Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC5870				**Date: September 8, 2015**
Perry Health Care Center		**Survey dates: July 15- August 18, 2015**		
2625 Iowa Street				
Perry, Iowa 50220	**Ds/ss/ks**			
		Class	**Fine Amount**	**Correction date**
58.19(2)j	**481-58.19(135c) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24 hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.I9(2)** *Medications and treatment* *j*. Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition (I, II, III). **DESCRIPTION:** Based on observation, record review, staff and physician interviews and review of the facility policy/procedures, the facility failed to assess and intervene with interventions when residents experienced condition changes and following a fall with injury for 3 of 12 residents reviewed (Residents #4, #5 and #9). The facility identified a census of 26 residents. Findings include: 1. Review of an Admission Orders sheet signed by a physician 5/28/15, Resident #4 had diagnosis that included a history of alcohol abuse and alcohol encephalopathy, seizures, chronic obstructive pulmonary disease (COPD), dementia with behavior disturbances, depression and a brain injury. The orders included the following: a. Duoneb treatments (dilates the bronchial tubes) every 4 hours as needed (PRN) for shortness of breath. b. Oxygen per nasal cannula (NC) at 2 to 5 liters to keep oxygen saturation levels above 90% PRN. Resident #4 had an admission Minimum Data Set (MDS)	**I**	**$8000**	**Upon Receipt**

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	assessment with a reference date of 6/8/15. The MDS reflected Resident #4 had diagnoses that included diabetes mellitus and non-Alzheimer's dementia. The assessment reflected the resident had the ability to make self- understood, rarely/never understood others, had short and long term memory deficits, continuous inattention, fluctuating altered level of consciousness and psychomotor retardation, behaviors daily not directed at others, dependent on staff with transfers, ambulation, eating, toilet use and personal hygiene. The resident's Care Plan dated 6/15/15 documented the resident required assistance for all cares. Review of the Daily Resident Report sheets revealed the following documentation as dated: On 6/14/15 from 2 p.m. to 10 p.m. - lethargic, not eating. On 6/15/15 from 6 a.m. to 2 p.m. - sleepy in am [morning], poor appetite. On 6/16/15 into 6/17/15 from 10 p.m. to 6 a.m. - lungs gurgly, vital signs stable. On 6/17/15 from 6 a.m. to 2 p.m. - blood pressure (B/P) 95/58, pulse (P) 112 and respirations (R) 20, hospital. Review of the Nurse's Notes reflected the following as dated: On 6/14/15, the 2 p.m. to 10 p.m. shift failed to document an assessment. On 6/14/15 into 6/15/15 the 10 p.m. to 6 a.m. shift had no assessment completed. On 6/15/15, the 6 a.m. to 2 p.m. shift, reflected to be no assessment completed. On 6/15/15 the 2 p.m. to 10 p.m. shift, no assessment completed. On 6/15/15 into 6/16/15, the 10 p.m. to 6 a.m. shift reflected no assessment was completed.			

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	On 6/16 from 6 a.m. to 2 p.m., there was no assessment completed. On 6/16 from 2 p.m. to 10 p.m. the resident seemed very lethargic, unable to take by mouth (po) medications. No assessment was completed. On 6/17/15 (no time) B/P 124/75, P 116, R none documented, pulse oximetry (PO2) 92% at room air, temperature (T) 97.1, noted congestion in the upper lung lobes, no cough noted, resting quietly and slept through the assessment. On 6/17/15 at 7 a.m. the resident's blood sugar tested at 58, gave resident a tube of liquid glucose. At 7:30 a.m. the nurse rechecked the blood sugar and still registered at 58. Initiated Glucagon 1 milliliter (ml) intramuscular (IM) injection. At 10 a.m. the nurse rechecked the blood sugar and registered 200. B/P 95/58, P 112 (normal is 60-100), R 20 (normal is 16-20), PO2 88 (normal 96-100) at room air, lung sounds with crackles, refused all medications, fax sent to the physician, order obtained for portable chest x-ray, call to lab and would arrive at facility when able. At 12 p.m. a portable x-ray tech arrived, lung sounds very diminished, PO2 88% at room air, abdominal breathing noticed, B/P 94/58, P 120 R 26. At 12:30 p.m. the physician ordered the resident be sent to the hospital for an evaluation and treatment. At 12:45 p.m. the ambulance service arrived and transported the resident to the hospital. The ED (Emergency Department) dated 6/17/15 at 2:00 p.m. identified the resident had diagnosis of hypernatremia (elevated sodium level) with significant dehydration (excessive loss of body water) and hypoxia (diminished availability of oxygen to the body tissues). A Portable Chest x-Ray One View form dated 6/17/15, identified the following:			

