Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#5465	**Fine amount reduced by 35% to $325 on June 26, 2014, pursuant to Iowa Code section 135C.43A.**			**Date: June 3, 2014**
Timely Mission Nursing Home		**Survey date: May 6-8, 2014**		
109 Mission Drive				
Buffalo Center, Iowa	**Ds/pg/mw**			

		Class	**Fine Amount**	**Correction Date**
58.45(1)	**481-58.45(135C) Dignity preserved** **58.45(1)** Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II) **DESCRIPTION:** Based on record review, resident and staff interviews and review of the facility Resident Bill of Rights document, the facility failed to display respect for Resident #1 when providing care and in order to affirm the resident's individuality and dignity as human beings. The sample consisted of 4 residents and the facility identified a census of 34 residents. The resident had requested not to get out of bed and staff pried the resident's hands off of the side rails. The resident did not wish to go to the dining room and the resident was taken to the dining room by wheelchair and propelled backwards. Findings include: 1. Resident #1 had a quarterly MDS (Minimum Data Set) assessment with a reference date of 2/18/14. The MDS identified the resident had diagnosis that included a neurogenic bladder, urinary tract infection and pulmonary hypertension. The Assessment reflected the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, no mood, delirium or behavior problems (including refusal of cares), required extensive staff assistance with transfers and toilet use, limited assistance of 2 staff members with ambulation in his/her room and personal hygiene. According to a Care Plan dated 2/19/14, the resident had a nursing diagnosis of impaired mobility with approaches which included the following: a. [Staff] will put call light within reach. b. [Staff] will assist the resident with transfers.	**II**	**$500**	**Upon Receipt**

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	c. [Staff] will have 1/2 side rail when [the resident is] in bed to self- assist with turning. d. [Staff] will apply leg brace after baths and examine the skin. Additionally, a care plan entry reflected the resident had a nursing diagnosis of alteration in thought processes and mood (not dated). The approaches directed staff to: a. Continue to provide meals and medications with resident education. b. Provide 1 to 1 [1 staff to 1 resident] in room to provide support and encouragement. c. Allow the resident to voice concerns and to validate his/her self- worth. According to a Progress Reassessment form dated 4/30/14, an entry reflected the following: a. Refer to social services reassessment dated 4/30/14, #6, and no discharge planned. Social Service will discuss recent decline physically and cognitively. During an interview on 5/8/14, the DON stated the date of the nursing diagnosis of alteration in thought process and mood should be 4/30/14. According to a Restraint Assessment form, reviewed on 2/19/14, the resident utilized half side rails to assist with turning in bed and self- positioning. A Timely Mission Nursing Home Medication Review Report form dated 3/11/14 reflected the resident received a physician order on 11/15/13. The order directed the staff to use ½ [half] side rails when the resident had been in bed for self- positioning. A Nursing Assessment form dated 4/15/14 identified the resident as alert and oriented times (x) 3 (person, place and time).			

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	Review of the Nurse's Notes revealed the following entries: On 4/11/14 at 12 p.m. the resident refused all cares and angry with family. The resident refused oral intake. When transferring, the resident refused to bear weight and total lift. The resident stated "I don't care who gets hurt". Staff transferred the resident to the wheel chair for position change. The staff informed the family. On 4/11/14 at 1:05 p.m., the resident refused a nebulizer treatment at 11 a.m., noon medications and to eat and drink at lunch. Staff tried to redirect several times without success. The resident's family is aware of the resident's behavior. On 4/11/14 at 6:40 p.m., the resident very argumentative with staff; did not want to get out of bed. Physical therapy finished on repositioning to avoid sores. The resident was teary eyed and stated no one cares anyway. Staff explained to him/her that family does care and we need to do what is best for him/her. The resident did finally agree to sit up in the wheel chair. He/she refused to go to the dining room or to eat or drink anything for supper. Provided 1 to 1 [staff person to resident] with no success. On 4/11/14 at 9:35 p.m. the family came to visit, convinced him/her that he/she needed to eat, and stated they got two smiles from the resident. The resident agreed to only eat popcorn. The resident refused to eat the popcorn when taken to the resident. The resident refused to talk with staff. On 4/14/14 at 12:40 p.m. the resident refused to get into the wheelchair and out of bed. The resident claims he/she does not need position changes. He/she refused to eat, take medications and take nebulizer treatment. The physical therapy made position changes and unsuccessful with eating habits and care done with resident. Different food offered for			

