Citation Numb	er: 6784				oril 11, 2018
Facility Name:	QHC Winterset North		Survey D	ates:	
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Rule or Code Section	Natur	e of Violation	Fine Amount Correct date		
58.19(2)j	Medication and treatment. Provision of accurate assessment and timely		ı	\$10,000	UPON
	intervention for all res	sidents who have an onset of thich represent a change in		(Held in Suspens	ion)
		DESCRIPTION:			
	DESCRIPTION:				
	Based on clinical recording review and resident, interviews, the facility and intervene after si	failed to properly assess gnificant condition changes eviewed (Residents #6 and			
	Based on clinical recovereview and resident, interviews, the facility and intervene after si for 2 of 36 residents (#49). The facility rep	physician and staff failed to properly assess gnificant condition changes eviewed (Residents #6 and			

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	diagnoses. The MDS skills for daily decision impaired. According the required extensive as ADLs (activities of data and Very poor cognitions that the same assess his behaviors changes to the doctor Resident #6's risk for incontinence and sitting time. The care pland facility protocol for sk doctor as needed. The Care Plan instructed incontinence cares. A staff to anticipate the	o the MDS, Resident #6 sistance of one for most ily living). In documented that Resident elated to severe dementia on. The Care Plan instructed afe in his environment and apervision whenever plan also instructed staff to for a decline and report the r. The care plan also noted skin breakdown related to ng or lying for periods of irected staff to follow the in issues, report them to the e 12/14/17 addition to the staff to assist him with 12/21/17 revision instructed				Page 2 0

Fig. 10. Add 12. Add 1

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Rule or Code Section	Nature	e of Violation	Class	Fine Amount C			
	documented that Restake medication. An untitled document 3/9/18 of recorded infinity shift to be relayed to the day shift could not medication and the experience of the day shift could not medication and the experience of the fluids had been experience of the following shift in "OK" on the overnight on the day shift and remedication on the execution of the execution of the execution of the execution of the day shift and remedication on the execution of the execution of the execution of the execution of the day shift and remedication on the execution of the exe					Page 3 o	

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	the doctor because R very red skin and she wanted a follow up Uresident just complete UTI (urinary tract infer A Physician Fax Order notified that Resident lethargic after just contain antibiotics for a UTI. Resident #6 had loos she could not get him document noted the pUA (urinalysis) and late responded to the responded to the responded to the following shift rows on the overnight during the day shift at After requesting the 3	er Request dated 3/11/18 #6 continued acting mpleting a round of The nurse also noted that e stools, very red skin and to take medication. The ohysician ordered a follow up b tests the on 3/12/18 when request. dated 3/12/18 of recorded during a shift to be relayed noted that Resident #6 was t shift, but hospitalized				Page 4	
Eacil	ity Administrator		ate			i age 🕶	

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ı					April 11	, 2018
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Code Section	Natur	e or violation	Class			date
	stated she could not	find those documents.				
	authored by the currence Resident #6 was leth respond to command documented that Resmembranes were dry bleeding, orbital (eye he had poor skin turg dehydration). The nu orders to have Resid ambulance. Nurse's Notes from N					
	3/12/18 at 11:05 a.m. mental status and ac The presentation data noted the presenting LOC (level of conscionmental status, finished UTI last Wednesday	. with diagnoses of altered				
						Page 5 of
Facil	ity Administrator		Date			

Rule or Code Section #6 appeared emaciated, malnourished and described his behaviors as listless, somewhat obtunded (lethargic) and only responded to stimulus. The ER physician's 3/12/18 exam report at 11:55 a.m. revealed a hard mass of the lower right and left abdomen and extreme distention (swollen and/or stretched) per nursing report on arrival. The doctor noted special observations as the resident being markedly cachectic with a superficial pressure sore on the right hip. The Patient Care Notes dated 3/12/18 at 1:01 p.m. and authored by an RN noted that Resident #6 finished antibiotics for UTI on Wednesday, had lowered LOC, mental status change and decreased output. The nurse noted they catheterized the resident in ER with significant dark urine output with moderate sediment present. The nurse documented Resident #6's eyes would not focus and he only responded to painful stimuli. The resident appeared very emaciated. While turning the resident, the nurse noted her observation of his rectum being dilated	Citation Numb	er: 6784]			Date:	
Facility Address/City/State/Zip MW Rule or Code Section Rule or Code Section Rule or Nature of Violation Class Fine Amount Correction date #6 appeared emaciated, malnourished and described his behaviors as listless, somewhat obtunded (lethargic) and only responded to stimulus. The ER physician's 3/12/18 exam report at 11:55 a.m. revealed a hard mass of the lower right and left abdomen and extreme distention (swollen and/or stretched) per nursing report on arrival. The doctor noted special observations as the resident being markedly cachectic with a superficial pressure sore on the right hip. The Patient Care Notes dated 3/12/18 at 1:01 p.m. and authored by an RN noted that Resident #6 finished antibiotics for UTI on Wednesday, had lowered LOC, mental status change and decreased output. The nurse noted they catheterized the resident in ER with significant dark urine output with moderate sediment present. The nurse documented Resident #6's eyes would not focus and he only responded to painful stimuli. The resident appeared very emaciated. While turning the resident, the nurse noted her observation of his rectum being dilated						April 11	, 2018
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		described his behavior obtunded (lethargic) a stimulus. The ER physician's 3 a.m. revealed a hard left abdomen and extrand/or stretched) per The doctor noted speresident being marker superficial pressure superficial pr	ors as listless, somewhat and only responded to 1/12/18 exam report at 11:55 mass of the lower right and treme distention (swollen nursing report on arrival. ecial observations as the dly cachectic with a sore on the right hip. The dated 3/12/18 at 1:01 or an RN noted that Resident is for UTI on Wednesday, had a status change and the nurse noted they dent in ER with significant in moderate sediment ocumented Resident #6's and he only responded to esident appeared very ning the resident, the nurse				Page 6 of
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		ollar with stool visible. The				
	nurse documented the firm stool had been docleaning the resident noted multiple areas prominences. They a medical surgical floor. The Patient Care Note noted that Resident # a sepsis (potentially for an infection) patient status changes, sever of acute kidney failure. The Patient Care Note noted Resident #6 lyis stimuli with a mass to size of a fist.	at a small amount of very igitally removed before s buttocks. The nurse also of redness on the bony dmitted Resident #6 to the at 1:49 p.m. es on 3/12/18 at 4:19 p.m. to met admission criteria as ife threatening complication at with significant mental re dehydration and evidence				

