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	495068	A. BUILDING _____ B. WING _____	02/03/2017

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SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/31/17 through 2/3/17. An extended survey was conducted 2/1/17 through 2/3/17. Immediate Jeopardy was identified in Quality of Care Accident Hazards, F323. A corrective action plan was submitted and approved on 2/1/17. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 169 bed facility was 147 at the time of the survey. The survey sample consisted of 24 residents: 21 current residents (Residents #1 through #21) and 3 closed records (Residents #22 through #24). The Expanded survey sample consisted of 30 residents: Residents #25 through #54.	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (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 misappropriation of their property; or	F 225		3/3/17

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

Electronically Signed | 02/24/2017

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(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.

(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.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or 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.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

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F 225	Continued From page 2 (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: Based on a resident group interview, clinical record review, staff interviews, and facility document review the facility staff failed to report an injury to the Office of Licensure and Certification State Survey Agency resulting in a 2nd Degree Burn for 1 of 54 residents in the survey sample, Resident #25. The facility staff failed to report/and complete a Facility Reported Incident (FRI) of an injury to the Office of Licensure and Certification State Survey Agency which resulted in a 2nd Degree Burn from hot coffee on 7/26/16 for Resident #25. The findings included: On 2/1/17 at 10:30 a.m. during the Resident Group Interview with 15 residents present, the residents were asked about their coffee grievance in their resident council minutes. The resident council president stated, "Coffee has been a problem since that lady got burned." On 2/1/17 at approximately 12:00 noon the Administrator was asked if he had a resident that had been burned from hot coffee and if the resident had significant injuries. The Administrator stated, "Yes, there was a resident burned after spilling her coffee and she did have	F 225	The investigation and action plan that was implemented for Resident #25 unusual occurrence was provided to the State. The resident is comfortable and in no distress. All residents have this potential The Abuse Coordinator and Director of Nursing were educated on Federal / State regulations concerning reporting criteria and the facility will report unusual events as required. Accidents / reportable incidents will be reviewed weekly during RISK meetings and the findings will be presented at the QAPI meeting monthly until sustainability is attained.	

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a pretty significant burn." The Administrator was asked to see a copy of the Facility Reported Incident (FRI) that was sent to the Office of Licensure and Certification regarding the burn. The Administrator stated, "I did not do a FRI because we knew how the injury occurred, it was not an injury of unknown origin." The Administrator was then asked to see his investigation documentation for the burn which was provided.

A review of the facility investigation was completed and Resident #25 was added to the survey sample.

Resident #25 was a 60 year old admitted to the facility on 1/1/15 with diagnoses to include Psychosis (1), Major Depressive Disorder (2), Anxiety Disorder (3), and Bipolar Disorder (4).

The most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 1/20/17. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #25 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating= the resident was coded as being independent with setup help only.

Resident #25's Interdisciplinary Care Plan dated 7/26/16 documented in part, as follows:

Impaired Skin Integrity

7/26/16-Problem: Resident has disruption of skin surface, not related to pressure

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F 225	Continued From page 4 *Burn-location-Abdomen. Goal: The resident's disruption of skin surface will remain free from infection and show evidence of healing by- 90 days. Approach: 7/26/16 *Wound care as ordered, see current treatment record and physician's orders; observe effectiveness of/response to treatment as ordered. *Observe for pain and medicate PRN (as needed) per physician's order. *Silvadene cream to affected area BID (twice a day). 7/28/16 *D/C (discontinue) silvadene cream BID, silvadene cream to affected area Tuesday, Thursday, and Saturday with telfa and ABD (absorbent breathable dressing) PAD then secure. Bacitracin and xerofoam with ABD and secure Monday, Wednesday, and Friday. (Company Name) wound physicians to evaluate. 7/29/16 *Coffee cup with lid. *Coffee temperature not to exceed 180 degrees. (The 180 degrees was marked out and 150 degrees was added.) 8/4/16 *D/C silvadene, bacitracin to upper abdomen, santyl to lower abdomen, clean with normal saline and cover with telfa and ABD pads.	F 225		

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F 225	Continued From page 5 8/12/16 *D/C Bacitracin, continue santyl to lower abdomen daily. Resolved 8/26/16. The Nursing Assessment for Resident #25 dated 7/26/16 at 12:15 p.m. was reviewed and is documented in part, as follows: Category: Burn (2nd Degree or Greater)- @ (at) 2nd degree Creator Name: (Name) Licensed Practical Nurse (LPN) #1. Indicated Locations: Dining Room. Detailed Description: Resident spilled cup of hot coffee on herself. Description and Patient Assessment: Resident was attempting to drink a cup of coffee, when resident accidentally spilled the hot coffee on herself. Upon assessment noted resident's abdominal area to be red and blistering. Zinc Oxide applied. Burn specific information: *Burn location: Abdominal area. *Cause of burn known: Yes, hot coffee. *Patient knows how burn occurred: Yes, Resident was reaching for coffee cup, when cup spilled over onto residents abdominal area. *Patient location when burn occurred: Dining Room. *Any Additional Information: New order received for Silvadene cream to be applied to affected area BID and as needed until resolved. Diagnosis: Depression and Anxiety Disorder Vital Signs: *Blood Pressure: 178/108 *Pulse: 88 *Respirations: 18	F 225		

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*Temperature: 98.0
Cognitions: Alert
Notifications and Orders:
*Doctor: 7/26/16 at 12:20 p.m.
*Family: 7/26/16 at 12:30 p.m.
*DNS (Director of Nursing Services): 7/26/16 at 12:30 p.m.
First aid/treatment Information: Zinc oxide applied to affected area with protective nonstick border gauze applied.
Bodily Injuries: Abdominal
*Burn: 2nd Degree (5)
*Burn Description: Hot coffee spilled on resident.
*Pain: Yes
*Pain Verbal: 5
Nursing Interventions:
*Were any new nursing interventions implemented? No
Care Plans: Care Plan Reviewed.

The SBAR (Situation Background Assessment Recommendation) tool completed by LPN #1 for Resident #25 dated 7/31/16 was reviewed and is documented in part, as follows:
Situation: The change in condition, symptoms, or signs observed and evaluated is/are: Resident was burned with hot coffee.

This started on: 07/26/2016

Vital Signs:
BP (blood pressure) 178/108
Pulse: 88

Resident Evaluation:
1. Mental Status Evaluation: Resident in pain d/t (due to) 2nd degree coffee burn to her abdominal area.

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2. Behavioral Evaluation: Depression, Social withdrawal, Resident wants to stay in bed.
6. Abdominal/GI (gastro-intestional) Evaluation: Abdominal Pain, Abdominal Tenderness.
8. Skin Evaluation: Burn, area bright red, and top layer of skin peeling.
9. Pain Evaluation:
*Does the resident have pain?: Yes.
*Is the Pain?: New, abdominal area.
*Intensity of Pain (rate on scale 1-10, with 10 being the worse): 8
*Does the resident show non-verbal signs of pain?: Yes, moaning. Relieved by Tylenol 325 milligrams 2 tablets.
Appearance: S/P (status-post) coffee burn, noted resident's abdominal area to be bright red with top layer of skin peeling.

The Non Ulcer Skin Condition Assessment completed by the facility wound nurse RN (Registered Nurse) #2 dated 7/28/16 at 4:34 p.m. for Resident #25 was reviewed and is documented in part, as follows:

Wound Location: 4-Naval
Wound Type: Burn
Wound Measurements: 21.0 X 15.0 cm (centimeters).
Depth: .1 cm
Exudate: Moderate
Pain With Treatment: True
Pain Scale Score: 1-3 Mild Pain
Pain Meds. (medications) Administered: True
Treatments: ABD Pad, silvadene BID.
Notes: Resident spilled coffee on abdomen and to bilateral legs on 7/26/16 burn now blistered and opened.

Resident #25's Nurses Notes were reviewed and

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are documented in part, as follows:

7/26/16 10:58 p.m.: Resident noted with several blisters to abdomen and left inner thigh, Sites are red and pink.
7/27/16 8:02 p.m.: Resident continue to note several blister intact and open to abdomen and left inner thigh. Site are red and pink. Some amount of drainage was noted but no odor present.
7/28/16 4:39 p.m.: Rec'd (received) this am approximately at 0745 (a.m.) no c/o (complaint) of abd. (abdominal) pain tylenol 325mg given po (by mouth), noted 4 plus erythemia noted to abdominal area, with brown drainage no odor noted some blister noted to be open at this time, treatment done per MD (medical doctor) orders.
7/28/16 5:10 p.m.: Call to update MD on changes to burn. Blisters open pink and yellow areas. No oral ABT (antibiotic) order at this time. MD request Bacitracin and Silvadene Cream alternating days until healed.
7/29/16 12:18 a.m.: Resident awake and alert. Open red areas noted to abdomen with yellow drainage. Dressing placed by wound nurse and remains intact to abdomen. Complained of burning to area. Tylenol given and expressed effectiveness. Adls (activities of daily living) with assist of one. Remained in bed this shift.
7/29/16 1:37 p.m.: Resident alert and responsive, in bed resting quietly. Resident medicated as ordered for pain d/t (due to) s/p (status post) coffee burn. Noted area prior to dressing change. Abdominal area red with yellowish drainage marks noted. 4 fluid filled blisters noted. No odor noted. Treatment rendered.
7/30/16 12:33 p.m.: Resident alert and responsive, skin warm, no s/s (signs or

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symptoms) of distress noted. Treatment rendered for abdominal area d/t s/p coffee burn. Area remains red, fluid filled blisters have erupted, drainage noted, no odor noted. Resident medicated as ordered for c/o (complaint of) pain, with good result noted.
7/31/16 9:59 p.m.: Resident in bed, Medication tolerated denies any discomfort. MD in, and assess resident sites. New order was noted for Ultram PRN (as needed).
8/3/16 2:23 p.m.: Resident in bed alert and responsive, skin warm. Resident medicated for pain d/t s/p burn with good result. Abdominal dressing in place. Wound Dr. (Doctor) to Assess and Tx. (treat).
8/5/16 11:55 a.m.: (Name) Resident #25 has started with restorative nursing for transfers and self care. She has refused to participate and is being treated at this time for 3rd degree burns to her abdomen. Will continue to encourage to participate, and monitor for any further decline.

