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	165288	A. BUILDING _____ B. WING _____	C 12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

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F 000	INITIAL COMMENTS Correction Date_____ The following deficiency relates to the Focused Infection Control Survey and Facility Reported Incident # 94637 conducted by the Department of Inspection and Appeals on December 2 - 4, 2020. Facility Reported Incident #94637-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 689 SS=G	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)(1) The resident environment remains as free of accident hazards as is possible; and §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 observations, record review, interviews and facility investigation notes, the facility failed to provide adequate supervision for 1 of 3 sampled on quarantine (Resident #1). The facility found Resident #1 unsupervised in the kitchen. Resident #1 sustained a burn to her right 3rd, 4th and 5th fingers. The facility reported a census of 49. Findings include: Review of the Minimum Data Set (MDS)	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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assessment tool dated 11/10/2020 revealed the following diagnoses for Resident #1: Alzheimer's disease, malnutrition, COVID-19, moderate protein-calorie malnutrition, difficulty walking, disorder of the brain and unsteadiness on feet. The MDS listed a Brief Interview of Mental Status (BIMS) score of 14 indicating no cognitive impairment. Resident #1 required extensive assistance of two staff for bed mobility, transfers, dressing, and toilet use and used a wheelchair. Resident #1 wandered 1 to 3 days during the 7-day review period.

Review of Resident #1's Care Plan 11/30/2020 showed impairment to skin integrity of the 3rd, 4th, and 5th fingertip related to a burn. On 11/30/2020, the facility applied a stop sign to her doorframe to remind her to stay in her room until the COVID-19 outbreak precautions are lifted. Review of Care Plan dated 12/21/2017 showed impaired cognitive function/dementia or impaired thought processes and wandering behaviors.

Review of Resident #1's Care plan dated 12/21/2017 noted impaired cognitive function/dementia or impaired thought processes. Care plan dated 12/26/2019 noted a behavior problem related to wandering in the facility.

Observation on 12/2/2020 at 10:20 a.m. of kitchen entry revealed locking doors with keypad entries. Both doors had stop signs posted and witnessed staff members entering code to gain access to kitchen and verbal queues from Dietary Staff to Kitchen Staff to ensure doors were closed after entering.

Review of incident report dated 11/28/2020 documented that at 10:25 a.m. CNAs saw

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F 689	Continued From page 2 Resident #1 go through the kitchen doors. CNAs removed Resident #1 from the kitchen and were advised by Resident that she had burned her right hand by touching the steam table. Resident's 3rd, 4th, and 5th fingertips were red, blanchable, and tender to the touch. Resident #1 stated she was just seeing what was going on. The nurse applied a cool washcloth for comfort. Review of Resident #1's skin evaluation form dated 11/28/2020 noted another type of skin injury on her upper limb(s) that needed evaluated today. Facility response on form indicated a new injury of right 3rd, 4th, and 5th fingertips burned, red, blanchable, and tender to the touch and a 0.2 centimeter (cm) x 0.2cm intact blister on right 4th fingertip. Record review of nursing notes for Resident #1: -11/28/2020 at 10:36 a.m.: CNAs brought Resident #1 out of the kitchen and told this nurse that she had burnt her hands on the stove in there. The nurse took Resident #1 to her room and assessed her fingers. Her 3rd, 4th, and 5th fingers are reddened, blanchable, and tender to the touch, no blisters noted at that time. Cool washcloth applied to fingertips for comfort. The CNAs stated that they did not see her touch the stove but they witnessed her going through doorway and went to remove her from area. The CNAs stated they had not arrived prior to her touching it. The entry way doors to kitchen were open. The kitchen staff stated that they did not see or hear her in there. The kitchen staff told her that one staff member was in the dishwashing room and the other had her back turned to the doorway. This nurse educated staff that doors were to be kept shut at all times to prevent	F 689		

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residents and other people besides staff to enter the kitchen. Resident #1 stated that she was just seeing what was going on and was roaming around. She was educated that she needed to remain in her room or down her hall due to COVID-19 and isolation policies. She stated that she understood and wouldn't go past the double doors.
Resident #1's family was contacted with update on incident, her primary care provider and Director of Nursing (DON) were notified too. This was documented by Staff E Registered Nurse (RN).

