

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	Nursing description: An agency CNA waiting for a ride when Resident #1 came to the dining room, attempting to put in eye drops and asked the CNA for assistance. The CNA placed the eye drops into Resident #1's right eye and then looked at the bottle, realizing then it was nail glue. The CNA reported to the charge nurse and left her shift. Resident description: Resident #1 stated he thought the bottle was eye drops and brought it out for assistance to administer. The resident stated he did not know the bottle was nail glue. Immediate action: call placed to 911 and the Emergency Medical Services (EMS) arrived to assess and flush his eye. The Progress Notes for Resident #1 revealed: a. On 11/12/22 at 12:08 AM, a Health Status Note (HSN) revealed that at approximately 10:43 PM, the resident went to the dining room and asked Staff A to put in some drops in his eyes. Staff A proceeded to put drops in the resident's eye when the resident complained of burning. Staff A then identified the bottle to be nail glue. The resident stated he found the bottle on his bedside table. At 10:45 PM, the emergency services and the doctor on call were notified. The EMT's arrived at 10:58 PM and flushed the resident's eye for 20 minutes. During the flushing of the eye the resident received tramadol and Tylenol for pain. Once the eye was opened, his eye appeared red and the resident complained of blurry vision. At 11:30 PM,			

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	the on-call provider got notified of the outcome and requested a face to face to visualize Resident #1's eye. b. On 11/12/22 at 4:47 AM, a telemed note revealed the resident had an initial visit via telemedicine for superglue in the eye. The eye appeared to have slight redness, slight irritation, and no drainage. The resident denied changes in vision. c. On 11/12/22 at 11:13 AM, a telemed note revealed the resident got seen due to crazy glue being applied to his right eye the night before. The resident complained of pain 8 out of 10 to his right eye. The assessment of the right eye revealed visible swelling to the surrounding tissue, more to then to his lower lid. The conjunctiva was red and the resident complained of pain and burning. The resident reported distorted/blurry vision to his right eye. The provider requested the resident be sent to the emergency room (ER) for further evaluation and treatment. d. On 11/12/22 at 11:26 AM, HSN indicated notification of the on-call provider occurred on 11/11/22. The resident complained of blurred vision and rated his pain at an 8 out of 10. The resident's sclera was red with the surrounding area red and swollen. e. On 11/12/22 at 6:01 PM, the Medication Administration Note (MAN) revealed the resident received Tylenol 650 milligrams (mg)for pain rated at a 6 out of 10.			

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	f. On 11/12/22 at 7:19 PM, MAN revealed the resident received tramadol 50 mg for right eye pain g. On 11/13/22 at 1:29 AM, HSN revealed the resident's right eye was red and irritated. The resident complained of pain to his right eye. Resident #1 received tramadol and Tylenol to manage his pain. The resident reported the tramadol and the Tylenol were not controlling the pain to his right eye. The resident went to the ER and returned at approximately 6 PM, with a new order for erythromycin ointment four times a day to his right eye for seven days. h. On 11/13/22 at 1:14 PM, MAN revealed the resident received tramadol 50mg for pain in the right eye, rated 6 out of 10. i. On 11/14/22 at 1:22 PM, MAN revealed the resident received tramadol 50mg for pain to the right eye j. On 11/15/22 at 2:09 AM, HSN indicated the resident right eye continued with redness and antibiotic ointment applied. k. On 11/15/22 at 9:00 AM, HSN indicated the resident was seen by the primary care provider during an in-house visit. l. On 11/15/22 at 12:27 PM, MAN revealed the resident received tramadol 50 mg for pain to his right eye. m. On 11/16/22 2:33 PM, HSN indicated the resident woke up most of the night and complained			

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	of discomfort to his eye. The right eye appeared red and the ointment applied. n. On 11/16/22 at 11:26 AM, MAN revealed the resident received tramadol 50 mg due to pain in his right eye. o. On 11/16/22 at 2:09 PM, HSN revealed the resident returned from an appointment with the optometrist (eye doctor) and received orders to continue the antibiotic ointment and start a steroid eye drop. The resident was to return to the clinic in two weeks for a follow-up appointment. p. On 11/30/22 at 3:10 PM, HSN revealed the resident returned from the eye appointment in order to discontinue the antibiotic ointment and continue with the steroid eye drops. The Emergency Services Prehospital Care Report dated 11/11/22, revealed that upon arrival at the facility Resident #1 sat in a wheelchair holding a warm cloth to his eye. Resident #1 gave the staff a bottle of what he originally thought was eye drops and had asked the CNA to administer. After the CNA administered the eye drops, she realized the bottle was nail glue. Resident #1's lashes were covered with a thick layer of glue and had to be flushed for 25 minutes. Resident #1's eye had to be pulled at the eyebrow and cheek to break the eyelids apart. Resident #1's eye was red and swollen. No transport required to the emergency room.			