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).

Date

Citation Numb	er: 6784			Date:	, 2018
-	QHC Winterset North	DAM.	Survey Dates:		21 2019
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Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
	saw a large about of a determined the correl The Patient Care Not noted Resident #6 ha extra/extra large soft/ The Patient Care Not noted Resident #6 ha large amount of dark The Patient Care Not noted Resident #6 ha large amount of stool The Patient Care Not noted Resident #6 ha loose with hard bowe The Patient Care Not noted Resident #6 ha loose with fard bowe The Patient Care Not noted Resident #6 ha amount of dark stool.	es on 3/13/18 at 7:16 a.m. ad an episode of an hard bowel movement. es on 3/13/18 at 7:20 a.m. ad been incontinent of a stool. es on 3/13/18 at 8:45 a.m. ad been incontinent of a stool. es on 3/13/18 at 9:09 a.m. ad been incontinent of large I movement. es on 3/13/18 at 10:45 a.m. ad been incontinent of large I movement.			Page 8 o

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Date

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	The Patient Care Not noted that Resident # of his mouth were dry The Patient Care Not noted the doctor disc with the family. The fagastric (through nose placement for administrate The Patient Care Not documented they produced	es on 3/14/18 at 7:45 a.m. 66 's mouth, tongue and roof and bleeding. es on 3/14/18 at 9:45 a.m. ussed the treatment of C differmily agreed to NG (naso into stomach)) tube stration of oral antibiotics. es on 3/18/18 at 3:17 a.m. nounced Resident #6 dead. g/Discharge Notice dated that the previous DON had regligence or carelessness, ctful interpersonal and abandoning or failing to				Page 9 of

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	noted the DON had been suspended on 3/12/18 pending the outcome of an investigation. The document also referred to a 3/13/18 email correspondence provided by the Administrator about a conversation she had with Resident #6's family. The Administrator documented that Resident #6's son complained that his father's abdomen was distended; which was relieved once he expelled 1100 ml of urine when hospital staff catheterized the resident after being admitted on 3/12/18. The email also noted that the resident's son wanted to know why nobody noted the distention and took preventative measures. Resident #6's son also complained about the "lack of medication administration" since Thursday, extreme dehydration and that a fax had been sent to the doctor's office. An Employee Warning/Discharge Notice dated 3/16/18 documented that Staff G, LPN received a written warning for abandoning or failing to perform her job responsibilities. According to the document, Staff G failed to document the change in Resident #6's condition on the 3/10/18 day					Dog 40 4
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	condition to the docto weekend when the do statement written by Sof the document note: #6's family on 3/10/18 resident's behaviors a LPN wrote that she re Resident #6's change DON at shift change a resident. A Nursing Note dated that Resident #6's sof father died at 4:00 a.r When asked for their Resident #6's 3/12/18 DON submitted a doc Condition-Resident P According to the docuphysician/NP (nurse p call should be notified condition or health states.)	octor's office was closed. A Staff A on the second page d that she spoke to Resident B about monitoring the and changes in status. The elayed information about in status to the previous and asked her to assess the 1 3/18/18 at 6:08 a.m. noted in notified them that his m. at the hospital. Protocol they used prior to B hospitalization, the current cument titled Change of hysician/GNP Notification.				Page 11 c

