

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

Citation Number: #9074				
Facility Name: Crestridge Care Center		Date: 3/16/21		
Facility Address/City/State/Zip 1015 Wesley Drive Maquoketa, IA 52060		Survey Dates: 2/24-3/3/21		
		SB		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

	<p>The Minimum Data Set (MDS) dated 12/16/2020 documented Resident #1 had the ability to sometimes make self understood and understand others, inattention, disorganized thinking and cognitive impairment. The resident required extensive assistance of two staff for bed mobility and to transfer from one surface to another. The MDS indicated the resident did not ambulate, had urinary and bowel incontinence, and diagnoses included: anemia, dementia and anxiety. The resident had a fall since the prior assessment without injury.</p> <p>The Care Plan initiated 8/4/20 revealed Resident #1 used a wheel chair for mobility, a history of falls and self transferring, incontinence, and hard of hearing. The care plan instructed staff to position the bed with one side against wall for safety. The bed contained upper half rails for positioning and for transfer assistance. Staff were to provide transfer assistance back to bed after meals and an antiroll wheel chair with brake extenders. The resident transferred using a mechanical sit to stand lift with staff assistance, a wheel chair for mobility and required incontinence cares.</p> <p>The Physician's Order dated 5/26/2016 included 2 half side rails to assist with bed mobility,</p>			
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	<p>positioning, aide in transferring and for boundary identification.</p> <p>Progress Notes included:</p> <p>The resident had Covid 19 and hospitalization from 11/25/2020 - 12/7/2020.</p> <p>1/6/2021 - at 8:44 p.m. Staff B, LPN (Licensed Practical Nurse) documented staff found the resident on the floor on his/her knees with forehead resting on the floor. Staff assessed the resident and found no injuries and assisted him/her to bed with three staff. Prior to the fall, the resident sat in the wheel chair by bedside table for supper.</p> <p>1/20/2021 - at 3:38 p.m. Staff found the resident sitting next to the bed on his/her bottom on the floor. Staff assisted the resident to bed approximately 15 minutes prior and last observed him in bed 10 minutes prior to sliding out of bed. Staff placed a fall mat next to the bed.</p> <p>2/16/2021 - at 5:27 p.m. Staff C, LPN documented the resident self propelled the wheel chair to the dining room and staff found him with knees and elbows on the ground in front of the wheel chair. Staff observed the resident's buttocks almost in the chair. The resident</p>				
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	<p>sustained an abrasion to the forehead that measured 4.5 centimeters (cm) X 3.5 cm. Staff assisted the resident back to the wheel chair using a Hoyer lift. The resident did not sustain other injuries and staff notified the physician.</p> <p>2/20/2021 - at 2:00 a.m., Staff B, LPN documented staff entered the resident's room and found him laying against the baseboard heater. Staff assisted the resident back to bed with two staff and noted a large burn to the right knee to ankle and left knee. The physician directed staff to transfer the resident to the Emergency Department (ED) for evaluation. At 2:20 a.m, the ambulance arrived and transported the resident to the hospital.</p> <p>2/22/2021 - University of Iowa Health Center informed the facility the resident required a feeding tube placed for nutritional support to aid in recovery.</p> <p>The Incident Report dated 2/20/2021 at 2:00 a.m. and prepared by Staff B, LPN included: Nursing description: Found resident on floor next to bed, right leg resting on heater and left knee pushed against corner of heater. Resident incontinent of bowel and bladder. Resident unable to give description.</p>			
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	<p>Injury Type: Burn left knee, front and right lower leg, front. Predisposing Environmental Factors: None Predisposing Physiological Factors: Confused and incontinent. Incident occurred in the resident's room with no witness to the event.</p> <p>Resident #1's 2/20/2021 Hospital ED Notes included: A complete history is unavailable secondary due to dementia. The last known normal was 2/19/2021 at 11:00 p.m. The patient, not able to provide any substantive history whatsoever, has significant dementia. Information came from Emergency Medical Services (EMS), and the nursing home. Somewhere between 11:00 P.M. and midnight, staff observed the patient, and patient doing fine. Thirty minutes prior to the ED arrival, staff discovered the patient fell off the bed and landed on a space heater. Total duration of time there is unknown. Assume the patient is in significant pain but cannot communicate well. Skin: Warm, dry, intact, patient has approximately 5% superficial partial burns on the medial (middle) aspect of the right leg. 20% of that is above the knee on the right with the rest below the knee on the medial tib-fib (tibia fibula bones in lower leg) area. There is already some blistering</p>				
