Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **FC # 6743**			**Date:** **January 25, 2018**
Facility Name: **Accura Healthcare Of Ogden**		**Survey Dates:** **January 2, 3, 4, 8 and 9th, 2018**	
Facility Address/City/State/Zip **625 East Oak Street** **Ogden, IA 50212**			
	HL		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.28(3)e	**481- 58.28(3) Resident safety.** **e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)**	**I**	**$9500.00** **Held In Suspension**	**Upon Receipt**
58.28(3)f.	**481- 58.28(3) Resident safety.** ***f.* Residents shall be protected against physical or environmental hazards to themselves. (I, II, III)** **[ARC 1398C, IAB 4/2/14, effective 5/7/14]** **DESCRIPTION:** Based on record review, observations, and staff interviews, the facility failed to ensure residents were not at risk for bed rail entrapment as identified for 5 of 35 residents. Specifically, the facility failed to ensure the space between the bed rail and mattress did not create a risk of entrapment for Resident #33; and failed to implement a system to ensure side rails gaps did not create the risk of entrapment for Residents #1, #25, #90, & Resident #190. Observations of side rail gaps showed the space large enough for head entrapment; and the space between the mattress and side rail was large enough for head entrapment to occur. In addition, the facility failed to ensure they monitored bed rails to prevent entrapment for residents and identified which residents used side rails; and failed to obtained resident consent forms for side rails until 1/8/18. Interview with the DON revealed she was unaware of			

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Facility Administrator Date

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	the allowable space/dimensions for side rails used by residents or the allowable space between the side rail and mattress to prevent entrapment; and unable to provide an updated list of residents that used side rails. Interviews with the Administrator confirmed the facility failed to train staff on the correct dimension when using side rails; and acknowledged there was not a process followed or used by the facility to determine if bed rails were safe after applied to a resident's bed. The facility reported a census of 35 residents. Findings include: 1. Review of the Food and Drug Administration's (FDA) Hospital Bed Safety Workgroup article, "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", dated April 2003, indicated, in pertinent part,"...Use of bed rails should be based on patients' assessed medical needs and should be documented clearly and approved by the interdisciplinary team...Bed rail use for patient's mobility and/or transferring, for example, turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...Inspect, evaluate, maintain, and upgrade equipment(beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment of patient needs, considering all relevant risk factors...If it is determined that bed rails are required...The mattress			

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	to bed rail interface should prevent an individual from falling between the mattress and bed. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items...should be ongoing..." According to the FDA's Guidance for Industry and FDA Staff article, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued 3/10/06, "For 20 years, FDA has received reports in which vulnerable patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities. The term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. FDA received approximately 691 entrapment reports over a period of 21 years from January 1, 1985 to January 1, 2006. In these reports, 413 people died, 120 were injured, and 158 were near-miss events with no serious injury as a result of intervention. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or footboards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Entrapments have occurred in a variety of patient care settings..."			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	A. The FDA recommended dimensional limit for zones 1 through 4, and suggested if any alternative approach be least as stringent as the ones describe below: a. Zone 1 - within the rail. Zone 1 is any open space within the perimeter of the rail. Opening in the rail should be small enough to prevent the head from entering. The recommend space is less than 4 and ¾ inches, representing head breadth. b. Zone 3- between the rail and the mattress. Zone 3 is the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment when taking into account the mattress compressibility, and shift of the mattress or rail, and the degree of play from loosened rails. The FDA recommended a dimensional limit of less than 4 and ¾ inches for the area between the inside surface of that rail. The facility provided an email dated as received on January 30, 2017 from the Director of Clinical Services Accura Healthcare which directed the facility to implement a new screen on all residents to check all beds rails for proper use. The email directed specifically that there cannot be any opening wider than 4 and ¾". A document titled Side Rail Rationale directed, if side rails are indicated, asses measurement of rails to ensure gaps are no greater than 4 ¾ inches. The Facility failed to provide a facility policy or procedure that addressed side rail use when requested by surveyor.			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	1.) The Minimum Data Set (MDS) assessment tool dated 12/02/2017 for Resident #33 identified his diagnoses as stroke (cerebellar stroke syndrome), non-Alzheimer's dementia, hypertension, and anxiety disorder. The assessment revealed Resident #33 required one staff assistance for personal hygiene, bathing, and eating. The MDS revealed Resident #33 required assistance of 2 staff for bed mobility, transfers, dressing, and for toilet use. The MDS showed the resident's BIMS (Brief Interview for Mental Status) cognitive test was not completed because the resident was severely cognitively impaired. The MDS identified the resident had 2 or more falls without injury since the previous assessment. A care plan dated as revised on 12/8/17, did not indicate bed rails were used. The care plan identified the resident had falls on 11/14/17, 11/28/17, 12/5/17, 12/10/17, and 12/14/17. The care plan revealed the resident had poor safety awareness due to advanced dementia and psychotropic medications. Resident #33 would be re-evaluated for hospice services. A facility fall investigation showed Resident #33 had 2 falls on 11/28/17 when found on the floor next to the bed between the wall and bed. The 2 falls were back to back falls on the 2-10 shift. According to the "Side Rail Rationale Screen" dated 9/9/17, Resident #33 had an assessment which revealed the following information:			

