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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165452	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAPELLO SPECIALTY CARE	601 HIGHWAY 61 SOUTH WAPELLO, IA 52653

(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 Complaints #85131 and #95076 and Facility Reported Incidents #95007 and #95063 were investigated January 5 - 12, 2021. Complaint #85131-C was not substantiated. Facility Reported Incident #95007-I was substantiated. Facility Reported Incident # 95063-I was substantiated. Complaint #95076-C was substantiated. See code of Federal Regulations (45 CFR) 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 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	F 689	Past noncompliance: no plan of correction required.	

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

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 689	Continued From page 1	F 689		

arm. The facility reported a census of 39 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 10/20/20 revealed Resident #1 had diagnoses of 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.

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.

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.

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.

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F 689	Continued From page 2 The staff notified the Physician's Assistant and received an order to apply a wet to dry dressing over the burn and transfer Resident #1 to the Emergency Department. 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. 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. 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. 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	F 689		

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F 689	Continued From page 3 fall, the facility did not conduct temperature audits or address a need for safety covers for the baseboard heaters. 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. The Past Non-Compliance Checklist provided by the facility revealed the following corrections as of 12/30/20: 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. The Surveyor confirmed past non-compliance achieved during the survey through record review and interviews.	F 689		