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Code Section	114141		Class			date
	The policy also direct	ed that any change in			ш	
	condition, health state	us or incident should be ling physician or physician				
	on call between 10:00	0 p.m. and 8:00 a.m. for				
	acute symptoms that in mental or psychoso conditions that are de					
	Treatment of Skin Bro facility's policy as pro assessing residents va- increase the risk for in implement preventation appropriate treatments standards of care. Ac skin will be observed concerns should be re immediately. The nur	whose clinical conditions mpaired skin integrity, to ve measures and to provide t according to the industry cording to their procedure, daily during cares and eported to the nurse se should notify the				
	protocol should be initial until orders are received. An interview on 3/19/	18 at 3:05 p.m. with Staff G				
	revealed that Resider	nt #6 had not taken his				Page 12 of
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		- computer hut the might	<u> </u>	<u> </u>		<u> </u>
	1	e computer, but she might em on the 24 hour sheet				
		she sent a fax to notify the				
	doctor on 3/11/18.					
	An interview on 3/20/	18 at 8:05 a.m. with the				
		d that she learned on				
		Resident #6's condition ekend. The Administrator				
		ely educated staff on 3/14/18				
		ot following their protocol.				
		18 at 9:30 a.m. with Staff L				
		rked with Resident #6 on Staff L said she and Staff M.				
		aturday (3/10/18) morning				
		g weaker than usual. Staff L				
		d be on the edge of his bed				
		ot that day. The CNA said				
		n when they asked him how emed lethargic. Staff L said				
		ergy to participate in getting				
	dressed like he norm	ally would. The CNA said				
		nt #6 did not always want				
	preaktast, they could	usually get him to eat				<u> </u>
		assany got min to out	I	1		Page 14

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Date

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	something. Staff L said they could not get him to eat anything that morning, which she also considered to be abnormal for him. The CNA said his family visited before lunch and had been asking if he had any medication changes because of being so sluggish. They referred the family to his nurse; Staff G. The CNA heard Staff G tell them Resident #6 just finished a round of antibiotics for a UTI, but she had not noticed any other medication changes. Staff L said she had been off for a couple of days, but nobody told her anything about a change in his condition when she returned that day. Staff L said she wondered why he still acted like that if he just finished an antibiotic. Staff L said she told Staff G how she noticed Resident #6 had not been acting like himself, and asked why in light of the fact that he just finished his antibiotics. According to Staff L, Staff G told her she would fax the Dr. to see what he thought. Staff L expressed concern that Staff G had not been taking the matter as seriously as she should have. The CNA said Resident #6 had a relatively normal BM on Saturday. The CNA said despite their efforts to get him to eat something, he still refused to take a drink or a bite					Page 15 of 9	
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	of anything at lunch time. Staff L said they laid him down after lunch. Staff L said she saw the previous DON when she reported to work at 2:00 p.m. and told her how Resident #6 had been acting. Staff L said she told the DON that special attention should be shown to repositioning him and checking up on him frequently. Staff L said she and Staff M were the only CNAs up front on Sunday 3/11/18 and Staff G was the nurse. Staff L said the previous DON worked all night too, so she saw her on Sunday morning also. Staff L said she did not hear anything about Resident #6 in shift report, nor did the DON say anything about him. Staff L said Resident #6 would not respond to them when they went in to help him about 8:00 a.m. Staff L said she noticed a strong urine smell when she entered the room. Staff L said it looked as if he was in the same position they left him in at 1:00 p.m. on the day before. The CNA said Resident #6's brief, the pad under him and the bedding was saturated in urine and dark brown watery feces that smelled awful when they pulled the covers back. Staff L said she identified a purplish red oval shaped area on his right hip bone that measured approximately 2" x 3" that					Page 16 of
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	Staff M went and got Resident #6 cleaned said Staff G returned being "ridiculous that since the day before. again did not seem to quite as seriously as said she believed Resent to the ER to be ignoring him without declined. Staff L said throughout the day if leave him lying in be reported his condition improved to Staff G erepositioned him. Staff is condition to the orto reposition to the orto reposition him freq found that they had rehim clean when she smorning about 7:00 a	they should get him up or d. Staff L said Staff G said ed was fine. Staff L said she and that he had not every two hours after she aff L said she also reported incoming aids and told them uently. Staff L said she epositioned him and kept saw Resident #6 on Monday a.m. Staff L said although he, he "was completely out of				
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	the current DON enterspot on his hip. Staff about the same size told the DON how the DON primarily focuses sent out; which happed An interview on 3/20/revealed that she wo on 3/10/18 and 3/11/10 nobody told her anyth Resident #6 at shift restaff M said she and about 7:50 a.m. The incontinent with what bowel movement for not noticed any skin is anywhere else. Staff According to the CNA breakfast and he mig and had a few drinks M said Resident #6 lo	ant DON. Staff L said she and ered his room and saw the L said the sore was still and color. Staff L said she expected went, but the ed on getting Resident #6 ened within a half an hour. In at 11:15 a.m. with Staff M rked 6:00 a.m. to 2:00 p.m. According to Staff M, hing about a change in eport on Saturday 3/10/18. Staff L got Resident #6 up CNA said he had been appeared to be a normal him. Staff M said she had issues on his buttocks or M said he seemed tired.				Page 18 of 5
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	any lunch despite their efforts prompting him to eat. Staff M said they laid him down after lunch about 12:45 p.m. or 1:00 p.m. and she did not see him any more during her shift. Staff M said she told Staff G that he had not been eating and was more tired than usual. Staff M said she reported off to the oncoming shift. Staff M said when she checked on him first thing Sunday (3/11/18) he was in the same spot they left him in on Saturday. Staff M said he only had a tee shirt and a soiled brief on. Staff M said his urine seemed much darker than the day before and his brief, pad and sheets were soaked in urine and dark brown runny feces. The CNA said she saw a purplish red pressure sore about 2" x 3" on his hip (unsure of which side) which she did not see the day before. Staff M said she went straight from his room after helping him and told Staff G about the sore and how it looked like he had not been moved from the day before. Staff M said they later asked Staff G if she looked at it and she told them she had. Staff M said Resident #6 stayed in his bed for the rest of the day. The CNA said they went in there every 2 hours to reposition him and offer him something to drink; which he declined					Page 19 o
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	been in and out of his during their shift. An interview on 3/20/doctor revealed he at he arrived in ER on 3 that Resident #6 had disease and was mar with loss of weight ar bony prominences of his hips. The physicia Resident #6 had a direct consciousness and with stimuli in the ER did not know what Rehad only a minimal re(aggressive rubbing of physician said Reside (large hard mass of secolon or rectum and which could be caused dehydration and medionce they started to he	the fluids. Staff M said she and/or Staff L had been in and out of his room at least 6 times suring their shift. In interview on 3/20/18 at 12:25 p.m. with the ER octor revealed he attended to Resident #6 when he arrived in ER on 3/12/18. The doctor recalled that Resident #6 had dementia, Parkinson's sease and was markedly cachectic (wasting ith loss of weight and muscle mass) with all his only prominences observed and redness over ships. The physician said he remembered that the esident #6 had a diminished level of consciousness and would not interact or track ith stimuli in the ER. Although the doctor said he do not know what Resident #6's baseline was, he ad only a minimal reaction to a sternal rub aggressive rubbing on the breast bone). The mysician said Resident #6 had a fecal impaction arge hard mass of stool that gets stuck in the colon or rectum and cannot be pushed out), which could be caused by lack of mobility, ehydration and medication. The doctor said not they started to hydrate him with IV fluids he arted having massive bowel movements; the				Dogo 20
						Page 20
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	before it turned to dia Resident #6 tested poinfection). The doctor bowel movements; where the doctor would have intervene sooner if the condition over the we could not say that del Resident #6's death, seen sooner certainly. An interview on 3/20/LPN revealed that the been responsible for overnight shift, so she shift report about him Resident #6's room while she changed him. An interview on 3/20/An int	ey knew about his change of ekend. Although the doctor ayed intervention caused he would say that being could have been beneficial. 18 at 5:08 p.m. with Staff J, exprevious DON would have Resident #6 on the 3/10/18 exwould not have received. Staff J said she went into with Staff K, CNA during their taff K changed Resident #6 is roommate. 18 at 5:50 p.m. with Staff K, rked the overnight shift on Staff K, she did not				Page 21 of	

