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F 000	INITIAL COMMENTS Correction date 4/19/17 Investigation of facility-reported incident # 67229-I resulted in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		

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

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.

POC accepted 4/20/17 VK

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F 323	Continued From page 1 Based on observation, record review and family and staff interviews, the facility failed to ensure that (1) The resident environment remained as free from accident hazards as is possible; and (2) each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 6 residents. Resident #1 required staff assistance with food and drink. The resident received a burn from hot coffee. No staff saw the resident receive the coffee or spill the coffee. The facility reported a census of 68 residents. Findings include: 1. A Minimum Data Set (MDS) assessment, with a reference date of 3/18/17, identified Resident #1 with short and long term memory impairments and severely impaired decision making ability. The resident had the following indicator of delirium: disorganized thinking that came and went and fluctuated in severity. The resident had the following behavioral symptoms identified: physical and verbal behaviors directed towards others 1 to 3 days out of 7. The resident required extensive staff assistance with bed mobility, transfers, locomotion on unit, dressing, eating, personal hygiene and toileting. The resident was non-ambulatory. The resident used a wheelchair for mobility. The resident had diagnoses that included: dementia and anxiety. The MDS did not identify the resident with burns. The resident was admitted to the facility 11/10/15. A CAT (care area triggers) worksheet for ADL (activities of daily living) functional/ rehabilitation potential dated 3/21/17 identified the resident required assistance with cares. The resident admitted to the facility with a sacral fracture that limited the resident's mobility and ability to	F 323		

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complete cares and the resident continued to require extensive assistance with cares. The resident had a diagnosis of dementia with cognitive deficits. The resident received Hospice care.

A Care Plan containing a problem with an onset date of 12/4/15 revealed the resident was particular about meal selections and had a poor appetite. The Care Plan directed staff to "assist the resident with meals as necessary". An addendum to the Care Plan dated 3/24/17, directed staff to put "ice in hot drinks to cool down prior to thickening (coffee spill)." The approach indicated the nursing/kitchen staff were educated to "place lids on beverages".

The Nurse's Notes dated 3/25/17 at 12:55 p.m. and documented by Staff A RN (registered nurse) identified a CNA (certified nurse aide) alerted Staff A that she removed a coffee filled blanket from the resident's lap after lunch and observed a burn to the resident's leg. Staff A assessed a 22 centimeter (cm.) by 23 cm. red area with scattered intact blisters to the right thigh. The resident denied pain. Staff A notified the physician and obtained a treatment order for the burn. Staff A instructed dietary to put ice in the resident's hot drinks before serving the hot drinks to the resident. Staff A also placed a note in the staff communication book that contained the same information.

A form titled Incident/Accident/Unusual Occurrences, identified an event occurred on 3/25/17 at 12:55 p.m. A CNA noted the resident's right thigh appeared blistered after taking a blanket off the resident's lap. The right thigh contained a 22 cm by 23 cm red area with

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scattered intact blisters. An injury investigation dated 3/25/17 revealed staff last saw the resident at lunch eating. The resident could not tell staff what happened. The form titled Injury Investigation, asked "what do you think contributed to the injury?" Staff A documented the resident declined in function which led to the resident's inability to hold a cup. An internal quality assurance investigation form identified the resident "dumped coffee". Preventive measures implemented and dated 3/27/17 revealed the resident should have ice added to hot drinks prior to serving to cool prior to thickening. The resident should not have beverages/food without staff present. The facility educated the staff to ensure the resident had lids on all hot/warm drinks.

A telephone order dated 3/25/17 indicated the following physician order for the right thigh burn: Cleanse gently with 3M wound cleanse and pat dry. Apply Silvadene 1% cream to the area. Cover with Telfa dressing and paper tape BID (twice a day) and PRN (as needed). Discontinue the treatment when healed.

The Nurses Notes dated 3/27/17 at 1 p.m. indicated the right thigh area measured 22 cm. by 22 cm. with scattered superficial areas, red areas and blisters.

