

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6684		Date: October 24, 2017		
Kathleen's Residential Care	Fine amounts reduced by 35% to \$6,500.00 on November 13, 2017 pursuant to Iowa Code Section 135C.43A	Survey Dates: September 27-October 5, 2017		
1505 East Fifth Street Emmetsburg, Iowa 50536	DS			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

64.60 + W339	<p>481—64.60 (135C) Federal regulations adopted—conditions of participation. Regulations in 42 CFR Part 483, Subpart D, Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319. Classification of violations is I, II, and III, determined by the division using the provisions in 481—Chapter 56, “Fining and Citations,” to enforce a fine to cite a facility. This rule is intended to implement Iowa Code section 135C.2 (3).</p> <p>483.460(c)4 Standard: Nursing Services (4) Other nursing care as prescribed by the physician or as identified by client needs.</p> <p>DESCRIPTION: Based on observation, interviews and record review, the facility failed to provide adequate nursing services and oversight in accordance with client needs. The facility failed to adequately identify and address the development of pressure</p>	I	\$8,000	Upon Receipt
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	<p>ulcers. The facility failed to ensure documentation of medication treatments, communicate treatments being utilized, complete and update changes on the nursing care plan and failed to follow general nursing practices regarding charting. This affected 1 of 3 sample clients (Client #1).</p> <p>Findings follow:</p> <p>1. Client #1 had a physical exam completed on 12/21/16. The exam report identified the resident's diagnosis included: cerebral palsy (abnormal motor function), severe mental retardation, lower extremity edema, scoliosis (curvature of the spine), history of anorexia (eating disorder), enlarged thyroid (gland) and hiatal hernia (upper part of stomach pushes through diaphragm).</p> <p>On 9/27/17 at 4:30 p.m. observation identified an open area behind Client #1's right knee. The area measured 2 cm x [by] 1.5 cm x 0.5 cm with tan exudate in the wound. The surround area appeared red. No active bleeding observed. The area behind the left knee also was covered with Telfa (dressing) and measured 1 cm x 1.5 cm x 0. The linear area appeared slightly swollen with surround redness. Photographs were obtained</p>			

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	<p>from both the right and left and right areas.</p> <p>The Centers for Medicare and Medicaid Services (CMS) identify the following stages of pressure ulcers:</p> <p>Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.</p> <p>Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.</p> <p>Stage III 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 tissue loss. May include undermining and tunneling.</p> <p>Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</p> <p>Record review on 9/27/17 revealed a Medical Incident, completed by the Director of Nursing</p>			

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	<p>(DON) 7/28/17, noted an injury to the back of Client #1's right knee. Under medical treatment, the DON documented the following: No active drainage noted. Measuring 1.0 centimeters (cm) x 0.5 cm (L x W) (length x width) and 0.3 cm depth. Cleansed. Bacitracin applied. Covered with Telfa and secured with Mediplex tape. A 24 hour update documented by the DON on 7/29/17 at 9:00 p.m., documented and noted the following: Decreased redness noted on surrounding skin. Area measuring 0.7 x 0.3 and 0.2 depth. Area cleansed, Bacitracin (antibiotic treatment) applied and covered with Telfa. Secured with Medi-pore tape.</p> <p>Further record review revealed the client's Nurses Notes documented the following:</p> <p>On 7/28/17 at 8:50 p.m. Staff reports blood noted to soaker pad on wheelchair. Noted to have open area to back of right knee. No active drainage noted. The area measured. Cleansed and Bacitracin applied and covered with Telfa. Secured with Medi-pore tape. No outward signs of pain noted. Skin assessment sheet initiated. This note was signed by the DON.</p> <p>On 7/28/17 at 9:10 p.m. 24 hour F/U (follow up) - Decreased redness noted to surrounding skin.</p>			

