PRINTED: 01/20/2016
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495392 | A. BUILDING _____ B. WING _____ | C 01/13/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SENTARA NSG CENTER-WINDERMERE | 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated standard survey was conducted 1/11/16 through 1/13/16. Two complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Corrected deficiencies are identified on the 2567B report.<br><br>The census in this 90 certified bed facility was 80 at the time of the survey. The survey sample consisted of 3 residents, 2 current Resident reviews (Resident #1 through 2) and 1 closed record review (Resident #3). | F 000 | Past noncompliance: no plan of correction required. | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report 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 to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency) | F 225 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1-25-2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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:
Based on staff interviews, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to report an injury of unknown origin (IUO) immediately to the Administrator and other officials in accordance with State Law for 1 of 3 residents in the survey sample, Resident #1.

Past noncompliance: no plan of correction required.

Resident #1 was found to have first and second degree thermal burns to the right inner and outer thigh areas, right lower abdomen and right knee on 12/25/15. The facility staff failed to immediately notify the Administrator of the IUO and the State Survey and Certification Agency until 12/28/15.

The findings included:

Resident #1 an 86 year old was admitted to the facility on 9/14/15 following a hospitalization requiring skilled services. The resident's

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diagnosis included Non-Alzheimer's Dementia with behavioral disturbances.

The current MDS (Minimum Data Set) with an assessment reference date of 12/3/15 coded the resident as scoring a 5 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident had received the antipsycholic medication Seroquel 12.5 mg (milligrams) daily during the seven days of the assessment period. The resident was wheelchair bound due to a left above-the-knee amputation.

A Facility Reported Incident (FRI) was sent to the State Survey and Certification Agency on 12/28/15. The FRI described an injury of unknown origin noted by a CNA (certified nurse aide) on Resident #1's right thigh on 12/25/15 at approximately 11:27 pm. The injury was described as "Blisters...intact and some open." The resident stated "she spilled coffee on her leg." The Administrator documented, "This occurrence was brought to the attention of the administrator on 12/28/15 at approx. 9:15 am."

The Administrator was interviewed on 1/11/16 at 3:00 pm. He stated, "...the patient spilled coffee on herself...she did not tell the nursing staff until they were changing her...I found out on Monday (12/28/15) and met with the son (Responsible Party/RP) to recap what had happened...the coffee machine in the dining room was initially turned off Sunday (12/27/15).

The Director of Nursing (DON) and the unit one nurse manager were interviewed on 1/11/16 at 3:45 pm. The DON stated, "I was notified of the injury on Sunday (12/27/15) at 8:00 pm by (name

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of unit one manager), she called me at home...she (the unit one manager) instructed the 3-11 pm nurse supervisor to turn off the coffee machine."

The unit one nurse manager stated she was notified of the thermal burns by one of the nurses through a phone call on Sunday evening(12/27/15) due to Resident #1's son threatening to call APS (Adult Protective Services) in response to the injuries. Prior to this phone call the DON, the Administrator and the nursing manager on weekend duty (the unit one manager) had not been informed of the injury of unknown origin (thermal burns) identified by the staff on 12/25/15.

The DON stated, "I notified the Administrator the next day during morning meeting (12/28/15)." The DON stated the resident often refused care, could be combative and drank coffee everyday, stating the resident, "... takes multiple cups of drinks at a time and places them in the wheelchair and between her legs...they slosh." The DON stated an investigation was initiated on 12/28/15. The facility was unable to determine exactly when the injury occurred.

The CNA (certified nurse aide #1) who discovered the thermal burns on 12/25/15 was interviewed on 1/11/16 at 5:30 pm. She stated when she first arrived on duty she observed the resident sitting in a wheelchair in the hallway outside the resident's room. CNA #1 stated later she noted the resident was "gone for a little while down on the second unit. There was some altercation that happened between the resident and another staff...she (the resident) swung at a pregnant nurse...the police were called because of the

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resident's combativeness." CNA#1 stated after the police left she assisted the resident to bed at approximately 7:00 pm. She stated when she was assisting the resident with putting on a gown she observed the "burn" to the resident's right thigh area. She asked the resident how this happened, the resident responded, "I spilled coffee on myself...it happened the day before". The CNA stated she notified the nurse who then assessed the resident.