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	dinner and the resident refused. Resident argumentative, rude and belligerent with staff. The resident brought to the front lobby for safety and the tab alarm was applied. The resident removed the Tab alarm several times. The doctor was notified of the resident's status. An entry on a Behavior/Mood Checklist form dated 4/11/14, documented the following: The resident very argumentative, resistive with all positioning. Patient teaching related to the importance of repositioning, pressure areas and skin integrity [provided to resident]. The resident stated "I don't care". Positioned in wheel chair with the assistance of 2 staff. The resident stated "I don't care who gets hurt". The resident refused all weight bearing. The resident noncompliant with safety. Staff brought the resident to office to be able to visualize the resident and for safety. Offered dinner, pushed table and plate away. The resident refused any other food choices. Staff returned the resident to the room via wheel chair, transferred to bed with 1 staff assistance. The resident bore weight for transfer. The resident verbalized comfort and the call light within reach. The resident requested the doctor be informed. The staff nurse informed the doctor and family. A physician progress note dated 4/17/14 at 1:09 p.m., included the following documentation: A nursing home visit as not all that pleasant. Per nursing staff as well as, obviously, visited with the resident and his/her cognition seemed to have been slipping a little bit. The resident having some episodes of paranoia, with a little bit of psychosis that would go along with probably some underlying dementia. The physician documented, we'll just continue to monitor and offer as much as possible. On 5/7/14 at 11:15 a.m., Staff E, CNA (Certified Nursing Assistant) was interviewed and stated there			

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	had been an incident when the resident thought he/she was going shopping at Walmart with her/his family. The family had said they were not going shopping. The resident then started to refuse to eat and get out of bed. The staff member stated there had been a couple of times the resident had been forced to get out of bed and one of which she witnessed. The staff member could not recall the exact date but she knew the Administrator and DON (Director of Nursing) were not present. The staff member attempted to assist the resident to get out of bed however he/she refused. She then went to Staff F, RN to report the refusal. Staff E and Staff F returned to the resident's room as Staff F told the resident he/she had to get up. The resident cried and said “No”. I do not want to get up as he/she had been positioned in bed facing the window holding onto the side rail with both hands. Staff F then began prying the resident's hands off of the bed rails while calling the resident by name and saying you [the resident] have to get up. The staff member stated at that point she just stood there as Staff F asked for her assistance because she knew her actions had been wrong. Staff F did get the resident's hands pried off of the side rail and positioned the resident on the edge of the bed. Once positioned on the edge of the bed, Staff E assisted Staff F and transferred the resident to the wheelchair, however, the resident refused to bear any weight which was abnormal for the resident. Once in the wheelchair, Staff F took over from there and propelled the resident to the lounge area just outside of her office and gave him/her a lunch tray. The resident had not been crying at that point however he/ she just sat in the wheelchair with his/her right elbow on the arm rest and his/her hand on her forehead and refused to eat. The staff member stated she went past the resident several times with other residents but did not know who put him/her back to bed. Staff E stated she went back to the resident the next day and apologized because she knew the situation had not been handled correctly. The resident stated it was not her fault but did say he/she			

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	felt like he/she had been in a prison. During an interview 5/8/14 at approximately 9 a.m., Staff E indicated she did not believe the resident had been incontinent during the above stated incident but she knew the resident's bed and pants were not wet. During an interview on 5/6/14 at 3 p.m., Staff F (Registered Nurse, MDS Coordinator), confirmed she worked on 4/11/14 and the resident had been angry with any staff who entered his/her room because he/she wanted to go on a shopping trip prior to this day but family could not take her at that time. The staff member stated she had been given a directive to change the resident's position and get him/her up. The staff member entered the resident's room with an aide that could have been Staff E or Staff G. Upon entry, the resident had been positioned on his/her back in bed. The staff member told the resident you know you have to get up on the commode but you do not have to go to the dining room and you need your bed changed because it had been soiled but could not recall the entire scenario. The staff member stated the resident's body language and demeanor said he/she did not want to get up. The resident had been described as angry and not making good judgment calls. The staff member could recall the resident rolled over a little and got his/her leg caught in the blankets because he/she wore a brace on his/her leg but could not recall if he/she held onto the side rails. The staff member recalled she informed the resident she planned on placing the head of the bed in an upright position and transfer him/her onto the commode. The resident stated she did not want to go to the dining room and Staff F told her/him that she/he would not have to go to the dining room. The staff member, along with Staff E, performed a man lift and transferred the resident into the wheel chair and to the office area for approximately 30 minutes. The staff then came and returned the resident to his/her room. Staff F denied the resident as crying, yelling and/or screaming rather he/she just sat quietly outside of her office.			