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	<p>Area cleansed, Bacitracin applied. Covered with Telfa and secured with tape. Will continue to monitor. Signed by the DON.</p> <p>On 9/19/17 at 6:30 a.m. the area resolved. No further treatment required. Initiated thigh high TED (thromboembolic disease-compression stockings to prevent blood clot formation) stockings at this time. The Nurse's Notes was signed by Staff A (Licensed Practical Nurse).</p> <p>Continued record review revealed Non-Pressure Skin Condition Records that noted the following:</p> <p>On 7/28/17 an open area to the posterior (back) right knee, characterized as intact, surrounding skin reddened, not changed. Continue Treatment. Measured length 1.0 cm (centimeters) x width cm 0.5 x depth 0.3.</p> <p>The Progress Notes documented: Area cleansed and Bacitracin applied, covered with non-stick Telfa and secured with tape. The DON signed this entry.</p> <p>On 7/29/17, the measurements were noted as length 0.7 cm x width 0.3 cm and depth 0.2 cm. Area noted as not changed. Progress notes documented the area as cleansed and Bacitracin</p>			

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	<p>applied. Bacitracin applied. Covered with non-stick Telfa and secured with tape. This entry signed by the DON.</p> <p>On 8/4/17 the measurements were noted to be length 0.6 cm x width 0.3 cm x depth 0.2 cm. Area noted as improved. Progress Notes documented the area continues covered with non-stick Telfa and Bacitracin applied to surrounding skin. A scant amount of serous drainage noted. The DON signed this entry. .</p> <p>On 8/11/17 the measurements noted as length 0.4 cm x width 0.2 cm x depth 0.2. The area noted as improved. The Progress Notes identified the nurse covered the area with Telfa after left open to air to dry after bath. No outward signs of pain noted and afebrile (without fever). This entry was signed by the DON.</p> <p>On 8/18/17 the measurements were noted as length 0.4 cm x width 0.1 x depth 0.1 cm. The area noted as improved. Progress Notes identified the day bath changed to every other day on 8/17/17. Area continues covered with non-stick Telfa, secured with tape, TED hose held and (not applied) on 8/14/17." This entry signed by the DON.</p> <p>On 8/25/17 the measurements noted to be: length</p>			

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	<p>0.3 cm x width 0.1 cm x depth 0.1 cm. Area noted as improved. Comments documented: TED hose remain off. Area remained normal in color. No drainage noted. Afebrile and area covered with Telfa and secured with tape. The entry signed by the DON.</p> <p>On 9/1/17 the measurements noted to be: length 0.2 cm, x width 0.1 cm depth 0. Comments noted: Area remained free from s/s (signs and symptoms) of infection. Continue to cover area with Telfa for protection. Staff A signed this entry.</p> <p>On 9/15/17 the measurements noted to be: length 0.1 cm x width 0.1 cm. Comments noted: Area scabbed over. No s/s of infection. Remains covered with Telfa. TED hose remain off. Entry signed by Staff A.</p> <p>On 9/19/17 the measurements noted to be: length 0 cm x width 0 x depth 0. Comments noted: Area resolved. Thigh high TED hose initiated. Entry signed by Staff A.</p> <p>Record review identified Client #1's physician orders included: Bacitracin Ointment 500 Units/GM (gram). Orders directed to apply topically to open or affected areas BID (twice a day)/ PRN (as needed) until clear may repeat. (See W365 for additional information)</p>			

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	<p>When interviewed on 9/28/17 at 10:45 a.m. the DON stated she documented on the Medical Incident report initially and at the 24 hour follow-up. She completed a non-pressure skin assessment at the time it was noticed and weekly thereafter. She denied a policy regarding documentation of prolonged skin assessments. She explained the nurses met weekly to discuss verbally any issues. She informed LPN A of the Bacitracin treatment. She said if she would pass the information to the other staff it would be by a note or on the communication log at the nurse's station.</p> <p>Record review on 9/28/17 revealed lack of any documentation at the nurses station or communication log regarding the treatment of Client #1's wound behind his/her right knee.</p> <p>When interviewed on 9/28/17 at 1:20 p.m. the Administrator stated staff were trained to check the skin during bathing and notify nursing if problems occurred. She denied any documentation or training or a policy/procedure to indicate this was expected/completed.</p> <p>Record review on 9/28/17 revealed Client #1's Nursing Care Plan undated. The plan instructed staff to check the client's skin at least once daily,</p>			