-11/28/2020 at 11:01 a.m., clarification, Resident #1's right 3rd, 4th, and 5th fingers were burned on the steam table in kitchen and not the actual stove. This was documented by Staff E.

-11/28/2020 at 12:37 p.m., Resident #1 had 1 small blister on her 4th finger on the right hand: 0.2 cm x 0.2cm. This nurse called Resident #1's family to notify her of area, updated her primary care provider and will continue to monitor area. This was documented by Staff E.

-12/1/2020 at 12:04 p.m., weekly skin evaluation completed. Resident #1 had no blisters noted on her fingertips and all skin was blanchable. She stated the skin was tender to touch but nothing more than that. They will discontinue the weekly monitoring of skin as there was nothing to monitor at that time.

Review of facility's investigative file noted education provided to staff after the incident on 11/28/2020. Education included: doors to the kitchen and entryway doors are to be kept shut at all times. If residents are roaming around the

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F 689	Continued From page 4 facility then they need to be reminded to return to their rooms and hallways since they are not allowed in the main parts of the facility yet due to COVID-19 and isolation policies. If a resident is a known wanderer they need to be checked on frequently. At no point should a resident ever be inside the kitchen or the entry ways doors. All stop signs should be put into place at all times. Resident #1 now has one in her doorway and the kitchen doors will have one also. Please sign at the bottom to show that you have read and acknowledged this. Staff signatures are on education form showing acknowledging new policy. During interview of Resident #1 on 12/2/2020 at 10:39 a.m., observed stop sign affixed to door fame of room. Resident sitting in recliner with feet elevated, call light within reach, and her wheelchair in the bathroom. Resident #1 was asked what happened to her fingers on Saturday, she stated she touched a skillet. Resident #1 was asked why she went into the kitchen, she stated she did not remember why she went in there and "people just do dumb things some times." When asked if the kitchen doors were open off of the main dining room leading to the kitchen, she indicated she thought they were open. When asked if they are usually open, she stated "not usually." Resident #1 was asked how long she had her hands on the skillet she stated not very long and once she felt it was hot, she took her hand off of it. She stated they took care of her right away and her fingers are healing up good, fingers are a bit stiff. Observed a red oblong circle on her right middle finger, no open areas noted. During interview of Staff C Certified Nursing	F 689		

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F 689	Continued From page 5 Assistant (CNA) on 12/2/2020 at 11:06 p.m., advised doors used to remain open when passing trays or serving and that key pads have always been on the doors. Stated she used to work in the kitchen and a long time ago they could keep the doors open but not anymore. During interview of Administrator on 12/2/2020 at 11:10 a.m., she stated meal times are: breakfast 7:30 a.m. - 9:00 a.m., lunch 12:00 p.m. - 1:00 p.m., dinner 5:30 p.m. - 6:30 p.m. and that the times are skewed based on delivering all meals to residents in their rooms. During interview of Staff A Cook on 12/2/2020 at 11:15 a.m., stated his back was turned to the door when he heard Staff B Dietary Aide talking. Staff A turned around and saw Resident #1, at which time Staff B advised Resident #1 she could not be in kitchen. Resident #1 touched the steam table and said "ow, that is hot, don't touch that it is hot." CNA arrived and took Resident #1 out of kitchen. Staff A stated he did not know why kitchen doors were open and that he keeps doors shut when he is working. He advised "before the incident the doors were allowed to be open during meal service, but it is not allowed anymore." He confirmed that doors are now locked at all times and required a key code to enter. He advised he was not certain if kitchen staff were allowed to remove residents from kitchen and would not feel comfortable doing so since he is not a CNA or a Nurse. Staff A stated on the day the incident took place, the Dietary Manager sent out a text message to everyone that the kitchen doors needed to be shut at all times even during service.	F 689		

