

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

<b>Number</b> 5863		<i>Fine amount reduced by 35% to \$5,525 on November 2, 2022 pursuant to Iowa Code Section 135C.43A</i>			<b>Report date</b> September 29, 2022
<b>Facility name</b> Ridgewood Specialty Care		<b>Survey dates</b> August 15, 2022- September 7, 2022			
<b>Facility address</b> 1977 Albia Road					
<b>City</b> Ottumwa		<b>CMD</b>			
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction Date</b>	
481-58.19(2)j	<p>Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition.</p> <p><b>DESCRIPTION:</b></p> <p>Based on facility record review, clinical record review, and staff and physician interviews, the facility failed to provide ongoing assessments after observing signs of poor circulation in a foot for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment tool dated 10/21/21 showed Resident #5 had diagnoses including stroke, hemiplegia, dementia, and diabetes. The resident required extensive assistance of staff for transferring, dressing, and hygiene. The Brief Interview for Mental Status (BIMS) scored "4" indicating severely impaired cognition.</p> <p>The Care Plan, dated 12/27/21, documented the resident had an alteration in musculoskeletal status related to right foot drop and needed a right AFO brace (a brace to support the resident's foot in a natural position) placed prior to all transfers.</p>	I	\$8,000	Upon Receipt	

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	<p>On 12/28/21, a Physical Therapy Treatment Encounter Note revealed Resident #5 cried out in pain when the PTA (Physical Therapist Assistant) scooted the resident's right foot back for proper foot placement. The PTA removed the resident's sock and shoe and observed her right foot to be purplish in color with the foot, ankle, and calf swelling (a potential sign of tissue injury, including blocked arteries). Therapy notified Staff F, Licensed Practical Nurse (LPN).</p> <p>On 12/28/21 at 3:59 p.m., A Progress Note by Staff F, LPN, documented Resident #5 had 2 toes with a blue hue and poor circulation (a potential sign that Resident #5 had blocked arteries in their leg). The note indicated that Staff F added the concern about Resident #5's toes to a list of concerns for the physician to review the next time the physician came to the facility to provide care to residents. Staff F also encouraged Resident #5 to move their right leg.</p> <p>On 12/31/21, a Physical Therapy Treatment Encounter Note recorded the PTA assessed Resident #5's feet and legs when Resident #5 grimaced while the PTA assisted Resident #5 with the placement and removal of the AFO brace and shoes. The nursing staff was aware that Resident #5 had 2 toes which were dark in color (a sign Resident #5 potentially had blocked arteries in their leg).</p>			

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	<p>Review of Resident #5's medical record, from 12/28/21 through 1/3/22, revealed the medical record lacked any nursing documentation regarding Resident #5's right foot, especially regarding the appearance or assessment of Resident #5's right foot.</p> <p>Review of the Physical Therapy Treatment Encounter Notes revealed therapy staff did not work with the resident on 1/1/22 or 1/2/22.</p> <p>On 1/3/22, a Physical Therapy Treatment Encounter Note documented Resident #5 complained of pain when therapy staff moved Resident #5's right foot and Resident #5 did not want to bear weight on their right foot. The PTA removed the resident's right sock and shoe and observed the plantar/dorsal (bottom/top) areas of Resident #5's right foot discolored a dark purple. The second and third toes appeared purplish/black (late signs of possible arterial blockage), and the underside of Resident #5's foot contained blisters.</p> <p>On 1/3/22 at 11:42 a.m., a Progress Note by Staff E, Registered Nurse (RN), described Resident #5's right foot as extremely blue, cold, and without palpable pedal pulses (emergent signs of arterial blockage, indicating the foot was not receiving blood flow). The facility staff transferred Resident #5 to the Emergency Department (ED) for further evaluation of Resident #5's right foot.</p>			

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	<p>On 1/3/22, the ED Physician Record noted Resident #5 had several black toes with ulcerations and redness noted to the right leg. A Computed Tomography Angiography (CTA-a CT scan with injection of dye), showed complete blockage of the right iliac, femoral, and popliteal arteries (the major arteries in Resident #5's right leg). The ED Physician's clinical impression included gangrene (death of body tissue due to a lack of blood flow). The ED staff transferred Resident #5 to a second hospital so that a vascular surgeon specialized in treating blocked arteries could evaluate Resident #5 and determine if they could save Resident #5's toes.</p> <p>The hospital Discharge Summaries, dated 1/7/22, listed the reason for admission as critical limb ischemia (blocked blood flow to Resident #5's right leg) and the principal diagnosis as thrombosis (blood clot) of arteries of lower extremity. The vascular surgeon's note indicated that the damage to Resident #5's right foot was likely irreversible. The vascular surgeon discussed the possibility of amputating parts of Resident #5's right foot, but Resident 5's family declined surgery and instead opted to place Resident #5 in hospice care.</p> <p>On 8/24/22 at 3:40 p.m., Staff D, LPN, stated when nursing monitored concerns, they triggered hot charting in the Progress Notes (additional focused charting kept separate so the nursing staff will document more frequently). Staff D did not recall receiving any information about Resident #5's</p>				

