

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

Citation Number: #9095		Date: April 22, 2021		
Facility Name: Trinity Center at Luther Park		Survey Dates: March 29, 2021 to April 8, 2021		
Facility Address/City/State/Zip: 1555 Hull Ave Des Moines, IA 50316		VW, JS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.28(3)e	<p>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)</p> <p>58.28(3) Resident safety.</p> <p>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on clinical record review, observations, facility policy review and staff interviews, the facility failed to provide an environment free of accidents hazards and failed to provide adequate supervision for six residents. The facility failed to adequately assess and implement effective interventions for Resident #21, at risk for elopement, who removed his wander-guard device. The facility failed to respond to a sounding door alarm. Resident #21 eloped from a 2nd floor alarmed door and ambulated down 16 concrete stairs with a walker and exited the facility without staff knowledge. The facility failed to properly transfer Resident #33, #81, #90. Resident #90 sustained a laceration to the lower extremity requiring 14 sutures. Resident #81 hit her head. The staff failed to safely transport Resident #90 her wheelchair. The facility failed to assess the safety of a power chair for Resident #82. Resident #82 lost control of the power wheelchair and had her feet pinned between the power chair and the wall. Resident #82 sustained a</p>	I	\$9,500 (Held in Suspension)	Upon Receipt
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Facility Administrator

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	<p>rolled skin tear that required a transfer to the emergency department for repair. The facility reported a census of 100 residents.</p> <p>1. Elopement:</p> <p>The Minimum Data Set (MDS) assessment dated 1/20/21 indicated Resident #21 had a diagnosis that included diabetes, dementia, vascular dementia, depression, asthma, mood disorder, spinal stenosis, Chronic Obstructive Pulmonary Disease, and falls. Resident #21 had a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairments. The MDS documented physical behaviors and wandered 1-3 days during the lookback period. Resident #21 had independence with bed mobility, transfers, and walking in and out of the room. Resident #21 required staff assist of one for dressing and toileting. Resident #21 not steady when moving from seated to standing position, required the use of assistive devices at all times for balance. Resident #21 wore wander/elopement alarm daily.</p> <p>Review of Care Plan, updated 2/25/21 revealed resident had major depressive disorder with psychotic symptoms and received an anti-depressant. The Care Plan revealed Resident #21 at risk for wandering due to dementia, noncompliant, and refused to wear a wander-guard. The Care Plan directed staff to complete wander-guard checks each shift, if staff notice wander-guard off, locate it and reapply, and complete elopement assessment per protocol.</p>				
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	<p>Progress notes revealed the following:</p> <p>a. On 2/27/2021 at 11:52 a.m., Resident #21 exhibited anxious behaviors and was moving from chair to chair. Resident unable to follow direction at times related to dementia. Resident #21 often unaware of safety needs and does not ask for assistance. Observed Resident #21 standup from his chair, begin walking without his walker, lose balance, and fell to his knees. No injuries were noted and the staff notified the physician and family. The staff implemented an intervention when exhibiting anxious behaviors, offer activities i.e. walking, snack, drinks, etc. to see if this will help calm down and eliminate risk of getting up from chair to chair. The staff documented Resident #21 continued to remain at risk for falls.</p> <p>b. On 2/27/2021 at 11:32 p.m., Resident hard to redirect, going to other residents rooms and not using his walker as instructed.</p> <p>c. On 3/19/2021 at 12:25 a.m., Resident awake and wandering around the hallway. Will continue to monitor.</p> <p>d. On 3/29/2021 at 9:52 p.m., Resident #21 outside to the courtyard between B1 and C1 halls from the B-2 hallway door. Resident #21 eloped without any witnesses. The Nurse shut off the alarm when noticed it was alarming, and proceeded to locate all residents. A Nurse Aide noticed Resident #21 outside in the courtyard and assisted him back to C1 hall.</p>			
