Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **6871**			**Date:** **October 19, 2018**
Facility Name: **Parkview Sac City**		**Survey Dates:** **October 1-4, 2018**	
Facility Address/City/State/Zip **601 Park Avenue**			
	MW		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.19(2)b	**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 adequate pressure reduction interventions and complete a dietary assessment related to the new onset of pressure ulcers for 1 of 4 residents reviewed (Resident #12). The facility reported a census of 46 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 7/19/18, Resident #12 demonstrated long and short term memory problems and moderately impaired skills for daily decision making. The resident required extensive assistance with bed mobility, transfer, dressing, and personal hygiene. The resident's diagnoses included non-Alzheimer's dementia. The resident	**I**	**$4500 (held in suspension)**	**UPON RECEIPT**

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	had no pressure ulcers but had the risk for developing pressure ulcers. The MDS described pressure sores as the following: 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. 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. 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. 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. Unstageable: known but not stageable due to coverage of wound bed by slough and/or eschar. The Progress Notes dated 8/23/18 at 10:36 a.m. documented the resident transferred to the hospital. At 2:45 p.m. the facility inquired about			

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	the resident and found he admitted for observation. A Plan of Care from the resident's hospital stay dated 8/23/18 at 3:44 p.m. documented the resident's heels were scaly and purple in color. The resident repositioned every 2 hours and heels elevated/floated on a pillow. A Progress Note dated 8/25/18 and faxed 8/25/18 notified the physician the resident returned from the hospital with a blister like stage 2 area of the left heel measuring 3.5 by 3 cm. The resident had an open area of the scrotum and the coccyx with 1 by 1 and 1 by 0.5 cm purple areas that were suspected deep tissue injury. They would encourage the resident to float heel when in bed. A Braden Scale For Predicting Pressure Ulcer Risk dated 8/25/18 scored the resident at 13 indicating moderate risk. The assessment included the resident had very limited mobility, making occasional slight changes in body or extremity position but unable to make frequent or significant changes independently, and had a problem with friction and shear. The undated Care Plan with a goal target date of 8/31/18 identified the resident with the potential for pressure ulcer with interventions including to			

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	attempt to float heels with a pillow when in bed as allowed, cushion in wheelchair, and pressure relieving mattress on the bed. The care plan included the intervention for supplement for weight maintenance and skin healing (interventions in place prior to the new pressure ulcer development). During an interview on 10/2/18 at 2:03 p.m. Staff B Registered Nurse (RN) stated the resident had a standard pressure reduction mattress on return from the hospital. The Care Plan lacked any new interventions for pressure reduction related to the new pressure ulcers, or interventions for protecting the heels when not in bed. The clinical record lacked documentation of whether they were able to float the resident's heels, or of a turning or repositioning program. A Progress Note dated 9/12/17, communication with the physician at 2:42 p.m. documented the resident's left heel, stage 2 pressure area had opened up, and a large skin flap came off. There was a new area on the resident's right heel, a stage 1, skin intact over the site, non blanchable area 2 by 1.8 cm and a new area over the outer aspect of the right foot, measuring 2 by 1 cm, dark purple, also a stage 1.			

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	A Weekly Pressure Ulcer Progress Report dated 9/12/18 documented the right heel measured 2 by 1.8 cm, dark purple, stage 1. The report defined suspected deep tissue injury: purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and or shear. The Progress Note dated 9/12/17 included in a facsimile (fax) on 9/17/18 notified the physician of the 9/12/18 documentation and questioned if he would like to continue the treatment, and the right foot was open to air. The note documented blue boots would be utilized at all times to decrease pressure with a foot cradle on the bed. An Edit Intervention document showed the blue boots on at all times, initiated 9/12/18 (the date the pressure ulcer of the right heel discovered). A Nursing Home visit dated 9/25/18 documented the resident seen for follow up of ulcers of both heels. Both heels had necrotic (dead) tissue, with the plan to have a wound care consult for the heel ulcers. A Progress Note dated 9/28/18 at 2:22 p.m. documented the resident out of the facility to the wound clinic at 11:40 and returned at 1:10 p.m.			

