Citation Num	ber:			Date: Februa	ry 6, 2024	
#10196					-	
Facility Name	:		Survey D	Survey Dates:		
Mississippi Va	alley		January	January 18, 2024- January 24, 2024		
Facility Address/City/State/Zip		СР				
500 Messeng	er Road					
Keokuk, IA 52	632					
Rule or Code	Nature of Violation		Class	Fine Amount	Correction date	
Section						
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50.20(2)	404 50 20/4250) 6. (• The Product of Constant				

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) Resident safety e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements 	CLASS I	\$7,500.00 (HELD UNDER SUSPENSION)	UPON RECEIPT
	in the environment. (I, II, III). DESCRIPTION:			
	Based on clinical record review, observation and staff interviews the facility failed to identify increased water temperatures during a shower that resulted in second degree burns to one of three residents reviewed (Resident #1). The facility reported a census of 60 residents.			
	Findings include:			
	The Quarterly Minimum Data Set (MDS) Assessment for Resident #1 dated 12/14/23, listed diagnoses including debilitating cardiorespiratory (relating to the action of both heart and lungs) condition, quadriplegia (paralysis of all four limbs) and respiratory failure. The MDS identified Resident #1 in a persistent vegetative			

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state, and dependent on staff for all activities of daily living (ADL).		
The Care Plan for Resident #1 dated 11/21/219, directed staff as follows: the resident required total assistance of 2 staff with bed mobility, positioning, dressing, grooming, hygiene and transfers with a full body lift.		
Resident #1's Event Report dated 1/16/24 at 10:25 p.m., documented that a Certified Nurses Aid (CNA) alerted Staff B, Registered Nurse (RN) that he failed to realize as he sprayed water over Resident #1's chest and torso that the water temperature got hot and caused the resident skin to turn red. The Note described Resident #1's abdomen/torso appeared red from the nipple line to just below umbilicus (belly button) and across abdomen, a small intact blister to the left border. Staff applied a normal saline soaked gauze to the area, obtained vitals and assessed pain on a "faces" scale at 4 out of 10. The nurse notified the Physician, who ordered a wound treatment to start as soon as the pharmacy delivered, ordered to continue saline soaks as needed to cool the area, monitor for blister worsening throughout the night and call with changes.		

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Facility Administrator

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	n	
The Medication Administration Record (MAR) dated January 2024, showed on 1/16/24 staff administered		
an as needed (PRN) Oxycodone 5 milligrams (mg) at		
10:44 p.m., and a PRN Acetaminophen 650 mg at 2:42		
a.m.		
The Wound Information for Resident #1 dated		
1/17/23 at 8:46 a.m., identified a burn to the mid		
chest, anterior (front) torso 60 centimeters (cm) long		
by 47 cm wide. The description reflected a large		
amount of serous (clear, amber, thin and watery)		
drainage, and described the burn type as partial		
thickness: redness, blistered, moist, painful.		
The Progress Notes included a Wound note dated		
1/20/24 at 11:31 a.m., from Staff C, Nurse Practitioner		
(NP) Chronic Wound Care Nurse (CWCN) documented:		
Resident#1 recent burn injury to anterior torso from		
chest to navel. The burn reportedly caused from hot		
water during a shower. The burns covered with		
Silvadene cream. The burns classified as superficial		
partial thickness with blisters that have unroofed (skin		
rubbed off), moist, red, weeping areas. Some burn		
areas are dried with dried drainage encrusted wound		
bed. Planned to continue Silvadene cream and add		
Xeroform gauze (fine mesh gauze occlusive dressing)		
over Silvadene, then dry gauze or abdominal (ABD)		