Resident #25's Physician Progress Note dated 8/9/16 is documented in part, as follows:
F/up (follow-up) Coffee Burn to Abdomen.
Patient stated was in dining room when happened. Stated someone handed her cup of coffee and it spilled. Wound Nurse called me last week, reports looking better. She has been using silvadene cream and just recently changed to bacitracin ointment as healing well.
A.(Assessment)
1. Coffee Burn to Abdomen, 2nd degree Burn.
2. Bipolar
P. (Plan)
Continue current treatment and wound care.

CDC (Centers for Disease Control) DEFINITION OF TYPES OF BURNS: (2)

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First-Degree Burns: First-degree burns involve the top layer of skin. Sunburn is a first degree burn.
Signs:
* Red
* Painful to touch
* Skin will show mild swelling

Second-Degree Burns: Second-degree burns involve the first two layers of skin.
Signs:
* Deep reddening of the skin
* Pain
* Blisters
* Glossy appearance from leaking fluid
* Possible loss of some skin

Third-Degree Burns: A third-degree burn penetrates the entire thickness of the skin and permanently destroys tissue.
Signs:
* Loss of skin layers
* Often painless
* Skin is dry and leathery
* Skin may appear charred or have patches that appear white, brown, or black

Resident #25's Physician Orders were reviewed and documented in part, as follows:

7/26/16: Silvadene cream to apply to affected area BID and PRN until resolved.
7/28/16: 1. D/C Silvadene Cream (6) BID. 2. Apply silvadene cream to affected area on Tuesday, Thursday, and Saturday with telfa and ABD and secure. 3. Apply bacitracin and xeroform with ABD and secure to affected area

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on Monday, Wednesday, Friday, and Sunday until resolved.
7/28/16: (Name) Wound Care Specialist Group, wound physician to evaluate.
7/29/16: OT (occupational therapy) evaluate and treat.
7/31/16: Ultram 50 mg po q(every) 6 hours prn times 2 weeks then d/c.
8/1/16: PT (physical therapy) evaluate and treat.
8/4/16: D/C Silvadene, Bacitracin to upper abdomen/santyl to lower abdomen. Santyl to lower affected area on abdomen, cleanse with normal saline and cover with telfa then abd pads daily.
8/12/16: D/C Bacitracin (7) to upper abdomen. Santyl (8) daily to lower abdomen and cover daily cleanse with NS (normal saline).
8/24/16: D/C Santyl to abdomen area resolved.

Resident #25's Physician Wound Care Specialist Evaluations were reviewed and documented in part, as follows:

8/11/16:
History of Present Illness:
CHIEF COMPLAINT: Patient has a wound on their abdomen.
STATEMENT: At the request of Name (Resident #25's Attending Physician) this 60 year old female was seen and evaluated today. She presents with a burn wound of the left abdomen of at least 1 days duration. There is moderate serous exudate.
Physical Exam: Abdomen: Wound.
Burn Wound Of The Left Abdomen: FOCUSED WOUND EXAM (SITE 1)
ETIOLOGY: Burn
WOUND SIZE (L (length) x W (width) x D (depth): 2.0 x 15.0 x Not Measured cm

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(centimeter).
SURFACE AREA: 30.00 cm squared.
EXUDATE: Moderate Serous
THICK ADHERENT BLACK NECROTIC TISSUE (ESCHAR): 70%
SKIN: 30%
ADDITIONAL INFORMATION: Non black eschar
DRESSINGS: Santyl-Once Daily
REASON FOR NO DEBRIDEMENT: Debridement refused.
Assessment and Plan:
BURN WOUND OF THE LEFT ABDOMEN
INVESTIGATIONS: The total length of this visit was 39 minutes and greater than 50% were spent in counseling and coordination of care specific to A Burn Wound Of The Left Abdomen. New patient, who was burned from hot coffee on the abdomen- now with large burn on her stomach-still with non-black eschar present--Refuses debridement today. Will soften up the eschar for possible debridement next week.

8/16/16:
History of Present Illness:
CHIEF COMPLAINT: Patient has a wound on their abdomen.
STATEMENT: At the request of (Name of Resident #25's Attending Physician) this 60 year old female was seen and evaluated today. She presents with a burn wound of the left abdomen of at least 5 days duration. There is moderate serous exudate.
Physical Exam: Abdomen: Wound.
Burn Wound Of The Left Abdomen: FOCUSED WOUND EXAM (SITE 1)
ETIOLOGY: Burn
WOUND SIZE (L (length) x W (width) x D (depth): 1.0 x 13.5 x Not Measured cm.

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SURFACE AREA: 13.50 cm squared.
EXUDATE: Moderate Serous
THICK ADHERENT BLACK NECROTIC TISSUE (ESCHAR): 25%
SKIN: 75%
WOUND PROGRESS: Improved
DRESSINGS: Santyl-Once Daily
REASON FOR NO DEBRIDEMENT: Debridement refused.
Assessment and Plan:
BURN WOUND OF THE LEFT ABDOMEN-IMPROVED EVIDENCED BY DECREASED SURFACE AREA.

8/23/16:
History of Present Illness:
CHIEF COMPLAINT: Patient has a wound on their abdomen.
STATEMENT: At the request of Name (Resident #25's Attending Physician) this 60 year old female was seen and evaluated today. She presents with a burn wound of the left abdomen of at least 12 days duration. There is exudate. Prior healing wound has improved and required confirmation of current clinical status and evaluation with preventive recommendations to prevent recurrence.
Physical Exam: Abdomen: Normal
Burn Wound Of The Left Abdomen: FOCUSED WOUND EXAM (SITE 1)
ETIOLOGY: Burn
WOUND PROGRESS: Resolved
Assessment and Plan:
BURN WOUND OF THE LEFT ABDOMEN-(RESOLVED ON 8/23/2016)-RESOLVED.

Resident #25's Weekly Skin Assessment dated 2/2/17 at 1:06 p.m. was reviewed and documented in part, as follows:

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Wound Location: Naval
Wound Type: Scar
Status: Still Present
Comments: Abdomen scar measures L (length) 7 x W (Width) 20 cm from previous documented burn.

The facility investigation Witness Statements of Resident #25's Coffee Burn were reviewed and documented in part, as follows:

7/26/16 RN #1 Unit Manager 4th Floor: I was coming out of the kitchen and (Name of Resident #25) had just been served coffee and she kept moving up to the table and back from table that she was sitting at. Then she attempted to grab her coffee and knocked it over instead with her hand onto herself. She then yelled I'm on fire and I told her to come with me so that she could be assessed by a nurse. I took her upstairs with me on elevator and made sure she got beck to 2nd floor and then I told nurse to assess her because she spilled coffee on herself.

7/26/16 CNA (Certified Nursing Assistant) #1: I gave the resident coffee in plastic cup. I filled it halfway. I left her went to another table to serve, heard her yelling turned around and look the coffee was running off the table and she told me she had spilled the coffee on her.

7/26/16 Morning Kitchen Supervisor: During lunch time (Name of Resident #25) was served her juice and coffee in Styrofoam cup. As we were pouring other residents drinks, we heard (Name of Resident #25) scream. Both of us turned into her direction and realized she had

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spilled her cup of coffee in her lap. (Name of CNA) began wiping her and pulling her top from against her skin.

7/26/16 LPN #1: To whom it may concern on a Monday during lunch time. (Name of Resident #25) came to me in a very upset state, she was wet from hot coffee. I immediately assisted resident to her room, removed the wet shirt. I assessed the area. At the time of my initial assessment, area was bright red with top layer of skin peeling. I pat dried the area and apply bacitracin ointment to affected area covered with ABD pads. I then notified the MD made him aware of situation. I received a new Tx. (treatment) order.

7/28/16 Wound Nurse RN #2: This writer went to assess burn to abdomen in resident's room. Resident's abdomen showed redness with blisters noted. Open areas with pink/yellow wound bed. Peri-wound redness noted. Moderate ser-sangious drainage noted. Treatment per MD order silvadene daily. After assessment this writer with unit manager (Name of LPN #2) place call to MD to see if we could get prophylaxis antibiotic to decrease infection. MD order for bacitracin and silvadene alternate thru out the week was given. Treatment was completed per MD order.

On 2/1/17 at 4:30 p.m. an interview was conducted with RN #1 Unit Manager 4th Floor and she was asked to explain what happened the day Resident #25 received a coffee burn. RN #1 stated, "I was in the kitchen, getting ready to walk out. (Name of Resident #25) was at the table and was impulsive moving back and forth. The next I knew she was screaming, "I'm on fire". I turned

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around and she had knocked her cup of coffee over. I took her to the 2nd floor to have her assessed."

On 2/2/17 at 12:00 noon an interview was conducted with LPN #1 and she was asked to explain what happened the day Resident #25 received a coffee burn. LPN #1 stated, "The resident was brought to me on the floor by another nurse. The resident was hysterical, shaking and crying saying coffee spilt on me. I immediately took the resident to her room to assess her. I removed her clothes because she was wet in the abdominal area. She was bright beet red on the abdomen and with in minutes the top layers of skin started peeling. It was a 2nd degree burn. She was in some discomfort, scared and afraid. I gave her something for pain and called the Director of Nursing, the Doctor, and (Name of Responsible Party)."

On 2/2/17 at 12:20 p.m. an interview was conducted with the Wound Nurse RN #2 and she was asked what day she observed the burn area on Resident #25. RN #2 stated, "I heard about the burn. I saw it on 7/28/16 and it was a 2nd degree burn."

