

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

Citation Number: 7038		Date: September 4, 2019		
Facility Name: Heartland Care Center		Survey Dates: August 12, 2019 – August 20, 2019		
Facility Address/City/State/Zip 604 East Fenton Marcus, IA 51035		MW/DC		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.19(2)j	<p>481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p> <p>58.19(2) Medication and treatment.</p> <p style="padding-left: 20px;"><i>j.</i> 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. (I, II, III)</p> <p>Description: Based on observation, record review and staff interview, the facility failed to provide adequate assessment and timely intervention for 1 of 13 residents reviewed, (Resident #25). The facility reported a census of 27 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set assessment, dated 6/13/19 Resident #25 scored 4 on the Brief Interview for Mental Status indicating severe cognitive impairment. The resident's diagnoses included cancer.</p> <p>The current Care Plan with a problem onset date of 6/5/19 identified the resident with an open lesion of the left ear, with a goal for the area to remain free of</p>	I	\$9,250 (Held in suspension)	UPON RECEIPT
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	<p>infection. The interventions included the resident needed wound care as ordered by the physician, administer pain medication prior to initiating treatment, daily observation of skin with routine care, monitor for changes in skin status that may indicate worsening of the open lesion and notify the physician.</p> <p>The care plan identified the resident experienced pain in the left ear due to ulcerated area during treatment changes. The interventions included to evaluate pain using the 1-10 scale or the PAINAD (pain scale) score, administer pain medication as ordered, 1 hour prior to the treatment, and monitor for worsening of symptoms and report to the physician.</p> <p>The Nurse's Notes dated 6/5/19 at 4:50 p.m. documented the resident admitted to the facility. The resident had open ulcers to the left ear related to radiation for cancer.</p> <p>The Nurse's Notes dated 6/6/19 at 12:40 p.m. documented a routine dressing change started and noted a large amount of pus and eschar (dead) tissue sloughed off. Consulted with the wound nurse at the hospital and a telephone order received.</p> <p>A Physician's Telephone Order dated 6/6/19 directed to clean the resident's left ear with normal saline, pack with Aquacel AG (sterile dressing with silver), cover with a 4 by 4 dressing every day and as needed.</p> <p>A Physician's Telephone Order dated 6/12/19 directed left ear dressing change 2 times a day.</p>			
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	<p>An untitled facility wound form dated 6/24/19 documented the resident had a wound of the left ear and behind the ear. The documentation included the wound not measurable due extreme pain. The wound had large amount green/black drainage with a yellow base. The wound treated with silver cel packed into the wound and covered with a dressing.</p> <p>A Physician's Telephone Order dated 6/24/19 directed to discontinue left ear 2 times a day dressing changes and change every day and as needed due to increased pain.</p> <p>A Patient Transfer Form dated 6/29/19 documented the resident had been very restless and complained of severe head pain. The resident had brain cancer and a necrotic wound of the left ear related to radiation. The resident noted to have apnea every time he fell asleep then bolted up gasping for air and clearing his throat, with a pulse oxygen reading of 70-75% while attempting to rest. Needed assessment for pain management and apnea.</p> <p>The Emergency Department (ED) Notes dated 6/29/19 at 2:02 p.m. documented the resident brought by ambulance for evaluation and treatment of pain management and respiratory depression. The resident had a wound behind the left ear, a combination of cancer and radiation. An Ear Nose and Throat (ENT) physician consulted and felt conservative management with dressings would be best.</p>			
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	<p>A hospital Plan of Care dated 6/30/19 at 5:34 a.m. documented the left ear wound remained covered with dressing, and reinforced the dressing as needed.</p> <p>The Discharge Summary dated 7/1/19 at 9:10 a.m. documented the diagnoses included glioblastoma, narcotic induced respiratory depression, and altered level of consciousness. The physical exam documented the skin warm to touch, the left ear dressed and had been clean per nursing. The discharge instructions did not include treatment orders.</p> <p>The Nurse's Notes dated 7/1/19 at 11:28 a.m. documented a call out to the wound center related to the resident's right ear dressing not on when returned from the hospital.</p> <p>A Resident Assessment Post-Hospital Stay dated 7/1/19 documented the left ear the same as pre-hospital, no change.</p> <p>The Nurse's Notes dated 7/2/19 at 4 a.m. documented the resident had been restless. The resident did not complain of pain but placed his hand by his ear frequently.</p> <p>Physician's Orders for 7/1/19-7/31/19 signed by the physician on 7/3/19 included to cleanse the left ear with normal saline, pack with Aquacel Ag, and cover with 4 by 4 and tape daily.</p>			
