

**Iowa Department of Inspections and Appeals**  
**Health Facilities Division**  
**Citation**

FC6459		Date: February 21, 2017		
Westwood Specialty Care		Survey Dates: January 30, 31, February 1-2, 2017		
4201 Fieldcrest Drive				
Sioux City, Iowa 51104	Ds			
		Class	Fine Amount	Correction date
58.19(2)b	<p><b>481-58.19(135C) Required nursing services for residents.</b> 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:</p> <p><b>58.19(2) Medication and treatment.</b></p> <p><i>b.</i> 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).</p> <p><b>DESCRIPTION:</b></p> <p>Based on observation, record review, and staff interviews, the facility failed to prevent the development of avoidable pressure ulcers and failed to provide care to promote healing of the pressure ulcers (Resident #1, #3, #9). The sample consisted of 5 residents and the facility identified a census of 67 residents.</p> <p>Findings included:</p> <p>1. According to the MDS (Minimum Data Set) assessment, with a reference date of 11/3/16, Resident #9 scored 6 on the BIMS (brief interview for mental status) test. A score of 6 identified the resident with a severe cognitive impairment. Resident #9 required extensive assistance with ADL's (activities of daily living) including bed mobility, transfers, personal hygiene, and toilet use. Resident #1's diagnoses included diabetes and dementia. The MDS documented Resident</p>	I	\$2,000 <b>Held in suspension</b>	Upon Receipt

Facility Administrator

Date

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	<p>#9 was not at risk for developing pressure ulcers and did not have arterial or venous ulcers. The resident had a pressure reducing device for the bed.</p> <p>A Pressure Ulcer Healing Record dated 8/17/16 documented Resident #9 had a Stage II pressure ulcer of the right heel measuring 0.8 by 1 cm. The nurse identified the wound healed on 9/26/16.</p> <p>The MDS identified a Stage II pressure ulcer as a partial loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister.</p> <p>According to the MDS assessment, with a reference date of 1/26/17, Resident #9 Resident #9 required extensive assistance with ADL's including bed mobility, transfers, personal hygiene, and toilet use. The MDS documented Resident #9 was not at risk for developing pressure ulcers and did not have venous or arterial ulcers. The MDS documented Resident #9 had an unstageable pressure ulcer due to presence of slough and/or eschar, measuring 2.7 by 3.5 cm. Resident #9 had no pressure ulcers on the prior assessment.</p> <p>The MDS identified slough as necrotic tissue in the process of separating from the viable portions of the body and is usually light colored, soft, moist and stringy (at times). The MDS described</p>			

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	<p>Eschar as a thick leathery, frequently black or brown in color comprised of necrotic dead or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound.</p> <p>A facsimile dated 10/21/16, indicated the staff notified the physician that Resident #9 had orders for heel lift boots to bilateral feet when in bed, off when out of bed. The fax questioned if they could have orders to apply heel boots to bilateral feet in bed, and may be worn during the day if tolerated. The physician responded and approved. The physician signed the order.</p> <p>The Treatment Record for December 2016 showed Resident #9 wore the heel boots to each foot in bed. The record lacked any documentation of Resident #9 wearing the heel boots during the day as tolerated. The record documented the staff assisted Resident #9 to the recliner after meals, 3 times a day.</p> <p>The Treatment Record for January 2017 showed Resident #9 wore the heel boots in bed until 1/9/17 and then had a new order. The record lacked any documentation of Resident #9 wearing the heel boots during the day as tolerated. The record documented Resident #9 assisted to the recliner after meals 3 times a day.</p> <p>The Treatment Record showed Resident #9 had the heel boots to the bilateral lower extremities at all times, may remove for hygiene and transfers</p>			

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	<p>only, starting 1/9/17.</p> <p>The Care Plan, with an initial goal target date of 8/26/16, identified the resident needed assistance with bed mobility. The interventions included a pressure reducing mattress to the bed and wheelchair cushion, 5/12/15 air mattress to bed, 4/15/16 heel boots to bilateral lower extremities while in bed, 9/5/16 recliner after meals, 1/9/17 heel boots at all times, remove for hygiene and transfers.</p> <p>A fax dated 1/9/17 notified the physician Resident #9 had an area to the inner left heel, white hard area with fluid surrounding measuring 3 by 3.5 cm, and asked for a treatment order.</p> <p>A Pressure Ulcer Healing Record dated 1/9/17 documented Resident #9 had an unstageable pressure ulcer of the inner left heel measuring 3 by 3.5 cm. The record defined an unstageable ulcer as a known ulcer but not stageable due to coverage of the wound by slough and/or eschar (dead/necrotic tissue). The area measured 2.8 by 4.5 cm on 1/30/17 and described as a black, dark purple wound bed.</p> <p>During an observation on 1/31/17 at 1:35 p.m. Resident #9 sat in the recliner. Staff E Licensed Practical Nurse (LPN) performed the treatment to Resident #9's left heel. With the heel boot off, Resident #9's heel rested on the footrest of the recliner. The ulcer appeared purple, circular, with raised crusted edges.</p>			

