**Association of Health Care Journalists**

IMPROVING PUBLIC UNDERSTANDING OF HEALTH AND HEALTH CARE



*The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.*

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| **TEN LAKES CENTER, LLC** | **819 NORTH FIRST STREET, 3RD FLOOR DENNISON, OH** | **May 19, 2015** |
| **VIOLATION:** *INFECTION CONTROL OFFICER RESPONSIBILITIES* | | **Tag No:** A0749 |

Based on observation, interview and manufacturer instructions for use of cleaning agents, the facility failed to ensure environmental services personnel used cleaning products according to manufacturer instructions for one of one rooms observed being terminally cleaned and failed to ensure hand washing was performed by contracted environmental services staff. The facility census was 15 active patients.

Findings include:

1. On 05/19/15 at approximately 9:30 AM, Staff A was observed performing a terminal cleaning of room 309 B. Staff A was observed spraying a disinfectant C on the sink room 309 B. Staff A immediately wiped the disinfectant C from the sink. At the time of the observation, Staff A stated he/she was supposed to allow the disinfectant to remain on the surface for 10 minutes and reported not having time to wait the ten minutes before removing the disinfectant C.

The manufacturer's directions for use of disinfectant C were reviewed and stated to apply solution and allow solution to remain wet for 10 minutes, then remove excess liquid.

2. On 05/19/15 from approximately 9:30 AM to 10:00 AM, Staff A, was observed washing his/her hands two times. Staff A did not apply soap during both hand washings observed. Staff A, at the time of the observations, reported he/she does not use soap when washing hands.

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| TEN LAKES CENTER, LLC | 819 NORTH FIRST STREET, 3RD FLOOR DENNISON, OH | March 6, 2014 |
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**VIOLATION:** *PATIENT RIGHTS* — **Tag No:** A0115

Based on medical record review and staff interviews, the facility failed to ensure the physical safety of four of five discharged patients whose medical records were reviewed that experienced a fall (A144) and failed to ensure all patients were protected from abuse following reported allegations of abuse by a staff member (A145). The cumulative effect of these systemic practices resulted in a risk to the health and safety of all patients.

**VIOLATION:** *PATIENT RIGHTS: CARE IN SAFE SETTING* — **Tag No:** A0144

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on medical record review, staff interview and review of policy, the facility failed to ensure the physical safety of four of five discharged patient medical records reviewed who experienced a fall, Patients' 8, 9, 11 and 12. The census at the time of the survey was 12.

Findings include:

1) Per the initial Nursing Assessment completed on 02/03/14 at 4:00 PM, Patient 11 was noted to have a history of falls, be unsteady on his/her feet, and require the use of a walker for ambulation. Based on this information, the nurse was directed to conduct a Falls Risk Test. Patient 11 was noted to have failed the test and the nurse was then prompted to implement fall risk precautions.

The Patient Care Observation Record for Patient 11's length of stay was reviewed. These records include an area for staff to document patient safety every shift. The safety checks included: ID band on, Location of Band, Allergy ID on Band, Fall Risk Indicator Band, Side Rails x 2, Bed Alarm, Chair Alarm, Low Bed Position, Environmental, and Suicide Risk assessed.

The Patient Care Observation Record for Patient 11 lacked documentation the safety checks were completed on 02/03/14 and 02/04/14. A documented Incident Report Form revealed Patient 11 fell on [DATE] at 3:00 PM. According to the incident report, Patient 11 was in a chair in the hallway. Patient 11 went to stand up, barely got off the chair and fell to the floor face first. Patient 11 was noted to have an actively bleeding cut above his right eye. On doctor's order Patient 11 was sent to the emergency department (ED) for evaluation.

Following Patient 11's return to the facility from the ED, the medical record lacked any evidence that staff implemented additional interventions to prevent other falls. The treatment plan (multidisciplinary plan of care) also failed to address Patient 11's risk for falls.

The Patient Care Observation Records for 02/05/14 through 02/11/14 were also left blank. And on 02/12/14, a second Incident Report Form revealed Patient 11 experienced another fall. Staff documented the fall was unobserved and Patient 11 reported to staff "he had slipped." Patient 11 denied hitting his head. There was no evidence the family or physician were notified of this fall. Staff failed to implement interventions to prevent future falls or address Patient 11's risk for falls on the treatment plan.

The remainder of the Patient Care Observation Records for Patient 11 (02/12/14 through 02/17/14) were also left blank. There were no documented safety checks as required.

