Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#6379	**Fine amount reduced to $325 on the Class II fine on January 10, 2017 pursuant to Iowa Code Section 135C.43A**			**Date: December 27, 2016**
Clarion Wellness & Rehabilitation		**Survey dates: December 5-8,2016**		
110 13th Ave. SW				
Clarion, Iowa 50525	**Ds/pg/mw**			

		Class	Fine Amount	Correction date
58.19(2)b	**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.* *b.* Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (I,II). **DESCRIPTION:** Based on observation, record review, and staff interview, the facility failed to prevent AN avoidable pressure ulcer and provide necessary treatment and services to promote healing and prevent infection of A pressure ulcer for 1 of 2 residents with pressure ulcers (Resident #3). The facility reported a census of 49 residents. Resident #3 developed an ulcer to the great toe on 10/8/16. The facility identified the area as open, draining and red, but failed to document a complete assessment. The facility asked for treatment of betadine 2 times a day to the area until healed. On 10/28/16 the facility received orders for antibiotic for the toe, indicating decline, but lacked any assessment of the area and failed to address the treatment. On 11/3/16 the physician saw Resident #3 and ordered a podiatrist consult. The facility completed assessment of the area on 11/4/16. In November 2016, the podiatrist diagnosed the ulcer as	**I**	**$2,000 Held in suspension**	**Upon Receipt**

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	pressure, related most likely to a sock rolled up in the shoe causing irritation. The Director of Nursing confirmed the resident did not put socks and shoes on him/herself or take them off him/herself. The podiatrist debrided the ulcer 3 times in November of necrotic tissue, and changed the treatment. The bone was visible at the base of the ulcer, and the podiatrist documented high suspicion of bone erosion related to osteomyelitis. Findings include: 1. Resident #3 had a Minimum Data Set (MDS) assessment, with a reference date of 9/23/16, Resident #3 scored 9 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. Resident #3 required extensive assistance of 2 people with activities of daily living (ADL's) including bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. Resident #3's diagnoses included non-Alzheimer's dementia. Resident #3 had no pressure ulcers but identified at risk for the development of pressure ulcers. The MDS defined a Stage IV pressure ulcer as full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed, and often included undermining and tunneling. The Care Plan dated 6/20/16 identified Resident #3 with actual skin impairment, history of left heel pressure wound and right great toe wound. The interventions included to identify potential causative factors and eliminate/resolve when possible, and			

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	monitor/document location, size and treatment of skin. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to the physician. The Progress Notes dated 10/8/16 at 11:14 AM documented Resident #3 noted with right great toe redness, warmth to touch, denied any discomfort, and noted yellow discharge from site. Staff cleansed the area and left open to air dry. They applied no shoe, bilateral TED (improves circulation and reduced risk of blood clots) stockings, and gripper socks. Staff faxed the physician, updating on right great toe and requesting treatment until resolved. At 12:04 PM, the facility received a signed fax back from the physician with orders for treatment with betadine 2 times a day to the right great toe until resolved. A facsimile dated 10/8/16 notified the physician Resident #3 had a right great toe open area with yellow discharge, warm to touch. The fax questioned if the physician would recommend Betadine 2 times a day until the area resolved, no shoe, transfer with gripper on, and continue with TED stockings. The physician responded okay. The clinical record lacked an assessment including size, ulcer bed and surrounding skin appearance, extent of redness, or cause of the ulcer. The Progress Notes dated 10/9/16 at 6:46 a.m. documented treatment completed to right great toe, no redness or drainage noted.			

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	The Progress Notes dated 10/10/16 at 11:22 p.m. documented Resident #3 continued with the reddened area to his/her great toe. The Progress Notes dated 10/11/16 at 12:05 a.m. documented Residents #3 denied pain to his/her right great toe. The toe was red with no swelling, increased warmth, or drainage. A Weekly Nursing Summary dated 10/12/16 documented Resident #3 free of any open areas. The summary lacked any documentation of the status of the toe. A Weekly Nursing Summary dated 10/19/16 documented Resident #3 free of any open areas. The summary lacked any documentation of the status of the toe. The Progress Notes dated 10/28/16 at 3:25 p.m. documented a new verbal order from a Physician for Augmentin 2 times a day for 5 days. At 5:45 p.m. antibiotic initiated for right great toe. The clinical record lacked any assessment of the right great toe. A Weekly Nursing Summary dated 10/26/16 documented Resident #3 had a treatment to the right great toe. The summary lacked any documentation of the status of the toe. A Weekly Nursing Assessment dated 11/2/16 documented Resident #3 had a red right toe, on antibiotic. The summary lacked any documentation			

