STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175508	A. BUILDING _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS NURSING & REHABILITATIVE CENTER	**302 E IOWA STREET HIAWATHA, KS 66434**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00177417. the 2567 was sent electronically on 02/06/23.	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: The facility identified a census of 51 residents. The sample included one resident reviewed for accidents. Based on record review, interview, and observations, the facility failed to prevent an avoidable accident when staff failed to safely apply and monitor a warmed rice pack. On 01/11/23, Resident (R)1, who required assistance with cares asked for a warm pack for her stomach. Certified Nurse Aide (CNA) M warmed a rice pack in the microwave for one minute and 30 seconds then wrapped the rice pack with two towels and placed on R1's abdomen. After lunch, roughly one hour, R1 still had the rice pack on her abdomen. CNA M removed the rice pack and noted that R1 had a reddened area that was blistering and painful. Findings included: - R1's Electronic Medical Record (EMR)	F 689	Past noncompliance: no plan of correction required.	

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

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recorded diagnoses of chronic bladder pain, type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), muscle weakness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, and burn of unspecified degree of abdominal wall.

The "Annual Minimum Data Set" (MDS) assessment dated 02/23/22 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required extensive assistance of two staff members for bed mobility, dressing, and total dependence of two staff members with transfers.

The "Quarterly MDS" assessment dated 11/09/22 documented a BIMS score of 14, which indicated intact cognition. R1 required extensive assistance of two staff members for bed mobility, transfers, and dressing.

The "Visual Function Care Area Assessment" (CAA) dated 02/23/22 documented R1 had poor eyesight in bilateral eyes due to diabetes and only saw shapes and light.

The "Activities of Daily Living (ADL) CAA" dated 02/23/22 documented R1 required two-person assistance with a full body lift for transfers and was propelled by staff in her wheelchair. R1 could eat and drink with set up, but was noted to be dependent on staff for all other ADL cares.

The "Pressure Ulcer Care Plan" initiated 03/03/22 directed staff to report any signs of skin breakdown (sore, tender, red, or broken areas).

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The "ADL Functional/Rehabilitation Care Plan" initiated 03/03/22 directed staff to report any noted impaired skin integrity to the medical director and responsible party and document findings.

The "Nursing Note" dated 01/11/23 at 02:04 PM documented R1 requested a hot pack from CNA M due to lower abdominal discomfort. CNA M obtained and applied a hot pack without consulting LN G. When the hot pack was removed it was noted that R1 had a reddened skin with blistering five inches by three and a half inches under the hot pack. LN G notified Administrative Nurse D.

The "Facility Investigation" dated 01/12/23 recorded on 01/11/2023 at approximately 01:00 PM CNA M reported to Licensed Nurse (LN) G that she had placed a rice filled hot back on R1 and that when she removed it, R1's skin was red. CNA M had obtained a rice pack from the nursing supply closet, heated it in the microwave, wrapped it in a towel and applied it without the charge nurse's knowledge earlier in CNA M's shift. R1 asked for her to apply another rice pack again at lunch time because the first one helped. CNA M re-heated the rice pack, wrapped it in a towel, and re-applied it to the resident's abdomen area, again without licensed nursing staff knowledge. After lunch, when staff were assisting R1 to bed, CNA M removed the pack and noticed a reddened area. CNA M immediately notified the charge nurse. LN G immediately notified Administrative Nurse D. Staff assessed R1's stomach and noticed a reddened area approximately three inches by five inches that appeared red with some skin breakage.

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The "Nursing Note" dated 01/12/23 at 12:06 PM noted R1 had some skin slightly peeled away.

The "Nursing Note" dated 01/13/23 at 03:17 PM documented R1 had an abdominal burn pink in color, the size of a lemon. R1 was missing the top layer of blister not intact to area.

The "Nursing Note" dated 01/14/23 at 12:16 PM documented R1 complained the burn area was painful, and itching.

The "Nursing Note" dated 01/15/23 at 09:33 AM documented R1's abdomen had very mild blistering on the outskirts of the burned area. The burned area measured four centimeters (cm) by five cm, with no depth noted. R1 had very little drainage that appeared serous (thin, clear, watery) in color and viscosity, mild sticking was noted. R1 reported that there was periodic pain associated with rubbing of clothes.

