

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

Citation Number: <b>#6170</b>		Date: <b>July 25, 2023</b>		
Facility Name: <b>Harmony Davenport</b>		Survey Dates: <b>June 19, 2023 – July 6, 2023</b>		
Facility Address/City/State/Zip: <b>815 East Locust Street Davenport, IA 52803</b>		TAG		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

<b>58.28(3)e</b>	<p><b>481—58.28(135C) Safety.</b> 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><b>58.28(3) Resident safety.</b></p> <p><b>e.</b> Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p><b>DESCRIPTION:</b></p> <p>Based on clinical record review, observations, staff interviews, and review of the facility's Falls Practice Flow Chart, the facility failed to prevent a fall with serious injury for one of three residents reviewed for supervision (Resident #10). The facility reported a census of 59 residents.</p> <p>Findings Include:</p> <p>1. The Minimum Data Set (MDS) dated 5/18/23 identified Resident #10 with moderate cognitive status with a Brief Interview for Mental Status (BIMS) of 12 out of 15 points and had the following</p>	<b>CLASS I</b>	<b>\$5,000.00 (HELD IN SUSPENSION)</b>	<b>UPON RECEIPT</b>
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Facility Administrator

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	<p>diagnoses: Cancer, Cerebrovascular Accident (stroke) and Non-Alzheimer's Dementia. The MDS also identified Resident #10 required extensive staff assistance with most activities of daily living (ADL's) and had a history of falls one month prior to admission to the facility.</p> <p>The Incident Report dated 6/8/23 at 7:20 PM, documented the following: Resident #10's roommate stated he was on the floor. Resident #10 found sitting on the floor with legs crossed, stated he stood to use urinal, floor got wet and he fell. He was using a bedside table to walk in the room. Resident #10 able to stand with assist of 2, then stated his left leg hurt. Emergency Medical Services (EMS) notified and arrived at 7:35 PM. Resident #10 transferred from bed to gurney with assist of 4 then taken to the hospital. Injury: possible fracture left trochanter.</p> <p>A review of the Nurse's Notes revealed the following:  a. On 6/8/23 at 7:20 PM, Resident #10 found on the floor, range of motion normal without complaints of pain. After staff assisted the resident to stand and transfer him to bed, he complained of pain to his left upper outer thigh area. Resident #10's Power of Attorney (POA) and Physician notified. Orders received to send to the Emergency Department for evaluation and treatment. EMS transported the</p>			
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	<p>resident to the hospital at 7:35 PM.</p> <p>b. On 6/9/23 at 5:04 PM, Resident #10 returned from the hospital after hospitalized for left hip fracture after a fall. Family decided to leave untreated and continue with Palliative Care.</p> <p>c. On 6/13/23 4:22 PM, Resident #10 found unresponsive without heart rate or lung sounds.</p> <p>The Major Injury Determination Form had documentation of the following:</p> <p>a. Date and time of injury: 6/8/23 (no time documented).</p> <p>b. Description of injury: left femoral neck fracture, mild proximal migration of left femoral shaft.</p> <p>c. Circumstances of incident causing injury: up to use urinal, stood, slipped and fell next to bed.</p> <p>d. Resident's previous functional ability: supervision and cueing for transfers.</p> <p>Completed by DON (Director of Nursing) on 6/9/23 at 11:09 AM.</p> <p>Response by the facility to Medical Director on 6/19/23 at 11:00 AM.</p> <p>On 6/16/22 the Care Plan identified Resident #10 with the problem of ADL's - Self-care deficit and directed staff to transfer with supervision/ as needed (PRN) assist with a walker.</p>			