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	<p>e. On 3/30/2021 at 7:50 a.m., the staff notified the Physician of the incident from last night and received an order to place a wander-guard that was discontinued last month.</p> <p>Review of the Treatment Administration Record (TAR) dated 2/1/21 to 2/28/21 revealed wander-guard initiated on 7/8/20 and discontinued on 2/25/21. The TAR ordered the staff to check the placement and function of the wander-guard every shift.</p> <p>The TAR dated 3/1/21 to 3/31/21 revealed wander-guard placement check every shift for elopement risk initiated 3/29/21.</p> <p>Elopement Assessment dated 2/25/21 revealed Resident #21 scored "1", indicating an elopement risk and a wander-guard needed.</p> <p>A fall risk evaluation dated 1/10/21 revealed Resident #21 at risk for falls.</p> <p>A 24 Hour Report sheet dated 2/25/21 revealed Resident #21's wander-guard discontinued and an elopement assessment completed.</p> <p>An Elopement Wandering Policy revised March 2021 revealed, the facility ensured that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accident, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement.</p>				
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	<p>A Daily Clinical sheet dated 2/26/21 revealed Resident #21's wander-guard removed due to Resident #21 removing the wander-guard by himself. The sheet documented elopement assessment completed to evaluate behavior of wandering versus elopement and Resident #21 not seeking an exit.</p> <p>Review of Video Surveillance on 3/30/21 from 7:08 p.m. to 7:18 p.m. showed Resident #21 exiting 2nd floor B hall; Staff N approach the exit door, turned off the alarm and pulled the door shut; Resident #21 walked in courtyard past the 1st floor window on C hall; resident brought inside to common area on C hall on 1st floor.</p> <p>During an interview on 3/30/21 at 2:28 p.m., the Director of Nurses reported Resident #21 had no previous attempts of exit seeking behavior until this incident. Resident #21 had dementia and this was the first time he had exited through the exit door. Resident #21's had a usual behavior of walking from his room to the common area (on 2nd floor), walk to/from meals, and walk back to his room.</p> <p>During an interview on 3/30/21 at 2:43 p.m., Staff N (Registered Nurse) reported working at the time of the Resident #21's elopement. Staff N worked at the facility for 3 years and had no knowledge of the elopement policy. Staff N did not hear an alarm sound but noticed the exit door on hall B had a red light instead of green light. Staff N walked to the door and ensured it was shut and then heard the alarm and</p>			
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	<p>turned it off. Staff N reported the staff working did not hear the exit door alarm from the common area. He thought someone wearing a wander-guard tripped the alarm. Staff N did not open the door and look to see if anyone exited. Staff N checked to see if the two residents he thought were wearing wander-guards were on the unit. He saw a man with a walker, thought it was Resident #21, and the other man was in bed. Staff N had no knowledge Resident #21's wander-guard was removed the month prior. Staff N did not think it should ever come off due to Resident #21's wandering behaviors. When Staff N learned Resident #21 eloped he notified the manager. When Resident #21 returned to the unit the staff placed a new wander-guard on him. Staff N reported Resident #21 requested to go home when he eloped. Staff N was surprised resident #21 met the criteria to have the wander-guard removed. Staff N had concerns for Resident #21 walking down a flight of concrete stairs carrying his walker due to balance issues.</p> <p>During an interview on 3/31/21 at 9:27 a.m., Staff L (Clinical Administrative Assistant) reported Staff N (Registered Nurse) notified her on 3/29/21 at 7:30 p.m. of the elopement. Staff L reviewed the surveillance camera footage and placed a new wander-guard on resident #21's right wrist. Staff L reported Resident #21 had a wander-guard removed in February as he wouldn't leave on. On Monday 3/29/21, Staff L implemented another style of wander-guard that requires to be cut off and not reusable. Staff L reported in February 2021, Resident #21 did not have exit seeking behaviors when assessed for elopement</p>			
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	<p>and that he scored low enough to not require a wander-guard.</p> <p>During an interview on 3/31/21 at 10:45 a.m., Staff U (Maintenance) reported he reported to the facility the evening of 3/29/21 to make ensure the exit doors and alarms functioned properly. He pulled and tested the doors to ensure they were working. He did not find any issues. Staff U reported when the exit door is pushed open an alarm goes off. If the bar on the door is pushed for 15 seconds the door opens. While pushing on door, you hear beeping, light on magnet turns from light green to amber color and then door opens. Goes into alarm, a solid tone goes to radios. Get message the door has been breached and which door breached or needs checked. He gets message on his company phone about door alarms, but only says "door breach". On 3/29/21, a resident without a wander bracelet went through the fire exit doorway on Redwood "B". System does self-check daily. Email report automatically sent to facility manager/ maintenance supervisor every day at 6:45 a.m. The nurse pull system, call buttons, wander management, and door security are all tied into one system.