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Rule or Code Section	**Nature of Violation**	**Class**	**Fine Amount**	**Correction date**
	a. the resident was non-ambulatory. b. the resident had an alteration in safety awareness related to cognitive decline. c. had a history of falls. d. had difficulty with balance or poor trunk control. e. took medications which required extra safety precautions. The resident demonstrated poor bed mobility, difficulty moving to a sitting position on the side of the bed, and the resident would benefit from using side rail for positioning or support. The conclusion revealed side rails would provide for safety. The assessment revealed, if side rails are used, assess measurement of the rails to ensure gaps are no greater than 4 & ¾ inches. An observation on 1/4/18 at 8:00 a.m., revealed the resident lying on his/her right side in bed resting. One side of the bed was against the wall and one side of the bed had top ½ side rail up. An observation on 1/4/18 at 8:30 a.m., revealed the space between the mattress and ½ bed rail measured 6 inches by the maintenance supervisor with the mattress pushed against the wall. [This area is the space between the inside surface of the rail and the mattress.]The maintenance supervisor confirmed this measurement. The resident was not in the bed at this time. [The space should be small enough to prevent head entrapment.] An observation on 1/4/18 at 1:20 p.m., revealed			

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	Resident #33 in bed lying on his/her right side. The space between the [inside surface] of the mattress and side rail remained. An observation on 1/4/18 at 4:45 p.m. revealed the bed had been replaced with a different bed from the hospice agency. 2. The MDS assessment tool dated 12/11/2017 listed diagnoses for Resident #1 included anemia, heart failure, (orthostatic) hypertension, cerebrovascular accident (stroke), and history of falls. The MDS indicated the resident received anticoagulant medication, diuretic medication, and opioid medication. The MDS revealed the resident required one staff assistance for bed mobility, dressing, toilet use, and personal hygiene; and two staff assistance for transfers. The MDS listed the resident's BIMS as 14 out of 15, indicating intact cognition. The MDS identified the resident had no falls since the previous assessment. A care plan initiated on 3/15/17 and revised on 1/2/2018, did not indicate bed rails were used. According to the "Side Rail Rationale Screen" dated 12/27/17, Resident #1 had an assessment which revealed the following information: a. the resident was non-ambulatory. b. had difficulty with balance or poor trunk control. c. took medications which required extra safety precautions.			

