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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Number FC# 2707		Report date May 8, 2006
Facility name Countryside Retirement		Survey date(s) March 29-April 24, 2006
Facility address 6120 Morningside Avenue	Surveyor(s) S. Benson, RN	
City Sioux City, IA 51106	vc	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.28(3)e	**58.28(135C) Safety.** The licensee of a nursing care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. 58.28(3) Resident safety. e. Each resident shall receive adequate supervision to ensure against hazard from self, others, or elements in the environment. **DESCRIPTION:** Based on observations, clinical record review and physician and staff interview, the facility failed to adequately supervise residents against hazard from self or elements in the environment for 1 of 6 residents reviewed for supervision (Resident #5). The facility reported a census of 68 residents in the licensed-only Intermediate Care area of the facility. Findings include: 1. Resident #5's admission and discharge summary identified the resident with diagnoses that included the following: Alzheimer's disease, hypertension, difficulty walking, generalized anxiety, hallucinations and insomnia. The Rehab Skilled Flow Sheet/Nurse Notes, dated 2/12/06, identified the resident as totally dependent on staff for transfers, bed mobility, dressing and toileting. The resident was not ambulatory. The form identified the resident as confused with long and short term memory impairments. The form identified the resident as incontinent of bowel and bladder. The form identified the resident as utilizing a personal alarm, chair sensor and bed sensor. The 1/24/06 care plan identified the resident with a problem of "At risk for falls, injury related to Alzheimer diagnosis as manifested by unsteady gait and history of falls and rolling out of bed." The care plan directed staff to implement the following measures: personal alarm on at all times, chair sensor alarm, bed sensor alarm when in bed, 30 minutes checks,	II	400	Upon Receipt

Facility Administrator _____ Date _____

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	lay down between meals as allows, use pillows to prevent rolling out of bed, wedge cushion in wheelchair. An incident/accident report, dated 6/27/05 6:05 a.m. documented, "Found by CNA (certified nurse aide) sitting on mat next to bed with legs extended out to front, back against bed. No redness/bruising noted to back. No signs or symptoms of pain displayed. Bed alarm in place but did not go off." Nurse's notes dated 6/27/05 at 0550 identified the personal alarm as not sounding due to "still attached and had not pulled loose to set off alarm." The facility applied a bed sensor to the bed. During discussion on 4/6/06 at 3:08 p.m., with the Administrator, Director of Nursing and Unit Manager, they identified the personal alarm string as too long and explained they shortened it after the 6/27/05 fall. The resident had a history of leaning forward and falling from the wheelchair. Incident reports identified the following information: 9/24/05 at 4:15 p.m. "Wheeling self and got foot caught in chair. CNA pulling wheelchair back. Resident leaned forward and fell out of wheelchair. Has 2.5 cm. (centimeter) by 2 cm. bruise to right side of forehead." Intervention: The facility told the CNA to watch the resident's feet when moving the wheelchair. 11/30/05 at 2:10 p.m. "Resident seen leaning forward in wheelchair. Staff attempting to get to resident but resident leans to his/her knees and then off to the right side. Did not hit head. Alarm was triggered. No injury." Staff then implemented a wedge cushion. 2/10/06 at 9:45 a.m., "Resident leaned forward in chair. Left wheel was locked and resident leaned forward and fell out on right side. Resident was holding head. Complained of headache." The resident's alarm sounded. Staff then implemented that the resident's wheelchair brakes should not be locked. The 3/5/06 at 7:55 a.m. incident report stated the resident			

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	was observed leaning forward in wheelchair reaching towards the floor. Dietary aide observed after this after hearing the personal alarm sound and was unable to get to resident prior to her falling forward and striking head on floor. The resident was observed after the fall holding his/her head with both hands. The fall resulted in 2 areas of bruising. 4.2 cm. by 3.7 cm. contusion to the forehead and 1 cm. by 0.4 cm. faint purple area near the right eyebrow/temple. Ice was applied for 20 minutes. The incident report did not identify the resident's wheelchair wedge as in place. Staff then wrote to consider a merry walker or lap buddy to prevent resident from leaning forward. The record lacked evidence of any immediate interventions instituted to keep the resident safe. Nursing Notes dated 3/7/06 documented facility staff placed a call to the physician to request an occupational therapy consultation. On 3/9/06 the facility received approval from the physician for an occupational therapy evaluation. An incident report dated 3/9/06 at 7:30 a.m. documented The resident was sitting in wheelchair in the dining room. Personal alarm and chair alarm were intact. Resident # 5 jerked forward out of wheelchair hitting his/her head on the right side of the forehead and landed laying on their right side. Both alarms sounded. On 3/9/06 at 7:55 a.m. the resident was transported to the hospital. The transfer form identified the primary diagnosis at time of transfer as "pupils non-reactive to light, hit head twice this week." At 12:45 p.m. nurse notes indicated the resident returned to the facility. The emergency room physician identified the resident with the following diagnoses: Fall, Frontal Contusion and a urinary tract infection (UTI). The physician ordered "Fall precautions" and an antibiotic for the UTI. Nurse's notes, on the same date at 12:45 p.m.,			