</p> <p>During an interview on 3/31/21 at 11:00 a.m., Staff Q (Certified Nurse Aide) reported she observed Resident #21 on 3/29/21 between 5:00 p.m. and 6:00 p.m. in the Courtyard with his walker. Staff Q ran outside, placed gait belt on Resident #21 and assisted him inside. Staff Q reported Resident #21 walks independently with a walker, but often forgets to take walker with him. Resident #21 had a steadier gate later in day.</p>			
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	<p>During an interview on 3/31/21 at 1:30 p.m., the Director of Nurses (DON) reported Staff U (Maintenance) verifies the wander-guard is functioning correctly by running a daily report. Staff L (Clinical Administrative Assistant) had the training on how to initiate a wander-guard into the system and set up a new bracelet. The DON reported all residents should have an order if they are to wear a wander-guard and have a care plan indicating this as well as resident behaviors. When Resident #21 had his wander-guard discontinued it was documented on the 24 hour report sheet. He had been ripping off his wander-guard and was not demonstrating exit seeking behaviors prior to the incident. DON stated they do have an elopement binder where high risk resident pictures are kept at the nurses' station. DON stated resident #21 needs more supervision and when a bed is available on the 1st floor they would like to move him. DON stated it is everyone's responsibility to check when an alarm sounds. The facility started education with staff on 3/31/21.</p> <p>During an interview on 3/31/21 at 4:50 p.m., Staff O (Certified Nurse Aide) reported he looked out the window on 3/29/21 and saw another Nurse Aide from a different neighborhood running. He looked to see what was going on and observed Resident #21 standing by the courtyard gate. He then realized why the Nurse Aide was running towards the gate. Staff O informed Staff N (Registered Nurse) that Resident #21 eloped. The exit door should not open and Resident #21 should have a wander-guard on his wrist. Staff O</p>			
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	<p>reported the nursing staff utilize a walkie. The call buttons ring to the walkie and they have 15 min to respond to the resident's needs. Staff O stated the facility changed the call service at the beginning of the year. Staff have to enter a number to get out of any door, but that didn't happen on Monday night. Resident #21 pushed on the door and walked through it and there was not an alarm or alert on the walkie. Resident #21 had a wander-guard bracelet but didn't have one on at the time of the incident. Staff O stated if Resident #21 would have had wander-guard on and he got near the door, he would've received a message on his walkie to tell him which resident and what door resident at. It would let him know, but on Monday, he didn't get any kind of notification, not even that the door alarm had went off.</p> <p>Staff had training on new alarm system/call system when started to use new system. Had an in-service. Staff O believed something was wrong with the system. Staff L and Staff O tested the door after the incident happened. When they held the door for 2 seconds, they could open the door and get out. There was a "system fault", something wasn't right, he stated. The fire emergency door shouldn't just open when you push on it. There is a delay (per sign on door, need to hold x 15 sec before door latch releases). Staff L had tried the door first, pushed on it for 2 seconds, opened the door, then reset the alarm, then Staff O tried it and the same thing happened. Staff O revealed staff is supposed to get alert on computer, but no one could hear the alarm. Maintenance had to come in and check the system</p>			
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	<p>and doors after the incident. Staff O said he isn't sure which residents have wander-guards on and knows when he gets an alert on the walkie, to visually go check for a resident.