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	a. Bibasilar linear atelectasis (partial or complete collapse of the lung) on the left lung greater than the right. b. Nodular opacity (abnormal area) at the right lung base. Review of a Medication Administration Record (MAR) dated 6/1/15 thru 6/30/15 reflected the staff failed to administer the Duoneb treatment and/or oxygen on 6/16 or 6/17. During an interview on 7/16/15 at 2:06 p.m., Staff D, Certified Nursing Assistant (CNA) stated he noted the resident coughed but that was nothing out of the ordinary. Staff D stated the resident's lethargy increased while at the facility. During an interview 7/16/15 at 1:32 p.m., Staff H, Registered Nurse (RN) confirmed she failed to perform an assessment or interventions for the resident on 6/16/15 on the 2 p.m. to 10 p.m. shift and looking back she should have done so. During an interview on 7/16/15 at 1:07 p.m., Staff G, LPN confirmed she did not apply oxygen to the resident. Additionally, the staff member confirmed staff should have assessed the resident when he/she first showed signs of lethargy and not eating. During an interview on 7/16/15 at 12:15 p.m., the Director of Nursing (DON) confirmed staff should have applied oxygen to the resident when their PO2 rate went below 90% but they failed to do so. During an interview on 7/16/15 at 1:27 p.m., the resident's physician stated he would have expected the staff to monitor/assess a resident with the first symptom of a condition change to establish a pattern. However 2			

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	to 3 days of continued issues/symptoms were more concerning and the physician felt staff should have been assessing the resident with the first symptom. The physician stated he could not validate if the resident would have still been alive if the staff had assessed him/her but he would have certainly sent the resident to the hospital if the resident showed signs of change. Additionally the physician confirmed he would have expected staff to have administered the oxygen per order. Review of a Final Progress Note form from the hospital and signed by a physician on 6/21/15, identified the resident had pneumonia/hypoxia. The hospital Patient Discharge & Transfer Form dated 6/28/15 identified the physician discharged the resident on 6/28/15 to a hospice house with diagnosis of pneumonia, dementia, renal insufficiency, dysphagia and hypernatremia, coagulopathy (bleeding & clotting disorder). The resident was transferred to a hospice house and expired on 7/1/15. The State of Iowa Certificate of Death filed 7/10/15, identified the resident's immediate cause of death had been aspiration pneumonia due to dysphagia (difficulty eating/drinking) with other significant conditions as anoxic brain injury (loss of oxygen to the brain). 2. Resident #5 had a MDS assessment with a reference date of 6/12/15. The MDS identified the resident had diagnoses that included peripheral vascular disease, diabetes mellitus, arthritis, quadriplegia (paralysis of arms and legs), traumatic brain injury, depression and schizophrenia (mental illness). The assessment reflected the resident with a Brief Interview for Mental Status (BIMS) score of 14. A score of 14 identified no cognitive loss. The MDS reflected the			

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	resident as dependent upon 2 staff members for transfers and showers, non-ambulatory, required extensive assistance of 2 staff members with personal hygiene and with impairments on one side of his/her upper extremity and both sides of the lower extremities. A Care Plan dated 6/15/15 reflected the resident had a potential for falls related to quadriplegia, poor trunk control and required assistance with activities of daily living (ADL's) due to multiple chronic physical and mental health problems. The approaches directed the staff to do the following: Utilize a Hoyer lift (mechanical lift) for transfers. Staff assistance for mobility in a Broda Chair. Set up for cares so the resident may do as much as he/she could. Provide hand over hand or full assistance with remainder of ADL's. Provide the resident with at least 2 showers a week. Resident required staff assistance for mobility throughout the facility. According to a shower form, the resident had been assigned to shower/bathe 7/20/15 and 7/24/15 on the day shift. The Nurse's Notes entry dated 7/20/15 from 6 a.m. to 2 p.m., reflected a nurse documented the following entry: At 9:45 a.m., a Certified Nursing Assistant (CNA) called a nurse to the shower room in the west hall. The nurse witnessed the resident as sitting on the shower room floor in the shower stall in front of the shower chair with a CNA holding the resident up with an arm behind the resident's back. The Hoyer pad still underneath the resident. The resident's legs were outstretched in front of the resident. The resident complained of right knee pain. The resident's great toenail had been hanging by			