The facility sent the resident to the emergency department following the discovery of the blisters. The resident arrived at the first emergency department (ED) on 12/26/15 at 00:13 am. The ED notes read, in part: "...thermal burns to the right thigh, knee and leg after spilling coffee on self this am at~0800. Blisters ruptured at this time. Pain improved. Given morphine in the ER (emergency room)...Patient likely requires burn scrub. Discussed with (name of second ED) and will transfer patient for evaluation by burn team."

The resident arrived at the second ED on 12/26/15 at 02:33 am. The resident was diagnosed with second degree burns. The ED note read, in part:"...approx 3-4% TBSA (total body surface area) 2nd degree burn. Non-circumferential (did not go around the leg). The burns were cleaned, treated with Bacitracin 500 unit/ gram topical and a dressing was applied. A follow up appointment with the burn clinic was to be scheduled as soon as possible for a visit in 2 days for burn care and to ensure healing. The resident was discharged from the ED at 04:08 am on 12/26/15 back to the facility.

The resident was assessed by the nurse practitioner on 12/28/15. The burns were

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described as: Right thigh & knee with 1st and 2nd degree burns with the larger areas measuring 6.5 x 1.5 cm (centimeter) 6.5 x 4.5 cm, and 8 x 3 cm with few scattered areas of 1st degree erythema (redness), small approx 3-4 cm area on the RLQ (right lower quadrant) abdomen 1st degree erythema.

The resident was seen in the burn clinic on 1/4/16. The burn clinic notes read, in part:" Mental health: Occasional anxiety and dementia causing altered mental status...she is awake, alert, and oriented slightly confused extremely feisty...right lower extremity has a 4% total body surface area burn involving her thigh, knee and calf that is varied stages of healing from epithelialization to an area on her proximal medial knee that is significantly granulated with some pseudo eschar (dead tissue) that is present. The treatment was changed to Silvadene dressing changes with thorough cleansing with chlorhexidine and premedicating with morphine one hour prior to the daily dressing changes.

On 1/13/16 at 11:58 am, a second interview was conducted with the DON. The failure of the staff to notify the Administrator and the State Survey and Certification Agency immediately of an injury of unknown origin involving 1st and 2nd degree burns was shared. The DON stated, "They should have called to let us know immediately."

The DON stated there have been no allegations of abuse, neglect, misappropriation of property or injury of unknown origin since 12/25/15. She stated the facility implemented a plan of correction to address this identified deficiency as follows:
1. All RN Supervisors were inserviced on 1/4/16

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on the facility policy titled Abuse: Investigation, Protection and Reporting.
2. The nursing manager on duty will call the building on the weekends to ensure all incidences have been correctly addressed.
3. The findings will be discussed in QAPI (Quality Assurance Performance Improvement) on a monthly basis.
Date of compliance 1/4/16.

The facility policy titled Abuse: Investigation, Protection and Reporting revised 1/13/15 read, in part:
Also, in accordance with state regulations and the Code of Virginia, Life Care employees will immediately report all incidents of alleged violations involving resident mistreatment, neglect or abuse, including injuries of unknown sources and misappropriation of resident property to their supervisor, the DON and Administrator.

F 225

COMPLAINT DEFICIENCY-PAST NON COMPLIANCE

F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility

F 280

1. Resident's #1 care plan has been revised to include management of the unsafe behavior.
2. All residents that demonstrate unsafe behaviors have the potential to be affected by this deficient practice.
3. The Clinical Manger (designee) will identify all residents with unsafe behaviors and verify that there is an appropriate plan of care to manage the behavior(s).