The "Wound Management" assessment dated 01/15/23 at 09:43 AM documented a wound with partial thickness with redness, blistered, moist, and painful. The area of blistering was present on the outskirts of the wound, peeled skin noted to cover 20% of the wound. The wound had light/scant tissue moisture, enough to stick to clothing/dressing. R1 reported pain occurred with pressure or rubbing. The wound was non-blanching and had scabbing present with serous drainage noted.

The "Wound Management" assessment dated 01/20/23 at 02:08 PM documented the wound was full thickness, dry, and discolored with no pain. The burn progressed and showed more tissue damage. The wound had more tissue

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exposed with serosanguineous (thin, blood tinged) drainage noted.

The "Nursing Note" dated 01/20/23 at 02:14 PM documented R1's burn had the presence of blistering and eschar (dead tissue). Eschar covered 60 % of the burn surface with blistering around the edges. R1 denied pain or discomfort but stated that it hurt when pressure or rubbing occurred from clothing, for example. The wound was four cm by five cm, depth in unmeasured, very little moisture or exudate (drainage) present.

The "Nursing Note" dated 01/23/23 at 03:51 PM documented R1 had notable eschar in a slightly deformed "X" shape. On the left side of the "X" shape and area appeared to be blistered skin leftover from a ruptured blister. The entire burned area measured 5.5 cm by 8.25 cm, eschar was present in a 5.5 cm by 6.6 cm area. Estimated 70 % of the wound bed was covered in eschar and the remaining 30% was sloughing tissue.

On 01/24/23 at 01:25 PM observation of R1's abdominal area revealed the area was a lemon-shaped open area with a donut shape in the center of opened area. The donut shape area was three quarters eschar with one quarter slough (soft dead tissue and exudate). There was scant reddish/pink discharge noted on the island dressing that was removed. R1 stated the day she received the rice pack the second time she noted the area had started to hurt but did not realize it was from the heat. R1 further stated that when her clothing rubs on the dressing or any type of pressure is on the area, the area is painful.

On 01/24/23 at 12:50 PM CNA M stated that she

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gave R1 the rice bag two different times on 01/11/23; the first time was when R1 was in bed. CNA M stated she heated the rice pack up in the microwave for one minute and then wrapped it in a towel for R1 and placed it on her lower abdomen. CNA M revealed that R1 asked CNA M to reheat the rice pack a second time when R1 was getting up for lunch. CNA M stated she heated the rice pack up in the microwave for 1.5 minutes and then wrapped the rice pack in two towels. CNA M further stated she did not think that the rice pack was "too hot" because she placed it on her chest, over her scrub top, while she walked back to R1. CNA M revealed that she placed the reheated rice pack on R1's lower abdomen and took R1 out to lunch. CNA M further revealed that the approximate time the heated rice pack was on R1's lower abdomen the second time was roughly one hour. When CNA M went to lay R1 down, CNA M removed the rice pack and noted the red mark. CNA M immediately notified LN G. CNA M stated she thought that anyone could get R1 a rice pack and heat it up. CNA M further stated an unidentified CNA told her where to locate a rice pack.

On 01/24/23 at 01:45 PM Administrative Nurse D stated CNA M was taught in her training to become a CNA that CNA M had to go to the nurse before applying any type of heating pad to a resident. Administrative Nurse D revealed that she was aware CNA M had been taught that because Administrative Nurse D taught CNA M's class.

The facility's "Compress, Applying Warm" policy revised February 2018 documented the purpose of the procedure was to ease the body of pain caused by inflammation and congestion, to aid in

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treatment of the resident's condition, to promote drainage in infections, to improve circulations and to apply heat to an area. The general guidelines directed staff to check the resident's skin often for redness or discoloration. It further directed that a heating pad should only be used for the prescribed length of time and should not be used for extended periods.

The facility failed to prevent an avoidable accident when staff failed to safely apply and monitor a warmed rice pack. Which resulted in a burn for R1. The facility implemented corrective actions by educating all nursing staff regarding use of heat, CNA M also received instruction on the CNA scope of practice. All rice packs were removed from the facility and the incident reveiewed at the Quality Assurance and Performance Improvement committee.

The deficient practice was cited at past non-compliance.