Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: **#6125**			**Date:** **June 9, 2023**
Facility Name: **Northern Mahaska Specialty Care**		**Survey Dates:** **May 3, 2023 to May 10, 2023**	
Facility Address/City/State/Zip: **2401 Crestview Drive Oskaloosa, IA 52577**	**CP**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
56.6(1)	481-56.6(135C) Treble and double fines. 56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481- 56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that time period and a penalty was assessed therefor.			
58.28(3)e	**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) **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) **DESCRIPTION:** Based on observations, interviews and record review, the facility failed to ensure safety for 1 out of 3 residents reviewed (Resident #2). Resident #2 was transferred from her bed into her wheelchair without removing/moving the leg rests/foot pedals from Resident #2's wheelchair. This resulted in a large skin	**Class I**	**$14,250.00 ($4,750.00x3)** **TREBLED** **(HELD IN SUSPENSION)**	**UPON RECEIPT**

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	tear, which required the need to transfer Resident #2 out to the Emergency Room (ER). The facility reported a census of 68 residents. Findings include: A Minimum Data Set dated 3/9/23, documented that diagnoses for Resident #2 included heart failure, diabetes, and malnutrition. This resident's Brief Interview for Mental Status revealed a score of 14 out of 15, which indicated intact cognition. This resident was an extensive assist of 2 for bed mobility, and transfers. A Medical Diagnoses list for this resident printed on 5/9/23, documented diagnoses of lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system. It most commonly affects the arms or legs). A Care Plan with a focus area initiated on 3/3/23 and revised on 5/7/23, documented that Resident #2 was at risk for skin breakdown due to diabetes, incontinence, and fragile skin due to lymphedema and hart failure. It documented that resident had edema to her bilateral lower extremities. It documented that			

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	this resident was re-admitted from the hospital with a left shin laceration. A resident Census page documented that this resident went to the Emergency Room on 3/29/23. A Progress Note dated 3/29/23 at 3:25 p.m., documented that this nurse was called to the resident's room STAT (immediately). Resident was observed sitting up in her wheelchair with a large skin tear to her inner leg. Area was cleaned with wound wash and steri strips were applied. Moist dressing was also applied and wound was covered with gauze. The provider was notified and a new order was received to send this resident to the ER to evaluate and treat wound. Daughter was agreeable to hold this resident's bed while out of the facility. The DON (Director of Nursing) and ADON (Assistant Director of Nursing) were at bedside. The Certified Nurse Aides explained that resident was being assisted to her wheelchair with the Hoyer lift and while bringing the resident down into her wheelchair, her left leg slipped off the wheelchair pedal, so it was moved causing a skin tear. A Progress Note on 3/29/23 at 3:35 p.m., documented the skin tear measured Length 6.9 centimeters (cm),			

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	Width 4.6 cm, and the Depth was 1.5 cm. This resident was sent to the ER for bleeding and pain. A Progress Note dated 3/29/23 at 4:44 p.m., documented that in a phone call with Resident #2's daughter to let daughter know about the skin tear, the daughter stated she wasn't surprised as her mom's skin is very fragile. A Progress Note dated 3/29/23 at 8:00 p.m., documented that this resident returned from the ER. A new order was received to moisten gauze, cover (wound) with dry gauze, watch for signs of infection, and protect area from further trauma. A Skin and Wound Evaluation dated 3/31/23, documented that a skin tear on the left shin had complete tissue loss and the wound was acquired at the facility on 3/29/23. The length of the wound was 10.3 cm and the width was 10.6 cm with no depth. The edges of the wound were not attached and appeared as a cliff. The surrounding tissue was black and blue, intact and fragile. This resident had edema extending more than 4 centimeters around the wound. It documented that this resident had occasional labored breathing with a short period of hyperventilation, occasional moan or groan, facial			

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	grimacing and that this resident rated her pain at a 5 out of 10 (which indicated moderate pain). On 5/9/23 at 11:40 a.m., Staff A, CNA, stated on the day of this incident she was going over to talk to a staff member about something, when she walked into this resident's room they were transferring Resident #2 to her wheelchair. When Staff A walked into the room she noticed that Resident #2's leg was on the wrong side of her wheelchair pedal, which the leg rest should not have been on (the wheelchair) in the first place. The leg was on the left side of Resident #2's foot pedal, so Staff A believed it would have been her left leg. Staff A stated the middle of this resident's lower leg caught on the foot pedal, it was like the calf area. Staff A stated when that happened it opened up the skin and it started bleeding. Staff A stated they then went and got a nurse. Staff A did not remember which nurse. Staff A stated the Assistant Director of Nursing (ADON) was there, the Administrator and Director of Nursing (DON) came and one of the Certified Medication Aides also came to the room. Staff A stated that basically the whole team came. Staff A stated that they are supposed to transfer people without the foot pedals (and leg rests) on the wheelchair. Staff A stated she was trained that way. Staff A stated she was trained at the facility and through her CNA training to remove the foot pedals			