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	a piece of skin and bleeding. The nurse left the shower room and informed the Director of Nursing (DON) at 9:40 a.m. that she needed assistance. Returned to shower room with DON and 3 CNA's and housekeeping brought the Hoyer lift to the shower room. The staff lifted the resident and placed the resident in a Broda chair. The resident was screaming and complained of right knee pain, rating the pain at 8 out of 10 (10 being worse). This nurse and CNA got the resident to the resident's room. The nurse did an assessment of the skin. The right knee appeared swollen and had been very painful for the resident to move from side to side. No other skin issues noted. Blood pressure 127/73, pulse 98, respirations 20, oxygen saturation at 98%. At 11:30 a.m. medications given included Tylenol 325 2 tablets for pain. A fax had been sent to the physician. An order to send the resident out to the hospital. The ambulance arrived at the facility at approximately 3:20 p.m. and the resident left the facility. During an interview on 7/23/15 at 10:49 a.m., Staff A stated she went to get assistance while Staff E stayed with the resident. When she returned with Staff G (licensed practical nurse), who had screamed for the DON's assistance both of the resident's legs had been extended in front of him/her. When the DON entered she directed the staff to place the Hoyer sling device under the resident to get the resident off of the floor. The staff member confirmed there had been no assessment performed while the resident had been on the floor. Staff A and Staff E placed the sling under the resident by rolling him/her back and forth and transferred him/her via a Hoyer lift device to a Broda chair, propelled the resident to his/her room and again transferred the resident via the device from the Broda chair to bed and then the nurse assessed the resident. The staff member confirmed the resident complained of knee pain through the entire process.			

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	During an interview on 7/23/15 at 11:48 a.m., Staff G, LPN stated she heard screaming down the east hallway in the shower room. When she entered, she saw the resident positioned on the floor with his/her legs extended in front of him/her and bleeding from a toe. Staff G gave the directive not to move the resident and went to get the DON. Staff G and the DON returned to the shower room at which point, she saw the Hoyer sling device had already been placed under the resident. The staff members then transferred the resident per Hoyer device from the floor to a reclined Broda chair, propelled the resident to his/her room and then again transferred him/her via a Hoyer device to his/her bed at which time, she completed an assessment and knew something was wrong. Staff G then went to the nurse's station called the physician and received an order for a portable x-ray. When the x-ray results were obtained, Staff G called the physician and received an order to transport the resident to the hospital for an evaluation. Staff G confirmed the facility policy had been to assess a resident as soon as they fall and on the floor but she had not followed proper procedure with this resident because her concern had been to get the resident off of the floor because the floor had been wet and cold and the resident had been bleeding from the toe and in pain. Staff G stated that looking in hind-site, she should have assessed the resident while on the floor. Staff G also confirmed the resident screamed in pain during the entire process stating it hurt. Staff G stated she did not think the shower chair had a safety belt for staff to have used for safe transfers. During an interview on 7/23/15 at 1:09 p.m., the DON confirmed after Staff G asked her for assistance she entered the east shower room and observed the resident positioned on the floor with legs extended out in front of him/her and blood on the floor from a toenail. The staff placed a full body mesh Hoyer sling under the resident			

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	by positioning him/her from side to side while the resident complained of pain. The staff then transferred the resident with a Hoyer lift device off the floor and into a reclined Broda chair, propelled the resident to him/her room, transferred the resident to bed utilizing the same technique at which time she left the resident's room to call the physician and received orders for a portable x-ray. When the x-rays had been completed, she returned a call to the physician and received an order to have the resident transported to the hospital for an evaluation. The DON confirmed she would have expected the staff to have left the Hoyer sling device positioned under the resident during the showering process but if staff removed the sling they should have utilized a gait belt device as the resident had not been able to bear any weight at all. The DON also confirmed she would have expected staff to not move the resident until an assessment had been performed and Staff G should have performed an assessment while the resident had been positioned on the floor. Review of the x-ray form dated 7/20/15, revealed the resident received nondisplaced fractures of the right distal femoral metaphysis and proximal tibial metaphysis (upper and lower leg bones). 3. Review of a MDS assessment form dated 7/28/15 revealed Resident #9 had diagnosis that included a psychotic disorder and schizophrenia. The assessment reflected the resident had a BIMS score of 15. A score of 15 identified no cognitive problems. The MDS reflected the resident had fluctuating inattention and disorganized thinking, verbal behavior and rejection of care 1 to 3 days a week, daily other behaviors not directed at others, hallucinations, delusions, independent with cares and shortness of breath (SOB) with exertion, sitting at rest and when lying flat.			

