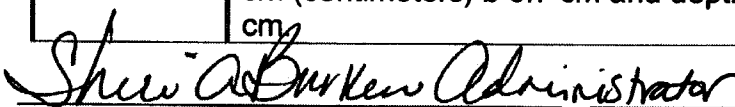


**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

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Facility Name: Manorcare Utica Ridge		Survey Dates: June 25-28, 2018		
Facility Address/City/State/Zip 3800 Commerce Boulevard Davenport, IA 52807				
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.19(2)b	<p>58.19(2) Medication and treatment. <i>b.</i> 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)</p> <p>FACILITY DESCRIPTION:</p> <p>Based on observation, clinical record review and staff interview, the facility failed to follow planned interventions for two of seven residents reviewed with pressure ulcers. (Resident #54 & #197) The facility census was 110 residents.</p> <p>Findings:</p> <p>1. The Minimum Data Set (MDS) assessment completed 5/30/18, documented Resident #54 had diagnoses of paraplegia, osteomyelitis and pressure ulcer of right buttock Stage III and required extensive staff assistance with most activities of daily living. The Stage III pressure ulcer measured 5.3 cm (centimeters) b 8.7 cm and depth of 0.1 cm</p>	I	\$3,100	UPON RECEIPT
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6/29/18
 Facility Administrator Date

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	<p>The care plan with the target date of 8/31/18 identified the resident with the problem of pressure wound to the right buttock related to impaired mobility, incontinence, Braden score of 14. It directed the staff to complete the following interventions</p> <ul style="list-style-type: none"> Administer analgesia per physician orders (offer prior to treatment/therapy) Administer treatment per physician orders Diet and supplements per physician orders Encourage and assist as needed to turn and reposition, use sassiest devices as needed Follow up care with physician as ordered Obtain labs as ordered and report results to physician Pressure reducing surface on bed and wheelchair Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician as needed. Use pillows and/or positioning devices as needed. <p>A review of a pressure ulcer assessment completed in the electronic medical record on 5/25/18 at 1:57 p.m. identified the resident</p>			
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	<p>with a pressure wound to the right buttock with measurements of 6.0 cm by 9.0 cm by 0.1 cm. with no description of the appearance of the wound or surrounding skin edges.</p> <p>During observation on 6/25/18 at 11:16 a.m., the resident sat up in the chair in her room, talking on cell phone wearing non-skid shoes. At 12:18 p.m., the resident remained in the wheelchair wearing shoes to both feet. At 12:53 p.m., remained in the wheelchair in her room wearing shoes to both feet</p>			
	<p>On 6/26/18 at 9:49 a.m., Staff L, registered nurse, RN and Staff X, certified nurse aide entered the resident's room to perform cares. Staff X removed the prevalon boots from the resident's feet. Staff L placed clean towel underneath the resident's gluteal folds, removed the dressing to the right gluteal fold which had moderate amount of serous drainage, the wound bed appeared large with red/pink granulation tissue, peri wound blanchable without odor, without tendon/muscle or bone exposed. The wound had no signs of infection noted. Staff L reported she needed to measure wound to</p>			

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	<p>area behind right ankle as it was a new area. The open area noted to the right Achilles appeared pale in color with scant amount of serous drainage.</p> <p>On 6/27/18 at 6:09 a.m., the resident was asleep in bed lying on their back without prevalon boots on and wore only gripper socks to her feet.</p> <p>On 6/28/18 at 7:20 a.m., the resident laid in bed on her left side without prevalon boots on at this time and only gripper socks to her feet without her heels floated.</p> <p>A review of a skin alteration record which should not be used for pressure ulcers identified an open area to the backside of the right ankle first identified on 6/26/18 with measurements of length of 1.8 cm width of 0.8 cm and depth of 0 cm. The wound had pale, pink tissue, scant amount of serous drainage and the surrounding skin with maceration - skin softening related to fluid and no pain at the site.</p>			
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	<p>A review of the progress notes dated 5/25/18 at 2:13 p.m., documented the right buttock pressure ulcer measured 6.0 cm by 9.0 cm and depth of 0.1 cm. with a large amount of yellow serous drainage, wound bed large red/pink granulation tissue with margins that were well defined and rolled, that the periwound to be blanchable , without odor or exposed tendon, muscle or bone. Recommendations for air mattres, roho cushion to chair Assessments had been completed weekly.</p>			
	<p>An assessment dated 6/26/18 at 7:41 p.m., documented the wound measured 4.6 cm by 5.0 cm and depth of 0.1 cm with a moderate amount of yellow serous drainage, large red/pink granulation tissue, margins well defined with periwound that was blanchable and no odor or exposed tendon, muscle or bone.</p> <p>During an interview on 6/27/18 at 12:40 p.m., Staff G, CNA reported the resident had an open area to her bottom, and was care planned to not allow her to sit for long periods</p>			