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	The resident demonstrated poor bed mobility, difficulty moving to a sitting position on the side of the bed, and the resident expressed a desire to have a side rail. The conclusion revealed the resident would benefit from using the side rail for positioning or support. The assessment revealed, if side rails are used, assess measurement of the rails to ensure gaps are no greater than 4 & ¾ inches. Observation on 1/4/2017 10:30 a.m., revealed the Maintenance Supervisor measured a gap within the bed rail that measured 7.5 inches. The bed rail was observed to have a two mesh panels attached to the outer side of the rail. A triangle shaped gap in the mesh was observed where the two mesh panels met in the middle of the bed rail opening. The Maintenance Supervisor confirmed the measurement. Observation on 1/4/2017 at 1:00 p.m., the Director of Nursing, (DON) was able to pass an object of 4 ¾ inches circumference through the gap within the bed rail. The object was provided and measured by the facility. [The opening in the rail should be small enough to prevent a head from entering.] 3. The MDS assessment tool dated 1/11/2017 listed diagnoses for Resident #25 included arthritis, anxiety, and muscle weakness. The MDS revealed the resident required set up for eating and supervision for bathing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) as 15 out of 15, indicating intact cognition. The MDS stated the resident had no falls			

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	since the previous assessment. A care plan initiated on 2/14/2017 and revised on 12/28/2017 did not indicate bed rails were used. Resident # 25 care plan revealed she required services to address mental health and had diagnosis of major depressive disorder, alcohol dependence and adjustment disorder. According to the "Side Rail Rationale Screen" dated 11/24/17, Resident #25 had an assessment which revealed the following information: a. took medications which required extra safety precautions. The resident demonstrated poor bed mobility and the conclusion was the resident would benefit from using side rail for positioning or support however, the resident expressed a desire to not use side rails. The assessment revealed if side rails are used, assess measurement of the rails to ensure gaps are no greater than 4 & ¾ inches. Observation on 1/4/2017 10:30 a.m. revealed the Maintenance Supervisor measured the gap within the bed rail for Resident #25, which measured 8 inches. The Maintenance Supervisor confirmed the measurement. Observation on 1/4/2017 1:00 pm revealed the DON was able to pass an object that measured 4 ¾ inches circumference through the gap within the bed rail. The object was provided and measured by the facility.			

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	4. The MDS assessment tool dated 12/14/2017 listed diagnoses for Resident #90 included peripheral vascular disease, diabetes mellitus, and spastic hemiplegia. The MDS indicates the resident received anticoagulant medications and diuretic. The MDS revealed the resident required extensive assist of 2 staff for bed mobility, transfers and toilet use and dressing. The MDS listed the resident's BIMS (Brief Interview for Mental Status) as 15 out of 15, indicating intact cognition. The resident had a fall with fracture on 12/14/2017. A care plan dated as last revised on 12/27/2018, indicated side rails were not used. The care plan initiated on 7/14/17 and revised on 12/27/17 revealed the resident required extensive assistance from two staff with bed mobility. Resident #90's "Side Rail Rationale Screen" dated 12/20/17, revealed the resident: a. took medication that would require increased safety precautions. b. had poor bed mobility. c. expressed a desire to have side rails while in bed. d. had a history of falls. e. the resident was non-ambulatory. The resident demonstrated poor bed mobility, difficulty moving to a sitting position on the side of the bed, thus the resident would benefit from using side rail for positioning or support. The conclusion revealed side rails would provide for safety and to promote			

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	independence with bed mobility. The assessment revealed, if side rails are used, assess measurement of the rails to ensure gaps are no greater than 4 & ¾ inches. Observation on 1/4/2017 10:30 a.m., revealed the Maintenance Supervisor measured the gap within bed rail which measured 7.5 inches. The Maintenance Supervisor confirmed the measurement. Observation on 1/4/2017 1:00 pm the DON was able to pass object of 4 ¾ inches circumference through the gap within the bed rail. The object was provided and measured by the facility. [The opening in the rail should be small enough to prevent a head from entering.] 5. The MDS (Minimum Data Set) assessment tool had not been completed as resident 190 was admitted 1/3/2018. According to the Physician Order Sheet and Plan of Care form, Resident #190's listed diagnoses for Parkinson's, exacerbation altered mental status, pseudomonas urinary tract infection. A care plan dated 1/4/2018 identified ½ side rails are used for safety and independence. The resident's "Side Rail Rationale Screen", dated 1/3/17, revealed the resident: a. took medication that would require increased safety			