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	<p>During the investigation survey, observations of the Resident #10 lying in bed on his back with continuous oxygen maintained at 2 liters per nasal cannula per concentrator on the following dates and times:</p> <ul style="list-style-type: none"> <li>a. On 6/19/23 at 11:51 AM, at 12:42 PM, at 3:45 PM, and at 3:48 PM.</li> <li>b. On 6/20/23 at 7:47 AM, and at 9:29 AM.</li> <li>c. On 6/21/23 at 8:01 AM, at 10:08 AM, at 12:36 PM, and at 12:42 PM.</li> <li>d. On 6/27/23 at 3:00 PM. Resident #10 made no attempts to get up out of bed on his own.</li> </ul> <p>In an interview on 6/28/23 at 11:17 AM, Staff I, Certified Nurse Aide (CNA) reported before Resident #10 fell on 6/8/23, he was independent with transfers, but sometimes the staff would need to monitor him closely because his feet would swell and would not sit still.</p> <p>In an interview on 6/28/23 at 11:35 AM, Staff J, CNA reported before Resident #10 fell on 6/8/23, he was independent in his room with his walker.</p> <p>In an interview on 6/28/23 at 12:54 PM, Staff K, Registered Nurse (RN) reported before Resident #10 fell on 6/8/23, he was to be transferred with the assistance of one staff member with a gait belt, however, he was non-compliant and would use his</p>			
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<b>58.19(2)j</b>	<p>bedside table and push that around. The staff should have made rounds on him at least every 15 or 30 minutes because of his history of getting up on his own.</p> <p>In an interview on 7/3/23 at 10:10 AM, the DON (Director of Nursing) reported before Resident #10 fell on 6/8/23, he was to be transferred with the assistance of one staff member to provide standby assistance, that he had been pretty impulsive and had a history of falls prior to this one.</p> <p>A review of the facility Falls Practice Flow Chart revealed a process to include assessment, plan, implementation and evaluation.</p> <p><b>481—58.19(135C) Required nursing services for residents.</b> The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p> <p><b>58.19(2) Medication and treatment.</b></p> <p><b>j.</b> Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)</p>	<b>CLASS I</b>	<b>\$5,250.00 (HELD IN SUSPENSION)</b>	<b>UPON RECEIPT</b>
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	<p><b>DESCRIPTION:</b></p> <p>Based on clinical record review, resident and staff interviews, the facility failed to ensure a resident's pain control during wound care was maintained for two of five residents reviewed (Residents #3 and #9). The facility reported a census of 59 residents.</p> <p>Findings Include:</p> <p>1. The Minimum Data Set dated 5/16/23 identified Resident #3 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 of 15 points and had the following diagnoses: Cancer, Peripheral Vascular Disease and Malnutrition. The MDS also identified Resident #3 required extensive staff assistance with most activities of daily living (ADL's) and with one Stage 2 pressure ulcer and four venous/arterial ulcers.</p> <p>In an interview on 6/19/23 2:15 PM, a nurse from the Veteran's Administration (VA) reported the following: The VA Nurse and Physician observed the dressing change. The VA Physician informed the Facility Nurse that Resident #3 should be premedicated prior wound care. The resident received Morphine earlier,</p>			
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	<p>however, it was short acting, and by the time the Facility Nurse did the dressing, an hour had passed and by then Resident #3 was in agony and the VA Doctor directed the Facility Nurse to give Resident #3 pain medication. The VA Nurse reported, even after the Floor Nurse had medicated the resident again and he still looked like he was in pain.</p> <p>A review of the facility Nurse's Notes revealed the following:</p> <ul style="list-style-type: none"> <li>a. On 5/11/23 at 11:04 AM, Rates pain as 10 out of 10.</li> <li>b. On 5/12/23 at 11:29 PM, Give as needed (PRN) Ativan (medication to treat anxiety) and PRN Morphine (medication to relieve pain). Resident #3 is crying and grimacing. Hospice notified.</li> <li>c. On 5/16/2/23 at 5:47 PM, Reported pain for MDS assessment.</li> <li>d. On 5/26/23 at 12:50 AM., Resident #3 reported pain to both legs and rated as a 10 on a scale of 0 to 10.</li> </ul> <p>Multiple entries of administration of Morphine, Lorazepam, Trazadone documented daily.</p> <p>2. The MDS dated 4/6/23 identified Resident #9 as severely cognitively impaired with a BIMS score of 0 out of 15 points and had the following diagnoses: Dementia, Coronary Artery Disease and Benign</p>			
