

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

Number 5827					Report date August 17, 2022
Facility name North Crest Living Center		Survey dates July 27, 2022- August 5, 2022			
Facility address 34 Northcrest Drive					
City Council Bluffs, IA 51503		MW			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
58.28(3)e	58.28(3) Resident safety. shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) DESCRIPTION: Based on observation, record review and resident, family and staff interviews the facility failed to ensure the resident environment remains as free of accident hazards as possible. Boiling water from a pot was used to make hot chocolate and then served to Resident #1 which resulted in burning of the resident's mouth. The resident required hospitalization and pain control for the burns. The facility's failure resulted in an immediate jeopardy to resident's health and safety. The facility reported a census 46 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment tool dated 6/27/22	I	\$8500 Held in Suspension	Upon Receipt	

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	documented a Brief Interview Mental Status (BIMS) score of 13. A BIMS score of 13 suggested Resident #1 had no cognitive impairment. The MDS documented she was independent with set up help for eating and limited assistance of one staff for personal hygiene which included brushing her teeth. The MDS listed the following diagnoses: stroke, nontraumatic intracranial hemorrhage, anemia, renal failure, diabetes mellitus, dementia, and anxiety. The care plan focus area dated 10/5/21 documented Resident #1 needed assistance with her Activities of Daily Living (ADLs) because she had muscle weakness and decreased mobility due to a stroke that affected her right side. The care plan encouraged staff to offer set up help with meals but Resident #1 was able to feed herself. The care plan documented the resident wore a full set of dentures and ha no natural teeth in			

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	place. She was independent with oral and denture care after set up help. Clinical record documented Resident #1 was to receive a regular texture diet with regular consistency fluids with a start date of 2/4/22 and end date of 8/1/22. When she returned to the facility on 8/1/22 her diet was changed to a puree diet, regular consistency. The following progress note was documented in Resident #1's Electronic Health Record (EHR): - 7/22/22 at 5:48 AM around 4:30 AM the Certified Nursing Assistant (CNA) who had provided care to the resident noted Resident #1 to be warm to the touch and the resident's initial temperature was 104.1 degrees Fahrenheit. The resident was lethargic but aroused when prompted but then fell back asleep. Her oxygen saturation was at 77% on 2 liters (L) of oxygen via nasal cannula. Resident was repositioned, her				

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	oxygen was turned up to 4L and her oxygen saturation increased to 92%. She remained warm and lethargic with a temperature of 103.7 degrees Fahrenheit. Resident was sent to the Emergency Room (ER) for further evaluation. - 7/22/22 at 10:06 AM the resident's daughter reported she was being admitted for slight pneumonia and will be kept overnight, at least. -7/23/22 at 8:54 AM the resident's daughter came to the facility to pick some clothing for her. She reported the resident may be aspirating due to the sores on her lips, tongue and in her mouth. Ears, Nose and Throat (ENT) will be evaluating her today. -8/1/22 at 9:14 PM Resident #1 remained on Skilled Level of Care (SLOC) for acute hypoxic respiratory failure due to lower respiratory infection and oral burns. Her lips and inside of her mouth have pinpoint open areas of				

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	redness. She is on a puree diet at this time with thickened liquids, required set up help only. -8/2/22 at 4:54 AM Resident's lips are dry with thick, caked on debris. Oral gives were provided and lip balm applied. The inside of her mouth and outer lips have a tiny amount of bloody drainage. On 7/22/22 a History and Physical was completed by the Hospitalist, documented the following information: Resident #1 presented with severe mucosal pain -difficulty speaking due to pain and inflammation. Yesterday she went to drink her hot chocolate with her dentures in, and it caused severe mucosal burns. She denies any aspiration like events. Overnight she was febrile, found to have a temperature of 105 degrees Fahrenheit around 5:00 AM and was sent to the ER. A head, ears, nose and throat assessment revealed the following: normocephalic (normal sized head), thick				

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	coating to oral mucosa - tongue and lower gums, left sided buccal coating also. Under the plan section she documented: magic mouthwash before meals and at bedtime (ACHS), will need to monitor oral mucosa/inflammation closely to avoid worsening respiratory status. Also suffered an extensive oral burn last night due to hot liquid. Clear demarcation of burn on mucus membranes in her mouth. Has reduced mobility of her tongue with increased risk for aspiration. On 7/22/22 the ER physician provided the following ER note: Resident #1 transferred to the ER with complaints of fever and hypoxemia. Shortly prior to arrival the resident was noted to have a temperature of 103 degrees at the nursing home. The Emergency Medical Services (EMS) noted oxygen saturation of 76% on 2L of oxygen. She was brought in on a nonrebreather and was titrated down to 2L at which she was running 91-92% oxygen saturation. Her oxygen was				