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	<p>A Treatment Administration Record (TAR) for 7/1-31/19 showed the resident orders included to cleanse the left ear with normal saline, pack with Aquacel AG and cover with 4x4 and tape daily. The TAR showed the treatment for 7/1, 7/2, 7/3, 7/4, and 7/5/19 with initials circled. A PRN Record for 7/2, 7/3, 7/4/19 documented the treatment to the ear held awaiting wound clarification. On 7/5 the TAR documented cleaning the ear.</p> <p>A Patient Transfer Form dated 7/5/19 documented the resident was in the hospital the previous week and since return they had waited for a wound consult, which they scheduled for Monday, 7/8/19. Staff had been cleaning to the best of their ability within the residents pain tolerance. When they cleaned the wound white bugs noted. The clinical record lacked any additional documentation of cleaning the ear from 7/1-5/19.</p> <p>A hospital surgery report with date of service 7/5/19 at 5:07 p.m. documented the resident presented with ulcer on the left ear for debridement and removal of maggots. The surgery performed included irrigation and debridement of the left side of the nose and left ear ulcer and removal of foreign bodies (maggots). The resident received intravenous sedation and a regional air block (local anesthetics to block sensations of pain), debridement and removal of foreign body.</p> <p>The Nurse's Notes dated 7/5/19 at 6:30 p.m. documented the resident returned to the facility from</p>				
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	<p>the hospital with new orders for treatment to the left ear. Staff called for a nurse to the resident's room at 9:30 p.m. The resident pulled the dressing from the hospital off with maggots noted in the ear and on the resident's shirt. The resident stated he pulled the bandage off because his ear itched. The resident went to the hospital by ambulance.</p> <p>A Patient Transfer Form Dated 7/5/19 documented the resident had an ear ulceration related to radiation/cancer and developed maggots when left open to air and draining. The resident seen by the surgeon that day and the left ear debrided. The resident returned to the facility and ate supper. At 9:30 p.m. the resident pulled the dressing off of the ear and maggots were noted coming out of his ear and on the dressing.</p> <p>A hospital surgery report with date of service 7/6/19 at 9:36 a.m. documented the resident with an ulcer of the left ear had maggots within the ulcer and had debridement the previous day and additional maggots were found and the resident was again brought to the operating room for evacuation of additional maggots. The resident had general anesthesia. Preoperative antibiotics were given. They performed manual removal of the maggots. Anterior to the ear, maggots were extruded from the tissues. The area cleansed with soap and water and irrigated with Dakin's solution to kill any additional eggs or maggots. Suction used to remove additional maggots that had crawled into the ear canal and thoroughly irrigated.</p>			
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	<p>A Wound Assessment per Wound Nurse dated 7/9/19 documented the resident had a 5.5 by 3 cm wound in the back of the ear and the canal had a 5 by 3 cm wound.</p> <p>A Physician Transfer Order Report printed 7/11/19 documented the resident returned from the hospital with orders for antibiotics and dressing changes.</p> <p>During an observation on 8/12/19 at 10:35 a.m. the resident laid in bed asleep with a bandage over his left ear. At 1:10 p.m. the resident sat in the recliner with his feet up. The dressing remained to the left ear. At 3:30 p.m. the resident laid in bed toward the right, with the dressing intact.</p> <p>During observation on 08/13/19 at 8:06 a.m. the resident laid in bed with a dressing covering the entire left ear area. At 11:38 a.m. the ear area remained covered. At 2:15 p.m. the ear area covered.</p> <p>During observation on 8/14/19 at 8:08 a.m. the resident's ear area remained covered.</p> <p>During an interview on 8/14/19 at 10:23 a.m. the Director of Nursing (DON) stated when the resident returned from the hospital 7/1/19 he did not have a dressing on the left ear. They called to the wound center. She said the ear was draining and that would indicate a need to clean the site. She stated it should have been cleaned and probably dressed. She</p>			
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	<p>thought they had an order to leave open after the hospital return 7/1 but had not found it. At 2:04 p.m. the DON stated during the time the ear was left open to air the resident did go outside.</p> <p>During an interview on 8/15/19 at 8:05 a.m. the DON stated she found no order for the ear to be left open to air, only the documentation by the nurse that he returned from the hospital without a dressing.</p> <p>During an interview on 8/15/19 at 8:17 a.m. the Administrator stated they found nothing on the hospital information with an order to leave the ear open to air. He said he was sure there were some flies (at that time) it was seasonal, but nothing out of the ordinary.</p> <p>During an interview on 8/15/19 at 8:29 a.m. Staff B Licensed Practical Nurse (LPN) stated when the resident returned from the hospital on 7/1/19 he did not have a dressing. She said she called the hospital and they left the dressing off so it could dry up, not documented. The wound nurse had not seen the resident while in the hospital or made recommendations to leave the wound open. She called the wound center for clarification and they held the dressing. The resident was going to be seen by the wound nurse, but she did not know when. She said they normally call again the next business day if they do not hear back. She said she did have concerns about the ear draining. She stated if the wound drained she cleaned it otherwise she left it alone. She said she was sure there were some flies</p>			
