

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

Citation Number: #8016		Date: 2/25/2020		
Facility Name: Touchstone Healthcare Community		Survey Dates: 2/10-18/2020		
Facility Address/City/State/Zip 1800 Indian Hills Drive Sioux City IA 51104				
		SB		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.28(3)e, f	<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 observation, staff interview, policy and procedures review, the facility failed to ensure that a thermostat hazard in the Edenberry spa room was corrected in a timely manner. The facility was aware of a thermostat malfunction 1/26/2020 and failed to take appropriate action on the concern which resulted in a hazard for which the facility activated the fire alarm activated on 1/30/2020, and the fire department dispatched to the scene two days after the initial malfunction of the thermostat placing the resident in an immediate jeopardy situation. Facility census was 78 residents.</p>	I	\$9,750 (Held In Suspension)	Upon receipt
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Facility Administrator

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	<p>Findings include:</p> <p>The facility summary of the incident (undated and no author identified) revealed on 1/30/20, a certified nursing assistant summoned the Administrator to the Edenberry Spa room. The CNA stated when she reached in to turn the light on, she observed sparks come from the wall. Upon entering the room, the administrator noted it felt very warm in the room and the dial outlet box above the thermostat felt warm to the touch and she observed sparking from thermostat. The facility administrator immediately called 911 and pulled fire pull station. The facility nurse consultant who was present with the Administrator at the time of the report, responded and utilized an ABC fire extinguisher to the area. Sioux City Fire and Rescue (SCFR) responded on the scene and inspected the area of concern. They identified no fire and that faulty wiring caused the outlet box to spark. The dial/outlet connected to a small heater unit used to heat the spa room. The heater continued to run, which is why the room felt so warm upon initial inspection. SCFR advised the facility to have an electrician disconnect the heater from electrical power source to remove any remaining fire/safety risks. Thompson Electric dispatched an electrician who removed the equipment from electrical circuit, pulled and capped the outlet box that shorted,</p>			
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	<p>and also inspected the remaining spa room heaters to ensure the same issue did not exist with those heaters. Nursing staff on 1/27/2020 that the Edenberry Spa room heater would not shut off, despite being turned off at the wall dial outlet. This problem was reported to maintenance and a work order was completed. Per interview, the maintenance associate, stated he responded to the work order, but could not determine how to shut the piece of equipment off from electrical power at the circuit breaker. He did admit he removed the outlet box from the wall, but halted work on the equipment when he realized could not determine how to disconnect it from power (Lock out/ Tag out). He did not call an electrician or notify the facility administrator at this time of concern. As a result of the investigation, the facility determined maintenance did not implement appropriate lock out tag out procedures, potentially adding to the fire safety risk.</p> <p>A SCFR Incident Report prepared on 2/11/20 at 12:09 p.m., identified a fire alarm activated at 1800 Indian Hills Drive, Sioux City Iowa on 1/30/20 at 5:03: p.m., due to heat from short circuit (wiring) defective/worn, dispatch at 5:03:43 p.m., fire department in route at 5:04:27 p.m., arrived on seen at 5:08:15 p.m., and cleared at 6:01 p.m.</p>			
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	<p>The SCFR Narrative report dated 1/30/2020 at 7:21 p.m. revealed a thermostat in Spa room malfunctioned causing sparks to emit from it. E-7 was dispatched for smoke in building, responded code 3 from Fire Station 7. Upon arrival E-7 entered building from the rear and were met in a common area by the manager who stated that a thermostat in the Spa Room popped and sparked. An employee then used a dry chemical extinguisher on it and activated the Fire Alarm via pull station. E-7 entered Spa Room and noticed the thermostat had popped out of wall and was hanging. The room was very hot from the heater still on, E-7 silenced alarm, looked for electrical breaker for room, could not find one, E-7 disconnected power from inside heater panel. T-3 reset alarm panel. Thermal camera showed no hot spots, E-7 and T-3 used ejectors to ventilate common area and hallways. Maintenance personnel arrived on scene, electrician was called in, E-7 went clear from call and en-route to quarters.</p> <p>Interview on 2/11/20 at 2:00 p.m., Staff E, certified nursing assistant (CNA), explained that Staff F (CNA) and Staff E were going to be giving a resident a shower in the Edenberry Spa room, when Staff E opened up the locked door to the spa room, it seemed to be extremely hot, so Staff</p>			