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	precautions. b. would benefit from using the side rail for positioning or support. c. expressed a desire to have side rails while in bed. d. had a history of falls. e. had an alteration in safety awareness due to cognitive decline. f. had poor bed mobility. Observation on 1/4/2017 10:30 a.m. the Maintenance Supervisor measured a gap within the bed rail which measured 9 inches. The Maintenance Supervisor confirmed the measurement. Observation on 1/4/2017 1:00 p.m. the DON was able to pass an object of 4 ¾ inches circumference through the gap within the bed rail. The object was provided and measured by the facility. [The opening in the rail should be small enough to prevent a head from entering.] B. The CNA Pocket care plan listed current residents' names and included information specific to each residents care needs. Residents # 1, #25, and #90 were not listed for side rails. C. Record review for Residents #33, #1, #25, #90 and #190 showed no side rail consent forms. Interviews: During an interview on 1/4/17 at 8:30 Am., the DON			

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	stated The Maintenance Supervisor is responsible for checking and maintaining side rail compliance. The maintenance Supervisor stated is unaware of any formal checklist for this task. The Maintenance Supervisor further stated he checks the beds and rails the first and third weeks of the month to make sure they are tight. The Maintenance Supervisor confirmed he does not document this check. He stated the nursing department is going to provide him with a list of beds to check. During an interview, conducted with the Director of Nursing (DON) on 1/4/18 at 10:20 a.m., the DON stated she was aware of the regulation to monitor that bed rails meet the guidelines established for zones [1-4 dimensional limits] to prevent entrapment. The DON first reported side rails monitoring occurred during rounds; yet when asked to explain how the monitoring occurred, she responded the pocket care plans listed the type of side rail and monitoring occurred during rounds. The DON then updated her previous statement and said she did not know the side rail dimensions to prevent entrapment or how much gap (space) was allowed between a side rail and mattress. The DON was unable to provide an updated list of residents that used side rails. The DON stated the facility used older beds that failed to meet the bed rail requirements. The DON stated Corporate had directed bed rails be inspected and that a mesh bag be placed over any side rails that failed to meet the requirements. The DON was unable to identify a process for monitoring beds in the facility.			

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	She stated the nurse assesses the need for them (side rails) and then Maintenance placed them on. The DON indicated the "Side Rail Rationale Screen" was used to determine if a bed rail would be useful for a resident. In an interview on 1/4/18 at 2:15 pm with the Administrator and the Corporate Nurse Consultant, the corporate nurse provided an email from the Director of Clinical Services received by the facility which directed side rails should not have an opening or gap greater than 4 and ¾ inches. The Corporate nurse further stated, Side Rail Rationale Screen implemented on Saturday January 30, 2017. They reported confirmed the facility failed to train staff to correctly measure opening to assure side rail in compliance. The Administrator shared documentation of an in-service completed today [1/4/18] that directed staff to report holes or deviations in protective mesh immediately and fill out a work order. The Administrator confirmed there was not a process followed by the facility to determine if bed rails were safe after they were applied to a bed. In an interview on 1/8/18 at 12:40 pm, the MDS/Care planning nurse stated consents for side rails are obtained upon admission and updated with changes to type of side rail, addition or deletion of side rails. The MDS nurse then provided consents for Residents #1, #25, #33, #90, and Resident #190 dated as signed today (1/8/18). The MDS/Care planning nurse confirmed consents were obtained after requested by surveyor. Stated may have been signed upon admission, but was unable to locate these. She			

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	confirmed Resident #190 had been admitted on 1/3/18 and a consent form was not obtained upon admission or when side rails had been placed. In an interview on 1/8/18 at 11:45, the DON stated upon admission, signed consent form for side rails were expected; and when there was a change in side rails screening. She confirmed she could not locate consent from admission for Residents #33, #1, #25, #90 and #190; and obtained signed consent forms today (1/8/18). Further confirmed consent should have been signed for Resident #190 upon admission (1/3/18). The DON further stated the facility does not obtain physician's orders for side rails. **FACILITY RESPONSE:**			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.19(1)i	**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(1) *Activities of daily living.*** ***i.* Mobility (assistance with wheelchair, mechanical lift, or other means of locomotion); (I, II, III)** **DESCRIPTION:** Based on observation, record review, and staff interview, the facility failed to ensure staff provided safe transfers with a mechanical lift for 1 of 14 active residents reviewed (Resident #90). The facility reported a census of 35 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 9/1/17, listed Resident #90's diagnoses included diabetes and history of a stroke with hemiplegia (paralysis)or hemiparesis (weakness on 1 side of the body). The MDS revealed the resident required extensive assist of 2 staff for bed mobility, transfers and toilet use and dressing. Resident #90 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The care plan initiated on 7/14/17 revealed the resident required extensive assistance from two staff	**I**	**$5750.00** **Held In Suspension**	**Upon Receipt**

