| Citation Numb # 6873 | er: | | | Date: Decem | ber 19, 2018 |
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| Facility Name: Holy Spirit Retirement Home | | | Survey Dates: December 2 to December 5, 20 | | er 5, 2018 |
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| 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) | I | \$ 4750.00 | Upon Receipt |
|-----------|--|---|------------|-----------------|
| | DESCRIPTION: | | | |
| | Based on clinical record review and staff interview, the facility failed to provide adequate supervision to prevent accidents for 3 of 7 residents sampled for nursing supervision (Residents #232, #44 and #78). The facility reported a census of 85 residents. | | | |
| | Findings include: | | | |
| | 1. According to the Minimum Data Set (MDS) assessment, dated 7/16/18, Resident #232 scored 5 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident required the assistance of one for activities of daily living (ADL's) including bed mobility, transfers, ambulation, toilet use and dressing. The resident's diagnoses included Alzheimer's disease, and the resident received Hospice care. | | | |
| | A Fall Risk assessment dated 6/17/18 scored the resident at 80 indicating a high risk for falls. | | | |

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| The Care Plan revised on 8/6/18 identified Resident #232 had impaired cognitive function related to periods of confusion and diagnosis of dementia, and extreme restlessness later in the day and at night. The interventions included to keep her safe during periods of extreme confusion and provide 1 to 1 with her as needed. The Care Plan revised on 5/2/18 identified the risk for falls due to a history of falls and cognitive loss. The interventions included use of a bed/chair alarm for safety as she got up without assistance, especially later in the day. | | |
|---|--|--|
| The Progress Note dated 7/27/18 at 5:58 p.m. documented at 3:45 p.m. staff observed Resident #232 sitting on the floor beside her bed with her back facing the bedside stand. She stated she sat on the floor while getting out of bed and did not fall and did not hit her head. Resident #232 did not complain of pain or discomfort. The resident had an abrasion on her right lower back measuring 14 cm (centimeters) by 6 cm and a yellowing bruise with small purplish blotches within the bruised area with no firmness noted that measured 6 by 6 cm. A Fall SBAR (Situation, Background, Appearance and Response) form documented the resident last seen 1 hour prior to the fall but lacked any documentation about whether the alarm was on or functioning. | | |
| The Progress Note dated 8/10/18 at 11:28 a.m. documented the resident fell that morning at the breakfast table, as witnessed by the dietary aide. The resident stood out of her wheelchair and tried to walk, | | |

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| r | | | 1 |
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| | tripped on the wheelchair pedal and fell on her buttock. A Fall SBAR form dated 8/10/18 described actions to | | |
| | | | |
| | prevent further falls as to put resident in recliner when she finished eating. The form lacked documentation of | | |
| | whether the alarm was on or functioning. | | |
| | whether the alarm was on or functioning. | | |
| | The Progress Note dated 8/10/18 at 11:42 p.m. | | |
| | documented she was found slightly on her right | | |
| | side/back on the floor in front of her bathroom doorway | | |
| | around 5:50 p.m. Staff took her to the bathroom about | | |
| | 10 minutes before the incident. She could not say what | | |
| | she was trying to do when asked her how the fall | | |
| | occurred. Upon assessment, the resident complained | | |
| | of severe pain to the right hip and outward rotation of | | |
| | the right leg. Staff notified Hospice and they came and | | |
| | assessed the resident and directed to send the | | |
| | resident to the hospital. The Hospice nurse also | | |
| | helped the nurse gives the resident an as needed | | |
| | (PRN) Roxanol while this nurse tried to call the on-call | | |
| | doctor. Staff updated the resident's family of the event. | | |
| | The on-call doctor ordered to send the resident to the | | |
| | emergency room for evaluation and paramedics | | |
| | transported her at 7 p.m Th nurse called the hospital | | |
| | for an update and learned Resident #232 admitted for | | |
| | a right hip fracture. | | |
| | | | |
| | A History and Physical dated 8/10/18 documented | | |
| | Resident #232 fell at the nursing home and was not | | |
| | able to ambulate. The assessment included the | | |
| | resident had a right intertrochanteric femur (hip) | | |
| | fracture. The physician documented that surgery was | | |
| | in the resident's best interest because without it she | | |
| I | | 1 | <u> </u> |