Staff Interviews:
Staff working when the incident occurred:

On 4/3/17 at 1:22 p.m. Staff A RN (registered nurse) stated Staff B CNA got her after lunch and asked if anyone told Staff A the resident received a burn. Staff B only noticed it when she took the blanket off the resident's lap after lunch. Staff A stated Staff C CNA sat at the resident's table at

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F 323	Continued From page 4 lunch. She stated she did not know who delivered the coffee to the resident's table but Staff D (dietary) and Staff E (dietary) delivered drinks that day. Staff A stated the resident sat at an "assisted table" so someone was supposed to sit at the table with the resident if the resident had food or drink. Staff A did not know when the resident received the coffee. She stated she did not recall seeing the resident with food/drink items and no one present. Staff A stated the resident had spills in the past. The resident sometimes drops the glass or throws the liquid. Staff A stated it was probably not safe to leave the resident alone with hot coffee. She stated she assessed the burn. It was red and slightly raised with a couple fluid filled blisters only on the upper thigh. Staff A stated that prior to the incident, dietary was not supposed to deliver drinks or food and leave it at the table without staff present with the resident. Staff A didn't give the resident coffee and didn't know who did. On 4/3/17 at 1:35 p.m. Staff B CNA stated she was the resident's CNA that day. She got the resident up from bed and the resident's leg looked fine. She took the resident to the table around 11:40 a.m. to 11:45 a.m. She did not apply a clothing protector. When Staff B placed the resident at the table she did not see drinks present. After the meal, she took the resident from the table and she and Staff F CNA laid the resident down. The resident wore a clothing protector and had a blanket over his/her lap with a wadded up clothing protector in the resident's lap. She stated the spill area on the blanket felt cool and smelled like coffee. It was brown in color. Staff B removed the clothing protectors and blanket and she and Staff F laid the resident down. As she positioned the resident's legs, she	F 323		

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observed one had a large red area with blisters on the upper thigh. Staff B stated it looked like a hot liquid poured on the leg. Staff B stated the resident was not acting normally that day. The resident appeared sleepy. Staff B tried to wake the resident to ask if the burn hurt and the resident did not respond. Staff B reported all of her findings to Staff A who came right away and took care of the resident. Staff B stated she didn't see who passed coffee that day. The resident is not supposed to get coffee unless someone is with the resident. She stated staff were instructed of this directive through meetings and the communication book. Staff B stated the wadded up clothing protector showed that someone tried to clean up the coffee spill. The resident was not his/herself that day and not able to speak and let anyone know he/she was burning. Staff B stated the person sitting with the resident at the meal must have known the resident spilled. They would have seen the wadded clothing protector and wondered about it. Staff B stated the resident needed supervision at the table and needed to be fed. The resident spills a lot. It's not safe the leave the resident with hot coffee without someone there. Staff knew this before the incident.

On 4/4/17 at 1:59 p.m. Staff C CNA stated when she arrived at the resident's table; the resident already had his/her drinks. Staff C stated she observed a spill streak about 4 inches long on the resident's shirt on the chest area. The spill spot was cold. She looked under the shirt and didn't see any red areas so she applied a clothing protector. She did not look elsewhere. The blanket could have had a spill on it but she may not have noticed it due to the way the resident sat at the table. She stated the resident ate and

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grabbed drinks per self that meal. The resident had a blanket covering his/her lap. Staff C stated she did not notice a wadded clothing protector. Staff C stated the resident did not spill or throw drinks at the meal and there were no spills on the table. After the resident finished, Staff B took the resident away from the table. She stated she saw the resident 6 times in the past few months with drinks and no one with the resident. Staff C stated all assisted residents should have someone there if they have food or drink present. She stated she informed the dietary manager when she saw it. The Dietary manager didn't say anything. Staff C didn't know who served the liquids that she observed. She also denied knowing who gave the resident coffee on the day of the incident. She thought someone from the kitchen served it. Staff C didn't know the resident had a burn until the end of her shift.

On 4/3/17 at 1:33 p.m. Staff D dietary aide stated she didn't know the resident got burned that day. She didn't know until Wednesday when someone asked her about it. On the day of the incident, she stated she first observed the resident with coffee when she observed Staff C sitting with the resident. The coffee did not have a lid. Staff D stated the resident's blanket was up to the resident's neck and the resident sat with his/her eyes closed. Staff D stated she served the resident a coffee with a lid when Staff C sat at the table. The one without the lid was there when she gave the resident the cup of coffee with the lid. Staff D stated she did not know who gave the resident the coffee before she did. The other dietary aide (Staff E) only served juice and water. When she served the coffee, she asked Staff C if Staff C would stay with the resident and Staff C said yes. Staff D stated she takes break from