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	Resident #6 because that was her first night working at the facility. Staff K said she never had any training before that night; she just started working the floor. The CNA said she rounded on every resident 3 times because that is what they told her to do. According to Staff K, Resident #6 had been sleeping every time she went in there. Staff K said she checked Resident #6 every time she rounded, but she could not remember if the resident's brief was dry every time she went in there. Staff K said she remembered that she changed him at least twice during the night. The CNA said she repositioned him every time she rounded on him that night. Staff K said she worked with the previous DON that night. Staff K said the DON never told her anything about the resident having a decline in his physical health. Staff K said the DON assisted her with every resident that she had anything to do with that night. The CNA considered her workload to be manageable and completed everything for her residents. Staff K could not recall if Resident #6 had a bowel movement during the night. The CNA said Resident #6 woke up lightly whenever she went in there to explain what she was going					Page 22 of 9	
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	her. Staff K said she the oncoming shift or they walked down the of the resident's room up again. Staff K said between 5:00 a.m. ar not remember if Resichanged then. An interview on 3/21/current DON revealed	18 at 8:30 a.m. with the d they have not found the hour reports and nobody				
	A subsequent interview with the Administrato Resident #6 had been 3/12/18, but she did resituation until his at 4:30. The Administration and about concerns	ew on 3/21/18 at 9:40 a.m. r revealed that she knew n sent to ER on Monday not know the magnitude of family called on Wednesday trator said the resident's son s that his father expelled the when they catheterized				

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		P 4 4	1	<u> </u>		1
	him at the hospital. A	•				
	<u> </u>	Administrator, Resident #6's son expressed concern about staff not following up with the				
	change in his father's	• .				
		istrator said the resident's				
		ing with Staff G over the				
	weekend, but he was	•				
	Administrator said sh	•				
		ne on each shift when a				
	resident has a change	e of condition. The				
	Administrator said sh	e also expected them to				
	document their finding	gs completely and				
	accurately and she co	onsidered anything less to				
	be unacceptable.					
	2. The MDS assessm	ent dated 1/3/18 for				
		ented an admit date of				
		dentified a Brief Interview				
	signs/symptoms of de	MS) score of 15 without				
		tion. The MDS revealed the				
		limited physical assistance				
	-	ers, walking in room and				
						Page 24 (