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	<p>apply Ted hose, elevate legs and reposition at least every 2 hours. The Nursing Care Plan lacked any indication of a skin wound, changes with TED hose, or interventions for staff to be aware of. The Care Plan lacked nursing direction for staff to maintain skin integrity, cleanliness or be alert to any unusual alarming symptoms which could have occurred.</p> <p>Review of the communication log at the nursing area identified a note on 9/19/17 from LPN A communicated as: (Client #1) now has thigh high TED hose. Any questions see nursing.</p> <p>Continued record review revealed no documented assessment of the area from 9/19/17, after initiation of the TED hose, until 9/25/17, when the area was again noted to be open.</p> <p>On 9/28/17 at 10:45 a.m. the DON was interviewed and explained on 9/25/17, during the p.m. shift, and Staff B (licensed practical nurse) telephoned the DON. Staff B informed her of Client #1's open area behind the right knee. Staff B sent the DON a picture of the area. DON checked with LPN A via phone to find out if she knew anything about the open area. LPN A denied knowledge of the area. LPN B explained the area opened when the TED hose were</p>			

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	<p>removed that evening. The client did not have a fever and the area not actively bleeding. The DON told Staff B to cover the area.</p> <p>Record review on 9/28/17 identified a Nurses Note dated 9/25/17 at 8:25 p.m. and written by the DON. The note indicated she received a telephone call from Staff B that while staff removed the TED hose on the right leg, a skin tore from area behind the right knee and the area opened. The client had no elevated temperature and skin surrounding the area had a reddened appearance. Area covered with ABD and serosanguinous (yellow or pink watery) drainage noted. The documentation failed to note the entry as a "late entry."</p> <p>When interviewed on 9/28/17 at 10:45 a.m. the DON confirmed she was not present at the facility on 9/25/17, but wrote the note the following day. Also on 9/26/17 she documented: At 6:45 a.m. the area to the back of the right knee measured 1.1 cm (centimeters) x 0.4 cm with 0.3 cm depth. Skin surrounding is reddened in appearance. Active drainage noted. No outward signs of pain noted. Skin assessment sheet initiated.</p> <p>Review of the Pressure Skin Condition Report dated 9/26/17 revealed documentation by the</p>			

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	<p>DON of 1.1 x 1.4 with a depth of 1.3 cm. The comment section indicated the surrounding skin reddened in appearance. Wound bed pink with visible tendon and a Dr. appointment made for that morning.</p> <p>Record review on 9/28/17 revealed a consult with the physician from 9/26/17 and documented a subcutaneous abscess of posterior R (right) knee. Read x-ray of right knee. Referred to a general surgeon and to check CBC (Complete Blood Count) and antibiotics were ordered.</p> <p>When interviewed on 10/2/17 at 2:10 p.m., the general surgeon revealed the area did not require surgical intervention. The surgeon stated the client was referred to a wound nurse.</p> <p>Record review on 10/3/17 revealed a wound nurse consultation at 10:35 a.m. that day. The doctor's orders and progress notes documented the following: Initial evaluation and treatment for full thickness ulcer to RT (right) popliteal space (behind right knee). Patient has had this ulcer since 9/25/17 when it re-opened. Quite possibly even if the wound had sealed over there was still infection in the sealed over wound. Have seen this happen in my time in my experience. The ulcer measured 1.0 cm x 1.0 cm x 0.4 cm depth.</p>			