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F 323	Continued From page 7 10:30 a.m. to 11 a.m. and about 7 times in the past 2 or 3 weeks she has seen the resident sitting by self with a cup of coffee without a lid. When Staff D has asked who gave it to the resident, no one knows. She stated she informed the dietary manager who said there was nothing they could do because they didn't know who was giving the coffee. Staff D thought a resident's spouse could be serving the coffee. Staff D saw her give it to the resident in the past. On 4/4/17 at 9:05 a.m. Staff D stated she observed a resident's spouse give an assisted resident coffee about 2 weeks ago. She couldn't recall who it was for. She informed the dietary manager. She stated a couple months ago the same spouse fixed the resident coffee with thickener and she informed the dietary manager. On 4/3/17 at 4:05 p.m. Staff E (dietary aide) stated she worked when the incident occurred. She stated she passed juice and water. She did not pass any coffee. Staff E stated on the day of the incident, the resident was "out of it" and was covered with a blanket up to the neck. When she passed juice and water to the resident, he/she already had coffee. She stated she entered the dining room area around 11:35 a.m. and she supplied drinks to the first half of the dining room. She got to the second half of the dining room (where the resident sat) around 11:45 a.m. When she was doing the first half, the CNAs brought the resident to the dining room. She stated she didn't see who gave the resident coffee. She stated a resident's spouse was in the dining room and that person could have given the resident coffee. That person has given drinks to residents before. Staff talks to her and she quits for a while and then starts doing it all over again. She observed the resident with coffee without a lid on the resident's	F 323		

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table. She stated the resident was asleep and the coffee was at the center of the table so she didn't tell anyone or take it away.

On 4/3/17 at 2 p.m. Staff F CNA stated after lunch she helped Staff B transfer the resident to bed. She left the room immediately after the transfer because she had to assist another CNA. She stated she did not see the resident in the dining room and she did not give her any coffee and didn't know who did. She stated she assisted Staff B with the transfer into the wheelchair before lunch and didn't see anything. Staff F stated it was not safe to leave the resident unattended with hot coffee. That is why the resident sat at an assisted table. The resident has spilled and dropped drinks and food before. Staff F stated the resident used lids on a blue cup before the incident. Staff E stated the rule (even before the incident) was assisted residents could not have food or liquids without staff sitting there. The kitchen knows they are not to serve the food until someone is there.

On 4/4/17 at 1:41 p.m. the Activity Director stated she saw the resident's spouse (that has been known to give residents coffee) around 1 to 1:30 p.m. that day. The spouse could have been at the facility earlier but that was the first the Activity Director saw her/him. The Activity Director stated she saw the resident in the dining room unattended with coffee once or twice in the past few months. She stated she didn't report it to anyone. The coffee did have a lid on the cup when she saw it but she did not see who gave it to the resident on those occasions.

On 4/4/17 at 12:08 p.m. Staff G CNA stated she heard about the burn when she was asked to

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write a statement. She stated the resident would throw glasses of liquid but she never actually saw the resident spill. She also observed a resident's spouse give assisted residents' liquids before and also use thickener in liquids. It has been awhile since Staff G saw the spouse do that. Staff G stated even before the incident, assisted residents were not to have coffee or food when they were unattended. She didn't see anyone in the dining room before lunch because she works on hall 3 and doesn't get to the dining room until everyone is already out there.

On 4/4/17 at 2:26 p.m. Staff H RN stated she knew the resident received a burn but did not know how it happened. She stated Staff C was at the resident's table at lunch. She didn't see anything or anyone give coffee to the resident. Staff H stated dietary usually waits before they give assisted resident's their meal until staff is present. She thought it was Ok for dietary to give the drinks before staff was present. She stated she thought it was OK because she saw drinks served without staff present before. She observed Resident #1 unattended with coffee before.

On 4/4/17 at 10:58 a.m. Staff I LPN (licensed practical nurse) stated she was charting and heard Staff A call the doctor about the burn. She stated she did not see anything on the day of the incident. She stated she observed the resident at meals and the resident usually needs assistance. She stated she heard a resident's spouse gave drinks to residents needing assistance. If she observed that, she would talk to the spouse.

