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RED OAK REHAB AND CARE CENTER	1600 SUMMIT STREET RED OAK, IA 51566

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F 000	INITIAL COMMENTS Correction date 3-27-2021 The following deficiencies were identified during the facility's annual survey and investigation of facility reported incident #96046-I on March 17 - 25, 2021. Facility reported incident #96046-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, subpart B-C.)	F 000		
F 689 SS=K	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 observation, staff interview, and record review, the facility failed to protect residents against burn hazards from the baseboard heating elements in their rooms for 1 of 6 residents reviewed. All 6 of the residents in the sample occupied beds facility staff had placed in a parallel position next to the baseboard heaters under the windows in their rooms. Resident #13 had a diagnosis of paraplegia and utilized an adjustable bed next his in-room heating element. On 3/16/21 at 2:10 PM, staff found Resident #13 on the floor between his bed and the wall. His	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Kuney — TITLE: Administrator — (X6) DATE: 4-13-2021

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 backside lay against the baseboard heater, which resulted in 1st and 2nd degree burns. These findings constituted an Immediate Jeopardy (IJ) to the residents' health and safety. The facility reported a census of 22 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 12/22/20, Resident #13 scored 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) test, which meant the resident demonstrated intact cognitive abilities. The MDS documented the resident required extensive assistance of two staff for bed mobility and remained totally dependent on one staff for surface-to-surface transfers. An MDS dated 1/21/21, showed the resident's cognitive stated had declined prior to the month before, The MDS documented the resident scored 11 on the BIMS test, which meant the resident showed moderate cognitive deficits. An MDS dated 2/3/21 showed the resident's cognitive status had again deteriorated. The MDS revealed the resident could not participate in the BIMS test and scored 0 out of a possible 15, which meant the resident displayed severe cognitive impairment. A care plan last updated on 3/18/21 revealed Resident #13 admitted to the facility on 8/20/15 with diagnosis that included: heart disease, paraplegia, chronic pain, colostomy and muscle weakness. A focus area initiated on 1/8/19, documented the resident had expressive dysphasia related to a Cerebrovascular Accident (CVA, or stroke). The care plan directed staff to	F 689		

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offer the resident a note pad to utilize if he had difficulty communicating. The care plan also included an impaired mobility focus area related to paraplegia and identified the resident utilized 2 assist bars on the bed to help him with body positioning.

According to the electronic chart census page, Resident #13 admitted to Hospice services on 2/2/21.

A nursing note dated 3/18/21 at 11:33 PM documented the resident passed away in bed on 3/18/21 at 10:29 PM.

A fall assessment dated 9/21/20 documented Resident #13 had not had any falls in the previous 6 months.

An incident report dated 12/11/20 at 4:48 AM revealed staff found the resident on the floor and next to the bed with his head at the foot of bed. The resident stated at that time he was unaware of how he had gotten there.

A fall assessment dated 1/28/21 at 11:56 AM identified the resident as at a high risk for falls. The assessment lacked information related to any fall interventions or protocols initiated by the facility at that time.

A nursing note dated 3/16/21 at 2:15 documented staff found the resident floor in his room, laying in-between the bed and the baseboard heater. Staff had completed resident rounds at 1:50 PM that day and saw the resident asleep in bed. At 2:10 PM, staff filled water pitchers and delivered linens and found the resident on the floor. The nursing note described burns identified on the

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resident's body. Staff notified the hospice nurse and primary care physician, and administered pain and antianxiety medications given for pain and comfort. Facility staff also moved the resident's bed to the "A" side of the room (near the door, opposite side of the room from the heater), put it in in low position, and notified family.

According to the incident report dated 3/18/21, staff found Resident #13 on the floor on 3/16/21 at 2:10 PM. The subsequent nursing assessment revealed the resident had sustained a 1st degree burn on his upper back that measured 5.0 centimeters (cm) x 1.5 cm and a 2nd degree burn to the right trochanter (hip/thigh area) that measured 6.0 cm x 14.0 cm. The report documented the facility moved the resident to a room located closer to the nurse's station.

The incident report revealed staff conducted an audit of the rooms on 3/16/21 to determine if any other residents were at risk of injury due to bed placement. They determined that no other residents were at risk. The leadership team met to discuss the fall and possible solutions.

The US Department of Health and Human Services, Centers for Disease Control and Prevention provided the following description of burn injuries to the skin:

1) A first degree burn involves the top layer of the skin and presents as red and painful to the touch and the skin will show mild swelling.

