STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	C 01/19/2018

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BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/16/18 through 01/19/18. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1-16-18 through 1-19-18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 116 certified bed facility was 85 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #73, 81, 58, 24, 23, 18, 52, 69, 53, 54, 70, 47, 57, 35, 25, 233, 64, and #133) and four closed record reviews (Residents #12, #83, #85, and #383).	F 000		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or	F 606		3/2/18

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

Electronically Signed 02/09/2018

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F 606	Continued From page 1 misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Cass, Nathan Based on staff interview and employee record review, the facility staff failed to ensure the certifications for 1 of 13 Certified Nurse Assistants (CNAs) were in good standing. For Employee #15, their certification was expired and not rechecked by facility staff. The findings included: On 01/19/18, Employee Record Reviews were conducted. Employee #15 was hired on 02/15/17. At the time of hiring, Employee #15's certification to work as a CNA was listed as expiring on 12/31/17. At the time of survey, no further documentation showing that the facility rechecked the employee's certification after expiration was found in Employee #15's Human Resources (HR) File. An interview was conducted with the Director of	F 606	F 606 - Employment of Staff 12 VAC 5-371-210 Licensure Verification Employee #15□s certification was renewed on January 16, 2018. The employee was removed from the working schedule at the time that the expired license was identified, and has been verbally counseled of the need to maintain current certification to practice as a Certified Nurse Aide. All licensed staff are potentially affected by failure to renew their licenses. Personnel files of all currently employed, Certified Nurse Aides and licensed nurses have been audited to determine that their licenses are current. In investigating this deficiency, it was determined that the filters were incorrectly set on the software that provides our Human Resources Department with a monthly report of licenses that are due for renewal. The company was notified and a review of the report criteria was completed, which resulted in editing the	

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F 606	Continued From page 2 Human Resources on 01/19/18 at 1:20pm. An up-to-date document showing that Employee #15's certification was renewed on or before 12/31/17 was requested. The copy provided by the facility was dated 1/16/18. A copy of Employee #15's time clock punches were requested. Review of the time clock punches showed Employee #15 worked 10 times, and had continued to work after their certification expired on 12/31/17. The Human Resources Director stated that Employee #15's lapse in certification was discovered during an internal audit on 01/16/18, and that Employee #15 was removed from the schedule on that date until their certification was confirmed as renewed. The facility policy on abuse, dated 09/15/2017, was reviewed. Section I. Screening - Subsection B. defines facility requirements for checking employee/candidate professional licensures and certifications with the relevant state agencies. The policy states that no candidate will be hired that has a disciplinary action or other sanction against them from the licensing Board. The Administrator was made aware of findings.	F 606	filters and enabling a complete and accurate monthly report of licensed staff renewal dates. This report will be used each month to generate a list of employees for whom license renewal is due. The list will be posted at the employee time clock as a reminder to staff, and a copy of the list will be emailed to the Administrator and the Vice President of Quality and Operations. Any employee whose license is not renewed before expiration will be removed from the schedule until proof of active licensure / renewal is produced. On a monthly basis, the Vice President of Quality and Operations will audit the list of licenses that were due for renewal against the Department of Health Professions database, to validate that the license has been continued without interruption. The VP will provide a summary report to the Quality Assurance and Performance Improvement (QAPI) Committee each month, for determination that this plan of correction has been effective.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		3/2/18

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F 609	Continued From page 3 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Trevilian, Rose Based on observation, staff interview, clinical record and facility documentation review, the facility staff failed to, for two residents (Resident #53 and Resident #23) in a survey sample of 22 residents to report incidences of residents receiving second degree burns from spilling hot soup. 1. Resident #53 sustained second degree burns on her thigh/groin area on 10/5/17. The incident was not reported to the SA (state agency). 2. Resident #23 sustained second degree burns	F 609	F 609 - Reporting of Alleged Violations The incident involving the spilled soup, which resulted in a burn to the upper thigh of resident #53, has been reported to the Office of Licensure and Certification as a facility reported incident. The incident involving the spilled soup, which resulted in burns to the inner thighs of resident #23, has been reported to the Office of Licensure and Certification as a facility reported incident. All residents are potentially affected by the facility□s decisions regarding reporting to outside agencies. An audit is being conducted by the VP of Quality and	