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	of the status of the toe. A clinic visit dated 11/3/16 documented Resident #3 had infection in his/her right foot finishing antibiotic, and ulcer of the right 1st toe. The right first toe had a 5 mm ulcer with some drainage. The plan included a podiatry consult and physical therapy consult for ulcer treatment. A Weekly Skin Ulcer Non-Pressure report dated 11/04/16 documented an initial review with an unknown start date of the right great toe. The area measured 0.9 by 0.8 cm. The area was scabbed with 0.2 cm diameter dark area central to the outer reddened area. The area was tender to touch, with no drainage or odor, and treated with betadine. A Weekly Skin Pressure Ulcer report dated 11/08/16 documented the right toe area measured 0.8 by 0.7 cm, with serous drainage. A Weekly Skin Pressure Ulcer report dated 11/15/16 documented the right toe measured 1.1 by 0.8 cm and unstageable due to slough/eschar. A Weekly Skin Pressure Ulcer report dated 11/22/16 documented the right toe measured 0.8 by 0.9 cm and unstageable due to slough/eschar. A Weekly Skin Pressure Ulcer report dated 11/29/16 documented the right toe measured 0.8 by 0.8 cm and unstageable due to slough/eschar. A Weekly Skin Pressure Ulcer report dated 12/6/16			

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	documented the right toe measured 0.8 by 0.7 cm and unstageable due to slough/eschar. Then podiatry consult dated 11/8/16 at 8:32 AM documented Resident #3 seen for right foot ulcer, stating pain at three out of 10 on the pain scale. The family thought the cause of the ulcer most likely a sock rolled up in his/her shoe causing irritation. It had been open for the past couple of weeks and quite painful. Resident #3 had one short course of antibiotics which consisted of Augmentin. Pre-debridement measurements of the wound at 0.4 by 0.2 cm with anatomic depth probes to the bone. The wound base and edges with fibrous necrosis in the base and hyper keratosis around the edges. Probing of the base of the wound showed no undermining and no exposed tendon, but there was exposed bone directly in the base of the wound. The surrounding tissue showed mild erythema and edema, and mild cellulitis. The x-ray and clinical findings were suggestive of bone erosion secondary to osteomyelitis (inflammation/infection of bone). The wound was debrided of all abnormal tissue. A podiatry note dated 11/16/16 at 2:38 p.m. documented Resident #3 returned for follow-up of the ulcer on the right great toe with pre-debridement measurements of 0.4 by 0.3 cm. There was a large flood of fibrous necrosis well adhered to the base of the ulceration. Probing of the base of the wound showed no undermining and no exposed tendon but there was exposed bone in the base of the ulceration. There was mild surrounding erythema and edema which was markedly improved from the			

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	previous visit. Culture report was reviewed with the family which showed Methicillin Resistant Staphylococcus Aureus (MRSA) which was sensitive to his/her current antibiotics. The ulcer was sharply debrided of all abnormal tissue using a combination of a scalpel, sharp curette, and tissue nipper to remove all abnormal tissue. The debridement carried to healthy bleeding tissue at the base of the ulceration and the edges. Excision of both subcutaneous and fascial (connective) tissue was carried out. The post procedure dimensions measured at 0.5 by 0.6 cm with anatomical death of 0.4 cm into the fascial space. They extended the course of antibiotics due to the high likelihood of osteomyelitis with exposed bone. The podiatry follow-up dated 11/30/16 at 2:13 p.m. documented Resident #3 returned for follow-up of the ulcer with pre-debridement measurements of 0.2 by 0.2 cm with an atomic death indeterminate with a complete covering of fibrous necrosis in the base of the ulceration. The ulcer was sharply debrided of all abnormal tissue. Post procedure dimensions measured 0.4 by 0.4 cm with an atomic death of 0.3 cm. During an observation on 12/6/16 at 8:45 a.m. Staff A Certified Nursing Assistant (CNA) and Staff B CNA assisted Resident #3 with a.m. cares. Resident #3 had a small ulcer to the right big toe, with no redness. Staff put Resident #3's TED socks on and Resident #3's right shoe had cut out (open) for toes.			