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	<p>that time of year, but she did not see any around the resident's ear. She worked 7/5/19 and the resident had drainage and yellow exudate visible on the ear and she went to clean it and saw the maggots kind of swimming around in it.</p> <p>During an interview on 8/15/19 at 8:55 a.m. Staff C, LPN stated the resident had no dressing to the ear area when he came back from the hospital, so they held the dressing until he could be seen by the wound nurse, she thought July 15th. She stated she worked 7/3/19 and the ear was soupy and she felt a dignity issue so she put an ABD dressing over it. She did nothing else other than cover it. She does not know how long the dressing remained on and did not document any of this. She felt the ear should be covered. She did not note flies in the facility, but the family did take the resident outside.</p> <p>During an interview on 8/15/19 at 9:20 a.m. Staff D, Certified Nursing Assistant (CNA) stated she remembered seeing the resident without the dressing on around that time but did not see it drain. She stated they had some flies in the facility but nothing out of the ordinary.</p> <p>During an interview on 8/15/19 at 9:25 a.m. Staff A, CNA stated she assisted the resident out of the van the day he returned from the hospital without a dressing. She said she told the nurses he needed a dressing to his ear. She said the ear had a bad odor so she didn't get close enough to see if it was draining.</p>			
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	<p>She said it didn't smell that way when it had a dressing on it. She was with Staff B when she saw the maggots. She said she thought Staff B was trying to get rid of the smell, it was pretty powerful. She said the family took him outside the day before. She did not see flies around him.</p> <p>During an interview on 8/15/19 at 9:32 a.m. Staff F, CNA stated the area looked terrible and it stunk. She did not see anything coming out of it but it looked like it had puss, and white milky looking. She said she saw 1-2 flies in his room and he complained about flies in his room.</p> <p>During an interview on 8/15/19 at 10:30 a.m. the Wound Nurse stated she saw the resident in January while the resident was at home and recommended a treatment with a dressing. She was supposed to follow up with the resident but they kept canceling appointments. She did not see the resident again until 7/10/19 (during the hospitalization after the maggot infestation) when the doctor asked her to teach the facility staff how to do a dressing change. She did not see the resident during the 6/29-7/1/19 hospital stay. She said there would have to be extenuating circumstances not to treat and cover a draining wound. She said a wound with a dressing could get maggots, but the fact the resident did not have them when he had a dressing on, and developed them when the area was not treated or dressed certainly showed it increased the risk for them.</p>			
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	<p>During an interview on 8/15/19 at 11:40 a.m. the DON stated when the resident admitted to the facility he had a cotton ball in his ear and a bandage behind his ear. She called the wound nurse about a treatment, because it drained and she knew he needed a treatment and dressing. She said the family had no complaints about the treatment, telling them whatever needed to be done. She stated it did have a strong odor without the dressing. She said she thought they got an order from the hospital to leave the area open to air, but apparently did not. She concurred the hospital nurse telephone report did not constitute an order. She called to get an order for a wound consult because she thought it needed a treatment, but did not ask to continue the treatment he had prior to the hospitalization. She said the appointment was scheduled for 7/8/19 and by that time the resident was in the hospital.</p> <p>During an interview on 8/19/19 at 9:59 a.m. the resident's Physician stated he checked the ear wounds when the resident was in the hospital (6/29-7/1/19) and they were covered. He said the wounds should have continued to be treated and covered. The wound nurse had recommended the treatments he had prior to the 6/29/19 hospitalization and it was his understanding they would continue those. He said when you have a wound like that you treat it. He was not aware they had not been doing the treatments from the time he returned from the hospital until the resident came in with the maggots. He said the resident had eaten so they did a local anesthetic for the removal.</p>			
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	<p>When he came back again they used a general anesthetic so they could do a more thorough cleaning. He said it was possible to get a maggot infestation in a dressed wound, but it would have been much less likely. He had not seen a maggot infestation in a wound being treated and dressed. He said the resident was treated with antibiotics preemptively for the maggots.</p> <p>Facility Response:</p>			
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