On 2/2/17 at 12:45 p.m. an interview was conducted with Resident #25 and she was asked to tell the surveyor about the day she was burned by her coffee. Resident #25 stated, "I was getting a second cup pf coffee and when I got it, it was boiling hot. When I got it, it spilled on me. It burnt me bad; I have a scar and it took a long time to heal. It was burning hot I cried, my skin was peeling off and (Name of LPN #1) kept saying hold your horses."

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On 2/2/17 at 1:15 p.m. an interview was conducted with LPN #2 and she was asked to describe the appearance of Resident #25's abdominal burn area on 7/28/16 when she was with the Wound Nurse assessing it. LPN #2 stated, "I was off when the burn occurred, I went down to look at it with the Wound Nurse. It was red with yellow slough, top layer of skin gone and they had dressed it. We pulled the dressing back and it didn't look the best. (Name of Resident #25) said she was in the dining room at the table, she had gotten coffee,spilled it and burnt herself." Surveyor asked, "What degree burn was it?" LPN #2 stated, "I would say a 2nd degree burn."

On 2/2/17 at 1:30 p.m. an interview was conducted with the Morning Kitchen Supervisor and she was asked prior and up to Resident #25 receiving a coffee burn on 7/26/16 how when was the coffee being temped (temperture taken). The Morning Kitchen Supervisor stated, "We were only testing the coffee before it came to the dining room from the kitchen and it was running at 170 degrees."

According to an American Burn Association document titled "Fire and Burn Safety for Older Adults Educator's Guide", under the heading "General Background Information ...Risk Factors ...Physical Changes", the document read "Older adults experience a myriad of physical and cognitive changes associated with the aging process that makes them more vulnerable to fire and burn injuries... there are significant changes in sensory perception. The ability to see, hear and feel potential fire and burn dangers diminishes proportionally as one gets older...Since older adults also have thinner skin, they may experience a much deeper burn than a younger

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person, when exposed to the same amount of flame or other burn injury source.. Under the heading Working with the Older Adult Population, the document continues "With 12.5% of the population age 65 and older, there is a need to assess and address injury risks affecting them as they age".

According to a second document based on the above Burn Association Kit, found at http://www.ameriburn.org/Preven/2000Prevention/Scald2000PrevetionKit.pdf : "The severity of injury with scalds depends on two factors - the temperature to which the skin is exposed and the length of time that the hot liquid is in contact with the skin... When the temperature of a hot liquid is increased to 140o F / 60o C. it takes only five seconds or less for a serious burn to occur. Coffee, tea, hot chocolate and other hot beverages are usually served at 160 to 180o F./ 71-82o C. degrees, resulting in almost instantaneous burns that require surgery to heal". The two factors addressed above are underscored in a Burn Foundation document: Which states "Hot Water Causes a Third Degree Burns ...
...in 1 second at 156º
...in 2 seconds at 149º
...in 5 seconds at 140º
...in 15 seconds at 133º.
https://www.burnfoundation.org/programs/resource.cfm?c=1&a=3

On 2/3/17 at 9:30 a.m. an interview was conducted with the Administrator. The Administrator asked about the reference of reporting. This surveyor directed the Administrator to the federal regulations and the Office of Licensure and Certification document

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titled "Facility Internal Investigations of Abuse, Neglect, and Misappropriation of Resident Personal Property". The Administrator presented this surveyor with his copy of the Office of Licensure and Certification document titled "Facility Internal Investigations of Abuse, Neglect, and Misappropriation of Resident Personal Property revised 2008". The Administrator was shown and given a copy of the Office of Licensure and Certification document titled "Facility Internal Investigations of Abuse, Neglect, and Misappropriation of Resident Personal Property revised 2014". The Administrator was again asked why the facility failed to report Resident #25's 2nd degree burn from hot coffee to the Office of Licensure and Certification State Agency. The Administrator stated, "I didn't have and wasn't up to date on the current regulations."

The Office of Licensure and Certification document titled "Facility Internal Investigations of Abuse, Neglect, and Misappropriation of Resident Personal Property revised 2014" is documented in part, as follows:

Principle: Nursing facility residents shall be free from abuse, neglect, corporal punishment, involuntary seclusion and misappropriation of resident property.

General Rules:
Unusual Occurrences: Facility procedures and protocols should include unusual incidents or occurrences to their reporting criteria and report any such occurrences immediately, if applicable. Examples of unusual occurrences include:
-Any event involving a resident that is likely to result in legal action;
-Medication errors that result in the resident being

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hospitalized or dying;
-Suicides-attempted or successful;
-Death or serious injury associated with the use of restraints;
-Ingestion of toxic substances requiring medical intervention;
-Accidents or injuries of known origin that are unusual, e.g., a resident falling out of a window, a resident exiting the facility and sustaining an injury on facility property, or a resident being burned;
-A resident procuring and ingesting enough medication to result in an overdose; and
-Any unusual event involving a resident or residents that may result in media coverage.

On 2/2/17 at 4:20 p.m. a pre-exit interview was conducted with the Administrator and the Director of Nursing where the above findings were shared. Prior to exit the no further information was provided.

(1) Psychosis: any major mental disorder of organic or emotional origin characterized by a gross impairment in reality testing, in which the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect references about external reality, even in the face of contrary evidence.

(2) Major Depressive Disorder: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality.

(3) Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms

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range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal.

(4) Bipolar Disorder: a major mental disorder characterized by episodes of mania, depression, or mixed mood.
(1), (2), (3), (4) The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(5) Burn: is defined as any injury to tissues of the body caused by hot objects or flames, electricity, chemicals, radiation, or gases in which the extent of the injury is determined by the nature of the agent, length of time exposed, body part involved and depth of burn. Second-degree burns may be divided into superficial partial-thickness and deep partial-thickness wounds. Damage in second-degree burns extends through the epidermis to the dermis but is usually not sufficient to prevent skin regeneration.
The above definition was derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(6) Silvadene: Sulfadiazine, having bactericidal activity against many gram-positive and gram-negative organisms, as well as being effective against yeasts; used as a topical antiinfective for the prevention and treatment of wound sepsis in patients with second and third degree burns.
The above definition was derived from Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health 7th Edition.

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F 225	Continued From page 22 (7) Bacitracin: An antibacterial, a common component of topical antibiotic ointments used for treating skin infections. (8) Santyl: Trademark for an enzyme (collagenase). A medication applied as an ointment for debridement of decubitus ulcers, burns, and other epidermal lesions. (7) (8) The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 225		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and facility document review the facility staff failed to provide the necessary	F 314	Past noncompliance: no plan of correction required.	2/24/17

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treatment and services, consistent with professional standards of practice, to prevent pressure ulcers from developing for 1 of 54 residents in the survey sample, Resident #12.

The facility staff failed to provide appropriate monitoring (1) for Resident #12 who was assessed as at risk for pressure ulcer development. As a result, a newly developed pressure ulcer (2) was not identified until it had advanced to a stage III (3). The left ankle pressure ulcer was first identified on 9/2/16.

The findings included:

Resident #12 was admitted to the facility on 3/5/16 with diagnoses to include diabetes and stroke with left sided hemiplegia (weakness on one side of the body).

The significant change MDS (Minimum Data Set) with an assessment reference date of 9/2/16 coded the resident as scoring a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired daily decision making skills. The resident required extensive assistance of two staff for bed mobility (how a resident moves to and from lying position, turns side to side, and positions body while in bed). The resident did not exhibit any behaviors that would interfere with resident care or exhibit rejection of care. The resident weighed 172 pounds and did not trigger for weight loss. The resident was coded as having a stage III pressure ulcer.

On the Braden Scale Pressure Ulcer Risk Assessments dated 3/15/16 the resident scored a 10, and on 12/23/16 scored a 12. Both scores

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indicated the resident was at high risk for pressure ulcer development.

The comprehensive plan of care dated 3/14/16 identified the resident was at risk for developing skin breakdown due to need of extensive/total assistance with bed mobility and incontinence of bowel and bladder. The goal was the resident will have intact skin, free of redness, blisters, or discoloration over bony prominence through the next review date. Approaches to achieve the goal included; report changes in skin status (i.e., signs and symptoms of infection, non-healing, new areas) to physician, assist PRN (as needed) to reposition/ shift weight to relieve pressure, minimize pressure over bony prominences, complete Weekly Skin Checks, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing or daily care.

A facility internal Event Report dated 9/2/16 evidenced the resident was first identified with a newly developed pressure ulcer-stage III to the left ankle. The pressure ulcer was found by the Restorative Aide during treatment. Predisposing Factors were listed as: Non-Ambulatory, Non-Compliance to Turn and Reposition, Incontinence of Urine and Bowel, and Resists care. Nursing interventions included preventative skin care, elevation/ float heels, protection of body prominences. Additional information listed Prevalon boots (4) "reapplied with new ones".

Review of the clinical nurses notes, comprehensive plan of care and the current MDS failed to evidence any behaviors of non-compliance with turning and repositioning/ resistance of care; as noted on the

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aforementioned Event Report.

Furthermore, the Director of Nursing (DON) and the Unit 2 (name of unit) nurse manager were not able to provide any evidence to support the resident had exhibited any behaviors of non-compliance with turning and repositioning/ resistance of care.

The facility wound nurse assessed the newly developed stage III pressure ulcer on 9/2/16. The ulcer measured 1.5 cm (centimeters) x 1.0 cm x 0.2 cm., tissue types were granulation and slough (5). The wound nurse documented the resident was her own responsible party and was educated on the importance of off loading heels off mattress and new treatment to aide in healing.

New physician orders dated 9/2/16 included Prevalon boots (heel protectors) to be worn while in bed every shift except during ADL (activities of daily living) care, diagnosis: preventive.

