

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

PRINTED: 08/26/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255150		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/05/2024	
NAME OF PROVIDER OR SUPPLIER BEDFORD CARE CENTER OF MENDENH				STREET ADDRESS, CITY, STATE, ZIP CODE 925 WEST MANGUM AVENUE MENDENHALL, MS 39114			
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F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #25877 and CI MS #24339), at the facility from 8/1/24 through 8/5/24. The complaints were investigated regarding resident rights and additionally, CI MS #25877 was investigated related to accidents/hazards. There were no deficiencies cited related to CI MS #24339. During the investigation of CI MS #25877, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F561, F656, and F689. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 4/11/24 when the facility failed to ensure adequate supervision for Resident #1, who had diagnoses including Diabetes Mellitus (DM), Hemiplegia (left side), Vascular Dementia, and moderately impaired cognition, spilled hot coffee onto his left thigh, which resulted in a third-degree burn. The IJ and SQC existed at: CFR §483.25(d)(2) Accidents/Hazards - F689 - Scope/Severity "K" The IJ existed at: CFR §483.21(b) Comprehensive Care Plans - F656 - Scope/Severity "K" The facility Administrator was notified of the IJ and SQC on 8/2/24 at 11:15 AM. The facility provided an acceptable Removal Plan on 8/2/24, in which they alleged all corrective actions to remove the IJ were completed and the			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/19/2024

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

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F 000	Continued From page 1 IJ removed on 8/3/24. The SA validated the Removal Plan on 8/5/24 and determined the IJ was removed on 8/3/24, prior to exit. Therefore, the scope and severity for CFR 483.25(d)(2) Accidents/Hazards and CFR 483.21(b) Comprehensive Care Plans were lowered to an "E" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	F 000			
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561			9/10/24

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F 561	Continued From page 2 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure a resident's right for self-determination as evidenced by facility staff taking a resident's chewing tobacco without notice, which he was previously granted permission to have, and resulted in the resident crying and begging in distress and continued fear of staff taking away his tobacco for one (1) of three (3) residents sampled for tobacco usage. (Resident #1) Findings include: A record review of the facility's policy "Smoking/Tobacco -Free Policy-Residents" dated 2019 revealed " ...All residents, employees, and visitors are prohibited from using any type of tobacco, snuff, e-cigarettes, and similar products, in company buildings, parking areas, on company property, or in any company owned or leased vehicle. No resident who uses any of these products will be admitted unless the Resident and Resident Representative agree for the Resident to accept and continue a smoking cessation program or cessation patch ..." A record review of the facility's policy "Resident Rights" with revision date of 06/01/23 revealed " ... The facility will inform the resident both orally	F 561	1. Resident one (1) was allowed to have chewing tobacco on the evening of 7/4/2024 and and continues as resident one (1) is grandfathered for smokeless tobacco use. 2. One resident had the potential to be affected by the deficient practice as facility policy precludes the use of tobacco. 3. An inservice was conducted by the Director of Long Term Care Operations for the Facility Administrator on 8-7-2024 regarding the Tobacco Free Policy for Residents and the importance of following the policy. On 8/20/2024, an in-service was conducted by the Resident Care Coordinator Nurse, with the direct care workers with respect to the facilities tobacco free policy and the fact that resident one (1) is exempt from the tobacco free policy and the fact that resident one (1) is exempt from the tobacco free policy for smokeless tobacco only. 4. Beginning 8/20/2024, the nurse supervisor will audit resident one (1) twice		

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F 561	Continued From page 3 and in writing, in a language that the resident understands, of his or her rights and all the rules and regulations governing resident conduct and responsibilities during the stay in the facility ...5. Self-determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice ...b.The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident ..." At 09:25 AM on 08/01/2024, during an interview with the Administrator, he explained Resident #1 was admitted to the facility two (2) years ago. Because the facility's census was very low at the time, he agreed to give special permission for the resident to chew tobacco at the facility even though the facility's policy did not allow it. He explained Resident #1 was passionate about his tobacco as he had used it almost his entire his life. When the agreement was made upon admission, Resident #1 should have used the chewing tobacco outside of the building only, but it had gotten to the point that he was allowed to use chewing tobacco in his room and inside the facility. The Administrator reported that on 7/4/24, there was a communication issue as it had been discussed with staff that the facility's tobacco-free policy was going to be strictly enforced. He had notified the family prior to 7/4/24 and had explained the tobacco-free policy was being strictly enforced and he had no choice but to take the tobacco away. The family asked the Administrator to allow them some time to discuss what to do and he agreed. He explained the resident has now been allowed to continue to use chewing tobacco while at the facility. On 08/01/2024 at 09:55 AM, an interview with	F 561	daily for two weeks and then three times per week for two weeks to ensure compliance. The Social Services Director will audit all new admission paper work weekly beginning 8-19-2024 for twelve (12) weeks to ensure that the Tobacco Free Policy is signed on admission and that the policy is being followed. All audits will be reviewed by the Quality Assurance and Performance Improvement Committee monthly for three (3) months beginning 9-9-2024 to ensure sustained compliance.		