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	documented diagnos arthritis, other fracture uncomplicated opioid syndrome, and chron insufficiency. The M fell and sustained an admission to the facil The MDS assessmer #49 documented a di hospital with return as recorded the resident without injury since the assessment. The MDS assessmer #49 documented a re The MDS identified a signs/symptoms of dethe resident experien injury since the previous The care plan focus as	dependence, chronic pain ic peripheral venous IDS documented the resident injury 2 or more times since ity. Int dated 2/5/18 for Resident scharge on 2/5/18 to the intcipated. The MDS experienced 2 or more falls he previous MDS Int dated 2/19/18 for Resident eadmission date of 2/12/18. BIMS score of 15 without elirium. The MDS recorded ced 2 or more falls with				Page 25 of 5
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	assist, did not use was musculoskeletal deformation history of fractures, as changes. The Progress Notes of documented by Staff the floor, stated she thanked and landed on her but the resident complair and skin assessment mark to butt cheek. Ships/legs not sore to (certified nurse aide) feet and into the whe documented the resident and into the whe documented the resident screamed, I now. Staff C wrote sore ident the pain pill of was too soon for the medication, and the resident screamed in the pain pill of the medication, and the resident screamed.	dated 2/4/18 at 3:22 a.m., C, recorded the resident on cripped on oxygen tubing, attocks. The entry recorded ned of pain to her buttocks showed thumbnail size red Staff C wrote the resident's palpitation; Staff C and CNA assisted the resident to her				Page 26 of
						. ago 20 01
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	resident had her head stated she could not performed to give her a pain pill. It is made that she could had documented the resident that she could had documented the resident refused a get me a pain pill. Stexplained that it was she had one 2 hours the resident got agitar room to get an ice parecorded she knocker room and the resident room with no signs at to face Staff C with a and Staff C asked the better after giving the C documented the re onto the table and tol	dent stated, then call the I will. Staff C wrote she ss ROM (range of motion), and said, I will stop if you go aff C wrote she again too early for the hydro that prior. Staff C documented ted so she left the resident's ck and washcloth. Staff C d and entered the resident's at ambulated across the nd symptoms of pain, turned shocked look on her face, a resident if leg was doing a resident threw the ice pack d Staff C to leave. Staff C ed the doctor and would				Page 27 of

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			1	1	"	
	2/4/18 at 3:22 a.m., we documented by Staff Vital Signs, blood presepirations 15, temp to the resident's room tripped over O2 (oxygobutt. ROM WNL (with thumbnail size red may rotation of BLE (bilate no painful palpation to legs, noted. The resident had 2 hours tramadol or Tylenol, to profanities and told the they would give her of be monitored, up wall of pain immediately in reach. Under the ord different handwriting documented Send to	ER, no signature. Under e receiving orders, Staff B				Page 28 of 5
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	documented at 9:30 at the resident's room at thigh swollen, hard, a recorded the resident sink, chocolate milk so down her legs. The effect with the stated she didn't denied hitting her head discomfort; vitals take extremities per normal staff assisted the resident stated, I don The nurse notified the sent to the Emergence. The Physician Fax O 2/4/18 at 3:22 a.m., we received 2/5/18 at 4:3 same information as at 3:22 a.m. without a second fax did not contain the second fax did not contain th	al. The entry documented ident up by 3 staff and er. The note recorded the 't know what happened. e doctor and the resident by Room (ER) at 10:30 a.m.				Page 29 (
						Page 29 (
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	monitor per facility pr	otocol Under the signature		<u> </u>	Ш	<u>'</u>
		otocol. Under the signature ders, Staff B signed and				
	with a sent fax time s received time of 4:16 hip and thigh. The Alas above, update, dupt (patient) to ED (En Under the signature of	The Physician Fax Order Request dated 2/5/18, with a sent fax time stamp of 11:11 a.m. and received time of 4:16 p.m., recorded x-rays of left hip and thigh. The ARNP wrote orders of: okay as above, update, due to extensive swelling, send pt (patient) to ED (Emergency Department). Under the signature of nurse receiving orders, Staff B signed and dated 2/6/18. The Progress Notes dated 2/5/18 at 10:33 p.m., documented by Staff B, recorded a fax sent to the doctor regarding X-rays of left hip and thigh with a fax back stating due to extensive swelling send PT to ED.				
	documented by Staff doctor regarding X-ra fax back stating due to					
	documented by Staff	dated 2/5/18 at 10:37 p.m., B, recorded a fax back from nitor per facility protocol.				
		dated 2/5/18 at 11:20 p.m., B, recorded received fax				
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	The Hospital Dischard admit date of 2/5/18 at The summary docum Admission History of Course. The summa with LLE (left lower et 2 days prior and had swelling of the left this summary recorded the and LLE pain second occurred prior to arrive tripping on oxygen tull documented the residence of the course, and transfuse blood cells due to low protein in red blood of throughout the body). diagnoses of circumfered admits the control of the course of th	ge Summary recorded an and discharge of 2/12/18. ented the resident Present Illness and Hospital ry documented the patient extremity) pain following a fall pain with progressive gh since then. The e resident admitted for fall ary to mechanical fall that ral at the hospital after bing at home. The summary dent found to have a large t scan), otherwise no acute ed with 2 units of packed red or hemoglobin levels (a ells that carries oxygen. The summary included erential hematoma with LE due to mechanical fall				Page 31 o