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F 609	Continued From page 4 on both her inner thighs on 10/5/17. The incident was not reported to the SA (state agency). The findings included: 1. Resident #53 was admitted to the facility on 6/18/10. Diagnoses included but not limited to are dementia with behavioral disturbance, psychosis, and depression. Resident #53's most recent MDS was a quarterly assessment with an ARD of 12/7/17. Resident #53 had a BIMS score of "0" out of a possible 15, or severe cognitive impairment. The resident required extensive assistance with her ADL's (activities of daily living including bed mobility and dressing) of one staff member. The resident required stand by assistance for eating. Review of the clinical record revealed the resident had sustained a first degree burn on 10/5/17 at lunch by spilling her soup on her lap. The area was assessed by the unit manager (RN-registered nurse) A who noted the measurements as 17 cm (centimeters) by 6 cm of a reddened area, no blistering. Cold compresses were applied. A nurse's note dated 10/6/17 read: "Area has two blisters intact." Wound care notes dated 10/11/17 documented : "Second degree burn to upper left thigh/groin." The FNP (family nurse practitioner) examined the resident and documented: "The patient spilled soup on her upper thigh that caused a burn... The patient noted with a first degree burn area reddened... The patient complained of some pain." The physician ordered Bacitracin ointment and as needed Tylenol every 8 hours.	F 609	Operations of all past reports incidents and accidents to determine if there have been any other unusual occurrences that are mandated reports to the state survey agency or other interested entities. The audit will include all of calendar year 2017, and any incidents identified will be reported to the survey agency as part of this Plan of Correction. The facility□s Policy and Procedure for Abuse Prevention will be reviewed by the QAPI Committee to clearly identify to staff what types of incidents are mandated for reporting, and what constitutes an unusual occurrence. Following this review and any needed revisions, department heads and nursing management will receive in-service training regarding the policy and procedure, with any questions regarding reporting requirements addressed. The Education Director will be responsible to in-service charge nurses and Certified Nurse Aides regarding what events or incidents must be immediately reported to the Director of Nursing (or supervisor on off shifts and weekends) in order for the facility to achieve reporting compliance and sustained correction. Each month, the VP of QA and Operations will provide the QA Committee with a listing of all recorded incidents and accidents involving residents, the type of incident, the date that the incident occurred, whether it was reportable according to regulations and policy, and the date that the report was made (if required). The Committee will be responsible to review the incidents and	

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F 609	Continued From page 5 2. Resident #23 sustained second degree burns on both her inner thighs on 10/5/17. The incident was not reported to the SA (state agency). Resident #23 was admitted to the facility on 2/7/17. Diagnoses included but not limited to are Vascular dementia with behavioral disturbance, high blood pressure and dysphagia (difficulty swallowing). The resident resided in the Memory Care Unit. Resident #23's MDS (minimum data set) with an ARD (assessment reference date) of 11/9/17 was completed as a significant change in status assessment. The resident had a BIMS (brief interview of mental status) of 2 out of a possible 15, or severe cognitive impairment. Resident #23 required extensive assistance with ADL's (activities of daily living such as eating and bed mobility. Review of the clinical record revealed on 12/10/17 at 5:45 PM, resident "noted to have spilled soup from soup mug onto lap. Resident was taken to room immediately and clothing changed. Bright pink areas noted to bilateral thighs, no blistering noted." Further clinical record review revealed on 12/10/17 at 9:27 PM, "Areas to bilateral thighs re-examined and a blister to the right inner thigh was discovered. It is noted to measure 3.5 by 1.5 cm. Smaller blisters were noted to left inner thigh. All were still intact." Further clinical record review on 12/11/17 at 8:39 AM, revealed a note by the wound care nurse (LPN- licensed practical nurse) which read: "Assessed residents right and left upper	F 609	the timeliness of reporting, in making a determination of the effectiveness of the Plan of Correction and making any needed revisions to ensure sustained compliance.	

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F 609	Continued From page 6 thighs/groin area with NP. Resident has a fluid filled blister on right thigh and groin by groin area (lower) measuring 6 by 3 by 0 cm, right thigh/groin area (upper) measures 5 by 2 by 0 cm, . Left thigh/groin area (lower) 1 by 1 by 0 cm, 0.5 by 1.2 by 0 cm, 0.5 by 0.5 cm, 0.7 by 1.5 by 0 cm, ... all stage two." On 12/28/17, the FNP followed up on Resident #23. The note read: "For second degree burn after hot food spilling on right thigh and groin area, patient had multiple areas noted at time of burns... had Silvadene cream treatment done... today area scabbed, no signs of infection." Review of the facility's Policy and Procedure : Abuse Prevention, Investigation and Reporting revealed: "The Quality Assurance Committee will review and provide recommendations in response to any unusual occurrence...and other unusual incidents that may require reporting to regulatory, investigative or legal entities." 01/18/01/18/18 11:19 AM: The Administrator was questioned regarding why an FRI (facility reported incident) for the second degree burns from soup spills on Residents #53 and Resident #23 was not reported to the SA, The Administrator stated, "We knew what happened." When asked if this was an usual occurrence, the Administrator replied, "Yes." On 1/18/18 at approximately 4:00 PM, the Administrator and Director of Nursing were notified of above findings.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		3/2/18