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| F 280 | Continued From page 7<br>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, clinical record review and during the course of a complaint investigation the facility staff failed to revise a care plan to include unsafe behaviors for 1 of 3 residents in the survey sample, Resident #1.<br><br>Resident #1 was identified to have unsafe behaviors of placing multiple beverage cups filled with cold and hot beverages to include coffee in between her legs and tucked inside the wheelchair arms next to her thighs while ambulating in the wheelchair throughout the facility.<br><br>On 12/25/15 the resident was found to have first and second degree thermal burns to the right inner and outer thigh areas, right lower abdomen and right knee. The thermal burns were a result of coffee spillage. The resident had dementia with behavioral disturbances and poor safety awareness.<br><br>The findings included:<br><br>Resident #1 an 86 year old was admitted to the | F 280 | 4. Clinical Manager (designee) will present any resident newly exhibiting unsafe behavior weekly in the standards of care meeting for four weeks and then twice a month for two months to ensure there is plan of care to manage the behaviors(s). Report finds to QAPI.<br>5. Date certain 1/27/2016 | |

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facility on 9/14/15 following a hospitalization requiring skilled services. The resident's diagnosis included Non-Alzheimer's Dementia with behavioral disturbances.

The current MDS (Minimum Data Set) with an assessment reference date of 12/3/15 coded the resident as scoring a 5 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident had received the antipsychotic medication (Seroquel 12.5 mg (milligrams) daily during the seven days of the assessment period. The resident was wheelchair bound due to a left above-the-knee amputation.

A Facility Reported Incident (FRI) was sent to the State Survey and Certification Agency office on 12/28/15. The FRI described an injury of unknown origin was noted by a CNA (certified nurse aide) on Resident #1's right thigh on 12/25/15 at approximately 11:27 pm. The injury was described as "Blisters...intact and some open". The resident stated "she spilled coffee on her leg."

The Administrator was interviewed on 1/11/16 at 3:00 pm. He stated, "...the patient spilled coffee on herself...she did not tell the nursing staff until they were changing her." He stated the vendor came to check the self serve coffee machine on 12/29/15. The vendor turned down the dispensing hot water temperature from 191 degrees to 175 degrees. The Administrator stated at that time he decided to keep the coffee machine off permanently. He stated Resident #1 was known to place cups of beverages (independently obtained from the self service juice dispenser and coffee dispenser) between

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her legs while moving about the facility in her wheelchair.

The director of nursing (DON) and the unit one nurse manager were interviewed on 1/11/16 at 3:45 pm. The DON stated the resident often refused care, could be combative and drank coffee everyday, stating the resident, "... takes multiple cups of drinks at a time and places them in the wheelchair and between her legs...they would slosh." She stated a cup holder was placed on the resident's wheelchair sometime in December but the resident continued to place multiple cups of beverages to include coffee between the wheelchair arm rests and between the resident's leg. She stated the son had brought in a cup with a lid. The DON stated the resident recognizes her son but does not remember the staff's name and has poor safety awareness.

The unit manager stated after the cup holder was placed on the wheelchair the resident, "Still placed cups on her lap."

The 7 am-3 pm nursing supervisor for 12/25/15 was interviewed on 1/12/16 at 2:30 pm. He stated, "She (Resident #1) was seen on unit two...she had spilled a couple of cups of juice...the nurse attempted to remove the cups and the resident swung at her hitting her on her left arm, I grabbed the wheelchair arm and swung it around away from the nurse and the resident hit me in the gut and scratched my arm...I called the police to see if we could get a TDO (temporary detaining order) and a record of her violent behavior...she had five cups of juices, one in the cup holder, one on the inside of each wheelchair arm rests and one between her legs and one on

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the armrest...but there was no coffee..."

