

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

Little Flower Haven	Fine amount reduced by 35% to \$1462.50 on February 22, 2018 pursuant to Iowa Code Section 135C.43A.	Date: January 23, 2018		
736 Highway 37		Survey Dates: January 2-4,9, 2018		
Earling, Iowa 51530	DS			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

<b>58.19(2)b</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:  <b>58.19(2) Medication and treatment.</b>  <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 record review, observation, staff interviews and review of policy and procedures, the facility failed to implement preventive measures to relieve pressure on a resident's bilateral heels to prevent the development of an avoidable suspected deep tissue injury pressure sores (Resident #37). The sample consisted of 1 resident with pressure ulcers and the facility reported a census of 38 residents.</p> <p>Findings include:</p> <p>The MDS (Minimum Data Set) assessment</p>	<b>I</b>	<b>\$2250</b>	<b>Upon Receipt</b>
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Facility Administrator

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	<p>identifies the definition of pressure ulcers:</p> <p><b>Stage I</b> 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><b>Stage II</b> 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><b>Stage III</b> 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><b>Stage IV</b> 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><b>Unstageable Ulcer:</b> inability to see the wound bed.</p>				
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	<p>Other staging considerations include:  <b>Deep Tissue Pressure Injury (DTPI):</b> Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.</p> <p>1. Resident #37 had a MDS (Minimum Data Set) assessment with a reference date of 12/14/17, due to a significant change in condition. The MDS identified the resident had a Brief Interview for Mental Status (BIMS) score of 8 with no signs or symptoms of delirium. A score of 8 indicated the resident had a moderately cognitive impairment. The MDS indicated the resident as dependent upon 2 staff persons for physical assistance with bed mobility and transfers. The MDS documented impairment with range of motion on both sides of the lower extremities.</p>				
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	<p>The MDS reflected the resident used a wheel chair. The MDS identified diagnoses that included hypertension (elevated blood pressure), diabetes mellitus, arthritis, non-Alzheimer's dementia, chronic pain, and history of malignant neoplasm of the breast. The MDS recorded the resident at risk for pressure ulcers but did not have any pressure ulcers at the time of the assessment.</p> <p>The Care Plan problem area dated 10/25/17 identified the resident at risk for pressure ulcers related to frequently incontinent. The Care Plan approaches dated 10/25/17 instructed staff to provide assist as needed with bed mobility and transfers; Braden assessment quarterly (skin assessment tool); and report any signs of skin breakdown (sore, tender, red, or broken areas). The Care Plan problem area dated 10/25/17 identified the resident at risk for falls and directed staff to provide the resident with safety device/appliance wheelchair. The revision dated 12/4/17 identified the use of a Geri chair (reclining wheelchair with elevated foot rest).</p> <p>The Braden Scale for Predicting Pressure Sore Risk dated 10/17/17 identified a score of 17. A score of greater than 16 indicated the resident not</p>				
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	<p>at increased risk for skin breakdown.</p> <p>The Braden Scale for Predicting Pressure Sore Risk dated 12/14/17 identified a score of 14. A score of 13 or 14 indicated the resident at moderate risk for skin breakdown.</p> <p>The Non-Pressure Ulcer Skin Condition Record dated 12/17/17 documented an area on the resident's left heel first observed 12/17/17. The record documented an origin from Geri chair positioning and a treatment plan of skin prep, moon boots (soft foam) until healed. The record identified the following measurements and skin condition assessments:</p> <ul style="list-style-type: none"> <li>a. 12/17/17 - 2.7 centimeters (cm) by 1.9 cm, surrounding skin color red</li> <li>b. 12/23/17 - 2.9 cm by 4.7 cm, surrounding skin color pink</li> <li>c. 12/29/17 - 3.2 cm by 3.3 cm, surrounding skin color pink</li> <li>d. 1/6/18 - 3.1 cm by 3.4 cm, surrounding skin color red, progress deteriorated with middle of area boggy.</li> </ul> <p>The Non-Pressure Ulcer Skin Condition Record dated 12/17/17 documented an area on the</p>				