The Wound Care Specialist Evaluation dated 9/6/16 read, in part: Stage 3 Pressure Wound of the left lateral (side) ankle, etiology-pressure. Wound size- 1.0 cm x 0.7 cm, depth not measured, 40% black necrotic (6) tissue, 60% granulation. The wound was debrided (7) by surgical excision. Treatment orders were for daily dressing changes with Santyl (a debriding ointment) and calcium alginate dressing (a type of dressing that forms into a gel when it comes into contact with liquid) once a day.

The Wound Care Specialist evaluated the resident's left ankle pressure ulcer weekly from 9/6/16 through 11/11/16. The wound required

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surgical excisional debridement to remove dead tissue to aide in healing on the following dates: 9/6, 9/13, 9/20, 9/26, and 10/4/16. The left ankle pressure ulcer was noted as resolved on 11/11/16.

On 2/1/17 at 10:00 a.m., and 6:00 p.m. the resident was observed in bed. The resident continued to be confused and speaking nonsensical. The Prevalon boots were on the resident's feet both times.

The Treatment Administration Record (TAR) for August 2016 was reviewed. The TAR failed to evidence Resident #12 was provided Prevalon boots and or any other documentation of off loading/ protection of skin to the residents ankles prior to the development of the stage III pressure ulcer.

On 2/2/17 from 12:00 p.m. to 1:30 p.m., an interview was conducted with the Director of Nursing (DON) and the above findings was shared. The DON stated all refusals of care are to be documented by the CNAs (Certified Nurse Aides) and reported to the nurse. The nurse was then responsible to revise the plan of care to include this behavior. The pressure ulcer prevention program included the CNAs to observe and monitor for changes in skin condition during the provision of twice weekly showers and daily baths. If a change is observed they are to be reported immediately to the nurse and documented on the shower sheet. The nurse should then go and do a full skin assessment. She stated that the nurses should be checking pressure points during provision of direct care every day. She stated she would have expected

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the CNAs to have found the skin changes to the residents left ankle prior to it being found at an advanced stage. She further stated, "If it was found with blanchable (8) redness we could have got right on it...put on boots right then and there...off load heels, off the surface not just put pillows underneath...have OT (occupational therapy) screen/evaluate for other options for off loading." The DON was asked about monitoring and stated, "That's a problem we had been trying to fix, to get the CNAs to do what they say they are doing." The DON stated they had identified concerns with their pressure ulcer prevention program in November (2016).

The above findings was further shared with the Administrator and the DON at an end of day briefing on 2/2/17 at 4:20 p.m. A copy of the Performance Improvement Action Plan developed on 11/15/16 was reviewed. In addition to the Action Plan the Administrator stated changes were also made within the clinical nurse managers. The DON stated a 100% body sweep was also conducted (a skin assessment on all residents) at this time, no additional facility acquired pressure ulcers were identified.

On the morning of 2/3/17 the DON provided additional information to the survey team for review. This additional information was reviewed with the DON from 12:00 p.m.- 1:20 p.m. The DON stated the facility staff failed to monitor Resident #12's skin (ankles) for changes, stating, "It didn't just open up...the resident is dependent on staff to do their job".

The Performance Improvement Action Plan dated 11/15/16 read, in part:
Topic/Opportunity/Problem: Decrease In House

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F 314	Continued From page 28 Acquired Pressure Ulcers Action/Interventions: 1. Admitting nurse will complete skin assessment and document and Braden Score within 4 hours of arrival. 2. Assigned nurse will complete weekly skin checks and document in Woundsense (electronic record). 3. Assigned CNA will complete a full body assessment and document on Shower sheet. 4. Daily skin assessment during ADL's. 5. All residents identified as being high risk of breakdown will be placed on a Specialty Mattress according to policy. 6. Frequent rounding on high risk resident to assure all interventions in place. 7. Risk Management meeting held every Friday with IDT (interdisciplinary team). 8. Careplans to be completed with resident specific interventions. 9. Assure communication to line staff of intervention implemented. 10. If a decubitus (pressure ulcer) occur, ensure the following: Assessment of wound and location, Notify MD, responsible party, obtain order for treatment procedure, document in Woundsense, document in event manager, new decubitus and interventions are communicated to line staff, careplan to be updated with new interventions, evaluate for effectiveness of intervention, identify if any other consultations or interventions are required, document response in medical record. Compliant date 1/4/17. There were no other concerns identified during the survey with pressure ulcers. Citation F-314 will be cited as Past Non-Compliance. The facility policy titled "Pressure Ulcer Risk	F 314		

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Assessment" (not dated) read, in part: The purpose of this procedure is to provide guidelines for assessment and identification of residents at risk for developing pressure ulcer.
Assessment:
1. Risk Assessment- A pressure ulcer risk assessment will be completed upon admission, and then weekly x 1, with significant changes, and quarterly.
2. Skin Assessment- Skin will be assessed for the presence of developing pressure ulcer on a weekly basis or more frequently if indicated.
*3. Monitoring:
a. Staff will perform routine skin inspections (with daily care).
b. Nurses are to be notified to inspect the skin if skin changes are identified.
c. Nurses will conduct skin assessments at least weekly to identify changes.

(1) Monitoring - At least daily, staff should remain alert to potential changes in the skin condition & should evaluate & document identified changes. National Pressure Ulcer Advisory Panel (NPUAP)

(2) Pressure Ulcer - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). (NPUAP)

(3) Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. (NPUAP)

(4) The Prevalon Heel Protector was specifically designed to address the problem of patient

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F 314	Continued From page 30 movement and its negative effect on heel offloading. Prevalon's unique dermasuede fabric interior gently grips the limb so it remains fully offloaded, even when the patient is moving. http://www.medline.com/product/Prevalon-Heel-Protectors-by-Sage-Products/Z05-PF26037/ (5) Slough tissue is yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous. (RAI-Resident Assessment Instrument) (6) Necrotic (dead) or devitalized tissue that has lost its usual physical properties & biological activity. (NPUAP) (7) Debridement - Debridement is the removal of devitalized/necrotic tissue & foreign matter from a wound to improve or facilitate the healing process. Various debridement methods include: Sharp or surgical debridement refers to removal of foreign material or devitalized tissue by a surgical instrument. (NPUAP) (8) Blanchable skin test- Press on the red, pink or darkened area with your finger. The area should go white; remove the pressure and the area should return to red, pink or darkened color within a few seconds, indicting good blood flow. skilledwoundcare.com/pressure-ulcers	F 314		
F 323 SS=K	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		3/3/17

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F 323	Continued From page 31 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on a resident group interview, clinical record review, observations, staff interviews, and facility document review the facility staff failed to ensure safe coffee temperatures on 7/26/16 to prevent an avoidable accident for Resident #25 resulting in second degree abdominal burns after spilling hot coffee on herself, and on 2/1/17 during the survey the coffee served to Residents #26, #27, #28, #29, and #30 in the dining room at 5:45 p.m. was identified at temperatures sufficient to cause third degree burns resulting in the identification of Immediate Jeopardy. The findings included:	F 323	Residents #26,#27,#28,#29,#30 Facility immediately educated Dietary Staff on new standard of hot liquid service temps. All residents at the center have the potential for this deficiency. "Facility had vendor adjusted brewing temperatures on coffee /hot water pot brew at 180degrees. "Dietary Staff educated on proper serving temp on hot liquids and completed competency tests. "Floor staff educated on proper serving	

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F 323	Continued From page 32 On 2/1/17 at 10:30 a.m. during the Resident Group Interview with 15 residents present, the residents were asked about their coffee grievance in their resident council minutes. The resident council president stated, "Coffee has been a problem since that lady got burned." On 2/1/17 at approximately 12:00 noon the Administrator was asked if he had a resident that had been burned from hot coffee and if the resident had significant injuries. The Administrator stated, "Yes, there was a resident burned after spilling her coffee and she did have a pretty significant burn." The Administrator was asked to see a copy of the Facility Reported Incident (FRI) that was sent to the Office of Licensure and Certification regarding the burn. The Administrator stated, "I did not do a FRI because we knew how the injury occurred, it was not an injury of unknown origin." The Administrator was then asked to see his investigation documentation for the burn which was provided. A review of the facility investigation was completed and Resident #25 was added to the survey sample. Resident #25 was a 60 year old admitted to the facility on 1/1/15 with diagnosis to include Psychosis (1), Major Depressive Disorder (2), Anxiety Disorder (3), and Bipolar Disorder (4). The most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 1/20/17. The Brief Interview for Mental Status (BIMS) was a 15 out	F 323	temp on hot liquids. "Hot liquid will be tested for temp every 15 minutes and will not leave the kitchen until it is 155 degrees or under. Resident coffee will only come from the kitchen "Nursing completed a hot liquid assessment on each resident "Care plans will be updated to reflect resident-specific interventions. "Immediately ordered mugs & lids for all hot liquids "Floor staff will add sugar/cream at point of service. "Coffee will be served with appropriate lids The dietary manager /designee will review coffee/hot water temperature logs daily. Any findings will be presented at the QAPI committee immediately and reviewed monthly at QAPI meeting.	

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of a possible 15 which indicated Resident #25 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as being independent with setup help only.

Resident #25's Interdisciplinary Care Plan dated 7/26/16 documented in part, as follows:

Impaired Skin Integrity

7/26/16-Problem: Resident has disruption of skin surface, not related to pressure
*Burn-location-Abdomen.

Goal: The resident's disruption of skin surface will remain free from infection and show evidence of healing by- 90 days.

Approach:
7/26/16
*Wound care as ordered, see current treatment record and physician's orders; observe effectiveness of/response to treatment as ordered.

*Observe for pain and medicate PRN (as needed) per physician's order.

*Silvadene cream to affected area BID (twice a day).

7/28/16
*D/C (discontinue) silvadene cream BID, silvadene cream to affected area Tuesday, Thursday, and Saturday with telfa and ABD (absorbent breathable dressing) PAD then secure. Bacitracin and xerofoam with ABD and

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secure Monday, Wednesday, and Friday. (Company Name) wound physicians to evaluate.

7/29/16
*Coffee cup with lid.
*Coffee temperature not to exceed 180 degrees. (The 180 degrees was marked out and 150 degrees was added.)