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F 689	Continued From page 6 During interview of Staff B on 12/2/2020 at 3:05 p.m., verified at time of incident she was in the kitchen rolling silverware with her back turned towards the door. She heard someone talking, turned around and a CNA was talking to Resident #1. She stated Resident #1 had already put her hand on the steam table. She did not see her hand because the CNA was already there helping the resident out of the kitchen. When asked if the doors were open, she stated they were open and she wasn't aware they needed to be closed all the time. She added she was not sure who opened them. She stated since the incident she was told the doors have to be closed now all the time, even during meal service. When asked what time the incident happened she said maybe 1:30 p.m. An attempt was made to speak with Staff E RN on 12/03/2020 at 11:26 a.m. with no response. During an interview on 12/3/2020 at 11:50 a.m., Staff D CNA confirmed she worked on 11/28/2020. She was asked to describe what happened with Resident #1. She stated she worked on hall 3 that day. She stated she was walking down the hall, looked towards kitchen and saw Resident #1 had propelled in to the kitchen. Staff D stated when she got to the kitchen, Resident #1 had just gone through the 2nd door. When she arrived Resident #1 had turned towards the steam table in her wheelchair. She stated she did not see her touch the steam table. Staff D was asked if the kitchen doors were open she stated she assumed so since Resident #1 went in to the kitchen. When asked if Resident #1 told her why she went in the kitchen, Staff D stated the resident didn't make sense when she told her she was trying to find something. She stated after she removed her from the kitchen,	F 689		

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F 689	Continued From page 7 she took Resident #1 to her room and the other CNA got the nurse. Staff D stated Resident #1 liked to wander around the facility. During a follow-up interview on 12/3/2020 at 11:28 a.m., Staff C was asked what Resident #1's level of care was, she stated she required assistance of 1 staff for dressing. She stated Resident #1 could get herself around the facility in her wheelchair. She stated Resident #1 does have camera in her room that is monitored at the nurse's station, but she likes to move it around alot in her room. When asked what the purpose of this camera was, she stated Resident #1 liked to transfer herself, so staff would watch to see movement. Staff C was asked if Resident #1 liked to wander around the facility and she stated she did. When asked if the kitchen doors can be open she stated from her understanding they needed to be closed at all times. She stated they are not always closed, especially when residents were eating in the dining room they would leave the doors open during service. During an interview on 12/3/2020 at 1:35 p.m., DON was asked what her role was after the incident took place. She stated Staff E called her to let her know what had happened and asked the DON what else she needed to do. The DON stated they had already applied cold wash cloths to Resident #1's fingers, put a Velcro stop sign on the resident's door way, closed the kitchen doors and put stop signs on them. They held a 5 minutes meeting that informed staff to keep an eye on residents that wander and keep the kitchen doors closed at all times. They monitored her wound and put her on hot charting. The DON was asked what Resident #1's level of care was she stated she transferred with stand-by	F 689		

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F 689	Continued From page 8 assistance, she needed help with dressing herself, and was able to propel herself around the facility in her wheelchair. DON stated she does get confused and requires frequent redirection. Stated Resident #1 did wander, but never tried to leave, she just liked to go up and down halls to check on every one. The DON was asked if Resident #1 had a camera in her room, she confirmed she does and there is another one at the nurse's station. She stated staff can watch at the nurse's station and she indicated someone was not up at the nurse's station before the incident and that is why they did not see her going to the kitchen. The DON was asked if they require staff to be at the nurse's station at time, she stated they are not required to be up there all the time to check. She stated she expected staff to check it regularly. When asked what the purpose of the camera was, she stated to help prevent falls at night because she got up a lot. The DON was asked if the kitchen doors could be left open before incident occurred, she stated they were ok to be open, from her understanding the doors are allowed to be open when serving and when they are done they should be shut. When asked what time Staff E called her she stated approximately at 10:30 AM. The DON was asked what injuries Resident #1 sustained, she stated just the one blister on her 4th finger. During interview on 12/3/2020 at 1:47 p.m., Dietary Manager (DM) was asked if the kitchen doors were allowed to be open before the incident that took place on 11/28/2020. She stated they could leave them open frequently because it would get hot in the kitchen and so staff could come in a get items for the residents when they wanted. She stated since the incident, it has changed and the doors are kept shut. The DM	F 689		