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	The MDS assessment dated 7/24/15 documented the resident sometimes understood others and had no SOB. A Care Plan dated 2/1/15, indicated the resident as a potential for falls but failed to identify any issues with SOB and/or potential for respiratory problems. Review of the Resident Daily Report sheets revealed the following information as identified: On 7/26/15 from 2 p.m. till 10 a.m. the resident had a B/P reading of 148/88, P 104, R 16, resident droopy with a cough, try for a urinalysis (UA). On 7/27/15 from 10 p.m. till 6 a.m. a UA, vital signs stable, slept on floor for an hour, lungs congested with very unusual behavior. From 6 a.m. till 2 p.m. and x-ray clear, complete blood count (CBC) obtained. From 2 p.m. till 10 p.m. the resident refused a shower and vital signs. On 7/28/15 from 10 p.m. till 6 a.m. the PO2 71%, refused oxygen, follow up on CBC and x-ray, T 98.6, UA positive for blood. From 6 a.m. till 2 p.m. the PO2 represented 78%, T 97.2, refused oxygen, Cipro, fax out to nurse. From 2 p.m. till 10 p.m., the resident's temperature registered 98.3; resident did take Cipro, at 9 p.m. to hospital. On 7/29/15 from 10 p.m. till 6 a.m. the hospital physician called the facility and informed the staff the resident was intubated (a tube placed in the airway to assist with breathing). Review of the Nurse's Notes revealed the following documentation as dated: On 7/26/15 from 2 p.m. to 10 p.m. the resident spent most of shift setting in a chair by the television and that			

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	had not been usual for him/her. B/P 148/88, P 104, R 18, T 97.9. Incontinent of a large amount of foul smelling urine. Non-productive cough, lungs with diminished wheezing, Instructed to have resident give a urine specimen. Resident ambulated to his/her room at 9 p.m. At 9:30 p.m. the resident in room and refused to give a UA, wanted to have the nurses in the morning check him/her. On 7/26/15 at 11:30 p.m. the resident fell asleep in the recliner in the day hall. The staff awakened the resident and he/she went to his/her room without asking for the usual ice water, juice and snack. This nurse took ice water to the resident and asked if he/she had been feeling OK [alright]. Resident stated yes, I do and why are all of you asking me this. I explained that other nurses voiced a concern over him/her and that he/she had been quite that night. The resident stated I was being considerate of another resident that's all. This nurse then asked for a urine sample from the resident at his convenience and the resident stated I'm worried someone would change the urine. Assured the resident I would not and left the room. Would continue to monitor. No assessment occurred. On 7/27/15 at 1 a.m. The resident slept in the recliner with the door open. Unusual for the resident to have the door open. Will continue to monitor. No further assessment occurred. On 7/27/15 at 3:30 a.m. the resident laid on the floor with a pillow under his/her knees. Very unusual for the resident. The nurse approached the resident and asked if he/she fell and the resident stated no, she/he wanted to lie there. This nurse than asked would you like me to find you a bed or mattress and the resident stated "no I'm fine, thank you". No further assessment occurred.			

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	On 7/27/15 at 4:15 a.m. the nurse approached the resident again and asked if the resident would like to get up or maybe get a bed. The resident stated s/he could get up now and felt cool. Staff assisted the resident to stand with the assistance of 2 staff and noted the resident's skin cool to touch. The resident had a hard time sitting on his/her folding chair and leaned forward with elbows on legs. The resident breathed heavily. This nurse asked if he/she would like some assistance transferring to a recliner and the resident stated that would be OK [alright]. Staff assisted the resident to the recliner and noted the resident as incontinent of bladder with wet brief and shirt. The resident agreed for the nurse to assist with the change of brief and t-shirt. During the change, the nurse noted the resident coughing and moist sounding breath tones. Resident agreed to vital signs. B/P 140/76, apical pulse 86, R 24, T 96.9. Unable to obtain PO2. The writer tried several digits and could not get a reading. Staff noted congestion throughout all lobes. The nurse asked if the resident would like to go to the hospital, stating the resident should get their lungs and urine checked for infection. The resident did not want to go right now. This nurse informed the resident she would continue to check on him/her every 1/2 hour. On 7/27/15 at 5:30 a.m. every 15 minute checks performed. Resident resting quietly in recliner. Respirations are 20 [normal] and easier. On 7/27/15 at 6:00 a.m. till 2 p.m. the Resident checked at 6:30 a.m. B/P 146/90, P 82, R 24, PO2 91% at room air. Resident resting in recliner. This nurse rechecked the resident at 8 a.m. B/P 150/96, P 90, R 28-30, PO2 on room air 94%. Call to physician. Order for chest x-ray, CBC, antibiotic and Albuterol nebulizer treatment. On 7/27/15 at 10 a.m. the portable chest x-ray was			

