DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICALD OF DUICEO

PRINTED: 02/06/2024 FORM APPROVED OMB NO 0938-0391

	MEDICAID SERVICES				
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LETED
	165151	B. WING			C 1 24/2024
ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PPI VALLEY					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
Correction date: <u>F</u> The following deficier investigation of Comp on January 18, 2024 Complaints #118208- See code of Federal	Eebruary 16, 2024 ncies resulted from plaint #118208-C, conducted to January 24, 2024. -C was substantiated.	F 000	Alease see separate attachment for 1906 in "Word" Document		
Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(1) The re as free of accident has §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on clinical rec staff interviews the fa increased water temp that resulted in secon three residents review facility reported a cer Findings include: The Quarterly Minimu Assessment for Resi listed diagnoses inclu cardiorespiratory (rel heart and lungs) con	 (2) (3) (4) (4)	F 689	TITLE		(X6) DATE
	(EACH DEFICIENC REGULATORY OR I INITIAL COMMENTS Correction date: The following deficier investigation of Comp on January 18, 2024 Complaints #118208- See code of Federal 483, Subpart B-C. Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on clinical reo staff interviews the fa increased water temp that resulted in secor three residents review facility reported a cer Findings include: The Quarterly Minimu Assessment for Resi listed diagnoses inclu cardiorespiratory (rel heart and lungs) con	IDENTIFICATION NUMBER: 165151 ROVIDER OR SUPPLIER PI VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Correction date: February 16, 2024 The following deficiencies resulted from investigation of Complaint #118208-C, conducted on January 18, 2024 to January 24, 2024. Complaints #118208-C was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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	CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ 165151 B. WING	IDENTIFICATION NUMBER: A. BUILDING	CORRECTION IDENTIFICATION NUMBER: A BUILDING COMM 165151 B. WING OT ROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE SOM MESSENGER RD PPI VALLEY STREET ADDRESS, CITY, STATE, ZIP CODE SOM MESSENGER RD RECOVER LSC DENTIFYING INFORMATION) IN PROVIDER'S PLAN OF CORRECTION RECOVER LSC DENTIFYING INFORMATION) IN PROVIDER'S PLAN OF CORRECTION INITIAL COMMENTS IN PROVIDER'S PLAN OF CORRECTION Correction date: FEBRUARIZED TO THE RECEPTOR DIVIDUE PROVIDER'S PLAN OF CORRECTION INITIAL COMMENTS F 000 IMALS SEE SEPARATE Correction date: FEBRUARIZED TO THE APPROPRIATE DEFICIENCY INITIAL COMMENTS F 000 IMALS SEE SEPARATE Correction date: FEBRUARIZED TO THE APPROPRIATE DEFICIENCY INITIAL COMMENTS F 000 IMALS SEE SEPARATE Complaint #118208-C was substantiated. See code of Federal Regulations (42 CFR), Part 433 Subject and Segure To an environment remains as free of Accident. F 689 G483.25(d)(12) F 689 F 689 G483.25(d)(2) F 689 F 689 G483.25(d)(2) F 689 F 689 G483.25(d)(2) F 689 F 689 G483.25(d)(2)

2-7-2024

<u>Mulerel Blumer LNH4 LASW, ALCM, B5 - Administrator</u> 2-7-2024 Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