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	On 5/8/14 at 9:33 a.m., Staff A, nurse, was interviewed and confirmed she worked 4/14/14 on the 6 a.m. to 2 p.m. shift and when she entered the resident's room with a CNA (states unknown) she observed the resident positioned on the commode. Staff A stated the Administrator, DON and a student nurse wanted the resident to get into a chair because the bed had been a mess. The resident had not been happy about getting into the wheelchair because he/she would not stand. The resident was able to stand but would not stand. The staff member stated it took 2 people to transfer the resident with another person providing the perineal care. Once the resident had been positioned in the chair he/she kept intentionally sliding down in the wheel chair. The staff members placed a blanket along the back of the foot pedals to enable proper positioning. The staff member could not recall who propelled the resident to the lounge area and positioned him/her in front of the nurses' station. Staff A stated she sat with the resident and tried to talk to him/her during the time frame he/she sat in the lounge area but the resident would not speak to her. The resident sat there for approximately 15 minutes until the sister in law arrived. Then the resident began to cry. The staff member then called a CNA (doesn't remember which CNA) to lay the resident down in bed. On 5/8/14 at 10:05, Staff D, CNA was interviewed and confirmed she worked on 4/14/14 when Staff A asked her to help encourage the resident to get off of the commode. When she entered the resident's room he/she had been crying. When questioned why she/he had been crying, the resident stated they [the staff] were going to make him/ her go up there and be humiliated again. The resident refused to be transferred off of the commode so the staff member informed Staff A of the resident's refusal. At that point the Administrator, DON, Staff A and a student nurse entered the resident's room and assumed the care while Staff D assisted with feeding in the dining room. When Staff D came out of the dining room, she			

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	observed the Administrator propelling the resident in a backwards motion down the hall and position the resident across from the nurses' station. The staff member observed a blanket along the foot rests and the placement of a Tab alarm. The resident kept removing the Tab alarm so someone placed it in a lower area and out of the reach of the resident. The staff member felt the resident had been in the lobby area for approximately 1/2 hour before a family member arrived and the CNA's were requested to lay the resident down. During an interview 5/8/14 at 11:10 a.m., the Administrator indicated on 4/14/14 there were 4 staff involved due to the resident's refusal to get out of bed however the staff were able to talk the resident into transferring onto the commode. When the toileting process had been completed the staff talked the resident into standing with the assistance of a student nurse and Staff A while the DON cleansed the resident's perineal area and she removed the commode. The Administrator described the resident as behavioral by placing his/her feet down on the floor by the foot rests. At that point the student nurse tied a blanket around the foot rests to enable proper placement of the resident's feet. The resident had been asked to go to the dining room for lunch but he/she refused. The staff then asked if he/she would go to the lobby of the facility which he/she agreed to do. The Administrator stated Staff A started to take the resident to the lobby and then she took over and propelled the resident in the wheelchair in a forward motion to the lobby, and placed a Tab alarm on the resident. The resident had not been making good decisions. The Administrator stated she could not remember if the resident removed the Tab alarm but she knew she sat with him/her for a little bit and got him/her a lunch tray. The resident refused to eat, she then offered him/her a snack which the resident also refused and told the Administrator to leave. The Administrator stated it had been her understanding that later the resident began to cry so a CNA returned			