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	ordered and a CBC drawn. On 7/27/15 at 2 p.m. till 10 p.m. the resident remained in the room most of the shift. A chest x-ray done and results pending. Resident refused shower and vital signs. Non-productive cough noted. Respirations labored but the resident continued to refuse all interventions. On 7/28/15 at 11 p.m. the Resident watching TV in the day hall. R 24 and labored. Resident agreed to assessment. T 98.4, PO2 71%. Discussed using oxygen as PO2 down. Resident stated he/she would talk about it with the nurse when he/she returned to his/her room. On 7/28/15 at 12 a.m. [the nurse] notified the DON that the resident still had not left the day hall and falling asleep in the recliner. Woke up the resident and asked if he/she would like assistance to his/he room. Resident refused to allow the nurse to touch him/her but allowed an escort to his/her room. Resident walked very slow and with an unsteady gait. When reached room, had discussion with resident about oxygen, types of delivery systems and noise levels of the delivery systems. The resident refused oxygen. Resident requested a snack, juice and ice water per usual. Resident offered a UA sample for urinal. Resident stated just too please tell him/her the results of the litmus paper. A dipstick performed on foul smelling dark amber urine with results of 300 + protein, a moderate amount of blood and a PH of 5. Sample prepared for lab in AM. Resident informed of results and that a UA would have been sent to the lab in the AM. Resident requested the room light to have remained on. Resident agreed to leave door open for nurse to check on him/her. Resident agreed to use the urinal tonight and call if he/she needed to get up.			

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	On 7/28/15 at 2:30 a.m. the resident got up per self and rearranged his/her furniture, shut the door and overhead light had still been on. The resident's respirations reflected to be 22 and easier. No further assessment completed. On 7/28/15 from 6 a.m. till 2 pm the resident had a B/P of 140/79, P 70, R 20, PO2 79%. UA results back and order for Cipro (antibiotic) 500 MG 2 times a day for 5 days obtained. Transcribed to MAR. On 7/28/15 from 2 p.m. till 10 p.m. the resident assisted out to the dining room with an unsteady gait. Resident did not eat much supper. Cough noted but had not spit out any sputum. T 98.3. Resident took Cipro with much encouragement. No further assessment obtained. On 7/28/15 at 8:30 p.m. rapid respirations noted, P 120, PO2 at 72% at room air. Resident refused oxygen but eventually allowed oxygen placement at 2 liters per nasal cannula. PO2 up to 84%. The physician was notified of the patient status and order received to send to the hospital via ambulance for treatment. On 7/28/15 at 9 p.m. 911 called and report given. During an interview 8/5/15 at 9:25 a.m., the Director of Nursing confirmed the nurses got caught up in the resident's refusals and failed to follow protocol. During an interview on 8/6/15 at 3:38 p.m., Staff G, LPN confirmed any time a resident had been found on the ground it should have been considered a fall. During an interview 8/6/15 at 3:41 p.m., Staff G, indicated the facilities policy when a resident had respiratory problems had been to check all vital signs and a PO2 of less than 90% required physician notification and placement of oxygen.			

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	The facility document titled **Admission Assessment Protocol And Procedure** form dated 7/7/08, the facility staff had been directed to follow through according to the following paragraph: Regarding resident assessment subsequent to the admission assessment, the nurse on duty would perform an adequate assessment of the resident as based on the resident's complaints and/or signs/symptoms the resident had been resending or exhibiting as per the nursing standards as based on the nurse's current scope of practice. **FACILITY RESPONSE:**			

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC5870				**Date: September 8, 2015**
Perry Health Care Center		**Survey dates: July 15- August 18, 2015**		
2625 Iowa Street				
Perry, Iowa 50220	**Ds/ss/ks**			
		Class	**Fine Amount**	**Correction date**
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) 481-58.19(135C) **Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: 58.19(1) *Activities of daily living.* *g.* Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III). **DESCRIPTION:** Based on observation, record review, staff, resident and physician interviews and review of a facility policy and procedures, the facility failed to provide adequate supervision to protect against hazards when transferring a resident from a shower chair (Resident #5). The sample consisted of 12 residents and the facility identified a census of 26 residents. Findings include: 1. Resident #5 had a MDS (Minimum Data Set) assessment with a reference date of 6/12/15. The MDS identified the resident had diagnosis that included peripheral vascular disease, diabetes mellitus, arthritis, quadriplegia, traumatic brain injury, depression and schizophrenia. The MDS reflected the resident as dependent upon 2 staff members with transfers and showers, non-ambulatory, required extensive assistance	**I**	**$5,000**	**UPON RECEIPT**