2) A second degree burn involve the first 2 layers of skin. These may present as deep reddening of the skins, pain, blisters, glossy appearance from

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F 689	Continued From page 4 leaking fluid and possible loss of some skin. Retrieved on 3/23/21 from https://www.cdc.gov/masstrauma/facesheets/public/burns.pdf Observations: On 3/18/21 at 1:15 PM Registered Nurse (RN) Staff C provided a wound treatment for Resident #13. The burn to his right trochanter was red with some bloody drainage, and the resident did not interact or respond to the staff as they turned him from side to side to change the bedding. Staff C cleaned the area and applied a new Xeroform dressing. The resident record revealed an order dated 3/16/21 at 6:15 PM that directed staff to apply Xeroform (a moist dressing often used for burns and skin graft sites) to the right hip wound and cover with a dry dressing. Observation of Resident #13's room with the Director of Nursing (DON) on 3/18/21 at 1:15 pm revealed the heating unit set at "high." The DON used a surface thermometer to test the temperature of the top of the heating unit and she measured the following temperatures in three different areas of the baseboard heater: 146 degrees, 155 degrees, and 131 degrees. On 3/18/21 at 1:00 PM, observation revealed 19 rooms in the facility had baseboard heaters similar to the type that caused Resident #13's burns and 7 of those rooms contained the 2 x 4 boxes framed around the heating units. Observation also revealed 5 of the 19 rooms unoccupied, 9 contained a furniture arrangement	F 689		

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F 689	Continued From page 5 with the bed not positioned parallel to the heater, 5 rooms were occupied with no 2 x 4 boxes and arranged as follows: 1) Room 103 revealed Resident #20's bed positioned parallel to the heater. An MDS dated 3/9/21 showed Resident #20 scored 11 out of possible 15 (moderate cognitive impairment) and remained independent with transfers and bed mobility. 2) Room 100 revealed Resident #72's bed arranged parallel to the heater. The resident's MDS dated 3/16/21, showed a BIMS test score of 12 (moderate cognitive impairment) and documented the resident required extensive assistance of one staff for transfers and locomotion. 3) Room 203 revealed Resident #9's bed arranged parallel to the heater. An MDS dated 1/14/21, showed Resident #9 scored 15 on the BIMS test (intact cognition) and remained independent with bed mobility and transfers. 4) Room 208 revealed Resident #3's bed sat parallel to the heater. The MDS dated 1/7/21 showed a BIMS score of 15 (intact cognition) and required assist of one staff for transfers and locomotion. 5) Room 210 revealed Resident #14's bed set parallel to the heater. The MDS dated 2/2/21, identified Resident #14 scored 15 on the BIMS test (intact cognition) and remained independent with bed mobility and transfers. Interviews:	F 689		

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F 689	Continued From page 6 1) On 3/18/21 at 9:51, the DON reported approximately a year earlier, a resident had rolled out of bed and sustained burns from the baseboard heater. She said they subsequently hired a heating and cooling specialist to test the heaters and the technicians found the heaters emitted the correct amount of British Thermal Units (BTU's, a measure of the heat content of energy sources). She stated the facility also considered purchasing smaller heaters, but those would not supply an adequate amount of heat for the rooms. She added they then decided to add a 2 x 4 box built as a barrier around the heaters, and then moved the residents with lower BIMS scores in the rooms that contained the barrier. She said although at the tie it seemed to work but acknowledged the solution as problematic because the resident could still fall on top of the heating unit. The DON acknowledged Resident #13 had not been in a room with the 2 x 4 barrier at the time of his fall. She added Resident #13 had a health decline in health with increased confusion late in January and was admitted to Hospice services in February. The DON said Resident #13 had a diagnosis of paraplegia and he would use his upper body to reposition himself in bed with the use of the assistive bars on his bed. She said that after much discussion with the staff, they believe that he may have been trying to reposition himself in bed and hadn't realized where the lower part of his body was in bed. She surmised this pulled him off balance, off the side of the bed and onto the floor next to the heater. The DON stated Resident #13 had not gone to the hospital after the fall and the Hospice nurse was closely involved in his follow up care. The facility notified the physician regarding the burn and obtained an	F 689		

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order for wound care. The DON completed the assessment after the fall and she said that the resident had a blister on the trochanter area that she had determined to be a stage 2 burn. The DON stated after the incident with Resident #13 on 3/16/21, they decided to order some covers for the baseboard heaters that were due to be delivered quickly, but the company would not guarantee that this would prevent burns.

2) On 3/22 at 10:12 AM, the DON reported Resident #13 often suffered with phantom pain and spasms in his legs so he would use his call light to ask the nurses for pain medications. She said that he would also try to move his lower body to relieve the pain and he wasn't always aware of the position of his lower body.