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	<p>During an interview on 2/1/17 at 9:48 a.m. Staff B Certified Nursing Assistant (CNA) stated prior to the left heel ulcer Resident #9 often sat in the recliner after meals with his/her feet elevated. She did not recall anything under his/her legs (to float his/her heels), and thought he/she wore gripper socks. Resident #9 wore the boots in bed.</p> <p>During an interview on 2/1/17 at 9:50 a.m. Staff C CNA stated prior to the left heel ulcer, Resident #9 wore gripper socks. She did not recall using anything under Resident #9's legs (to float his/her heels). Resident #9 wore the heel boots only in bed.</p> <p>During an interview on 2/1/17 at 9:53 a.m. Staff D CNA, stated they had tried a device under Resident #9's legs when in bed at first, but it didn't work, so they used the boots in bed. Staff D stated Resident #9 often sat in the recliner with the footrest elevated, and they did not put anything under his/her legs to float his/her heels that she could remember. Resident #9 currently wore the boots all the time.</p> <p>During an interview on 2/2/17 at 7:30 a.m. the Director of Nursing stated they could find no documentation they tried the boots during the day when out of bed or that Resident #9 could not tolerate them. She could find no documentation they implemented other measures to protect the heels, or to float the heels.</p>			

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	<p>2. Resident #1 had a MDS assessment with a reference date of 1/26/17. The MDS identified Resident #1 demonstrated long and short term memory problems and severely impaired skills for daily decision making. Resident #1 required extensive assistance with activities of daily living (ADL's) including bed mobility, transfers, dressing, and toilet use. Resident #1's diagnoses included dementia. Resident #1 was at risk of developing pressure ulcers and had a pressure ulcer.</p> <p>A Hospice Face to Face Encounter Attestation Form dated 10/26/16 documented Resident #1 had a non-healing stage III coccyx ulcer despite treatment. Resident #1 reliant (dependent on someone) for all ADL's.</p> <p>A Braden Scale-For Predicting Pressure Sore Risk dated 1/19/17 scored Resident #1 at 14 indicating a moderate risk for developing pressure ulcers.</p> <p>A Pressure Ulcer Healing Record documented Resident #1 had a pressure ulcer of the coccyx with an onset date of 1/3/16. On 1/30/17 the area measured 4 by 2 cm.</p> <p>The Care Plan dated 2/25/16, identified Resident #1 required assistance with bed mobility, with a goal. Resident #1 would have no skin breakdown related to pressure with a goal target date of 2/9/17 (resident already had breakdown related to pressure). The interventions included a pressure reducing cushion to the wheelchair and bed, and Prafo boots to bilateral lower extremities at all</p>			

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	<p>times. The care plan lacked any kind of repositioning program (the resident required extensive assistance with bed mobility).</p> <p>During an observation on 1/31/17 at 6:25 a.m. Resident #1 sat in the wheelchair. At 8:45 a.m. Resident #1 sat in the wheelchair in his/her room. Staff stated he/she had just had a whirlpool. Resident #1 asked several times if he/she could go to bed. Staff A Certified Nursing Assistant (CNA) and Staff B CNA transferred Resident #1 to bed. Resident #1 laid with his/her legs leaning toward the right, but staff provided no support to keep off his/her back/buttocks/coccyx area. At 10:22 a.m. Staff E, Licensed Practical Nurse (LPN) changed the dressing to Resident #1's coccyx ulcer. The open area had a red base with pink surrounding skin. The ulcer had depth. At 1:30 p.m. Resident #1 laid in bed toward the right. At 4:35 p.m. Resident #1 remained in the same position.</p> <p>During an observation on 2/1/17 at 6:20 a.m. Resident #1 sat in the wheelchair with his/her eyes closed. At 8:20 a.m. Resident #1 remained in the wheelchair. At 8:33 a.m. Resident #1 in bed toward the right. At 10:25 a.m. Resident #1 remained toward the right. At 11:10 a.m. staff went in Resident #1's room. At 11:20 a.m. Resident #1 sat in the wheelchair.</p> <p>During an interview on 2/2/17 at 7:30 a.m. the Director of Nursing stated hospice noted Resident #1's wounds were unavoidable due to terminal</p>			