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| would be unable to ambulate or mobilize. | | |
|--|--|--|
| During on interview on 12/02/19 at 0:25 a.m. Staff A | | |
| During an interview on 12/03/18 at 9:25 a.m. Staff A Dietary Aide stated she is hard of hearing but she can | | |
| hear the alarms in the dining room. On 8/10/10 the | | |
| resident was standing up during the meals trying to go | | |
| on her own. Staff A stated during the morning meal | | |
| the resident kept standing up. During the noon and the | | |
| evening meal the resident continued to try and get up. | | |
| At the evening meal the nurse took the resident back | | |
| to her room. While she cleaned up at the kitchenette, | | |
| another resident's husband told her Resident #232 | | |
| was on the floor. She went to the resident's room and | | |
| saw her laying on the floor. She did not hear the alarm | | |
| sounding. She looked for someone to help. She said | | |
| 1 CNA was giving a shower, the nurse was on break, | | |
| and she could not find the other CNA. She went to | | |
| another unit and asked for help. A CNA on the floor | | |
| stated she could not leave the unit, so she went to the | | |
| office and they paged for help. She said she asked | | |
| the husband who told her the resident was on the floor | | |
| if he heard the alarm, and he said no. | | |
| During an interview on 12/3/18 at 2:39 p.m. Staff B | | |
| Certified Nursing Assistant (CNA) stated she did not | | |
| witness the fall 8/10/18 a.m., but heard about it | | |
| afterward. She said she worked in a room giving a | | |
| resident a shower so she did not hear the alarm. | | |
| Resident #232 had been restless that day, constantly | | |
| trying to get up. When she was like that they would try | | |
| to keep her with someone. It would not be safe to | | |
| leave her in her room in the recliner or the wheelchair, | | |

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| because she would just try and get up. | | |
|---|--|--|
| During an interview on 12/4/18 at 11:00 a.m. Staff C CNA stated she worked on 8/10/18 and they would have checked at 2 p.m. to see the resident had the alarm on and it worked. Resident #232 tried to get up without assistance so they kept her where they could see her. She said the last time she saw the resident she sat at the dining room table. At the time of the fall, she gave another resident a whirlpool bath. She did not hear the alarm, but she wouldn't in the whirlpool room. | | |
| During an interview on 12/4/18 at 11:12 a.m. Staff G Licensed Practical Nurse (LPN) stated she worked the evening shift on 8/10/18. The resident acted restless and just wanted to walk. She told her she couldn't walk by herself and sat Resident #232 by her until someone could walk with her. The resident continued to attempt to get up and she asked her if she wanted to go to the bathroom. A CNA (Staff H) came by and Staff G asked her to take Resident #232 to the bathroom. She gave another resident medications and then let the CNA know she was going on break. About 10 minutes later she got the call about the fall. She asked Staff H why after she asked her to take the resident to the bathroom she was on the floor by the bathroom door. The CNA told her the resident wanted to watch TV so she left her in the room. Staff G stated the CNA should not have left the resident in the room by herself when she had been making attempts to get up by herself, but the CNA was new and she didn't | | |