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	<p>discolored toes, either through nurse-to-nurse report or a staff member reporting a concern to Staff D. If the patients expressed pain to the therapy staff, the therapy staff would notify the nursing staff.</p> <p>On 8/24/22 at 3:42 p.m., Staff G, Certified Nurse Aide (CNA) could not recall any circulation concerns or discolored toes on Resident #5.</p> <p>On 8/24/22 at 3:53 p.m., Staff H, RN, did not recall hearing anything about Resident #5's discolored toes in nurse-to-nurse report prior to the nursing staff sending Resident #5 to the hospital.</p> <p>On 8/24/22 at 5:15 p.m., Staff I, CNA, reported seeing a purple area on the top of Resident #5's foot that had not been there the day prior. Staff I recalled telling the nurse but did not work with the resident after that day.</p> <p>On 8/24/22 at 7:48 p.m., Staff E, RN, felt the poor circulation documented on 1/3/22 came on abruptly. She could not recall hearing anything in shift-to-shift report.</p> <p>On 8/25/22 at 8:38 a.m., Staff J, CNA, could not recall the resident or any discolored feet/toes.</p> <p>On 8/25/22 at 8:56 a.m., Staff K, CNA, described the resident as being cold a lot and but could not recall seeing or hearing about any foot discoloration. The</p>			

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	<p>resident wore gripper socks and usually slept in the gripper socks.</p> <p>On 9/6/22 at 9:25 a.m., the Director of Nursing indicated they expected that if the nursing staff received a report of discolored toes or discovered a resident with discolored toes, the nursing staff should check the resident's discolored toes every shift and that the physician would follow-up on any concerns. The nurse practitioner or physician rounded 3 days a week and so they should have seen Resident #5 within a couple of days of the nursing staff writing the progress note on 12/28/21.</p> <p>On 9/7/22 at 8:30 a.m., Resident #5's Primary Care Physician (PCP reported being in the facility on 12/30/21 (2 days after the therapy and nursing staff identified possible concerns with the circulation in Resident #5's foot), but Resident #5's PCP did not see Resident #5 on 12/30/21. Neither Resident #5's PCP, nor Resident #5's PCP's Nurse Practitioner, saw or documented any notes regarding Resident #5's right foot during the 12/30/21 visit. Resident #5's PCP did not believe the nursing staff informed Resident #5's PCP about the concerns regarding Resident #5's foot discoloration. Given Resident #5's history of poor blood flow to their feet and dark, purplish appearing skin on Resident #5's feet, Resident #5's PCP would not have paid much attention to a report of Resident #5 experiencing skin discoloration, unless the resident experienced pain (Resident #5 had pain in their feet, starting on</p>				

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	<p>12/28/21) or the development of sores (Resident #5 developed blisters, a potential start of a sore, on 1/3/22). Resident #5's PCP expected the nursing staff to continue to monitor Resident #5's right foot if they identified concerns and notify Resident #5's PCP of any changes (such as Resident #5 developing blisters on 1/3/22).</p> <p>The facility's Charting and Documentation Policy, revised July 2017, indicated that any changes in the resident's medical, physical, functional, or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.</p> <p><b>FACILITY RESPONSE:</b></p>				

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481-51.43(9)	<p>Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52.</p> <p><b>DESCRIPTION:</b></p> <p>Based on clinical record review, staff interview, policy review, and observation, two facility staff failed to immediately, no later than two hours, report alleged violations of abuse to administration for 3 of 3 residents reviewed (Residents #1, #2, and #3). The facility reported a census of 54 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated 7/19/22 listed dementia and psychotic disorder as diagnoses for Resident #3. The resident's Brief Interview for Mental Status (BIMS) scored 1, which indicated severe cognitive impairment.</p> <p>The Care Plan, dated 8/8/19 stated Resident #3 had impaired cognitive function or thought process and had difficulty expressing herself so needed plenty of time to get words out and reassurance and support if upset.</p> <p>An observation on 8/15/22 at 12:00 p.m. revealed the resident in a wheelchair, eating lunch in the</p>	II	\$500	Upon Receipt	