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F 561	Continued From page 4 Resident #1's family member revealed Resident #1 had been at the facility for two (2) years and was cleared on admission by the Administrator and the doctor to use chewing tobacco while at the facility. On 07/03/24 while the family member was at the facility, the Administrator talked to her husband and advised the resident would have to stop using tobacco and said the tobacco-free policy was now going to be enforced. The family explained to the Administrator they would need about two (2) weeks to discuss what to do, and the Administrator agreed to allow time to plan a method to "wean" him from chewing tobacco. The family member stated that she felt it was unfair for the Administrator to enforce the tobacco-free policy now, when he had been given permission upon admission two years ago when the policy was in place then as well. She explained on 07/04/24, she received a call from the current Director of Nursing (DON) explaining she had taken Resident #1's tobacco away because the facility stopped allowing him to use chewing tobacco. She was told the DON had taken his tobacco, locked it up in her office, and told all the staff that Resident #1 was not to get any tobacco, and she would not support the nurses if they gave it to him. She explained that staff members called her and told her Resident #1 was heartbroken and was yelling and screaming for his tobacco. A family member went to the facility to give the resident some tobacco and the DON would not allow them to give it to him. The next day, 07/05/24, she received a call from staff at the facility who stated they were going to allow him to use chewing tobacco, and they were going to try to wean him off the tobacco products. However, there was still confusion among staff because some staff were still not allowing him to use tobacco, and some	F 561			

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F 561	Continued From page 5 were allowing him to use it. The following Wednesday, 07/10/24, she had a meeting with the Administrator who informed her that Resident #1 could either stop chewing tobacco or she could remove him from the facility. She had contacted the facility's Ombudsman about the tobacco situation and other concerns and was told to file a grievance and the facility would have to follow through with the problems and resolve them, therefore, she filed a grievance on 7/11/24. She stated Resident #1 was now allowed to have chewing tobacco, but he continued to fear daily the facility was going to take it away. At 12:20 PM on 08/01/24, during an interview with Licensed Practical Nurse (LPN) #1, she explained she was working on 07/04/24 when Resident #1's tobacco was taken away and she was told he could no longer have tobacco due to the facility's tobacco free policy. LPN #1 explained Resident #1 yelled and screamed and was very upset and the other residents could hear him. She did not give the resident any tobacco on that day or any other days until it was later cleared for him to have tobacco. At 12:50 PM on 08/01/24, during an interview with Resident #1, he reported that approximately one (1) month ago, he went almost two (2) weeks without chewing tobacco because the nurses had taken it from him. He explained he had been chewing tobacco for what seemed like his entire life and the doctor had told him he could chew tobacco while in the facility, which is why he agreed to come to the facility in the first place. He said that he did not want the facility to take his tobacco again and admitted he was afraid every day that someone was going to take it away.	F 561			

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F 561	Continued From page 6 On 08/01/24 at 01:00 PM, during an interview with Resident #5, she stated Resident #1 cried, screamed, and begged for his tobacco to be returned to him when the facility took it away. On 08/01/24 at 01:30 PM, during an interview with Social Services #1, she explained she was responsible for the facility's grievances. She reported she was aware of the incident with Resident #1 that happened on 07/04/24, and afterward on 7/11/24, the family filed a grievance. On 07/12/24, the Administrator advised the family Resident #1 would be allowed to continue using chewing tobacco and he would be "Grandfathered" in. At 01:50 PM on 08/01/24, during an interview with Certified Nurse Aide (CNA) #1, she reported Resident #1 was heart-broken, screaming, crying, and even begging for her or anyone to give him some tobacco during the time the facility took it away from him. She reported that some of the other residents complained about Resident #1 yelling and screaming for his tobacco because he got very loud. At 03:00 PM on 08/01/24, during an interview with the DON, she explained it was brought to her attention the first of July that Resident #1 was chewing tobacco in the facility and the facility was a tobacco-free facility. It was decided that the staff would strictly enforce the tobacco free policy, and she thought the Administrator was going to discuss this with Resident #1's family at that time. The DON had advised all the nurses the policy would be enforced and on 7/4/24, the nurse refused to allow Resident #1 to use tobacco. The DON explained that on 07/04/24, she took Resident #1's tobacco and told him he could no	F 561			