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	During an interview on 12/6/16 at 2:10 p.m. the Director of Nursing (DON) stated initially they thought the ulcer was venous because the family member stated Resident #3 had a venous ulcer on the 2nd toe, but the family member also stated they had found a TED stocking in the shoe which may have caused pressure. The Podiatrist diagnosed a pressure ulcer. The DON started doing skin assessments in November. She could not say what the toe looked like before that. She did not know why they did not complete wound assessments before then; normally they did wound assessments weekly. She could not find documentation of the area for 10/28/16 when they 1st started the antibiotic. She could not say how big the ulcer was when 1st discovered because no one documented it. During an interview on 12/7/16 at 3:30 p.m. the DON stated Resident #3 would/could not put on or take off his/her own TED socks or shoes. Someone had to do that for him/her. The facility policy and procedures titled **Wound Management,** reviewed 7/2016, documented a resident having pressure ulcers received necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable sores from developing. The policy indicated in order prevent existing pressure ulcers from worsening, nursing staff should implement approaches including monitoring the impact of interventions and modifying interventions as appropriate based on any identified changes. They should review and/or			

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	re-evaluate existing treatment regimens in connection with the resident's clinical presentation, to include interventions and care plan considerations, if any wound was non-healing or not showing signs of improvement after a given time or any time a wound worsened. **FACILITY RESPONSE:**			

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50.7(5)	**481-50.7(10A,135C) Additional notification.** The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(5) When a resident attempts suicide, regardless of injury. **DESCRIPTION:** Based on record review and staff interview, the facility failed to report to the Iowa Department of Inspections and appeals of a resident attempted suicide (Resident #7). The sample consisted of 12 residents and the facility reported a census of 49 residents. Findings include: Resident #7 had a Minimum Data Set (MDS) assessment with a reference date of 11/8/16. The MDS identified a BIMS (Brief Interview for Mental Status) score of 9. A score of 9 indicated the resident had a moderate impairment for cognitive status. The MDS indicated the resident experienced hallucinations and delusions. Resident #7's diagnoses included non-Alzheimer's dementia. The Progress Notes dated 11/8/16 at 8:23 a.m. documented staff reported Resident #7 making fearful statements at the breakfast table. Resident #7 talked about being afraid of what they're doing to him/her and having no idea what he/she should be doing. Resident #7 had difficulty finding words and forming sentences, and jumped from the subject	**II**	**$500**	**Upon Receipt**

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	often. He/she talked about bad things happening at night stating he/she and seen and heard things that scared him/her but unable to elaborate on what things he/she saw or heard. When asked what he/she meant, Resident #7 stated not understanding the question. Staff placed a call to the psychiatric practitioner to have him call back ASAP (as soon as possible). The Telehealth chart notation dated 11/8/16 at 9:40 a.m. documented the Assistant Director Of Nursing (ADON) said Resident #7 heard a lot of voices. He/she said he/she didn't know to walk out, freak out or kill him/herself. We just had a nurse go to his/her room and the resident had a belt around his/her neck. The note directed to please immediately remove all means of self-harm from his/her room, start 15 minute checks until further notice, give Haldol (antipsychotic) 1 mg now, and we'll see him at 5:00 PM today for a visit. The Progress Notes dated 11/8/16 at 9:48 a.m. documented new orders received for Haldol 1 mg, 15 minute visual checks, and psychiatric health appointment scheduled for 5:00 p.m. Call cords were replaced with call bell, and belts removed from room. A psychiatric Telehealth visit dated 11/8/16 at 5:00 p.m. documented the ADON stated Resident #7 had no other issues the rest of the day. There was nothing else in his/her room that could hurt the resident. Resident #7 made no further verbalizations of wanting to hurt self and stated they			

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	had been doing the 15 minute safety checks. Resident #7 did not remember trying to strangle self with a belt this morning and stated everyone over rated it really bad. Resident #7 did not completely remember the morning's suicide attempt. Please continue 15 minute safety checks for 24 hours. The Progress Notes dated 11/8/16 documented continuation of frequent visual checks. A Frequent Checks form dated 11/9/16 lacked documentation of Resident #7 having every 15 minute safety checks. The facility failed to produce documentation of Resident #7 having 15 minute checks on 11/8/16 as ordered. During a findings meeting with facility staff on 12/7/16 at 3:30 PM the Director Of Nursing (DON) stated they did frequent checks on Resident #7 (not 15 minute checks). During an interview on 12/8/16 at 9:45 AM the DON stated they could not find documentation for the frequent checks on 11/8/16. On 12:05 p.m. on 12/7/16, the DON stated she did not report an attempted suicide because it was not an attempted suicide. The DON stated the resident frequently has something hanging around his/her neck. **FACILITY RESPONSE:**			

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