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	of 2 staff members with personal hygiene and had impairments on one side of his/her upper extremity and both sides of the lower extremities. A Care Plan dated 6/15/15, reflected the resident had a problem due to the potential for falls. The potential for falls was related to quadriplegia and poor trunk control and required staff assistance with activities of daily living (ADL's) due to multiple chronic physical and mental health problems. The approaches included the following: a. Utilize a Hoyer lift for transfers. b. Staff assistance for mobility in a Broda Chair. c. Set up for cares so that resident may do as much as he/she could. d. Provide hand over hand or full assistance with remainder of ADL's. e. Provide at least 2 showers a week. f. Resident required staff assistance for mobility throughout the facility. Review of a PT - Therapist Progress & Updated Plan of Care form dated 7/1/15, reflected a goal as follows: The patient will safely transfer from the bed to the commode with safe staff completion and the use of a Hoyer lift with an open back to increase the patient toileting independence. A Fall Risk assessment form dated 6/2/15, reflected the resident received a score of 10 (a score of 10 or above represented a high risk for falls). According to a shower form, the resident had been assigned to shower/bathe 7/20/15 and 7/24/15 on the day shift.			

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	Review of a Nurse's Note entry dated 7/20/15 from 6 a.m. to 2 p.m., a nurse documented the following entry: This nurse had been called to the shower room down the West hall by Certified Nursing Assistant (CNA) at 9:45 a.m. This writer witnessed the resident sitting on the shower room floor in the shower stall in front of the shower chair with a CNA holding the resident up with an arm behind the resident's back. The Hoyer (mechanical lift sling) pad still underneath the resident. The resident's legs were outstretched in front of the resident. The resident complained of right knee pain. The resident's great toenail had been hanging by a piece of skin and bleeding. This writer left the shower room and informed the Director of Nursing (DON) at 9:40 a.m. that the writer needed assistance. Returned to shower room with DON and 3 CNA's and housekeeping brought the Hoyer lift to the shower room. The staff lifted the resident and placed the resident in a Broda chair. The resident was screaming and complained of right knee pain rated at an 8 out of 10. This nurse and CNA's got the resident to the resident's room. This writer did an assessment of the skin. The right knee appeared swollen and had been very painful for the resident to move from side to side. No other skin issues noted. Blood pressure 127/73, pulse 98, respirations 20, oxygen saturation at 98%. At 11:30 a.m. the medications given included Tylenol 325 2 tablets for pain. The physician ordered the resident sent to the hospital. The ambulance arrived at the facility at approximately 3:20 p.m. Review of a Fall Investigation form dated 7/20/15, reflected the description of the fall as follows: CNA's had been giving the resident a shower and went to remove the Hoyer sling and the resident fell forward onto his/her right knee and ripped the right great toenail off. The resident complained of right knee pain.			

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	The report reflected the contributing factors to the fall as staff removing the Hoyer sling device. The immediate action of the staff post fall had been staff lifted the resident via a Hoyer device to a geriatric chair and into bed. A skin assessment was performed and the physician notified. Review of a Falls Investigation Report form dated 7/20/15, reflected proper transfer techniques had not been followed as staff failed to utilize a gait belt. During an interview 7/23/15 at 10:35 a.m., the resident confirmed he/she fell from the shower chair and landed with both legs bent towards the chair and he/she experienced instant pain. During an interview 7/23/15 at 3:44 p.m., Staff E, CNA confirmed he and Staff J, CNA transferred the resident from the bed to a shower chair utilizing a Hoyer lift device and a mesh full body sling. Staff E then propelled the resident to the shower room without attaching the safety belt on the shower chair. Staff E stated he never utilized the safety belt during any resident transfers and/or showering process. When they arrived in the shower room, the staff member put on the call light for assistance. Staff A, CNA responded at which time each of the staff members lifted the resident under his/her arms and without a gait belt up and forward from the chair in an attempt to remove the Hoyer sling device. The resident then fell forward out of the chair onto the floor with his/her right leg bent at the knee and positioned under the shower chair with a toenail partially removed and his/her leg positioned in front of his/her body. Staff E stayed with the resident as Staff A went to get assistance. As the staff member waited with the resident who had been complaining of right leg pain, the staff member straightened the right leg and positioned it in front of the resident. When the DON and Staff G,			

