Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: February 15, 2022
Program Name: Emery Place
Address: 901 South Mentzer Road Robins, IA 52328
Type of Action: Recertification & Infection Control Visits and Complaints #95611-C, #95612-C, #95613-C, #98302-C
Date(s) of Action: 1/10/22 – 1/26/22
Citation #: 5592

State Rule #	State Rule	Amount of Civil Penalty
481- 67.3(2)	**481-67.3 Tenant rights. All tenants have the following rights:** **67.3(2) To receive care, treatment and services which are adequate and appropriate.** Based on interview and record review the Program failed to provide adequate and appropriate care, treatment and services to 1 of 3 current tenants reviewed (Tenant #4). Findings follow: 1. Record review revealed an electronic Incident Report, dated 2-5-21 at 8:40 a.m., indicated direct care staff responded to Tenant #4's spouse's pendant. Tenant #4's spouse reported Tenant #4 fell when he tried to sit on the toilet. Tenant #4 was laying in bed when direct care staff responded to the pendant. Tenant #4 said "I fell, I'm fine." There was a skin tear to the left elbow. A nurse was notified, Tenant #4 refused vitals and denied hitting his head. The report indicated a skin tear to his left elbow with no other injuries. The Former Assistant Healthcare Coordinator (HCC) completed the report. The handwritten Incident Report, dated 2-5-21 at 8:40 a.m. indicated Tenant #4's spouse pressed her pendant and reported he fell attempting to sit on the toilet. When direct care staff responded, Tenant #4 was laying in bed. The report indicated Tenant #4 was not sent out to the hospital and noted a skin tear to the left forearm. The report indicated Tenant #4's primary care provider (PCP) was notified on 2-5-21 at 3:00 p.m. The Former Assistant HCC was notified on 2-5-21 at 8:40 a.m. The Former Assistant HCC signed the report. Continued Record review revealed a Prehospital Care Report indicated on 2-6-21 a fire rescue and emergency medical services (EMS) unit arrived at the building to get equipment that was left there from a prior call. Staff handed the	**$3000.00**

	equipment over and asked if they could evaluate an injured tenant. The unit notification time was 11:09 a.m. and the assessment exam time was 11:10 a.m. The emergency medical technicians (EMTs) responded to the apartment and observed two adults, including Tenant #4 seated in a chair with a towel under his left arm arm. It was noted there appeared to be a "large laceration proximal to elbow traversing to distal to elbow joint with bleeding controlled." Staff reported Tenant #4 fell the day prior, a nurse "evaluated the injury and placed some skin closures and left. Wife of the male reports feeling this was insufficient at the time." Both Tenant #4 and his spouse reported the wound bled since the fall the day prior. The report further noted, "...Wound is evaluated and found to be approximately 7" in length and oozing. There are two skin closures on it and adipose tissue is visible along with the elbow joint." The report indicated, "Patient reports pain is 8/10 at this time." A call was placed to dispatch for a an ambulance service unit based on the "severity of the wound." The impression noted on the report indicated "sub standard wound care was provided this patient will likely need sutures and antibiotics." Further record review revealed hospital records indicated Tenant #4 arrived to the hospital on 2-6-21 at 12:05 p.m. and was discharged on 2-8-21 at 1:30 p.m. Diagnosis included a skin avulsion injury (on the left elbow) due to a fall. The document indicated Tenant #4 had a "mechanical fall" on 2-5-21 and sustained a skin avulsion to the left elbow. The laceration was "seen by nursing who applied two steri-strips." EMS returned to the building to get equipment from the day before, were asked to look at the wound and observed exposed bone and depth of the wound. It was determined to bring Tenant #4 to the emergency department. He had mild elbow pain, that was sharp and constant. When it was touched the pain went to severe. It was noted Tenant #4 had a "Large linear lac noted on left elbow, skin mostly detached from fascia and very moveable around joint." It was noted EMS was told Tenant #4 fell the day prior and had a injury to the left elbow. The report documented, "Allegedly nurse on duty yesterday assessed pt's elbow and placed 2 steri strips on it, no further follow up reported." The open laceration on his elbow was four inches long (approximately) and there was swelling and bruising noted. Two steri strips were placed across the laceration. Records indicated a silicone adherent was placed to "reduce the skin flap." Tenant #4's would need "follow-up outpatient closely to evaluate for necrosis, that possibly later would need debridement and and intervention." Tenant #4 received intravenous (IV) antibiotics in the hospital and was transitioned to oral antibiotics at discharge.	