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	turned off and she promptly dropped to about 81-83% oxygen saturation. At 7:47 AM her case was discussed with the hospitalist and will be admitted for further treatment and evaluation. On 7/22/22 an ENT otolaryngologist saw the resident and dictated the following report: Resident #1 had been drinking some hot chocolate with her dentures in and it caused some severe mucosal burns. She stated that because it was so hot she just tried to swallow it very quickly. On July 23, the Oral Surgery Department was consulted and they discussed the concern for desquamation, magic mouthwash and lukewarm saline rinses, have been doing this since then. She did have some increased oxygen requirements and Pulmonology was involved in her care. This morning the resident was evaluated by Speech and Language Pathology department, who have cleared her for pureed diet. She has desquamation and a white discoloration of her oral cavity and mucosa on her				

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	tongue, lower lips, and gums, specifically worse on the left side over the alveolar ridge. She has been encouraged to not use her lower denture for a least two weeks as everything heals. On 7/22/22 the Speech Therapy dictated the following note: Resident #1 reported, she did not usually sound like this, her tongue is not working right. The therapist noted white issue on her tongue and lips following a burn from yesterday. She was drinking hot chocolate yesterday and burned her tongue and bottom lip. She reported increased difficulty with swallowing since then due to her tongue swelling and reduced mobility. Noted to have moderate oral stage dysphagia due to inability to wear her lower dentures and difficulty with oral bolus control due to lingual swelling. Resident #1 would benefit from modified diet to decrease discomfort and effort with plans to upgrade as swelling decreases.				

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	On 7/23/22 the Hospitalist dictated the following note: Resident #1 possibly moving her tongue a little better today. She continued to have a very sore mouth. The Hospitalist spoke with the oral surgeon-nothing to do but watch and continue with lukewarm saline rinses-once desquamation begins, need to observe for exposed bone/muscle, etc. Under the assessment section she documented mucosal thermal burn-magic mouthwash before meals and had bedtime (ACHS), lukewarm saline rinses at least three times a day. Will need to monitor oral mucosa/inflammation closely to avoid worsening respiratory status. On 7/23/22 the Speech Therapist dictated the following note: resident was taking nothing by mouth (NPO) due to significant difficulty managing any by mouth status post burns on her tongue, palate, inner lips, gingiva, with subsequent lingual edema. The physician				

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	was considering a feeding tube due to probably aspiration. On 7/24/22 the Hospitalist dictated the following note: On 7/24/22 Resident #1 was at high risk for nutritional deficit. It will be quite awhile before her mouth will heal. The resident and her daughter agree to a feeding tube. Her mouth continues to be sore and she was not safe for oral nutrition/fluids-high risk for aspiration. On 7/25/22 an Interventional Radiology consult note documented: Resident #1 had a moderate to large hiatal hernia making the placement of a feeding tube unsuccessful. On 7/25/22 the Hospitalist dictated the following note: Resident #1 still had difficulty swallowing and talking. Placement of a feeding tube was not successful because of her large hiatal hernia. Oral mucosa with large areas of thermal burn. They will ask				

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	Gastrointestinal (GI) department to see her for a feeding tube placement. On 7/25/22 GI consult note documented: on interview Resident #1 denied a history of dysphagia. Only began having trouble swallowing at the nurse home after she drank a cup of scalding hot chocolate and burned her tongue. On 7/26/22 the Speech Therapist dictated the following note: Resident #1 with improving oral stage swallow with continued throat clearing with then and mildly thick liquids. Tolerated puree by ½ teaspoons and sips of moderately thick liquids with success. Remains high risk for aspiration. On 7/26/22 a GI progress note included the following information: Resident #1 was sitting up in a chair. An Registered Nurse (RN) at the bedside feeding her small bites of full liquid diet. The Speech and Language Pathologist had placed her on a pureed diet. She seems to be				

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	tolerating full liquid diet much better today. Hopefully they can advance this and avoid any tube feedings whatsoever. On 7/26/22 the following hospital progress note was documented: today Resident #1 was moving her tongue better-there was also now some pink healthy tissue visible on the inferior aspect of her tongue. She was not able to swallow pills yet, although her swallowing has improved today. On 7/27/22 Speech Therapy dictated the following note: Resident #1 seen at her bedside to address swallow function. She reported her lips were really hurting today and felt like they were "way out there." Nursing present during session to provide medications. Educated on recommendation to crush medications unless they were not able to be crushed. She was given trials of mildly thick liquids by teaspoon and spoon. She denied sensation of sticking with intake. Continue with puree diet, upgrade to				