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	<p>E stated that the dial for the temperature should be turned down by moving the dial on the thermostat to the left, and wait for about 10 minutes for the room to cool down, after 10 minutes or so, Staff E and Staff F re-entered the locked spa room and noticed that the room was still very hot. Staff E and Staff F went to find the maintenance man and explained that the Edenberry spa room was very hot and that the thermostat should be looked into, because when Staff E turned the dial on the thermostat to the left it didn't seem like it was working. Upon further interview with Staff E on 2/12/20 at 3:42 p.m., stated that no one else was told about the Edenberry Spa room being very hot on 1/28/20.</p> <p>Interview on 2/12/20 at 10:10 a.m., Staff F, CNA, stated that on 1/28/20 around 7:30 a.m.-7:45 a.m., Staff E and Staff F proceeded to open up the locked door into the Edenberry Spa room to give resident their shower/bath. Upon opening up the door, staff noted extreme heat in the spa room. Staff E told Staff F to turn the dial on the thermostat to the left to cool the room down prior to giving any baths/showers and to wait about 10 minutes to let the spa room cool down. Staff F stated after about 10 minutes or so, Staff E and Staff F unlock the Edenberry spa room door and it still felt very warm in there, so Staff F informed the maintenance man of the situation and asked</p>			
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	<p>him to look at the thermostat in the Edenberry Spa room due to the room still feeling extremely warm even after turning the dial on the thermostat down to cool the room.</p> <p>Interview on 2/10/20 at 4:50 p.m., the facility maintenance man stated Staff E and Staff F notified him per verbal communication of the Edenberry Spa room feeling extremely warm and the dial on the thermostat not working on 1/28/20 around 9:00 a.m. The maintenance man stated that on 1/28/20, around noon he removed the cover from the thermostat and observed a spark. He left the spa room to go to the boiler room and locate the breaker. He could not locate the breaker so was unable to turn off power to the thermostat. He then went into the attic and could not shut off power in the attic either. He came down from the attic and went on with his day, failing to take any action with the thermostat situation. He stated he should have placed a call to the electrician on 1/28/20 to request the electrician come to the facility to look at the faulty thermostat in the Edenberry Spa room when he first knew about the thermostat.</p> <p>Further interview with Staff F on 2/12/20 at 10:10 a.m., revealed on 1/30/20 around 7:30 a.m.- 8:00 a.m., Staff F worked on the Edenberry hallway and unlocked the spa room and observed the</p>			
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	<p>thermostat cover off. Staff F shut the door and notified Staff G (the charge nurse for the day shift). Staff G directed Staff F to fill out a work order request and place it in the maintenance box in the front hallway, for which Staff F stated that they did.</p> <p>Interview on 2/10/20 at 4:15 p.m., Staff G, Licensed Practical Nurse (LPN), revealed that on 1/30/20 around 7:45 a.m.- 8:00 a.m., Staff F notified her the cover to the Edenberry Spa room thermostat was off and that the room felt extremely warm. Staff G stated when she went into the Edenberry spa room she noticed a line of soot going up the wall next to the cabinet hanging on the wall. Staff G stated she instructed Staff F to fill out a work order request and place the request in the maintenance box in the front hallway. Staff G stated she then went on with her day. Further interview with Staff G on 2/12/20 at 3:35 p.m., revealed she attempted to notify the facility administrator on 1/30/20 between 8:00 a.m. -9:00 a.m., per the facility telephone on the administrator's extension, with no answer from the administrator and no voice message left from Staff G. Staff G further stated that she went on with her day and did not make any further attempts to contact the Administrator of the thermostat concern.</p>			
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	<p>Interview on 2/12/20 at 3:40 p.m., the facility maintenance man confirmed and verified he did not inform the Administrator the thermostat malfunction in the Edenberry Spa room on 1/28/20.</p> <p>On 2/10/20 at 3:45 p.m., Staff D, CNA, stated that on 1/30/20 around 4:30- 4:45 p.m., they did rounds on all the Spa rooms to make sure the Spa rooms contained bath/shower supplies for after supper baths/showers. Staff D opened the Edenberry Spa door and noticed it felt extremely hot in the room, Staff D then touched the thermostat that was on the wall to turn the dial to the left to cool the room off. When Staff D touched the thermostat dial a spark flew up with a little puff of smoke. Staff D stated the puff of smoke smelled like an electrical wire. She shut the door right away and went down G hallway to find the facility administrator. Staff D and the facility administrator then went back to the Edenberry spa room and opened the locked door by the key code. After entrance, the Administrator touched the thermostat's outer covering and it started to spark. The Administrator told Staff D to run and get an ABC fire extinguisher. Staff D then stated the Administrator called 911 and pulled the fire alarm pull station for which sounded the fire alarm system throughout the facility.</p>			