	2. When interviewed on 1-19-22 at approximately 12:35 p.m. Tenant #4 and his spouse reported he had fallen or slipped in the bathroom. The nurse looked at it, wrapped it with gauze and left. When an ambulance was there for another tenant, Staff F asked them to look at Tenant #4's injury. The EMTs were concerned it could be sepsis and Tenant #4 was taken to the hospital. When interviewed on 1-19-22 at 5:30 p.m. the Former Assistant HCC said Tenant #4's spouse pushed her pendant and a direct care staff responded and called for a nurse. Tenant #4 had a fall in the bathroom getting on or off the toilet and his spouse had gotten him up. When the Former Assistant HCC arrived he was in bed. Tenant #4 had some pain and his spouse said she would give him as needed Tylenol. The Program did not manage Tenant #4's medications. The Former Assistant HCC said four to six weeks earlier Tenant #4 had a fall and sustained a skin tear. Two weeks prior (to this fall), Tenant #4's spouse refused assessment of the skin tear. The Former Assistant HCC said Tenant #4 had re-opened the skin tear with this fall. She applied steri strips and wrapped with Coban, so he did not touch the dressing. There was no muscle or tissue exposed. When it was assessed she did not feel it warranted being sent out and Tenant #4's spouse did not want him sent out. Friday afternoon (day of the fall) Tenant #4's spouse asked staff to secure the dressing and more gauze was applied. She did not take the dressing off at that time per Tenant #4's spouse's request. She did not look at the wound at that time, she had observed it on Friday morning (day of the fall) when it first happened. She was not on-call over the weekend, on Monday she was notified Tenant #4 went out on Saturday morning. She said the paramedics were in the building and staff asked them to re-wrap the dressing. Tenant #4 complained of pain and wanted to be sent out. Tenant #4 returned on Monday with a large gauze dressing and strict orders not to remove the dressing. At a follow up appointment Tenant #4's wound was debrided and sutures were placed. When interviewed on 1-19-22 at 3:48 p.m. the Former HCC indicated she was not involved with the incident with Tenant #4 and the said the Former Assistant HCC was involved. The Former HCC said she was on-call and received a telephone call on Saturday from Staff F after Tenant #4 had been transported to the hospital. Paramedics were in the building and transported him out. Staff F said he was bleeding through the bandage, paramedics dressed it and he was sent out. Staff F was the staff that worked Friday (day of the fall) and	

	Saturday (day Tenant #4 went out). The Former HCC said the Former Assistant HCC looked at Tenant #4's wound at 3:30 p.m. or 4:00 p.m. on Friday and told the Former HCC it looked fine. The Former HCC did not receive a call from 5:00 p.m. until Staff F called, after Tenant #4 was sent out. The Former HCC did not observe Tenant #4's injury on Friday. She followed up with the Former Assistant HCC and who said she put a bandage and wrapped it with Kerlix. It was wrapped to ensure Tenant #4 would leave it alone. Attempts to interview Staff F related to the incident with Tenant #4 were unsuccessful. 3. Continued record review on 1-13-22 of Tenant #4's service plan dated 2-8-21, reflected Tenant #4 was hospitalized for a skin avulsion on 2-6-21 to 2-8-21. The service plan reflected Tenant #4 a history of falls and he required no staff assistance with ambulation. An electronic Incident Report dated 1-11-21 at 6:00 p.m. indicated Tenant #4's spouse informed the nurse that Tenant #4 fell in the shower last evening, hit his left side and left elbow against the wall, and got up independently. He complained of pain to the left rib cage and two skin tears were noted to the left elbow. Further record review revealed Progress Notes indicated the following: -On 1-15-21 (late entry on 1-22-21) it was noted Tenant #4's skin tears were healing. -On 1-22-21 (late entry) it was noted Tenant #4's skin tears were healing. -On 1-28-21 (late entry on 1-29-21) it was noted Tenant #4 did not allow the nurse to assess his skin tear to the left elbow and forearm. Tenant #4's spouse said it was healing and would take some time. -On 2-5-21 (late entry on 2-7-21) it was noted staff responded to Tenant #4's spouse's pendant. Tenant #4's spouse said he fell when he tried to sit on the toilet. Tenant #4 was laying in bed when staff came responded. A nurse was notified and Tenant #4 refused vital signs. Tenant #4 denied hitting his head and had a skin tear on the left elbow. There were no other injuries noted.	