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F 655	Continued From page 7 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be	F 655		

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F 655	Continued From page 8 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #233) of 22 residents in the survey sample to ensure a base line care plan was complete. For Resident #233, the baseline care plan did not document that the resident had an infection which required contact precautions. The findings included: Resident #233 was admitted to the facility on 1/11/18. His diagnoses included clostridium difficile, chronic kidney disease, hypertension and edema. Since Resident #233 was new to the facility, a Minimum Data Set assessment was not complete. Resident #233 was observed on 1/17/18 at 10:25 a.m. sleeping in his bed. Personal Protective Equipment (PPE) was available in the hallway outside of the door. A Licensed Practical Nurse on the unit was asked why Resident #233 was on contact precautions. She stated that he had C. diff. When asked what a person needed to do to enter the room, she stated that a gown and gloves were required. After removing the gown and gloves, hands should be washed.	F 655	F 655 - Baseline Care Plan Resident #233 was admitted with clostridium difficile diarrhea as a discharge diagnosis on 1/11/18. When the resident was admitted, the nurse manager initially implemented precautions due to the fact that the discharge documentation from the hospital was not clear as to whether or not the c-diff had resolved. The precautions were continued as the resident remained symptomatic, but the illness and the interventions were not placed on the baseline care plan. There is no correction to the individual omission. The c-diff has since resolved, but the facility is monitoring this resident for recurrence of symptoms and will care plan them accordingly if they occur. All newly admitted residents who are transferred from the hospital with an infectious disease are potentially at risk if the facility does not communicate the need for treatment and precautions on the baseline care plan. The records of residents admitted since 11/28/17 will be reviewed to identify any others for whom this problem may not have been placed on the baseline care plan. Upon completion, a copy of the baseline care plan will be placed in a binder [Admission Binder] with copies of the resident□s discharge summary from the	

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F 655	Continued From page 9 Resident #233's baseline care plan was kept in a binder at the nursing desk. The care plan indicated that the resident was on an antibiotic. The care plan did not document what type of infection the resident had or that contact precautions were required to care for the resident. On 1/18/18 at 1:10 p.m., the care plan was reviewed with the Minimum Data Set (MDS) coordinator. She stated that the nursing staff initiated the baseline care plan and the MDS staff would follow up. She stated that the type of infection and the contact precautions should be documented on the care plan. The Administrator and Director of Nursing were notified of the issue at the end of day meeting on 1/18/18.	F 655	hospital, admission history and physical, and admission orders. The information will be brought to the morning, interdisciplinary report [i.e. standup meeting] for review and validation that the baseline care plan includes any resident infections and interventions that may be required in treatment and transmission control. The ID team will be responsible to ensure that the baseline care plan includes these measures, and the Nurse Managers for each unit will be responsible to ensure that they are communicated to the nursing staff. Within 72 hours of a new admission, The DON will monitor the effectiveness of this Plan of Correction by reviewing the baseline care plans against the newly admitted residents discharge histories, admission orders and diagnosed infections. The DON will provide a summary report to the QAPI Committee on a monthly basis, for evaluation of the effectiveness of this Plan of Correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		3/2/18

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F 656	Continued From page 10 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #64) of 22 residents in the survey sample to implement the care plan. For Resident #64, the "falls" care plan and the "nutritional status" care plan were not implemented.	F 656	F 656 - Develop / Implement Comprehensive Care Plan Resident #64 has been re-assessed, and the interventions addressing her falls and nutrition have been revised within her care plan and communicated to the C.N.A. staff. All residents with individualized care plan	

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F 656	Continued From page 11 The findings included: Resident #64, a 92 year old, was admitted to the facility on 9/18/14. Her diagnoses included dysphagia, insomnia, depression, anorexia, constipation and dementia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 12/20/17. She was coded with a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment. She required assistance with activities of daily living. The "falls" care plan date 12/27/17 read that "(resident) is at risk for falls r/t (related to) short term memory loss r/t dementia". One of the "Approaches" included "Place bed controller at foot of bed." The "nutritional status" care plan dated 12/27/17 read "(resident) has a hx (history) of impaired swallowing related to dx (diagnosis) dysphagia. (resident) is at increased nutritional risk r/t texture modified diet, medication side effects, advanced geriatric age, decreased p.o (oral) intake, low body weight, refusing to get out of bed, eating in bed while lying flat, and other progressive disease state." On of the "Approaches" read "Encourage (resident) to keep the head of the bed elevated during meals." Resident #64 was observed in bed on the following occasions: 1/16/18 at 12:25 p.m., Resident eating with the head of the bed reclined at approximately 20 degrees. The bed controller was on the bed next to the right arm.	F 656	interventions carried out by Certified Nurse Aides are potentially affected and are included in this Plan of Correction. Care plans that include specific, individualized interventions that are carried out by the Certified Nurse Aides will be linked to the Point of Care system, which will permit the facility to communicate those interventions each day to the C.N.A.s who are assigned to the resident. This portion of our software system has previously been under-utilized. The professional who is adding the intervention will be responsible for linking any individualized care plan intervention to the profile utilized by the direct care staff and making any changes needed in keeping the profile current. The direct care staff will be in-serviced on the profile, how it is linked to the care plan and their responsibility to check it each day prior to assuming care for the resident. In addition, the facility will increase C.N.A. communication about changing resident needs and preferences, by formally including them in the care planning process. For each admission, quarterly, annual and significant change MDS, the C.N.A.s who routinely care for a resident will be asked for their observations and input, which will be recorded for inclusion into care planning. Direct care staff will be in-serviced on the importance of their contribution into the assessment and care planning process, and how this input can be communicated effectively to the care planning team. The VP of Quality and Operations or her	

