

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

Citation Number: #5985	Fine amount reduced by 35% to \$4,387.50 on February 09, 2023 pursuant to Iowa Code Section 135C.43A	Date: February 1, 2023
Facility Name: The Gardens of Cedar Rapids	Survey Dates: January 10, 2023 – January 18, 2023	
Facility Address/City/State/Zip: 5710 Dean Road SW Cedar Rapids, IA 52404	TAG	
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58.19(2)b	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: 58.19(2) Medication and treatment. b. 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) DESCRIPTION: Based on clinical record review, staff and Physician interviews, and facility policy review the facility failed to assess and implement interventions to prevent the development of a necrotic pressure area related to a cast worn for one out of four residents reviewed (Resident #89). The facility reported a census of 36 residents.	CLASS I	\$6,750.00 (TO BE COLLECTED)	UPON RECEIPT
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	Findings Include: The MDS (Minimum Data Set) Assessment identifies the definition of pressure ulcers as follows: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). May be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.			
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	Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The Minimum Data Set (MDS) Assessment for Resident #89 dated 11/17/21, listed diagnoses of fracture of right Tibia, end stage renal disease (ESRD), and diabetes mellitus. The MDS recorded a Brief Interview of Mental Status (BIMS) score of 1 out of 15 indicating severe impaired cognition. The MDS reflected Resident #89 totally dependent on the assist of 2 staff for bed mobility, transfers, toileting, dressing and bathing. The MDS documented Resident #89 totally dependent on 1 staff for personal hygiene and at the time of the MDS lacked any pressure ulcers and			
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	was at risk for development of pressure ulcers. The Care Plan for Resident # 89 dated 11/24/21, identified the resident at risk for skin breakdown related to incontinence and the use of assistive device for activities of daily living (ADL's). The Goal read, Resident's skin will remain intact. The interventions directed to report any signs of skin breakdown (sore, tender, red or broken areas). The Care Plan identified the resident's diabetes mellitus and directed Nursing Staff to check all of body for breaks in skin and treat promptly as ordered by doctor. The Braden Scale for Predicting Pressure dated 12/1/21, showed a score of 16 (at risk). The Physician's Orthopedics (Ortho) Progress Note dated 12/8/21, read right tibia - fibula (Tib-Fib, the two long bones located in the lower leg). He is about a month out from the injury in a long cast non weight bearing (NWB). With the cast removed his skin is intact. Placed back into a fiberglass SL cast. The Health Status Notes dated 12/8/2021 at 4:12 PM, read Resident #89 went out to Ortho appointment today and returned with a new cast below the knee. Report showed the fracture has not started to heal yet and resident remains NWB to right lower ext.			
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	Physical Therapy department made aware and staff made aware that resident weight bearing status has not changed. The Skin/Wound Note dated 1/3/2022 at 8:16 PM, read unstageable pressure ulcer located at the right posterior knee just at the top of the cast, surrounding tissue is warm to the touch with induration (soft tissue becomes thicker and harder due to an inflammatory process caused by various triggering factors) noted. Blanchable but painful to resident. Measurements 5.6 centimeters (cm) by 2.7 cm by 0.4 cm, difficulty getting proper measurement due to cast blocked rest of wound. Wound bed appears to be at least a Stage II (2) with bed presenting with dark tannish yellow slough. It appears to be dry but when cleaned a purulent foul smell drainage came off on the rag. Superior aspect of the wound is presenting with brown and orange slough possibly necrosis especially with the decay smell being present. Reported to the Physician and she wanted the resident seen by Ortho as soon as possible. The Physician ordered an antibiotic for the wound. The Wound Skin Healing Record for Resident # 89 dated 1/4/22, showed an unstageable pressure wound to the right posterior knee measured 5.6 centimeters (cm) by 2.7 cm and 0.4 cm. The			
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	description of the wound read a small amount of purulent drainage with a foul odor and described the wound bed with slough and black or brown eschar. The skin around the wound read bright red, hardness or indurated edges. The record reflected the Physician notified on 1/3/22, but failed to reflect resident representative notification. The Physician's Progress Note dated 1/4/22, read January 3rd, the Care Center called and described a terrible ulcer close to and under the cast. Resident #89 is scheduled to see Ortho on January 5th 2022, hopefully that can be done on the 4th. Augmentin (antibiotic) 875 milligrams (mg) two times a day for 10 days ordered. Cast is resting into the wound with a foul odor. The Physician's Ortho Note dated 1/5/22, read Resident #89 is about 2 months out from the injury and treated with a short leg cast. The Care Facility called and reported a malodorous wound. The Note reflected, above the posterior aspect of the cast with about a 12 cm by 4 cm area with a superficial wound that had a little bit of necrotic fibrinous tissue at its base. There is surrounding erythema (superficial reddening of the skin), that went up the leg proximally (part of the body that is closer to the center of the body) and distally (away from the center of the body)			
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	by 15 cm in each direction. The wound is indurated there is no obvious fluctuant area, no gross drainage or pus noted. The Note directed, the strong need for wound care, IV antibiotics and admission to the hospital. The Physician's Progress Note dated 1/5/22, revealed Resident #89 seen at the Ortho Clinic. Necrotic (the death of most or all of the cells in an organ or tissue due to disease, injury, or failure of the blood supply) wound in the right popliteal space (behind knee joint), sent to the Emergency Room (ER) for intravenous (IV) antibiotics and admission to the hospital. On 01/11/23 at 4:51 PM, Staff A, Licensed Practical Nurse (LPN), reported on 1/3/22 she helped a Certified Nursing Assistant (CNA) transfer Resident #89 and noted a foul odor. She stated she directed the CNA to look for the cause of the odor after dinner that night. She revealed, she and the CNA found the wound to the back of Resident #89's knee (as described on the Skin/Wound note). Staff A stated, she reported the wound to the Director of Nursing (DON) and the Physician. She commented, she checked his toes and completed the finger test, to see if she could put her fingers between the skin as a circulation assessment related to the cast placement. She said, on that day, she failed to do that. She			
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	revealed, she failed to observe any obvious symptom of Resident #89's wound before the foul smell. She reported, he lacked any complaints of pain, only complained of the itch of the cast. She said many times Resident #89 pulled the stuffing from the cast. Staff A, revealed the Bath Aides, and the CNA's are expected to check residents skin and report to the nurses if they find anything. On 01/12/23 at 7:52 AM, the Administrator/Registered Nurse (RN), confirmed the Bath Aides were educated after Resident #89's wounds were identified. She stated the Bath Aides were not terminated. She reported she is unclear the reason for the education provided to the Bath Aides after staff identified Resident #89's wound. She remarked, possibly they failed to do a thorough check of the skin. The Demonstrator confirmed, she and the DON are new in their management rolls after this incident occurred. On 01/12/23 at 9:31 AM, the Administrator, reported she failed to locate any Bath Skin Records for Resident #89 from 12/8/21-1/3/22, before staff found the wound to the posterior knee. On 01/12/23 at 9:53 AM, the Restorative RN, stated she started here around 6 months ago. She reported,			
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	she is expected to checks the skin around any of the resident's braces or casts as well as the nurses on the floor, she indicated it's like a double check. 01/12/23 at 11:26 AM, the Administrator reported she failed to see the wound. She said, she knew of the NWB status due to the cast on the right leg. She stated, she thought Resident #89 required a stand pivot transfer (SPT) assist of 2 staff for transfers. She reported, she failed to know of any behaviors from Resident #89. She said, with a cast she expected the nurses to do circulation and skin check, and expected documentation if the nurses noted an abnormality. She confirmed, she expected the CNA's to report any complaints of pain or anything abnormal to the nurse. On 01/12/23 at 11:58 AM, the Administrator reported the facility failed to have a Cast Care Policy. On 01/16/23 at 1:34 PM, the Physician reported, she wouldn't call it neglect but, as soon as they removed Resident #89's pants, they saw the wound to the back of his knee. She said she expected the facility Nursing Staff removed the resident's pants to see the wound. She stated the wound resulted from pressure, friction and a lack of padding from the cast due to his positioning. She remarked it may have developed for a week or more.			
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The facility provided a policy titled Skin Checks dated 7/12/18, read the Bath Aides will observe all resident's skin for abnormalities during each bath or shower and report abnormalities to the Charge Nurse. Any abnormalities noted during resident bathing will be documented by the Bath Aide on the Skin Check Forms. This form will be given to the Charge Nurse upon completion. The Charge Nurse will complete an assessment of the skin and document on the appropriate Skin Assessment Form. The Physician will be notified of any new or worsening area. A treatment order will be obtained and the resident representative will be notified. FACILITY RESPONSE:		

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