8/4/16
*D/C silvadene, bacitracin to upper abdomen, santyl to lower abdomen, clean with normal saline and cover with telfa and ABD pads.

8/12/16
*D/C Bacitracin, continue santyl to lower abdomen daily.

Resolved 8/26/16.

The Nursing Assessment for Resident #25 dated 7/26/16 at 12:15 p.m. was reviewed and is documented in part, as follows:

Category: Burn (2nd Degree or Greater)- @ (at) 2nd degree
Creator Name: (Name) Licensed Practical Nurse (LPN) #1.
Indicated Locations: Dining Room.
Detailed Description: Resident spilled cup of hot coffee on herself.
Description and Patient Assessment: Resident was attempting to drink a cup of coffee, when resident accidentally spilled the hot coffee on herself. Upon assessment noted resident's abdominal area to be red and blistering. Zinc Oxide applied.
Burn specific information:
*Burn location: Abdominal area.

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*Cause of burn known: Yes, hot coffee.
*Patient knows how burn occurred: Yes, Resident was reaching for coffee cup, when cup spilled over onto residents abdominal area.
*Patient location when burn occurred: Dining Room.
*Any Additional Information: New order received for Silvadene cream to be applied to affected area BID and as needed until resolved.
Diagnosis: Depression and Anxiety Disorder
Vital Signs:
*Blood Pressure: 178/108
*Pulse: 88
*Respirations: 18
*Temperature: 98.0
Cognitions: Alert
Notifications and Orders:
*Doctor: 7/26/16 at 12:20 p.m.
*Family: 7/26/16 at 12:30 p.m.
*DNS (Director of Nursing Services): 7/26/16 at 12:30 p.m.
First aid/treatment Information: Zinc oxide applied to affected area with protective nonstick border gauze applied.
Bodily Injuries: Abdominal
*Burn: 2nd Degree
*Burn Description (5): Hot coffee spilled on resident.
*Pain: Yes
*Pain Verbal: 5
Nursing Interventions:
*Were any new nursing interventions implemented? No
Care Plans: Care Plan Reviewed.

The SBAR (Situation Background Assessment Recommendation) tool completed by LPN #1 for Resident #25 dated 7/31/16 was reviewed and is

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documented in part, as follows:

Situation: The change in condition, symptoms, or signs observed and evaluated is/are: Resident was burned with hot coffee.

This started on: 07/26/2016

Vital Signs:
BP (blood pressure) 178/108
Pulse: 88

Resident Evaluation:
1. Mental Status Evaluation: Resident in pain d/t (due to) 2nd degree coffee burn to her abdominal area.
2. Behavioral Evaluation: Depression, Social withdrawal, Resident wants to stay in bed.
6. Abdominal/GI (gastro-intestional) Evaluation: Abdominal Pain, Abdominal Tenderness.
8. Skin Evaluation: Burn, area bright red, and top layer of skin peeling.
9. Pain Evaluation:
*Does the resident have pain?: Yes.
*Is the Pain?: New, abdominal area.
*Intensity of Pain (rate on scale 1-10, with 10 being the worse): 8
*Does the resident show non-verbal signs of pain?: Yes, moaning. Relieved by Tylenol 325 milligrams 2 tablets.
Appearance: S/P (status-post) coffee burn, noted resident's abdominal area to be bright red with top layer of skin peeling.

The Non Ulcer Skin Condition Assessment completed by the facility wound nurse RN (Registered Nurse) #2 dated 7/28/16 at 4:34 p.m. for Resident #25 was reviewed and is documented in part, as follows:

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Wound Location: 4-Naval
Wound Type: Burn
Wound Measurements: 21.0 X 15.0 cm (centimeters).
Depth: .1 cm
Exudate: Moderate
Pain With Treatment: True
Pain Scale Score: 1-3 Mild Pain
Pain Meds. (medications) Administered: True
Treatments: ABD Pad, silvadene BID.
Notes: Resident spilled coffee on abdomen and to bilateral legs on 7/26/16 burn now blistered and opened.

Resident #25's Nurses Notes were reviewed and are documented in part, as follows:

7/26/16 10:58 p.m.: Resident noted with several blisters to abdomen and left inner thigh, Sites are red and pink.
7/27/16 8:02 p.m.: Resident continue to note several blister intact and open to abdomen and left inner thigh. Site are red and pink. Some amount of drainage was noted but no odor present.
7/28/16 4:39 p.m.: Rec'd (received) this am approximately at 0745 (a.m.) no c/o (complaints) of abd. (abdominal) pain tylenol 325mg given po (by mouth), noted 4 plus erythemia noted to abdominal area, with brown drainage no odor noted some blister noted to be open at this time, treatment done per MD (medical doctor) orders.
7/28/16 5:10 p.m.: Call to update MD on changes to burn. Blisters open pink and yellow areas. No oral ABT (antibiotic) order at this time. MD request Bacitracin and Silvadene Cream alternating days until healed.
7/29/16 12:18 a.m.: Resident awake and alert.

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Open red areas noted to abdomen with yellow drainage. Dressing placed by wound nurse and remains intact to abdomen. Complained of burning to area. Tylenol given and expressed effectiveness. Adls (activities of daily living) with assist of one. Remained in bed this shift.
7/29/16 1:37 p.m.: Resident alert and responsive, in bed resting quietly. Resident medicated as ordered for pain d/t (due to) s/p (status post) coffee burn. Noted area prior to dressing change. Abdominal area red with yellowish drainage marks noted. 4 fluid filled blisters noted. No odor noted. Treatment rendered.
7/30/16 12:33 p.m.: Resident alert and responsive, skin warm, no s/s (signs or symptoms) of distress noted. Treatment rendered for abdominal area d/t s/p coffee burn. Area remains red, fluid filled blisters have erupted, drainage noted, no odor noted. Resident medicated as ordered for c/o (complaint of) pain, with good result noted.
7/31/16 9:59 p.m.: Resident in bed, Medication tolerated denies any discomfort. MD in, and assess resident sites. New order was noted for Ultram PRN (as needed).
8/3/16 2:23 p.m.: Resident in bed alert and responsive, skin warm. Resident medicated for pain d/t s/p burn with good result. Abdominal dressing in place. Wound Dr. (Doctor) to Assess and Tx. (treat).
8/5/16 11:55 a.m.: (Name of Resident #25) has started with restorative nursing for transfers and self care. She has refused to participate and is being treated at this time for 3rd degree burns to her abdomen. Will continue to encourage to participate, and monitor for any further decline.

Resident #25's Physician Progress Note dated

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8/9/16 is documented in part, as follows:
F/up (follow-up) Coffee Burn to Abdomen. Patient stated was in dining room when happened. Stated someone handed her cup of coffee and it spilled. Wound Nurse called me last week, reports looking better. She has been using silvadene cream and just recently changed to bacitracin ointment (6) as healing well.
A. (Assessment)
1. Coffee Burn to Abdomen, 2nd degree Burn (7).
2. Bipolar
P. (Plan)
Continue current treatment and wound care.

Resident #25's Physician Orders were reviewed and documented in part, as follows:

7/26/16: Silvadene cream (8) to apply to affected area BID and PRN until resolved.
7/28/16: 1. D/C Silvadene Cream BID. 2. Apply silvadene cream to affected area on Tuesday, Thursday, and Saturday with telfa and ABD and secure. 3. Apply bacitracin and xeroform with ABD and secure to affected area on Monday, Wednesday, Friday, and Sunday until resolved.
7/28/16: (Name of Wound Care Specialist Group), wound physician to evaluate.
7/29/16: OT (occupational therapy) evaluate and treat.
7/31/16: Ultram 50mg po q (every) 6 hours prn times 2 weeks then d/c.
8/1/16: PT (physical therapy) evaluate and treat.
8/4/16: D/C Silvadene, Bacitracin to upper abdomen/santyl to lower abdomen. Santyl (8) to lower affected area on abdomen, cleanse with normal saline and cover with telfa then abd pads daily.

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8/12/16: D/C Bacitracin to upper abdomen. Santyl daily to lower abdomen and cover daily cleanse with NS (normal saline).
8/24/16: D/C Santyl to abdomen area resolved.

Resident #25's Physician Wound Care Specialist Evaluations were reviewed and documented in part, as follows:

8/11/16:
History of Present Illness:
CHIEF COMPLAINT: Patient has a wound on their abdomen.
STATEMENT: At the request of (Name of Resident #25's Attending Physician) this 60 year old female was seen and evaluated today. She presents with a burn wound of the left abdomen of at least 1 days duration. There is moderate serous exudate.
Physical Exam: Abdomen: Wound.
Burn Wound Of The Left Abdomen: FOCUSED WOUND EXAM (SITE 1)
ETIOLOGY: Burn
WOUND SIZE (L (length) x W (width) x D (depth): 2.0 x 15.0 x Not Measured cm.
SURFACE AREA: 30.00 cm squared.
EXUDATE: Moderate Serous
THICK ADHERENT BLACK NECROTIC TISSUE (ESCHAR): 70%
SKIN: 30%
ADDITIONAL INFORMATION: Non black eschar
DRESSINGS: Santyl-Once Daily
REASON FOR NO DEBRIDEMENT: Debridement refused.
Assessment and Plan:
BURN WOUND OF THE LEFT ABDOMEN
INVESTIGATIONS: The total length of this visit was 39 minutes and greater than 50% were spent in counseling and coordination of care specific to

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A Burn Wound Of The Left Abdomen. New patient, who was burned from hot coffee on the abdomen- now with large burn on her stomach-still with non-black eschar present--Refuses debridement today. Will soften up the eschar for possible debridement next week.