2) Per the initial Nursing Assessment completed on 02/04/14 at 5:45 PM, Patient 12 was noted to be unsteady on his/her feet and have generalized weakness. Based on this information, the nurse was directed to conduct a Falls Risk Test. Patient 12 was noted to have failed the test and the nurse was then prompted to implement fall risk precautions.

The Patient Care Observation Record for Patient 12's length of stay was reviewed. There were no documented safety checks from 02/04/14-02/11/14. A documented nursing progress note written on 02/12/14 at 12:30 PM revealed Patient 12 experienced a fall. Per the note, Patient 12 was "observed lying on floor in front of nurse's station. Patient stated he/she slipped and fell ." There was no Incident Report completed for this fall and no evidence the physician or family were notified.

The medical record lacked any evidence that staff implemented additional interventions to prevent future falls or updated the treatment plan to address Patient 12's risk for falls.

On 02/13/14 staff documented Patient 12 had a fall risk band on. And a documented Incident Report Form revealed Patient 12 fell again on 02/13/14 at 9:45 AM. According to the incident report, Patient 12 was walking in the dining room when he fell to the ground and "hit the back of head on the floor." The physician was notified and Patient 12 was sent to the ED for evaluation.

Subsequent Patient Care Observation Records for 02/13/14 through 02/18/14 again lacked evidence that the safety checks were completed. On 02/19/14 and 02/20/14 staff documented Patient 12 had a fall risk band on. There were no documented safety checks from 02/21/14 through 02/29/14.

3) Review of the medical record for Patient 8 completed on 03/06/14 revealed an admission date of [DATE] with a diagnosis of Dementia with periods of agitation. Nursing documentation dated 02/07/14 revealed a fall at 6:00 PM, the nurse reported Patient 8 went to another patient's room and attempted to sit on the bed then slid off onto the floor in a sitting position. No injury was noted. No action was noted in the medical record to prevent future falls for this patient. The treatment plan did not have documentation of the patient being at risk for falls.

The Patient Care Observation Record revealed 15 minute checks were completed but the safety checks completed every shift were blank on all documentation in the record. These safety checks include fall risk indicator band, side rail checks, bed alarm check, chair alarm check, low bed position check, and environmental check.

4) Review of the medical record for Patient 9 completed on 03/06/14 revealed an admission date of [DATE] with a diagnosis of Dementia with behavioral disturbances and Depression. Nursing documentation dated 02/16/14 revealed staff found the patient on the floor by the bed on her blanket and the bed alarm was unattached from the patient and laying on the bed. Patient 9 did not show any signs of injury. Nursing documentation dated 02/18/14 at 2035 revealed Patient 9 "tipped" off the bed and hit head on dresser. A small laceration to bridge of nose and a bruised and swollen forehead was noted. Physician and family was notified. A pressure alarm was added to protect the patient from a fall. Minimal documentation was noted in Patient 9's medical record showing the alarms were checked for placement and functionality. The Patient Care Observation Record revealed 15 minute checks were completed but the safety checks completed every shift were blank on all documentation in the record. These safety checks include fall risk indicator band, side rail checks, bed alarm check, chair alarm check, low bed position check, and environmental check.

5) Review of the Performance Improvement documentation for 2013 completed on 03/06/14 revealed 10 falls in the first quarter in which staff received education on assessing for fall risk and the new fall prevention policy. Fourteen falls were noted in the second quarter and staff were reeducated on fall precautions. Seventeen falls were noted in the third quarter, new bed and chair alarms were purchased, staff instructed to be in the hallway and patient activity rooms with patients at all times. In the fourth quarter of 2013 20 falls were noted and the facility will research, revise Fall Program and present to safety committee, and staff will then be educated on the proper procedures.

Review of the staff meeting for October completed 03/06/14 revealed staff were trained to use the observation sheets including the checks for fall safety.

6) The Fall Prevention Program was reviewed on 03/06/14. Per the program, "fall risk assessment is an on going process, beginning on admission and is monitored by all staff until discharge." The falls prevention program "needs to be documented in the patients chart, kardex, and report sheets."