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F 656	Continued From page 12 1/17/18 at 12:45 p.m., Resident eating with the head of the bed reclined at approximately 20 degrees. The bed controller was on the bed next to the right arm. 1/18/18 at 12:45 p.m., Certified Nursing Assistant C (CNA C) delivered the lunch tray and placed it on the over bed table. The head of the bed was reclined at approximately 20 degrees. The bed controller was on the bed next to the right arm. CNA C did not raise the head of the bed. She did not encourage the resident to be elevated or repositioned. CNA C did not relocate the bed controller to the foot of the bed. CNA C was asked why she did not raise the head of the bed for the resident to eat. CNA C stated that the resident told her at breakfast that she didn't want to be raised. CNA C was informed that it was lunch time now and she was not heard to ask the resident about raising the head of the bed for this meal. CNA C was asked to locate the bed controller. She pointed to it lying next to Resident #64's arm. CNA C did not move the controller to the foot of the bed. The Administrator and Director of Nursing were notified of the findings at the end of day meeting on 1/18/18.	F 656	designee will complete a monthly audit of a sample of resident care plans, to ensure that the interventions are being carried out by direct care staff and remain appropriate to the resident. Ten percent (10%) of all resident care plans will be selected each month, representative of each unit. The residents will be observed and (if capable) interviewed, and the reviewer will validate that direct care measures (such as positioning, placement of devices, etc.) are in accordance with the resident□s plan of care.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		3/2/18

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F 657	Continued From page 13 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to, for one residents (Resident #23) in a survey sample of 22 residents, to revise the care plan to include interventions to prevent future burns. Resident #23's care plan was not revised for the sustained second-degree burns on 12/10/17. The findings included: Resident #23's care plan was not revised for the sustained second-degree burns on 12/10/17.	F 657	F 657 - Care Plan Timing and Revision Resident #23□s care plan has been revised to reflect that she has had a history of burns related to hot liquids, and the reference to pressure ulcers on her care plan instead of burn has been removed. Any resident who receives a burn is at risk for the problem being inappropriately categorized on the care plan as a pressure ulcer. The care plans of any residents who received a burn in the past year will be reviewed for accuracy and correct identification of the problem. The interdisciplinary team, including the	

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F 657	Continued From page 14 Resident #23 was admitted to the facility on 2/7/17. Diagnoses included but not limited to are Vascular dementia with behavioral disturbance, high blood pressure and dysphagia (difficulty swallowing). The resident resided in the Memory Care Unit. Resident #23's MDS (minimum data set) with an ARD (assessment reference date) of 11/9/17 was completed as a significant change in status assessment. The resident had a BIMS (brief interview of mental status) of 2 out of a possible 15, or severe cognitive impairment. Resident #23 required extensive assistance with ADL's (activities of daily living such as eating and bed mobility. Review of the care plan dated 12/10/17 revealed under the pressure ulcer category: "Resident has fluid filled blisters right and left thigh." Interventions included: "Apply Silvadene per MD order, assess resident for pain related to fluid filled blisters, assist with turning and repositioning as needed and keep clean and dry as possible." On 1/18/18 at 11:40 AM, LPN (A) was asked the rationale for including the blisters sustained from burns on the pressure area category, LPN (A) stated, "On our program, there is no category for burns." She later stated, "I found out I could have put it the "other" category." On 1/18/18 at approximately 4:00 PM, the Administrator and Director of Nursing were notified of above findings.	F 657	facility□s wound nurse, will be in-serviced on the method of selecting a care plan category from the standard library and from the customized templates within our software system, with emphasis on care planning for skin conditions or problems other than pressure ulcers, such as burns. The MDS (Minimum Data Set) Coordinators will monitor the correct classification of skin problems for any resident that receives a burn or other unusual injury. The Coordinators will review each resident□s care plan following each care plan meeting, to ensure that skin problems other than pressure ulcers, are not care planned as pressure ulcers. On a monthly basis, the QAPI Committee will receive a summary from the MDS Coordinators identifying any problems and trends of mis-categorization of skin problems on resident care plans. The Committee is responsible for evaluating the effectiveness of this plan of correction and recommending any further actions as required.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/2/18