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Facility Address/City/State/Zip **625 East Oak Street** **Ogden, IA 50212**			
	HL		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	for Hoyer lift transfers to and from bed, wheelchair, bed, and from commode to bed. A Fall Scene Investigation Report dated 12/14/17 at 8:38 p.m., documented the left leg part of the Hoyer (mechanical lift) sling came off the Hoyer during a transfer assisted by staff from the commode. A re-enactment of the fall documented after using the commode, staff placed Resident #90 on a Hoyer shower sling. Staff A Registered Nurse (RN) secured the 2 straps by Resident #90's head with the middle and longest straps both secured inside the metal bars. Staff B Certified Nursing Assistant (CNA) secured the bottom leg straps on the longest strap around the metal bars. They lifted the resident with Staff A at his/her head and Staff B controlling the switch. The left leg strap became unfastened. Staff A saw this and tried to get in between the resident and the floor. She could not get under the resident or between the resident and the night stand due to the [transfer] pole in the resident's room. Resident #90 went down on his/her left side. The root cause of the fall included the commode needed to face the window in the resident's room, not the nightstand, so she didn't have to turn 180 degrees in the lift to get to the head of the bed. Due to the [transfer] pole in the room, it could not be done. In a written statement Staff B wrote on 12/14/17 she and Staff A had Resident #90 on the commode. They stood her to wipe her and put the Hoyer sling beneath her, and laid a soaker pad between her butt and thighs			

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	and the sling because the resident stated the sling cut into her. They hooked the bottom to the purple loops and top to green. They lifted her as normal, turned her slinged body to face the right way, and as they moved to lay her on the bed, somehow one of the bottom loops slipped off. Staff B wrote the resident landed on her left side and was yelling that her hip hurt and she needed up. Staff B sat with Resident #90 until the paramedics took her out [to the emergency room]. In a Fall Investigation Witness Statement dated 12/14/17 Staff A documented she had a theory as to what may have caused the incident. She documented the space was too cluttered to adequately transfer the resident in the safest possible way. The way they had the room arranged, Resident #90 had to make a 180 degree turn to get off the commode and into bed. A History and Physical dated 12/15/17 documented Resident #90 had a history of stroke with left side hemiparesis, poorly controlled diabetes with left sided foot ulcer, hypertension, coronary artery disease, and peripheral vascular disease. The resident suffered a displaced left femoral neck fracture after a Hoyer (mechanical lift) related incident on 12/14/17. Resident #90 cleared for left hip hemiarthroplasty (surgical repair). A Quality Assurance Monitoring Tool dated 12/14/17 documented Resident #90 fell from the Hoyer to the floor in his/her room during a transfer from the commode to the bed. Environmental reasons for the			

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	fall included clutter in the room, too many objects. The report documented they needed to remove the [transfer] pole from the room. The new interventions included rearrangement of the room and removal of the pole. During an observation on 1/2/18 at 11:40 a.m. Staff C Certified Medication Aide (CMA) and Staff D Certified Nursing Assistant (CNA) transferred Resident # 90 to bed with the Hoyer lift with hip abductor pillow in place (between legs). Staff used green loops of full body sling on all 4 hooks. Resident #90 transferred to the bed. During an interview on 1/3/17 at 2:45 p.m. Staff A Registered Nurse (RN) stated the incident where Resident #90 fell out of the sling was the 2nd time she had assisted to transfer him/her with the lift, but she had assisted with other residents and her dad was a quadriplegic so she had used a lift since she was young. Resident #90 used a transfer pole during the day to transfer from the wheelchair to the commode. She grabbed onto it to assist with the transfer. It was bolted to the floor and stationary. She went to assist Staff B Certified Nursing Assistant (CNA) with the transfer off the commode. Resident #90 stood using the pole and Staff A washed her buttocks. They placed a blue mesh sling with a cutout for the commode under the resident and hooked the straps to the metal hooks. She applied the straps at the residents head and Staff B at the lower body. Staff B was at the resident's feet and ran the lift and raised the			

