

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

Citation Number: #6670		Date: October 23, 2017	
Pearl Valley Rehabilitation and Healthcare Center		Survey Dates: July 11-13, August 28-31, September 6-7, and October 13, 2017.	
601 E. Polk Street Washington, Iowa 52353			
DS			
Rule or Code Section	Nature of Violation	Class	Fine Amount
			Correction date

56.6(1)	481-56.6 (135C) Treble and double fines. 56.6(1) Treble fine 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	\$12,000 (trebled fine-\$4,000 x 3) (Held in suspension)	Upon Receipt
+				
58.28(3)e	<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) <b>58.28(3) Resident safety.</b> e. Each resident shall receive adequate supervision to ensure against hazard from self, others, or elements in the environment. (I,II, III)  <b>DESCRIPTION:</b>  Based on observation, record review, and resident, family and staff interviews, the facility failed to ensure that each resident received adequate supervision to prevent accidents and injuries during a mechanical lift transfer (Resident #3). The sample consisted of 3 residents who required a mechanical lift transfer. The facility			

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	<p>reported a census of 50 residents.</p> <p>Findings include:</p> <p>1. Resident #3 had a Minimum Data Set (MDS) assessment with a reference date of 8/21/17. The MDS identified the resident had an admission into the facility on 8/14/17 and had diagnoses that included congestive heart failure, arthritis, edema and chronic pain. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15. A score of 15 identified no cognitive impairment. The MDS identified the resident absent of symptoms of delirium, and required extensive assistance of at least 2 staff persons for transfers to and from bed and chair, bathing, toileting and personal hygiene. The MDS did not have a recorded height or weight and the resident could not stand or ambulate. The MDS identified the resident's primary mode of transportation as the wheel chair.</p> <p>The Care Plan identified a problem on 8/15/17 with the resident's activity of daily living (ADL) deficit. The Care Plan interventions included and directed staff of the following:</p> <p>Staff are to use a bariatric mechanical lift and bariatric mechanical lift sling when transferring</p>			
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	<p>the resident. This intervention was revised on 8/31/17.</p> <p>Observation on 8/28/17 at 12:20 p.m. identified the resident seated in a recliner chair in her room, skin of lower legs intact, no sling under the resident, and 2 mechanical lift slings, both size "Large" located in the room. The slings were labeled by the manufacturer "User Weight Guideline For Proper Fit", with 175 to 249 pounds listed for the Large sling.</p> <p>During an interview on 8/28/17 at 12:20 p.m., the resident stated the staff hurt her when they pushed on her legs during a mechanical lift transfers. The resident stated the staff do that in order to move her legs around the post of the lift when they used the smaller lift with blue padding on the hangers (Invacare 450 lift) or to position her farther over on the bed.</p> <p>The resident's first weight, obtained on 8/29/17, was 355 pounds.</p> <p>During an interview on 8/30/17 at 10:20 a.m. the facility's corporate nurse acknowledged the bariatric lift was required to transfer Resident #3 due to her height and stated staff should follow manufacturer's recommendations for mechanical</p>			
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	<p>lift sling selection based on the resident's size and weight. The corporate nurse stated all of the staff would be educated on lift sling selection specific to the resident and to use the bariatric lift for all Resident #3's transfers. The facility could not provide documentation that staff received training for the operation of a mechanical lift transfer.</p> <p>During an interview on 8/31/17 at 10:30 a.m., the corporate nurse stated all staff were educated on mechanical lift transfers, to transfer Resident #3 with the bariatric lift and appropriate sized sling.</p> <p>During an interview on 8/31/17 at 11:45 a.m., Resident #3 stated a CNA entered his/her room at 3 p.m. the day before and stated staff didn't have to use the bariatric lift, used the Invacare 450 lift to transfer the resident, the resident's feet hit the post of the lift during the transfer and it hurt. The Tollos size Large sling remained in the resident's room, the resident stated staff continued to use that sling even though it hurt her legs when they did.</p> <p>Observation on 9/6/17 at 10:45 a.m. revealed the resident seated in a recliner chair with her legs elevated. The resident had a large deep purple bruise that nearly covered the anterior aspect of the right lower leg, with 2 fluid filled blisters</p>			
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	<p>present. The resident stated the injury occurred when Staff A, certified nursing assistant, grabbed her right lower leg when they transferred her to bed on 9/4/17. The resident stated as the staff tried to position the resident further over on the bed, Staff A must have pushed her leg too hard and it hurt. The resident stated she yelled out that it hurt and the staff said there was a bump on the leg. The resident stated the staff obtained a nurse (Staff C) and they transferred and weighed her in the therapy room. The resident stated she continued to have "awful" pain in the leg and Staff C informed her she had to go to the hospital emergency room.</p> <p>Documentation recorded by Staff H, registered nurse (RN), on 9/6/17 at 2:11 p.m. revealed the right leg hematoma (collection of blood outside of the blood vessel) measured 22 centimeters (cm) by 24 cm, with a fluid filled blister that measured 11 cm by 0.5 cm.</p> <p>A hospital ER physician report dated 9/4/17 indicated the resident received treated for a hematoma on the right leg. The physician ordered to apply an ice pack to the area for 15 minutes, 5 times per day for 2 days, with follow-up by physician.</p>			
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	<p>A nurse practitioner (NP) from the hospital's physician's group, Staff I, assessed the resident on 9/6/17 and ordered an evaluation of the right lower leg that day at the hospital's wound clinic. The wound clinic visit note dated 9/6/17 revealed a blood filled blister, located on the right anterior lower leg. The NP "deroofed" (top layer over fluid removed) the blister and resulted in a 15 cm by 15 cm by 0.5 cm partial thickness wound. The open area required application and treatment with a Mepilex AG dressing (soft absorbent dressing that contains silver nitrate, used as an antibacterial treatment).</p> <p>Observation on 9/7/17 at 11:55 a.m. identified the resident seated in a recliner chair with both legs elevated and a large gauze dressing covered the anterior portion of the right lower leg. The gauze dressing had approximately 2 inch by 4 inch area of serosanguinous drainage (yellow-pink colored body fluid) was visible on the lower margin of the dressing, towards the inner aspect of the leg, the skin visible below the dressing appeared reddened, and the right lower leg appeared larger than the left lower leg. The resident stated he/she had to return to the wound clinic that day for a dressing changed, and concerned about the potential for wound infection.</p>			