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F 689	Continued From page 9 was asked to describe what education was provided after the incident took place. She stated that once informed of incident she sent out a blast text message to all the kitchen staff and held a meeting after arriving to the facility. She advised staff there had been an incident and now stop signs were to remain on kitchen doors and the doors needed to be closed at all times. She stated when she sent out the text to all staff, she asked them to respond yes to text so she knew everyone had read it. Review of facility provided past non-compliance effective on 11/28/2020 at 10:25 a.m., Resident #1 entered the kitchen unattended and received a burn to her right hand 3rd, 4th, and 5th digits. The digits were red, blanchable, and tender to the touch immediately following the incident. The resident rated her pain 2 out 10, 10 being the worst pain. A cold washcloth was immediately applied to the resident's fingertips. An intact blister developed on Resident #1's 4th digit approximately 2 hours after the incident, the blister had reabsorbed by 11/30/2020. The resident is known to wander through out the facility due to her underlying cognition and diagnosis of Alzheimer's. The main area of the kitchen was left unattended with the door left open. Resident #1 wheeled herself through the kitchen door and was able to access the steam table. Plan of correction: Resident #1 was immediately assessed and treatment to digits was provided. Stop signs were placed on Resident #1's door as a visual reminder to stay in her room, stop signs were also placed on the dining and kitchen doors as a visual reminder. Staff members were educated on ensuring staff was in the kitchen at all times when residents are present. If not staff members are in the kitchen	F 689		

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F 689	Continued From page 10 the door is to be locked, and the key pad is to be utilized. The kitchen door should remain closed at all times. The Dietary Supervisor or designee will be auditing at different times a minimum of 3 times weekly to ensure the stop signs are in place and the kitchen doors are closed. In-depth analysis- the kitchen door was left open as kitchen staff were present in other parts of the kitchen, but not able to visually see the steam table. A resident with known Alzheimer's entered through this door not knowing the steam table was hot and burned her right hand. Due to the residents being in isolation, kitchen staff felt it was ok to have the door open to the dining room at that time. The root cause was because of lack of education of staff members; the kitchen door should remain closed at all times, even with residents in isolation. Corrective action taken for resident(s) affected: a stop sign was placed on Resident #1's door and stop signs were placed on the dining room and kitchens doors to provide a visual cue. Kitchen doors should remain closed at all times, the doors are to be locked, and the key pad will be utilized if no kitchen staff are present in the kitchen. Staff will provide verbal reminder and support residents to redirect them to their room during the isolation period. Planned monitoring of corrective actions to ensure practice is corrected and will not occur: Dietary Supervisor or designee will completed an audit minimum of 3 times weekly at random times to ensure the kitchen door is closed, locked when staff not present in the kitchen. Stop signs are in place on the doors and visible. The results of these audits will be taken to the morning quality assurance (QA) meetings and reviewed. Any areas of concern will be addressed and documented follow up will be completed. The audits will continue until reviewed at the quarterly	F 689		

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F 689	Continued From page 11 QA meeting and substantial compliance is met. The checklist had an anticipated date of completing for this plan of correction of 11/28/2020. The checklist was signed and dated by the Director of Nursing (DON) on 12/2/2020.	F 689		