3) On 3/22/21 at 10:30, Certified Nursing Assistant (CNA) Staff A said she had been working with Staff E the day of the fall and Resident #13's bed had been parallel to the baseboard heater under the window. When she came into the room, the resident lay on the floor between the bed and the heater. They found the resident's head positioned on the floor and facing the head of the bed. She stated he wore a hospital gown with bare skin touching the heater, with legs positioned straight out; his calves did not come into contact with the heater. She saw a blanket on the floor in front of him and she tucked it behind the resident, between his body and the heater. Staff A reported the resident had been moaning but hadn't said much other than that his knee was burning. She said she thought that he may have been confused because it was the back of his leg that was burnt. Staff A said that she hadn't noticed the burn at that time and the nurses came in and moved him with the sheet,

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then used the Hoyer lift to transfer him to bed. Staff A reported prior to his decline in health, the resident could move himself from side to side using his upper body strength.

4) On 3/22/21 at 10:40 AM Staff E, Licensed Practical Nurse (LPN) recalled she worked the 6 am-6 pm shift the and the 2-10 staff had just reported to work the day Resident #13 fell out of the bed. She also recalled the CNA had mentioned she had shut Resident #13's door due to the loud television across the hall from his room. Staff E commented the resident had usually preferred to have his door closed. At 2:13 PM the CNA's started to pass ice, but soon after they told her they found Resident #13 on the floor. She entered the room and saw Staff A sitting on the floor with the resident and he sat upright with a blanket behind his back with Staff A's support. Staff E reported they obtained the resident's vital signs, utilized the blanket to pull him away from the heater, lay him on the floor, put the Hoer sling under him, and transferred him to the wheel chair while they waited for a replacement bed. She stated when staff transferred him back to bed, the DON discovered the burns on the resident's backside.

Staff E offered, before his decline, Resident #13 used his upper body to assist staff with bed mobility, but a few weeks before his fall, he hadn't had the strength to help as much. She added the resident had his call light attached to the grab bar on the right side of the bed and often used it, usually to ask for a pain pill.

5) On 3/22/21 at 11:00 AM, Staff D, LPN recalled when the Resident had fallen in 12/2020 of 2020, she had worked in the 300 hall because the

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F 689	Continued From page 9 facility had used the 100 hall for the Covid positive residents (Resident #13 had lived in room 111). She remembered she had gone into his room to administer a medication close to 5:00 AM and found him on the floor with his head at the foot of the bed. He reported he didn't know how he had gotten into that position. Staff D stated the CNA took vital signs, checked for injury, obtained the Hoyer and transferred him back into bed. She said he could use his call light, especially if he had pain. He also wanted his door closed most of the time. Staff D reported he pulled himself up and roll over, so after the 12/2020 fall, they checked him hourly to ensure his safe positioning in bed. She commented on their surprise about the 12/2020 fall due to his lack of a fall history. 6) On 3/22/21 at 2:00 PM CNA Staff B reported on 3/16/21, she and another CNA had just began their shift and started filling the residents' water and ice at the end of the hallway. When they entered Resident #13's room they heard him moaning but did not see him at first, but then found him on the floor between the bed and the heater. They then pulled the bed away from him and Staff E went to the floor to pull him away from the heater. Staff B left the room to get the nurses. Staff B said that while in bed, the resident often pushed against the wall to move the bed away from the wall because he wanted his bed positioned diagonally to better see out of the window. When Staff B returned to the room, Staff E had remained on the floor with Resident #13 while he sat up with her support. She reported that they obtained vital signs and checked him every 5-10 minutes after the fall.	F 689		

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Staff B said she moved the bed because the heaters could get very hot. She added Resident #13 liked to keep his room very warm, although she did not know of any other residents that kept their rooms that warm.

Staff B stated she returned to the room with a Hoyer lift and they had replaced his bed with a different one. When asked why they switched beds, she reported she thought they replaced the one he had because he could adjust it; he refused to keep his bed in low position because he wanted to look out the window.

7) On 03/22/21 03:39 PM, the DON reported they replaced Resident #13's bed with a different one after his fall because the original bed did not adjust to the lowest position possible. She added that after his fall, they felt they needed to give him a bed that would go into a lower position.

8) On 03/23/21 11:09 AM, the DON said that the 2 x 4 barrier solution installed after the fall and that resulted in a burn on 1/23/20 was not completely fail safe. She said she believes it helps for those in wheel chairs to keep their distance from the heaters, but she sees where it is still a problem because a resident could fall on top of it.

9) On 3/22/21 at 4:29 PM, a service technician said when he was at the facility on 1/27/20, he found the heating units in working condition but confirmed the baseboard heaters would definitely get very hot. He said in his opinion, a resident falling to the floor next to the heater would have less severity if the resident had lain 3 inches away from the heating unit.