AND FLAN OF CORRECTION DENTIFICATION NUMBER A BUILDING COMPLETED 188151 18.0100 STREET ADDRESS, CITY, STATE, JP OODE 01/24/2024 MALE OF PROVIDER OR SUPPLICR STREET ADDRESS, CITY, STATE, JP OODE 00 00 MALE OF PROVIDER OR SUPPLICR STREET ADDRESS, CITY, STATE, JP OODE 00 00 (#4)10 EAUMARY STATEMENT OF DETIFICIENCIES ID PREFIX CACHORRECTIVE ATOM SOLD BR 000 (#ACH OFFICIENCY MUST BE FLACEDED BY FULL ID PREFIX (#ACH OFFICIENCY MUST BE FLACEDED BY FULL PREFIX (#ACH OFFICIENCY MUST BE FLACEDED BY FULL ID F 689 Continued From page 1 of all four limbs) and respiratory failure. The MDS Identified Resident #1 in a persistent vegatative state, and dependent on staff for all activities of datal yliving (ADL). F 689 F 689 If cache EFLICATION QUICES State at A for all activities of datal statistance of 2 staff with bed mobility, positioning, dressing, grooming, hygiene and transfers with a full body lift. F 689 F 689 If the the failed to realize as the sprayed water over Resident #1's Event Report dated 11/6/24 at 10:25 p.m., documented that a Certified Nurses Aid (CNA) altered Staff B, Registered Nurse (RN) that the taff or all activities of abdomen, a small lista of assessed pail on a "faces" scale at 4 out of 10. The nurse notified the area, contained withs and assessed pail on the area, activated water adverse resident #1's backed backed pail on the list Dorder. Staff applied anormal sall secold do coof	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
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Contract Contract Contract Contract Contract Contract Tx3 Continued From page 1 of all four limbs) and respiratory failure. The MDS identified Resident #1 in a persistent vegetative state, and dependent on staff for all activities of daily living (ADL). F 689 F 689 The Care Plan for Resident #1 dated 11/12/1219, 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. F 689 Resident #1's Event Report dated 11/16/24 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 Event Report dated 11/16/24 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 Event Report dated rover. 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 staft as soon as the pharmacy delivered, ordered to continue saline soaks as needed to cool the area, nonitor for billster worsening throughout the angth and call with changes. The Medication Administration Record (MAR) dated January 2024, showed on 11/16/24 staff administered an as needed (PRN) Oxycodone 5 miligrams (mg) at 10.44 p.m. and a PRN	MISSISSIP	PIVALLEY		к	EOKUK, IA 52632		
of all four limbs) and respiratory failure. The MDS identified Resident #1 in a persistent vegetative 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, dress at staff with bed mobility, positioning, dress at staff with bed mobility. positioning, dress at staff or all activities of data difference of the staff as follows: All (CNA) alerted Staff B, Registered 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 go thot and caused the resident skin to turn red. The Note described Resident #1's abdomentorso appeared red from the nipple line to just below unbilicus (belly button) and across abdomen, a small intact bister to the left border. Staff applied a normal saline soaked gauze to the area., obtained vitals	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLETION	
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) FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CTCT11 Facility ID: IA0921		of all four limbs) and identified Resident #1 state, and dependent daily living (ADL). The Care Plan for Re directed staff as follow total assistance of 2 s positioning, dressing, transfers with a full be Resident #1's Event I 10:25 p.m., documen Aid (CNA) alerted Sta that he failed to realiz Resident #1's chest a temperature got hot a to turn red. The Note abdomen, a small int Staff applied a norma area, obtained vitals "faces" scale at 4 out Physician, who order start as soon as the p to continue saline so area, monitor for blist night and call with ch The Medication Admi dated January 2024, administered an as n milligrams (mg) at 10 Acetaminophen 650 The Wound Informat 1/17/23 at 8:46 a.m., chest, anterior (front)	respiratory failure. The MDS in a persistent vegetative con staff for all activities of sident #1 dated 11/21/219, ws: the resident required staff with bed mobility, grooming, hygiene and ody lift. Report dated 1/16/24 at ted that a Certified Nurses aff B, Registered Nurse (RN) te as he sprayed water over and torso that the water and caused the resident skin described Resident #1's ared red from the nipple line us (belly button) and across act blister to the left border. It saline soaked gauze to the and assessed pain on a tof 10. The nurse notified the ed a wound treatment to oharmacy delivered, ordered aks as needed to cool the ter worsening throughout the anges. inistration Record (MAR) showed on 1/16/24 staff eeded (PRN) Oxycodone 5 0:44 p.m., and a PRN mg at 2:42 a.m. ion for Resident #1 dated identified a burn to the mid torso 60 centimeters (cm)				