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	the resident to his/her room. During an interview 5/7/14 at 2:27 p.m., the Director of Nursing (DON) confirmed she gave the directive to Staff F on 4/11/14 to get the resident up or at least provide a position change because he/she had sensitive skin and prone to skin breakdown. On Thursday, prior to the directive the DON stated the resident called his/her daughter and told her she wanted to go to Walmart. The resident's daughter had been unable to do so at that time so the resident called his/her sister in law who had been 80 plus years old and asked her to take him/her to Walmart. The DON had not been in the building at the time so the facility staff called her, informed her of the situation. At that time, the DON gave the directive the sister in law could not take the resident out of the facility due to safety reasons which resulted in the resident being very upset. When she returned to work on 4/14/14, staff informed her resident had been refusing to eat and get out of bed. Staff A, the Administrator, a student nurse and herself went to the resident's room and found him/her refusing to get off of the commode. After much encouragement the resident continued to refuse so with the assistance of one staff member on each side and herself positioned posterior to the resident, the staff stood the resident while she cleansed him/her all the while the resident's feet kept slipping forward until positioned in the wheel-chair. While positioned in the wheelchair, the resident kept sliding down but even with staff encouragement he/she kept throwing his/her feet backwards between the foot pedals. The DON stated she gave the directive to the student nurse to position a blanket along the back of the food pedals for positioning and his/her safety. Due to the emotional effect of the situation, she stayed in the resident's room with Staff A and then went to her office while another staff member (DON doesn't remember name of staff) propelled the resident to the lounge area. During an interview 5/8/14 at 11:10 a.m., the DON			

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	confirmed the resident as not given a choice to return to bed on 4/14/14 because he/she had been in bed all morning. During an interview 5/8/14 at 10:50 a.m., Staff H, CNA stated she observed the Administrator propelling the resident in a backwards motion down the hallway and position the resident in the lobby. The staff member did not know if the resident had been crying but she felt the resident had been upset based his/her facial expression and the way he/she sat in the lobby with his/her hand on his/her head. The staff member confirmed it had been the facility policy and procedure to propel residents in a forward motion while positioned in a wheelchair. During an interview 5/7/14 at 2 p.m., Staff I, CNA stated as she came out of the dining room she witnessed the Administrator propelling the resident in a backwards motion down the hallway and into the lobby area. When she went around the nurses' station with another resident at a later time, she observed the resident positioned in a wheelchair with a blanket on the foot rest and a Tab alarm present. The resident had removed the alarm. The staff member asked the resident if he/she needed anything and the resident said no everyone says I am fine. The resident had been crying so the staff member asked him/her what had been wrong and the resident again said everyone said I am fine. The staff member described the resident as visibly upset and had been prior to the event because a family member could not take her out of the facility and he/she felt like he/she could not do anything. On 5/7/14 at 1:40 p.m., Staff J, CNA was interviewed and stated she had not been working the days of the alleged incidents but felt it had been the residents right to stay in bed if they wanted. During an interview 5/8/14 at 9:15 a.m., Staff B, RN confirmed it had been the facility's policy and			

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	procedure to propel resident's in a forward motion when positioned in a wheelchair with foot rests. During an interview 5/7/14 at 1:13 p.m., Staff C, CNA confirmed it had been the facility's policy and procedure to propel residents in a forward motion when positioned in a wheelchair with foot rests present. On 5/8/14 at 11:20 a.m., the resident was interviewed and stated he/she recalled the events that occurred in April when staff made her/him go to the lobby area of the facility. The resident stated this made her feel angry and humiliated (as he/she started to cry). The resident stated he/she preferred to stay in his/her room. On 5/8/14 at 12:02 p.m., a family member was interviewed and stated on Thursday, she/he received a telephone call from the resident and the resident wanted to go shopping but she had been unable to do so. The resident became very upset. The family member stated when the resident became upset; he/she became obstinate and would not do anything. The family member stated she spoke with the staff to assure the resident had been treated fairly and with respect and then came to the conclusion the staff did nothing incorrectly but rather in the resident's best interest. According to the Resident's Bill of Rights document, dated 3/20/11, each resident had the right to considerate and respectful care and to have been treated with honesty, dignity, respect and with reasonable accommodation of individual needs except where the health, safety, or rights of the resident or other individuals of the facility would have been endangered. It had been recognized that every resident is an individual who had feelings, preferences, personal needs and requirements.			

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	FACILITY RESPONSE:			