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F 561	Continued From page 7 longer chew tobacco in the facility. The resident was calm and wanted to tell his daughter he was ready to go home, however, she was unsuccessful when she attempted to call his daughter. The DON said that she took the resident's tobacco from him and locked it in her office. She was unaware the Administrator had talked with the family previously and they had agreed to allow him a couple of weeks to be weaned from tobacco. Therefore, the tobacco was given back to the nurses and it was determined the nurses could use their discretion on whether they wanted to give him the tobacco. To her understanding, some of the nurses gave him tobacco and some did not. The night shift nurse complained one morning that he was told not to give the resident tobacco and felt like the facility needed a plan on whether to give Resident #1 the tobacco. The nurse said that some staff were giving Resident #1 tobacco on day shift, but he was told not to give it to the resident, which caused the resident to yell, scream and beg for tobacco all night. The Administrator was informed, and a meeting was set up with Resident #1's family on Wednesday 07/10/24. At 03:30 PM on 08/01/24, during a follow up interview with the Administrator, he admitted the confusion regarding Resident #1's use of chewing tobacco was his fault. He confirmed he had a meeting on 07/03/24 with Resident #1's family and discussed the options regarding the facility having to strictly enforce the tobacco free policy. The family asked for some time to think of a plan, and he told them the only option was to take away the resident's tobacco or transfer him to another facility that allowed tobacco products. He did not talk to the staff about the outcome of the meeting or what was discussed. Then on	F 561			

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F 561	Continued From page 8 07/04/24 he was phoned by Resident #1's daughter, who was very upset and angry because the facility's staff had taken her father's tobacco even after he agreed to give them a couple weeks to decide on a plan. The Administrator explained he then called the facility and told staff that Resident #1 was allowed to have his tobacco, and the facility was going to wean him from the tobacco. On 07/10/24, he had another meeting with Resident #1's family and the daughter was visibly upset and told him she had filed a complaint with the State Agency (SA) and she would go further if needed. The Administrator said he had explored changing the policy but that was not an option and that only left two (2) choices, to create a plan to wean him off tobacco or relocate the resident to another facility. The daughter explained Resident #1's tobacco use was more psychosocial than nicotine addiction. Then on 07/11/24 the family filed a grievance. The Administrator talked to Resident #1's physician about the tobacco-free policy being enforced and the Physician stated he would talk to the family about transferring him to other nearby facilities, but the doctor did not think that would help. After all the considerations, it was decided that Resident #1 would be grandfathered in and would be allowed to use chewing tobacco, and he was given back his tobacco full time on the 07/12/24. The family was notified and pleased with the resolution. On 08/02/2024 at 08:30 AM, in an observation, Resident #1 was in the hallway talking with Registered Nurse (RN) #1 who explained she had him a cup of chewing tobacco and an empty cup to spit in, and she would place it by his bed. Resident #1 stated, "You better not throw my tobacco away."	F 561			

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F 561	Continued From page 9 At 10:30 AM on 08/02/24, during an interview with RN #1/Supervisor, she explained she was at the facility on the day the DON took away Resident #1's tobacco. Resident #1 was visibly terribly upset, crying out for staff to bring him his tobacco and was begging any staff member to bring him some tobacco. She stated when she left the building for the day, she could hear the resident still yelling and asking for tobacco from outside the building. To her understanding, he was to be weaned from the chewing tobacco and that it would not be taken away "cold turkey." She reported he would yell out and scream, "they have taken my tobacco away" and that he did not want to be here anymore. She said he was still afraid someone would take his tobacco away. She confirmed that once the tobacco was taken on 07/04/24, some nurses would allow him to have it and some would not and it depended on which way they defended their decision, to follow policy or to just give him his tobacco. She said she gave him tobacco anytime he asked for it because the facility was going to have to wean him from it gradually. She confirmed that as of 07/12/24, Resident #1 could have his tobacco at any time. At 12:30 PM on 08/02/24, during a phone interview with CNA #5, she explained she was working on 7/4/24 when the DON took Resident #1's tobacco. The resident was very upset and was crying, screaming, and yelling for staff to get away from him. He refused care and refused to let anyone do anything for him even after staff tried and tried to calm him down. She said Resident #1 was upset all day and some of the other residents complained about all the yelling and screaming he was doing. Several days later,	F 561			