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F 689	Continued From page 15 §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, staff interview, clinical record and facility documentation review, the facility staff failed to ensure a safe dining environment to prevent burns from spilling hot soup, resulting in harm from second degree burns for Resident #53 and Resident #23 in a survey sample of 22 residents. Both residents resided on the memory care unit. 1. On 10/5/17, Resident #53 sustained a second degree burn to her left upper thigh from spilling hot soup in her lap. 2. On 12/10/17, Resident #23 sustained six second degree burns on her inner thighs from spilling hot soup in her lap. The findings included: 1. Resident #53 sustained a second degree burn to her left inner thigh from spilling hot soup in her lap. Resident #53 was admitted to the facility on 6/18/10. Diagnoses included but not limited to are dementia with behavioral disturbance, psychosis, and depression. Resident #53's most recent MDS was a quarterly	F 689	F 689 - Accidents and Supervision Resident #53□s burns from the soup spilled on 10/5/17 were healed as of 11/8/17. She has had no further incidents of this nature. Her hot liquid assessment has been reviewed and is current. Resident #23□s burns from spilling her soup on 12/10/17 were assessed as healed on 1/2/18. She has had no further incidents of this nature. Her hot liquid assessment has been reviewed and is current. All residents who are at risk for mishandling of hot liquids and desire soup, coffee or other hot liquids at meals are potentially affected; the facility completes a hot liquid assessment on all residents. The facility will also survey residents to determine their menu preferences with respect to hot liquids, such as soups and hot cereals and the frequency with which they want to receive these items. The facility has changed policy regarding the serving of soups, coffees and other hot liquids. Previously, all residents were receiving soup and hot beverages items routinely with every lunch and dinner. The policy has been changed to make these	

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F 689	Continued From page 16 assessment with an ARD of 12/7/17. Resident #53 had a BIMS score of "0" out of a possible 15, or severe cognitive impairment. The resident required extensive assistance with her ADL's (activities of daily living including bed mobility and dressing) of one staff member. The resident required stand by assistance for eating. On 01/16/18 12:39 PM, an observation of the dining experience was conducted. Resident #53 was served soup by a CNA (certified nursing assistant) who gave her a spoonful: Resident #53 drew back and stated "that's hot." Temperature of the of soup was 180 degrees at serve (tray line in the kitchen) per dietary aide (Employee A), now was 138 degrees at the table before being served to residents. The temperature was taken by the dietary aide. The soup was served in a Styrofoam bowl as the dishwasher was not functional. The resident was able to eat the soup at this time and the aide was feeding the resident. Resident attempting to suck at end of spoon, "She is so tired today, she usually feeds herself." Very hard of hearing. Feeding self sandwich and mashed potatoes. Review of the clinical record revealed the resident had sustained a first degree burn on 10/5/17 at lunch by spilling her soup on her lap. The area was assessed by the unit manager (RN-registered nurse) A who noted the measurements as 17 cm (centimeters) by 6 cm of a reddened area, no blistering. Cold compresses were applied. A nurse's note dated 10/6/17 read: "Area has two blisters intact." Wound care notes dated 10/11/17 documented : "Second degree burn to upper left thigh/groin." The FNP (family nurse practitioner) examined the resident and	F 689	selected or requested items. They are available to residents who want them, but hot liquids will not be routinely placed for all residents. Cold liquids are supplied at every meal. This change in itself with provide for the staff to commit more attention and supervision in the serving of hot liquids. Residents and their responsible parties have been informed, and the facility will re-evaluate resident and RP satisfaction with this change in 60 days. The responsibility for checking the initial temperature of our hot liquids (e.g. soups and coffee) has been removed from the individual pantries and placed in the main kitchen. No hot items will leave the kitchen unless they are at a temperature of 140 degrees or less. The items will be transferred to cauldrons or pots (depending on the liquid) which will be maintained at 140 degrees or less on each pantry. Temperatures will be taken again prior to serving soup or other hot liquid to the resident. Kitchen staff have been in-serviced on this Plan of Correction and that all soups, hot cereals, and coffees need to be monitored and maintained at temperatures at 140 degrees for serving. As an additional precaution, residents who are at risk for spilling hot liquids (per their assessment) will be afforded the opportunity to wear a plastic lined, liquid-resistant clothing protector. While the facility does not require residents to wear these, residents who are at risk for spillage will be encouraged to wear one. Residents and responsible parties will be	

