| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165396 | A. Building<br>B. Wing | 07/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| River Hills Village IN Keokuk | 20 Village Circle<br>Keokuk, IA 52632 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336<br><br>Based on clinical record review, facility policy, resident and staff interviews, and facility investigation documentation the facility failed to use the necessary transfer equipment when assisting a resident in the bathroom, resulting in a lower leg fracture for 1 of 3 residents (Resident #2) reviewed. The facility reported a census of 64 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) dated [DATE] revealed Resident #2 scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. The MDS assessed the resident as dependent on staff for toileting hygiene and chair/bed to chair transfers. The MDS listed diagnoses included: stroke, arthritis, and hemiplegia and hemiparesis (paralysis on one side of the body) affecting the right side.<br><br>The Electronic Health Record (EHR) revealed Resident #2 admitted to the facility on [DATE] after a hospitalization for a stroke.<br><br>The Care Plan, dated 4/26/24, included a Problem area related to Resident Care. An Approach, dated 5/1/24, specified Safe Resident Handling Procedures - Transfer Method: Manual STAND AID Level of assistance; assist of 1; Must be wearing shoes for transfers.<br><br>The Care Plan, also identified a Problem area for Risk of falling R/T (related to) recent illness/hospitalization and new environment, impaired mobility, generalized weakness, CVA (cerebrovascular accident, or stroke) with right sided hemiplegia, Anemia, COPD (chronic obstructive pulmonary disease), CKD (chronic kidney disease), HTN (hypertension, or high blood pressure), Arthritis, Neuropathy (pain related to nerve damage), incontinence, and possible side effects of medication. An Approach, dated 5/1/24, specified Assist x1 (of one staff) with Manual Stand Aid for transfers.<br><br>A Progress Note, dated 5/1/24 at 10:46 AM, communicated Therapy recommendation: Assist x1 with Manual Stand Aid for transfers.<br><br>A Progress Note dated 5/7/24 at 12:16 PM, revealed the resident complained of pain in right hip and leg. She stated her leg got caught under the wheel chair and behind her other leg when the CNA did a stand pivot transfer from the toilet to her wheelchair. Resident #2 stated she had pain in her hip like her socket is hurting on the right side.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The Progress Note dated 5/7/24 at 12:27 PM, revealed nurse spoke with daughter about incident . NP (Nurse Practitioner) here and gave order to send to ER to rule out FX (fracture). Notified daughter, that we would be sending to [name redacted] ER (emergency room ) for x ray to rule possible fracture.<br><br>Impressions for a X-Ray of the right knee due to injury, pain from the hospital Final Report dated 5/7/24:<br><br>a. Obliquely oriented comminuted fracture through the proximal fibula.<br><br>b. Increased density projects over the joint space interval which can be seen with CPPD (calcium pyrophosphate dihydrate) arthropathy (crystal build up in joint).<br><br>A Progress Note dated 5/7/24 at 5:33 PM from nursing staff documented will utilize Assist x2 with Full Mechanical Lift for transfers, until therapy can re-evaluate transfer status.<br><br>The Facility Investigation Witness Statements, dated 5/7/24, revealed:<br><br>a. Staff A, Registered Nurse (RN):<br><br>Staff A approached at 12:15 PM by Staff C, OTA (Occupational Therapy Assistant) and asked what happened to Resident #2. Staff A was unsure of any incident. Staff C pointed out that Resident #2 had an ice pack on her leg and the family told her they were concerned that she been injured during a transfer in her bathroom. Staff A immediately asked Resident #2 what happened and she stated her leg got caught under the wheelchair and behind her other leg when the CNA (Certified Nursing Assistant) took her off the toilet and put her in her wheelchair. Resident #2 stated she had pain in her hip like her socket and it hurt on the right side. Staff A then approached Staff B, CNA and asked what happened. She said her right leg got twisted up when she transferred her to the toilet.<br><br>b. Staff B, CNA:<br><br>Staff B took Resident #2 to the restroom and put her on the toilet with a stand pivot transfer. On the transfer back into the wheelchair Resident #2 leg was close to the wheelchair leg and it twisted. Resident #2 said ow [ouch] but did not yell out. Resident #2 said my knee kind of hurt so Staff B got an ice pack for her. Staff B did not let the nurse know right away because Staff B had not found her yet. But the resident saw her before me and told her. Afterwards, a fell ow CNA said Resident #2 was a stand aid. Staff B got her confused with another resident.<br><br>c. Staff C, OTA:<br><br>Staff C attempted to see Resident #2 for her OT therapy session. Upon entering Resident #2 room Staff C noticed that Resident #2 had an ice pack on her right knee. Staff C questioned what the ice pack was for and Resident #2 stated that her knee felt a little sore since going to the bathroom with the CNA earlier. Resident #2 stated it was a little sore but did not have any abnormal facial grimacing and was able to carry conversation and smile.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Staff C spoke with Staff A and asked about the ice pack .Staff A stated she was unsure of an incident and would see what she could find out. Staff A returned to the gym around 12:30 PM with Resident #2 and asked if Staff C would assist in completing a sit to stand with the stand aid, as per care planned, to assess if there were any concerns with the current transfer recommendation. Staff C applied a gait belt around Resident #2 and instructed Resident #2 to perform a sit to stand transfer within the stand aid but to let me know if she was having any increased pain during the process. Resident #2 was able to set her feet on the platform of the stand aid without any additional difficulty or facial grimacing and was able to pull herself to a standing position with contact guard, very minimal, assist as per her normal. During weight bearing within the stand aid, Resident #2 reported having increased discomfort in her right hip.