The following preventative measures were to be implemented based on fall risk assessment:

Yellow wrist band on
Stars on doorframe to patient's room
Mobility alarms applied
Toileting before meals, before bedtime, and every two hours
Documentation each shift in the nurse's notes
Review and document proper use of assistive devices with patient to reinforce safety
Review, discuss, and document patients at risk status and behaviors at treatment plan

7) Interview of Staff A confirmed the above findings on 03/06/24 at 1:23 PM. Staff A stated all patients are considered a fall risk and the treatment plan should reflect this. Staff A confirmed this was not done for Patients' 11, 12, 8 and 9. Staff A also stated staff should be documenting safety checks at least every shift on the Patient Care Observation Record and confirmed this was not done.

| **VIOLATION:** *PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT* | **Tag No:** A0145 |
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**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on review of facility policies, incident log review and staff interview, the facility failed to ensure all patients were

protected from abuse or harassment following receipt of an allegation of abuse by a staff member. This affected one of one discharged medical record reviewed for reported abuse (Patient 13) with the potential to affect all patients receiving services at the facility. The census at the time of the survey was 12.

Findings include:

1) During entrance conference with Staff A and B on 03/04/14 at 8:44 AM, Staff A stated that in the Spring of 2013 a staff member was terminated following an allegation of improperly handling a patient.

At 10:07 AM, the personnel file of former Staff C (licensed practical nurse) was reviewed. Per the file and documented incident report, Staff C was terminated on 06/07/13 following an allegation of patient abuse first reported on 05/20/13.

During shift change on 05/20/13, the day shift RN (registered nurse) reported to the evening RN (Staff D) that there had been an altercation involving Staff C and Patient 13. Upon hearing about the altercation, Staff D assessed and took photographs of Patient 13, interviewed other staff members who were present at the time of the altercation (2 former agency, state tested nurse aides), and notified the facility's former Chief Executive Officer (CEO).

A full investigation of the incident was not initiated until 05/29/13, after it was brought to the attention of the facility's corporate Director of Clinical Services, Chief Clinical Officer, and Risk Management. Review of that investigation revealed Staff C was not placed on suspension until 05/30/13, 10 ten days after the alleged incident, and ultimately terminated on 06/07/13.

2) Facility policy entitled Alleged Patient Neglect and Abuse by Staff (CS-100.4) was reviewed on 03/04/14 at 2:14 PM. Per said policy, "Human Resources will determine if the staff member will be removed from the schedule or reassigned to another unit/position during the investigation."

The employe Code of Conduct handbook was also reviewed. The facility has a zero tolerance policy for patient physical or emotional abuse. Each staff member has a responsibility for reporting any activity that appears to violate this zero tolerance policy.

3) Patient 13 was admitted to the facility on [DATE] with diagnosis of paranoid schizophrenia. On 05/20/13 at 7:05 PM Staff D made a late entry in the nursing progress notes which read "LPN reported that patient was physically aggressive towards him. Patient 13 was restrained for safety. RN was called to room patient on right side with staff holding limbs."

At 7:10 PM Staff D obtained a physician's order for Haldol and administered the Haldol at 7:15 PM. At 7:25 PM Staff D then documented "patient sitting with staff calm and cooperative."

At 8:00 PM Staff E documented "received in report that patient was in altercation" with staff. Patient "calm at this time." At 8:15 PM Staff E obtained photo documentation and at 8:20 PM the administrator was notified. At 9:00 PM Staff E documented there was no physical or verbal aggression by Patient 13. Patient 13 complained of pain for which he/she received Tylenol.

Review of the photo documentation obtained by Staff E revealed the following: scattered ecchymosis on inner aspect of right arm; scattered ecchymosis on inner aspect of right axilla; reddened areas on right elbow; scratches on left chest; abrasion on left temple; scratches on outer aspect of right arm.

4) The staffing schedule for the month of June 2013 was also reviewed on 03/05/14 at 4:06 PM. According to the schedule, Staff C worked three additional days immediately following the allegation of abuse on : 05/22/13, from 7:00 AM to 7:00 PM; 05/25/13, from 7:00 AM to 7:00 PM; and 05/26/13, from 7:00 AM to 7:00 PM.

5) Staff A confirmed in interview that Staff C continued to work for a period of three days after the alleged abuse took place on

03/05/14 at 5:00 PM. Staff A stated Staff C should not have continued to work in direct patient care.

6) Review of the Abuse, Neglect, and Exploitation Zero Tolerance Policy Education/Training completed on 03/05/14 at 2:15 PM revealed any staff member guilty of any abuse/exploitation will be automatically terminated. Also any staff that does not report abuse of a patient can be terminated.