

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: #9049		Date: January 27, 2021		
Facility Name: Wapello Specialty Care		Survey Dates: January 5 – 12, 2021		
Facility Address/City/State/Zip: 601 Highway 61 West Wapello, IA 52653		VW JS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.28(3)ef	<p>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)</p> <p>58.28(3) Resident safety.</p> <p>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</p> <p>f. Residents shall be protected against physical or environmental hazards to themselves. (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on record review and staff interviews the facility failed to ensure the environment remained free of accident hazards for 1 of 4 sampled (Resident #1). Resident #1 had a history of attempting to self-transfer from the bed. The staff found Resident #1 face down between the bed and wall with her arm on the baseboard heater. Resident #1 sustained a burn to the right upper arm. The facility reported a census of 39 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated 10/20/20 revealed Resident #1 had diagnoses of</p>	I	\$5,000	Upon Receipt
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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	<p>anxiety, depression, hypertension, diabetes mellitus, and non-Alzheimer's dementia. Resident #1 had a Brief Interview for Mental Status (BIMS) score of "4" indicating severe cognitive impairments. Resident #1 required extensive assistance of two staff with bed mobility and transfers.</p> <p>Review of the Incident Reports dated 7/25/20, 8/12/20, and 12/20/20 revealed the staff found Resident #1 sitting on the floor beside the bed without injury.</p> <p>The Care Plan directed the staff to check on Resident #1 frequently and offer 1:1 if necessary, winged mattress on the bed, bed lowered close to floor, floor mat for safety, upper transfer rails to assist with bed positioning. The update on 7/25/20, directed staff to frequently remind Resident #1 to use the call light when wanting to get up. The update on 12/20/20, directed staff to move Resident #1 if restless for closer supervision.</p> <p>The Progress Note dated 12/26/20 5:28 a.m., revealed the staff found Resident #1 face down on the floor between the bed and wall. The staff noted the bed in lowest position and a floor mat on the other side of the bed. Resident #1 sustained a burn on the right upper arm, a skin tear to the left arm, and the right elbow deformed. Resident #1 had pain when the area touched. The staff notified the Physician's Assistant and received an order to apply a wet to dry dressing</p>			
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	<p>over the burn and transfer Resident #1 to the Emergency Department.</p> <p>According to the #604 Un-Witnessed sheet dated 12/26/20, the staff found Resident #1 lying face down with her arm against the baseboard heater. The right upper arm that had contact with the baseboard heater measured 1.5 centimeters (cm) by 5 cm. When Resident #1 returned from the hospital the staff moved Resident #1 to bed against a wall without a baseboard heater.</p> <p>During an interview on 1/6/21 at 12:18 p.m., Staff A (Nurse Aide) reported finding Resident #1 face down on the floor between the bed and wall. The wall beside Resident #1's bed contained a baseboard heater. Resident #1's right upper arm rested on the heater. Resident #1's feet remained in bed, shoulders back and elbows bent. A piece of wood on the floor held the bed back 8 inches from the heater. Staff A reported she last observed Resident #1 at 2:30 a.m. with the bed in the lowest position, and a floor mat on the open side of the bed.</p> <p>According to the ED Note Physician sheet dated 12/26/20 Resident #1 reported moderate to severe right upper arm pain and pain worse with movement. Resident #1 had a superficial partial-thickness burn to the right upper arm and a fractured right distal humerus.</p>			
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	<p>During an interview on 1/11/21 at 2:30 p.m., Staff D (Corporate Nurse Consultant) stated two to three years the facility installed pieces of wood to keep the bedding away from the baseboard heaters. Staff D reported prior to Resident #1's fall, the facility did not conduct temperature audits or address a need for safety covers for the baseboard heaters.</p> <p>During an interview on 1/12/21 at 10:30 a.m., Staff B (Maintenance) confirmed the facility did not complete audits of the baseboard heaters to assess safety prior to 12/26/20.</p> <p>The Past Non-Compliance Checklist provided by the facility revealed the following corrections as of 12/30/20:</p> <ul style="list-style-type: none"> a. Audited all beds for proper placement and safety. b. Audited heat source in all rooms and identified 4 that required repairs. c. Reviewed all residents to determine high fall risk and relocated to bed away from baseboard heaters. d. Educated staff on bed placement. e. Ordered baseboard safety cover to test on current heat system for additional safety. 			
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	<p>The Surveyor confirmed past non-compliance achieved during the survey through record review and interviews.</p> <p>FACILITY RESPONSE:</p>			
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