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	<p>condition, but agreed all interventions should be implemented including at least every 2 hour repositioning.</p> <p>The facility policy/procedures titled <b><u>Prevention of Pressure Ulcers</u></b>, January 2015 Edition, identified the purpose of the policy was to relieve pressure, restore circulation and promote skin protection in the affected area. The guidelines included utilizing pressure reduction devices on bed and chair as necessary, repositioning resident routinely and positioning with pads and pillows to protect bony prominence's and maintain proper alignment, using elbow and/or heel foot protectors if needed. The care plan would identify the problem, establish goals, and develop approaches.</p> <p>The facility policy and procedures titled <b><u>General Wound and Skin Care Guidelines</u></b>, January 2015 edition, documented the following general wound and skin care guidelines should be followed for all residents with potential and/or actual impairment in skin integrity.</p> <p>Turn/reposition every 2 hours while in bed and at least hourly when in a chair.</p> <p>3. Resident #3 had a MDS with a reference date of 11/19/15. The MDS documented the resident had no impairment of cognitive function and required extensive assistance of staff for bed mobility and transfers. The resident's Braden Scale Pressure Sore Risk assessment documented the resident at mild risk for the</p>			

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	<p>development of pressure sores from 2/15/16 through 1/6/17.</p> <p>During an observation on 2/1/17, Staff E, Licensed Practical Nurse (LPN) provided a treatment to an open area on the resident's coccyx/sacrum. Observation identified the resident's mattress as a standard mattress and not pressure reducing. Staff F, LPN stated and confirmed the mattress to be a regular mattress and not pressure reducing.</p> <p>During an interview on 2/1/17 at 11:15 a.m. the Director of Nursing (DON) stated the area was not due to pressure, but due to the resident picking at the area.</p> <p>A 1/19/16 Wound Clinic Progress Note documented the resident had an open wound in the gluteal crease that measured 0.8 by 0.4 by 0.2 cm. which underwent excisional debridement of surrounding necrotic tissue and scar to a size of 1.4 by 0.7 by 0.2 cm. The Progress Note diagnosed the wound as a Stage III decubitus ulcer of the coccyx. The MDS defines a Stage III Decubitus (Pressure) Ulcer as full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling.</p> <p>On 1/28/16 Wound Clinic notes documented the coccyx wound 1.0 by 0.8 by 0.4 cm.</p>			

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	<p>The facility staff documented the area healed on 2/8/16. On 2/18/16 Wound Clinic notes documented the coccyx ulcer 1.0 by 1.3 by 0.2 cm. and described the area as Stage III decubitus ulcer with the fat layer exposed.</p> <p>Facility records lacked any further assessment of the coccyx ulcer until 5/30/16. Wound Clinic notes documented the following:</p> <p>On 3/15/16 the Stage III decubitus coccyx ulcer with fat layer exposed measured 1 by 0.3 by 0.1 cm.</p> <p>On 3/29/16 the Stage III decubitus coccyx ulcer with fat layer exposed measured 1 by 0.4 by 0.4 cm.</p> <p>On 4/12/16 the Stage III decubitus coccyx ulcer with fat layer exposed measured 0.4 by 0.3 by 0.2 cm.</p> <p>On 4/26/16 the Stage III decubitus ulcer with fat layer exposed measured 0.1 by 0.1 by 0.1 cm.</p> <p>On 5/10/16 the Stage III decubitus ulcer with fat layer exposed measured 0.6 by 0.3 by 0.1 cm. slightly larger. They also identified an open wound to the right upper posterior back 1.4 by 1.5 by 0.4 cm. which may have been a remnant from an abscess.</p> <p>On 4/11/16 at 3:20 p.m. staff documented in the Nurse's Notes the resident had a red area to the right back/shoulder which measured 1.2 by 1.2 cm.</p> <p>Wound Clinic Notes subsequently documented on 5/26/16 the Stage III decubitus of the</p>			