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	resident off the commode. Staff A removed the commode from under the resident. Staff B started turning the lift and Staff A guided Resident #90's body. They had to turn the resident 180 degrees to get her head toward the head of the bed due to the pole in front of the nightstand and having to get around everything. When they turned Resident #90 she seemed to tilt lower to the left and the strap came off the left lower hook. She had never seen this happen before and felt the arrangement of the room was a factor. During an interview on 1/4/17 at 3 pm Staff B CNA stated Resident # 90 used the pole to transfer to the commode. She used the lift to transfer to bed. They used a blue mesh sling with a hole cutout. She didn't know what size. She said she had used all different lifts with the resident, whatever was available. They also used a soaker pad between the resident and the sling. She said the resident had never previously complained of slipping with the pad in place. Staff B put the straps on the lower end and Staff A by the head. She said it was just habit to double check the straps. She ran the lift at the resident's feet and Staff A at her head. They turned her around and something happened. The strap came off and the resident fell. She said they had done it the same way many times. During an interview on 1/3/17 at 3:15 pm the Director of Nursing (DON) stated she did not contact the company after the incident. They took the lift sling out of circulation after they did a reenactment with the			

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	nurse consultant. Observation of the sling showed the loops were intact. The tags were worn and unreadable. During a call on 1/4/17 at 8:47 a.m. a customer service representative at Invacare regarding the incident with the lift, stated they had not had reports of this type of incident when the lift was used properly and functioned properly. She said if the loop of the sling was properly in the lift hook it should not come out. She said if you watch the videos on you tube they use only the lift sling, nothing between the resident and the sling. During an interview on 1/4/18 at 10:03 a.m. the DON stated they used the incontinent pad between the resident and the sling per the resident's request. She said she questioned it's use also, at the time. She did not know if they counseled the resident on the safety of it's use prior to. She said the sling with the hole in it caused discomfort and that is why they used the pad between. She did not know why they used the sling with the hole since Resident #90 had finished on the commode and was cleaned up prior to placing the sling. The Manual/Electric Portable Patient Lift page 9 directed a warning when using the sling do not use any kind of plastic back incontinence pad or seating cushion between the patient and sling material that may cause the patient to slide out of the sling during transfer. Page 10 of the manual documented a warning when transferring a patient and directed staff			

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	to: when elevated a few inches off the surface of the stationary object (wheelchair/commode/bed) and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the hanger bar. If any attachments are not properly in place, lower the patient back onto the stationary object and correct this problem. **FACILITY RESPONSE:**			

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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 assure a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, to promote healing for 1 of 14 active residents (Resident #90). The facility reported a census of 35 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 9/1/17, Resident #90 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #90 required extensive assistance with bed mobility, transfer, and toilet use. Resident #90's diagnoses included diabetes and history of a stroke with hemiplegia (paralysis) or hemiparesis (weakness on 1 side of the body.	**II**	**$500.00** **Held In Suspension**	**Upon Receipt**