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	<p>Prostatic Hyperplasia. The MDS failed identify the resident with pressure or venous stasis ulcers.</p> <p>On 5/5/22 the Care Plan identified Resident #9 with the problem of chronic wounds to his left foot related to plasmocytic perivascular spongiotic dermatitis to the left heel, foot and toes. The left great toe callus (scab off and treated 6/20/23). The Care Plan failed to direct the staff to offer the resident analgesics (used to relieve pain) prior to wound care.</p> <p>A review of the June 2023 Medication Administration Record (MAR) and Physician Order Summary revealed an order dated 3/17/20 for Acetaminophen (Tylenol) 325 mg tablet, give 2 tablets orally every 4 hours as needed for pain related to right foot. The MAR lacked documentation to show any doses had been administered for the entire month.</p> <p>During an observation/interview on 6/19/23 at 11:30 AM, Resident #9 sat up in bed with the air mattress inflated and Prevalon boots to both feet (to relieve pressure and help prevent ulcers). Resident #9 reported when the nurses change his dressings and touch a spot on his left heel, it causes a lot of pain and none of the nurses offer to medicate him prior to the dressing changes.</p>			
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	<p>During an observation of wound care on 6/20/23 at 1:01 PM, Staff B, Licensed Practical Nurse (LPN) and Staff D, Certified Nurse Aide (CNA) both washed their hands, donned gloves and assisted Resident #9 to turn to his left side. After Staff B removed the dressing to Resident #9's coccyx area, he yelled "Ow! I tell you what!" At 1:18 PM, as Staff B wrapped a dressing around Resident #9's left foot, the resident flinched with a facial grimace of pain when Staff D lifted his leg. At 1:21 PM, when Staff B left the room for more dressings, Resident #9 reported he was not given any pain medication prior to the dressing change and rated his pain level as "9"</p> <p>In an interview on 6/28/23 at 9:37 AM, Staff E, CNA reported he had helped nurses turn Resident #9 during wound care and 9 times out of 10 Resident #9 looked like he was having pain and will let the staff know this when they turn him.</p> <p>In an interview on 6/28/23 at 10:12 AM, Staff H, CNA reported she helped nurses turn Resident #9 during wound care and observed him complain of pain when the staff are too rough when turning him.</p> <p>In an interview on 6/28/23 at 10:29 AM, Staff B, LPN reported Resident #9 did not like being turned over on his side too long and had complained that she took</p>			
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	<p>too long to clean him up during wound care. When asked if there was a reason why he was not being pre-medicated prior to his wound care, she reported she never thought of it.</p> <p>In an interview on 6/28/23 at 2:33 PM, Staff A, RN reported Resident #9 complained of pain when they clean his wound. When asked if he was being pre-medicated prior to his wound care, she said no, however, that is a great idea. She also reported she thought the intervention of pre-medicating Resident #9 prior to wound care should be addressed on his Care Plan and felt the Nurse Practitioner (NP) should consider writing an order to pre-medicate.</p> <p>In an interview on 7/3/23 at 10:10 AM, the Director of Nursing (DON) reported Resident #9 had complained during wound care when repositioned or when staff lifted his leg. When asked why he was not being pre-medicated prior to wound care, the DON reported Resident #9 will say he did not want it, the nurse will ask and he will refuse. She also reported they should be documenting when he refuses. She also reported she felt the need to offer to pre-medicate did not need to be addressed on the Care Plan.</p> <p>The facility policy titled: Pain Quick Reference dated November 2021, documented the following tips for</p>			
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	<p>nurses to advocate pain management for your patients:</p> <ul style="list-style-type: none"> <li>a. Avoid labeling and judging patients.</li> <li>b. Ask "Is there anything we can do to make you more comfortable?"</li> <li>c. Consider age, culture, religion, and previously used successful intervention when creating a Plan of Care.</li> <li>e. Treat pain early - delays can make pain more difficult to control.</li> <li>f. Non-pharmacological interventions are a key 1st step in pain management.</li> <li>g. Consider analgesics (medications to treat pain) for continuous pain or cognitive impairment with regular signs of pain.</li> <li>i. Regularly evaluate the effectiveness of the Pain Management Plan.</li> </ul>			
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	<b>FACILITY RESPONSE:</b>			
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