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	The local hospital Emergency Department note dated 11/12/22 at 3:20 PM, identified Resident #1 reported irritation, redness, and pain to his right eye due to nail glue placed into his eye. Resident #1 reported tearing and blurred vision to the right eye. Suspected corneal irritation. The November Medication Administration Record (MAR) revealed Resident #1 received the medications below following the administration of nail glue in his right eye: a. Prednisolone 1% eye drops, apply one drop to the right eye two to four times a day from 11/17/22 - 11/30/22. b. Erythromycin eye ointment three to four times per day from 11/12/22 - 11/30/22. c. Tramadol 50 mg 1 tablet every 12 hours as needed, received daily 11/12/22 - 11/16/22. d. Tylenol 325 mg 2 tablets every six hours as needed, received 11/12/22. The facility investigation dated 11/12/22, identified Resident #1 had super glue placed in his eye by a CNA. The investigation revealed Resident #1 brought a bottle out of his room to Staff A holding the bottle over his eye and asked the CNA to assist him. Staff A placed the drops in the resident's eye and the resident immediately complained of his eye burning. Staff A noted the bottle to be nail glue and notified the nurse immediately.			

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	The facility Medication Administration Guidelines dated June 2022, revealed: a. Only a licensed nurse would be allowed to administer medication as per the state/federal laws and regulations (follow the state policy on medication aide) b. Upon administering medication, the license nurse would compare the label on the medication to the Medication Administration Record (MAR) to ensure accuracy. c. The resident's MAR would be reviewed to determine what medications are to be administered and then the staff removes those medications from the medication cart d. The staff would compare the MAR with the label of each medication for: the right person, right medication, right date, right time, right route, right dose, and expiration date. The facility document titled Dress Code, undated indicated: a. Fingernails would be neat and not exceeding one-fourth inch in length for clinical and dietary staff b. Artificial gels and overlays not permitted for purposes of infection control On 11/28/22 at 10:35 AM, Resident #1 laid in bed with oxygen on at 4L/NC (liters/nasal cannula) with a tray table beside his bed that contained a water mug, cell phone, and a box that the resident stated			

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	contained ostomy supplies. The resident stated he never had been able to keep eye drops in his room, however, on 11/11/22, he saw a small bottle on his tray table and assumed the small bottle was eye drops so he took the bottle to the front and asked the CNA to put drops in his eyes. Resident #1 stated his eyes were too bad and he could not read the label on the bottle. The resident stated the CNA did not read the bottle and just put a drop into his right eye. Resident #1 stated as soon as the CNA put the eye drop into his right eye, he felt pain immediately. The resident stated the CNA then read the bottle and stated it was a bottle of fingernail glue, not eye drops. The resident stated the EMT's (Emergency Medical Team) came to the facility and applied heat compression to open the right eye. The resident stated "boy it sure hurt, when the fingernail glue was placed into my right eye." Resident #1 stated the EMT's had worked for approximately 45 minutes to get the glue out of his eye, and to where he was able to open his eye. Resident #1 stated he went to the ER (emergency room) for further evaluation of the right eye and within two days saw an eye doctor. The resident stated the eye doctor informed him that the right eye wouldn't bother him forever, however, he continued to have blurry vision. Resident #1 stated when he saw the bottle on the tray table, he assumed the bottle was eye drops due to recently complaining to the staff about dry eyes. Resident #1 stated he did not know why the fingernail glue was			

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	in his room, on the tray table or where the glue came from. Resident #1 stated he was not allowed to have any medications left in his room, before, or after the incident on 11/11/22. Resident #1 stated he was not aware of any staff being in his room that could have left the fingernail glue on the tray table. The resident stated the bottle was artificial fingernail glue and that he was sure one of the facility staff girls left it in his room. The resident stated one of the facility staff must have left the bottle of glue in his room sometime during the day on 11/11/22. On 11/28/22 at 12:04 PM, Staff B, CNA, confirmed that she worked 6 AM - 2 PM on 11/11/22. Staff B stated she did not have artificial nails and that Staff G, CMA (Certified Medication Aide), had artificial nails. Staff B stated she never recalled seeing a bottle of glue on Resident #1's bedside table. Staff B stated she was not aware if the resident had ever received eye drops in his eyes prior to the incident. Staff B stated if a resident had asked her to administer eye drops, she would tell the resident that she was unable to administer eye drops and that she would notify the nurse on duty. On 11/28/22 at 12:06 PM, Staff C, CMA, confirmed that she worked on 11/11/22. Staff C stated she did not have artificial nails. Staff C stated she did not recall seeing a bottle of nail glue on Resident #1's bedside table on 11/11/22. Staff C stated she never			