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		165151	B. WING		01	/24/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 MESSENGER RD KEOKUK, IA 52632			
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F 689	large amount of serou watery) drainage, and partial thickness: redr painful. The Progress Notes i dated 1/20/24 at 11:3 Practitioner (NP) Chm (CWCN) documented injury to anterior torso burn reportedly cause shower. The burns co cream. The burns co cream. The burns cla thickness with blisters rubbed off), moist, red burn areas are dried of encrusted wound bed Silvadene cream and mesh gauze occlusive then dry gauze or abd drainage. The NP sta patient is febrile (feve Resident #1 needed a checked. On 1/18/24 at 9:01 a. Supervisor, reported at 115 degrees, as of stated the water heat 120 degrees. Staff E, directed the water ter someone received a On 1/18/24 at 10:25 a upper chest appeared	The description reflected a us (clear, amber, thin and d described the burn type as ness, blistered, moist, ncluded a Wound note 1 a.m., from Staff C, Nurse onic Wound Care Nurse I: Resident#1 recent burn of from chest to navel, The ed from hot water during a overed with Silvadene ssified as superficial partial is that have unroofed (skin d, weeping areas. Some with dried drainage d. Planned to continue add Xeroform gauze (fine e dressing) over Silvadene, dominal (ABD) pad for rited oral antibiotic as the er) today. The note confirmed a dietary consult and labs m., Staff E, Maintenance both of the water heaters set i the day before. Staff E, ers previously were set at revealed management mperature lowed because burn. a.m., Resident #1's right d like a popped blister, r than 50% of the torso	F	689			
FORM CMS-256	underneath the left ni 7(02-99) Previous Versions Obs	solete Event ID: CTC	CT11	Facility ID: IA0921	If continuation	sheet Page 3 of 5	

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FUR MEDICARE &	VIEDICAID SERVICES				OND NO	0900-0091
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
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		105151	Si mite	_		1 01/	24/2024
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				1			
F 689	Continued From page	e 3	F	689			
	direction of the reside	ent's back, and a blistered					
	left middle chest. Stat	ff D, RN, treated the wounds					
	with cream per the Ph	nysician's order.					
	On 1/18/24 at 10:48 a	a.m., the Director of Nursing					
	(DON) reported the P	hysician ordered scheduled					
	pain medication, incre	eased free water flushes via					
	tube feeding and orde	ered labs done. The DON					
	identified the burn as	second-degree burns.					
	On 1/22/24 at 2:52 p.	m., Staff A, Certified Nurses					
	Aid, (CNA) explained	and demonstrated the					
	process of the showe	r he provided Resident #1		- 1			
	on 1/16/24. He explai	ned at the end of the shift		1			
	on 1/16/24 about 10:0	00 p.m. the nurse reminded					
	him of the shower and	d he thought he'd get it done					
0	fast. Staff A, reported	he got Resident #1 in the					
	shower chair, took hir	n in the shower room. Staff					
	A, demonstrated he to	ook the hand-held shower					
	head off the mount wi	ith his gloved hands and					
	turned the water on. I	He reported the water					
	temperature felt warm	n with his gloved hand, but					
	not hot. Staff A report	ed he held the shower head					
	in one hand, wet the r	resident and washed the					
		r hand. Staff A, confirmed					
	he kept the water on	Resident #1 as he washed					
	him to keep him warm	n. Staff A confirmed he failed					
	to notice the water ter	mperature got increased.					
		dentified something's wrong					
	as he dried Resident	#1 and his skin peeled off.					
	Staff A, stated he imm	nediately reported to the					
	nurse. Staff A reporte	d the whole shower took					
	about 10 minutes.						
		a document signed by the					
	DON dated 1/18/24, t						
		y. The document reflected		- 1			
		e that the temperature of the					
	water changed during	the shower he gave					
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: CTCT	11	Faci	ility ID: 1A0921 If con	tinuation sh	eet Page 4 of 5

CENTERS FOR MEDICARE & MEDICAID SERVICES

				CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				COMPLETED	
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		165151	B. WING		01/24/2024
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
MISSISSIPPI VALLEY			00 MESSENGER RD EOKUK, IA 52632		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORT OR		IAG	DEFICIENCY)	
F 689	Continued From page	e 4	F 689		
		ument reflected staff A			
	received and signed a	a disciplinary action form.			
	The facility Progressi	ve Discipline Notification			
		s dated 1/16/24, identified			
	Staff A, rushed during	care resulting injury.			
		he Bathing The Patient			
		hat directed at point number			
	seven, fill the tub half temperature of 110 do	egrees Fahrenheit and			
		nermometer. Or turn on the			
	shower and adjust the	e water temperature.			
FORM CMS-256	67(02-99) Previous Versions Ob	solete Event ID: CT	CT11 Fa	acility ID: IA0921 If co	ntinuation sheet Page 5 of 5