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	<p>and desquamation (skin peeling) of skin. The area of involvement is on the medial aspect of the right leg. On the left leg, the medial aspect of the knee. There is approximately 0.75% deep partial burn through the epidermis (outer layer of the skin) and the dermis (layer underneath the epidermis) into the adipose (fat) tissue. The physician consulted the University of Iowa Hospital Burn Unit and Resident #1 transferred to the Burn Unit.</p> <p>The University of Iowa Health Care Progress Notes dated 2/23/2021 included: Admit Date: 2/20/2021 History of Present Illness: 80 year old who sustained a 5 - 10% body surface area contact burn on left lower extremity and right lower extremity on 2/20/2021, unknown time but after 11 P.M. on 2/19/2021 at the nursing home while he presumably slipped out of bed and landed with his bilateral lower extremities on a space heater. The resident is nonverbal and unable to tell us what happened. Extremities: Right lower extremity with about 2-3% total body surface area superficial to partial deep partial burns extending from medial distal thigh to shin anteriorly, mostly blanching. Left lower extremity, medial prepatellar (in front of the knee cap), with deep partial burn 1%.</p>			
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	<p>2/24/2021 - Burn excision/debridement (removal of damaged tissue) under general anesthesia with or without skin graft. A feeding tube was placed while patient under general anesthesia. 3/1/2021 - Burn excision/ debridement, wound vac (to assist with healing) placement and skin graft under general anesthesia.</p> <p>On 2/24/2021 at 9:00 a.m., Staff D, Administrator reported Resident #1 transferred from the facility to a local hospital and then to the University of Iowa hospital. The facility had difficulty reaching the resident's next of kin and had to contact police to assist. The resident had Covid-19 and lost strength but made progress working with therapy. At approximately 2:00 a.m. staff observed the resident on the floor on the left side of the bed near the window. The resident 's left knee landed on the base board heater and the right knee landed on top of it. The resident never yelled out for help. The bed contained "U' bars for side rails and an alternating air flow mattress. When the resident had an incontinent bowel and bladder episode, the chux (under pad) went with him out of the bed and the blanket remained on the bed.</p> <p>On 2/24/2021 at 9:55 a.m., Staff E, Maintenance checked the Resident's room temperature using an infra-red thermometer. The room temperature</p>			
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	<p>read 71.5 Fahrenheit and the baseboard heater temperature, cool to the touch, read 75.2 Fahrenheit.</p> <p>Staff D, Administrator, indicated thermostats were set at mid range, approximately 75 degrees Fahrenheit. Currently the bed sat approximately 16 inches from the wall. Staff D reported the facility moved beds away from the walls, which contained baseboard heaters, during winter months for safety. Staff D reported Resident #1 made no recent attempts to self transfer from the bed.</p> <p>At 1:30 p.m. on 2/24/21, Staff D, Administrator reported the facility followed up with staff working at the time of the incident to ensure they performed frequent rounds. Resident #1 resided on East Hall with a census of 16 residents. The night shift staffed one nurse in the facility from 10 p.m. until 6 a.m. and three CNA's (Certified Nurse's Aides), one on each unit. Staff D expected nursing staff to complete resident rounds every two hours and provide incontinence cares if needed. Staff D indicated she currently worked on a plan instructing staff to visually check each resident every thirty minutes.</p> <p>A report dated 2/20/21 completed by the Administrator, identified the "reasonable conclusion" regarding the incident as: Resident</p>			
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	<p>with alternating air mattress slid off the side of the bed without making enough noise to alert staff immediately. His inability to move, resulted in his legs resting against base board heater. Staff did appropriate tasks, completing rounds and assessing residents.</p> <p>On 2/24/2021 at 1:45 p.m., Staff A, DON (Director of Nursing) revealed she completed the initial investigation when Resident #1 fell from the bed. Staff working at the time of the incident reported they last observed the resident in bed around midnight. Staff found the resident on the floor at approximately 2 a.m. The resident was incontinent. The resident previously had Covid-19 and suffered from weakness since recovery. The facility pulled beds away from the walls for safety due to the baseboard heaters.</p> <p>On 3/1/2021 at 11 a.m., Staff A provided a copy of the education given to staff instructing them to provide residents with hourly checks and toileting or incontinence cares every 2 -3 hours. Staff A also provided a copy of staff education with instructions regarding how to help someone after a fall.</p> <p>On 2/24/2021 at approximately 2 p.m., Staff B, LPN reported working at the facility for four years on the night shift, from 6 p.m. until 6 a.m. After 9:30 p.m. the facility staffed one nurse for Unit</p>			