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	The Patient Dischard	o 8 Transfer form from the	1	1		lJ T]
	hospital dated 2/12/13 Resident #49's Prima anemia due to acute Medical Diagnosis as	left leg hematoma. The port given to the facility				
		flected no Progress Notes then the resident returned return assessment				
	49 responded since libeen to the hospital of # 49 reported she couweek or the date, but go to the hospital for overnight nurse, 10 pit would be too expended the said warrived she thought the hospital and the office of the sident # 49 said warrived she thought the hospital and the office of the sident # 49 said warrived she thought the hospital and the office # 49 said warrived she thought the hospital and the sident # 49 said warrived she thought the hospital and the sident # 49 said warrived she thought the hospital and the sident # 49 said warrived she thought # 49 said warrived she thought the sident # 49 said warrived she thought # 49 said warrived she	6/18 at 10:45 a.m. Resident # diving at the facility she had once due to the flu. Resident all not recall the day of the one night she requested to breathing problems and the .m. to 6 a.m. nurse, told her asive to call an ambulance. Then the day shift nurse he resident needed to go to day shift nurse called an t # 49 reported she waited				Page 32 of

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	about 8 hours to be a	ble to go to the hospital.				
	feel bad, and felt like about her. Resident person to just run to the needed to go. Reside hospital found any brothe hospital took x-ray came back fine. Resulting a good bruise on her puffed up.	ident # 49 stated it bothered her, made her bad, and felt like the staff did not give a shit at her. Resident # 49 stated she was not a on to just run to the hospital; she felt she ded to go. Resident # 49 did not think the bital found any broken bones and commented hospital took x-rays but she thought they e back fine. Resident # 49 said she just had od bruise on her left groin area that had ed up. Eview on 3/7/18 at 6:15 a.m. Staff C stated worked 6 p.m. to 6 a.m. shifts at the facility, 3				
	16 months. Staff C a Resident #49's care. Resident #49 very wind putting self on the flood Resident #49 had blood C said Resident #49's C responded 1 time F then said she wanted	cknowledged familiar with Staff C stated usually th it but had one behavior of or. Staff C reported wen up a couple times. Staff s behaviors really bad. Staff Resident #49 had pain pill I her to call an ambulance. did not call an ambulance as				Page 33 of

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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	the hospital but said of down, not need to go Resident #49 wanted resident would do any it. Staff C confirmed Staff C responded shon 2/4/18 and confirm physician before 2/4/talked to doctor thru from said they were well as behaviors. Staff C resident's pain acute, resident put herself of pain but when Staff C not limp. Staff C state resident went to the resident had cellulitis reported the resident the hospital (2/5/18). liked the resident but allowed to do; only do C confirmed she did to not go to the hospital	knowledged Resident #49 had the right to go to e hospital but said when the resident calmed own, not need to go. Staff C stated whatever esident #49 wanted at a given moment the sident would do anything and everything to get Staff C confirmed she wrote the 2/4/18 fax. aff C responded she did not call the physician a 2/4/18 and confirmed she had never called the hysician before 2/4/18. Staff C commented she ked to doctor thru fax only and the physician id they were well aware of the resident's chaviors. Staff C responded she didn't know the sident's pain acute, but back at that time, the sident put herself on floor and said she had in but when Staff C saw the resident she did at limp. Staff C stated she was not aware the sident went to the hospital and not aware the sident had cellulitis at the time (2/4/18). Staff C ported the resident also fell the day she went to be hospital (2/5/18). Staff C stated she really led the resident but she couldn't do more than lowed to do; only do what doctor ordered. Staff confirmed she did tell Resident #49 she could be go to the hospital. Staff C said the fax 2/4/18 becumenting send to ER she did not know who				Page 34 of 9
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		ted she would have told				
	the last time she saw around 5 a.m. and Re need anything but Sta	yshift about the fax she wrote. Staff C stated e last time she saw Resident #49 on 2/4/18 was bund 5 a.m. and Resident #49 said she didn't ed anything but Staff C said she still faxed out nat happened that night.				
	she started working for January 2018, fulltime Staff B acknowledged Staff B reported she of fax 2/4/18 to send the stated when the faxed progress note and she see if she wrote a prostaff B confirmed she 2/4/18 fax that docum 2/13/18, but comment the fax and definitely send to ER. Staff B round stacks of faxes hours at night proces problem but all faxes	at 7:00 a.m. Staff B stated or the facility again in e 10 p.m. to 6 a.m. shift. It distributes a familiar with Resident #49. It did not remember seeing a e resident to the ER. Staff B is came back she wrote a rewould need to check to organize and noted the nented send to ER on the send to ER on the send to the organize and not recall the order to reported she sometimes a no one had done and spent sing. Staff B stated faxes a caught up at the time of the ported she had found some	again in 5 a.m. shift. Resident #49. hber seeing a he ER. Staff B she wrote a I to check to bout the fax. and noted the o ER on ot recognize the order to sometimes done and spent stated faxes a the time of the			
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	In an interview on 3/8 Director of Nursing (E find out what hospital order to retrieve the h Resident #49's most DON acknowledged sobtain hospital record the facility for continuthe nurses did get the find any.	a/18 at 8:50 a.m., the DON) stated she needed to the resident had gone to in a nospital records from recent hospital stay. The she would expect staff to dis upon a resident's return to ity of care and said usually expected but she couldn't fax cover sheet documented of 3/8/18 at 10:04 a.m.				
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58.19(2)a +	Medication and treatment. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only)			\$7,000 (Held Suspe		UPON RECEIPT
58.20(1)	nursing facility shall h supervisor who shall: the physician's orders	Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall: Direct the implementation of the physician's orders.				
	and staff interviews, t administer the correct medication which resi subsequent hospitaliz reviewed (Resident # census of 61 current Findings include:	t dose of a narcotic pain ulted in overdose and cation for one of 36 residents 113). The facility reported a				Page 37 of 5