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| know. | | | |
|---|--|---|---|
| During an interview on 12/5/18 at 8:24 a.m. Staff K Clinical Coordinator stated if they didn't document whether the alarm was on and sounding (at the time of the incidents) she could not say if it was or not. It would be up to the caregiver to assure the alarm on and working. | | | |
| At the time of exit Staff H had not returned calls. | | | |
| 2. According to the quarterly MDS assessment dated 10/4/18, Resident #44 had a BIMS score of 8, indicating moderate cognitive and memory impairment. The MDS indicated Resident #44 required the assistance of two staff for bed mobility, transfers, and toilet use. The MDS listed he had diagnoses that included dementia, Parkinson's disease, seizure disorder, anxiety, depression and insomnia. The MDS recorded Resident #44 fell twice without injury since the previous assessment. | | | |
| Review of Resident #44's care plan recorded he had a long history of falls prior to admission to facility. He has fallen at home and at a previous nursing facility. He has also had falls and been lowered to the floor since admission. He is impulsive and does not always make safe choices. He had a high risk of falls related to Parkinson's disease, depression, anxiety, dementia, and diabetic neuropathy. The care plan listed the following interventions for staff | | | |
| | During an interview on 12/5/18 at 8:24 a.m. Staff K Clinical Coordinator stated if they didn't document whether the alarm was on and sounding (at the time of the incidents) she could not say if it was or not. It would be up to the caregiver to assure the alarm on and working. At the time of exit Staff H had not returned calls. 2. According to the quarterly MDS assessment dated 10/4/18, Resident #44 had a BIMS score of 8, indicating moderate cognitive and memory impairment. The MDS indicated Resident #44 required the assistance of two staff for bed mobility, transfers, and toilet use. The MDS listed he had diagnoses that included dementia, Parkinson's disease, seizure disorder, anxiety, depression and insomnia. The MDS recorded Resident #44 fell twice without injury since the previous assessment. Review of Resident #44's care plan recorded he had a long history of falls prior to admission to facility. He has fallen at home and at a previous nursing facility. He has also had falls and been lowered to the floor since admission. He is impulsive and does not always make safe choices. He had a high risk of falls related to Parkinson's disease, depression, anxiety, dementia, and diabetic neuropathy. | During an interview on 12/5/18 at 8:24 a.m. Staff K Clinical Coordinator stated if they didn't document whether the alarm was on and sounding (at the time of the incidents) she could not say if it was or not. It would be up to the caregiver to assure the alarm on and working. At the time of exit Staff H had not returned calls. 2. According to the quarterly MDS assessment dated 10/4/18, Resident #44 had a BIMS score of 8, indicating moderate cognitive and memory impairment. The MDS indicated Resident #44 required the assistance of two staff for bed mobility, transfers, and toilet use. The MDS listed he had diagnoses that included dementia, Parkinson's disease, seizure disorder, anxiety, depression and insomnia. The MDS recorded Resident #44 fell twice without injury since the previous assessment. Review of Resident #44's care plan recorded he had a long history of falls prior to admission to facility. He has also had falls and been lowered to the floor since admission. He is impulsive and does not always make safe choices. He had a high risk of falls related to Parkinson's disease, depression, anxiety, dementia, and diabetic neuropathy. The care plan listed the following interventions for staff | During an interview on 12/5/18 at 8:24 a.m. Staff K Clinical Coordinator stated if they didn't document whether the alarm was on and sounding (at the time of the incidents) she could not say if it was or not. It would be up to the caregiver to assure the alarm on and working. At the time of exit Staff H had not returned calls. 2. According to the quarterly MDS assessment dated 10/4/18, Resident #44 had a BIMS score of 8, indicating moderate cognitive and memory impairment. The MDS indicated Resident #44 required the assistance of two staff for bed mobility, transfers, and toilet use. The MDS listed he had diagnoses that included dementia, Parkinson's disease, seizure disorder, anxiety, depression and insomnia. The MDS recorded Resident #44 fell twice without injury since the previous assessment. Review of Resident #44's care plan recorded he had a long history of falls prior to admission to facility. He has fallen at home and at a previous nursing facility. He has also had falls and been lowered to the floor since admission. He is impulsive and does not always make safe choices. He had a high risk of falls related to Parkinson's disease, depression, anxiety, dementia, and diabetic neuropathy. The care plan listed the following interventions for staff |

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| Ask and/or encourage him to use the bathroom and then get into recliner after meals, started on 1/21/18; Assist to the bathroom after all meals, started on 10/20/18; Assist with toilet use between 5:00 AM and 6:00 AM, started on 10/23/2018; Place a chair pad alarm to the wheelchair, started on 7/30/18; Educate staff to use a textured bedspread on his bed or one with non-slip materials, started on 10/14/17; Education given to overnight staff that his bed alarm needs to be plugged in when he is bed for the whole shift; Encourage him to sit in the lounge or by nurses desk for closer observation when awake, started on 9/14/17; Gripper socks on at bed and off in morning, started on 12/6/17; Keep the bed wheels locked; Keep the call light in reach when in his room; Low bed to the floor when resident is resting during the day and at night, started on 5/14/18; Make sure shoes are in good condition. A Progress note dated 7/30/18 documented Resident #44 observed on the floor at 9:00 AM in front of his had with his head against a disting an his | | |
| A Progress note dated 7/30/18 documented Resident | | |