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	Licensed Practical Nurse (LPN) arrived, a decision had been made to transfer the resident off of the floor before they could do anything so the staff laid the resident down, moved him/her side to side to position the Hoyer sling under the resident and transferred the resident off of the floor and into a Broda chair. The staff then propelled the resident to his/her room and again transferred the resident from the Broda chair to bed at which time Staff G assessed the resident. The staff member confirmed the resident had been crying out in foot and leg pain with transfers. During an interview 7/23/15 at 10:49 a.m., Staff A (CNA) confirmed he/she responded to the call light in the shower room and had been requested by Staff E to remove the Hoyer sling device from under the resident positioned in the shower chair by lifting the resident under his/her arms and leaning forward while pulling up on the sling. As they did so the resident fell forward off the shower chair and landed with his/her right leg bent under the shower chair and a toenail partially removed. The left leg extended forward. Staff A went to get assistance while staff E stayed with the resident. When she returned with Staff G who had screamed for the DON's assistance, both of the resident's legs had been extended in front of him/her. When the DON entered, she directed the staff to place the Hoyer sling device under the resident to get him/her off of the floor. Staff A and Staff E placed the sling under the resident by rolling him/her back and forth and transferred via a Hoyer lift device to a Broda chair, propelled the resident to his/her room and again transferred the resident via the device from the Broda chair to bed and then the nurse assessed the resident. The staff member confirmed the resident complained of knee pain through the entire process. The staff member also confirmed the safety belt on the shower chair had not been fastened because she did not believe the chair even had a safety belt or			

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	gait belt. During an interview 7/23/15 at 11:48 a.m., Staff G, LPN stated she heard screaming down the east hallway in the shower room. When she entered she observed the resident positioned on the floor with legs extended in front of him/her and bleeding from a toe. The staff member gave the directive not to move the resident and went to get the DON. The staff members then transferred the resident per Hoyer device from the floor to a reclined Broda chair, propelled the resident to his/her room and then again transferred him/her via a Hoyer device to his/her bed at which time he/she completed an assessment and knew something had been wrong so went to the nurse's station, called the physician and received an order for a portable x-ray. After the x-ray results were obtained, the physician ordered the resident be transferred to the hospital for an evaluation. Staff G stated the shower chair did not have a safety belt in order to utilize safe transfers. During an interview 7/23/15 at 1:09 p.m., the DON confirmed she would have expected the staff to have left the Hoyer sling device positioned under the resident during the showering process but if staff removed the sling they should have utilized a gait belt device as the resident had not been able to bear any weight at all. Review of an x-ray form dated 7/20/15, revealed the resident received a nondisplaced fractures of the right distal femoral metaphysis and proximal tibial metaphysis (upper and lower leg). During an interview 7/24/15 at 9:40 a.m., Staff A, Certified Nursing Assistant (CNA) confirmed he/she had not been orientated on what Hoyer sling to have utilized when showering residents.			

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	During an interview on 7/24/15 at 9:55 a.m. Staff B, CNA stated there had been no facility policy on which Hoyer sling to utilize in a resident transfer to a shower chair. During an interview on 7/24/15 at 9:59 a.m. Staff J, CNA stated there had been no facility policy on which Hoyer sling to utilize in a resident transfer to a shower chair however, he/she would not have removed the shower sling from under the resident while positioned in the shower chair. During an interview on 7/23/15 at 2:30 p.m., Staff D, CNA stated he would have always utilized a mesh Hoyer sling device to shower the resident but never would have removed the device. During an interview 7/23/15 at 3:05 p.m., Staff C CNA stated he had utilized a recliner shower chair without a safety belt a couple weeks prior when the wheels to this shower chair had been repaired. During an interview 7/24/15 at 8:36 a.m., a physician confirmed if it had been the facility protocol to utilize safety devices such as the safety belt on the shower chair and a gait belt then their protocol should have been followed. The facility policy titled **Shower Chair Safety/IC Measures**, amended 3/4/11 identified the purpose was to make the shower chair use safe for the resident to use. The procedures directed the staff to perform the following: Ensure the safety belt has been secured when the resident is in the shower chair. A gait belt may be utilized as a safety belt substitute The facility policy titled **Transfer/Gait Belt** policy (not			

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	dated), identified the purpose is to assure a patient and employee safety is protected in transferring and ambulating. All employees providing direct patient care are required to utilize a transfer belt whenever assisting a resident who cannot transfer or ambulate independently. The policy directed all direct care staff shall be required to wear a transfer belt while on duty. The facility provided an ordering invoice #22930484 dated 7/23/15. The invoice reflected the facility ordered a safety belt for a shower chair. **FACILITY RESPONSE:**			

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58.19(2)a **+** **58.21(15)c**	**481-58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:** **58.19(2)** *Medication and treatment* *a*. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I,II). **481-58.21(135C) Drugs, storage, and handling.** **58.21(15)** Drug Administration. c. The health service supervisor shall be responsible for the supervision and direction of all personnel administering medications. (II) [ARC 1050C, IAB 10/2/13, effective 11/6/13]. **DESCRIPTION:** Based on record review, staff and physician interviews and review of facility policy/procedures, the facility failed to administer the correct medication as ordered by the physician to Resident #8 which resulted in a significant medication error. This error could have resulted in an acute medical condition. The facility reported a census of 26 residents. Findings include: During an interview 8/6/15 at 10:07 a.m., a physician confirmed he/she had not been informed the facility staff had failed to administer Coumadin (lengths clotting time) for Resident #8 from 7/4/15 through 7/10/15 due to no	**II**	**$500**	**UPON RECEIPT**