On 1/13/16 at 9:52 am, the Food Service Director (FSD) was interviewed. He stated he observed the resident on an almost daily basis throughout the day obtain not only juice but coffee from the self service machines. He stated, "She has a habit of placing it between her legs...she adamantly refuses to let you take the cups to the table to help her...she would have a cup of something in between her legs I would say 80 to 90% of the time."

On 1/11/16 at 3:05 pm, on initial tour the resident was observed in bed and awake. The resident was asked about the incident. She stated, "I burned myself with coffee" the resident pointed to her right leg. When asked where she had obtained the coffee from she yelled abruptly, "I don't know where they got the coffee from." The resident was observed agitated at that point and the interview was stopped. A clear plastic tumbler with a lid and straw was observed empty on the sink, away from the residents reach. A pink sip cup was observed on the residents night stand, away from the residents reach with approximately 30 ml of clear fluid inside it. The residents wheelchair was observed with a cup holder attached to the right arm rest.

The clinical record evidenced the resident was sent to the emergency department following the discovery of the blisters on 12/25/15. The resident arrived at the first emergency department (ED) on 12/26/15 at 00:13 am. The ED notes read, in part: "...thermal burns to the right thigh, knee and leg after spilling coffee on self this am at~0800. Blisters ruptured at this time. Pain improved. Given morphine in the ER

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(emergency room)...Patient likely requires burn scrub. Discussed with (name of second ED) and will transfer patient for evaluation by burn team. In my opinion, this is a condition that a prudent lay person (who possesses an average knowledge of health and medicine) may expect to result in serious jeopardy, or cause serious impairment of bodily function, or serious dysfunction of bodily organs...Pt (patient) with both 1st and 2nd deg (degree) burns to rle (right lower extremity), will tx (treat) pain and txfer (transfer) to (initial of second ED) for burn care."

The resident arrived at the second ED on 12/26/15 at 02:33 am. The resident was diagnosed with second degree burns. The ED note read, in part:"...approx 3-4% TBSA (total body surface area) 2nd degree burn. Non-circumferential (did not go around the leg). The burns were cleaned, treated with Bacitracin 500 unit/ gram topical and a dressing was applied. The resident was discharged back to the facility with a recommendation to have a follow up appointment made with the burn clinic.

The resident was assessed by the nurse practitioner on 12/28/15. The burns were described as:
Right thigh & knee with 1st and 2nd degree burns with the larger areas measuring 6.5 x 1.5 cm (centimeter) 6.5 x 4.5 cm, and 8 x 3 cm with few scattered areas of 1st degree erythema (redness), small approx 3-4 cm area on the RLQ (right lower quadrant) abdomen 1st degree erythema.

The Followup Psych Assessment & Treatment Plan dated 10/1/15 read, in part: (Resident name) is awake, delusional, confused and

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uncooperative. She continues to be violent with staff when touched. When asked why she is hitting staff states "they are aggravating me that's why." She is currently on Seroquel 12.5 mg po (by mouth) qd (every day). This dose of Seroquel is not sufficient to alleviate delusions or stop physical aggression.

A nurses note dated 11/13/15 read, in part:...Resident was pouring coffee in cups and had several cops of coffee that were spilling on resident and floor informed resident was going to assist her with the coffee and went to take coffee from resident to assist with placing in her room and resident raised her fist at staff. Resident went to closed meal cart opened it up and pulled trays out onto the floor..."

A nurses note dated 11/24/15 read, in part: ...reminded son of incidents of resident going to juice machine and pouring several cups of juice and coffee and placing (sic)wheelchair and then resident spilling beverages on floor as she mobilizes wheelchair and staff having to clean the floor...Asked son to bring in cup with a lid that resident could use."

A nurses note dated 12/16/15 read, in part: Call placed to son to request a cup with cover for resident to use to drink fluids. Resident obtains fluids from drink machine and spills on floor and down hallway and when try to assist resident she becomes agitated and refuses or try's and throws the fluids on staff.