On 4/4/17 at 11:12 a.m. Staff J CNA stated she didn't know anything occurred on the day of the incident. She stated she didn't know how the

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resident got the coffee. She stated the resident used lids on cups before the incident. Staff J observed the resident throw cups and spill usually just on the table or ground.

On 4/4/17 at 11:33 a.m. Staff K CNA stated she didn't know anything occurred. She didn't see anything or know how the resident got the coffee.

On 4/4/17 at 1:35 p.m. Staff L housekeeper stated she was in the resident's room around 8 a.m. the morning of the incident and saw a coffee cup with half cup of thickened coffee sitting on the resident's night stand. The coffee wasn't hot and was not spilled and was far enough away that the resident could not reach it.

On 4/3/17 at 2:12 p.m. Staff M stated she didn't know anything about the incident until the next day. She stated it would not be a good idea to give the resident coffee without someone present. She denied giving the resident coffee.

On 4/3/17 at 2:18 p.m. with Staff N (dietary cook) stated she didn't know much about the incident. She stated dietary knows if resident are at an assisted table that a staff needs to be present. She did not know of staff not to following that rule. Staff N stated she did not give the resident coffee that day. She stated the resident used lids on cups for a long time (years). She stated Staff D told her there was a cup of coffee already at the table when Staff D passed coffee that day. She stated she informed the dietary manager a couple months ago that a resident's spouse gave residents coffee.

Other interviews:

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F 323	Continued From page 11 On 4/4/17 at 8:36 a.m. the dietary manager stated she wasn't present on the day of the incident. Staff told her the resident got coffee and it spilled and the resident's legs got burned. The coffee was thickened and no one knew who gave it to the resident. She stated a resident's spouse pours coffee and tea for residents a lot and she was sure that person still did that. She stated she remembered a couple months ago that Staff D told her that person fixed coffee and thickened it for assisted residents. She stated she told the Administrator. The spouse stops for a week or so and then starts doing it again. She stated the coffee comes out of the wall at 190 degrees. When it sits in the warmer in the coffee pot it is 165 degrees. She put some in a cup (like the resident used) and then checked the temperature. It was 161 degrees. She did the testing after the incident. On 4/4/17 at 12:30 p.m. the dietary manager stated she did not recall Staff D telling her about the 7 times in the past 2 weeks that she observed Resident #1 alone with hot coffee. On 4/5/17 at 1:11 p.m. Staff O CNA stated the policy before the incident was there had to be someone with residents if they had food or drink. This policy was in place ever since Staff O worked at the facility which was 12 years. Staff O stated the resident needed help at meals. On 4/5/17 at 10:05 a.m. Staff P CNA stated she needed to feed the resident most of the time. On 4/5/17 at 11:30 a.m. the Administrator stated he remembered discussing thickener with a spouse of a resident but couldn't 100% say he talked to the spouse about serving assisted residents coffee. He stated he spoke with the	F 323		

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F 323	Continued From page 12 spouse awhile back-he did not have a date. On 4/4/17 at 12:49 p.m. the Director of Nursing (DON) stated on 3/25/17, she got a text from the on call nurse. When she returned the call, they said the resident spilled coffee and had a red blistered thigh. The DON called Staff A at home and discovered the incident occurred at lunch and staff discovered the burn when staff removed a blanket that covered the resident and was wet with coffee prior to laying the resident down. She did not apply a clothing protector and there was no food or drink present at that time. The resident had a shirt on and a brief. The resident did not have pants on and was covered with a blanket over the legs. That was the same blanket that was wet with coffee. Staff C assisted the resident at lunchtime and said she did not see a spill. She did see a spill on the chest so she looked to see if there was a red area under the shirt. Staff C didn't see a red area. When Staff C arrived at the table, the resident had coffee. On 3/27/17 the MDS/care plan nurse informed her that Staff A told her the day after the burn, the resident had a cup of coffee that Staff A took away. There was no ice in the coffee and no staff present and Staff D gave it to the resident. The DON stated she first observed the burn on 3/27/17 and saw some red areas going towards the groin and blistering on the top of the thigh. The look of the burn made the DON think the coffee was thickened because if the coffee was thin it would have run more. Throughout her investigation, no one confessed to giving the resident the coffee. She stated that the policy prior to the incident was that no assisted resident should have coffee without a staff present. Assisted residents are not to have food or drink	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165271	A. BUILDING _____ B. WING _____	C 04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 13	F 323		

until a staff is there. There have been many meetings containing this information and it has also been in the communication book. The new intervention was to place ice in the resident's coffee prior to thickening and serving to the resident. The facility is also placing lids on assisted resident's drinks. The DON stated it is not safe to leave coffee with the resident unattended.