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	supply. The physician stated he/she would have expected to have been notified as soon as it had not been administered. The physician stated there would not have been side effects of not administering the medication; however, it put the resident at increased risk for a cerebrovascular accident (CVA-stroke). The physician stated the resident's ideal INR (test to determine amount of time for blood to clot) range as 1.8 however 2-3 had been perfect. If the INR fell to 1.7 or below he would have changed the Coumadin order and then ordered to re-check the INR. Resident #8 had a MDS (Minimum Data Set) assessment with a reference date of 6/15/15. The MDS identified Resident #8 had diagnosis that included a CVA. The assessment reflected the resident had a Brief Interview for Mental Status (BIMS) score of 11. A score of 11 identified a moderate cognitive loss. The MDS reflected the resident had fluctuating inattention and disorganized thinking. Review of a Laboratory Coagulation report dated 6/30/15 at 11:49 a.m., reflected the resident's INR had been 1.5 (preference range 0.9 - 1.5) and Protime (PT) of 15.0 (preference range 9.2 - 11.2). The physician wrote an order to increase the resident's Coumadin to 4 mg every day and re-check the INR in 1 week. The Medication Administration Record (MAR) dated 7/1/15 through 7/31/15, identified the resident received a physician order for Coumadin 4 milligrams (MG's), to be given every day and dated 6/30/15. From 7/4/15 through 7/10/15 the staff initials had been circled (which indicated not administered) however from 7/4/15 through 7/6/15 there had also been initials present not circled (which indicated the medication as administered). On the back of the MAR there had been the following documentation:			

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	a. On 7/9 - Coumadin 4 MG - none in cart. b. On 7/10 - Coumadin 4 MG - none in cart. c. On 7/4 - 7/8 - Coumadin 4 MG - unavailable. Review of a Laboratory Coagulation report dated 7/7/15 at 12:03 p.m., reflected the resident's INR had been 1.8 and a PT of 18.9. The physician documented no change in Coumadin dosage and recheck the INR in 1 week. Review of a Laboratory Coagulation report dated 7/14/15 at 12:13 p.m., reflected the resident's INR had been 1.0 and a PT of 9.9. The report reflected the nurse informed the physician that the resident had been currently receiving Coumadin 4 mg every day. The physician increased the Coumadin to 5 mg every day and to recheck the INR in 1 week. Review of a Laboratory Coagulation report dated 7/21/15 at 12:29 p.m., reflected the resident's INR had been 3.3 and a PT of 34.1. The physician directed the staff to hold the Coumadin on that day and then give 4 mg alternating with 5 mg and recheck the INR in 1 week. Review of a Laboratory Coagulation report dated 7/28/15 at 11:41 p.m., reflected the resident's INR had been 3.4 and a PT of 34.1. The physician changed the Coumadin order to 4 mg Tuesday, Thursday, Saturday and Sunday and 5 mg Monday, Wednesday and Friday and recheck the INR in 1 week. Review of a Laboratory Coagulation report dated 8/4/15 at 11:45 p.m., identified the resident's INR had been 3.2 and a PT of 33.5. The physician changed the Coumadin order to 5 mg Monday and Friday and 4 mgs all of the other days and to recheck the INR in 1 week. Review of the facilities Emergency kit supply list (not dated), revealed the facility staff had a supply of eight			

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	Coumadin 1 MG tablets which could have been utilized. During an interview on 8/5/15 at 9:20 a.m., the Director Of Nursing (DON) stated she had not been aware the Coumadin had not been administered until several days after the fact and agreed the nurses should have utilized the medication in in the ER kit. The DON also confirmed she failed to fill out a Medication Error Report. The facility policy/procedure titled **Medication Error Report** (not dated) identified a significant medication error meant one which caused the resident discomfort or jeopardized his/her health and safety. The guidelines and procedures included the following: a. The person finding the error must have initiated the medication error report form. b. The Director of Nursing is responsible for assuring that follow-up had been completed on medication errors. c. Medication errors or drug reactions must be reported to the physician. d. The medication error must be documented in the resident's record. Document physician and family notification and their response. e. Monitor the resident for any adverse effects caused by the error for 24 hours or otherwise directed. **FACILITY RESPONSE:**			

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