</p> <p>During an interview on 3/31/21 at 5:10 p.m. with Staff P (Certified Nurse Aide) reported Staff Q Nurse Aide) was in break area getting a drink of water when she saw a resident outside in the courtyard. The resident pushed on the door/gate trying to get out but the door was locked. Staff P reported the staff assisted Resident #21 to the Cedar common area, and called the nurse upstairs to see if they were aware of a resident missing. Within a few minutes Staff L (Registered Nurse) entered the Cedar common area wondering what happened and why they didn't hear the alarm. Staff O (Nurse Aide) assisted Resident #21 back upstairs to his unit. Resident #21 had his walker when she observed him outside. Staff P wondered how he got downstairs without anyone noticing. The staff all carry walkies and when an alarm goes off, an alert goes to the walkie and indicates the location of the door and unit. On 3/29/21 she did not get alert or alarm message. Staff P checks residents at night during her shift to check for a bracelet on their ankle or wrist. She knows which residents wear a wander-guard.</p> <p>During observation of door checks by Health Facilities Surveyors on 4/1/21 at 9:00 a.m. the surveyor sounded the door alarm at the far end of Hall A on the second floor and it took 10 seconds to release to open. The door alarm was an intermittent high pitched tone</p>			
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	<p>for the 10 seconds prior to release. At the time the door released the alarm tone become a solid high pitched tone. Two additional surveyors were located in the common area where all hallways meet. One surveyor reported she was able to faintly hear the alarm while the third surveyor was not able to hear the high pitched tone. Staff H (Nurse Aide) walked past and stated "what is that noise?" An activity staff member who was present in the common area stated, "O don't hear anything". Staff H carried a walkie that sounded with a notification that an emergency door on opened on Hall A. Staff H proceeded down the hall looking into the rooms as she passed. She disabled the alarm and went through the door to look down the stairs. Two minutes lapsed between the notification on the walkie and the staff response. The surveyor proceeded to test the door in hallway B where there was a 10 second delay before the door released. Two staff responded to this alarm within 45 seconds.</p> <p>During an interview on 4/1/21 at 10:40 a.m., Staff R (Registered Nurse) reported she worked at the facility for two years. The staff complete elopement risk assessments every 3 months, as well as whenever staff noticed any resident behaviors, or a near elopement incident. The elopement risk assessment helped determine whether residents needed a wander guard device. Staff R reported Staff Z (Licensed Practical Nurse) completed an elopement assessment on Resident #21. Staff R reported Resident #21 had a wander risk due to dementia, he ambulated up and down the hallways but had no exit seeking. Resident #21 had a wander-guard for a period of time, but</p>			
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	<p>noncompliant with wearing it. During an Interdisciplinary Team (IDT) meeting, they discussed whether the resident an elopement risk versus a wander risk. They determined the resident not an elopement risk. Staff R reported the IDT team met around 2/26/21 and discussed Resident #21, who kept removing the wander-guard bracelet off. Staff R stated she was unsure why they didn't use an alternative type of wander-guard, and did not recall any discussion about getting or using something else. Staff R reported the facility had switched to a new type of wander-guard band due to a new alarm system installed. The resident had a wander-guard on when had the old system. Staff R acknowledged she entered a late entry progress note 3/29/21 at 8:29 p.m., but made the progress note effective 2/25/21. Staff R stated there had been confusion as to whether the floor nurse who worked 2/25/21 documented or progress note when the wander-guard for Resident #21 discontinued. It was brought to her attention by the DON that no note had been entered, so she entered the progress note 3/29/21 evening regarding Resident #21's wander-guard discontinued last month. The resident's wander-guard had been off as of 2/25/21. Staff R reported staff wrote on the 24 hour report sheet whenever changes on a resident or to know if a wander-guard removed. Staff documented the wander-guard checked on the Treatment Administration Record, and each unit had a wander binder with which residents had a wander-guard.</p> <p>During an interview 4/1/21 at 3:25 p.m., Staff X (Certified Nurse Aid) acknowledged she had education</p>			