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F 561	Continued From page 10 Resident #1 had calmed down, but was still upset and kept asking for his tobacco to the point where he was begging staff for it. Some of the nurses did allow him to have tobacco, but others would not because it was against the facility's policy. She explained that since he has gotten his tobacco back, he continues to tell staff "no one better not take or throw my tobacco away." A record review of "Admission Record" revealed the facility admitted Resident #1 on 09/15/22 with current diagnoses including Type 2 Diabetes Mellitus, Vascular Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/25/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) Score of 11, which indicated his cognition was moderately impaired. A record review of Resident 's "Progress Note" dated 07/10/24 07:40 AM revealed " ... Resident was chewing tobacco that was given on previous shift. Resident was screaming and asking for more tobacco, while he had tobacco in his mouth. Explained to the resident that he had tobacco already, and that it was against our policy for me to give it to him. Resident refused to take, his meds because he wasn't given more tobacco. Resident kept screaming for the nurse (Proper Name) who does not work on this rotation. Informed Nurse Supervisor ..." A record review of Resident #1's "Progress Note" dated 07/11/24 02:04 PM created by the Physician revealed " ... This patient is doing well and receiving excellent care at this institution.	F 561			

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F 561	Continued From page 11 The problem we have now is that for two years he was using his chewing tobacco and now the regulation of no tobacco is being enforced strictly in this too very unhappy that he can't use his chewing tobacco. The administrator has no choice to follow the rules of his institution. The family is very unhappy about this ..."	F 561			
F 656 SS=K	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656			9/10/24

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F 656	Continued From page 12 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to develop comprehensive care plan interventions to prevent burns and for the use of tobacco for one (1) of seven (7) sampled residents. (Resident #1) The facility's failure to develop comprehensive care plan interventions resulted in Resident #1, who had diagnoses including Diabetes Mellitus (DM, Hemiplegia - left side, Vascular Dementia, and moderately impaired cognition sustaining a third-degree burn to his left thigh and placed other residents who drink hot coffee at risk for sustaining serious injury, serious harm, serious	F 656	1. Resident one (1) care plan was updated on 8-2-2024. The care plan was updated by the minimum data set nurse. 2. All Residents have the Potential to be affected. 3. The interdisciplinary team set up the "at risk" criteria for all residents that may be at risk for burn injuries from hot liquid spills. At risk was identified as those diagnosed with Alzheimer's, Dementia, Parkinson Disease, Narcolepsy, Ataxia and Tremors. The Minimum Data Set		

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F 656	Continued From page 13 impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 4/11/24 when Resident #1 sustained a third-degree burn to his left thigh. The facility Administrator was notified of the IJ on 8/2/24 at 11:15 AM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 8/2/24, in which they alleged all corrective actions to remove the IJ were completed on 8/2/24, and the IJ removed on 8/3/24. The SA validated the Removal Plan on 8/5/24 and determined that the IJ was removed on 8/3/24, prior to exit. Therefore, the scope and severity for CFR 483.21(b) Comprehensive Care Plans was lowered to an "E" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A record review of the facility's policy "Comprehensive Care Plans" with revised date of 08/24/22 revealed " ... It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment ..." A review of the medical record for Resident #1 revealed there were no care plan interventions developed for preventing burns from hot coffee or	F 656	nurse updated their care plan to reflect precautions to be taken with the identified residents with respect to hot liquids. The care plans were reviewed by the director of nursing to ensure that the hot liquids policy was addressed within the care plan. 4. The director of nursing will audit all new admits care plans beginning 8-19-2024 for twelve (12) weeks to ensure that the identified resident risk are properly planned for with appropriate interventions. Audits will be taken to the Quality Assurance and Performance Improvement Committee for three (3) months beginning on September 9, 2024 to ensure sustained compliance.		

