Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 9087	Fine amount reduced by 35% to $3,575 on May 10, 2021 pursuant to Iowa Code Section 135C.43A	Date: April 27, 2021
Facility Name: Tanager Place		Survey Dates: March 1, 2021 – March 16, 2021
Facility Address/City/State/Zip 2309 C Street S. W. Cedar Rapids, IA 52404	LK	Survey

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
64.60 W331	**481-64.60(135C) Federal regulations adopted - conditions of participation. Regulations in 42 CFR Part 483, Subpart D, and Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319. Classification of violations is I, II, and III, determined by the division using the provision in 481-Chapter 56, Fining and Citations," to enforce a fine to cite a facility. This rule is intended to implement Iowa Code Section 135C.2(3).** **DESCRIPTION:** **The facility must provide clients with nursing services in accordance with their needs.** Based on interviews and record review, the facility failed to provide adequate nursing and health care training, assessment, and follow up related to client head injuries and client fractures. This affected 3 of 4 sample clients (Client #1, Client #12 and Client #17). Findings follow:	I	$5,000.00	Upon Receipt

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	1. Observation at Terry Cottage on 3/02/21 from 7:03 a.m. to 8:04 a.m. revealed Client #17 without his orthopedic boot for his broken foot. Client #17 ran around the cottage, aggressed toward Client #13, ate standing up, and pretended to fight with Client #12, while wearing nothing on his feet. At 7:25 a.m. Client #17 climbed the couch to the ledge and climbed over the ledge to the upper level, in his bare feet. The staff present did not prompt Client #17 to wear his boot during the approximately one hour observation. Client #14 prompted Client #17 to wear his boot at 7:37 a.m., but Client #17 did not put the boot on. When interviewed on the afternoon of 3/02/21, Health and Practice Manager (HPM) confirmed Client #17 should wear his boot at all times, but he did have the right to refuse to wear it. During a follow-up interview on 3/04/21 at 10 a.m., the HPM provided three emails regarding Client #17's foot fracture and orthopedic boot. The HPM confirmed on the afternoon of 3/04/21 the three emails were the only documentation of staff training and there was no health care plan related to the broken foot. Record review on 3/02/21 revealed an Incident Report (IR) for Client #17 on 2/01/21 at 4:45 p.m., noting Client #17 fell on the stairs at Terry			

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	Cottage. The IR indicated "displacement and fracture of his 5th metatarsal bone". On 2/02/21 at 9:25 a.m. the Registered Nurse followed up with an email, which noted "non weight bearing to the right foot". According to the email Client #17 "cannot participate in rec/gym activities that would require him to be up on his foot". A follow up physician's appointment on 2/05/21 indicated a new order from the doctor to "wear boot at all times; remove to bathe or shower". On 2/05/21 at 4:49 p.m. the Health Assistant (HA) sent a foot restriction email to Terry Cottage staff. According to the email, Client #17 was able to go without crutches, but he needed to wear his boot at all times (he could remove it to bathe or shower). On 3/02/21 at 5:11 p.m. the HA sent an updated email regarding Client #17's foot. The email indicated Client #17 needed to have his boot on when he woke up until he went to bed and if client #17 "is walking around the cottage without his boot, he needs to be prompted by staff to put his boot on". The email on 3/02/21 was sent to staff after the surveyor spoke to the HPM that afternoon regarding concerns that Client #17 did not wear his boot during observations on the morning of 3/02/21. Additional observation at Terry Cottage on 3/10/21 from 7:09 a.m. to 7:43 a.m. revealed			

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	Client #17 up and about in his bare feet. Client #17's orthopedic boot was on the floor in the common area of the second level of the cottage. Youth Service Worker (YSW) E, YSW C, and Shift Lead A walked by the boot throughout the observation. Client #17 walked around the cottage, ate breakfast standing up, and danced with staff. YSW E and Shift Lead A interacted with Client #17 throughout the time frame, but did not prompt the client to put on his boot. Client #17 independently put on his boot to leave for school at approximately 7:43 a.m. 2. Record review on 3/03/21 revealed multiple Incident Reports for Client #1 and Client #12 regarding self-injurious behavior to their heads. a) Client #1 had the following Incident Reports (IR) between 12/01/20 and 2/28/21: 12/29/20: Client #1 banged the back of her head on the door three times and then once on the floor. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed. 1/09/21: Client #1 hit her head on the floor three times before staff could put a pad between her head and the floor. Client #1 had redness on her forehead and complained of head pain. The IR			