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	<p>on 3/30/21 about alarms after an incident had occurred with one of the residents. Staff X stated if an alarm went off they are to run towards the alarm and stop the resident from exiting. Staff X reported residents who are at risk had bracelets or a wander-guard. The wander-guard got checked by the nurses each shift.</p> <p>During an interview 4/1/21 at 3:28 p.m., Staff K (Licensed Practical Nurse) reported she just heard about the incident and received instructions by management personnel on how to respond to alarms. Staff K reported wander-guards checked by ensuring the resident had the wander-guard on and lit up, which meant the wander-guard worked. Staff K reported when a resident moved close to an exit or tried to enter a code, an alarm sounded on the walkie system and alerted them that a resident loitering at a door/exit and needed to go investigate. Staff K reported if she wasn't able to get to the resident fast enough, other staff could run and get to the resident in time.</p> <p>During an interview 4/1/21 at 3:25 p.m., Staff Y (Certified Nurse Aide) reported when she heard an alarm sound, she went and investigated the source, and looked to ensure residents on the unit were accounted for. Staff Y reported an alarm signal came over the walkie with the location of the alarm. Staff Y acknowledged he had training regarding the new alarm system, what to do whenever she heard an alarm, and the process for checking the alarm.</p> <p>During an interview 4/1/21 at 3:21 p.m., Staff V (Certified Medication Aide) acknowledged she had</p>			
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	<p>been educated on 4/1/21 about the door alarms before her shift. Staff V stated whenever an alarm heard, she needed to check the doors, check the stairs, let other staff know, and take a census of all residents in the unit.</p> <p>During an interview 4/1/21 at 3:25 p.m., Staff E (Certified Nurse Aide) stated she had received education on 4/1/21 about the wander-guards and door alarms. If a door alarm sounded, she would check the door and look down the stairs, reset the door alarm, and report to the nurse. Staff E reported if she heard a wander-guard alarm, she needed to check for the resident and the area.</p> <p>During an interview on 4/1/21 at 3:31 p.m., Staff W (Certified Nurse Aide) had been educated on the alarms, call lights, and wander guards. Staff W reported if heard alarm, he checked on the resident, notified the nurse or a coworker.</p> <p>2. Improper Transfer:</p> <p>An MDS dated 12/8/20 documented Resident #90 had diagnoses of atrial fibrillation, coronary artery disease, hypertension, hyperlipidemia, thyroid disorder, depression, muscle weakness, multiple falls, and idiopathic peripheral autonomic neuropathy. The MDS revealed the resident had a cognition score of 7 out of 15, indicating severe cognitive impairments. Resident #90 had a fall prior to admission to the facility.</p>			
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	<p>Resident #90's Care Plan dated 12/10/20 revealed impaired though process and unawareness of safety. The resident is care planned as a risk for falls and skin integrity issues due to fragile skin and needing assistance with transfers. The care plan revealed the resident required assistance of one staff member to transfer.</p> <p>A fall risk assessment dated 12/10/21 revealed Resident #90 at risk for falls.</p> <p>#170 Skin Concern sheet dated 3/2/21 at 9:45 p.m., revealed resident #90 sustained a skin tear to right lower front leg during a staff assisted transfer. Resident #90 assessed for pain, area cleansed with normal saline, patted dry and steri strips applied.</p> <p>A Progress Note dated 3/3/21 9:58 p.m., revealed Resident #90 unstable in her recliner and attempted to get out more than once. Redirecting the resident failed. Staff attempted to transfer the resident and Resident #90 tried to fight back and slipped attempting to sit on the floor. Staff pulled her back from falling to the floor and another staff member assisted the resident into the recliner. The Nurse Aide transferred the resident to the wheelchair a cut noted to left inner thigh with scant bleeding. Manager notified, evening supervisor notified and a skin picture taken. The area to left leg cleaned and covered with gauze. The on-call physician notified and advised to send to the hospital for evaluation. Resident transferred to the hospital at 9:30 p.m.</p>				
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	<p>A Progress Note dated 3/4/21 at 12:34 a.m. revealed the resident returned from the hospital with sutures.</p> <p>An Emergency Department sheet dated 3/3/21 revealed Resident #90 sustained 6 centimeter (cm) (length) by 3 cm depth laceration to the left knee during a transfer. The laceration required 14 sutures.</p> <p>The Facility Investigation of the incident showed the incident occurred on 3/3/21. The resident sent to the ER for evaluation and sustained a 2-inch laceration on left knee during a transfer. The summary of the investigation revealed a root cause of the laceration due to improper transfer techniques. Witness statements showed Staff A (Registered Nurse) attempted to transfer the resident by placing his arms around the resident's upper body trunk. Staff B (Certified Nurse Aide) attempted to lift the resident the same way by putting her arms around the resident's upper body with her leg in between the resident's legs. After the resident transferred, Staff B noticed a skin tear to the resident's left leg. Resident at the time of the incident a one-person transfer.</p> <p>A written statement dated 3/4/21, Staff A (Registered Nurse) reported he tried to transfer the resident, the resident started to slip. He reported he put her back in the chair and Staff B and assisted the resident to the wheel chair and Staff B noticed her pants were wet and the resident's thigh had a cut on it. Staff A reported he had nothing in his pockets would have caused the cut on the resident's leg.</p>				
