

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16E637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Hegg Memorial Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2116 14th Street Rock Valley, IA 51247	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observation, interview and record review the facility failed to ensure that staff practiced safe transfer techniques for 1 of 2 residents. Resident #5 required the use of the mechanical lift for transfers and staff used a sling that was 2-sizes larger than the manufacturer recommended size for her weight. The resident had a decline in condition which changed her ability to tolerate the mechanical lift transfer. The facility reported a census of 55 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated [DATE], Resident #5 had a Brief Interview for Mental Status (BIMS) score of 0 (severe cognitive deficit). She was totally dependent on staff for sit to lying, chair to bed transfers and toileting. Resident #5 was frequently incontinent of urine and bowel and had diagnosis that included; anemia, heart failure, Diabetes Mellitus, malnutrition and anxiety disorder.</p> <p>The Care Plan last reviewed on 9/27/24, showed that Resident #5 was totally dependent on staff to assist with Activities of Daily Living. She transferred with the use of a total lift with 2 staff and used wheel chair for mobility. The resident was admitted to hospice services on 6/14/24. She could be forgetful and confused, had difficulty making herself be understood, sometimes, did not understand others. She had chronic pain.</p> <p>On 11/18/24 at 11:13 AM, Resident #5 was in her wheel chair near the table in the dining room, with her head hanging down into her chest. At 11:57 AM, her head was still down and a staff member was sitting next to her trying to encourage her to take bites and drink. The resident occasionally opened her mouth, she did not speak and did not reach for food or drink.</p> <p>On 11/18/24 at 12:14 PM, Resident #5 was in the whirlpool room sitting in the tub. Her head was hanging down in her chest, she did not respond or speak. The resident had a bruise on left shoulder. Staff F, Licensed Practical Nurse (LPN) said they thought that the bruise was from the sling used with the mechanical lift. She said that Resident #5 had a recent significant decline in health.</p> <p>An Incident Report dated 11/20/24 at 10:35 AM, showed that Resident #5 had a new bruise on posterior shoulder that measured 2.5 centimeters (cm) x 7 cm and one on the left upper outer arm 2 cm x 3.2 cm. The type of injury was defined as a skin tear. The documentation lacked description of the bruising or possible cause.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation on 11/19/24 at 7:20 AM, Resident #5 was in bed sleeping on her back. Staff A Certified Nurse Aide (CNA) and Staff B, CNA woke her up and explained that they would be getting her dressed for the day. They assisted her to sit on the side of her bed with Staff A lifting her upper body, and Staff B swinging her legs around so her feet landed on the floor. The resident did not open her eyes or say anything. As she tried to sit up, she leaned over to the left and Staff B held her up in the seated position. Staff A grabbed a mechanical lift sling that was on the shelf, and the two CNA's put the sling around her back, tucked the leg straps under her legs, and placed her arms on the outside of the sling. When Staff A hooked the sling to the lift, the padding on the upper part of the sling (designed to support the arms during transfers) landed parallel to the resident's forearms and her armpits rested on the fabric of the sling. She continued to lean to the left and she was not able to sit up. As the lift raised up in the air and Staff A moved the machine toward the bathroom, it was discovered that the bottom of the sling was at the middle of her back, and the leg straps were just above her knees. The weight of the resident rested in her armpits and the back of her knees. She was then lowered to the toilet.</p> <p>At 7:35 AM, Staff C, Certified Medication Aide (CMA) came into the room to apply a lotion while Resident #5 was on the toilet. The resident continued to lean further to the left and Staff B tried to hold her head up. Her left arm was hanging down alongside the toilet and her right shoulder hyperextended back as she slid further down in the sling. At 7:37 AM staff engaged the mechanical lift and hoisted her back off of the toilet. From the middle of her back (from the bottom of the sling) to just above the back of her knees (the leg straps) her body was unprotected and hung down while Staff A and Staff B applied a clean brief. At 7:38 AM, they moved her out of the bathroom and into the wheel chair.</p> <p>Upon further inspection, it was discovered that the sling used for Resident #5 was an extra-large.</p> <p>According to the Sling User Guide dated March of 2005, it was recommended that an extra-large sling would be used for resident in the weight range of 264-352 pounds. (According to the electronic chart, Resident #5 weighed 150 pounds)</p> <p>On 11/19/24 at 7:40, Staff D, LPN and Staff E, Registered Nurse (RN) looked at the sling that staff had used to transfer the resident and explained that it was a special design used for toileting. Staff E stated that they were going to get a different sling since the resident had a decline and she wasn't sitting up any longer.</p> <p>On 11/19/24 at 7:59 AM Staff C CMA said that at one point the resident was able to sit up during transfer but she had gotten much weaker. The resident was mostly incontinent and hadn't been using in the toilet so the toileting sling probably was not the best option for her. She said that the padding on the sling was to help support and protect the arms and she hadn't noticed the position of the padding when the resident was on the toilet.</p> <p>On 11/20/24 at 12:31 PM, the Director of Nursing (DON) said that the nurses used the sling chart with weights to determine size of sling to use but there was not a specific assessment form for determining appropriate sling size.</p> <p>On 11/21/24 at 8:32 AM, the DON stated that when the CNA's saw that Resident #5 was different on 11/19/23, they should have notified the nurse so she could have done a complete assessment before transferring the resident to the toilet.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the Arjo Sling User Guide: dated March of 2005, Using the correct sling for each patient was an essential element of safe patient handling. A sling that was the wrong size of a body fit for the patient created discomfort and increased the risk of injury.</p> <p>Indications of a badly fitted or wrongly sized sling included; 1. leg support of the sling digging into the back of the patient's knees with the sling clips/loops several inches above the front of the patient's thighs (sling may be too large). 2. The sling must adequately support the head 3. The patient's buttocks were not slipping through the sling aperture.</p> <p>It was not advised to use the toileting sling with residents that were flaccid as they could slip through the commode hole. The sling should be fitted with the top of the patients head as a guide to positioning. Both of the resident's arms should be positioned outside the sling, over the padded areas but under the head support straps.</p> <p>According to facility policy titled dated 11/5/05, the facility would provide a safe work environment for resident care areas by providing and requiring the use of safety materials, equipment and training designed to prevent personal and resident injury. The staff were accountable for utilizing proper body mechanics, lifting techniques and resident safety.</p>