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	Resident #90 did not have a pressure ulcer but at risk for developing. Resident #90 had a pressure reduction mattress and chair cushion. Resident #90 did not have a turning or repositioning program. According to the MDS assessment, dated 12/25/17, Resident #90 scored 13 on the BIMS indicating no cognitive impairment. Resident #90 required extensive assistance with bed mobility, and personal hygiene. Resident #90 depended on staff for transfer and toilet use. The MDS indicated #90 had a stage 2 pressure ulcer with the most severe tissue type, slough (yellow or white tissue that adhered to the ulcer bed in strings or thick clumps, or mucinous). Resident #90 had a pressure reduction mattress and chair cushion. Resident #90 did not have a turning or repositioning program. The MDS defines a stage 2 pressure ulcer as a partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough. The MDS defined a stage 3 pressure ulcer as full thickness tissue loss. Subcutaneous tissue may be visible but bone, tendon, tendon or muscle not exposed. Slough may be present but did not obscure the depth of tissue loss. The MDS defines an unstageable pressure ulcer as a known pressure ulcer but not stagable due to coverage of the wound by slough and/or eschar (necrotic tissue).			

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	The Nurse's Notes dated 12/21/2017 at 3:54 p.m. documented assessment of skin from admit included a coccyx Stage II pressure area that measured 3.5 x 4.4 x 0 cm and an area within the dark purple that measured 0.1 x 0.1 x 0.1 cm with a small amount of serous drainage noted. A Weekly Pressure Ulcer Progress Report dated 12/21/17 documented the pressure ulcer to Resident #90's coccyx present on admission from the hospital after a hip fracture. The report documented notification of the physician and the family. Preventative measures included an air mattress and Roho cushion in the wheelchair. The report documented turned every 2 hours if able, but was crossed through and initialed. The report lacked documentation of dietary notification. The Nurse's Notes dated 12/26/2017 at 11:55 a.m. documented the coccyx measured 3 x 5 x 0.1 cm, and superficial. One small area had adhered slough where the wound bed was not visible. Dead skin had sloughed off and granulated tissue more visible. The ulcer had a moderate amount of serous drainage, with no odor noted. Resident #90 had pain on palpation and when sitting up in the chair. The Nurse's Notes dated 12/28/2017 at 12:37 p.m. documented Resident #90 denied complaints of pain to the left hip, but rated her pain at a 9 out of 10 to her coccyx. New air mattress implemented for pain management and comfort related to/ Stage II pressure ulcer to the			

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	coccyx. The Nurse's Notes dated 12/29/2017 at 12:14 p.m. documented Resident #90 demonstrated severe pain during the shift. Resident #90 could not get comfortable in the wheelchair due to pain in the buttocks and hip. Resident #90 utilized as needed pain meds twice during the shift. Resident #90 voiced pain at a 12/10 while sitting in the wheelchair, stating the pain stabbing from the coccyx. Resident #90 voiced the pain a 9 out of 10 after pain medication and lying in bed. The Nurse's Notes dated 12/29/2017 at 6:30 p.m. documented Resident #90 had complaints of severe pain to the coccyx. Attempts to reposition unsuccessful and pain medication did not seem to help with the pain. Resident #90 reported pain at a 10 on a scale of 1-10 (10 the worst pain). An Emergency Room report dated 12/29/17 at 8:15 p.m. documented Resident #90 seen for the inability to tolerate pain of the coccyx/right buttocks ulcer. The ED Physician Documentation dated 12/29/17 at 8:23 p.m. documented Resident #90 developed a sacral ulcer and had pain not controlled with oxycodone. Resident #90 had pain at a 10 on a 1-10 scale. Resident #90 received Fentanyl 100 mcg (microgram) intramuscularly. A facsimile dated 1/1/18 documented Resident #90 incontinent causing the dressing to the coccyx to			

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	become soiled and wet. The fax requested the previous treatment orders discontinued and new orders for zinc based barrier cream 2 times a day and with incontinent episodes until resolved. The physician responded, " yes". The fax lacked any notification of the pressure ulcers characteristics. The Nurse's notes dated 1/2/2018 at 2:23 p.m. documented Resident #90 with a Stage 2 pressure ulcer of the Coccyx measuring 1.3 x 1.8 x 0.1 cm. The area had a small to moderate amount of purulent drainage, and 100% covered with adherent slough. The area was painful on palpation. Resident #90 had pain at a 7 out of 10. A Nutrition Data Tool dated 1/2/18 (nearly 2 weeks after the resident returned from the hospital with a pressure ulcer) documented Resident #90 readmitted 12/20/17 status post left hip fracture and repair. Regular diet, small portions related to diabetes diagnosis. Resident #90 disliked most meals served at the facility and ordered out often. Resident #90 readmitted with stage 1 medical device associated pressure area to the left hip due to abductor wedge strap. Also readmitted with stage 2 pressure to the coccyx. The Registered Dietician encouraged high protein foods- likes cottage cheese, choc milk, eggs. Resident refused prostat, but stated willingness to try house supplement. Recommend Multivitamin with minerals and 90 ml house supplement 2 times a day to promote wound healing.			