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	mildly thick liquids and crush medications. On 7/27/22 the Hospitalist dictated the following note: some of the mucosal tissue is now sloughing and being replaced by healthy mucosa. The resident seems to be able to speak easier and tongue movement had improved. Her diet has advanced by speech. She tolerated puddings which now opens the opportunity to give her medications that can be crushed. Lips were sore and peeling, respiratory status was improving. On 7/28/22 a GI noted documented the following: resident sitting up working with physical therapy. She was able to take pudding with her medications and was drinking supplements. Speech therapy continues to work with her. On 7/29/22 a hospital note documented the following: Resident #1 was subjectively better. Oral intake was				

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	gradually improving, tolerating full liquids and puree diet. She stated her mouth sores were improving. On 7/27/22 at 11:52 AM Resident #1 stated she went to drink her hot chocolate and it was hot. Resident #1 stated she did not want to spit out the hot chocolate in front of her tablemates so she swallowed it. It burned her throat when she swallowed it and could feel it burning her tongue. During our conversation, she was hard to understand as if her tongue was swollen. She added after that, she sat her cup down, to let it cool while she ate. When asked who her tablemates were she could not remember but stated they are so nice. She did not tell anyone in the facility what had happened but it did not hurt. She was asked who completes her oral care such as taking her dentures out and cleaning her mouth, she stated she does that all by herself. When asked about her injuries she stated she felt her throat swell, had burns to her lips, inside of her mouth and tongue. She indicated				

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	she was able to eat a little but now and was happy she does not need a feeding tube. She added her fever that morning just came out of nowhere. On 7/27/11 at 11:52 AM Resident #1 was in her hospital bed sitting up. Noted her lower lip to have brownish colored loose skin/scabs, even on her bilateral mouth creases. The inner portion of her top lip also had brownish colored loose skin/scabs. Her tongue had a thick white/beige color coating to it. The facility investigative file included the following: - On 7/22/22 at 5:05am Resident #1 was sent to the hospital for increased fever and shortness of breath and was admitted with pneumonia. On 7/22/22 the resident's daughter sent an email to the Administrator, DON, and Admissions Director about her mother saying that she burnt her mouth on her hot chocolate Thursday, 7/21/22. Resident #1 told her daughter on				

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	Wednesday she burnt her mouth on her hot chocolate. When her daughter asked her mom why she didn't spit out the hot chocolate Resident #1 answered, "I could not spit it out in front of my tablemates, and I do not know why I didn't tell anyone about this situation." -On 7/25/22 at lunch time the Administrator tested the hot water in a coffee cup. The hot water read 160 degrees Fahrenheit. Once the hot chocolate mix was added and mixed it in, the temperature dropped to 140 degrees Fahrenheit. She spoke with the Dietary Staff and instructed them to ensure the temperature of the water is no higher than 135 degrees Fahrenheit and to a log the temps of hot liquids to ensure the temperature was not higher than 135 degrees Fahrenheit. -On 7/25/22 DON went up to the hospital to visit Resident #1. She was in good spirits and able to answer questions appropriately. Her lips were noted to				

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	have dried, yellowish moist injured skin and her tongue and buccal areas of her mouth had grayish white patches. Her account of the hot chocolate was unchanged although she was unable to recall the exact date of the incident. When asked her reasoning for not reporting the incident, she merely stated "I didn't think much of it. Haven't you ever burned your mouth on something hot?" She stated she just swallowed the hot chocolate to avoid embarrassment with her tablemates. She reported that they found a large hernia (hiatal hernia) in her stomach. She asked about how everyone was at the facility and stated she was anxious to come back home. -On 7/25/22 the Administrator and DON conducted the following interviews: o Staff F Dietary Aide remembered she gave Resident #1 the hot chocolate on the morning and afternoon of 7/20/22. She did not remember if she complained of any pain				