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	acute care hospital or major depressive disconsisted as with collapse listed as The Interim Plan of Control Resident #113 dependance and ADLs (along would be staying at the and noted that the rewould be found with the total the resident of the would be found with the resident of the major of the work	care dated 3/8/18 noted that inded on staff for personal ctivities of daily living), the facility for long term care sident's current medications the admission orders. Passing Policy dated surpose as ensuring ication pass process and to edication errors that could policy also noted that all to receive safe and eare and are entitled to				Page 38 of
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	lowa Health Care not should receive 2.5 ml (milligram per millilite concentrate (narcotic total)) by mouth three The March 2018 MAF Record) documented administered 2.5 ml (Resident #113 at 8:00 3/9/18. The MAR also administered 2.5 ml (Resident #113 at 9:00 LPN administered 2.5 Resident #113 at 8:00 3/10/18. The Controlled Drug revealed that Staff I, I with Resident#113's r started the Administrated documented that 2.5 Resident #113 TID (the should be	R (Medication Administration that Staff F, LPN 5 mg) of morphine to 0 a.m. and 2:00 p.m. on 0 revealed that Staff H, LPN 5 mg) of morphine to 0 p.m. on 3/9/18 and Staff G, 5 ml (5 mg) of morphine to 0 a.m. and 2:00 p.m. on Administration Record LPN received the delivery morphine on 3/8/18 and				Page 39 of

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	and 2:00 p.m. on 3/9/revealed that Staff H of morphine to Reside 3/9/18 and Staff G admorphine to Resident p.m. on 3/10/18. A Medication Error N p.m. documented that incorrect dose of mor DON (Director of Nurreceive 2.5 ml of a 2 concentrate by mouth the pharmacy sent a morphine concentrate	o Resident #113 at 8:00 a.m. /18. The document also administered 2.5 ml (5 mg) ent #113 at 9:30 p.m. on dministered 2.5 ml (5 mg) of t #113 at 8:00 a.m. and 2:00 ote dated 3/10/18 at 10:27 at Resident #113 received an ephine. According to the sing), Resident #113 should mg/ml solution of morphine in TID. The DON noted that twenty mg/ml solution of e instead and the incorrect histered five times according in.				
	that Resident #113 di sleepiness) and had j her upper and lower of DON, she checked th	d 3/10/18 at 11:37 p.m. noted isplayed lethargy (extreme jerking movements of both extremities. According to the ne resident's medications the DON documented that				
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	had been prescribed pharmacy label on th DON called 911 after the resident sent to E The History and Physicated 3/11/18 noted to obtained from Reside the resident's encept damage or malfunction #113's daughter, her morphine as a patien The daughter said her discharged from the Inursing home 3 days noticed her mother has with episodes of twite document, Resident and of morphine TID in dosing error. According #113 had respiratory given Narcan (to courside the course of the c					Page 41 of 5
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	The doctor wrote that obtunded (a diminish did not respond to a srubbing breast bone) eye opening and multiwitching. After calling noted Resident #113 on a Narcan drip. A Nursing Note dated that they called the he Resident #113's heal documented that the nurse told her the rest Narcan drip. A picture provided by contained the bottle opharmacy label dated label, Resident #113 of a 100 mg/5 ml solution.	ng Note dated 3/12/18 at 11:15 a.m. noted / called the hospital for an update of t #113's health status. The nurse nted that the ICU (intensive care unit) ld her the resident was stable on a				Page 42 of	
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	morphine revealed the pharmacy label. According to the label, Resident #113 should receive 2.5 ml (5 mg) of a 100 mg/5 ml solution of concentrated morphine by mouth three times a day. An interview on 3/13/18 at 9:10 a.m. with Staff F revealed she administered the wrong dose of morphine to Resident #113. When asked, Staff F said precautions like having an RN double check narcotics with the nurse that accepts delivery might help prevent errors. Staff F said checking the pharmacy label with the manufacturer's label would also be a precautionary measure that could also help eliminate errors. Staff F said anyone administering medication should check the 5 Rs; the right name, the right medication, the right dose, the right route and the right time before giving it. An interview on 3/13/18 at 10:40 a.m. with the ADON (Assistant Director of Nursing) revealed that the overdose could have been prevented if they double checked the order. The ADON said					
		ninistering nurse to follow	-			Page 43 of \$
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	the 5 Rs; route, name medication. An interview on 3/13/revealed she receive filled out the narcotic cosigned for the deliving Staff I said she did not resident #113 becaute comfortably after received Trazodone (hypnotic Staff I said 2 people of Resident #113's admissional should have checked pharmacy. Staff I said practice those kind of that although she did morphine, she should sheet out correctly to her from making a medical morphine to Resident pharmacy sent the wind sheet out that she administration in the sheet out that she administration is not sheet out that sheet				Page 44 of 5	
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	incorrectly. Staff G sal label closely enough Staff G said she did r was wrong, nor did she figured it had been che facility. The LPN said label said 100 mg/5 nd the label and comparasked what would have error, Staff G said she concentration of the she concentration of t	orphine solution and they labeled the box correctly. Staff G said she did not check the bel closely enough to realize it was incorrect. aff G said she did not suspect that anything as wrong, nor did she question it because she gured it had been checked when it came into the cility. The LPN said she did not know that the bel said 100 mg/5 ml. The LPN said she read e label and compared it with the MAR. When sked what would have prevented the medication ror, Staff G said she should have checked the oncentration of the bottle's contents. In interview on 3/14/18 at 10:20 a.m. with the sident's doctor revealed that the doctor that escribed morphine for Resident #113 was her sident (under her supervision). According to the hysician, the facility did not let her know they dministered doses that exceeded the prescribed mount. A Social Worker interjected that they und out about the overdose when Resident 113's daughter contacted them asking for her other's discharge summary. The doctor stated ey faxed the orders to the facility well in				Page 45 of 5	
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	the hospital. The doc	tor said she would have				
	welcomed any questi had about the dose a would have liked the incident. Resident #1 the same dose as a pelieved Resident #1 doing well. The resident probably have been a order. The doctor said Resident #113 receiveresidents' organ function doctor said "quite frais survived it." The physworks have to double those types of errors those precautions." An interview on 3/14/ revealed she administioner morphine to Resident read on the bottle coron the order did not read on the order did not read the morphine, Staff Herein would have been a survived it."				Page 46 of F	
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	nurse or called the ph before giving it. Staff many times that she p little bit late. When as not understanding the pressured to make a					Page 47	
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58.20(2)	nursing facility shall h supervisor who shall: nursing care, services and other services in needs and choices, w DESCRIPTION: Based on clinical recoresident and staff interput interventions in pl for one of 36 resident The facility reported a Findings include The Minimum Data S	vice supervisor. Every have a health service Plan for and direct the s, treatments, procedures, order that each resident's where practicable, are met. Ord review, observation and erviews, the facility failed to lace for pain management as reviewed (Resident #112). A census of 61 residents. et (MDS) assessment dated desident #112 had diagnoses	II	\$500		UPON RECEIPT	