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	<p>resident's right heel first observed 12/17/17. The record documented an origin from Geri chair positioning and a treatment plan of skin prep, moon boots until healed. The record identified the following measurements and skin condition assessments:</p> <ul style="list-style-type: none"> <li>a. 12/17/17 - 2.7 cm by 1.8 cm, surrounding skin color red</li> <li>b. 12/23/17 - 3.3 cm by 4.0 cm, surrounding skin color pink</li> <li>c. 12/29/17 - 3.3 cm by 5.0 cm, surrounding skin color pink</li> <li>d. 1/6/18 - 2.5 cm by 4.5 cm, surrounding skin color red, progress deteriorated with middle of area boggy.</li> </ul> <p>The Client Coordination Note report dated 12/18/17 from the resident's hospice Registered Nurse (RN) Case Manager, Staff C, documented staff reported the resident's heels appeared to be breaking down. Staff C wrote she ordered optifoam (foam barrier to protect skin) and bed with air mattress.</p> <p>The Client Coordination Note report dated 12/18/17 documented staff applied skin prep to bilateral heels, used boots and floating heels to</p>				
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	<p>prevent skin breakdown.</p> <p>The Client Coordination Note report dated 1/4/18 documented the resident's heels becoming soft and Staff C instructed the facility to remove the boots and float heels only and continue with skin prep.</p> <p>The Care Plan revised 12/20/17, continued to identify a problem area of pressure ulcer risk related to frequently incontinent. The Care Plan did not reflect any changes to the previous interventions or addition of new interventions. The Care Plan lacked documentation to identify the presence of actual pressure sores on the heels.</p> <p>The Interdisciplinary Care Plan Conference Record dated 12/20/17 documented skin under areas reviewed. The comments section of the form identified the use of an air mattress and heel protectors as the heels had areas and hospice services.</p> <p>The Narrative Notes identified the following:</p> <p>On 12/5/17 at 9:00 a.m. the resident is now in</p>				
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	<p>Ger chair due to fall and the resident's son reported that the day before, the resident would continuously lean forward when seated in the Geri chair.</p> <p>On 12/10/17 at 12:20 p.m. the resident transferred with a Hoyer lift (mechanical lift) and the assistance of 2 staff persons. The note recorded the resident utilized a Geri chair for locomotion throughout the facility and staff propelled the chair.</p> <p>The Narrative Notes lacked any entries for the dates of 12/15/17 thru 12/17/17.</p> <p>On 12/18/17 at 9:10 p.m. a new bed and air mattress provided by hospice, the resident rested in bed, and bilateral heels floated with a body pillow.</p> <p>On 12/21/17, noted each of the resident's heels red.</p> <p>On 12/26/17 at 10:00 a.m. staff noted an increased redness to the resident's bilateral heels, heels floated to alleviate pressure, and the resident encouraged to sit in a recliner to provide</p>				
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	<p>feet some relief from sitting on Geri chair. The entry recorded the resident declined stating she didn't like that chair.</p> <p>On 1/7/18 at 8:38 a.m. the resident had areas to each heel, skin prep applied BID (2 times a day), and heels floated at all times.</p> <p>On 12/1/17 thru 1/6/18 the record lacked documentation to show skin prep treatment applied to the bilateral heels as a nursing order.</p> <p>The December 2017 and January 2018 Treatment Flowsheets lacked documentation of completion of the skin prep per nursing order.</p> <p>Observation on 1/2/18 at 11:32 a.m. revealed Resident #37 wore heel protectors on both heels. Staff D, Certified Nurse Aide (CNA), stated sores were present on both of the resident's heels.</p> <p>Clinical record review on 1/4/18 at 9:32 a.m. revealed no physician ordered treatment orders found.</p> <p>Observation on 1/4/18 at 9:45 a.m. revealed Staff G, Licensed Practical Nurse (LPN), completed a</p>				
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	<p>treatment to the resident's bilateral heel pressure ulcers. Staff G applied skin prep (protective barrier) to both heels. The bottom of the left heel observed with approximate 2 inch by 1 inch dark purple circular area. Staff G commented the center soft the day before but more firm at time of observation. Staff G reported the previous week the area measured about 4 cm by 3 cm. The tissue surrounding the pressure area appeared normal flesh tone with no break in skin. The bottom of the right heel observed with approximate 1.5 inch by 1 inch dark purple circular area with center of the area flesh tone in color. Resident #37 denied pain to the areas. Staff G stated the top portion of the circular area felt boggy and the other areas firm. Staff G confirmed the skin prep not listed on the TAR (Treatment Administration Record). Staff G stated the skin prep a nursing order and the treatment completed BID (2 times a day). Staff G reported Hospice aware the heels degrading as she talked to them the other day and Hospice okayed the continued use of skin prep. Staff G stated she would need to look at the skin sheet to see how long the treatment had been going but she thought approximately a month. Staff G said the use of skin prep only documented on the skin</p>				