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10) On 3/22/21 at 12:45 PM, a representative from the company that distributed the baseboard heating units reported unit UL number F2548NWC (the unit identification number located on the baseboard heater involved in Resident #13's incident could reach 150 degrees and should not be touched. He recommended the facility should keep items at least 6 inches away from the baseboard heater and added the heater could actually get hotter with items placed in the immediate proximity if it restricted the heating element's air flow.

The facility was notified of the Immediate Jeopardy situation on 3/23/21. The IJ was also removed on 3/23/21 when they implemented the following:

Room 103 and 100 beds were moved to the opposite side of the room from the heating element.
Rooms 203, 208 and 210, the beds were repositioned to have the head of the bed up against the heater with bedside tables next to the bed.

When the facility completed the above actions, the scope and severity of the IJ was lowered to an E.

03/24/21 11:41 AM, rooms 204, 203, 210, 103 108 all had new safety covers assembled over them. The DON said that they set all the heaters to medium heat and the residents could not access the knob without assist of maintenance staff. She added the facility ordered more covers with delivery expected within a couple of weeks.

Plan of Correction for Citation, F 689 and L 1093
Red Oak Rehab & Care Center

Please Accept this as the facility's credible allegation of compliance for Tag F689 and Citation 9090.

In effort to prevent residents from falling out of bed and landing on the baseboard heaters we have put the following items in place:

We moved all beds away from the wall where the heaters are placed. We moved them perpendicular on the wall with the head of the bed against the wall with the heater and a nightstand next to the head of the bed. This will prevent the resident from falling out of bed onto the heater.

Room #	What was done	Who made the changes	Date
101B	Moved to 101A (away from the heater, does not share a room)	Director of Nursing	3/18/2021
108B	Moved nightstand between the heater and the bed. Installed protective case that will not allow the resident to turn heaters to high heat.	Maintenance Dir.	3/23/2021
203B	Moved the bed the long way, with the head of the bed against the wall where the heater is, with a nightstand next to the bed to prevent falling onto the heater. Installed protective case that will not allow the resident to turn heaters to high heat.	Director of Nursing, Administrator, Maintenance Dir.	3/23/2021

204B	Moved her bed the long way, with the head of the bed against the wall where the heater is, with a nightstand next to the bed to prevent falling onto the heater. Installed protective case that will not allow the resident to turn heaters to high heat.	Director of Nursing, Administrator, Maintenance Dir.	3/23/2021
208B	Moved to 208A (away from the heater, does not share a room)	Director of Nursing, Administrator, Maintenance Dir.	3/23/2021
210B	Both residents decided to move to 302A and 302B. This room has a PTAC for heating and cooling. For any new residents to occupy 210B they will have to agree to safe bed placement mentioned above.	Director of Nursing, Administrator, Maintenance Dir.	4/2/2021

We have received some protective covers that will prevent the resident from turning the heaters up to high heat. We have ordered enough covers for all rooms with baseboard heaters, but they have not come in yet. We have installed the four we had in the occupied semi-private rooms.

We also educated all staff by text; PCC communication & note in the breakroom "All resident beds on 100 and 200 halls can only be placed the long way in shared room with a barrier next to the head of the bed, like a bedstand where the heater is. We need to do everything possible to make sure the resident cannot fall out of bed and land on the heater" (see attached supporting documentation).

The Administrator and the Director of Nursing be doing weekly audits for eight weeks, then every other week for eight weeks, to make sure beds are not moved alongside the baseboard

heaters (see attached supporting documents). Then we will do monthly audits, and this will be added to our monthly safety checklist and our QAPI and discussed at our monthly meetings.

Please Accept this as the facility's credible allegation of compliance for Tag L 1093.

Re: VA admission, transfers, discharges

Immediate Corrective action: Social Service Director (SSD) contacted the VA resident eligibility as SSD was unable to add veterans' widows and non-veteran information in the Electronic Health Record/Point Click Care. The website was updated, and the SSD now has the option to add veterans widow information.

Action as it Applies to Others: VA eligibility has been added to the facilities admission checklist. The SSD is assigned the task of checking and updating the VA Benefit Eligibility for the admitting resident(s).

Date of completion: April 13, 2021

Recurrence will be Prevented: The SSD is responsible for gathering VA Benefit Eligibility information at the time of admission. If the resident is unable to recall information, the SSD will contact the POA or next of kin to verify the resident's potential for VA benefits.

This correction will be monitored: SSD and Administrator. See the attached audit form to be filled out by the SSD for the next 6 months (when admitting a new resident) to be monitored by the Administrator.