

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165495	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER CLARKSVILLE SKILLED NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH HILTON ST CLARKSVILLE, IA 50619		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 323 SS=J	<p>The following past non-compliance deficiency relates to the investigation of incident #66891 & complaint #66958. (See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C). 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and family and staff interviews, the facility failed to ensure Resident #1 was protected against environmental</p>	F 323	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/31/2017

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.

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F 323	<p>Continued From page 1</p> <p>hazards. The sample consisted of 4 residents and the facility reported a census of 36 residents. Resident #1 laid in a low bed and rolled out of bed and onto a baseboard heater. The resident received 2nd degree burns to the groin, abdomen and right leg. The facility immediately evaluated all beds in the facility and found Resident #1 was the only bed resting parallel to the base board heater. On 3/20/17, the Administrator provided inservices to housekeeping and nursing staff to not place a resident's bed parallel to the base board heater that is less than 36 inches.</p> <p>Findings include:</p> <p>Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 2/2/17. The MDS identified the resident required extensive assistance of two staff persons for bed mobility, transfers, ambulation, dressing and toilet use. The resident's functional status with balance during transitions and walking identified the resident as not steady and only able to stabilize self with staff assistance. Resident #1 used a walker and wheelchair and had impairment of both lower extremities. The BIMS (Brief Interview for Mental Status) identified the resident had a severe cognitive impairment and had diagnosis of diabetes, non-Alzheimer's dementia, anxiety, depression, psychosis and macular degeneration.</p> <p>The resident experienced the following falls near the resident's bed:</p> <p>A form titled Fall Scene Investigation Report identified a fall on 11/1/16 at 12:10 a.m. The resident's call light was activated and the staff observed the resident on the floor. The form indicated the resident rolled out of bed and onto</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>the floor. A diagram indicated the staff found the resident lying on the floor between the recliner and bed. The recommendation to prevent this from happening again was to remind staff to ensure the left and right half side rails are in an up position. The staff placed Dycem (rubber like square item) under the incontinence pad so the resident would not slide out of bed.</p> <p>The Fall Scene Investigation Report, indicated on 3/19/17 at 3:50 a.m. Staff A, certified nurse aide, CNA responded to an alarm and found Resident #1 on the floor between the bed and the electric radiant baseboard heater. Both the left and right side rails were raised. Staff A called for the charge nurse who assessed the resident and found 1st and 2nd degree burns on both lower extremities and the left side of the resident's abdomen; caused by contact with the electric radiant baseboard heater. The nurse called for an ambulance and the resident was transported to the local hospital emergency room for treatment.</p> <p>During an interview on 3/22/17 at 2:50 p.m., Staff A, certified nursing assistant, verified they responded to the alarm for the resident and verified it was the resident's alarm since they could not reset the call light by simply pushing the reset button on the wall. Staff A had to first reset the resident alarm, then push the call light reset button on the wall - which Staff A did after the resident was pulled to a safe area away from the baseboard heater. Staff A verified the bed was placed parallel to the radiant baseboard heater and just far enough away that blankets hanging down from the bed would not rest on top of the heater and be a fire hazard.</p> <p>On 3/22/17 at 1:10 p.m., Staff B, registered</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>nurse, was interviewed and verified no call light was on when Staff A went to assist another resident and when finished came into the hall seeing the call light on for the resident and went immediately to the room. Staff B heard Staff A yelling so Staff B came to assist. Staff B verified the positioning of the bed and the resident against the radiant baseboard heater with Staff A trying to hold the resident away from the heater while they assessed the resident and called the ambulance, on-call physician and family.</p> <p>On 3/21/17 at 2:55 p.m., a family member stated they had the room arranged with the recliner between the bed and the baseboard heater so the resident could sit and look out the window. The facility rearranged the resident's room a couple of months ago, placing the bed along the wall against the baseboard heater to make it easier to use a mechanical lift to transfer the resident in and out of bed.</p> <p>Review of the report from the local Emergency Department dated 3/19/17, indicated the resident was treated for 2nd degree burns of the bilateral lower extremities and lower left abdomen that "approached 10% of the body surface area" and transferred the resident back to the facility. The report indicated the burns were scattered on each leg and abdomen. The physician ordered Silvadene (antibacterial topical medication) to be applied with dressing changes twice a day to the burn wounds located at the left abdomen/groin and lower extremities for 2 weeks. The pain medications orders were Acetaminophen (Tylenol) 1000 milligrams every 8 hours for 2 weeks and Roxanol (morphine sulfate-narcotic) 5 milligrams every 2 hours as needed for uncontrolled pain. The physician directed to</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>continue current other medications and treatments.</p> <p>During an observation and staff interview, on 3/22/17 at 9:35 a.m., the maintenance person found the electric radiant baseboard heaters used in resident rooms come on when the room temperature dropped below the temperature setting on the heater and remained on until the room temperature rose above that setting, the heaters are either on or off, when the heaters come on to warm the resident room they reach a temperature of about 135 degrees Fahrenheit (F) according to the infrared thermometer used by the maintenance person. While testing the heaters, the surveyor was only able to hold their hand on the heater for a few seconds before it became too hot to comfortably maintain contact.</p> <p>On 3/22/17 at 8:25 a.m., the Administrator stated after the resident rolled/fell out of bed and sustained burns from the radiant baseboard heater, the bed was moved away from the heater by maintenance personnel and they went through the facility to ensure all resident beds were away from the radiant baseboard heaters to prevent injury to other residents. Staff were educated to make sure resident beds were kept a safe distance away from the radiant baseboard heaters in the resident rooms.</p> <p>During observation throughout the survey days on 3/22/17 & 3/23/17, no resident beds were noted to be positioned against or near to the electric radiant baseboard heaters throughout the facility.</p> <p>On 3/20/17, all staff received notice that no beds were to run parallel with the baseboard heaters unless there is at the very minimum of 36 inches</p>	F 323			

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F 323	Continued From page 5 between the bed and the baseboard heaters. Observation of photographs of the abdomen and right thigh and lower leg, identified extensive first and second degree burns located on the right leg and left side of lower abdomen. Note: At the initial time of the complaint investigation, the complaint was coded at a "J" immediate and serious jeopardy. By 3/19/17, the facility had evaluated other beds to ensure of being parallel to the base board heaters and moved Resident #1's bed. On 3/20/17 the facility abated the immediate jeopardy with inservices to housekeeping and nursing staff are to not place resident's beds parallel to the base board heaters less than 36 inches. The Administrator posted the reminders to all staff.	F 323			