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F 689	Continued From page 17 documented: "The patient spilled soup on her upper thigh that caused a burn... The patient noted with a first degree burn area reddened... The patient complained of some pain." The physician ordered Bacitracin ointment and as needed Tylenol every 8 hours. Review of the temperature logs for October, 2017, revealed the following temperatures: From October 1 through October 4, second soup temperatures ranged from 154 degrees 200 degrees. On 10/5/17 at lunch (when the burns were sustained) the soup temperatures were 160 degrees to 159 degrees to 145 degrees. For the rest of the month, second soup temperatures ranged from 135 degrees to 190 degrees. Review of the facility's policy and procedure for hot liquid safety (revised 11/25/17) revealed the following: "The facility promotes safety with hot liquids, while assuring all residents receive liquids at temperatures they enjoy and prefer. Dining services cooks and holds liquid foods at temperatures to provide food safety, and serves food cooperatively with nursing staff at temperatures that are also safe for consumption... Hot liquids are defined at temperatures above 140 degrees." The Burn Foundation gives the following information on burns: "Coffee, tea, soup and hot tap water can be hot enough to cause serious burn injury: Hot Water Causes Third Degree Burns ... ...in 1 second at 156º ...in 2 seconds at 149º ...in 5 seconds at 140º ...in 15 seconds at 133º. "	F 689	informed of the purpose of the protectors in making their decision. At the facility□s weekly Resident at Risk meeting, the interdisciplinary team will review residents who have had positive hot liquid risk assessments to ensure the assessments are complete and interventions to reduce their risk have been identified on the care plans. To monitor compliance with this Plan of Correction, a member of the dietary services management team will verify that hot liquid temperatures have been taken as described above by the dietary staff. At each monthly QAPI meeting, the Committee will review the status of this plan of correction. The team will review for any incidences of spilled, hot liquids as well as the effective monitoring of hot liquid temperatures prior to delivery to residents. The QA Committee is responsible for the evaluation of the Plan as well as any additional interventions required to sustain compliance.	

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On 1/18/18 at approximately 10:30 AM, an interview with the Food Service Manager (Employee D) was conducted. He stated hot liquid temperatures for soup, oatmeal and coffee should be "135 to 140 degrees." He explained the soup comes from the main kitchen to the unit. He stated the third temperature is taken before the soup is served. He went on to say that the sous chef (Employee C) was to monitor the food temperatures.

A hot liquid assessment was completed for Resident #53 was completed on 10/10/17 and an Occupational Therapy consult was recommended and was done for positioning in her chair. All residents on the dementia unit were assessed for safety of hot liquids.

01/18/18 11:19 AM: The Administrator was notified that second degree burns could constitute a harm level deficiency.

01/18/18 02:37 PM: Met with kitchen supervisor (Employee C), worked in the facility for the last 6 yrs. Stated: "Hot liquids over 140 degrees, we are not supposed to serve." Also stated: "I started "thoroughly reviewing the food temperatures in December." Stated he was "not sure what happened" with missing temperatures on and after 12/24/17.

Review of the care plan for Resident #53 dated 12/12/17 contained the following: "Is at risk for spilling food or liquids at meals, due to recent incident when she tipped bowl of soup and spilled some on self." Interventions were documented as started on 12/12/17 and contained: "Conduct hot liquid assessment prn (as needed) change in

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condition, do not use Styrofoam or other lightweight materials in serving hot liquids."

2. Resident #23 sustained second degree burns on her inner thighs from spilling hot soup in her lap.

Resident #23 was admitted to the facility on 2/7/17. Diagnoses included but not limited to are Vascular dementia with behavioral disturbance, high blood pressure and dysphagia (difficulty swallowing). The resident resided in the Memory Care Unit.

Resident #23's MDS (minimum data set) with an ARD (assessment reference date) of 11/9/17 was completed as a significant change in status assessment. The resident had a BIMS (brief interview of mental status) of 2 out of a possible 15, or severe cognitive impairment. Resident #23 required extensive assistance with ADL's (activities of daily living such as eating and bed mobility.

1/16/18 at 4:15 PM, an interview was conducted with CNA (C) regarding Resident #23's hot liquids. She stated, "We supervise her hot liquids/soups."

01/17/18 11:53 AM, dietary aide (Employee A) washed her hands appropriately. Tray line temperatures were as followed: Tater tots 158, squash 170, soup 148, mechanical turkey 152, pureed soup 164 degrees, turkey salad: 46 degree, put on ice, lettuce and tomatoes 140 degrees. The soup's temperature was not rechecked.