8/16/16:
History of Present Illness:
CHIEF COMPLAINT: Patient has a wound on their abdomen.
STATEMENT: At the request of (Name of Resident #25's Attending Physician) this 60 year old female was seen and evaluated today. She presents with a burn wound of the left abdomen of at least 5 days duration. There is moderate serous exudate.
Physical Exam: Abdomen: Wound.
Burn Wound Of The Left Abdomen: FOCUSED WOUND EXAM (SITE 1)
ETIOLOGY: Burn
WOUND SIZE (L (length) x W (width) x D (depth): 1.0 x 13.5 x Not Measured cm.
SURFACE AREA: 13.50 cm squared.
EXUDATE: Moderate Serous
THICK ADHERENT BLACK NECROTIC TISSUE (ESCHAR): 25%
SKIN: 75%
WOUND PROGRESS: Improved
DRESSINGS: Santyl-Once Daily
REASON FOR NO DEBRIDEMENT:
Debridement refused.
Assessment and Plan:
BURN WOUND OF THE LEFT ABDOMEN-IMPROVED EVIDENCED BY DECREASED SURFACE AREA.

8/23/16:

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History of Present Illness:
CHIEF COMPLAINT: Patient has a wound on their abdomen.
STATEMENT: At the request of (Name of Resident #25's Attending Physician) this 60 year old female was seen and evaluated today. She presents with a burn wound of the left abdomen of at least 12 days duration. There is exudate. Prior healing wound has improved and required confirmation of current clinical status and evaluation with preventive recommendations to prevent recurrence.
Physical Exam: Abdomen: Normal
Burn Wound Of The Left Abdomen: FOCUSED WOUND EXAM (SITE 1)
ETIOLOGY: Burn
WOUND PROGRESS: Resolved
Assessment and Plan:
BURN WOUND OF THE LEFT ABDOMEN-(RESOLVED ON 8/23/2016)-RESOLVED.

Resident #25's Weekly Skin Assessment dated 2/2/17 at 1:06 p.m. was reviewed and documented in part, as follows:

Wound Location: Naval
Wound Type: Scar
Status: Still Present
Comments: Abdomen scar measures L (length) 7 x W (Width) 20 cm from previous documented burn.

The facility investigation Witness Statements of Resident #25's Coffee Burn were reviewed and documented in part, as follows:

7/26/16 RN #1 Unit Manager 4th Floor: I was coming out of the kitchen and (Name of Resident

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#25) had just been served coffee and she kept moving up to the table and back from table that she was sitting at. Then she attempted to grab her coffee and knocked it over instead with her hand onto herself. She then yelled I'm on fire and I told her to come with me so that she could be assessed by a nurse. I took her upstairs with me on elevator and made sure she got beck to 2nd floor and then I told nurse to assess her because she spilled coffee on herself.

7/26/16 CNA (Certified Nursing Assistant) #1: I gave the resident coffee in plastic cup. I filled it halfway. I left her went to another table to serve, heard her yelling turned around and look the coffee was running off the table and she told me she had spilled the coffee on her.

7/26/16 Morning Kitchen Supervisor: During lunch time (Name of Resident #25) was served her juice and coffee in Styrofoam cup. As we were pouring other residents drinks, we heard (Name of Resident #25) scream. Both of us turned into her direction and realized she had spilled her cup of coffee in her lap. (Name of CNA) began wiping her and pulling her top from against her skin.

7/26/16 LPN #1: To whom it may concern on a Monday during lunch time. (Name of Resident #25) came to me in a very upset state, she was wet from hot coffee. I immediately assisted resident to her room, removed the wet shirt. I assessed the area. At the time of my initial assessment, area was bright red with top layer of skin peeling. I pat dried the area and apply bacitracin ointment to affected area covered with ABD pads. I then notified the MD made him aware of situation. I received a new Tx.

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(treatment) order.

7/28/16 Wound Nurse RN #2: This writer went to assess burn to abdomen in resident's room. Resident's abdomen showed redness with blisters noted. Open areas with pink/yellow wound bed. Peri-wound redness noted. Moderate ser-sangious drainage noted. Treatment per MD order silvadene daily. After assessment this writer with unit manager Name (LPN #2) place call to MD to see if we could get prophylaxis antibiotic to decrease infection. MD order for bacitracin and silvadene alternate thru out the week was given. Treatment was completed per MD order.

On 2/1/17 at 4:30 p.m. an interview was conducted with RN #1 Unit Manager 4th Floor and she was asked to explain what happened the day Resident #25 received a coffee burn. RN #1 stated, "I was in the kitchen, getting ready to walk out. (Name of Resident #25) was at the table and was impulsive moving back and forth. The next I knew she was screaming, "I'm on fire". I turned around and she had knocked her cup of coffee over. I took her to the 2nd floor to have her assessed."

On 2/2/17 at 12:00 noon an interview was conducted with LPN #1 and she was asked to explain what happened the day Resident #25 received a coffee burn. LPN #1 stated, "The resident was brought to me on the floor by another nurse. The resident was hysterical, shaking and crying saying coffee spilt on me. I immediately took the resident to her room to assess her. I removed her clothes because she was wet in the abdominal area. She was bright beet red on the abdomen and with in minutes the

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top layers of skin started peeling. I was a 2nd degree burn. She was in some discomfort, scared and afraid. I gave her something for pain and called the Director of Nursing, the Doctor, and (Name of Responsible Party)."

On 2/2/17 at 12:20 p.m. an interview was conducted with the Wound Nurse RN #2 and she was asked what day she observed the burn area on Resident #25. RN #2 stated, "I heard about the burn. I saw it on 7/28/16 and it was a 2nd degree burn."

On 2/2/17 at 12:45 p.m. an interview was conducted with Resident #25 and she was asked to tell the surveyor about the day she was burned by her coffee. Resident #25 stated, "I was getting a second cup pf coffee and when I got it, it was boiling hot. When I got it, it spilled on me. It burnt me bad I have a scar and it took a long time to heal. It was burning hot I cried, my skin was peeling off and (Name of LPN #1) kept saying hold your horses."

On 2/2/17 at 1:15 p.m. an interview was conducted with LPN #2 and she was asked to describe the appearance of Resident #25's abdominal burn area on 7/28/16 when she was with the Wound Nurse assessing it. LPN #2 stated, "I was off when the burn occurred, I went down to look at it with the Wound Nurse. It was red with yellow slough, top layer of skin gone and they had dressed it. We pulled the dressing back and it didn't look the best. (Name of Resident #25) said she was in the dining room at the table, she had gotten coffee,spilled it and burnt herself." Surveyor asked, "What degree burn was it?" LPN #2 stated, "I would say a 2nd degree burn."

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F 323	Continued From page 46 On 2/2/17 at 1:30 p.m. an interview was conducted with the Morning Kitchen Supervisor and she was asked prior and upto Resident #25 receiving a coffee burn on 7/26/16 how when was the coffee being temped. The Morning Kitchen Supervisor stated, "We were only testing the coffee before before it came to the dining room from the kitchen and it was running at 170 degrees." The Administrator provided a Quality Performance/Facility Plan of Action dated 7/29/16 with a completed date of 8/31/16 for review by surveyor and is documented in part, as follows: DEFICIENCY IDENTIFIED: Unsafe practice of using a Styrofoam 16 ounce cup with coffee without a protective lid. 1. Immediate Corrective Action for Residents Affected: -Document efforts to remove the causative factors. (removal of coffee pot) Styrofoam cups for hot liquids. 2. Identification of Residents with potential to be affected: -Nursing to complete a hot liquid assessment on each resident. -Plant operations inspected coffee maker for proper functioning. 3. Measures or systems changes to prevent reoccurrence: -In-service 100% staff on identification of potential risk areas such as common areas without protective lid on cup which exposes all residents for injury. -Remove all coffee pots from the entire building	F 323		

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that are not in dining room for inspection and temperature logs documentation.
-Dietary Manager will be in-serviced on temperature logs and daily monitoring.
-Staff will be educated 100% on Hot Liquid Policy and Procedure.

4. Monitoring changes/systems to ensure no deficient practice:
-Plant operations will maintain a weekly check on coffee maker and all other hot beverage appliances to ensure compliance and required temperature.
-Random testing of coffee maker temperatures will be conducted weekly and reported to Quality Assurance meeting monthly.
-Random testing of coffee being served to residents is in proper cup with lid weekly and submitted.

The facility policy and procedure titled "SAFE HANDLING AND SERVING TEMPERATURES FOR HOT BEVERAGES" revised 7/29/16 that per the Director of Nursing was the policy used to educate staff on Hot Liquids was reviewed and documented in part, as follows:

Policy: The temperatures that hot beverages should be served at are governed by palatability and by the risk for a burn.

Procedure:
4. Skin on the arms and legs-being less sensitive than the mouth-can suffer a burn before the danger is realized. The elderly who are immobilized in a wheelchair and confused residents are more susceptible.

5. Because of this susceptibility, follow the

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following safety precautions:
a. Serve the hot beverages between 140 and 155 degrees. Dietary should record hot beverage temperatures for every meal.
c. Residents at high risk for spillage should be assisted as needed. Recommend using an insulated mug with a lid for all hot beverages when needed.
d. A staff member should pour the hot beverages, in a manner that protects the resident's safety. Fill hot beverage mugs to 75% or less of their capacity.
g. Transfer hot beverages from the urns or warmer to a serving container which may cause the temperature to drop.

6. When serving hot liquids to residents with behavioral or medical conditions that put them at risk for spills, consider the following:
b. Allow hot liquids to cool before serving.

The facility HOT LIQUIDS SAFETY EVALUATION for residents was reviewed for Resident #25 and documented in part as follows:

Date: 7/29/2016
Risk Factors: checked for Resident #25:
Mood-varies over course of day/easily agitated.
Behaviors-Frequent impulsive acts/short tempered.
Total check marks 2 indicating the resident is at risk for injury from spills of hot liquids.

Interventions for Resident #25 dated 7/29/16:
-Resident to use cup with lid.
-Temperature of liquid not to exceed 180 degrees.
-Staff to assist resident with all hot liquids.