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F 656	Continued From page 14 for the use of chewing tobacco. A record review of the "Order Summary Report" with an "Order Date Range: 04/01/24 - 04/30/24" revealed Resident #1 had a Physician's Order, dated 4/11/24 to "Clean blister to left inner thigh with NS (normal saline) gently, pat dry, apply Silvadene cover with dry dressing and paper tape QD (every day) and PRN (as needed) dislodgement until resolved. On 04/24/24, the Physician's Order was changed to "Clean blister to left inner thigh with NS, apply xeroform, dry dressing. Change daily and PRN dislodgement until resolved." At 9:25 AM on 08/01/2024, during an interview with the Administrator, he explained Resident #1 was admitted to the facility two (2) years ago. Because the facility's census was very low at the time, he agreed to give special permission for the resident to chew tobacco at the facility even though the facility's policy did not allow it. He stated the resident has now been allowed to continue to use chewing tobacco while at the facility. During an interview on 08/01/2024 at 9:55 AM, Resident #1's family member explained that her father was burned on his left side when staff on the night shift took Resident #1 into the dining room, gave him a cup of coffee, left him unsupervised, and he spilled the coffee on himself. The family member also stated that Resident #1 had been at the facility for two (2) years and was cleared on admission by the Administrator and the doctor to use chewing tobacco while at the facility. However, it was taken away for him on 7/4/24 but was returned to him on 7/11/24.	F 656			

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F 656	Continued From page 15 During an observation at 12:50 PM on 08/01/24, Resident #1 was sitting up in his wheelchair with his bedside table in front of him in which there were three (3) cups with tobacco in them. At 2:30 PM on 08/01/24, during an interview with Licensed Practical Nurse (LPN)#2/Care Plan/Minimum Data Set (MDS) Nurse, she stated she was responsible for updating resident care plans daily. She confirmed Resident #1 received a third degree burn after spilling coffee on himself and the facility never developed care plan interventions to prevent the re-occurrence of a burn from hot coffee. She stated the facility had developed interventions related to treating the burn. LPN #1 also confirmed she was aware Resident #1 used tobacco and the facility had never developed a care plan with interventions for the staff to follow on his tobacco use. She reported the purpose of a care plan was to provide instructions on how to care for the residents and if there was no care plan, then the staff would not be able to care for the residents as needed. During an interview at 3:00 PM on 08/01/24, the Director of Nursing (DON), reported she was working on 04/11/24 when Resident #1 spilled coffee on himself and had a burn to his left thigh. The DON stated it was a horrible accident and confirmed there were no interventions put in place to prevent the incident from occurring again. She was not aware Resident #1 did not have a care plan for chewing tobacco but expected the care plan nurse to develop care plans as required. At 3:30 PM on 08/01/24, during an interview with	F 656			

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F 656	Continued From page 16 the Administrator, he explained he had been made aware Resident #1 had no care plan related to the use of chewing tobacco and confirmed there were no interventions put in place to prevent further incidents with spilling coffee after Resident #1 received a third-degree burn. He stated he expected the staff to develop care plans and for care plans interventions to be implemented to meet each individual resident's needs. A record review of Resident #1's "Admission Record" revealed the facility admitted Resident #1 on 09/15/22 with current diagnoses including Type 2 Diabetes Mellitus with Foot Ulcer and Vascular Dementia A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/25/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) Score of 11, which indicated his cognition was moderately impaired. A review of Section M revealed resident had a burn (second or third degree). The facility submitted the following acceptable Removal Plan on 08/02/24: On 8-2-2024 at 11:15 P.M. the State Survey Agency notified the administrator that the facility failed to ensure adequate supervision when Resident 1, who had diagnoses including Diabetes Mellitus (DM), Hemiplegia (left side), Vascular Dementia, and moderately impaired cognition, spilled hot coffee onto his left thigh, which resulted in a third-degree burn. On 4/11/2024 at lunch, after 11:15 a.m., it was reported to the resident care coordinator (RCC)	F 656			

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F 656	Continued From page 17 nurse that Resident 1 had spilled coffee on himself and upon assessment it was noted that there was an intact blister to the left medial thigh. The site was cleaned with normal saline and Silvadene and dry dressing applied. The resident care coordinator notified the provider and order to continue the same treatment were received and to be completed daily. The resident did not complain of any pain at the time. The nurse attempted to notify the resident representative unsuccessfully initially. However, the resident representative did call back and was notified about the burn and the treatments and was updated weekly. After the blister ruptured, the wound care nurse practitioner classified the wound as a third degree burn with new treatment orders. The resident representative was notified and updated. Treatment and care to the burn was ongoing and have since been discontinued as the site has healed. 1. In an effort to immediately protect the residents, the coffee machine was taken out of service on 8-2-2024 so that individuals cannot serve themselves coffee. Individual pots of coffee will be made beginning today, 8-2-2024 and temperatures of the pots will be monitored to ensure that the coffee served is at or below 140 degrees Fahrenheit. Resident #1 will be served coffee at or below 140 degrees Fahrenheit. 2. The root cause of the accident was the hot liquid policy was not followed. This along with the lack of proper supervision resulted in the injury. 3. On 8-2-2024, Coffee Temperature logs were created to indicate the temperature of the beverage prior to serving. This will serve as	F 656			