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| The nurse educated the Certified Nursing Assistants (CNA) on proper bed positioning and to make sure his | | |
|--|--|--|
| call light is within reach. She also educated Resident #44 on the importance of asking staff for help. | | |
| A Fall SBAR form for Resident #44 recorded the fall occurred on 7/30/18 at 9:00 AM. The resident stated he attempted to get out of bed without requesting help/assistance via the call light. Resident #44 was observed sitting on the floor bedside the bed with his back towards the bed. Resident #44 stated he did not hit his head and had no complaints of pain. When asked to describe what happened, the resident stated he tried to get out of bed and fell straight down onto his bottom; he did not hit his head. The resident's call light was not within reach. The form asked what could have been done to prevent this fall from happening, staff documented having his side rails down, his call light within reach, place his bed in a low position and have the resident's alarm on. | | |
| During interview on 12/5/18 at 8:15 AM Staff M Registered Nurse Clinical Care Coordinator stated the resident had tried to self-transfer back to bed and that is when he fell. | | |
| During interview on 12/05/18 at 8:42 AM, Staff L, LPN (Licensed Practical Nurse) stated Resident #44 told her he put himself back into bed after breaks and self-transferred back to his wheelchair. When she walked in to the room she noted the side rails were up, his bed as not in the lowest position and the alarm not | | |

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| sounding. She stated when staff got him up the morning they did not leave the side rails down, left the bed in the high position and did not turn on the alarm. Staff L believed the alarm is one that staff click on and off. Once the alarm is turned on and pressure is applied the alarm will sound. So if the alarm had been on, it would have sounded when the resident self- transferred to bed and again when he tried to get out of bed. | | |
|---|--|--|
| 3. According to the MDS assessment dated 5/24/18, Resident #78 had severely impaired cognitive skills for daily decision-making. The MDS indicated he required the assistance of one staff member for transfers and toilet use. The resident had unsteady balance when moving from a seated to a standing position, moving on and off the toilet and during surface to surface transfers. The resident had diagnoses that included dementia, Parkinson's disease, anxiety and depression. | | |
| Review of Resident #78's care plan, with a revision date of 8/24/18, revealed he had an increased risk of falls related to use of antidepressant and antipsychotic medications and history of falls prior to admission to the facility. Resident #78 appeared to have balance issues related to visual changes from dementia. He would stop when the color of the floor changed or with a difference in visible texture. He would focus and concentrate on the areas and at times felt the need to touch the area. The care plan listed the following interventions for staff to utilize: | | |

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| Section | | | | | |

| Change the bed pad alarm to a trigger call light, | | |
|--|--|--|
| started on 8/28/18; | | |
| Educate the resident/family/caregivers about safety | | |
| reminders and what to do if a fall occurs; | | |
| Encourage the resident to sit in a recliner not the love | | |
| seat when he is wearing windbreaker style pants, | | |
| beginning 10/10/18; | | |
| Ensure Resident #78 wire appropriate footwear; he | | |
| preferred tennis shoes when walking; | | |
| Keep his walkway clear to avoid stumbling, started on | | |
| 9/10/18; | | |
| Lead the resident to less populated areas when he | | |
| wandered, started on 8/28/18; | | |
| Staff re-arranged his room, moved his bed and added | | |
| a motion sensor night light on 6/16/18; | | |
| Staff set up a workspace so Resident #78 may stay | | |
| busy and not wander into unfamiliar rooms and trip | | |
| over items, started on 8/1/18; | | |
| The resident needs activities that minimize the | | |
| potential for falls while providing diversion and | | |
| distraction drawing or music. | | |
| | | |
| An Incident/Accident report for Resident #78 dated | | |
| 6/16/18 at 10:45 PM documented Resident #78 found | | |
| standing in his room with blood over her face and | | |
| hands. Bed alarm was on the bed but not properly | | |
| attached. | | |
| | | |
| The Fall SBAR form dated 6/16/18 documented the | | |
| resident found standing in his room, with blood all over | | |
| his face and hands which appeared to be coming from | | |
| the resident's nose at the bridge. Under the | | |