	-On 2-6-21 (late entry on 2-8-21) it was noted Tenant #4 was sent out for evaluation to a hospital "for evaluation of skin tear." -On 2-6-21 (late entry on 2-8-21) it was noted a nurse at the hospital called and said Tenant #4 would be kept overnight for observation. -On 2-7-21 it was noted Tenant #4 was admitted to the hospital for IV antibiotic treatment for the skin tear. A special dressing was placed to help with natural skin growth and no sutures were placed. -On 2-8-21 it was noted Tenant #4 would be discharged back to the Program at approximately 1:30 p.m. -On 2-8-21 (late entry on 2-9-21) it was noted a change of condition was completed for Tenant #4 return from the hospital and a diagnosis of a skin avulsion. New interventions for falls were added. -On 2-8-21 it was noted Tenant #4 returned with new antibiotic orders and Tenant #4's spouse was aware and had the medications (independent with medications). There were several appointments, including one on 2-15-21. The dressing on the left arm was to stay in place until the follow up appointment on 2-15-21. -On 2-12-21 (late entry on 2-20-21) it was noted the wound was not able to be assessed and the dressing to the left elbow was in place until the appointment on 2-15-21. -On 2-19-21 (late entry on 3-6-21) it was noted Tenant #4's dressing was in place and nursing was not able to assess the wound. Tenant #4 had a surgical procedure the next week to debride and close the wound. -On 2-24-21 (late entry on 2-26-21) it was noted Tenant #4 returned following surgery to debride the wound on the left elbow and close the wound with sutures. The dressing was to be in place until his follow up with the surgeon next week. -On 3-3-21 (late entry on 3-6-21) it was noted the skin tear remained to the left elbow. Staples were removed by the surgeon today and the dressing was reapplied. Tenant #4 had a follow up appointment next week with the surgeon. 4. Continued record review revealed a Counseling Documentation Form dated 2-8-21, indicated on 2-5-21 direct	

	care staff notified nursing staff Tenant #4 slipped and his arm needed to be assessed. The Former Assistant HCC told Tenant #4, Tenant #4's spouse and the direct care staff, that it was a "small skin tear" and placed a "bandage with co-band on the area." Tenant #4's spouse called for assistance later that day to re-wrap the area "as the co-band was coming off." The Former Assistant HCC re-wrapped the area. On 2-6-21, the direct care staff called the Former HCC (nurse on-call) and said the bandage was "full of blood and it looked bad." EMS checked Tenant #4's arm and the skin tear was "down to the bone." It was recommended he go to the emergency room (ER). Tenant #4 was admitted to the hospital. The level of correction indicated it was a written warning and the type of violation indicated was performance. The report indicated the Former Assistant HCC would complete a "more thorough assessment of skin concerns." If the Former Assistant HCC was "unsure or would like to have a second opinion or another person look at the area" she would contact her supervisor. In summary, Tenant #4, who had a history of falls, had a fall on 1-11-21, that resulted in rib fractures on the left side and skin tears on his left elbow. He fell again on 2-5-21 and the staff who responded called for a nurse to assess the injury to his left elbow. The Former Assistant HCC responded and looked at the left elbow injury and said in interview she did not feel it warranted him being sent out and she said Tenant #4's spouse did not want him sent out. She applied two steri strips and Coban. She returned later, per Tenant #4's spouse's request, to re-wrap the wound; however, she did not assess the wound at that time. The next day, on 2-6-21, EMTs from a fire rescue unit, were in the building for a non-related issue and staff requested they look at Tenant #4's injury. At that examination Tenant #4's laceration was noted to be 7 inches and there was exposed bone. Tenant #4's pain was rated an 8 out of 10. The EMTs called for an ambulance service unit due to the "severity of the wound." Tenant #4 was transferred to the ER and was admitted to the hospital. It was noted there was large laceration, and "the skin was mostly detached from fascia and very moveable around joint." Tenant #4 received IV antibiotics while hospitalized and was also prescribed oral antibiotics at discharge. Tenant #4's diagnosis included a skin avulsion injury of the left elbow. The wound flap was initially sealed with a silicone adherent, in the weeks following his discharge from the hospital Tenant #4 had outpatient surgery. The wound was debrided and sutures were placed. Tenant #4 did not receive care, treatment and services that were adequate and appropriate related to the lack of a thorough nursing assessment, timely evaluation and medical treatment related to his injury post fall.	

Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation