

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

Number: #5655		Fine amount reduced by 35% to \$3,737.50 on April 1, 2022 pursuant to Iowa Code Section 135C.43A		Report Date: March 28, 2022	
Facility Name: Deerfield Healthcare Center		Survey Dates: March 8 – 14, 2022			
Facility Address: 13731 Hickman Road		JS VW			
City: Urbandale					
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
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) <i>Resident safety.</i> 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, record review, interviews and facility policy review the facility failed to complete skin and safety assessments and failed to provide adequate supervision to prevent a burn for 1 of 3 residents reviewed for supervision (Resident #1). Resident #1 required assistance of one staff for eating. Staff left Resident #1 unsupervised with a hot cup of coffee and Resident #1 sustained second degree burns on her thighs. The facility reported a census of 25 residents. Findings include: According to the Minimum Data Set (MDS) dated 2/8/22 Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, indicating in intact cognitive ability. The resident required extensive assistance with the help of two staff for bed mobility, transfers and toilet use, and	I	\$5,750 (Collect)	Upon Receipt	

If, within thirty (30) days of the receipt of the citation, you: (1) do not request a formal hearing or; (2) withdraw your request for formal hearing; and (3) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	required extensive assistance with the help of one staff for eating. The Care Plan interventions dated 9/2/22 directed staff to encourage the use assistive devices, safety measures to reduce the risk of infection, falls, and injury, and perform a safety risk evaluation on admission, as needed and upon changes in condition. The Care Plan updated 1/11/22 directed staff to be informed of special dietary and safety needs, on a mechanical soft diet, watch for difficulty swallowing, prolonged swallowing time, repeated swallows per bite, coughing, clearing throat, drooling, and pocketing of food. A review of POC Response History printed 3/9/22 at 11:49 AM, revealed staff documented Resident #1 had a new skin issue described as a reddened area noted on 2/17/22. According to an Incident Report dated 2/19/22 at 12:03 PM, Resident #1 was found to have wounds on her inner thighs. The overnight nurse had reported to the morning shift that they discovered blisters on the thighs while checking for incontinence. Some staff suspected that the injuries had been caused by the Hoyer sling but the resident later told them that a couple of days previous, she had spilled hot coffee in her lap. The follow up action to the incident included an interventions to put 3-5 ice chips in the coffee before serving coffee and dietary staff were instructed to wait for a Certified Nursing Assistant (CNA) before delivering the residents meals.				

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	Observation and interview on 3/8/22 at 10:37 AM revealed, Resident #1 sitting in a recliner chair in her room watching television. The resident had a severe left hand contracture, her speech was soft and slurred and her bottom lip was slumped on the right side. When asked about the injury she sustained on her thighs, Resident #1 said she that she had been alone in her room with a meal on the bedside table next to her recliner and with her right hand, she picked up her coffee thermos to take a drink. When she went to put the cup back on the tray it tipped over and spilled into her lap. Resident #1 said that she had not told the staff about the spill because she didn't think that they were interested. She said that a staff person had been with her in the room when the meal had been served to her, but "all of a sudden" the staff person left the room. The resident did not remember the specific meal or date of the incident. A review of the Nursing Notes and Physician Notes revealed the following entries: a. A fax communication dated 2/19/22 at 4:15 AM was sent to the doctor and stated that Resident #1 was found to have blisters and redness on bilateral inner thighs. The left thigh injury measured 5 centimeters (cm) x 3 cm. with an area of redness that measure 10 cm. long. The right thigh injury measured 2 cm. x 2 cm. On 2/22/22 the doctor signed the fax with a treatment order.				

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	b. A doctor's note dated 2/22/22 showed that the resident had a fluid filled blister to the right inner thigh and the left inner thigh had a stage 2 ulcer (previous blister). The posterior left thigh had a stage 2 ulcer, previous blister. c. On 2/24/22 a doctor's note included measurements as follows: left inner thigh 3 cm x 10 cm x 0.1 and right posterior thigh 0.5 cm x 1.0 cm x 0.1 cm. d. On 3/1/22 a doctor's note indicated that the resident had 2nd degree burns (second-degree burns affect the outer layer of skin and the next layer, the dermis) Retrieved from Second-degree burn: Causes, symptoms, and treatment (medicalnewstoday.com) on 3/14/22. The posterior left thigh had a stage 2 ulcer and the left inner thigh had a stage two ulcer, initially a blister (stage 2 ulcer is shallow with a reddish base) Retrieve from Stage 2 Pressure Ulcers Wound Source on 3/14/22. e. On 3/3/22 a doctor's note included; the left inner thigh injury measured 1 cm. x 0.5 cm. x 1 cm. The right posterior thigh injury measured 1.2 cm. x 2 cm. x 0.1 cm. A left posterior thigh injury measured 1.3 cm. x 2.0 cm. x 0.1cm. On 3/8/22 at 12:29 PM, Staff F, Registered Nurse, stated she first learned about the blisters on Resident #1 on the morning of 2/19/22 when the overnight nurse had passed on in report that they discovered the blisters				

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	during overnight rounds. Staff F said that the resident told her that she had spilled coffee on her lap but she hadn't told anyone about it at the time of the incident. On 3/8/22 at 2:26 PM, Staff B, Licensed Practicing Nurse, stated she worked the overnight shifts. She said that a Certified Nursing Assistant (CNA) came to her after doing rounds on the night of 2/18/22 and reported that Resident #1 had blisters on her thighs. Staff B said that no information about these wounds had been passed onto her at shift report. The next morning, she told the day nurse and she faxed the information to the doctor. Staff B said that she asked Resident #1 what happened but the resident hadn't responded because she was sleepy at the time. Staff B assumed that the injuries must have been from the Hoyer sling. On 3/8/22 at 2:10 PM, Staff C, Certified Nurse Aide, stated she saw the blisters on Resident #1 when she was doing rounds on the overnight shift of 2/18/22 and she passed on the information to the day shift. She said that when she told the staff about the blisters in the morning, a couple of people indicated that they knew about the injuries and that it had been caused by a coffee spill. On 3/8/22 at 2:40 PM, Staff D, Certified Nurse Aide, stated she discovered the blisters on the resident on a morning shift when she and another CNA were getting the resident up for the day. She said that they had not gotten any information about the injuries during the shift report that morning. She did not remember the date,				

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	and said that they reported the injuries to a nurse but did not remember the nurse's name. The Weekly Skin Check printed 3/8/22 at 12:55 PM, documented an assessment on 2/7/22 at 9:32 AM. The assessment documented no new skin issues at that time. The Clinical Record lacked a weekly assessment from 2/7/22 to 2/19/22. According to a policy dated 2/16/22 staff were to use the Hot Liquids Safety Assessment to determine a resident's risk of burns from hot liquids to be completed on admission/readmission, as needed and with quarterly and annual MDS assessments. Resident #1 did not have such an assessment completed until after it was discovered that she had spilled hot coffee in her lap. The assessment dated 3/8/22 indicated that Resident #1 was at high risk for burns and required extra precautions and interventions at meal times. On 3/14/22 at 8:27 AM, the Director of Nursing (DON), stated they did not have a Hot Liquids Safety Assessment completed for Resident #1 before the coffee spill and the expectation was that the assessment was completed upon admission, readmission, change of condition and quarterly. She said that the MDS nurse was expected to alert the nursing staff when these are due. The DON said that when they did their investigation of the burn incident they discovered that weekly skin assessments were not being completed weekly. She said that nursing			

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	staff were expected to complete these weekly and that she would oversee the process. FACILITY RESPONSE:				

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