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| appearance section, staff was unable to respond appropriately and found him standing in his room while doing rounds. The form asked what was different this time that may have led to the fall? Staff listed alarm did not function properly and lighting as not appropriate for the room. | | |
|---|--|--|
| A Progress Note dated 6/17/18 at 8:33 AM recorded Resident #78 fell in his room at the start of the shift. The evening nurse was with the resident. Staff called his doctor, who gave orders to send the resident to the emergency room to be evaluated and treated for fall injuries. The resident returned to the facility after being evaluated for a broken nose and head injury. Resident #78 had dementia and staff needed to anticipate his needs. | | |
| An Emergency Department Physician note dated 6/16/18 indicated Resident #78 sustained a nasal bone fracture following a fall at the nursing home. | | |
| On 12/5/18 at 10:00 AM the DON stated they removed furniture from his room and re-arranged it as part of their root-cause analysis. They also added a wall light. When asked the about the alarm not functioning she stated it was there to alert staff of him moving. He liked to fidget with things and could have moved it (information not relayed on the care plan). | | |
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| cican city, in | | | | | | |
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| 50.7(1)a | 481—50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. "Major injury" shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the resident, and the resident's prognosis. | II | \$ 500.00 | Upon Receipt |
|----------|---|----|-----------|-----------------|
| | DESCRIPTION: Based on clinical record review and staff interview, the facility failed to report a major injury to the Iowa Department of Inspection and Appeals (DIA) according to state law for one of seven residents reviewed for nursing supervision (Resident #4). The facility reported a census of 85 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/20/18 recorded Resident #4 required the assistance of two staff with transfers and bed mobility. The | | | |

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| resident did not walk during the 7 day assessment period. The assessment documented she had diagnoses that included diabetes, generalized muscle weakness, atrial fibrillation, abnormalities of gait and mobility and repeated falls. | | |
| A nursing Progress Note dated 11/21/18 at 5:20 P.M. documented Resident #4 had been found on the floor in her room at 12:10 P.M. Staff documented the resident could not move her right leg, complained of pain in her right hip and transferred to a local Emergency Room. | | |
| An Emergency/Trauma Department form dated 11/21/8, revealed the resident sustained a fracture of the tibia (right or left leg not identified). | | |
| A Major Injury Determination Form dated 11/21/8 at 4:00 P.M., revealed a physician documented after review of the circumstances of the incident that caused the tibia fracture, the physician believed the resident sustained a major injury pursuant to the 481 Iowa Administrative Code. | | |
| Review of an Online Incident Reporting form, with a print date of 12/3/18, revealed the facility Director of Nursing (DON) reported the above fracture/major injury to DIA on 11/25/18 at 9:50 P.M. | | |
| During interview on 12/4/18 at 9:55 A.M., the DON stated she had been late reporting the Resident #4's major injury to DIA. She reported being aware of the | | |

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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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|--|--|----------------|-------|---|--------------------|--|
| Facility Name: Holy Spirit Retirement Home | | | | Survey Dates: December 2 to December 5, 2018 | | |
| Facility Address/City/State/Zip: 1701 W 25 th Street Sioux City, IA 51103 | | MW/SS | | | | |
| , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | |
| Rule or Code Nature of Section | | e of Violation | Class | Fine Amount | Correction date | |

| fall on 11/21/8 and of the physician's determination of major injury on 11/21/18. She stated she had been at home and had difficulty logging on to her computer. She then forgot about submitting the report again until Sunday 11/25/18. | | |
|---|--|--|
| During additional interview on 12/4/18 at 3:05 P.M., the DON reported the facility had no specific policy in regards to reporting major injuries to DIA, but they needed to report major injuries according to the state code. | | |
| Facility Response: | | |
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Facility Administrator