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F 656	Continued From page 18 record of temperatures of coffee being served . 4. Training for all staff prior to working shifts was initiated on 8/2/2024 by the staff development nurse and the Director of Nursing on the following topics: Safety and supervision of residents · Care Plans · Temperature logs for coffee · hot liquids policy No staff will be allowed to work until they have received appropriate training. 5. Updated the care plans for resident # 1 and identified thirty-three residents that were at risk to include interventions to prevent burns. 6. Weekly body audits were completed for all residents on 8-2-2024 and there were no burns noted. 7. Quality Assurance and Performance Improvement committee meeting was conducted on August 2, 2024, at 12:21 p.m. and the issue was discussed including root cause and appropriate remedies. Attending the meeting: Medical Director, Administrator, Director of Nursing, Resident Care Coordinator/ Infection Preventionist, Dietary Manager, Social Worker, Business Office Manager, Staff Development Nurse, Minimum Data Set Nurse, Medical Records Clerk, Environmental Services Manager, Maintenance Director and the staff scheduler. The facility alleges all corrective actions were completed on 8-2-2024 at 2:00 p.m. and the IJ was removed on 8-3-2024. Validation:	F 656			

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F 656	Continued From page 19 The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation (CI) MS #25877 through record review and interviews on 8/5/24. The SA determined all corrective actions were completed on 8/2/24 and the IJ was removed on 8/3/24.	F 656			
F 689 SS=K	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: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure adequate supervision to prevent a burn from hot coffee for one (1) of seven (7) sampled residents, with the potential to affect all residents who drink coffee in the Dining Room. Resident #1 The facility's failure to ensure adequate supervision resulted in Resident #1, who had diagnoses including Diabetes Mellitus (DM, Hemiplegia (left side), Vascular Dementia, and moderately impaired cognition sustaining a third-degree burn to his left thigh and placed other residents who drink hot coffee at risk for sustaining serious injury, serious harm, serious impairment, or death. The situation was determined to be an Immediate	F 689	1. In an effort to immediately protect the residents, the coffee machine was taken out of service on 8-2-2024 so that individuals could not serve themselves coffee. Individual pots of coffee were made and temperatures of the pots were monitored by the kitchen staff and overseen by the temporary dietary manager. The maximum recorded temperature for serving a hot liquid was 140 degrees Fahrenheit. 2. All Residents that drink coffee have the Potential to be affected. 3. On August 2, 2024 at 7:50 a.m. the manufacturer of the coffee machine was contacted and a request was made to reduce the water temperature of	9/10/24	

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F 689	Continued From page 20 Jeopardy (IJ) that began on 4/11/24 when Resident #1 sustained a third-degree burn to his left thigh. The facility Administrator was notified of the IJ on 8/2/24 at 11:15 AM and was presented with the IJ Template. The facility provided an acceptable Removal Plan on 8/2/24, in which they alleged all corrective actions to remove the IJ were completed on 8/2/24, and the IJ removed on 8/3/24. The SA validated the Removal Plan on 8/5/24 and determined that the IJ was removed on 8/3/24, prior to exit. Therefore, the scope and severity for CFR 483.25(d)(2) Accidents was lowered to an "E" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's policy, "Safety of Hot Liquids," dated 7/25/22, revealed "Policy Statement Hot liquids are to be served at proper (safe and appetizing) temperatures using appropriate safety precautions ...Policy Interpretation and Implementation: 1. The potential for burns from hot liquids is an ongoing concern for elderly and compromised residents... 3. Appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include a. maintaining a hot liquids serving temperature of no more than 140 degrees Fahrenheit b. serving hot beverages in a cup with a lid; c. wide-based cups; d. limit Styrofoam cups to residents with no difficulties; e. encouraging residents to sit at a table while drinking or eating hot liquids; f. providing staff supervision or assistance with hot beverages. 4.	F 689	the coffee machine water to 140 degrees Fahrenheit. The task of reducing the coffee machine water temperature to 140 degrees Fahrenheit. The task of reducing the water temperature of the coffee machine was accomplished on 8-7-2024. In-services for dietary staff on the procedures for logging temperatures of the coffee water temperatures where conducted by the administrator on 8-8-2024. 4. On 8-2-2024, coffee temperature logs were created to indicate the temperature of the hot coffee being served prior to serving it to residents. These logs indicate the staff member who tested the temperature of the coffee, the time and the date. The logs are turned in daily to the administrator and continued until 8-8-2024. Once the coffee machine program was adjusted to ensure that the water temperature will not exceed 140 degrees Fahrenheit, sample cups are taken and the temperature of the liquid in the cups are measured and recorded prior to meals being served morning, mid-day, and evening to ensure that safe temperatures are maintained. The process will continue until 8-19-2024 and will be overseen by the acting dietary manager. Beginning 8-20-2024 sample cup temperatures will be recorded weekly for three (3) weeks ending on 9-16-2024 and then monthly beginning the first week in November and ending the first week in January, 2025. Temperature logs will be brought to the Quality Assurance and Performance Improvement Committee for		