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	or that the hot chocolate was too hot. o Staff G Dietary Aide reported Resident #1 did not come out for dinner on 7/21/22 and did not want a room tray. She added that Resident #1 usually asks for hot chocolate for break and lunch. o Staff C Certified Nursing Assistant (CNA) was Resident #1's CNA from 6:00 PM-10:00 PM on 7/21/22 and helped her on the overnight shift. He reported that Resident #1 had no complaints, and he did not see any blisters. Staff C stated that when Resident #1 pulled her call light 7/22/22 morning, she had spit up and he helped her clean her dentures and wash out her mouth. He stated that she was confused and that's when he called the nurse in. He stated he believed she might have had some thrush and he noted that to the nurse. He noted that he saw blisters the same time the nurse did				

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	on the morning of 7/22/22 before she was sent out to the hospital. o On 7/25/22 the DON placed a call to Resident #1's PCP and she spoke with the Hospitalist. She reported they noted demarcations in her mouth upon arrive to the ER. The Hospitalist felt that Resident #1's dentures retained the heat and caused further injury to her mouth. o Interventions: all hot liquids will be dispensed from the coffee machine. The dietary staff will check log the temperature of hot liquids prior to serving, ensuring that the liquid temperature is not above 135 degrees Fahrenheit. A dietary meeting was held on 7/26/22 to educate all changes to staff on the new temperature requirement.				

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	On 7/28/22 at 5:05 PM Resident #1's daughter stated she received a call about 5:00 AM that they were transporting her to the hospital with a temperature of 104 degrees Fahrenheit and fever blisters. She went to the hospital and stated there was redness around her lips, outside of her lips like she had drank from a cup. She said it reminded her of a kid drinking chocolate milk and the milk ring was left on their lips and mouth creases. She stated the right side of her mouth crease and lower lip, on the outside was black and her tongue was completely white. She added the hospitalist stated since Resident #1 had her dentures in, they held on to the heat in her mouth making the burns worse. She questioned her mom on why she did not spit out the hot liquid, she stated she did not want to do that to in front of her tablemates. The resident's daughter added that is just her etiquette. She stated the sores look better than it did the first day and she is eating puree food and a lot of ice cream.				

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	On 7/28/22 at 4:13 PM Staff B Licensed Practical Nurse (LPN) stated about 4:00 AM or later the CNA came to him and stated Resident #1 was running a temperature. Staff B went in to assess her and she was hot to the touch. He checked her temperature multiple times and the lowest temperature he obtained was 103.7 degrees Fahrenheit. He stated the resident was lethargic, she would respond by fall back asleep. He obtained a verbal order to send her to the ER for evaluation. He had noticed she had spit up some frothy stuff and it was on her chin so he asked the CNAs to make sure she was cleaned up before she left. When asked if he noted any injuries to her lips, mouth or tongue he stated as she was getting on the gurney he saw white spots on the bottom portion of her lips. Staff B was asked if any staff members had reported injuries to him he stated just the fever. He did add as the squad was leaving the CNA asked if he saw what looked fever blisters on her lips. Staff B was asked if Resident #1 was a reliable				

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Facility name North Crest Living Center		Survey dates July 27, 2022- August 5, 2022			
Facility address 34 Northcrest Drive					
City Council Bluffs, IA 51503		MW			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
	historian he stated normally yes, but that morning no because she was so confused. Staff B was asked if there was anything unusual about Resident #1 during his shift before being sent to the hospital, he stated just that she did not want to eat dinner. That was not typical of her but honestly did not think too much of it. He added Staff C noticed she was confused that night, he checked her oxygen saturations they were low so they put oxygen on her, completed some breathing exercises and she reported she felt better. On 7/28/22 at 4:57 PM Staff C CNA stated he worked the nightshift when Resident #1 was sent out the ER. He stated she was having some breathing issues, was hot, they put her oxygen on her, she had spit up so they cleaned out her mouth. He had noticed white spots on her tongue that looked like thrush. He added he's a CNA so he can't diagnose but that's what it looked like on the center of her tongue. He stated she had				

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	what looked like fever blisters on her bottom lips; she had a fever of like 102-103 degrees Fahrenheit. He was asked how Resident #1 was throughout his shift the stated about 10:00 PM she was confused, so he checked or oxygen saturation and it was in the lower 80's so they pumped her oxygen up. She was not normally confused but will get that way when her oxygen is low. When asked if she had reported any concerns to him during his shift, he stated no. On 7/29/22 at 8:35 AM Resident #1's Primary Care Provider (PCP) stated she spoke with the hospitalist that saw her in the ER, her daughter and the facility's Director of Nursing (DON). So all of her information was secondhand. She stated the hospitalist and ENT doctor believe the heat was held in her mouth because the resident had her dentures in at the time. The daughter told her the resident did not want to spit out the water in front of her tablemates. The PCP was asked if there was ever a discussion of the				