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	observed nail glue in any other residents' rooms. Staff C stated no residents were allowed to have medications in their room, including eye drops and inhalers, to self-administer. Staff C stated if a resident had approached her with eye drops to administer, she would give the bottle to the nurse on duty because the resident should not have eye drops in their room. On 11/28/22 at 12:10 PM, Staff D, CNA, confirmed she worked 6 AM - 2 PM on 11/11/22. Staff D stated she did not recall seeing a bottle of nail glue on Resident #1's tray table on the day of 11/11/22. Staff D stated she did not have artificial nails. Staff D stated she had never observed any nail glue in other resident rooms. On 11/28/22 at 12:18 PM, Staff G confirmed that she worked 6 AM - 6 PM on 11/11/22. Staff G stated that she did not recall seeing a bottle of nail glue in Resident #1's room on 11/11/22. Staff G stated the only things Resident #1 kept on the tray table was water, cell phone, wheelchair charger, Kleenex and ostomy supplies. Staff G stated the resident had never asked about anything in his room, like something being left in his room. Staff G stated she did have artificial nails; however, she kept the nails short and never carried a bottle of nail glue while at work. Staff G stated she did not recall seeing a bottle of nail glue being left in any other residents' room. Staff G stated there was			

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	never a reason to have a bottle of nail glue in the facility. Staff G stated all chemicals in the facility were locked up away from the residents. Staff G stated there was one resident in the facility that had nails done regularly, however, done outside of the facility and not artificial nails, shellac polish. Staff G stated the resident's family took that resident out of the facility to have nails done. Staff G stated if a resident for assistance with eye drops, if clocked out would have the resident ask the nurse. Staff G stated she would confirm the bottle the resident had was eye drops because the residents are not to have eye drops in their room. Staff G stated she would then check to confirm the resident had an order for the eye drops. Staff G stated Resident #1 did not have an order for scheduled or as needed eye drops and the resident rarely asked for anything as needed with the exception of his inhaler. Staff G stated Resident #1 had never complained of having dry eyes. On 11/28/22 at 1:02 PM, Staff H, Housekeeper, stated she had not observed any fingernail glue in any of the residents' rooms and was shocked that Resident #1 had fingernail glue in his room and that staff had thought it was eye drops. Staff H stated several female facility staff had long artificial fingernails, the aides and the nurses. Staff H stated she had previously worked in activities for a couple of weeks and the resident's activity supplies; fingernail polish and the nail polish remover were			

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	kept in the locked cupboard. Staff H stated the facility did not currently have an activity assistant and was not aware of when the last time the residents had their nails done. Staff H state some residents may have nail polish in their rooms, but no nail polish remover or nail glue. On 11/28/22 at 2:00 PM, Staff A confirmed she worked at the facility 2 PM - 10 PM on 11/11/22 as an agency staff. Staff A stated she had clocked out about 30 minutes prior around 10 PM and had been waiting for her ride. Staff A stated about 10:30 PM her ride showed up and she grabbed things to leave when as she walked to the door Resident #1 came up in his electric wheelchair with a bottle hovering over his eye and asked if she would help him get his eye drop in. Staff A stated instead of telling the resident she was not clocked in, she tried to be helpful and gave Resident #1 the eye drops. Staff A stated as soon as she gave Resident #1 the drop in the right eye, the resident bent down and complained of the eye burning. Staff A stated at that time looked at the bottle, and saw it was nail glue not eye drops. Staff A stated she had asked the resident where he got the bottle from and he said it was on his table. Staff A stated she didn't know where the bottle of nail glue came from or why it was even in the facility. Staff A stated she did not know why the bottle was there or how it got there. Staff A stated the facility wouldn't allow her to return to the facility to work due to the incident.			