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F 689	Continued From page 21 General safety precautions when serving hot liquids include ...d. Regulate temperature of hot liquids to which residents have direct access; e. Place filled containers directly on the table. Do not hand them directly to resident ...5. Food service staff will monitor and maintain food temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. A record review of the facility's policy, "Safety and Supervision of Residents," revised 8/2/22, revealed "Our facility strives to make the environment as free from accident hazards as possible, with resident safety, supervision, and assistance to prevent accidents being facility-wide priorities ..." On 08/01/2024 at 09:55 AM, during an interview, Resident #1's family member explained that her father was burned on his left side when staff on the night shift took Resident #1 into the dining room, gave him a cup of coffee, left him unsupervised, and he spilled the coffee on himself. At 10:55 AM on 08/01/24, during an observation of the dining room, residents were observed with coffee cups at their tables. Resident #1 was sitting in the dining room at a table with an empty coffee cup, and there was no lid on the coffee cup or on the table. At 11:30 AM on 08/01/24, during a dining room observation, some residents had coffee cups with lids, and some did not. An industrial-style coffee machine was on a countertop with cups and lids noted nearby. Resident #1 was sitting in his wheelchair eating lunch, and there was an empty	F 689	three months beginning on September 9, 2024.		

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F 689	Continued From page 22 coffee cup without a lid noted nearby. At 11:40 AM on 08/01/24, during an observation and interview with Resident #4, he explained he had always been able to get coffee anytime from the machine in the dining room whenever he wanted it. He said that he normally got up around 2:00 AM, came to the dining room, and served himself coffee. He mentioned he liked to use a lid on his coffee cup and reported that he had not spilled coffee on himself or received a burn from hot coffee. On 08/01/24 at 12:00 PM, during an interview with Housekeeper #1, she explained that residents came to the dining room early in the mornings, and some of them got coffee themselves while others needed staff assistance. She was working in the dining room on 04/11/24 when Resident #1 spilled his coffee on himself but was unable to recall what time it occurred. She thought someone from the night shift brought Resident #1 to the dining room, and someone gave him a cup of coffee. Housekeeper #1 said Resident #1 did not like having a lid on his coffee cup. He reported to her that he had spilled the coffee on his pants and needed to be changed. She took the resident to his room and told a Certified Nurse Aide (CNA) that he needed to have his pants changed. She was unable to recall which CNA assisted him, but the CNA changed his clothes and brought him back to the dining room. At 12:50 PM on 08/01/24, during an observation and an interview with Resident #1, he was sitting in his wheelchair with a bedside table in front of him. He explained he did not like to have a lid on his coffee cup because not having a lid helped to	F 689			

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F 689	Continued From page 23 cool the coffee. He stated that when he spilled coffee on himself on 4/11/24, it was an accident. He was unable to recall who had served him the coffee that day and commented that he liked to drink about three (3) cups of coffee a day. At 3:00 PM on 08/01/24, during an interview with the Director of Nursing (DON), she reported she was working on 04/11/24 when Resident #1 spilled coffee on himself and had a burn to his left thigh. She said the incident was discussed that morning in the daily "Stand-Up" meeting. She expressed that she was unaware of the incident until the morning meeting. She confirmed Resident #1 had hemiplegia affecting his left side, causing decreased or no sensation to his left leg. She confirmed that residents in the facility got coffee for other residents, as well as themselves, from the coffee machine in the dining room. She explained that she assessed Resident #1 and the area where he had spilled the coffee, around 11:00 AM when the day shift CNA reported he had a raised blister to his left inner thigh. The DON measured the blister, notified the facility's Nurse Practitioner and received orders for a treatment. She completed the incident report for the incident/burn, and during the investigation, it was determined Resident #1 had told the Housekeeper Supervisor he had spilled his coffee and wanted his pants changed. The DON stated it was a horrible accident and confirmed there were no interventions put in place to prevent the incident from occurring again. At 03:30 PM on 08/01/24, during an interview with the Administrator, he confirmed there were no interventions put in place to prevent further incidents with spilling coffee after Resident #1 received a third-degree burn. The temperature of	F 689			