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	documented "Resident continues with large contusion to right side of forehead-has had since fall on 3/5/06." The record lacked evidence of any immediate safety interventions instituted after the 3/9/06 fall. An incident report, dated 3/12/06 at 12:45 p.m., stated, "Resident in TV room with husband. Resident in wheelchair. Fell forward; husband caught resident but resident still hit head on corner of table." The resident's alarm sounded. Staff added the new intervention of a gerichair. Nurses notes dated 3/15/06 at 12 p.m. identified the resident with possible seizure activity. Staff also identified the resident's left foot as swollen and bruised. The facility notified the physician and the resident transferred to the emergency room. Documentation also revealed a 0.5 cm. by 0.5 cm. skin tear to the anterior left lower extremity, a 4 cm. by 2 cm. bruise to the right anterior knee, a 6 cm. by 4 cm. bruise to the right anterior foot and a 3cm. by 3.5 cm. bruise to the right posterior hand. On the same date, at 3:45 p.m. the resident returned from the emergency room. The physician again ordered "fall precautions." Regarding the orders of "fall precautions" ordered on 3/9/06 and 3/12/06, the physician stated during an interview on 4/17/06 at 9:50 a.m. "I was concerned why the resident kept coming in bruised. I know there are limitations on what can be done, but I was concerned because I had seen the resident so many times in a short time. I ordered the fall precautions to make them do something more about it." The record lacked evidence the facility instituted any new fall precaution measures or revised current measures after the 3/9/06 fall precaution order, until after another incident occurred on 3/12/06. After the 3/12/06 order, occupational therapy made their initial visit to see the resident on 3/14/06. Occupational therapy (OT) made alterations to the			

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	resident's wheelchair. OT notes dated 3/28/06 documented "Front wheels of wheelchair raised. New arm piece put on left wheelchair arm. Monitor patient for correct positioning. Alerted staff of wheelchair changes and of need for cleaning wheelchair." When asked why the facility did not institute new/revised fall interventions as ordered, the Administrator stated, on 4/6/06 at 3:08 p.m. "We already had fall precautions in place." Observation showed, on 4/5/06 at 12:30 p.m., the resident in a wheelchair. The resident self propelled the wheelchair by putting his/her whole body into a scooting motion to get the wheelchair to move. Observation showed the resident lean forward frequently. During observation of a resident transfer by Staff E and B on 4/6/05 at 1:50 p.m., the surveyor requested that staff not disable the alarm so the surveyor could see if it sounded when the resident arose from the wheelchair. Upon arising from the chair, the resident's chair sensor did not sound. Staff N (unit manager) stated, on 4/6/06 at 5:20 p.m. that she changed the chair sensor after the surveyor's observation. Incident reports also documented a history of falls from the resident's bed: An incident report, dated 3/9/06 at 4:35 a.m., stated, "Resident found sitting on grey mat next to bed. Was leaning against bed with legs crossed. No injury noted." The investigation identified the personal alarm as still attached to the resident's gown. The facility changed the alarm batteries. An incident report, dated 4/1/06 at 1:30 a.m. documented "Found resident on foam mat that lies next to bed. (Approximately 12 inch drop) Personal alarm on but not activated-only stretched to the maximum." The facility			

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	shortened the personal alarm string. The report also documented, "Personal alarm attached to wall side of bed from now on." Observation showed, on 4/6/05 at 1:50 p.m., Staff E and Staff B layed the resident in bed. Staff did not attach the personal alarm to the wall side of the bed.			

Facility Administrator

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	FACILITY RESPONSE:			