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	Staff A stated she admitted, she put the nail glue in Resident #1's eye, however, did not leave the nail glue in the resident's room. Staff A stated the way Resident #1 came up to her with the bottle over his he was attempting to self-administer so she assumed the bottle was eye drops. Staff A stated tried to be helpful and gave the resident the drops even though she was off the clock. Staff A stated she did not recall seeing the bottle of nail glue in the resident's room during the 2 PM - 10 PM shift. Staff A stated she took responsibility for what she did, putting the nail glue in the resident's eye. Staff A stated if they could go back and change, they wouldn't have assisted the resident with the drops. Staff A stated she was not surprised something like the nail glue was left in the residents, stated the facility was chaotic and had no organization. Staff A stated her first day to work at the facility was Friday 11/11/22 and the facility allowed her to work on Saturday 11/12 and Sunday 11/13, however, was then not allowed to return to the facility to work. On 11/28/22 at 2:56 PM, Staff E, CNA, confirmed that she worked 10 PM - 6 AM on 11/11/22. The 2-10p aide in the dining room had been waiting for a ride. The other night CNA and Staff E were down the hall and as we were coming to the dining room saw the 2 PM - 10 PM aide start to put the drop in the resident's eye. Did not see the resident trying to put drops in his own eye. The resident did bring the bottle of nail glue from his room. The resident had			

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	asked the 2 PM - 10 PM aide for assistance and then the resident put his head down immediately. We were through the dining room and the aide looked at the bottle and said it was nail glue. Never observed nail glue left in another resident's room. Too many staff have acrylic nails and I don't think they should have them. If they kept them short but we have too many with nails that are too long. As few staff as the facility had, probably the agency that has the acrylic nails. Did not witness, heard Staff A say she had placed nail glue in Resident #1's eye. The EMT's came right away and assisted with getting the resident's eye open. The facility had a policy regarding nails, and to be quarter inch in length. Did not think the facility had a policy related to fake nails specifically but the length. On 11/28/22 at 3:09 PM. Staff F, CNA, confirmed she worked 10 PM - 6 AM on 11/11/22. Staff F stated she had received a report with the other overnight aide (Staff E) and observed Staff A at the table in the dining room, awaiting her ride. Staff F stated she went down the north hall with Staff E to answer a call light and when coming back up the hall observed Staff A standing over Resident #1. Staff F stated she observed Staff A lean over Resident #1 and then heard the resident complain of his eye burning. Staff F stated she asked Staff A what she was doing and Staff A stated Resident #1 had asked for assistance with putting in eye drops and Staff A said it was nail glue. Staff F stated			

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	Resident #1's eye instantly was glued shut. Staff F stated the nurse informed us to place a warm rag on the resident's eye and called 911. Staff F stated Staff A had been on her phone at the time and picked up her belongings. As Staff A walked to the door she said into her phone, you wouldn't believe what just happened. Staff F stated the EMT's were at the facility for about 20 minutes to flush the Resident #1's eye. Staff F stated the resident had never asked for eye drops to be placed before, stating the resident knew the nurse would give him the eye drops. Staff F stated Resident #1 had informed the staff that the nail glue had been on his bedside table. On 11/28/22 at 3:40 PM, the Director of Nursing (DON) stated that she received a phone call from the facility on 11/11/22 that a CNA had placed nail glue in Resident #1's eye, instead of eye drops. The DON stated Resident #1 had an order for artificial tears as needed, however, the resident was not allowed to keep those in his room. The DON stated Staff A thought she was just helping the resident out because his hand was not steady enough to administer the eye drops. The DON stated the EMT's were at the facility and stayed for approximately 30-45 minutes to flush the Resident #1's eye and the EMT's took the nail glue. The DON stated Resident #1 was seen by telehealth on the night the incident occurred and then the following day. The DON stated Resident #1 went to the local			

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Department of Inspections and Appeals
Health Facilities Division
Citation

Number			Report date
5951			December 21, 2022
Facility name Aspire of Gowrie		**Survey dates** **11/28/2022 - 12/08/2022**	
Facility address 1808 Main Street			
City Gowrie	**JB**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
	emergency room (ER) the following day as recommended for further evaluation on 11/12/22. Resident #1 returned to the facility from the ER visit with orders for erythromycin ointment. Resident #1 went to the eye doctor on 11/16/22 and would return for a follow-up visit on 11/30/22. The DON stated Resident #1 had an order for artificial tear eye drops as needed, however, the resident was not allowed to keep the eye drops in his room. The DON stated no residents in the facility were allowed to keep their own medications in their room. The DON stated she had asked Resident #1 and the facility staff where the nail glue came from and none of them knew where the nail glue came from. Resident #1 saw the bottle on his table and assumed it was an eye drop. The DON stated Staff A had been at the table and Resident #1 came out with the bottle above his eye and asked Staff A to assist with putting the eye drops in due to the resident hand not steady. The DON stated Staff A thought she was helping Resident #1 because his hand was not steady enough to administer the eye drops himself.			

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Rule or Code Section	Nature of Violation	**Class**	**Fine Amount**	**Correction Date**
	FACILITY RESPONSE			

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Facility Administrator Date