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	<p>There is granulation tissue (new connective tissue and shows signs of healing) noted in the base of the ulcer. The periwound (skin around open area) clean and intact. Is finishing course of ATB (antibiotic), but culture had numerous organisms with one of the organisms being a bacteria called <i>Staphylococcus Aureus</i> (staph aureus). The staff re-cultured the ulcer with this visit (used swab and obtained drainage). Recommendation: Discontinue Triad cream to right popliteal ulcer (behind knee). Switch to silver calcium alginate, cover with Mepilex foam, and change 2 times per week on bath days and as needed if dislodged. Decrease baths to 2 times a week. Follow-up appointment on 10/10/17 at 10 a.m.</p> <p>FACILITY RESPONSE:</p>			

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	<p>affected 2 of 3 sample clients (Client #2 and #3).</p> <p>Findings follow:</p> <p>1. When interviewed on 9/28/17 at 10:30 a.m. Habilitation Training Aide (HTA) A denied seeing nurses on the weekends. The HTA reported insulin given on the weekends by Certified Medication Aide (CMA) A.</p> <p>In an interview with HTA B on 9/28/17 at 10:35 a.m. revealed CMA B administered insulin on weekends because she (CMA B) "was a CMA".</p> <p>Record review on 9/28/17 identified obvious changes to the Medication Administration Record (MAR) from weekend days and weekday initials. The documentation differences included: Staff A (licensed practical nurse) initials always appeared in blue ink. LPN A admitted on 9/28/17 she always used blue pens to chart (unless she did not have blue). On the weekend, chartings of the Certified Med Aids A and B, the initials were in black ink along with black ink initials of either LPN A or the DON in black ink.</p> <p>When interviewed on 9/28/17 at 7:30 a.m. the DON reported she or LPN A always came in on the weekends to administer insulin to Client #2</p>			

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	<p>and Client #3. On 10/2/17 at 12:15 p.m. the DON acknowledged she did not notice someone writing down her initials on the MAR over a weekend. She denied instructing CMAs to give the insulin, but did report communication problems when the CMAs would switch with an LPN and there would not be coverage available for a nurse to give the insulin. She thought the problem began in July and August. She did not recall the CMAs talking to her about this. She did not know if the Administrator was aware of the issue.</p> <p>When interviewed on 9/28/17 at 7:05 a.m. LPN A reported she or the DON came to the facility to administer insulin if the med passer was a CMA. She said it was usually the DON because she lived in town. She stated she did not document her time in the facility, as it did not take very long. She denied signing her initials after a weekend a CMA would have worked. When interviewed on 10/2/17 at 11:30 a.m. LPN A acknowledged a problem with nursing availability for administration of insulin on the weekends. She did not know how long it had been a problem. She reported she did notice her initials being forged, and was aware the two CMAs administered insulin.</p> <p>When interviewed on 9/28/17 at 2:00 p.m. the Program Coordinator/Certified Med Aide</p>			

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	<p>confirmed she administered insulin on the weekends when nursing did not come to give it. She was not sure how many weekends this occurred but guessed she worked 2-3 weekends the last year. She confirmed she gave six shots a day between the two clients receiving insulin. She acknowledged she had informed the DON of giving the insulin because no one had shown up to do it. She admitted this was beyond the scope of her job duties. She admitted she forged the DON's initials after she gave the injections.</p> <p>When interviewed on 10/2/17 at 1:00 p.m. CMA B reported she administered insulin on the weekends. She thought she probably did the injections three times on the weekends. She admitted it was beyond the scope of her duties.</p> <p>When interviewed on 10/2/17 at 12:50 p.m. the Administrator stated she had been aware of the CMAs administering the subcutaneous injections for a couple months. She informed the nurses to make sure they covered the shifts and assumed it never happened again. The Administrator was unable to provide documentation or any follow-up regarding the problem being resolved.</p> <p>FACILITY RESPONSE:</p>			

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6684		Date: October 24, 2017		
Kathleen's Residential Care		Fine amounts reduced by 35% to \$6,500.00 on November 13, 2017 pursuant to Iowa Code Section 135C.43A		
1505 East Fifth Street Emmetsburg, Iowa 50536		Survey Dates: September 27-October 5, 2017		
		DS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

Facility Administrator

Date

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