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	gave no indication a nurse was notified or that a nursing/medical assessment was completed. 1/11/21: Client #1 began banging her head on the bathroom mirror. Staff blocked her head with their hand. Client #1 then began banging her head on the bathroom paper towel holder. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed. 1/23/21: Client #1 was banging her head repeatedly on the floor and the wall. She also hit herself in the head. She began crying and said her head hurt. Staff called a facility nurse and transported Client #1 to the hospital emergency room. According to the IR, Client #1 was assessed at the emergency room and discharged with instructions to get rest and "needed to be monitored." The IR did not indicate how Client #1 should be monitored. A nursing note was entered for this incident, as noted below. 1/24/21: Staff escorted Client #1 to her room for behavioral issues, including aggression toward staff. Staff documented Client #1 laid on her bedroom floor and hit her head on the floor and the wall. Staff attempted to use pads to block Client #1's head from making contact with the hard surfaces, but she grabbed the pads and			

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	threw them at staff. Client #7 also punched herself in the head multiple times. The staff noted Client #7 banged her head three times "extremely hard" on the door and then laid on the ground grunting and not responding to staff questions. Client #7 seemed confused and disoriented. "She then fell asleep and staff tried waking her and she kept groaning at staff and not responding with works. She was asleep for 15-20 minutes and staff called nursing and they said to send her to ER." Staff transported Client #7 to the emergency room where she was diagnosed with a concussion. 1/27/21: Client #1 was banging her head. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed. 2/21/21: Client #1 "self-harmed by hitting her head, she hit her head around 5 times on the front of her head." The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed. 2/24/21: A peer kicked Client #1 in the head. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed. 2/26/21: Client #1 was banging her head on the			

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	wall. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed. 2/27/21: Client #1 punched herself in the face and was banging her head on the wall. The IR gave no indication a nurse was notified or that a nursing/medical assessment was completed. Client #1 had the following nursing notes between 12/01/20 and 2/28/21 regarding head banging and/or head injury: 1/23/21, 12:34 p.m.: The nurse was notified by staff that Client #1 had been head banging. Client then indicated she felt dizzy and her head hurt. The nurse directed staff to take the client to the emergency room (ER) for a possible concussion. The nurse discussed the situation with the agency physician. 1/23/21, 5:29 p.m.: The nurse documented Client #1 returned to the facility from the (ER), with no new orders. The nurse noted staff told her the ER had checked Client #1's vital signs and did a quick neurological exam. The nurse documented she notified the agency physician. There was no further nursing follow-up note related to this incident.			

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	1/24/21, 12:35 p.m.: The nurse was notified by staff that Client #1 had been head banging "pretty significantly". After she stopped, she appeared very tired and laid down and was making moaning and grunting noises. Client #1 told staff it felt like the room was spinning. The nurse notified the agency physician and they agreed to send the client to the ER. There was no additional nursing note regarding the outcome of the ER visit. 2/1/21, 9:12 a.m.: The nurse documented Client #1 was seen at a health clinic on 1/29/21 for follow-up for a concussion with loss of consciousness. Client #7 had improved. The nurse noted the clinic recommended, "continue to monitor symptoms", but provided no information on monitoring symptoms. A physician's referral form revealed Client #1 saw a physician for concussion follow-up on 1/29/21. The diagnosis was listed as concussion with loss of consciousness (on 1/24/21). The referral form noted an improvement in overall condition and indicated Client #1 could return to normal activity. The referral form noted "continue to monitor symptoms". Further record review revealed no type of facility			

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	follow-up related to the head banging incidents, such as neuro checks or monitoring for symptoms of concussion. The Emergency Room document for 1/23/21noted the diagnosis of injury to the head, with no follow-up recommendations. The Emergency Room document for 1/24/21 noted the diagnosis of injury of head and concussion with loss of consciousness of 30 minutes or less. They recommended rest and no strenuous activity for Client #1. The recommendation to rest and avoid strenuous activity was not noted in the agency nursing notes. b) Client #12 had the following IRs between 12/01/20 and 2/28/21: 12/27/20: Staff documented, "In an escalated state for about 30 minutes, (Client #12) banged the right and left sides of his head as well as his forehead on the wall approximately 20 times, making physical contact with the wall. At one point, it put a dent in the wall." 12/28/21: Client #12 was in his room "engaging in high intensity head-banging against walls, floors and the door." Staff attempted to use body positioning and pads but the client continued to			