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	<p>A written statement from Staff B (Certified Nurse Aide) reported she saw Staff A moving the resident from her chair to the wheel chair by lifting Resident #90 by the upper arms. Staff B reported Staff A almost dropped Resident #90 and she reported telling him to put the resident back in the chair. Staff B reported she told Staff A there is a proper way to transfer the resident. Staff B reported she wanted to get a gait belt but felt Staff A did not want to wait and wanted to get the resident in the chair. Staff B reported she told Resident #90 to give her a hug and Staff B stood up the resident and transferred the resident to the wheel chair. She reported Staff A requested to have the resident stand again so he could place a chair alarm. Staff B wrote Resident #90 put her left leg in between Staff B's legs when the resident stood up. Staff B reported the resident never complained about pain but when the resident sat back down, Staff B reported her leg wet. Staff B reported fat tissue and blood on her pant leg. Staff B reported #90 had a gash in her leg and brought it to Staff A and her night supervisor's attention.</p> <p>An employee education dated 3/4/21 revealed ten staff present for the time of the education on transfers for Resident #90.</p> <p>A Gait Belt Transfers and Ambulation policy reviewed 3/4/21 revealed staff are to utilize a gait belt, non-skid socks, slippers or proper fitting shoes. Staff should have push up from chair or bed when standing up. Resident should be on the edge of the chair or the bed with feet uncrossed. Staff should have resident</p>			
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	<p>support a weaker side. While lifting support is given around the waist by means of gait belt. Remind the residents to support themselves by placing hands on the arms of a chair. Staff are to move with the resident and to lower themselves with resident and bend their knees.</p> <p>During an interview on 3/30/21 at 1:06 p.m., Staff B (Certified Nurse Aide) reported she witnessed Staff A (Registered Nurses) attempt to transfer the resident by putting his arms around the residents upper body and move Resident #90 from her chair to the wheelchair. Staff B reported Resident #90 almost fell. Staff B reported she educated Staff A to utilize a gait belt for transfers for residents. Staff B reported she wanted to go grab a gait belt but saw Staff A grab the resident's arm as if to lift up Resident #90 again. Staff B reported she stopped him and transferred the resident herself by placing her arms around her and transferring her to the wheelchair. She reported the resident stood with no difficulty. Staff B reported Staff A told her to get Resident #90 up because he needed to place the chair alarm under her. Staff B reported she helped stand up the resident and put her knee between her legs to help her stand. Staff B reported when she sat Resident #90 back down to her wheel chair she noticed her leg wet and saw blood and fat tissue on her pant leg. Staff B noted a skin tear in the resident's thigh. Staff B reported she told the night supervisor what occurred. Staff B reported she was suspended the next day for improper use of transfer for resident safety.</p>			
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	<p>During an interview 4/01/21 9:34 a.m., the DON reported she felt the injury to Resident #90's leg was due to staff improperly transferring the resident. The DON reported she spoke with a physician regarding the resident's wound and what occurred and the physician reported the pressure from their knee could cause a skin tear.</p> <p>3. Hazard: A MDS assessment dated 12/27/21 revealed the Resident #9 revealed the resident had diagnoses of hypertension, Alzheimer's, anxiety, depression, psychotic disorder, and metabolic encephalopathy. The MDS revealed the resident's cognition is severely impaired. The resident required assistance of two staff members for transfers and does not ambulate. Resident #9's MDS revealed resident required assistance with a wheelchair for mobilization.</p> <p>A Care Plan revealed the resident required assistance of two for transfers and used a wheelchair for locomotion on the unit and staff are to assist resident with backing up from the table in her wheelchair. Care plan reported Resident #9 has altered mobility and self-propels in wheelchair. Resident #9 has impaired cognition.</p> <p>A fall risk assessment dated 3/20/21 revealed the resident at risk for falls.</p> <p>During an observation on 3/30/21 at 9:08 a.m., a staff member pushed resident up to her table in her wheelchair. Resident #9 did not have pedals on her</p>			
