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	165161	A. BUILDING _____ B. WING _____	C 02/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 000	INITIAL COMMENTS Correction Date: _____ The following deficiencies are the result of the investigation of complaints- #88853-C, #89276-C, and incidents #89277-I and Incident #89164-I, completed on February 10 - February 13, and February 17th and 18th, 2020. #88853-C, not substantiated. #89276-C, substantiated. #89277-I, substantiated. #89164-I, substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an	F 606		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/23/2020

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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employee, which would indicate unfitness for service as a nurse aide or other facility staff.
This REQUIREMENT is not met as evidenced by:
Based on review of an employee file and staff interview, the facility failed to assure that a nursing assistant was cleared before allowing her 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.

Findings included:

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".

The Iowa Record Check Request form dated 12/6/19, documented record attached.

Review of the employee file revealed no letter that Staff B may work in the facility.

Review of the Punch Source Report date range from 1/1/20-2/19/20, documented Staff B worked on these dates and times:
*1/12/20 from 5:48 a.m.,-2:02 p.m.
*1/15/20 from 8:49 a.m.-2:02 p.m.

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*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.-

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 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.

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

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F 606	Continued From page 3 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 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.	F 606		
F 689 SS=J	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:	F 689		

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F 689	Continued From page 4 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. Findings include: 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	F 689	Past noncompliance: no plan of correction required.	

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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, 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.

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.

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

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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.

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 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.,

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stated that no one else was told about the Edenberry Spa room being very hot on 1/28/20.

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 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.

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

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electrician come to the facility to look at the faulty thermostat in the Edenberry Spa room when he first knew about the thermostat.

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 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.

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.

Interview on 2/12/20 at 3:40 p.m., the facility

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maintenance man confirmed and verified he did not inform the Administrator the thermostat malfunction in the Edenberry Spa room on 1/28/20.

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.

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

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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 also to the heater hanging in the corner of the room.

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.

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

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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.

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).

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:

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	165161	A. BUILDING _____ B. WING _____	C 02/18/2020

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TOUCHSTONE HEALTHCARE COMMUNITY	1800 INDIAN HILLS DRIVE SIOUX CITY, IA 51104

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F 689	Continued From page 12 *Electric *Natural Gas *Water *Heating, Ventilating and Air Conditioning Equipment *Boilers *Computer Equipment 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.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		

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conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on employee record review and staff interview, the facility failed to complete two-step tuberculin (TB) testing per facility policy, for two staff reviewed. (Staff B and Staff C).The facility reported a census of 78 residents.

Finding include:

1. Review of staff hire dates revealed the facility hired Staff B on 1/2/20. The Baseline TB Screening Tool for Health Care Workers documented form completed on 12/31/19, identified Staff B received the first step of Tuberculin skin testing (TST) on 12/31/19 at 11:05 a.m., with the results read on 1/2/19, with a negative reading. The TST second step test was not completed.

2. Review of staff hire dates revealed the facility hired Staff C on 1/2/20. The Baseline TB Screening Tool for Health Care Workers documented form completed on 12/31/19, identified Staff C received the first step of Tuberculin skin testing (TST) on 12/31/19 at 3:45 p.m., with the results read on 1/2/20 at 1:45 p.m., with a negative reading. The TST second step test was not completed.

3. On 2/18/20 at 9:02 a.m., the facility nurse consultant confirmed and verified Staff B and Staff C needed to have the 2 step TB test done.

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F 880	Continued From page 15 The Human Resource Policy for Mantoux/Tuberculosis Testing policy dated 9/2015, revealed HDG (health dimensions group) Management Community complies with all policy and procedures for tuberculosis screening of health care workers. *Human Resources or designated individual within the community will use the two (2) Step TB scheduling form to ensure the new hires TB tests are completed in a timely manner. *First test is to be completed prior to the employees scheduled orientation date/hire date so that the test can be read on or prior to the actual orientation date/hire date. To ensure compliance and consistency, it is recommended that orientation/hire dates are best to be scheduled on days other than Tuesdays. *Please note that if the first test is not read with in 48 to 72 hours the employee is removed from the schedule until the first test is given again as well as read. *The second test is to be given 1-3 weeks after the first step is read. The second step must be read 48 to 72 hours after it is administered.	F 880		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		

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§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
This REQUIREMENT is not met as evidenced by:
Based on facility personnel record review and staff interview, the facility failed to provide and document a minimum of 12 hours of nurse aide training for 1 of 4 Certified Nurse Aide (CNA)employee files reviewed. (Staff A). The facility reported a census of 78 residents. .

Findings include:

Review of an employee date of hire roster, the facility initially hired Staff A CNA on 9/11/15. The Director of Nursing (DON)confirmed on 12/17/20 at 10:10 a.m., that the facility rehired Staff A on 11/2/18. The CNA job description also documented Staff A with a re-hire date of 11/2/18.

Review of the facility in-service forms and Staff A's employee file, revealed Staff A attended 2 in-services on 12/31/19 and 2/12/20.

On 2/18/20 at 11:10 a.m., the facility nurse consultant confirmed and verified that Staff A only attended two in-services and staff are required to have 12 hours of in-service every year.

Review of the Facility Policy for In-Service with a revision dated 6/2017, read that an on-going, planned education program is conducted for the

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F 947	Continued From page 17 development and improvement of necessary skills and knowledge for all facility personnel. Training will be preformed via computer (Medcom) or in-person. Each employee is responsible for attending the minimum required hours and the required programs: *Assure that all training records are complete and tracked back to the employee file on a monthly basis. *Each nursing assistant attends a minimum of 12 documented hours per year of in-service education programs.	F 947		