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	engage in the behavior. 12/31/21: Client #12 became upset at a doctor appointment and banged his head on the wall. There was a visible red mark on his forehead, with no signs of concussion. 2/11/21: Client #12 was in an escalated state and banged his head with "high intensity" on the wall. He had a big red mark in the middle of his forehead. 2/20/21: Client #12 "continuously punched and banged his head against the walls and doors. It became excessive after being escorted to his room. His head banging resulted in 2 sores on the front/top of his head." No nursing notes or nursing follow-up could be located in Client #12's record related to the incidents of head banging noted above. When interviewed on 3/03/21 at 10:30 a.m. the HPM stated the facility did not have a Head Injury Protocol, but they had been working on one. Per the HPM, staff had been trained to call a facility nurse if a client's head banging resulted in signs of concussion. The facility had a list with signs of concussion they had provided to staff during			

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	training, but the list was not posted. The facility also had a form indicating when staff should contact the nurse, which was provided to staff, but not posted. The facility trained staff on when to call the nurse and the signs of concussion every few months. The last training was done October 2020, but not all the staff attended, so email sent out with information on when to call nursing on 10/31/20. The facility provided the documentation for the training done in October 2020. During a follow-up interview on 3/04/21 at 3:45 p.m. the HPM noted Client #1's school had requested the facility complete daily forms entitled "Student Concussion Symptom Checklist" when Client #1 was diagnosed as having a concussion on 1/24/21. The HPM acknowledged the forms were completed and sent to the school, but not regularly reviewed by facility nursing staff. On 3/11/21 the HPM provided an agency packet entitled, "Caring for Clients at Tanager Place". The packet included signs and symptoms of concussion. According to the page with information regarding concussions, staff should notify nursing of any head injury with positive signs of a concussion. If no signs are present, staff should email nursing staff. The HPM provided samples of the emails on 3/11/21. The			

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	emails contained various information regarding what had occurred during the shift. As an example, an email dated 1/09/21 included, "(Client #1) - head", with no additional information. The email was sent to ICF/ID Cottage 3. The HPM said the nursing staff saw the emails sent to ICF/ID Cottage 3, but there was no indication when the nursing staff saw the email or of any follow up action/documentation. This finding resulted in a determination of Immediate Jeopardy (IJ) on 3/04/21 at 3:00 p.m. based on multiple incident reports of client head banging episodes, with little to no nursing assessment or follow-up. Two sample clients had several incident reports regarding banging their heads on hard surfaces. The staff typically did not contact nursing staff and there were no nursing notes related to the incidents except in two instances when a client went to the emergency room after showing signs of a possible concussion. The facility developed and implemented a plan of abatement to develop a head injury policy and retrain staff regarding head injury protocol, which included notifying nursing staff of head injuries.			
50.7	**481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next**	II	$500.00	Upon Receipt

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W153	**business day, by the most expeditious means available:** **DESCRIPTION:** Based on interview and record review, the facility failed to report all allegations of abuse in a timely manner. This pertained to 1 of 7 clients involved in allegations of abuse since 1/01/2020 (Client #6). Finding follows: Record review on 3/01/21 revealed a facility investigation regarding an allegation of abuse made by Client #6 on 9/24/20. According to the facility investigation, Client #6 became aggressive toward Youth Service Worker (YSW) A on the morning of 9/24/20. YSW A said her fingernail accidentally scratched Client #6's arm as she raised her hands up to block Client #6 from hitting her in the face. Client #6 began crying and said YSW A had purposefully scratched him. The facility separated YSW A from Client #6 and conducted an internal investigation. According to additional documentation, the facility reported the allegation of abuse to the Department of Human Services (DHS) and the Department of Inspections and Appeals (DIA) on 10/08/20, which was approximately two weeks after the incident. The facility reported the incident to DHS			

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	because the client was a minor. DHS accepted the abuse report for assessment and determined it to be not confirmed and not placed. When interviewed on 3/01/21 at 2:45 p.m. the Health and Practice Manager confirmed the facility did not immediately report the allegation of abuse. She said the agency had done some management staff restructuring around the time of the incident on 9/24/20 and the facility failed to immediately report the allegation due to an oversight. According to the agency Abuse Prevention policy, allegations of child abuse should be reported to DHS not later than 24 hours or the next business day. The policy further indicated the facility would notify DIA of a suspicion of a crime against a client within 24 hours or the next business day. When interviewed on 3/09/21 at 4:50 p.m. the Vice President of Operations reported the facility should report allegations of child abuse to DIA within 24 hours or the next business day based on their policy to report suspicion of a crime against a client.			

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	FACILITY RESPONSE:			

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