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	The resident returned with orders for a pressure relief mattress to bed, heel lift boots at all times, and keep pressure off areas at all times. The physician also wrote treatment orders and new orders for Zinc, vitamin C and Arginaid daily (supplements for wound healing). A Wound Clinic History and Physical dated 9/28/18 documented the resident's principle problem a stage 3 pressure area of the right heel, with active problems of unstageable pressure ulcers of the right and left heels. During the visit the ulcers were debrided to excise the eschar (necrotic tissue) and exudate from the ulcer surface. Complete removal of the material required extension into and including removing underlying subcutaneous tissue. The depth increased over 0.2 cm with the debridement. The physician recommended continuing the blue boots to help avoid pressure on the area, and also recommended zinc, vitamin C and Arginaid daily to promote healing. The facility clinical record lacked a dietary assessment to determine the resident's nutritional needs related to the development of the pressure ulcers.			

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	Discharge Instructions dated 9/28/18 included to keep pressure off areas at all times, and please provide the resident with an air mattress. During an interview on 10/2/18 at 2:03 p.m. Staff B Registered Nurse (RN) stated they were trying to float the resident's heels when he returned from the hospital (8/25/18) and then they got the heel boots 9/12/18 (when the new ulcer to the right heel identified). During an interview on 10/2/18 at 2:57 p.m. the Corporate Nurse stated the air mattress was initiated 9/28/18 after the physician recommendation. They didn't have specific documentation on the floating of the heels, except what was in the progress notes. She did not think he was on a specific repositioning program. During an observation on 10/3/18 at 8:10 a.m. Staff C Licensed Practical Nurse (LPN), and Staff D Certified Nursing Assistant (CNA) assisted with the dressing change to the resident's heels. The resident laid in bed slightly to the right with a pillow under his legs, and his knees bent. Staff removed the heel boots, and with them off, the resident's heels pressed on the mattress (with the pillow in place under the legs). The left heel ulcer had a black necrotic area surrounded by pink open skin. Staff C confirmed the necrotic tissue.			

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	Staff C completed the dressing change using clean technique. Staff C did the same treatment to the lateral right heel ulcer. The ulcer had black necrotic tissue at the upper ridge of the ulcer with the remaining tissue of the ulcer pink. During an interview on 10/3/18 at 8:55 a.m. Staff D stated working at the facility for about 2 years. She stated prior to the heel boots the resident usually had a pillow under his legs, but he also often had his knees bent the way they were this morning. She said if he was on his side his heels were off the mattress. During an interview on 10/3/18 at 1:44 p.m. Staff E CNA stated (prior to the blue boots) they would put a pillow under the resident's legs in bed, but he was stiff and bent his legs so his heels would be on the mattress. It was difficult to float them. During an interview on 10/3/18 at 12:22 p.m. the Director of Nursing (DON) stated the dietician had not assessed the resident in regards to the new pressure ulcers. She stated they usually had the dietician assess a resident with a pressure sore when noted. Review of a Pressure Ulcer Risk Assessment and Documentation policy and Procedure updated January 2011, identified the following: Residents			

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	will be assessed upon admission and re-admission for potential risk factors that may contribute to pressure ulcer development and interventions will be implemented to reduce that risk. The assigned nurse will complete the Admission and Readmission Pressure Ulcer Risk assessment tool on new admission and readmissions. Determine the factors/conditions that place the resident at risk for developing pressure ulcers. List any additional risk factors/conditions. Determine interventions in conjunction with each risk factor that has potential to reduce both the likelihood of pressure ulcer development and/or improve the clinical condition of the resident. Review the risk factors and interventions with the resident and /or responsible party. The following interventions may be incorporated as deemed pertinent to the resident's condition: Assist with repositioning immobile residents a minimum of approximately every two hours. Positioning devices such as pillows or foam wedges may be used to keep bony prominence from direct contact with each other. May use pillows under the calves of the residents who are immobile to relieve pressure on the heels or suspend heels off the foot of the bed. May use mechanical lifting devices, draw sheets or pads to move residents in bed who cannot			

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	assist during transfers and position changes to reduce friction/shearing. Assess nutrition and hydration needs quarterly/significant change to maintain skin integrity; encourage foods/fluids. May use pressure reduction mattress to bed and pressure reduction device to chair. Assess any new pressure ulcer as soon as discovered and document. Notify the dietary manager manager and she will be responsible to initiate dietary interventions. Update the care plan to reflect new interventions to aid in the healing process. **FACILITY RESPONSE:**			

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