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	<p>wheelchair. Staff member pushed the resident's wheelchair forward towards the table in a distance approximately six feet.</p> <p>During a second observation on 4/1/21 at 8:26 a.m., Staff C (Certified Nurse Aide) pushed the resident into her room from the hallway for cares. The resident at the time did not have pedals on her wheelchair. The staff member pushed the resident in her wheelchair approximately 12 feet.</p> <p>During an interview on 4/6/21 at 2:21 p.m., the DON reported she expected staff to use wheel chair pedals for residents when pushing a resident in a wheelchair.</p> <p>The DON presented a policy for safe transportation to and from resident's room, to an activity, and or safe assistance from staff and or family regarding locomotion on and off the unit dated April 2021. The policy directed staff to utilize wheel chair pedals when pushing a resident in the wheel chair.</p> <p>4. Improper Transfer:</p> <p>The annual MDS assessment dated 2/28/21 for Resident #81 revealed BIMS score of 13 that indicated intact cognition for decision-making. The MDS included she required extensive assistance of one staff for transfers and walking in room and used a walker and include diagnoses of arthritis, osteoporosis, and fracture. Further included she had falls with injury since her prior assessment.</p>			
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	<p>Resident #81's Care Plan revised on 8/28/19 included self-care deficit with limited physical mobility and required assist of 1 staff with all cares transfers, mobility and positioning, ambulation with her using a walker. If further included a focus are of high risk for falls and required a gait belt for all ambulation.</p> <p>The facilities Fall- Witnessed report dated 2/28/21 at 2:39 p.m., revealed a Nurse Aide reported the resident fell while she was assisting her. The Nurse found the resident on her right side with her head on the floor towards the roommate's bed. The walker with the gait belt on it in front of resident towards her TV. Resident stated she fell back coming from the toilet with assistance. The aide left her to grab something and she lost her balance and fell. Resident verbalized she did hit her head twice and it was hurting.</p> <p>The Gait Belt Transfers and Ambulation policy reviewed 1/20/21 included the following when assisting a resident with ambulation:</p> <ol style="list-style-type: none"> a. Put the gait belt around the resident securely. b. Assist the resident to a standing position. c. Walk on the resident weaker side. d. Walk with the resident by placing one hand around the back of the waist and the other in the loop of the gait belt. e. Walk the resident according to the Care Plan. 			
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	<p>During an interview on 4/6/21 at 8:02 a.m., Staff H (Registered Nurse) explained a Nurse Aide reported Resident #81 fell. Staff H found the resident on the floor. The gait belt on the walker. When the aide left the room she asked the Resident what happened and she explained she left me for a minute and I fell.</p> <p>During an interview on 4/6/21 at 8:13 a.m., Staff E (Certified Nurse Aide) confirmed she assisted Resident #81 to the bathroom. When finished after standing, removed her gait belt to pull up her pants and forgot to put it back on. Staff E explained she had one hand on the Residents back and used the other hand to change the pad in the chair when the resident fell.</p> <p>5. Improper Transfer:</p> <p>The quarterly MDS assessment dated 1/24/21 for Resident #33 revealed BIMS score of 9 that indicated impaired cognition for decision-making. The MDS included he required extensive assistance of one staff for transfers and walking in room and used a walker and include diagnoses of heart failure, hypertension, respiratory failure and repeated falls.</p> <p>Resident #33's Care Plan dated 2/8/21 included him at risk for falls and to assist as needed with transfers and ambulation.</p>			
