8-28

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

| Number<br>FC# 2763 | | Report date<br>August 28, 2006 |
|---|---|---|
| Facility name<br>Indian Hills Nursing and Rehab | | Survey dates<br>July 31- August 1, 2006 |
| Facility address<br>1800 Indian Hills Drive | Surveyor Donna Walters, RN | |
| City<br>Sioux City, IA 51104 | ck | |

| Rule or Code Section | Nature of Violation | Class | Fine Amount | Correction Date |
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| 58.19(2)k<br><br>+ | **58.19(135C) Required nursing services for residents.** The program plan for nursing care facilities shall have the following required nursing services under the twenty-four-hour direction of qualified nurses with ancillary coverage as set forth in these rules:<br><br>58.19(2) Medication and treatment.<br><br>k. 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. | II | $350 | Upon Receipt |
| 58.20(2) | **58.20(135C) Duties of health service supervisor.** Every nursing care facility shall have a health service supervisor who shall:<br><br>58.20(2) Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs are met.<br><br>**DESCRIPTION:**<br><br>Based on record review, staff interview and physician interview, the facility failed to ensure provision of accurate assessment and timely intervention for a resident with onset of adverse symptoms which represent a change in mental, emotional or physical condition and failed to ensure services in order that each resident's needs are met.<br><br>Findings include:<br><br>1. Resident #3, with diagnoses including diabetes mellitus with complication of peripheral neuropathy, peripheral artery disease and hypertension, obtained from a 1/18/06 history and physical, had a left foot with surgically absent second and third toes. According to the Minimum Data Set (MDS) assessment dated 4/15/06, the resident required limited staff assistance in order to transfer and complete personal hygiene activities. The assessment documented the resident with a history of resolved ulcers | | | |

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| | and that staff completed wound care during the assessment period.<br><br>The resident's care plan dated 5/25/06 documented the resident with impaired skin integrity and directed staff to complete a weekly and as-needed assessment of the wound and administer the treatment as ordered.<br><br>Physician's orders dated 6/27/06 directed staff to apply Silvadene (medication used to prevent and treat wound infections) cream to the resident's left foot ulcers every day with dressing changes. The 6/27/06 consultation/clinic referral sheet also confirmed this order.<br><br>A 7/6/06 consultation/clinic referral sheet noted the ulcer as healing and a plan for "surgical debridement (removal of dead tissue) next week."<br><br>Review of Nurse's notes dated 7/10/06 at 11:30 PM indicated Resident #3 had been out for a doctor appointment with the attending physician on the same date and returned with orders for laboratory tests. The nurse attempted to do a dressing change and when the nurse cut the dressing off, found maggots crawling in the wound area. The nurse notified the surgeon and the surgeon ordered staff to re-apply the dressing and that the maggots were supposed to be there. The entry indicated the dressing as saturated with red and brown drainage and the nurse applied a clean dressing.<br><br>In an interview with the Director of Nursing (DON) on 8/1/06 at 10 am., she indicated prior to 6/27/06 the nurses were to keep the dressing clean and dry. She indicated the treatment ordered 6/27/06 as transcribed onto the 6/06 Treatment Administration Record (TAR). She stated staff performed the treatment through the remainder of June but the order did not carry over to the new TARs printed for July. The staff missed doing treatments of a daily dressing change from 7/1/06 to 7/10/06. The DON stated she talked to the physician who told her the outcome was a reduction in assessment opportunities. The DON stated there was no way of identifying where the fly had the | | | |

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| | opportunity to deposit the eggs. She stated the physician did not provide an intervention to keep the foot from being exposed.<br><br>A review of a Quality Assurance Medication Error Report provided by the facility identified the error of the omitted treatment from 7/1/06 to 7/10/06.<br><br>On 7/11/06 Resident #3 had surgery to debride the ulcerated area of the left foot. A review of the dictated progress notes from the podiatry clinic dated 7/14/06 read "presents to the clinic today for follow up evaluation, status post incision and drainage with excisional debridement and irrigation of the left foot with removal of maggots and revision of ulcers at the distal aspect of [gender] left foot to promote closure in stages."<br><br>On 8/1/06 at 1:40 PM Staff A was interviewed by the surveyor with the DON present, per Staff A's preference. Staff A stated on 7/10/06 at about 7:30 PM, after supper, Resident #3 sat up in a wheelchair wearing a special open-toed shoe. An Ace wrap dressing covering the guaze dressing appeared saturated with burgundy red drainage. The documentation said to keep the dressing clean, dry and intact on the treatment MAR (medication administration record) so Staff A removed the dressing and noticed there were maggots on the dressing, maybe 5, and in the wound bed maybe 5 or 7. Staff A stated she didn't count them but "it wasn't an obscene amount." Staff A attempted to notify the podiatrist several times and received no return call so she contacted the hospital and the hospital contacted a colleague of the podiatrist. Staff A stated the physician told her to re-dress the wound with a clean dressing and reassured her it would be taken care of the next day. Resident #3 had a debridement procedure scheduled for the next day. Staff A went back to Resident #3 and put a clean dressing on the left foot and stated the wound appeared red with brownish tint. It was oozing drainage when Staff A assessed it. Staff A stated it "looked like peroxide, like when it bubbles, but it wasn't, it was the insects." Staff A stated the wound measured about 1/2 inch by 1 inch. Resident #3 voiced | | | |

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| | no complaints and denied any pain. Staff A stated the edges of the wound appeared red and beefy and the surrounding tissue did not appear with signs or symptoms of infection. Staff A stated she asked the physician if the maggots were put there, but indicated she could not remember what the physician responded but did say it was okay they were there. Staff A stated close to 10 PM the dressing remained dry when she re-checked it. Staff A reported it to the next nurse but did not remember the name of the nurse.<br><br>In an interview with the podiatrist on 8/1/06 at 3:30 PM she stated that technically the fly contamination could have happened anywhere but if the treatment would have been done the irrigation and the Silvadene cream would have prevented the maggots from living. The podiatrist stated being unaware of anything that could be used to protect the foot other than wrapping the foot and daily dressing changes should be adequate to keep it from happening. The podiatrist stated the surgeon dated the maggots as 4-day old maggots. The podiatrist stated since Resident #3 had a procedure scheduled, the surgeon probably wanted to document the presence of the maggots. The podiatrist stated the maggots were not put there therapeutically.<br><br>Observation on 7/31/06 at 2.38 PM revealed Staff B (Licensed Practical Nurse or LPN) completed a dressing change for Resident #3. The dressing change included the use of Silvadene cream. Staff B applied the ointment directly from the tube to the wound without the use of an applicator. The DON also present during the treatment provided the surveyor a copy of a 5-minute re-education presented on 7/14/06 regarding the importance of placing the physician orders on the new TARS. | | | |

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| | FACILITY RESPONSE: | | | |

Facility Administrator

Date