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	<p>sacrum/coccyx measured 1.2 by 0.3 by 0.2 cm. initially and 3.5 by 1.5 by 1.0 cm. after excision and debridement. The ulcer was then primarily closed. They documented the back lesion 0.8 by 0.8 by 0.2 cm. and described it now as a decubitus ulcer with breakdown of skin.</p> <p>Facility staff continued to document condition of the right back/shoulder lesion on a Non-Pressure Skin Condition Report. The record lacked any documentation indicating staff recognized either area as a pressure sore (decubitus ulcer) or implemented any interventions appropriate to treatment of pressure ulcers.</p> <p>On 5/30/16 facility staff documented on a Non-Pressure Skin Condition Report a surgical wound on the Gluteal Crease. They documented the area tender with assessment. Staff measured the area 4 by 1 cm.</p> <p>On 6/6/16 facility staff documented the area measured 4 by 2 cm. and noted the sutures spreading.</p> <p>On 6/9/16 Wound Clinic Notes documented the coccyx ulcer measured 4 by 2 by 1 cm. after the removal of the sutures. Wound Clinic staff documented another small ulcer on the left buttock measuring 0.3 by 0.3 by 0.1 cm. The sutures were removed and new sutures placed to re-approximate the edges.</p> <p>On 6/13/16 facility staff documented the area on</p>			

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	<p>the gluteal crease 4 by 2 cm. and noted 5 sutures.</p> <p>On 6/16/16 Wound Clinic Notes stated the resident still had a lot of pain at the site of the coccyx ulcer. The sutures tended to pull through the skin causing a lot of pain with movement. They removed the stitches. The note lacked any measurements of the coccyx ulcer or any mention of the left buttock ulcer.</p> <p>On 6/27/16 facility staff documented the wound on the gluteal crease measured 3 by 4 by 0.1 cm.</p> <p>On 6/28/16 Wound Clinic Staff documented the Stage III decubitus ulcer measured 3.7 by 1.4 by 0.8 cm. with the fat layer exposed. They did no debridement at that visit.</p> <p>On 7/4/16 facility staff documented the area measured 4.2 by 3.2 by 0.4 cm.</p> <p>On 7/5/16 Wound Clinic staff documented the resident had less pain with the sutures removed but was still bothered especially when they removed the dry dressings. They measured the Stage III decubitus ulcer of the coccyx 4 by 3 by 0.3 cm. They did not debride the ulcer.</p> <p>On 7/11/16 facility staff documented the area measured 4 by 3 by 0.2 cm. On 9/5/16 facility staff measured the area 3.5 by 1.1 by .1 cm.</p> <p>From 7/12/16 to 9/6/16 Wound Clinic staff documented the Stage III ulcer progressively</p>			

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	<p>decreased in size from 4 cm. by 3 cm. by 0.3 cm. to 3 by 1 by 0.6 cm. On 9/6/16 they also documented an open area on the right buttock 0.8 by 0.8 cm.</p> <p>On 9/12/16 facility staff documented the area on the gluteal crease as 3.5 by 1 by 0.1 cm.</p> <p>On 9/13/16, Wound Clinic staff documented the coccyx ulcer 3 by 0.5 by 0.5 cm. They noted an ulcer on the left buttocks, possibly related to tape trauma which measured 0.6 by 0.8 by 0.1 cm. The note made no mention of the open area on the right buttocks. They debrided both areas.</p> <p>On 9/20/16 Wound Clinic staff documented the left buttocks ulcer measured 0.8 by 0.8 by 0.1 cm. The sacral ulcer measured 3 by 1 by 0.1 cm. and noted it had developed an area of dead tissue. They measured it post debridement 3.7 by 1.7 by 0.1 cm.</p> <p>On 9/27/16 Wound Clinic staff documented the ulcer 4 by 2 by 0.4 cm. and noted it continued to enlarge in size. Again they debrided the ulcer which then measured 4 by 2.5 by 0.5 cm. From 10/11/16 to 1/31/17 Wound Clinic Notes documented weekly debridement of the coccyx/sacral ulcer. The size of the ulcer varied slightly from week to week. On 1/31/17 they measured the ulcer 3.2 by 2 by 0.3 cm.</p> <p>During an interview on 2/1/17 the DON stated they had not treated the coccyx wound as a</p>			

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	<p>pressure ulcer. She confirmed the resident did not have a pressure relieving device on the bed. She stated the facility had not obtained any of the Wound Clinic Progress notes until that day. They had not considered the open area a pressure ulcer.</p> <p>The resident's Care Plan stated he/she needed assistance with repositioning related to left hemiplegia and identified a goal the resident would have no skin breakdown related to pressure. The Care Plan indicated the resident should have a pressure reducing mattress on the bed, but staff identified the mattress as standard. The Care Plan made no mention of the open area on the resident's coccyx.</p> <p><b>FACILITY RESPONSE:</b></p>			

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