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	injuries being thrush versus thermal burns; she read the notes and stated they definitely talk about it being burns from hot liquid. On 7/29/22 at 3:37 PM Staff D Dietary Aide stated they boil the water on the stove for hot chocolate. She added if the resident can't determine if the water was too hot for them, staff will help cool it down for them but putting ice in it. For the ones that are cognitively with it, staff will let them know it was hot and to let it cool down. They will give the resident ice for their hot beverages if they ask for it. Staff D stated they were not checking the temperature of the hot beverages prior to Resident #1's incident; but now they do. On 7/29/22 at 3:43 PM Staff E Cook stated before the incident with Resident #1 they would serve the hot chocolate without obtaining a temperature first. Now they are to make sure the				

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	temperature of hot beverage was at or below 135 degrees Fahrenheit. On 7/29/22 at 3:48 PM Staff A Dietary Aide stated before the incident with Resident #1, dietary staff would boil the water for hot chocolate. She added they were not obtaining the water temperature before serving it to the residents. She stated now the cooks will make sure the hot water was not over 135 degrees Fahrenheit before being served. On 8/2/22 at 11:33 AM the Hospitalist reported seeing Resident #1 in the ER and that her oral burns were extensive. She had her dentures in when she drank the hot chocolate and that was what trapped the water and heat it. The burns were to her mouth, floor of mouth, palate, buccal mucosa and lips. When asked if it could have been thrush, she stated not even a thought in her mind; these were thermal burns based on the outline of them. There were several days the resident was not able to talk or				

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	swallow normally and had talked about placing a feeding tube. Resident #1's injuries began to improve so the feeding tube was not inserted. There was health tissue growing back and she was healing well before she was discharged to back to the facility. On 8/2/22 at 11:15 AM the Administrator stated when they went through their food policies they found one for hot liquids dated back to 1989. They did not have a current one they were using alongside their Food Temperature policy from 2013. On 7/26/22 they implemented a new policy the required the cooks to obtain the temperature of hot beverages, ensure they are at or below 135 degrees Fahrenheit before being served to the residents. All dietary staff were trained on the new policy. The policy is also placed in the breakroom for nursing staff to read and follow as well. An email with the expectations were sent to all staff.				

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	On 8/2/22 at 12:43 PM the Dietary Manager stated prior to the incident with Resident #1 they would boil water on the stove and put in service pots for just the hot water. Coffee was served straight from the coffee pot. When asked if the facility had policies about serving hot liquids, she stated just the one they found in their book from 1989. She believed the policy stated hot liquids could be served between 180-190 degrees Fahrenheit, but she was not 100% certain. They wrote a new policy last Tuesday 7/26/22 that encouraged cooks to obtain the temperature of hot fluids prior to service. The temperature must be at or below 135 degrees Fahrenheit prior to service. She added their dietician checked with her other facility and there is nothing in writing on what hot water should be served at. On 8/2/22 at 1:29 PM Staff F Dietary Aide stated she did give Resident #1 her hot chocolate. When asked where she received the water, she stated the put it				

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	on the stove to heat it up. They then scoop it out and put it in a pot/kettle. That is where she got the water to serve Resident #1 her hot chocolate. When asked how long from the time the water was placed in the pot/kettle to the time she served her, she stated about 20 minutes. Staff F stated the resident did not drink the hot chocolate in front of her, she did not obtain the temperature of the water prior to serving it to her and was unsure if the cook did. She could not tell if the water was too hot before serving her the hot water for her hot chocolate. She indicated now the cooks were to obtain the temperature of hot liquids and the staff know it was safe to be served. When asked at temperature was considered safe for hot liquids to be served, she stated 135 degrees Fahrenheit. The facility's policy titled Cooks' Responsibilities For Meal Service dated 1989 documented a guide for optimum temperatures at the point of service to				

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	include hot beverages at 185 degrees Fahrenheit. The facility's policy tilted Hot Liquids that was implemented, per the Administrator on 7/26/22, documented all hot liquids will come from the coffee dispenser and must be at a temperature of no greater than 135 degrees Fahrenheit. All hot liquids will be temped prior to serving the residents. All hot liquids will be poured into the carafe and then the liquid will be poured into a cup and be temped before being served to the residents. The temperature must be not greater than 135 degrees. The Cook will be responsible for temping all hot liquids and recording the temperature of all hot liquids for all three meals. FACILITY RESPONSE:				

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