A nurses notes dated 12/28/15 at 1:42 pm, read, in part: Resident at front door throughout this shift setting the alarm off. Resident was asked to move away from door and attempted to be

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| F 280 | Continued From page 13<br>redirected. Resident continued to swing both fists at this nurse when asked to move. later this shift resident was seen to have a cup on lap. Nothing in the cup. This nurse was told that resident had spilled coffee on floor in dinning (sic) area. Will monitor.<br><br>Review of the resident's plan of care failed to evidence a revised care plan to include the resident's unsafe behavior of placing multiple cups of hot and cold beverages along the inside of the wheelchair arm rests and between her legs.<br><br>On 1/13/16 at 11:58 am, a second interview was conducted with the DON. The failure to revise the resident's care plan was shared. When asked if the resident's care plan should have been revised to include these identified behaviors she stated, "It should have been." | F 280 | | |
| F 323 SS=G | COMPLAINT DEFICIENCY<br>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, clinical record review and during the course of a | F 323 | Past noncompliance: no plan of correction required. | |

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complaint investigation the facility staff failed to provide an environment free of accident hazards over which the facility has control and provide supervision to prevent an avoidable accident for 1 of 3 residents in the survey sample, Resident #1.

Resident #1 was found to have first and second degree thermal burns to the right inner and outer thigh areas, right lower abdomen and right knee on 12/25/15. The thermal burns were a result of coffee spillage. The resident was known by the facility to have dementia, poor safety awareness and unsafe behaviors such as placing multiple beverage cups filled with cold and hot beverages such as coffee in between her legs and tucked inside the wheelchair arms next to her thighs while ambulating in the wheelchair throughout the facility. The resident obtained these beverages independently from two self serve beverage machines located on Unit two and the main dining room.

The findings included:

Resident #1 an 86 year old was admitted to the facility on 9/14/15 following a hospitalization requiring skilled services. The resident's diagnosis included Non-Alzheimer's Dementia with behavioral disturbances.

The current MDS (Minimum Data Set) with an assessment reference date of 12/3/15 coded the resident as scoring a 5 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident had received the antipsychotic medication (Seroquel 12.5 mg (milligrams) daily during the seven days of the assessment period. The resident was wheelchair

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bound due to a left above-the-knee amputation.

A Facility Reported Incident (FRI) was sent to the State Agency Office on 12/28/15. The FRI described an injury of unknown origin was noted by a CNA (certified nurse aide) on Resident #1's right thigh on 12/25/15 at approximately 11:27 pm. The injury was described as "Blisters...intact and some open". The resident stated "she spilled coffee on her leg." The Administrator documented, "This occurrence was brought to the attention of the administrator on 12/28/15 at approx. 9:15 am."

The Administrator was interviewed on 1/11/16 at 3:00 pm. He stated, "...the patient spilled coffee on herself...she did not tell the nursing staff until they were changing her...I found out on Monday (12/28/15) and met with the son (Responsible Party/RP) to recap what had happened...the coffee machine in the dining room was initially turned off Sunday (12/27/15). He stated the vendor came to check the self serve coffee dispenser on 12/29/15. The vendor turned down the hot water temperature from 191 degrees to 175 degrees. He further stated the coffee machine contains a pouch of cold liquid coffee that is mixed with the hot water when dispensed. He stated after the hot water temperature setting was decreased the temperature of the coffee dispensed was 174 degrees. As corrective action he stated the self serve coffee machine was made inoperable effective 12/28/15. He stated the residents now have to ask staff for coffee during off hour meal times. The Administrator stated the self serve coffee machine had been kept on unit two inside the Coastal Cafe. The self serve coffee machine was moved from the Coastal Cafe to the main dining

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room after the renovations were completed (prior to Thanksgiving). He further stated Resident #1 was known to place cups of beverages (independently obtained from the self service juice dispenser and coffee dispenser) between her legs while moving about the facility in her wheelchair. The Administrator stated there is no assigned staff in the dining room to provide supervision to resident's outside of meal times and activities held in the dining room.