<br><br>d. Assistant Director of Nursing (ADON):<br><br>At approximately 12:00 PM to 12:30 PM, Staff A came to ADON office, and stated she needed to talk with me. Staff A then informed the ADON .an aide had come in to toilet [Resident #2] and now she complained of pain in her right leg. The ADON asked Staff A to go speak with the aides and find out who did the transfer and bring them back to the ADON office to discuss what occurred. At this time, Resident #2 sat in her wheelchair in the dining room, eating and having conversation with her table mate. No signs of distress noted asked how she felt. Resident #2 stated not bad, she had discomfort in her right leg .Staff B stated she transferred Resident #2 from the wheelchair to the toilet and then from the toilet to the wheelchair with an assist x 1 with pivot transfer. Staff B stated that Resident #2 right leg got twisted during the transfer from the toilet to wheelchair. The ADON asked Staff B if that was care planned transfer status of Resident #2 and she stated no, it wasn't, but at the time she got Resident #2 confused with another resident and didn't realize it at that time. Staff B reeducated on where to find the resident ' s transfer statuses. Staff B able to state all areas where it was posted.<br><br>e. Resident #2:<br><br>The girl took me to the toilet, got me up from the toilet and my bad leg caught on the wheelchair leg and twisted in. The CNA got me in the chair and it hurt and she got me an ice pack.<br><br>During an observation on 7/15/24 at 12:48 PM- Staff D, CNA (Certified Nurse Aide) placed gait belt around Resident #2 waist and brought her wheeled walker to her and turned the chair to face the walker. Staff D helped Resident #2 up and escorted her out of the dining room holding on to the gait belt and walked beside her.<br><br>During an interview on 7/15/24 at 1:06 PM, Resident #2 stated she been at the facility since April after she had a stroke and stated she hoped to go home in the beginning of August. She stated she wore a boot for a while because a girl kind of dropped her and busted her leg up. Resident #2 stated she never broke a bone before this and the fracture below her right knee. Resident #2 asked about the incident that caused her leg fracture, and she stated she remembered she wanted to go to the bathroom and then somehow started to fall. She stated it happened not long after she had her stroke. Resident #2 stated she cried out when it happened and the nurse came and checked on her soon after it happened.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 7/15/24 at 1:39 PM, Staff A, RN stated Resident #2 moved to a stand aid with an assist of 1 transfer status on 5/1/24. [On 5/7/24] Staff C asked her what happened to Resident #2 leg because she had an ice pack on it. Staff A stated Staff C told her, Resident #2 got hurt when a CNA transferred her to the bathroom . Staff A stated she approached the CNA [Staff B] and asked her if she used the stand aid for the transfer and at first she said yes .with the ADON . the CNA [Staff B] stated she didn't use the stand aid, she used a pivot transfer with Resident #2. Staff A stated the residents' transfer status were placed on the white board in the nurse's station for everyone to see and they kept it up to date.<br><br>During an interview on 7/16/24 at 9:43 AM, Staff B, CNA stated she hadn't worked that hall very often. Staff B stated she remembered the incident with Resident #2 and she made a mistake and got two residents wrong. Staff B stated she did a stand pivot instead of using the stand aid. Staff B stated Resident #2 foot got caught and twisted when they did the stand pivot to the wheelchair. Staff B stated she told Resident #2 she would get a nurse and grabbed her an ice pack. Staff B stated she saw call lights going off and wanted to make sure all her residents safe before she spoke with the nurse. Staff B stated the incident was her fault and she didn't do it intentionally at all. Staff B stated Resident #2 said she felt a little bit of pain after it happened.<br><br>During an interview on 7/16/24 at 10:51 AM, Staff D, CNA stated if anyone questioned the transfer status of a resident, they could look at the computer for the resident's care plan and look at the white board in the nurse's station.<br><br>During an interview on 7/16/24 at 11:22 AM, Staff C,OTA stated the day of the incident she saw Resident #2 in the morning and Staff C noticed an ice pad on her knee. Staff C stated Resident #2 laughed about it and said she would let me know later. Staff C then asked Resident #2 if she wanted her to come back later for therapy since Resident #2 family present and she said yes. Staff C stated she asked the nurse if she knew what the ice pack was for and she said she didn't, but would find out. Staff C stated she wanted to make sure the stand aid transfers went okay. Staff C stated the nurse brought Resident #2 to her and they stood Resident #2 up and her hip didn't hurt and Staff C didn't think anything going on, but Staff A wanted to send her out to make sure nothing was wrong and the hospital found out, Resident #2 had a fracture. Staff C stated Ortho gave Resident #2 a choice between a boot or an immobilizer and she choose the immobilizer at first so they used the mechanical lift for transfers to prevent bending. Staff C stated a week after the incident Resident #2 moved to a boot and then transferred with the stand aid.<br><br>During an interview on 7/16/24 at 3:12 PM, the DON (Director of Nursing) stated the CNA didn't transfer her properly and it was an unfortunate situation that happened. The DON states she would of expected the CNA know the correct transfer for Resident #2 and if she felt uncertain, she should have checked the care plan.<br><br>During an interview on 7/16/24 at 3:53 PM, the Administrator stated she felt disappointed about the incident and she felt the CNA got Resident #2 mixed up with another resident and staff knew where to look for the resident's transfers.<br><br>The Facility Safe Resident Handling Policy dated 11/12 revealed the following information:<br><br>a. All residents assessed for safe resident handling and moving. The assessment will consider:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 1. The resident's needs/rights and ability to participate with transfers or lifts<br><br>2. The variability in resident behaviors and cognition<br><br>3. Staff and resident safety.<br><br>b. Lift assignment and strategy:<br><br>1. Residents evaluated for the type of lift necessary for their needs and the evaluation incorporated into the care plan. The lifting strategy may change during the day or the shift according to the resident's condition. These instructions were care planned and communicated to the staff. |