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	<p>One, Unit Two and the East Hall. The evening of the incident, Staff B checked every resident's room at approximately 10:15 p.m. and observed Resident #1 in a low bed, two half side rails in the up position and two blue boots on bilateral lower extremities. Staff left the television on in the resident's room so they could visualize him during the night. The resident had a habit of hanging his leg out over the side of the bed. The resident resided in the nearest room to the nurse's station without a roommate. At approximately 11 p.m. Staff B observed the resident in bed and Staff B went to assist a resident with bedtime cares. Staff B and Staff F, CNA started doing resident rounds on the opposite side of the hall and ended with Resident #1's room at approximately 2 a.m. Resident #1 slid off the bed, with lower extremities on the baseboard heater and incontinent bowel and bladder. One of the blue boots fell off and the other twisted sideways. Staff B observed the bed approximately 16 - 20 inches from the wall. Staff B unlocked the bed and moved it away from the resident. The room temperature felt comfortable and the heater felt hot to the touch. Staff B and Staff D used a stand up lift to get the resident off the floor and onto the bed. Observation showed the right leg contained blisters from the inside of the knee down to the ankle and the left knee contained an approximately three inch area that appeared</p>			
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	<p>indented where it pressed into the corner of the heater. The resident's blanket remained on the bed but the chux pad fell from the bed along with the resident. Staff B reported the resident had no prior similar incidents.</p> <p>On 2/24/2021 at 12:30 p.m., Staff F, CNA reported working for an agency and worked three shifts at the facility, with two of the shifts on East Hall. Between midnight and 1 a.m., Staff F answered a call light and observed Resident #1 in bed. At 1 a.m. Staff F and Staff B started resident rounds and provided incontinence cares per their usual routine. When they arrived at Resident #1's room at approximately 2:15 a.m., they observed the resident on the floor, in between the bed and wall, and laying on the heater. The resident had bowel and bladder incontinence. Staff F did not recall if the hand rail had been up or if the resident wore his blue boots. They assisted the resident to bed using the stand up lift. The resident did not use the call light and rarely spoke. After they transferred the resident to the bed, the resident said "right there" and pointed to his legs. Staff F let the resident know they called 911. The resident appeared in pain. The right knee contained an indentation as if it laid on a corner of the heater and the left knee from the inner shin to upper knee contained blisters and raw areas.</p>			
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	<p>Staff F's written statement provided to the facility after the incident, revealed Staff F observed all residents in bed at midnight and she and Staff B began rounds at 1:00 a.m.</p> <p>A 3/1/21 hospital procedure note identified the procedure performed as an OR (operating room) case: burn excision/debridement (major over 5% TBSA (total body surface area)) with split thickness skin graft to right lower leg and burn excision/debridement (minor less than 5% TBSA) without split thickness skin graft and wound vac placement. The burn wound physician performed the procedure under general anesthesia. The split thickness skin for grafting was harvested from the right thigh.</p> <p>On 2/24/2021 at 2:45 p.m., Staff E, Maintenance reported working at the facility for one year. Every room contained baseboard heat. Staff E started logging facility temperatures a couple of weeks prior when the outside temperatures were low. No resident ever complained and the inside temperature never dropped below 68 degrees Fahrenheit. Resident room thermostats are set at approximately 72 degrees Fahrenheit unless they request it be turned up. They moved all the beds away from the walls for safety. The facility had no baseboard heaters without covers. When Staff E learned of the incident involving Resident #1 he</p>			
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	<p>checked to be sure all beds were 18 inches away from the wall, and they were.</p> <p>The climatologist reported the temperature on 2/20/2021 at 1:00 a.m. at negative 9 degrees Fahrenheit.</p> <p>On 2/24/2021 with heat turned up, a probe thermometer read 127 degrees Fahrenheit when placed on a baseboard heater. The heater felt hot to the touch.</p> <p>A facility form provided from Staff A, DON revealed staff instructions for East Unit: Round times must be done every two hours, no exceptions, no skipping rounds. Round times: 11:30, 2:00 and 4:00 A.M.</p> <p>Staff education provided by Staff A on 03/01/2021 included:</p> <p>a. Please ensure that you are visually seeing each resident hourly and continue to complete toileting, repositioning and incontinence cares every 2 - 3 hours.</p> <p>b. Review of how to help someone up after falling: Only stand a resident with the assistance of two and a gait belt if the resident is able to transfer/ambulate independently or with a gait belt and one person. If there is a potential for injury or they cannot bear weight on at least one</p>			
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	<p>leg and usually require the use of a mechanical lift or two persons, a Hoyer lift must be used.</p> <p>FACILITY RESPONSE:</p>			
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