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	<p>On 2/10/20 at 3:45 p.m., the facility Administrator stated that while visiting with a family member in the G-hallway, Staff D came to them about 5:00 p.m., and identified an emergency in the Edenberry spa room that required immediate attention. The Administrator went with Staff D to the Edenberry spa room, opened the locked door and then felt how hot the spa room was. The Administrator touched the thermostat cover and observed a thrown spark and a black line of soot running up the wall next to the hanging cabinet. The Administrator told Staff D to get the ABC fire extinguisher, and she called 911 and pulled the fire alarm on the pull station which sent the fire alarm sounding throughout the facility. The facility nurse consultant had the ABC fire extinguisher and sprayed the foam at the thermometer box hanging on the wall in the Edenberry spa room. The Administrator waited for the fire department to arrive and met them at the common area and showed them the Edenberry spa room. They checked the walls for heat that might have traveled up the wall and they also then checked for a breaker in the boiler room which they could not find. They disconnected the power from the thermostat. The Administrator called the electrician and they waited for the electrician to arrive. When the electrician arrived, he disconnected the power to the thermostat and</p>			
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	<p>also to the heater hanging in the corner of the room.</p> <p>On 2/12/20 at 3:10 p.m., the Administrator stated she did not have prior knowledge of the thermostat malfunctioning. She expects the maintenance man to keep her informed of any hazards in the facility so that they can be addressed as soon as possible.</p> <p>On 2/13/20 at 8:20 a.m., the electrician that addressed the thermostat issue confirmed and verified he received a phone call from the Administrator stating the fire department was at the facility and that they needed an electrician at the facility due to electrical sparking from the thermostat in the Edenberry spa room. Upon inspection, he found burned wires inside the thermostat. He stated a fire could not be counted out and that anything could of happened just by bumping/touching the thermostat on the wall. He felt that once the facility found that the thermostat did not functioning properly on 1/28/20, the facility should of called the electrician right away to come and disconnect the power from the thermostat and the heater hanging from the ceiling. The electrician went on to say that it could of been a dangerous situation, due to the electrical wires being burnt.</p>			
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	<p>An email dated 2/13/2020 at 8:47 a.m. from the state Fire Marshall revealed the following regarding the thermostat incident: Yes, this should have been dealt with much sooner than it was. If Maintenance couldn't have fixed the issue on the 28th, they should have called an electrician since the electrical wiring sparked. It's hard to say if a fire would've been imminent, but obviously that is a possibility. A fire could have started in the wall creating a serious hazard (especially if not discovered right away).</p> <p>Emergency Shutdown Procedures policy dated 2009, revealed the policy should be utilized as a basic guideline during emergency situations that require the immediate shutdown of certain aspects of the operation. Deactivation of equipment within the facility may be required during a natural disaster, civil disturbance, terrorism attack, accidental event (power outage, power spike, over-pressurization, gas leak, etc) or other circumstances that may require the immediate and safe shutdown of equipment. Each aspect of the operation requires specific and unique steps to be initiated to safely and efficiently shut down equipment. These guidelines describe the basic steps that must be taken to perform an emergency shutdown of the following mechanical items: *Electric</p>			
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	<p>*Natural Gas *Water *Heating, Ventilating and Air Conditioning Equipment *Boilers *Computer Equipment</p> <p>The deficient practice detailed above resulted in an immediate jeopardy situation for the facility. The facility abated the immediate jeopardy on 1/30/2020 by re-training all nursing staff on 1/30/20 and on QA efforts related to Lock/out Tag/Out Procedure. This abatement resulted in past noncompliance for the facility.</p> <p>FACILITY RESPONSE:</p>			
