

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Anamosa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1209 East Third Street Anamosa, IA 52205	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48003</p> <p>Based on clinical record review, facility incident investigation review, policy review, and staff interviews, the facility failed to assess a resident after spilling hot thickened coffee during meal service which resulted in a second degree burn (tissue damage to the top and middle layers of skin in which blisters can develop). She required antibiotics and treatments at the wound care clinic for injury 1 of 1 residents reviewed (Resident #14). The facility reported a census of 60 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) for Resident #14 dated 4/24/24 documented a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. The MDS documented Resident #14 had diagnoses including hypertension, stroke, dementia, dysphagia, and hemiplegia to the left side. It further documents that the resident required supervision with eating (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.)</p> <p>The Care Plan for Resident #14 revised 2/07/24 with a focus area for Nutritional Status related to diabetes, altered textures, and need for supplement. Interventions listed to use plastic dinnerware due to behaviors and to monitor for chewing, swallowing problems.</p> <p>Review of the facility incident report investigation dated 6/01/24 documented Resident #14 was seated in the dining room for supper (supper meal served at 6 PM). She was served her thickened coffee in a styrofoam cup with a lid per her Care Plan. Staff laid her blanket on the table (the resident likes a blanket for her shoulders during the meal). Staff observed her grabbing onto her blanket and pulling it toward herself. When she pulled the blanket she spilled her hot coffee and juice on the table. Staff noted the spill and got rags to clean up the spill. They removed the wet blanket and rags from the table. The incident investigation lacked any documentation of the resident being assessed to make sure the hot coffee didn't spill on the resident. It documented it wasn't until staff was providing bedtime care that staff noticed the resident's thigh areas were red and had blisters. Staff then notified the nurse. The nurse then assessed the skin, tried to notify the resident representative and sent a message to the physician. The intervention done at the time was staff education to assess the resident right away after a spill of hot liquids.</p> <p>Review of the CNAs working the day of the incident lacked any documentation of assessing Resident #14 after the spill of the hot coffee to make sure it did not spill on the resident.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Progress Note, Health Status Note dated 6/01/24 at 9:39 PM Staff G, LPN documented Resident #14 spilled her hot chocolate on the table and herself and it wasn't found until HS (bedtime) cares noted blisters and red areas. It documented the left inner thigh with two blisters, the red area measured 12.7 centimeters (cm) by 7.6 cm. One of the fluid blisters measuring 2.4 cm by 1.2 cm.</p> <p>A Progress Note, Health Status Note dated 6/04/24 at 9:00 AM documented Resident #14 was seen by the Advanced Nurse Practitioner (ARNP) and she assessed the bilateral thigh burns. The ARNP ordered Cephalixin (antibiotic) four times a day for seven days.</p> <p>Review of the non-pressure skin condition report for 6/01/24 documented the resident had 12.7 cm by 7.6 cm burn area to left thigh with one blister measured 2.4 cm by 1.2 cm and the other blister 1 cm around. The right thigh burn measured 3.1 cm by 1.5 cm.</p> <p>A Progress Note, Health Status Note dated 6/22/24 at 5:32 AM documented the physician ordered a referral for Resident #14 to be seen at the wound clinic.</p> <p>The Wound Clinic Provider note dated 6/26/24 documented the resident's left thigh burn noted to have necrotic; partial granulation to the site. The physician debrided the wound (removal of the dead, damaged or infected tissue).</p> <p>During an interview on 7/22/24 at 4:58 PM Staff G, Licensed Practical Nurse (LPN) reported she was the nurse working the evening of the incident. She verbalized she was at the kitchen window when staff came up to get towels to clean up the spill but did not report any of the spill landing on the resident. She reported she did not assess the resident to make sure. She reported Staff I, Certified Nurse Aide (CNA) was sitting with the resident at the time of the incident. She reported it was not until Staff H, CNA came up at bedtime after 9 PM and reported the resident had a red area with blisters to the thighs. Staff G went to the residents room and assessed her.</p> <p>During an interview on 7/23/24 at 10:59 AM, the Administrator reported the staff failed to assess the resident to make sure the hot coffee did not spill on the resident. She reported Staff I, CNA was sitting at the table when the incident occurred.</p> <p>During an interview on 7/25/24 at 9:15 AM, Staff K, Dietary reported prior to the incident for Resident #14 staff had not been temping the coffee or hot chocolate.</p> <p>During an interview on 7/25/24 at 09:59 AM, the Dietary manager reported there was no policy in place prior to the incident to temp the coffee and hot chocolate.</p>		