DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165162	A. BUILDING _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTOONA NURSING AND REHABILITATION CENTER	200 SEVENTH AVENUE SW ALTOONA, IA 50009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: 4/6/21 A Centers for Medicare and Medicaid Services (CMS) Focused Concern Survey (FCS) was conducted on 4/6/21 following an Iowa Department of Inspections and Appeals Complaint Survey on 3/11/21. The following complaints were investigated; IA00094975, IA00096117, IA00096129, IA00095430 and IA00096267.	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, interview and record review the facility failed to prevent resident access to the steam table in the dining room, which was turned on to the highest setting. Steam could be observed rising from the water in the pans, and the water in the steam table had a temperature reading of 211 degrees Fahrenheit. Residents were observed in the dining room or traveled independently through the dining room without staff present. This failure had the potential to cause serious injury to cognitively impaired residents. Additionally, the facility failed to secure a cabinet in the ABC dining room, which contained resident smoking materials including cigarettes and multiple lighters. The smoking materials were plainly visible when the cabinet	F 689		

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

Administrator 4/6/2021

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 door opened, and were left unsecured inside the cabinet itself. The facility identified 17 cognitively impaired independently mobile residents. The facility reported a census of 92 residents. The facility's noncompliance with CFR(s): 483.25(d)(1)(2), had the potential to affect all 17 residents identified as cognitively impaired and independently mobile and resulted in an immediate jeopardy (IJ). The Administrator of the facility was notified of the IJ on 4/5/21 at 6:30pm related to the unsupervised steam table that was turned on to the highest setting. Findings include. 1. During constant observation by surveyors' on 4/5/21 between 3:53pm to 4:49pm, steam was rising from the steam table located in the dining room near the ABC halls. The steam table surface was hot to touch and accessible when standing beside the steam table while the approximately three foot unlocked door by the steam table was shut. Residents were observed traveling through the dining room independently and there were no staff visible in the area of the steam table to monitor resident access to the hot surface. During an interview on 4/5/21 at 4:35pm, dietary aide (D1) indicated the steam table had been on since 3:00pm to get it up to temperature and it did not take long to heat up and said, "gets hot, hot quickly." D1 further indicated staff may not touch the pans with bare hands because they get so hot. D1 indicated in the past eight years, the facility had always turned the steam table on full blast at 3:00pm, left it not attended by staff, but the door was supposed to be locked.	F 689		

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	165182	A. BUILDING _____ B. WING _____	04/06/2021

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F 689	Continued From page 2 On 4/5/21 at 4:49pm, the Administrator verified the steam table temperature was set on the highest setting to heat the water in preparation of the noon meal. The Administrator stood outside of the short door that lead to the steam table and said the door should have been locked. She then reached over the door without difficulty and touched her hand to the steam table surface, quickly retracted her hand and said, "That's hot" and indicated the surface heat hurt her hand. The Administrator used a thermometer to check the temperature of the water in the steam table and indicated the thermometer read 211 degrees Fahrenheit. The Administrator indicated staff turned on the steam table at approximately 4:00pm, an hour prior to the meal to heat the water to keep the food warm during meal service. The Administrator indicated that when the water was heated with the lids on, the lids would be hot to touch. When asked if the steam table should be monitored by staff when turned on, the Administrator indicated that kitchen staff had always turned the steam table on high to warm, then left it while they returned to the kitchen to prepare for meal service, which left the steam table not monitored. The Administrator indicated the short door next to the steam table could be locked, but it did not prevent a resident from touching the hot steam table and being burned. According to http://www.the-med.org/media/Scald%20Burns%20Flyer.pdf, a water temperature of 140°F caused a 3rd degree burn (affects all three skin layers, destroys hair follicles, sweat glands, and may damage nerve endings) in three seconds and at 155°F in one second.	F 689		

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F 689	Continued From page 3 The facility's revised October 2017 Policy and Procedure titled "Food Service/Distribution" did not indicate if staff would monitor the steam table while it was turned on to heat. The IJ was removed on 4/6/21 during the survey after surveyors' verified implementation of an acceptable removal plan that was provided by the facility which included, but was not limited to, staff monitoring of the steam table while heated/in use, to ensure residents were kept safe from burns. The scope and severity was lowered to an E. 2. On 4/5/21 at 3:45pm, four cabinets were observed on the south wall of the ABC hall dining room. The cabinets to the left of the entryway to the resident halls, nearest to the exit door leading to the resident smoking area, were found to be unlocked and slightly ajar. The easternmost cabinet door was also unlocked. When opened, the cabinet was found to have a clear plastic container which contained multiple packages of cigarettes and three visible lighters on the shelf at eye level. On 4/5/21 at 3:50pm, the Activity Director (AD) indicated that one of the responsibilities of the activity department was to oversee the resident smoking activities. Activity staff would escort the residents outside, where they would don firesafe apparel and smoke. The AD indicated that resident smoking materials, including cigarettes and lighters, were kept in locked cabinets at the front of the building and in the ABC dining room. The AD indicated that the cabinets must be locked because some of the residents would try to get to the smoking materials. On 4/5/21 at 3:52pm, the AD and the Federal	F 689		

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F 689	Continued From page 4 surveyor walked to the cabinet and the AD opened the unlocked door. The AD indicated that she was not aware the cabinet doors were unlocked. On 4/6/21, this writer observed the cabinet that had contained the smoking materials was locked. The facility did not provide a policy to address how smoking materials should be secured.	F 689		

Plan of Correction for Altoona Nursing and Rehabilitation Center for CMS survey exiting 4/6/2021

This serves as the credible allegation of compliance for Altoona Nursing and Rehabilitation. We assert that all correctives described on this plan of correction have been implemented. Regarding the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of Altoona Nursing and Rehabilitation Center is committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Altoona Nursing and Rehabilitation center is in substantial compliance as set forth below.

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Altoona Nursing and Rehabilitation Center has completed the following interventions as a result of the findings from survey exiting 4/6/2021.

The facility abated the IJ immediatley on 4/5/2021 was in substantial compliance on 4/6/2021.

F 689 SS=K ACCIDENTS AND SUPERVISION

Altoona Nursing and Rehabilitation Center will ensure that each resident is free from accidents hazards over which the facility has control and provides supervision to each resident to prevent avoidable accidents. Dietary staff were re-educated that the steam table is not to be turn on more than 30 minutes prior to serving, is to be unplugged when not in use and the door to the steamtable is to be locked at all times when not in use for serving. . Education was provided on 4/5/2021, by the facility Administrator. Edcuation included the above.

Additional plexiglass extending 36 inches beyond the width and height of the steamtable was afixed to the steamtable on both sides preventing any person(s)from reaching around or through prohibiting touching of the steamtable. In addition, a 2 foot sheet of plexiglass was added to the door leading to the steamtable as an added barrier on 4/6/2021. The steamtable door is locked at all times when not in use. See attached pictures.

Activites staff were re-educated by the facility Administrator on 4/5/2021

to ensure their closets are locked at all times when not in use and when not supervised. Education included smoking materials must be secured at all times in the appropriate facility designated secured area.

Monitoring of the steamtable and activites/smoker supply closets will be conducted 3-5 x weekly x 4 weeks then random thereafter to ensure ongoing compliance. The facility has developed a QA Auditing Tool to be utilitzed by the dietary staff and activities staff, with oversight by the Administrator. Any additional concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.