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	<p>of time, usually after meals, she is supposed to lay down in bed.</p> <p>During interview on 6/27/18 at 1:17 p.m., Staff H, CNA reported the resident had a pressure sore to her bottom and was to lay her down in bed after meals.</p> <p>During interview on 6/27/18 at 1:47 p.m., Staff L, RN reported the resident had a pressure ulcer to her right buttocks on admission. There was two on her left gluteal fold which was more from shearing. She also had an open area to the right Achilles which developed after she was admitted. She was care planned to be repositioned, when in bed she should have the prafo boots on, and should not be wearing any shoes until the Achilles wound heals.</p> <p>During interview on 6/28/18 at 7:28 a.m., Staff R, RN, Unit manager reported when residents have an open area to the feet or Achilles, the expectation would be to suspend the heels, or put heel protectors on as ordered. Staff R reported the resident had complained about the heel protectors and</p>			
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	<p>would not keep them on and that should have been care planned.</p> <p>3. The MDS assessment completed 6/1/18, documented Resident #197 had diagnoses of cancer, Non-Alzheimer's dementia and arthritis and required extensive staff assistance with most activities of daily living and had a Stage II pressure ulcer and one untraceable pressure ulcer.</p> <p>The care plan with the target date of 9/2/18 identified the resident with the problem of pressure ulcers to the coccyx, right heel and right great toe and left great toe and directed the staff to:</p> <ul style="list-style-type: none"> Administer analgesics as needed Daily body audit Friction reducing transfer surface Incontinence management Pain evaluation prior to treatment Pressure redistributing support surface Repositioning during activities of daily living Skin barrier 				
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	<p>It also identified the resident with the problem of being at risk for alteration in skin integrity and directed the staff to: Elevate the heels as able Encourage the resident to lay down and not sit up for long periods her chair to prevent more pressure to the coccyx.</p> <p>A review of the nursing admission assessment completed 5/25/18 at 6:46 p.m. had documentation the resident had one pressure ulcer to the coccyx.</p>			
	<p>Physician progress notes dated 5/29/18 at 9:55 a.m., documented the resident had an untraceable pressure ulcer to her coccyx and a fluid filled blister on her right heel.</p> <p>Physician progress notes dated 6/1/18 at 8:45 a.m., documented the resident had an untraceable pressure ulcer to her coccyx and a fluid filled blister on her right heel.</p> <p>Progress notes dated 5/29/18 at 11:09 a.m., documented the coccyx wound without measurements was blanchable and erythemic, without odor or appearance of</p>			

