STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175126	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW SENIOR LIFE	1417 W ASH ST JUNCTION CITY, KS 66441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation KS00168320. The 2567 was sent electroncially on 01/27/22.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included three residents with three reviewed for accidents. Based on observation, record review, and interview, the facility failed to assess and identify risk factors after a hot liquid spill in order to prevent future accidents and injuries for Resident (R) 1. This placed R1 at increased risk for injuries related to accidents and resulted in a first degree burn to R1's already injured thighs. Findings included: - R1's "Electronic Medical Record" (EMR) documented R1 was admitted to the facility on 12/22/21 with the diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), visual loss, and history of falling.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/27/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175126	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW SENIOR LIFE	1417 W ASH ST JUNCTION CITY, KS 66441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1	F 689		

The "Baseline Care Plan" dated 12/22/21 documented R1 required one-person assistance for eating.

The "Admission Minimum Data Set" (MDS) dated 12/31/21 documented R1 had Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS further documented R1 required extensive assistance of two staff for bed mobility, transfer, locomotion on and off the unit, dressing, personal hygiene, and toileting. R1 required supervision with set up help only for eating.

The "Activities of Daily Living Care Area Assessment" (CAA) dated 12/31/21 documented R1 was an elderly male who was admitted from independent living related to a decline in his condition. The CAA documented R1 would be receiving medication, labs, pain management, and assistance with his activities of daily living.

The "Fall CAA" dated 12/31/21 documented R1 had a history of falls. His responsible party declined therapy services. The CAA further documented R1 required extensive assistance with his cares and staff would assist him by anticipating his needs.

The "Baseline Care Plan" dated 12/22/21 documented R1 required one-person assistance for eating.

The "Skin/Wound Note" dated 01/01/22 documented the nurse was alerted by the on shift Certified Nurses Aides (CNA) that R1's thighs were red. The nurse, upon arriving to R1's room, observed R1's bilateral thighs had erythema (redness) and fluid filled blisters. The CNAs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175126	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW SENIOR LIFE	1417 W ASH ST JUNCTION CITY, KS 66441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

reported that they had immediately changed his clothing and there was no redness noted to the skin. R1 then requested to be toileted and complained of pain to his thighs and the injury was noted and the on-shift nurse was notified. The nurse questioned how the wounds had occurred and R1's responsible party replied that R1 had been dunking his cookie into his coffee and spilled the coffee on his lap. The areas were cleansed with wound wash, patted dry, xeroform gauze applied to affected areas, topped with non-adherent, absorbent pad, and secured with guaze wrap bilaterally. The primary care physician was notified.

The "Health Status Note", dated 01/02/22, documented the on-shift nurse was notified by a CNA that R1 had spilled coffee on himself and that it was hurting. Upon assessment, the licensed nurse documented R1 had spilled coffee on his previous burn on his right thigh and sustained a new probable first degree burn to the most superior and anterior part of his right thigh/groin area. A large blister on his previous burn site had become unroofed. The nurse asked R1 who had given him coffee and what kind of cup it was in and R1 could not recall this information. It was determined that whoever had given R1 coffee, had given it to him in a Styrofoam coffee cup. The new burn was treated the same as the previous burns were being treated and the primary care physician was notified.

The "Nutrition Note", dated 01/03/22 documented an adaptive eating device was implemented: insulated mug with lid for hot beverages.

On 01/13/22 at 09:00 AM Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175126	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW SENIOR LIFE	1417 W ASH ST JUNCTION CITY, KS 66441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

stated the facility did not have a formal assessment for hot liquid safety but rather, used the residents history of accidents, assessments on admission and verbal history of family to determine the resident's safety for hot liquids. Administrative Nurse D said if a resident had a diagnosis which caused functional debility or tremors, the facility knew the resident was a safety risk for hot liquids and interventions would be implemented without need of further assessment. Administrative Nurse D then stated that R1 admitted with orders for physical therapy (PT) and occupational therapy (OT) but R1 and his responsible party declined therapy services and at the time of admission there were no other factors which indicated R1 was a safety risk.

On 01/13/22 at 10:30 AM Certified Nurses Aide (CNA) M stated R1 would shake when he drank or ate but since the facility had started putting his coffee in a covered mug he was much safer when he was drinking his coffee.

On 01/13/22 at 11:45 AM, Administrative Nurse E stated the facility did not have a formal assessment for hot liquid safety. The nursing staff would assess residents at the time of admission on whether the residents were safe with hot liquids. If residents were not deemed safe on admission for hot liquids then safety measure would be put in place.

The facility's "Safe Serving of Coffee and Other Hot Liquids" policy, dated 06/22/21, documented coffee and other hot beverages will be consumed at 155 degrees F to 175 degrees F, noting that this temperature can result in burns if the beverage contacts the skin or mucous membranes. If a resident is at risk for handling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175126	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW SENIOR LIFE	**1417 W ASH ST JUNCTION CITY, KS 66441**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

hot liquids, the following measure will be implemented: access to coffee will be supervised, assistive devices will be offered as necessary but not limited to sealed covers on all hot liquids and prohibitions for straws for hot liquids, hot liquids will be cooled prior to allowing the residents to handle them, and appropriate interventions will be care planned. Limiting residents access to hot liquids in the dining room to the coffee bin thermos carafes no more than 30 minutes before meals. The thermos carafes will remain in the kitchen until staff I available in the dining room for meal service. Resident sill be discouraged from carrying cups of hot beverages without a lid while walking or in a wheelchair or while using a mobility device. No hot beverages will be re-heated in a microwave. Cups of hot beverages will be filled to no more than two-thirds full. Hot beverages will be placed at least ten inches away from the edge of any table. Hot beverages will be placed near the dominant hand of the resident. When serving hot beverages, staff will remind each resident that the served beverage is hot. Hot beverages will be placed in the field of vision of the resident and other residents at the same table. Hot beverages will be transferred into serving containers that will allow the temperature to drop.

The facility failed to adequately assess and identify risk factors after a hot liquid spill in order to prevent future accidents and injuries on admission for R1 which resulted in a first degree burn to R1's already injured thighs.