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	<p>Observation on 3/30/21 at 6:21a.m. Staff H CNA used hand sanitizer and donned gloves. Sat Resident on edge of the bed put his walker in front of him assisted him to stand. Walked Resident to recliner without the use of a gait belt.</p> <p>An interview on 4/5/21 at 1:52 p.m., with the DON reported an expectation of staff to utilize a gait belt with transfers.</p> <p>6. Hazard:</p> <p>The quarterly MDS assessment dated 2/28/21 for Resident #82 revealed BIMS score of 15 that indicated intact cognition for decision-making. The MDS included she required extensive assistance of one staff for transfers, walking in room and toilet use with the use of a wheelchair and include diagnoses of heart failure, abnormalities of gait and mobility and visual hallucinations.</p> <p>Resident #82's Care Plan revised 6/26/19 included a self-care performance deficit with gait disturbance and directed staff to assist as need using walker and requires assistance of 1 staff for transfers, walking and toileting.</p> <p>The Skin Concern dated 12/30/20 revealed the staff found Resident #82 in her room at 3:00 p.m. with her feet pinned into the corner of the wall by her bathroom and her power chair facing the wardrobe, her legs were out to the left side of the footrest on the power chair which caused them to get pinned against the</p>			
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	<p>corner of the wall. Resident stated she was going to the restroom and lost control of her power chair. Resident states she lost control of her chair controls and instead of going backwards, she went forward into the wall. Noted that Resident used power wheelchair for mobility throughout the unit. Resident sent to the ER due to the size and appearance of the skin tear, staff unable to retract the skin back without causing pain to the Resident.</p> <p>The Therapy Communication sheet dated 9/22/20 included information to walk resident to and from the bathroom using walker and gait belt with assistance of 1 staff.</p> <p>The Occupational Therapy Treatment Encounter Notes dated 9/18/20 summary for daily skilled services included the following; worked with Resident #82 on safety in powered wheelchair around room and facility to ensure good safety with use of it. Resident applied seat belt with cues. She kept the powered wheelchair at an appropriate speed to maneuver around obstacles and able to propel herself appropriately up to the dining table for meals. Resident had no close calls and demonstrated good safety on this date. Resident able to continue use of her power wheelchair in facility at this time. Will work on safety with self-transfers from power wheelchair to toilet.</p> <p>Resident #82's medical record lacked a Therapy Communication to the facility as to safe use of the power wheelchair use in the facility.</p>				
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	<p>The Occupational Therapy Treatment Encounter Notes dated 3/16/21 summary for daily skilled services included the following; Resident # 82 and therapist go over discharge this date. Per report completing toileting routine with assist of 1 and plans to continue for safety. Brings powered wheelchair to doorway and walks in with front wheeled walker with stand by assistance. Resident # 82 completes power wheel chair mobility to dining area without difficulty for meals. Educated on progressing toward goals and discharge occurring this date. Verbalizes agreement understanding and states no additional concerns at this time.</p> <p>Therapy Communication to the facility dated 4/6/21 included the following information; Resident is safe to use her power wheelchair in the facility and her room. She is not to use it in her bathroom. She will call for assistance of staff and walk to the bathroom.</p> <p>During an observation on 3/31/21 at 10:48 a.m., Resident #82 going down the hallway in her power wheelchair from her room to go to the dining room for lunch.</p> <p>During an interview on 3/30/21 at 1:10 p.m., Resident #82 explained she had a fall a few months ago and had to go to the hospital to have the skin unrolled.</p> <p>During an interview on 4/5/21 at 9:59 a.m., with the DON acknowledged she could not find an incident report of the time Resident #82 hit the wall with the</p>			
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	<p>power chair or an assessment for the safe use of the power wheelchair.</p> <p>During an interview on 4/5/21 at 10:24 a.m., with the DON she explained she called the nurse in to complete the incident report for 12/30/20 and provided the report. The DON further explained they had therapy working with the resident on power wheelchair safety, since she ran into the door and injured herself.</p> <p>During an interview on 4/05/21 at 11:54 a.m., the DON explained Resident #82 admitted with the power wheelchair and they did not have and assessment for safe use of it.</p> <p>During an interview on 4/6/21 at 7:02 a.m. with the DON acknowledged therapy notes show discharge date of 3/16/21. The DON explained she would expect therapy communication to be done right away so that everyone knows she is safe to use the power wheelchair.</p> <p>FACILITY RESPONSE:</p>			
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