

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

Number 5929		Fine amount reduced by 35% to \$2,437.50 on December 19, 2022 pursuant to Iowa Code Section 135C.43A		Report date November 29, 2022	
Facility name Prairie Gate				Survey dates October 24, 2022- November 1, 2022	
Facility address 16 Valley View Drive					
City Council Bluffs		CMD			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
IAC 481-58.19(2)j	j. 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) DESCRIPTION: Based on clinical record review, observation, staff interview, and facility policy review, the facility failed to assess a resident's wounds for 1 of 4 residents reviewed for wounds (Resident #4). The facility failed to perform follow up skin assessments and interventions on Resident #4's right lower extremity wound after first identifying the skin concern on 10/11/22, which subsequently resulted in deterioration of the wound. The resident's physician ordered antibiotics for the resident on 10/25/22. The facility reported a census of 16 residents. Findings include: The minimum data set (MDS) assessment dated 8/31/22 revealed Resident #4 had diagnoses of Alzheimer's disease, hemiplegia (paralysis on one side of the body), and an unstageable pressure ulcer to her right ankle. The MDS documented the resident had a brief interview for mental status (BIMS) score of 3, indicating severely impaired cognition. The MDS documented the resident had total dependence	I	\$3,750	Upon Receipt	

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	on two staff for transfers. The MDS documented the resident had an unstageable deep tissue injury but no infection or open lesions. The care plan initiated on 7/6/20 and revised on 10/26/22, revealed the resident had a risk for impaired skin integrity related to cognitive impairment, impaired mobility, and history of a pressure injury. The care plan also listed the resident had a skin tear and an infection to her right lower leg (revised on 10/26/22), and at risk for further infection. The staff directives included: administer antibiotics as prescribed (added 10/26/22), encourage fluid intake, watch for signs of increased infection such as increased redness, pain, swelling, or drainage, and pad the foot pedals for pressure prevention (initiated 11/18/21). Resident Occurrence Report dated 10/11/22 8:15 AM revealed the resident had a skin tear that required medical attention and first aid. A screw on the wheelchair foot pedal caused the injury. Occupational Therapy (OT) contacted on 10/11/22 at 12:27 PM to cover the screws of the wheelchair. The record lacked a skin assessment for 10/11/22 regarding the skin tear to the right lateral calf.				

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	A physician's order, dated 10/11/22, revealed the resident had a skin tear to her right upper ankle. The area was cleansed with soap and water, and territories applied. A skin and wound evaluation, completed 10/25/22, for a skin tear to the right lateral calf acquired on 10/11/22. The area measured 2.1 x 1.3 centimeters, and had evidence of infection including increased pain, redness, inflammation, and warmth. The physician evaluated Resident #4 and ordered an antibiotic on 10/25/22. A physician's order, dated 10/25/22, revealed culturelle capsule (Lactobacillus) one tablet by mouth 2 times a day (BID) for 14 days (a bacterial supplement to replace gut bacteria killed by the antibiotic), and doxycycline 100 milligrams (mg, an antibiotic) tablet BID for 10 days for right leg cellulitis. A physician's order, dated 10/27/22, revealed the facility staff should apply betadine to the resident's right lower leg twice a day until healed. The progress notes revealed the following: a. On 10/11/22 at 8:26 AM, resident had a skin tear and hematoma to the right outer upper ankle. Area cleansed with soap and water, and			

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	steristrips applied. An intervention included to apply foam higher up on the wheelchair legs to prevent scraping. Family and physician notified. At 12:27 PM, Occupational Therapy (OT) contacted to place something over the screw on the resident's wheelchair foot pedals. b. On 10/12/22 at 3:53 PM, a skin tear noted to right outer ankle approximated with steri-strips. Skin is otherwise clean, dry, and intact without signs or symptoms of infection or breakdown. c. On 10/16/2022 at 9:39 AM, pressure ulcers measurements performed to the right ankle deep tissue injury and right pinky finger. See skin and wound assessments for measurements. The progress note lacked information about the skin tear to the right outer ankle. d. On 10/25/2022 at 12:04 PM, a Physician's Order Note revealed the physician evaluated the resident's right leg and wrote orders for doxycycline 100 mg PO BID for 10 days for cellulitis and culturelle 1 tablet by mouth BID for 14 days. Observations on 10/25/22 at 2:10 PM with Staff G, Registered Nurse (RN), revealed the resident had a quarter sized skin tear 2 inches above her right ankle. Staff G reported the resident sustained the skin tear a couple of weeks ago when the CNAs (certified nursing assistants) transferred the resident with a hooyer into her			

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	wheelchair, and a screw by the wheelchair leg pedals caught and tore the resident's skin. In an interview 10/24/22 at 2:53 PM, a family member reported the resident had a sore on her ankle. In an interview 10/25/22 at 2:30 PM, the Clinical Care Coordinator reported no skin assessment other than a progress note regarding the skin tear on Resident # 4. The Clinical Care Coordinator reported since the resident had now developed a concern on how the wound looked, they now planned to initiate a skin assessment form on the electronic health record. A skin integrity management policy, modified 10/2022, revealed the purpose to properly identify, assess, and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers/injuries, to implement preventative measures, and to provide appropriate treatment modalities for pressure ulcers/injuries according industry standards of care. A care plan developed or modified to reflect alterations in interventions and implementation of new interventions specific to the resident. The care plan interventions shall be communicated to the appropriate staff via the nursing assistant assignment sheet or My Best Day and/or				

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	through report. The procedure included to inspect the skin with cares for signs and symptoms of breakdown, and a body audit performed by designated employee on shower day or other designated day at least weekly, and findings documented per facility policy. Upon discovery of a non-surgical wound: 1. Initiate Pressure Ulcer/Injury Management Checklist 2. Request treatment order from provider 3. Initiate Daily Wound Monitoring in the electronic treatment administration record. 4. Initiate new Wound Assessment using the Skin and Wound App to complete the measurements of the wound 5. Complete wound assessment in the electronic health record which included the onset of skin condition, type of wound, location, date, wound measurements, surrounding skin description, drainage, odor, and/or pain. The wound documentation completed at least weekly, or more frequently depending on the wound characteristics. 6. Implement appropriate interventions and update care plan and nursing assistant assignment sheets or My Best Day 7. Communicate changes with appropriate staff members FACILITY RESPONSE:			

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