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	<p>Staff interviews related to the resident's right lower leg injury identified the following:</p> <p>On 9/6/17 at 11:31 a.m., the physician that treated the resident in the ER on 9/4/17 stated the resident told him the injury occurred when an aide grabbed it during a transfer with the lift. The physician stated he didn't have a specific opinion on how the injury had occurred, other than it resulted from force applied to the area and the area injured was larger than a hand but he did not rule that out as a potential cause of the injury.</p> <p>On 9/6/17 at 12:08 p.m., Staff I, NP, was interviewed after he assessed the resident and stated the resident voiced an aide grabbed her leg that caused the injury, but heard the 3 aides telling 3 different stories. Staff I stated something happened that caused the injury. Staff I stated the resident was well-known to him and the resident was always honest and he had no reason not to believe the resident.</p> <p>On 9/6/17 at 12:02 p.m., Staff A, certified nursing assistant (CNA), stated she transferred the resident from the recliner to the bed on 9/4/17, with Staff B, CNA, and DON in room to ensure they used the right lift and sling, Staff B operated the controls and she held the loops of the sling as</p>			
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	<p>they moved the resident, turned the resident with her hands on the loops as they got her to the bed. Once the resident was in bed she complained of pain in the leg. Staff A stated she noticed a purple bump on the resident's leg, Staff B rubbed the area with lotion and they transferred the resident to the wheel chair for a weight check. Staff A stated after checking the weight, the resident said her leg really hurt and the bump had more than doubled in size by that time. Staff A stated Staff C sent the resident to the hospital emergency room.</p> <p>On 9/6/17 at 8:19 p.m., Staff B, CNA, stated she transferred the resident after lunch with Staff A. Staff B stated Staff A lifted the resident's legs so she could pull the sling down and the resident complained of pain as Staff A lifted the legs. Staff B stated once transferred to bed, the resident said her leg hurt and the resident asked her to rub the leg. Staff B stated she applied lotion to the leg, noticed an egg-sized bluish-gray bump on the right lower leg. Staff B stated she stopped and went to get the nurse, Staff C. Staff C looked at the leg. Staff B stated she transferred the resident again, to obtain a weight, and the area was noticeably larger by then. Staff B stated it was within 10 minutes of when she rubbed the leg.</p>			
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	<p>On 9/6/17 at 1:59 p.m., the Director of Nursing (DON), was interviewed and stated she observed the CNA's, Staff A and Staff B, transfer the resident on 9/4/17 after lunch. The DON stated the sling under the sling appeared too high. Staff A lifted resident's legs under the knees as Staff B pulled sling down. Staff A's hands were positioned on the sling, resident's shoulders and thigh area, as Staff B operated the lift. The staff lowered the resident to the bed when Staff C entered the room and the DON left the room when Staff C entered. The resident had not complained of pain before that time. The DON stated she was later informed by Staff C that the resident had a large area on the leg and the area had gotten bigger when they weighed the resident.</p> <p>On 9/6/17 at 1:11 p.m., Staff C, LPN, stated she worked 6 a.m. to 6 p.m. on 9/4/17. Staff C stated the staff had gotten the resident up around 8 a.m., and then transferred the resident to use the bedpan around 10 or 11 a.m. Staff C stated she had verified the staff used the right sling and lift at those times. Around 1:30 p.m. or 1:45 p.m., she was going to lunch break and not aware staff wanted to transfer the resident. The staff got the DON to observe the transfer. While in the breakroom, someone informed her of the transfer,</p>			
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	<p>when she went to the room the DON was in the room with the staff, so she went back to the break room. While still in the break room, staff came and informed her resident complained of pain in his/her leg. She assessed the resident's leg and observed a 50 cent-sized vesicle (blister) without color on the leg. Staff C stated she remained in the room as staff transferred the resident from the bed to the wheel chair and then to the therapy room for a weight. The resident complained of pain as they lifted her from the chair on the scale. Staff C stated she looked at the leg and the blister had more than doubled in size, still without color. The resident was sent to the emergency room. Staff C stated she assessed the area around 5:15 p.m. after return from the hospital. Staff C stated the area had no change of color or bruising and identified a rectangular shaped blister.</p> <p>On 9/6/17 at 3:22 p.m., Staff J, physical therapy assistant (PTA), stated he worked at the facility on 9/4/17 between 11:45 a.m. and 2:15 p.m. Staff J stated he provided therapy to the resident in her room before staff weighed the resident and did not observe anything abnormal on the resident's legs. Staff J stated he was in the therapy room when staff brought her in for a weight and he assisted with the transfer after he heard the resident say "owe". Staff J stated when</p>			
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	<p>he first saw the blister on the leg; it appeared as golf-ball sized as and more than twice the size when they left the therapy room. While in the therapy room he heard the resident say the aides hurt her leg, and the aides and nurse said "No, they did not".</p> <p>On 9/6/17 at 10:55 a.m., an incident report was requested and documents related to the resident's 9/4/17 injury. The Corporate Administrator stated the staff had not completed an incident report but would complete one and they would investigate the injury.</p> <p><b>FACILITY RESPONSE:</b></p>			
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