FC6747			Date: January 26, 2018		
Good Samaritan-Ottumwa			Survey I	Survey Dates: January 11-17, 2018	
2035 West Chester Avenue Ottumwa, Iowa 52501		DS			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
58.28(3)e	DS         Nature of Violation <b>Nature of Violation 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 (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 (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 (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 (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)</b> <i>Resident safety.</i> <b>6.</b> Each resident safety. <b>6.</b> Each resident safety. <b>6.</b> Each resident safety. <b>6.</b> Each resident shall receive adequate supervision to mitigate the risk for falls and injury. The facility reported a census of 137 residents. The facility identified Resident #2 to be at risk for falls due to a history of a cerebrovascular accident (stroke), anxiety and previous fall. Due to the risk, the facility planned to not leave the resident alone in the resident's room alone and in a wheelchair. The plan directed staff to place the resid			\$5,000	Upon Receipt

Page 1 of 6

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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Page 2 of 6

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dresser on her right side. Resident #2 assessed and reported pain to right elbow. Upon examination, a bruise was noted on lateral aspect of right forearm measuring 3 centimeters by 1 centimeters and a reddened area on the back lateral right arm measuring 9 centimeters by 3 centimeters. Resident #2 stated she was going to see her folks and then fell. Resident #3 assessed and she reported pain on the right elbow and could not rate her level of pain. The vital signs checked and all within normal limits. Staff lifted the resident off the floor with the help of a Hoyer lift and transferred into bed. Once in bed, the nurse noted the right leg was rotated outwardly. The nurse notified the physician and received orders to transfer to the hospital [emergency room].		
The Progress Notes dated 1/7/18 at 10:40 a.m., indicated the resident returned to the facility from the hospital. The resident had a fractured right hip and on Hospice level of care.		
On 1/16/18 at 2:00 p.m. Staff B, case manager, was interviewed and stated following Resident #2's fall on 1/5/18, she amended Resident #2's Care Plan to include not leaving Resident #2 unattended while in her wheelchair in her room. Staff B insisted she was certain she made the change under the fall risk section of the Care Plan		

Page 3 of 6

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Section					

and documented the revision in the progress notes 1/8/18. On 1/16/18 at 2:20 p.m. Staff C, case manager skilled unit, stated Resident #2 was initially on the skilled unit and following a second fall on 11/15/17, she added interventions to include having Resident #2 up at the nurse's station after her spouse leaves and to not leave Resident #2 in her wheelchair while in her room. These interventions were added on 11/16/17 and		
remained in place when Resident #2 was moved off of the skilled unit. Progress Notes dated 11/16/17 at 6:33 a.m. Care Plan Change, written by Staff C states: Intervention: ensure/provide a safe environment: Resident up to nurse's station after spouse leaves. Don't leave in wheelchair in room. Note Text: Review of resident fall. Resident stated she was getting ready for breakfast when she was found on the bathroom floor. Spouse had just left. Resident does not remember to use call light. Staff to bring resident up to nurse's station when spouse leaves. Staff instructed not to leave		
On 1/16/18 at 12:52 p.m. Staff D, certified nurse aide, stated he worked the 2:00 p.m. to 10:00 p.m. shift on the afternoon of 1/5/18. Sometime		

Page 4 of 6

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	r
around shift change and after supper, he was	
involved with laying residents down. Resident	
#2's spouse and son visited and left 15-30	
minutes earlier. Staff D stated he checked on	
Resident #2 shortly after the family had left and	
she was in her room, in her wheelchair with a	
bedside table in front of her. Staff D stated he	
had a conversation with his co-worker, Staff E,	
unrelated to Resident #2 and went about	
assisting other residents. Within a few minutes,	
Resident #2's roommate came out into the hall	
and alerted them Resident #2 had fallen. Staff D	
and Staff A responded and assessed Resident	
#2. Initially Resident #2 complained of right arm	
pain. Resident #2 was confused, stating she	
needed to meet her folks. They put a Hoyer sling	
under Resident #2 and lifted her into bed. At that	
time Resident #2 complained of hip pain and her	
right leg was turned outward. They called	
emergency medical services and had Resident #2	
transported to the hospital. Staff D stated he was	
not aware that Resident #2 was not to be left	
alone in her wheelchair when in her room. Staff	
D stated that information would be in the Kardex	
(electronic Care Plan).	
On 1/16/18 at 1:26 p.m. Staff E, certified nurse	
aide, stated she worked a 10:00 a.m. to 6:00 p.m.	
shift on 1/5/18. Staff E stated after supper she	
assisted residents back to their rooms and	

Page 5 of 6

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thought she had propelled Resident #2 back to her room, placed the bedside table next to her and gave her the call light. Staff E stated she then left to assist other residents. At around 5:50 p.m. Resident #2's roommate entered the hallway and alerted staff Resident #2 had fallen. Staff E and Staff D responded to the room and found Resident #2 on the floor. Staff E stated she was not aware Resident #2 was not to be left unattended in her room while in her wheelchair. Staff E stated that information should be in the Kardex (electronic Care Plan), but didn't recall seeing it. FACILITY RESPONSE:		
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Page 6 of 6

Facility Administrator

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