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01/17/18 12:07 PM: Soup was served to Resident #23 in a two handled cup in front of the resident; dietary staff was requested by surveyor to recheck the temperature of the soup before the resident could consume it.

01/17/18 12:13 PM: The temperature was rechecked by the dietician and was 144.8 degrees. The RD (registered dietician) stated, "We let it sit." The temperature of the regular soup in bowls was 120 degrees.

01/17/18 12:17 PM: The RD rechecked soup temperature, the temperature was 135 degrees. "I took the lid off." (RD). The soup cup was placed in front of the resident. Resident observed sipping soup on her own, CNA nearby. Resident able to reach for and sip from cup on her own.

Review of the clinical record revealed on 12/10/17 at 5:45 PM, resident "noted to have spilled soup from soup mug onto lap. Resident was taken to room immediately and clothing changed. Bright pink areas noted to bilateral thighs, no blistering noted."

Further clinical record review revealed on 12/10/17 at 9:27 PM, "Areas to bilateral thighs re-examined and a blister to the right inner thigh was discovered. It is noted to measure 3.5 by 1.5 cm. Smaller blisters were noted to left inner thigh. All were still intact."

Further clinical record review on 12/11/17 at 8:39 AM, revealed a note by the wound care nurse (LPN- licensed practical nurse) which read: "Assessed residents right and left upper thighs/groin area with NP. Resident has a fluid filled blister on right thigh and groin by groin area

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(lower) measuring 6 by 3 by 0 cm, right thigh/groin area (upper) measures 5 by 2 by 0 cm, . Left thigh/groin area (lower) 1 by 1 by 0 cm, 0.5 by 1.2 by 0 cm, 0.5 by 0.5 cm, 0.7 by 1.5 by 0 cm, ... all stage two."

On 12/28/17, the FNP followed up on Resident #23. The note read: "For second degree burn after hot food spilling on right thigh and groin area, patient had multiple areas noted at time of burns... had Silvadene cream treatment done... today area scabbed, no signs of infection."

On 1/17/18 at 3:00 PM, temperature logs for December 2017 were reviewed. On 12/10/17 for the supper meal (when the burns were sustained), the first soup temperature was recorded at 188 degrees. A second temperature was taken (no time documented) and was 160 degrees. A third temperature was taken (no time documented) which was 150 degrees. Review of December days 1-11, 2017, supper time food temperatures revealed that second soup temperatures were between 160-190 degrees until 12/11/17 in which the temperatures decreased to 118-161 degrees; majority were not above 140 degrees. In December, there were several days of no recorded temperatures for the supper meal. On 1/17/18 for the lunch meal, the food temperatures were not recorded.

Review of the care plan for Resident #23 dated 11/10/17 revealed the following: "Resident is at risk for spilling food or liquids at meals, due to poor safety awareness related to diagnosis of dementia." Interventions dated 11/10/17 were: "Do not use Styrofoam or other lightweight materials in serving hot liquids and monitor placement." On 12/191/7 the intervention was

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(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 689	Continued From page 22	F 689		

added: "To use 8 ounce glass versus 4 ounce glass or cup or cup with handle for liquids. Hot liquids in a lidded cup, encourage use of built up utensils to improve hold on fork/spoon." Resident #23's second degree burns were tracked and care planned as "pressure ulcers."

On 1/18/18, the Quality Assurance (QA) nurse (RN-A) presented a QA Action Plan dated 10/5/17 and revision date of 12/10/17. The plan contained the following actions:

* Identify residents at risk for hot liquid burns in dietary database, for inclusion in reference list used by serving staff on units. Nursing to provide list to dietary.
* Monitor serving temperatures to ensure that residents are not receiving liquids that remain over 145 degrees.
* Change frequency of hot liquids risk assessment from admission/annual/significant change to admission/quarterly/significant change.

On 12/10/17 "Evaluation" documented "Resident (not identified on plan) spilled soup into her lap, causing reddened area to thighs. Temperatures taken post incident support that soup was served at 138 degrees. In actuality the last temperature taken was at 150 Degrees. The QA nurse stated, "Oh, that was for the incident in October)." The plan for the incident in December was to "Reduce serving temperature of hot liquids to 135 (degrees) and complaints of food being too cold. In addition, "Purchase protective lap coverings for residents who will agree to wear the liquid resistant clothing protectors. No resident will be forced to wear these." The QA nurse stated: "We started those last week." They are slow to be accepted." Not observed during the meal

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	495291	A. BUILDING _____ B. WING _____	C 01/19/2018