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	The Nurse's Notes dated 1/9/2018 at 8:22 a.m. documented Resident #90's coccyx ulcer measured 0.9 x 1 x 0.2 cm with a moderate amount of serous drainage. The wound edges were macerated with induration. Complications and changes included maceration and slough. Staff contacted the wound care specialist and she would come and make recommendations for a change of treatment. Pain is still present, but resident is tolerating sitting up for longer periods of time and having less pain on palpation. The MDS Care Planning coordinator signed the Resident's Care plan on 1/2/18, revised on 12/27/17 and failed to address the resident's pressure ulcer, treatment, reposition needs, nutritional needs after the resident returned from the hospital with the pressure ulcer. During an observation on 1/2/18 at 11:40 a.m. Staff C Certified Medication Aide (CMA) and Staff D Certified Nursing Assistant (CNA) transferred Resident # 90 to bed with the Hoyer lift with hip abductor pillow in place. Staff used green loops of full body sling on all 4 hooks. Resident #90 transferred to the bed laying on the bedspread and square incontinence bed pad over the Medline normal pressure air mattress. The tab on the mattress pump set on static. Staff rolled resident to remove pants. Due to cream product the ulcer to the coccyx could not be well visualized, but obvious skin impairment present. Staff removed Resident # 90's disposable incontinence pad by pulling it out from under her. Resident # 90 stated she got the pressure			

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	ulcer because they didn't rotate her every 2 hours in the hospital. During an observation on 1/4/18 8:15 a.m. Resident # 90's air mattress pump set on static (not alternating air). During interview on 1/9/18 at 7:22 a.m. the DON stated Resident #90 did not have an air mattress on the bed until applied 12/28/17. She said before that she had the standard pressure reduction mattress on the bed. She didn't know why they crossed through repositioning every 2 hours on the skin sheet or if they did reposition routinely. She didn't know if the air mattress should be set on static or alternating. The MDS Coordinator concurred the resident had not previously had the air mattress. The MDS Coordinator did not know why the pressure ulcer was not addressed on the care plan. The DON stated the dietician came every other week, but they could call her if needed between. She said they had a fax out regarding the dietician's recommendations, but had not received a reply (3 weeks after initial identification of the ulcer and 1 week after the recommendation). The Nurse's Notes lacked documentation of a fax to the physician. During an interview on 01/09/18 8:30 Staff F Licensed Practical Nurse (LPN), skin nurse stated the resident came from the hospital with a static air mattress, which the resident thought was too hard. She said she crossed out the every 2 hour repositioning because			

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	she had an air mattress, and the DON told her to. She didn't know if the DON thought she could not be repositioned because of the abductor pillow, but Staff F repositioned her. She said the current air mattress should be set on alternating. She didn't know why it was set on static (which would be the same as the air mattress they took off). She said she would need to do education with staff to assure they are checking this routinely. She said there should only be 1 layer between the resident and the air mattress to avoid decreasing effectiveness of the mattress. She said she offered repositioning every 2 hours but she couldn't speak for everyone. According to the Operating Manual (Alternating Pressure Therapy Pump Overlay/Replacement Mattress system), page 8, explained the difference between the Alternate Pressure mode and Static Pressure mode. The manual documented the following: with Alternate Pressure mode, alternation air cells are partially deflated and inflated, avoiding prolonged pressure on any single point beneath the patient; this is to prevent pressure ulcers. The manual documented with Static Pressure mode, all the air cells are equally inflated. **FACILITY RESPONSE:**			

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