The Director of Nursing (DON) and the unit one nurse manager were interviewed on 1/11/16 at 3:45 pm. The DON stated, "I was notified of the injury on Sunday (12/27/15) at 8:00 pm by (name of unit one manager), she called me at home...she (the unit one manager) had instructed the 3-11 pm nurse supervisor to turn off the coffee machine."

The unit one nurse manager stated she was notified of the thermal burns by one of the nurses through a phone call due to the resident's son threatening to call APS (Adult Protective Services) in response to the injuries on Sunday evening (12/27/15). Prior to this phone call the DON and the nursing manager on weekend duty (the unit one manager) had not been informed of the injury of unknown origin (thermal burns). The DON stated, "I notified the Administrator the next day during morning meeting (12/28/15).

The DON stated the resident often refused care, could be combative and drank coffee everyday, stating the resident was known and observed to "takes multiple cups of drinks at a time and place them in the wheelchair and between her legs...they would slosh." She stated a cup holder was placed on the resident's wheelchair

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sometime in December but the resident continued to place multiple cups of beverages to include coffee between the wheelchair arm rests and between the resident's leg. She stated the son had brought in a cup with a lid. The DON stated the resident recognizes her son but does not remember the staffs name and has poor safety awareness.

The DON stated the facility had obtained a cup holder for the resident's wheelchair and asked the son to bring in a cup with a lid for the resident. There were no other interventions implemented or trialed to correct the unsafe behavior of placing multiple beverage cups filled with cold and hot beverages in between her legs and tucked inside the wheelchair arms while ambulating in the wheelchair throughout the facility. There was no increased supervision implemented to promote safety for the resident while in the dining room or the Coastal Cafe.

The unit manager stated after the cup holder was placed on the wheelchair the resident, "Still placed cups on her lap."

The CNA (certified nurse aide #1) who discovered the thermal burns on 12/25/15 was interviewed on 1/11/16 at 5:30 pm. She stated when she first arrived on duty she observed the resident in a wheelchair in the hallway outside the resident's room. CNA #1 stated later the resident was "gone for a little while down on the second unit. There was some altercation that happened between the resident and another staff...she (the resident) swung at a pregnant nurse...the police were called because of the resident's combativeness." CNA #1 stated after the police left she assisted the resident to bed at

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approximately 7:00 pm. She stated when she was assisting the resident with putting on a gown she observed the "burn" to the resident's right thigh area. She asked the resident how this happened, the resident responded, "I spilled coffee on myself...it happened the day before." The CNA stated she notified the nurse who then assessed the resident.

The 7 am-3 pm nursing supervisor for 12/25/15 was interviewed on 1/12/16 at 2:30 pm. He stated, "She (Resident #1) was seen on unit two...she had spilled a couple of cups of juice...the nurse attempted to remove the cups and the resident swung at her hitting her on her left arm, I grabbed the wheelchair arm and swung it around away from the nurse and the resident hit me in the gut and scratched my arm...I called the police to see if we could get a TDO (temporary detaining order) and a record of her violent behavior...she had five cups of juices, one in the cup holder, one on the inside of each wheelchair arm rests and one between her legs and one on the armrest...but there was no coffee..."

On 1/12/16 at 2:00 pm, the day shift CNA #2 assigned to care for Resident #1 on 12/25/15 was interviewed. She stated she assisted the resident with morning care by handing the resident wash clothes and clothes to change into. The CNA stated, "I stayed on the left side of the bed because she can kick you real fast with that right leg..." The CNA was asked if she noted any redness to the resident's right leg at that time and she stated, "No." She stated because she was on the left side of the bed she was not in a position to have had full visual access to the residents right thigh area. She stated the resident drank coffee everyday and would go to

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unit two to get it when the coffee machine was located on that unit. The CNA stated she had removed the resident's linen due to them being wet with urine as the resident had refused incontinent care from the night shift. She did not observe any coffee stains on the linen. CNA #2 stated the resident does not get into the wheelchair and ambulate in the hallways as she did prior to the injury, she indicated the resident now stays in bed.