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	<p>sheets. Staff G stated the treatment originated from a fax to the doctor. Staff G commented it could be a slow process for the resident's doctor to answer faxes.</p> <p>On 1/8/18 at 1:26 p.m., the Director of Nursing, DON, was interviewed and stated no physician had seen the heel pressure areas. The DON stated the resident's hospice nurse, Staff C, saw the areas on the heels and relayed the information to the doctor.</p> <p>On 1/8/18 at 3:17 p.m., Staff C, Hospice nurse, was interviewed and stated she first became aware of the heel pressure areas a couple weeks prior. Staff C stated the facility sent the forms to notify hospice and she notified the doctor. Staff C stated she and her office could not find the forms so she asked the facility to resend the form the previous week. Staff C said the doctor told them to make sure the heels did not breakdown further. Staff C stated she wanted the facility to treat the areas with skin prep and told the facility to float the heels. Staff C commented prior to first finding out about the pressure sores she did complete full nursing assessments of the resident and did not observe any skin issues. Staff C stated the</p>				
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	<p>resident's transfer status had been and remained a Hoyer lift with the resident not being able to reposition herself. Staff C stated in her professional opinion, the resident's legs contracting, the resident had poor nutrition, and co-morbidities contributed to the development of the pressure areas. Staff C said she ordered a new bed for the resident and told the facility to stop using the boots the previous week (week of 1/2/18). Staff C commented she wanted the facility to float heels only as the boots caused the resident to sweat and get restless. Staff C did not know if she had a lot of documentation of the pressure areas but she would attempt to fax her records to the facility as the facility did not have the hospice notes as of the interview.</p> <p>On 1/8/18 at 4:15 p.m., Staff E, CNA, was interviewed and stated the resident's decline came on fast. Staff E reported until the previous week, the resident got up for meals. Staff E stated when Resident #37 up in a regular wheelchair, she propelled herself up and down the halls. Staff E reported after the resident had an accident falling out of the wheelchair, her condition declined and she could not reposition herself.</p>				
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	<p>On 1/8/18 at 4:20 p.m., Staff F, CNA, reported she worked for the facility for 1/1/2 years during the 2 p.m. to 10 p.m. shift. Staff F stated Resident #37 used to move good in a regular wheelchair and would wheel herself around. Staff F stated the resident started declining after she fell from a wheel chair leading to the resident using a Geri chair instead. Staff F reported the resident became completely different and couldn't move her arms much and could move her legs only a little bit.</p> <p>On 1/8/18 at 4:25 p.m., Staff G, Licensed Practical Nurse, was interviewed and reported she worked for the facility as a nurse since 2012 and worked the 6 a.m. to 2 p.m. shift, filling other shifts as needed. Staff G stated prior to Resident #37 falling from a wheelchair, Resident #37 self-propelled throughout the facility, attempted to feed herself, and could move her legs a little bit. Staff G stated for the last couple of months the resident's arthritic pain became unbearable. Staff G stated the resident began leaning forward in a regular wheel chair that resulted in a fall. Kayla stated the facility changed the resident's chair to a Geri chair. Staff G responded she believed the</p>				
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	<p>Geri chair contributed to Resident #37's heel pressure areas. Staff G stated Resident #37's legs contracted and Staff G commented she could see Resident #37's heels pressed down into the Geri chair. Staff G reported they did not float the resident's heels or use heel protectors until after the pressure areas developed. Staff G stated Staff H, LPN, found the pressure areas on the heels and implemented floating heels, protector boots, and skin prep to the heels 2 times a day as a nursing order. Staff G reported they worked closely with the mobile wound clinic who recommended skin prep the best treatment. Staff G stated they completed the skin prep treatment as a nursing order and did not document anywhere when completed; they just did the treatment 2 times a day. Staff G commented the resident's decline and pressure sore development happened fast.</p> <p>A facility policy and procedures titled <b><u>Pressure Ulcer, Care and Prevention</u></b> (not dated) included and directed the staff to do the following:          Purpose:          To prevent and treat further breakdown of pressure sores.          Equipment:</p>				
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	<p>Point 3. Heel protector</p> <p><b>Procedure:</b> Point 5. Use pressure reducing devices to relieve pressure. Point 9. Use elbow and heel protectors if needed.</p> <p><b>Treatment:</b> Treatment of pressure ulcers will vary depending on the orders of the attending physician. The nurse is responsible for carrying out the treatment as ordered by the attending physician and for implementing measures to prevent pressure ulcers.</p> <p><b>FACILITY RESPONSE:</b></p>				
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