135C.33	135C.33 Employees and certified nurse aide trainees — child or dependent adult abuse information and criminal record checks — evaluations — application to other providers —penalty.	II	\$500	UPON RECEIPT

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50.9	<p>481—50.9(135C) Criminal, dependent adult abuse, and child abuse record checks. 50.9(1) Definitions. The following definitions apply for the purposes of this rule. “Background check” or “record check” means criminal history, child abuse and dependent adult abuse record checks.</p>			
58.11(3)	<p>481—58.11(135C) Personnel. 58.11(3) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on review of an employee file and staff interview, the facility failed to assure that a nursing assistant was cleared before allowing her</p>			

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<p>to work with residents for 1 of 4 staff reviewed. Staff B's Criminal History Background Check identified further research was required and directed the facility to await DCI's (Department of Criminal Investigation) final response. The facility did not receive final response before allowing Staff B to work. The facility reported a census of 78 residents.</p> <p>Findings included:</p> <p>1. During review of employee files, Staff B's record documented a date of hire 1/2/20 as Certified Nurse Aide (CNA). The Single Contact License and Background Check completed on 12/26/19 at 1:35 p.m., documented result of Criminal History Background Check with results to "await for further research is required. Please await DCI (department of criminal investigations) final response to criminal history".</p> <p>The Iowa Record Check Request form dated 12/6/19, documented record attached.</p> <p>Review of the employee file revealed no letter that Staff B may work in the facility.</p> <p>Review of the Punch Source Report date range from 1/1/20-2/19/20, documented Staff B worked on these dates and times:</p>				
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<p>*1/12/20 from 5:48 a.m.-2:02 p.m. *1/15/20 from 8:49 a.m.-2:02 p.m. *1/16/20 from 5:43 a.m.-2:13 p.m., and 9:46 p.m.-2:21 a.m. *1/20/20 from 3:57 p.m.-10:03 p.m. *1/21/20 from 6:12 a.m.-2:10 p.m. *1/23/20 from 8:51 a.m.-2:12 p.m. *1/25/20 from 6:06 a.m.-2:05 p.m. *1/26/20 from 6:03 a.m.-2:12 p.m. *1/27/20 from 10:31 a.m.-1:37 p.m. *1/28/20 from 6:03 a.m.-2:04 p.m. *1/29/20 from 4:03 p.m.-9:00 p.m. *1/30/20 from 6:09 a.m.-2:02 p.m. *1/31/20 from 8:54 a.m.-2:04 p.m. *2/3/20 from 3:50 p.m.-9:03 p.m. *2/4/20 from 6:05 a.m.-2:11 p.m. *2/6/20 from 6:18 a.m.-2:04 p.m. *2/8/20 from 6:01 a.m.-2:00 p.m. *2/10/20 from 3:59 p.m.-9:00 p.m. *2/11/20 from 6:10 a.m.-6:18 a.m. *2/11/20 from 6:40 a.m.-2:00 p.m. *2/11/20 from 9:47 p.m.-6:00 a.m. *2/12/20 from 3:50 p.m.-9:00 p.m. *2/13/20 from 6:01 a.m.-6:04 a.m. *2/17/20 from 5:47 a.m.-10:02 p.m. *2/18/20 from 6:03 a.m.-</p> <p>During an interview on 2/18/20 at 11:48 a.m., the facility nurse consultant confirmed and verified that the employee file lacked any documentation</p>				
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<p>of a letter from DCI, that Staff B may work in the facility. The facility consultant also confirmed and verified that Staff B has been working at the facility.</p> <p>Review of the Background Checks Policy and Procedure dated 9/15/15, stated that background checks serve as an important method of verifying compliance with the organizational processes and procedures of HDG (health dimensions group) Managed Community. The information collected from a background check helps HDG Managed Community promote a safe work environment for the employees, residents, and family members served, as well as comply with applicable state, federal, and local laws. Background checks also help obtain information necessary to determine an applicants overall employability and to ensure the protection of physical property, financial information, medical information, proprietary information, and other corporate assets. Human Resources will initiate all federal, state, and local required background checks at the time a contingent offer of employment is made to an applicant. The applicant will receive appropriate disclosure, authorization, and notice documents prior to conducting the background check. Human Resources will make all reasonable efforts to ensure that background checks are complete prior to the first day of employee orientation. If an</p>				
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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

	<p>individual begins employment before completion of the background check, and it is later determined that the individual has not passed the background check, HDG Managed Community reserves the right to withdraw the offer and terminate the employee.</p> <p>FACILITY RESPONSE:</p>			
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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).