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F 689	Continued From page 23 observations. On 1/18/18 at approximately 4:00 PM, the Administrator and Director of Nursing were notified of harm level deficiency for Resident # 53 and Resident #23.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review the facility staff failed to store and serve food in accordance with professional standards for food service safety. The walkin freezer was dirty, hair restraints were not used, temperature logs were not completed, and food was not held at appropriate cold holding	F 812	F 812 - Food Storage and Preparation The walk in freezer was cleaned at the time the observation was communicated by the survey team. Hair nets and beard guards for men with facial hair are to be applied upon entering the kitchen, and to be worn at all times while in the kitchen. All administrative	3/2/18

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F 812	Continued From page 24 temperature. The findings included: An initial tour of the main kitchen was conducted on 1/16/17 at 11:30 a.m. At this time, a man dressed in a blue sweater and slacks was observed in the kitchen without a hair restraint. At 11:35 a.m., one of the facility Administrators was observed in the kitchen without a hair restraint. The facility policy "Personal Appearance" was reviewed. The section titled "General Considerations- All Team Members" read "Approved uniform hat or hairnet must be worn." The walkin freezer was observed to have a sticky floor. Pieces of tape and paper were observed on the floor. An opened individual cup of ice cream was melted on the floor. The temperature log dated 1/16/18 was reviewed. No temperatures were recorded for the breakfast or lunch meal. On 1/16/18 at 12:10 p.m., Employee C, Kitchen Supervisor, was asked why the temperatures were not recorded. He stated it was because they had served cold food for those meals. On 1/17/18 at 11:52 a.m., the lunch tray line service was observed on the 200 unit. Employee F, dietary staff, was observed to take the holding temperatures of the food on the service line. The hot holding temperatures were acceptable. Employee F was having trouble measuring the temperature of the cold turkey salad and asked this surveyor what the temperature was on the thermometer. She was told that she needed to determine the temperature. At this time, the	F 812	staff have been made aware that this policy includes them. The employee who stated that temperatures were not necessary to record for cold meals has been re-educated. No correction is possible for missing temperatures. Cold holding temperatures are being observed and recorded. Any food that is not held at proper temperatures will be discarded prior to serving. All residents are potentially affected by the storage and serving of food in conformance with food service safety standards. The walk in freezer schedule cleaning schedule has been reviewed and revised, with tasks assigned to dining services team members on a daily basis. Dining services staff will be in-serviced on the importance of following cleaning guidelines and food storage policies. A cleaning check list will be used by staff members assigned to clean the walk in freezer and other storage areas, for documenting completion of these tasks. The requirement for anyone entering the kitchen to apply a hair net and beard guard has been reviewed with all administrative staff. Hairnets and beard guards are placed at each entrance to the kitchen, and signs reminding staff have been placed on each door. The temperature logs in use at the time of the survey have been revised. Cooks were also re- trained in the documentation required on the temperature logs for each meal (for both hot and cold foods), safe temperature zones and the guidelines	

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F 812	Continued From page 25 Food Service Manager entered the kitchen. He assisted Employee F with taking the temperature of the turkey salad. The cold turkey salad was measured at 44 degrees, three degrees above acceptable holding temperature. The Food Service Director worked for 20 minutes to bring the temperature of the turkey salad down to 40 degrees. The Food Service Manager was asked if the main kitchen took the temperature of the cold turkey salad before it left the kitchen. He stated yes. This surveyor followed the Food Service Manager to the main kitchen to review the the temperature log. Once back in main kitchen, the Food Service Manager asked Employee E, cook, to get the temperature log for the lunch meal. Employee E did not provide the log. Employee E was asked by this surveyor if he had taken the temperature of the cold turkey salad before it left the main kitchen for the unit. Employee E stated no. The Food Service Manager was asked to provide the temperature log for 1/171/8. On the temperature log for the lunch meal was written "chic salad" and 45 degrees was documented. The temperature log used by the facility read "Hot Foods 135 or above, Chilled Entree/ Side 45 or below". The cold food holding temperature is incorrect. Cold foods should be held at 41 degrees Fahrenheit or below. The issues with the kitchen were reviewed with the Administrator and Director of Nursing at the end of day meeting on 1/18/18. No further information was provided.	F 812	they are expected to observe in temperature monitoring and documentation. To monitor compliance with this plan of correction, the dining services supervisor will conduct a walk through inspection of the kitchen on a daily basis and communicate any findings re: sanitation to the responsible staff. The supervisor will also be held accountable to verify that any person entering the kitchen has properly restrained hair / beard. The dining services supervisor will also be responsible to check the record of food temperatures (both hot and cold) at each meal and verify that the temperatures have been recorded by the cooks and where necessary, action has been taken. The facility□s full-time Registered Dietitian is a member of the QAPI Committee and will be responsible to conduct a monthly inspection of the kitchen and to review the monthly documentation of temperatures. The RD will provide a compliance summary to the Committee. The Committee is responsible to evaluate the effectiveness of this plan of correction and to identify any additional measures required to sustain compliance.	