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	pad for drainage. The NP started oral antibiotic as the			
	patient is febrile (fever) today. The note confirmed			
	Resident #1 needed a dietary consult and labs			
	checked.			
	On 1/18/24 at 9:01 a.m., Staff E, Maintenance			
	Supervisor, reported both of the water heaters set at			
	115 degrees, as of the day before. Staff E, stated the			
	water heaters previously were set at 120 degrees.			
	Staff E, revealed management directed the water			
	temperature lowed because someone received a			
	burn.			
	burn.			
	On 1/18/24 at 10:25 a.m., Resident #1's right upper			
	chest appeared like a popped blister, approximately			
	greater than 50% of the torso affected, reddened to			
	-			
	the left mid chest underneath the left nipple area			
	extended in the direction of the resident's back, and a			
	blistered left middle chest. Staff D, RN, treated the			
	wounds with cream per the Physician's order.			
	On 1/18/24 at 10:48 a.m., the Director of Nursing			
	(DON) reported the Physician ordered scheduled pain			
	medication, increased free water flushes via tube			
	feeding and ordered labs done. The DON identified			
	the burn as second-degree burns.			
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On 1/22/24 at 2:52 p.m., Staff A, Certified Nurses Aid,			
(CNA) explained and demonstrated the process of the			
shower he provided Resident #1 on 1/16/24. He			
explained at the end of the shift on 1/16/24 about			
10:00 p.m. the nurse reminded him of the shower and			
he thought he'd get it done fast. Staff A, reported he			
got Resident #1 in the shower chair, took him in the			
shower room. Staff A, demonstrated he took the			
hand-held shower head off the mount with his gloved			
hands and turned the water on. He reported the			
water temperature felt warm with his gloved hand,			
but not hot. Staff A reported he held the shower head			
in one hand, wet the resident and washed the			
resident with the other hand. Staff A, confirmed he			
kept the water on Resident #1 as he washed him to			
keep him warm. Staff A confirmed he failed to notice			
the water temperature got increased. Staff A,			
revealed he identified something's wrong as he dried			
Resident #1 and his skin peeled off. Staff A, stated he			
immediately reported to the nurse. Staff A reported			
the whole shower took about 10 minutes.			
The facility provided a document signed by the DON			
dated 1/18/24, that included her investigation			
summary. The document reflected Staff A failed to			
notice that the temperature of the water changed			
during the shower he gave Resident #1. The			
	 (CNA) explained and demonstrated the process of the shower he provided Resident #1 on 1/16/24. He explained at the end of the shift on 1/16/24 about 10:00 p.m. the nurse reminded him of the shower and he thought he'd get it done fast. Staff A, reported he got Resident #1 in the shower chair, took him in the shower room. Staff A, demonstrated he took the hand-held shower head off the mount with his gloved hands and turned the water on. He reported the water temperature felt warm with his gloved hand, but not hot. Staff A reported he held the shower head in one hand, wet the resident and washed the resident with the other hand. Staff A, confirmed he kept the water on Resident #1 as he washed him to keep him warm. Staff A confirmed he failed to notice the water temperature got increased. Staff A, revealed he identified something's wrong as he dried Resident #1 and his skin peeled off. Staff A, stated he immediately reported to the nurse. Staff A reported the whole shower took about 10 minutes. The facility provided a document signed by the DON dated 1/18/24, that included her investigation summary. The document reflected Staff A failed to notice that the temperature of the water changed 	 (CNA) explained and demonstrated the process of the shower he provided Resident #1 on 1/16/24. He explained at the end of the shift on 1/16/24 about 10:00 p.m. the nurse reminded him of the shower and he thought he'd get it done fast. Staff A, reported he got Resident #1 in the shower chair, took him in the shower room. Staff A, demonstrated he took the hand-held shower head off the mount with his gloved hands and turned the water on. He reported the water temperature felt warm with his gloved hand, but not hot. Staff A reported he held the shower head in one hand, wet the resident and washed the resident with the other hand. Staff A, confirmed he kept the water on Resident #1 as he washed him to keep him warm. Staff A confirmed he failed to notice the water temperature got increased. Staff A, revealed he identified something's wrong as he dried Resident #1 and his skin peeled off. Staff A reported the whole shower took about 10 minutes. The facility provided a document signed by the DON dated 1/18/24, that included her investigation summary. The document reflected Staff A failed to notice that the temperature of the water changed 	 (CNA) explained and demonstrated the process of the shower he provided Resident #1 on 1/16/24. He explained at the end of the shift on 1/16/24 about 10:00 p.m. the nurse reminded him of the shower and he thought he'd get it done fast. Staff A, reported he got Resident #1 in the shower chair, took him in the shower room. Staff A, demonstrated he took the hand-held shower head off the mount with his gloved hands and turned the water on. He reported the water temperature felt warm with his gloved hand, but not hot. Staff A reported he held the shower head in one hand, wet the resident and washed the resident with the other hand. Staff A, confirmed he kept the water on Resident #1 as he washed him to keep him warm. Staff A confirmed he failed to notice the water temperature got increased. Staff A, revealed he identified something's wrong as he dried Resident #1 and his skin peeled off. Staff A reported the immediately reported to the nurse. Staff A reported the whole shower took about 10 minutes. The facility provided a document signed by the DON dated 1/18/24, that included her investigation summary. The document reflected Staff A failed to notice that the temperature of the water changed

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document reflected staff A received and signed a disciplinary action form.		
The facility Progressive Discipline Notification System for Employees dated 1/16/24, identified Staff A, rushed during care resulting injury.		
The facility provided the Bathing the Patient Procedure undated, that directed at point number seven, fill the tub half full of water at a temperature of 110 degrees Fahrenheit and check it with a bath thermometer. Or turn on the shower and adjust the water temperature.		
FACILITY RESPONSE:		

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