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The Hot Coffee Temperature Logs were reviewed from July 2016 through January 2017. The Dietary Manager stated, "These temperatures were the temperature of the coffee coming from the kitchen into the dining room." The Hot Coffee temperatures ranged from the following:

Month	High	Low
July 2016	190	174
August 2016	190	173
September 2016	182	170
October 2016	175	170
November 2016	170	170
December 2016	180	170
January 2017	175	170

On 2/1/17 at 5:30 p.m. in the facility dining room with two surveyors present 5 Residents asked and received a cup of coffee during their dinner meal, Residents #26 through #30. After each resident received their cup of coffee, they removed the lids and began drinking the coffee. Two extra cups of coffee were left over and this surveyor immediately asked the Dietary Aide to obtain a coffee temperature. The coffee temperature was 159.9 degrees in the first cup and 161.1 degrees in the second cup. Prior to checking the coffee temperatures the Dietary Aide stated, "I checked the temperature of the coffee before I brought it out of the kitchen and it's ok, it was under the 170 degrees." After the Dietary Aide temped the coffee no staff in the dining room proceeded to remove or replace the coffee from the 5 residents drinking coffee.

Resident #26 was a 63 year old admitted to the facility originally on 4/26/11 and readmitted on 7/1/16 with diagnoses to include Hypertension (10) and Depression (11).

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The most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 11/16/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #26 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating= the resident was coded as needing supervision with setup help only.

Resident #27 was a 84 year old admitted to the facility on 3/6/15 with diagnoses to include Hypertension and Left Eye Blindness (absence of sight).

The most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 2/3/17. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #27 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating= the resident was coded as being independent with setup help only.

Resident #28 was a 53 year old admitted to the facility on 1/28/15 with diagnoses to include Depression and Dementia (12).

The most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 1/27/17. The Brief Interview for Mental Status (BIMS) indicated the resident has short and long term memory problems and had modified independence in

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cognitive skills for daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating= the resident was coded as being independent with setup help only.

Resident #29 was a 58 year old admitted to the facility originally on 11/17/15 and readmitted on 4/2/16 with diagnoses to include Hypertension and Arthritis (13).

The most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 11/21/16. The Brief Interview for Mental Status (BIMS) indicated the resident had long term memory problems and was moderately impaired in cognitive skills for daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as being independent with setup help only.

Resident #30 was a 56 year old admitted to the facility on 8/20/10 with diagnoses to include Legal Blindness and Depression.

The most recent Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 12/20/16. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #30 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as being independent with setup help only.

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On 2/1/17 at 5:50 p.m. this surveyor called the supervisor at the Office of Licensure and Certification, State Department of Health, and informed the supervisor of the above findings and the concern for an Immediate Jeopardy situation due to hot coffee currently still being served in the facility. A return called was received at 6:05 p.m. from the supervisor confirming Immediate Jeopardy for failure to ensure an environment free from accidents and hazards in regards to hot coffee of sufficient temperature to cause tissue injury being available and served to residents. At 6:10 p.m. the Administrator and the Director of Nursing were informed of the above findings and Immediate Jeopardy was called at 6:15 p.m. Based on review and acceptance of the Facility Plan of Action dated 2/1/17, the Immediate Jeopardy was removed on 2/1/17 at 8:15 p.m.

The Facility Plan of Action dated 2/1/17 accepted at 8:15 p.m. documented in part as follows:

DEFICIENCY IDENTIFIED:
Hot Liquid Temperatures

ACTIONS:
1. Immediate Corrective Action for Residents Affected: Educating Dietary Employees on new standards. (per Administrator the facility policy and procedure titled "SAFE HANDLING AND SERVING TEMPERATURES FOR HOT BEVERAGES" revised 7/29/16 was used for inservicing).

2. Identification of Residents with potential to be affected: All residents drinking hot liquids.

3. Measures or systems changes to prevent reoccurrence:

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-Brew Hot Liquids at 170 degrees
-Remove and let set and temp every 15 minutes until it reaches 155 degrees, it will not leave kitchen until it is 155 degrees.
-Temperature logs and daily monitoring.

4. Monitoring changes/systems to ensure no deficient practice: Dietary will maintain a daily log on all floors and dining room for compliance and submitted to QAPI (Quality Assurance Performance Improvement) meeting monthly.

On 2/3/17 at 11:00 a.m. an interview was conducted with the Dietary Manager. The Dietary Manager was asked what the dietary department had been instructed to do after Resident #25's coffee burn. The Dietary Manager stated, "We were told to make sure we checked the temperature of the coffee after it was brewed before it went to the dining room. Maintenance changed the coffee brewer temp to 170 degrees. We let the coffee go out of the kitchen to the dining room at 170 degrees." Surveyor asked, "Were you ever told to make sure the coffee was 155 degrees before letting it leave the kitchen?" The Dietary Manager stated, "I can't remember anything about 155 degrees, but it will be 155 degrees now before it ever leaves the kitchen."

On 2/3/17 at 9:30 a.m. an interview was conducted with the Administrator asking him to explain what occurred after the July 2016 Corrective Action Plan after Resident #25 received a 2nd degree burn from hot coffee in regards to communication with the dietary department. The Administrator stated, "Dietary was only told to temp the coffee out of the coffee maker then they would send it out to the floors. It was never communicated to dietary to make sure

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the coffee temp was at 155 degrees before it left the kitchen and entered the dining room. Based on the temperature logs it was still running in the 170's for temps."

According to an American Burn Association document titled "Fire and Burn Safety for Older Adults Educator's Guide", under the heading General Background Information ...Risk Factors ...Physical Changes, the document read "Older adults experience a myriad of physical and cognitive changes associated with the aging process that makes them more vulnerable to fire and burn injuries... there are significant changes in sensory perception. The ability to see, hear and feel potential fire and burn dangers diminishes proportionally as one gets older...Since older adults also have thinner skin, they may experience a much deeper burn than a younger person, when exposed to the same amount of flame or other burn injury source.. Under the heading Working with the Older Adult Population, the document continues "With 12.5% of the population age 65 and older, there is a need to assess and address injury risks affecting them as they age".

According to a second document based on the above Burn Association Kit, found at http://www.ameriburn.org/Preven/2000Prevention/Scald2000PrevetionKit.pdf : "The severity of injury with scalds depends on two factors - the temperature to which the skin is exposed and the length of time that the hot liquid is in contact with the skin... When the temperature of a hot liquid is increased to 140o F / 60o C. it takes only five seconds or less for a serious burn to occur. Coffee, tea, hot chocolate and other hot beverages are usually served at 160 to 180o F./

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71-82o C. degrees, resulting in almost instantaneous burns that require surgery to heal". The two factors addressed above are underscored in a Burn Foundation document retrieved from the Internet :
Which states "Hot Water Causes a Third Degree Burns ...
...in 1 second at 156º
...in 2 seconds at 149º
...in 5 seconds at 140º
...in 15 seconds at 133º.
https://www.burnfoundation.org/programs/resource.cfm?c=1&a=3

On 2/2/17 at 4:20 p.m. a pre-exit interview was conducted with the Administrator and the Director of Nursing where the above findings were shared. Prior to exit the Administrator informed this surveyor that the coffee brewer had been adjusted back to a brewing temperature of 155 degrees instead of the previous temperature of 170 degrees. No further information was provided prior to exit.

(1) Psychosis: any major mental disorder of organic or emotional origin characterized by a gross impairment in reality testing, in which the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect references about external reality, even in the face of contrary evidence.

(2) Major Depressive Disorder: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality.

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(3) Anxiety Disorder: a disorder in which anxiety is the most prominent feature. The symptoms range from mild, chronic tenseness, with feelings of timidity, fatigue, apprehension, and indecisiveness, to more intense states of restlessness and irritability that may lead to aggressive acts, persistent helplessness, or withdrawal.

(4) Bipolar Disorder: a major mental disorder characterized by episodes of mania, depression, or mixed mood.
(1), (2), (3) The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(5) Burn: is defined as any injury to tissues of the body caused by hot objects or flames, electricity, chemicals, radiation, or gases in which the extent of the injury is determined by the nature of the agent, length of time exposed, body part involved and depth of burn. Second-degree burns may be divided into superficial partial-thickness and deep partial-thickness wounds. Damage in second-degree burns extends through the epidermis to the dermis but is usually not sufficient to prevent skin regeneration.
The above definition was derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(6) CDC (Centers for Disease Control)
DEFINITION OF TYPES OF BURNS:

First-Degree Burns: First-degree burns involve the top layer of skin. Sunburn is a first degree burn.
Signs:
* Red

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* Painful to touch
* Skin will show mild swelling

Second-Degree Burns: Second-degree burns involve the first two layers of skin.

Signs:
* Deep reddening of the skin
* Pain
* Blisters
* Glossy appearance from leaking fluid
* Possible loss of some skin

Third-Degree Burns: A third-degree burn penetrates the entire thickness of the skin and permanently destroys tissue.

Signs:
* Loss of skin layers
* Often painless
* Skin is dry and leathery
* Skin may appear charred or have patches that appear white, brown, or black

(7) Bacitracin: An antibacterial, a common component of topical antibiotic ointments used for treating skin infections.
The above definition derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(8) Silvadene: Sulfadiazine, having bactericidal activity against many gram-positive and gram-negative organisms, as well as being effective against yeasts; used as a topical antiinfective for the prevention and treatment of wound sepsis in patients with second and third degree burns.
The above definition was derived from Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health 7th Edition.

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(9) Santyl: Trademark for an enzyme (collagenase). A medication applied as an ointment for debridement of decubitus ulcers, burns, and other epidermal lesions.
The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(10) Hypertension: a common disorder that is a known cardiovascular disease risk factor, characterized by elevated blood pressure over normal values of 120/80 mm Hg (milligrams of mercury) in an adult.
The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(11) Depression: an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality.
The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(12) Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses.
The above definition derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

(13) Arthritis: any inflammatory condition of the

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F 323	Continued From page 59 joints, characterized by pain, swelling, heat, redness, and limitation of movement. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 323		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441		3/3/17

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F 441	Continued From page 60 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to maintain the handwashing and eyewash equipment in the laundry department in a clean	F 441	No residents cited All residents at the center have the potential for this deficiency.	