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	<p>dining room. The resident did not respond to any questions.</p> <p>A facility Incident Report dated 7/23/22 at 9:59 p.m. stated Staff A, Certified Nurse Aide (CNA) reported that on 7/22/22 around 11:30pm, Resident #3 began yelling out "Mommy". Staff A heard Staff B, CNA, respond to the resident by screaming, "Just shut up. Shut the fuck up."</p> <p>2. The MDS assessment dated 8/4/22 listed dementia and difficulty in walking as diagnoses for Resident #1. The resident's Brief Interview for BIMS scored 5, which indicated severe cognitive impairment.</p> <p>The Care Plan, dated 7/21/22 stated Resident #1 had impaired cognition function or thought process and needed consistent, simple, directive sentences. The resident needed assistance of one staff with a walker for walking.</p> <p>An observation on 8/15/22 at 12:05 p.m. revealed Resident #1 seated in her recliner, wheelchair and walker nearby. Resident #1 could not appropriately answer questions due to confusion.</p> <p>A facility Incident Report dated 7/23/22 at 9:59 p.m. stated Staff A, CNA reported hearing Staff B, CNA, gasp loudly as if she had been startled seeing Resident #1 ambulating toward the dining hall. Staff A witnessed Staff B roughly grab the resident's</p>				

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	<p>arm and start pushing the resident towards her room yelling loudly, "Go to your room!"</p> <p>3. The MDS assessment dated 7/19/22 listed non-traumatic brain dysfunction as a diagnosis for Resident #2. The resident's Brief Interview for BIMS scored 1, which indicated severe cognitive impairment.</p> <p>The Care Plan, dated 10/27/21, stated Resident #2 needed assistance with personal hygiene.</p> <p>An observation on 8/15/22 at 11:00 a.m. revealed resident walking independently up and down the halls and not acknowledging any comments or questions.</p> <p>A facility Incident Report dated 7/24/22 at 1:23 p.m. stated Staff B, CNA, reported during cares that her fingernails scratched the front of Resident #2's right shoulder. Another CNA present stated the CNA's nails, noted to be long and sharp, had scratched the resident's shoulder.</p> <p>On 8/22/22 at 12:35 p.m., Staff A, CNA, stated on 7/22/22 a little before midnight, Resident #3 began moaning "Mommy" and continued this for over an hour. Staff B, CNA, then went into the resident's room and yelled, "Just shut up. Shut the fuck up." A couple of hours later, around 1:30 a.m., Staff A reported she heard Staff B gasp she saw Resident #1 walking unassisted in the hall. Staff A then</p>				

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	<p>observed Staff B grab Resident #1's upper arm roughly, and pulling her towards her room, loudly say, "Go back to your room right now."</p> <p>Staff A said she reported her concerns to the Director of Nursing (DON) when working her next shift on 7/23/22 around 8:30 p.m. Staff A stated she held off notifying anyone of her concerns because nurses had not followed-up on concerns in the past, and she did not know if her concerns were abuse.</p> <p>On 8/23/22 at 12:00 p.m., Staff C, CNA, stated she reported concerns to Staff E, Registered Nurse (RN) that Resident #2 had what appeared to be new scratch marks on him. Staff C noted these marks when she went into Resident #2's room the beginning of the day shift, approximately 10-15 minutes after Staff B, CNA, had left the room on 7/23/22.</p> <p>On 8/23/22 at 2:00 p.m., Staff D, Licensed Practical Nurse (LPN), stated that on the afternoon of 7/24/22, the DON asked her to assess and document Resident #2's scratch marks. Staff D reported the incident had occurred the day prior but had not been documented at that time.</p> <p>On 8/24/22 at 4:50 p.m., the Administrator stated Staff A failed to report the concern for abuse from the night shift until the following evening shift when she spoke to the DON. On the afternoon of</p>			

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	<p>7/24/22, Staff C, CNA, reported she told Staff E, RN, the morning of 7/23/22, about concerns that Staff B, CNA had scratched Resident #2. The facility had no documentation completed or verbal report by Staff E showing the concern. Administration immediately submitted a report to the Department of Inspections and Appeals (DIA) and investigated the concerns once aware of them.</p> <p>On 8/24/22 at 7:48 p.m., Staff E, RN, reported Staff C, CNA, reported scratches on Resident #2. Staff E stated the way Staff C presented the concern, she did not feel it to be an allegation of abuse.</p> <p>The facility's Dependent Adult Abuse Protocols dated November 2019 documented all allegations or resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation should be reported immediately to the Charge Nurse. The Charge Nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.</p>			

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