7 February 2024

Iowa Department of Inspection, Appeals, & Licensing Health Facilities Division Lucas State Office Building 321 East 12th Street Des Moines, Iowa 50319-0083

To the Department of Inspections, Appeals, & Licensing

<u>RE: Plan of Correction, Mississippi Valley Healthcare & Rehab Center, Complaint</u> Inspection #118208-C, conducted 1/18/2024 through 1/24/2024, Provider #165151.

2567 Finding Document received: 6 February 2024

Preparation and execution of this written response and Plan of Correction does not constitute any admission or agreement by this provider regarding any alleged findings or conclusions set forth in the 2567 statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal & State law. For the purpose of any allegations that the facility is not in substantial adherence with Federal & State regulations of participation, this response and submitted Plan of Correction constitutes the facility's allegation of adherence in accordance with the State Operations Manual.

F 000

Date of Correction: The process of identifying & implementing the corrective steps contained in this Plan of Correction, which also included establishing the preventive measures to ensure the corrections are maintained, were initiated on 1/16/2024 and shall be in effect on 16 February 2024.

Identified F Tag: <u>F-689</u>

Alleged Deficient Practice: It is alleged that 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

Corrective Action

On 1/16/2024, the facility DON issued discipline action and provided re-instruction regarding the expected practices of providing proper showers at safe temperature, to the specific staff member that was involved in the showering event with the resident. On 1/17/2024, the facility Administrator instructed the facility Maintenance Director to re-adjust downward, boiler water temperature settings from 120 F to 115 F. On 1/18/2024, the Maintenance Director issued to all shower rooms, thermometer temperature probes so safe water temperatures could be directly ascertained to provide proper temperature for showers. On 1/18/2024, the DON and other administrative nursing department staff provided re-education to all nursing department staff on the proper procedures that are

expected to be utilized when providing showers to residents which included proper temperatures to be used. On 1/23/2024, the Maintenance Director did order specialized shower heads that have a temperature gauge built into the shower head that records the temperature of the water output from the shower head so water temperature can be assessed quickly and a safe temperature can be adjusted when providing a shower. These specialized shower heads were installed in each shower room being used on 1/29/2024 by the Maintenance Director.

<u>Preventive Measures</u>

The following identified preventive measures, as noted below, shall be implemented to maintain all corrective actions performed to alleviate the alleged deficient practice, as identified in the 2567 Statement of Deficiencies.

For **F-689**, the Maintenance Department Personnel will conduct & document shower water temperature audits at least 5x a week for the next 60 days to ensure water output temperatures are in a safe range to what the hot water boiler temperature settings are established. If there are temperature discrepancies, the Maintenance Department will report this to the Administrator so proper action can be determined and applied to make temperatures consistent & safe for all applied showers. The DON or her designee, shall conduct random visual audits of showers being provided by staff to ensure proper practices are being followed by staff when providing a shower to a resident that includes using a safe temperature range. Any concerns that are determined during an audit, shall be addressed immediately by the DON or designee with the applicable staff, so corrective action is maintained. Both the facility QAPI committee & daily QA stand-up group, over the next 60 days, shall review applicable documentation pertaining to this Plan of Correction AND any written & verbal statements from staff regarding showers. Any concerns found by either body shall initiate an immediate response to maintain corrective action of this Plan of Correction.

Statement of Adherence

The facility believes the implemented corrective action and preventive measures identified shall ensure those corrections are maintained, as identified under the following:

Under **F-689**, the corrective action & preventive measures, will protect **Resident 1**, along with all other residents of a similar nature residing in this facility from any future potential harm. This facility believes that this submitted Plan of Correction meets the stated requirements for a plan of correction and has resolved the alleged deficient practice. As a result, this facility is under the belief it is in adherence to State and Federal regulatory expectations. If you have questions or concerns regarding this submitted Plan of Correction, please contact the facility Administrator.