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F 441	Continued From page 61 and sanitary manner to help prevent the transmission of infection. The findings included: On 2/1/17 at 1:00 pm, a tour of the laundry department was conducted. In the soiled linen room, there was a hopper with a faucet used by laundry personnel for handwashing. According to the staff member present during the tour, this was used for handwashing only. There was no other sink available in the soiled linen room for handwashing. Approximately one-half of the inner surfaces of the hopper were covered with black slimy substance. The rest of the hopper, both interior and exterior surfaces, was covered with a light brown stain. The walls around the hopper area were also soiled and stained. Underneath the hopper, the floor was dirty and there were 12 missing tiles, soiled disposable gloves, soiled small broom, and other debris. The hopper faucet was very soiled with lime deposits around it. The left faucet handle for hot water was missing. The right side of the metal paper towel holder located above the hopper was dirty, dented, and very rusty. The soap dispenser was very soiled with the cover left open, exposing the bag of liquid soap. The eyewash station, directly connected to the right side of the hopper, was soiled. The eyewash covers were not in place, leaving the spray heads exposed to dust and dirt. On 2/1/17 at 1:20 pm, the Administrator and the Maintenance Director came to see the findings in the soiled linen room and the Administrator stated that they will replace the tiles and secure the area	F 441	"Facility immediately replaced eyewash station, facet and thoroughly cleaned the sink "Replaced the soap dispenser and paper towel holder "Implemented new cleaning schedule. Audit daily for 4 weeks weekly thereafter "Maintenance will continue to monitor eye wash station through weekly for 4 weeks and monthly thereafter. The weekly/monthly audit results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.	

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a little better. The Maintenance Director stated, "We will get on it right now". The Maintenance Director turned on the eyewash station and it failed to work. The water flow was very slow with not enough pressure to get in contact with the person's eyes when in use. He stated, "It was working before."

On 2/1/17, the Maintenance Director provided a copy of the inspection log titled "Instructions for Monthly Inspection of the Eyewash Station" with a due date of 2/18/17 and read, in part, as follows, "...Verify protective eyewash covers are properly positioned, clean and intact... Verify that the water flows for both eyepieces..." The eyewash station inspection dated 1/11/17 documented that the eyewash station in the laundry room was working.

On 2/1/17 at 1:45 pm, an interview was conducted with the Director of Environmental Services and Laundry. When asked about the condition of the handwashing and eyewash station area in the soiled linen room, she stated that the "area was terrible" and they are getting ready to replace them. She added, "I wouldn't wash my hands there". When asked who was responsible for cleaning in the soiled linen room, she stated that the laundry personnel were responsible and she is currently working on a cleaning schedule.

On 2/2/17 at approximately 1:00 pm, the Maintenance Director had corrected some of the above findings. New paper towel holder, soap dispenser and eyewash station were installed. The hopper was clean with some small brown spots remaining and the area around and underneath it was clean.

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F 441	Continued From page 63 On 2/4/17, the Administrator provided a copy of the new cleaning schedule in the laundry room dated 2/3/17. The cleaning schedule documented, "All shifts check and clean sink at end of shift. Soiled Room - Clean sink out, rub down walls on Mondays 6:00 am - 1:00 pm; Sundays 11:00 am - 6:30 pm; and mop floor on Tuesdays 9:00 am - 4:30 pm." The above findings were shared with the Administrator and the Director of Nursing during a pre-exit meeting on 2/3/17 at 4:20 pm. There was no additional information provided.	F 441		
F 465 SS=D	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure a safe walkway in front of the building for resident, staff and visitor safety. The findings included: On 2/2/17 at approximately 9:30 am, 2 holes	F 465	No residents cited. All ambulatory residents at the center have the potential for this deficiency. "Maintenance immediately fixed the holes and repaired crack. "Maintenance will maintain grounds to	3/3/17

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F 465	Continued From page 64 were found on the walkway in front of the building used by the residents, staff and visitors. One hole was approximately 3.5 inches in diameter and the other hole was 4.5 inches in diameter. The cement walkway had a crack of approximately 36 inches in length with a broken area of approximately 12 x 5.5 inches. On 2/2/17 at 10:00 am, the Maintenance Director and the Administrator came to see the findings on the walkway. The Maintenance Director stated that he was not aware of the 2 holes which he called the "main drain clean out". He stated that he could cover the 2 holes and have the cracked and broken walkway repaired. On 2/2/17 at approximately 1:00 pm, the Maintenance Director had corrected one of the above findings. The 2 main drain clean out were covered. On 2/3/17 at 10:30 am, the Administrator provided a copy of a policy and procedure titled, "Maintenance/Grounds" from a Plant Operations Manual dated January 2005. It read, in part, as follows, "Policy: Facility grounds shall be maintained in a safe and attractive manner. Procedure: ...3. Area around the buildings (i.e., sidewalks, patios, gardens, etc.) shall be maintained in a safe and orderly manner at all times. The above findings were shared with the Administrator and the Director of Nursing during a pre-exit meeting on 2/3/17 at 4:20 pm. There was no additional information provided.	F 465	ensure they are safe by doing a weekly rounds audit. The audits results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.	
F 468 SS=D	CORRIDORS HAVE FIRMLY SECURED HANDRAILS	F 468		3/3/17

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F 468	Continued From page 65 CFR(s): 483.90(i)(3) (i)(3) Equip corridors with firmly secured handrails on each side; and This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure handrails in the hallway were free of rough splintered surfaces. The findings included: On 2/2/17 at 2:40 pm, an inspection of the hallway handrails on the second floor was conducted. The handrails were made of wood. The handrails located in the short hallway, left of nurses station, were observed to have rough splintered surfaces. It is on the left side where medication, linen and food carts are frequently placed. On 2/2/17 at 2:50 pm, an interview was conducted with LPN #3, Nurse Manager, who stated that she was not aware of the rough splintered handrails on her unit. She stated that maintenance staff monitors the condition of the handrails in the facility. When asked regarding the process for reporting handrail issues if found by the nursing staff, she replied, "We have a Maintenance Work Order Book where we write any maintenance issues and flag it in the book. Maintenance staff checks this daily." She reviewed the unit Maintenance Work Order Book and there were no written work orders for handrails with splinter issues. She stated that rough splintered surfaces on the wooden handrails could potentially cause splinters on the residents.	F 468	No residents cited. All residents at the center have the potential for this deficiency. "Maintenance immediately sanded and finished the handrails in question "Maintenance checked all the handrails for compliance "Maintenance will check handrails monthly using audit tool The audits results and any findings will be presented at the QAPI meeting monthly until sustainability is attained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	02/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 468	Continued From page 66 On 2/2/17 at 3:00 pm, the Maintenance Director inspected the handrails, as described above, and stated that they will work on these. On 2/3/17, the Maintenance Director provided a copy of the Logbook Documentation, Common Areas: Inspection, Marked done on-time by (name of Maintenance Director) on 12/2/2016, 2/2/17, and 2/3/17. It read, in part, as follows, "Steps:...Miscellaneous...Check handrails". On 2/3/17 at approximately 9:45 am, observed a maintenance staff working on the handrails. About half of the handrails with issues have been repaired and painted. The above findings were shared with the Administrator and the Director of Nursing during a pre-exit meeting on 2/3/17 at 4:20 pm. There was no additional information provided.	F 468		
F 520 SS=E	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other	F 520		3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 67 individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on facility records, staff interviews and review of the facility plan of action to address an identified quality deficiency, it was determined staff failed to monitor the effect of the implemented changes resulting in the potential for a reoccurrence of burns from coffee served above a safe temperature. The safe temperature included in the plan of action implemented on 7/16/16 was 150 degrees. The findings included:	F 520	Residents #25,#26,#27,#28,#29,#30 All residents at the center have the potential for this deficiency. "Facility will develop and implement appropriate plans of action to correct identified quality deficiencies. "Facility will use root cause analysis to determine appropriate plan of correction. "Plans will be discussed in weekly Risk Management meeting.	

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F 520	Continued From page 68 Resident #25 suffered second degree burns to her lower abdomen, on 7/16/16 when she accidentally spilled hot coffee on herself. The facility did institute a plan of action to address/prevent the reoccurrence but failed to monitor the plan for continued implementation. During a 2/3/17 at 9:30 a.m. interview with the Administrator, he stated the July 2016 Corrective Action Plan was not clearly communicated to the dietary department. The Administrator continued, "Dietary was only told to temp the coffee out of the coffee maker then they would send it out to the floors. It was never communicated to dietary to make sure the coffee temp was at 155 degrees before it left the kitchen and entered the dining room. Based on the temperature logs it was still running in the 170s for temps." On 2/3/17 at 11:00 a.m. an interview was conducted with the Dietary Manager. The Dietary Manager stated, "We were told to make sure we checked the temperature of the coffee after it was brewed before it went to the dining room. Maintenance changed the coffee brewer temp to 170 degrees. We let the coffee go out of the kitchen to the dining room at 170 degrees." The Dietary Manager continued, "I can't remember anything about 155 degrees, but it will be 155 degrees now before it ever leaves the kitchen." The coffee temperature logs were reviewed from July 2016 through January 2017. The Hot Coffee temperatures ranged from the following: Month High Low July 2016 190 174 August 2016 190 173	F 520	The Plan of Correction will be presented at the QAPI meeting monthly until sustainability is attained.	

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F 520	Continued From page 69	F 520		

September 2016	182	170
October 2016	175	170
November 2016	170	170
December 2016	180	170
January 2017	175	170

During a noon interview on 2/3/17 with the Administrator he confirmed that the plan of action had not been monitored for effectiveness.