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	prior to transfer. It's been a few years. Staff A stated the CNAs that were transferring this resident were Staff B, CNA who was from an agency and Staff C, CNA. Staff A stated she did not ask why the foot pedals were on. Staff A stated she did not receive education afterwards regarding the foot pedals and she did not know if the facility did education with the other 2 CNAs. Staff A stated she had not transferred Resident #2 prior to this incident and it was the first time she had assisted with transferring Resident #2. Staff A stated she had tried to get her leg up and over the foot pedal but Resident #2's leg was probably too heavy. After the whole thing was done, the next day the DON and the Administrator said that the pedals should have been off of the wheelchair when they talked to me about the whole situation. On 5/9/23 at 11:52 a.m., Staff B stated that she was present with 2 other facility workers at the time of this incident. Staff B stated she was behind the wheelchair, and the other 2 were on either side of the wheelchair. Staff B stated Staff A and Staff B were both there at the beginning of the transfer. Staff B stated this resident's leg kind of slipped off to the side. Staff B stated she told Staff C that Staff C could push the red button and she could already be down. Staff B stated that Staff C then pulled the red button. Staff B stated the red button was on the Hoyer's pole			

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	at the bottom. Staff B repeated that she believed Staff A pulled the red button. Staff B stated that a lot of the facility's workers said it was okay to use the red button. Staff B stated it was iffy whether or not Resident #2's body was down in her wheelchair. Staff B stated the Hoyer arms weren't all the way down. Staff A stated this resident's bottom was in the wheelchair. Staff B stated this resident's skin had not broken open. Staff B stated they then were talking about lowering this resident the rest of the way, and then they were like, oh shoot, they saw that this leg had opened up. Staff B stated she immediately told Staff A and Staff C to call for a nurse. Staff B stated this resident's left leg was what had opened, and this resident's left leg was on the outside (of the leg rest), but it was nowhere near the pedal. Staff B stated that it wasn't the foot pedal that caused the injury as there were no sharp points on the foot pedal and there was cushions on the foot pedal. Staff B stated that the DON and the nurse couldn't figure it out. Staff B stated that nobody had said anything about moving the leg rests. With them (the facility) everything was backwards. Normally you would take the leg rests off prior to the transfer. Staff B learned this during CNA training. Staff B stated she had never seen a button like the one on the Hoyer, but she was told you could use the button for emergency purposes. Staff B stated she felt like this incident was an emergency.			

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	When asked why she felt it was an emergency, Staff B stated it was because this resident's leg was already to the side (of the leg rest/foot pedal). Staff B added she did not think they could have done anything differently at that point. On 5/9/23 at 12:05 p.m., Staff A stated that the red button was not used during this situation. Staff A stated it was the agency CNA who had mentioned using it. Staff A stated she pointed at the red button and asked Staff B if that was the button she was talking about and she said it was. Staff A stated she did not push it. Staff A stated that Staff C was running the Hoyer lift and he kept lowering the lift the regular way. Staff A stated she went into the room just when they had Resident #2 over her wheelchair. Staff A stated she had only been told that they can use the red button only in case of an emergency. On 5/9/23 at 12:50, the ADON stated she really was kind of a second set of hands at the point when she walked into Resident #2's room. The ADON stated she was hollered at and took off running. The ADON stated a Registered Nurse (RN), was the one who hollered for the ADON and they did grabbed the DON too. The ADON stated she went in to the room and noticed the significance of the wound, and stated this resident was bleeding. This ADON stated she then ran			