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	that included high blo infection (UTI) in the umbilical hernia and I documented the resid the Brief Interview for indicating mild cognit documented Residen assistance of two with walking and toilet use with dressing and per assessment documen almost constantly; the resident's sleep and I activities. The resident's care p contained no focus at the resident in pain m The Medical Progress documented Residen hospital for chest wal 10/12/17. The physic admitted to the hospit changes likely due to				Page 49 of 5	
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	pain at times. The repneumonia, which refrom the hospital to the the physician instruct Neurontin (or Gabape pain) 400 milligrams. Observation on 3/5/1 revealed the resident resident screamed ounursing assistant) entresident's call light and a lot of pain. Stadiet Director of Nursing (Aresident's medication order for any pain medication order for any pain medication order for any pain medicator Manager atternoom tray and the resident's her she had too much shot down her legs. At 12:45 p.m. the resident and the resident's p.m. the resident and the resident's her she had too much shot down her legs.	evelop which resulted in severe chest es. The resident developed a, which resolved, and she discharged ospital to the facility. Upon discharge, an instructed staff to administer (or Gabapentin, often used for nerve milligrams 3 times a day. on on 3/5/18 beginning 11:45 a.m. he resident's call light on and the creamed out. Staff, CNA (certified sistant) entered the room to answer the call light and Resident #112 stated she f pain. Staff notified the Assistant Nursing (ADON), who looked through medication list and could not find an any pain medication. At 11:47 a.m. the unager attempted to give the resident a land the resident refused the lunch tray. It is a land to much pain to eat and the pain her legs. In the resident had her call light while she asked for something for pain. At				Page 50 of
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	1:55 p.m. the ADON and DON stated they sent a facsimile to the doctor but have not received an order from the physician. In reading the resident's chart, she did not know why the medication had not been given. The resident's Order Review Report 2/1/18 through 3/31/18 lacked an order for any medications or interventions for pain. On 3/5/18 at 2:00 p.m. the resident had the call light on. Resident #112 cried, grimaced and moaned. The resident stated she had so much pain and asked why it was taking so long to give her something for the pain. Resident #112 stated tearfully she could not stand the pain and had pain everywhere. Review of the resident's Order Review Report 3/1/18 through 3/31/18 documented an order dated 3/5/18 for Gabapentin. Staff received the order at 6:00 p.m. The Discharge Summary dated 2/26/18 documented Resident #112 went to the hospital					Page 51 of

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	infection, mental state The discharge orders medication for pain. The Social Service N documented the resid	ote dated 3/6/18 dent stated the pain pills h better and slept so good.				
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