On 1/13/16 at 9:52 am, the Food Service Director (FSD) was interviewed. He stated he observed the resident on an almost daily basis throughout the day obtain not only juice but coffee from the self service machines. He stated, "She has a habit of placing it between her legs...she adamantly refused to let you take the cups to the table to help her...she would have a cup of something in between her legs I would say 80 to 90% of the time." The FSD stated as a result of Resident #1's thermal burns the self serve coffee machine was made inoperable on 12/28/15 by unplugging the electrical cord, removing the coffee bag from inside of it and locking it. He stated he maintains the key on his key chain and the spare keys inside the kitchen. He stated the nursing staff does not have access to these keys. He stated if the resident's request coffee the staff get it from the kitchen. He stated the kitchen staff were inserviced on 12/28/15. The FSD stated the plans include having the vendor remove the self serve coffee machine from the dining room. The FSD stated there is only one coffee machine in the facility and it is located inside the kitchen. The FSD stated at the time of the burn injury the facility did not have lids available for the cups at the self serve juice and coffee beverage stations. The FSD stated the facility is currently looking

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into options for lids for the cups.

The Followup Psych Assessment & Treatment Plan dated 10/1/15 read, in part: (Resident name) is awake, delusional, confused and uncooperative. She continues to be violent with staff when touched. When asked why she is hitting staff states "they are aggravating me that's why." She is currently on Seroquel 12.5 mg po (by mouth) qd (every day). This dose of Seroquel is not sufficient to alleviate delusions or stop physical aggression.

A nurses note dated 11/13/15 read, in part:...Resident was pouring coffee in cups and had several cops of coffee that were spilling on resident and floor informed resident was going to assist her with the coffee and went to take coffee from resident to assist with placing in her room and resident raised her fist at staff. Resident went to closed meal cart opened it up and pulled trays out onto the floor..."

A nurses note dated 11/24/15 read, in part: ...reminded son of incidents of resident going to juice machine and pouring several cups of juice and coffee and placing (sic)wheelchair and then resident spilling beverages on floor as she mobilizes wheelchair and staff having to clean the floor...Asked son to bring in cup with a lid that resident could use."

A nurses note dated 12/16/15 read, in part: Call placed to son to request a cup with cover for resident to use to drink fluids. Resident obtains fluids from drink machine and spills on floor and down hallway and when (sic) try to assist resident she becomes agitated and refuses or try's (sic) and throws the fluids on staff.

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A nurses notes dated 12/28/15 at 1:42 pm, read, in part: Resident at front door throughout this shift setting the alarm off. Resident was asked to move away from door and attempted to be redirected. Resident continued to swing both fists at this nurse when asked to move. later this shift resident was seen to have a cup on lap. Nothing in the cup. This nurse was told that resident had spilled coffee on floor in dinning (sic) area. Will monitor.

Review of the resident's plan of care failed to evidence a revised care plan to include the resident's unsafe behavior of placing multiple cups of hot and cold beverages along the inside of the wheelchair arms and between her legs.

On 1/11/16 at 3:05 pm, on initial tour the resident was observed in bed and awake. The resident was asked about the incident. She stated, "I burned myself with coffee" the resident pointed to her right leg. When asked where she had obtained the coffee from she yelled abruptly, "I don't know where they got the coffee from." The resident was observed agitated at that point and the interview was stopped. A clear plastic tumbler with a lid and straw was observed empty on the sink, away from the residents reach. Another pink sip cup was observed on the residents night stand, away from the residents reach with approximately 30 ml of clear fluid inside it. The resident's wheelchair was observed to have a cup holder attached to the right armrest.