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	and got the treatment cart, sanitized her hands and grabbed 4X4 gauze, wound wash, normal saline and applied directly to the wound. This ADON stated she had put pressure on the wound and then had the other nurse sanitize and glove (her hands) and then sat an absorbent pad under this resident's leg. The ADON stated this resident did not complain of pain and verbalized she was okay. The ADON stated this resident would just say 'oh, oh,' and this resident was kind of scared. There were a lot of people in there just trying to take care of the wound. The ADON stated she applied slight pressure. The ADON stated this resident had thin skin. The ADON stated the ambulance came and transferred this resident out of the facility and they then cleaned everything up and sanitized the area. The ADON stated the ER sent Resident #2 right back and the ER staff said there was nothing they could do. The ADON stated she was not in the room for the transfer and the staff had her already Hoyered Resident #2 down into her wheel chair. The ADON stated the lift was still in this resident's room. The ADON stated she asked what happened and the staff said they were trying to adjust this resident's leg and that's when it happened. The ADON stated she did not see the transfer but the leg rests were already on the chair when the ADON went in with her leg kind of propped up on the foot rest. The ADON stated this resident had a tilt wheelchair,			

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	so the ADON had the staff tilt the resident back in her wheelchair so the ADON could assess the wound better. The ADPN stated the foot pedals should be removed from wheelchairs with transfers. The ADON stated they did a lot of education afterwards regarding the leg rest/pedals needing to be removed prior to transfers. The ADON stated this resident's wheelchair had calf rests too and this resident's leg rests attached to her wheelchair just below the seat. The ADON stated they are the hook and swing into place type of leg rests. The ADON stated they used a Hoyer lift for the transfer. 5/9/23 at 3:00 p.m., Staff D, CNA stated that prior to any transfers out of or into wheelchairs, she removes the leg rests off of the wheelchair. She stated that most wheelchairs have a bag on the back of them where the leg rests/wheelchair pedals can be placed. On 5/9/23 at 3:17 p.m., Staff C, CNA, stated they were getting Resident #2 up for dinner(supper), from her bed to her wheelchair. Staff C stated he was operating the Hoyer and Staff B was turning Resident #2 toward her wheelchair. Staff C stated they got Resident #2 above her wheelchair and then Staff A saw them and came in to Resident #2 to help. Staff C stated they were lowering Resident #2 down (into her wheelchair) and then they realized her left leg was on			

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	the outside of the wheelchair pedal. Staff C stated that Staff A then tried to lift this resident's left leg up and over the left wheelchair pedal and the pedal kind of sliced Resident #2's leg open. Staff C stated they saw what he would call fat glands and then blood. Staff C stated there was nothing sharp on the wheelchair pedal, it was like the cut was from the fabric itself. Staff C stated the fabric was like normal wheelchair fabric, kind of like a tarp material. When asked if the red button was used, Staff C stated the only thing with the red button was that Staff A started to reach for it and Staff C told Staff A not to touch it and Staff A didn't touch it. Staff C stated that Staff B had told Staff A to push the red button. Staff C stated he had never been told they could use the red button, unless it was an emergency. The red button immediately lowers the resident down. Staff C stated they were supposed to have the leg rests off the wheelchair prior to the transfer and he knew that, but Staff B told Staff C to leave the leg rests on the wheelchair, and that it would be okay. Staff C reiterated that they were not supposed to have pedals on the wheelchair when they are transferring residents whatsoever. Staff C stated he had been at the facility approximately 1 ½ to 2 months. Staff C stated he was a fresh CNA. Staff C stated he thought Staff B knew what she was doing. Staff C stated he learned from this incident and he does not trust			

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	anybody anymore. Staff C stated they had training regarding all types of transfers after that. Staff C stated there were educational offerings for the next couple of weeks after this incident. On 5/9/23/ at 4:15 p.m., the Regional Director of Clinical Services acknowledged the concern regarding staff not removing leg rests/pedals prior to transferring Resident #2 to her wheelchair. This Corporate Nurse acknowledged that a wound resulted from not removing the leg rests. On 5/9/23 at 4:35 p.m., the Administrator acknowledged the concern of the leg rests on the wheelchair at the time of the transfer. The Administrator stated the facility provided education on transfers following this incident. The Administrator did not have questions regarding this concern. Resident #2 was in and out of the facility at the hospital when survey was taking place. A Wound Evaluation dated 5/5/23, documented the laceration on the left shin measured 12.73 cm in length and 6.37 cm in width.			

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	An In-Service Form dated 3/30/23, documented the education included that staff must be trained and be able to demonstrate competency using machines and devices to transfer a resident safely. It directed staff to remove pedals to wheelchair or move pedals to the side on wheelchair. A Lifting Machine, using a Mechanical policy revised on July 2017, documented that at least 2 staff are needed to safely move a resident with a mechanical lift. It documented that a mechanical lift may be used for tasks that require transferring a resident from bed to chair. **FACILITY RESPONSE:**			

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