Follow Up Interview with Staff A and Staff D:

On 4/4/17 at 1:30 p.m. Staff A stated the day after Resident #1 got burned, she observed the resident in the dining room around 11 a.m. with coffee and no staff present. The resident had a small coffee spill on the blanket (about 50 cent size) she dumped some thickened water on it and pushed the coffee away. The coffee was hot with a lid on the cup. She observed Staff D and Staff E passing liquids in the dining room. They had served liquids to Resident #1 because the thickened water they passed is what Staff A used to pour on the hot coffee. She said out loud that they should not pass liquids until staff was present with the resident. When told Staff D denied hearing Staff A say anything, Staff A stated Staff D may not know English well. The resident did not sustain injury because the blanket was folded in 4's so the liquid did not get through the blanket thickness.

On 4/4/17 at 1:41 p.m. Staff D denied knowing anything about the resident getting hot coffee on 3/26/17 or Staff A saying anything to her about it.

Observation of the coffee area with dietary manager at 9:22 a.m. showed the coffee area in a small room off the dining room. It contained

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F 323	Continued From page 14 coffee and a variety of other beverages. The coffee area was open and available to whoever may want to use it. A can of thickener was available on the counter. On 4/4/17 at 2:44 p.m. a resident's spouse denied giving the resident hot coffee. Coffee Temperature Checks: On 4/3/17 at 12:02 p.m. Resident #1's coffee temperature was 101.4 degrees. Other assisted resident coffee registered at 124.9 degrees. At that time, Staff D stated only Resident #1's coffee got ice. Staff D stated they pour the other resident's coffee and let it sit awhile before serving. They just started that after 3/25/17. On 4/4/17 at 12:05 p.m. Resident #1's coffee registered at 110.9 degrees and other resident's coffee registered at 121.3 degrees. Observation: Observation on 4/3/17 at 12:12 p.m. identified Staff P feeding the resident. The resident could hold finger foods and drinks. On 4/3/17 at 6 p.m. the resident fed with a spoon by staff. The resident had lids on cups. Observation identified on 4/5/17 at 12:10 p.m. the resident fed by staff. The resident had lids on cups. On 4/4/17 at 9:40 a.m. observation identified the resident in bed. Staff Q LPN performed a treatment to the burn area. Observation showed a large irregular area with redness around the outer edges on the inner right thigh. The area was covered with a thick yellow brown scab. There were also smaller scattered burn areas on the top of the right thigh. When Staff Q cleansed the	F 323		

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F 323	Continued From page 15 areas, the resident stated, "That pushes on it and I don't like it". When Staff Q applied Silvadene cream to the areas, the resident said "Ow Ow". A non-pressure skin condition report dated 4/3/17 identified the area measured 20 cm. by 20 cm. yellow with red areas. On 4/4/17 at 11:50 a.m. the resident's daughter stated about a week ago she asked to have someone with the resident because the resident needed assistance and to ensure the resident received proper nutrition. On 4/5/17 at 12:10 p.m. the Administrator stated they decided last night to lock the door to the coffee room and use a wireless doorbell for people to use so there would be a staff to assist when someone accessed the coffee room. The coffee room would no longer have open access. He confirmed the resident's daughter spoke with him about the resident needing assistance but that was after the incident. The policy titled Dining Room Service, dated February 2016, directed the staff that no meal would be served to residents eating in the dining room until at least one member of nursing staff or qualified designee was in the dining room to assist with meal service and to be available to handle any emergency that may arise.	F 323		

F 323 This facility does attempt to keep the environment as free from accident hazards as possible. The doors to the kitchen have been locked (with the exception of meal service times) and a wireless door bell has been installed to alert kitchen staff to assist residents/visitors with dietary needs and prevent random persons from serving hot drinks to residents not capable of managing these drinks safely.

All staff have been inserviced regarding serving liquids to residents requiring assistance. No liquids are to be served to the tables identified as assisted tables prior to a staff member being present. All hot beverages being served to residents requiring assistance are to be lidded for safety reasons.

Meals are being monitored by the QA team for compliance.

Completion date: 4/19/17