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	<p>tendon/muscle or bone. The left heel wound identified as Stage II measured 2.0 cm by 3.0 cm. Additional recommendations included heel protectors, floating heels on pillows while in bed. Assessments had been completed weekly.</p> <p>Progress notes dated 6/12/18 at 3:44 p.m., documented the residents left heel with measurements of 0.9 cm by 1.2 cm and depth of 0.1 cm. The wound had a small amount of serosanguinous drainage, the wound bed had large eschar and adherent slough noted with well defined margins and blanchable, erythemic macerated periwound. No odors, tendon/muscle or bone exposed. It also identified the resident to have another new pressure ulcer to the left great toe with measurements of a length of 0.9 cm width of 0.9 cm and depth of 0.1 cm. The wound had a large stable eschar with adherent slough noted, very small pink granulation noted around edges with well defined margins and blanchable erythemic periwound.</p> <p>The wound to the coccyx had measurements with a length of 3.0 cm width of 2.0 cm and depth of 1.9 cm. The wound had a small</p>			
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	<p>amount of serosanguinous drainage, the wound bed had large adherent slough with small pink/pale graunulation, margins had been well defined and the periwound blanchable.</p> <p>Progress notes date 6/26/18 at 8:21 p.m., documented the coccyx wound measured 2.5 cm by 1.6 cm and depth of 3.0 cm. The left heel wound measured 4.5 cm by 5.0 cm and depth of 0.1 cm.</p> <p>Observation on 6/26/18 at 6:21 a.m., Staff W, CNA removed the prevalon boots from resident's feet. Staff W transferred the resident and provided peri care after toileting the resident. Staff W did not place prevalon boots on the resident's feet prior to placing the resident's feet on the metal foot pedals while the resident only had gripper socks to her feet.</p> <p>At 7:34 a.m., the resident was sitting in the wheelchair in the dining room without Prevalon boots on feet which only had gripper socks on and resting directly on metal foot pedals. Still no air mattress on bed.</p>			
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	<p>At 8:54 a.m., the resident sat in her wheelchair wearing only gripper socks on both feet on foot pedals without heels floated. At 9:02 a.m., Staff W checked the resident's vital signs and did not place prevalon boots on the resident's feet which remained with only gripper socks and not floated. At 9:30 a.m., the resident remained in up in her wheelchair without prevalon boots and both feet resting directly on metal foot pedals wearing only gripper socks to both feet without heels floated. At 10:34 a.m., the resident remained in the wheelchair with no boots on as planned. At 12:52 p.m., the prevalon boots sat on top of the table at the foot of the resident's bed. Staff Y, RN entered the room, washed hands, donned gloves and placed a clean towel under the resident's hip. Staff Y used the correct technique to remove the dressings from the wound to the coccyx which appeared pale pink with a moderate amount purulent drainage. The surrounding skin did not have signs of infection. Staff Y removed her gloves, used hand sanitizer, donned new gloves and measured the wound with a</p>			
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	<p>length of 2.5 cm by 1.6 cm and a depth of 3.0 cm Staff Y removed gloves, used hand sanitizer, donned new gloves then measured the first tunneling located at 11:00 as 1.6 cm The wound had a moderate amount of adherence slough in wound, the peri wound had been macerated, erythemic, but blanchable. Staff Y used the correct technique to cleanse the wound and dress it with hydrofoam. At 1:08 p.m., Staff Y used the correct technique to remove the dressing from the wound to the left great toe, cleanse the wound and measured it with a length of 0.9 cm width of 0.9 cm and depth of 0.1 cm with large adherence slough eschar noted and very small pink granulation noted. The peri wound was macerated and erythemic. Staff Y used the correct technique to apply a new silver alginate dressing and cover with a foam dressing. At 1:17 p.m., Staff Y used the correct technique to remove the dressing to the right great toe, cleanse the wound and measured it with a length of 0.9 cm width of 1.2 cm and depth of 0.1 cm. The wound had a large amount of adherence slough noted to wound,</p>			
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	<p>erythemic and the peri wound with some maceration. Staff Y used the correct technique to apply a new silver alginate dressing and cover with a foam dressing. At 1:25 p.m., Staff Y used the correct technique to remove the dressing to the right heel. The wound had large stable eschar noted to right heel, peri wound dry, slightly calloused, erythemic and blanchable without drainage. Staff Y measured the wound with a length of 4.3 cm width of 5.0 cm and depth of 0.1 cm.</p> <p>At 1:30 p.m., Staff Y used the correct technique to cleanse the wound and applied silver alginate, covered it with gauze and kerlix and secured with tape and placed the prevalon boots to the resident's feet.</p> <p>During interview on 6/27/18 at 1:17 p.m., Staff H, CNA reported the resident had pressure ulcers to the coccyx and to her heels and care planned to have heel protector boots at all times, that she is to lay down after meals, elevate her feet and be repositioned every 2 hours. The only reason she would not have her heel protectors on</p>			
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	<p>would be if the aides forgot to place them on her.</p> <p>During interview on 6/27/18 at 1:39 p.m., Staff K, CNA reported the resident had been admitted with one large area to her coccyx and now had two open areas to each great toe and one open area to each heel. The right heel still had a black area. She is care planned for moon boots on her feet at all times, except during transfers or showers, lay her down after meals and after therapy and reposition her every 2 hours with a pillow underneath her coccyx.</p> <p>During interview on 6/27/18 at 1:47 p.m., Staff L, RN reported the resident had been admitted 3 weeks ago with open areas to both great toes, both heels and her sacrum. She is care planned to reposition frequently, should wear the prafo boots at all times.</p> <p>During interview on 6/28/18 at 7:28 a.m., Staff R, RN, unit manager reported the expectation fo residents with open areas to the heels would be to suspend the heels, or put heel protectors on.</p>			
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	FACILITY RESPONSE:			
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_____ Facility Administrator _____ Date

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