On 1/12/16 and 1/13/16 from 10:00 am to approximately 2:00 pm, the resident remained in bed. The clear plastic cup remained on the sink,

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the pink sip cup remained on the dresser drawer with the same amount of clear fluid as seen on initial tour.

The clinical record evidenced the resident was sent to the emergency department following the discovery of the blisters. The resident arrived at the first emergency department (ED) on 12/26/15 at 00:13 am. The ED notes read, in part: "...thermal burns to the right thigh, knee and leg after spilling coffee on self this am at~0800. Blisters ruptured at this time. Pain improved. Given morphine in the ER (emergency room)...Patient likely requires burn scrub. Discussed with (name of second ED) and will transfer patient for evaluation by burn team. In my opinion, this is a condition that a prudent lay person (who possesses an average knowledge of health and medicine) may expect to result in serious jeopardy, or cause serious impairment of bodily function, or serious dysfunction of bodily organs...Pt with both 1st and 2nd deg (degree) burns to rle (right lower extremity), will tx (treat) pain and txfer (transfer) to (initial of second ED) for burn care".

The resident arrived at the second ED on 12/26/15 at 02:33 am. The resident was diagnosed with second degree burns. The ED note read, in part:"...approx 3-4% TBSA (total body surface area) 2nd degree burn. Non-circumferential (did not go around the leg). The burns were cleaned, treated with Bacitracin 500 unit/ gram topical and a dressing was applied. A follow up appointment with the burn clinic was to be scheduled as soon as possible for a visit in 2 days for burn care and to ensure healing. The resident was discharged from the ED at 04:08 am on 12/26/15 back to the facility.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495392 | A. BUILDING _____ B. WING _____ | C 01/13/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SENTARA NSG CENTER-WINDERMERE | 1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454 |

| (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 |
|---|---|---|---|---|
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The resident was assessed by the nurse practitioner on 12/28/15. The burns were described as:
Right thigh & knee with 1st and 2nd degree burns with the larger areas measuring 6.5 x 1.5 cm (centimeter) 6.5 x 4.5 cm, and 8 x 3 cm with few scattered areas of 1st degree erythema (redness), small approx 3-4 cm area on the RLQ (right lower quadrant) abdomen 1st degree erythema.

The resident was seen in the burn clinic on 1/4/16. The burn clinic notes read, in part:" Mental health: Occasional anxiety and dementia causing altered mental status...she is awake, alert, and oriented slightly confused extremely feisty...right lower extremity has a 4% total body surface area burn involving her thigh, knee and calf that is varied stages of healing from epithelialization to an area on her proximal medial knee that is significantly granulated with some pseudo eschar (dead tissue) that is present. The entire area was cleansed with chlorhexidine today removing a significant amount of devitalized tissue (dead tissue) and roughly 50% of the pseudo eschar that is present over the area of granulation. This area is quite obviously the deepest burn that she sustained..." The treatment was changed to Silvadene dressing changes with thorough cleansing with chlorhexidine and premedicating with morphine one hour prior to the daily dressing changes.

During the initial tour of the facility on 1/11/16 and the survey days of 1/12/16 and 1/13/16 the self serve coffee machine was observed inside the main dining room. The coffee machine was inoperable. There were no other coffee

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|---|---|---|---|---|
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machines found in any of the resident common areas. One coffee machine was located inside the kitchen.

The plan of correction to prevent further accidents from the self serve coffee machine included:
1. The self service coffee machine was immediately turned off on 12/27/15.
2. The machine was made inoperable on 12/28/15.
3. Employees will obtain coffee for residents through the kitchen staff during off meal hours.
4. All kitchen staff were inserviced on maintaining the self service coffee machine inoperable on 12/28/15.
5. The vendor was contacted and will remove the self service coffee machine from the building.
The facility was in compliance as of 12/28/15.

COMPLAINT DEFICIENCY-PAST NON COMPLIANCE