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F 689	Continued From page 24 the coffee had never been checked and the coffee machine had been in the dining room at the facility for a long time. At 06:45 AM on 08/02/2024, during an observation of residents in the dining room waiting for breakfast, there were no staff present in the dining room and there were no kitchen staff at the serving line. Resident#1 had an empty coffee cup at the table, without a lid. Residents were drinking coffee, and some had lids and some did not. Resident #6 went to the coffee machine while sitting in a wheelchair and got a coffee cup and served herself coffee. Resident #6 did not get a lid for her coffee cup. At 06:55 AM on 08/02/2024, during an interview and observation with Dietary #1, she explained the residents can come into the dining room and get coffee at any time and they serve themselves, even though there were some residents who should not serve themselves. Dietary #1 and the SA poured a cup of coffee from the coffee machine, walked it over to Resident #1's table, and checked the temperature using a digital thermometer. The coffee was 167 degrees Fahrenheit (F) and Dietary #1 reported she was unaware the coffee was that hot. She explained the kitchen staff did not check and record the coffee temperatures. At 07:20 AM on 08/02/2024, during an observation and interview, Resident #7 was standing up in front of the coffee machine and got herself a cup of coffee. She explained the coffee was always hot and she tried to be careful not to spill it. At 07:25 AM on 08/02/2024, during an	F 689			

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F 689	Continued From page 25 observation and interview, the DON was checking the temperature of the coffee in the dining room. She explained she got a reading of 157 degrees F. The SA obtained another cup of coffee, walked over to Resident #1's table, and the DON obtained the temperature of the coffee which indicated it was 167 degrees F. Dietary #1 confirmed the temperature of the coffee was also 167 degrees F when it was checked earlier with the SA. At 09:45 AM on 08/02/2024, during an interview with the Administrator, he confirmed the coffee temperature had never been checked before or after Resident #1 received a burn from spilling hot coffee on himself. At 11:30 AM on 08/02/24, during a phone interview with the Wound Care Nurse Practitioner, she explained she made aware that Resident #1 received a burn, and she assessed it and classified the burn as a third-degree burn. She stated the area had slough and necrotic tissue (unviable and dead tissue) in the beginning and the treatments were changed a few times, but the area healed. At 12:55 PM on 08/02/2024, during an interview with Dietary #1, she explained the coffee machine was never turned off or put up, it ran continuously, and residents had access to it at any time they wanted it day or night. A record review of Resident #1's "Admission Record" revealed the facility admitted Resident #1 on 09/15/22 with current diagnoses including Type 2 Diabetes Mellitus with Foot Ulcer and Vascular Dementia	F 689			

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F 689	Continued From page 26 A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/25/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) Score of 11, which indicated his cognition was moderately impaired. A review of Section M revealed resident had a burn (second or third degree). A record review of the "Order Summary Report" with an "Order Date Range: 04/01/24 - 04/30/24" revealed Resident #1 had a Physician's Order, dated 4/11/24 to "Clean blister to left inner thigh with NS (normal saline) gently, pat dry, apply Silvadene cover with dry dressing and paper tape QD (every day) and PRN (as needed) dislodgement until resolved. On 04/24/24, the Physician's Order was changed to "Clean blister to left inner thigh with NS, apply xeroform, dry dressing. Change daily and PRN dislodgement until resolved." A record review of the facility's investigation report "Self Inflicted Injury" dated 04/11/24 revealed " ... Incident location: Dining room ... Incident Description: It was reported in standup this morning that resd(resident) had spilled his coffee in his lap this morning before breakfast. The housekeeper took him to his room to be changed but he was upset because he wanted the housekeeper to change him that she could not change him. Resident Description: Resd stated that he just spilled his coffee ... Immediate Action Taken ...RESD was taken to his room to have his clothes changed ...Other info Unable to determine predisposing environmental, physiological factors or situation at the time of the incident ... No witnesses found ..." A record review of Resident #1's "Progress Note"	F 689			

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F 689	Continued From page 27 with effective date 04/11/24 at 12:49 PM, revealed self-inflicted injury 04/11/24 10:40 AM, " ... It was reported in standup this morning that resd had spilled his coffee in his lap this morning before breakfast. The housekeeper took him to his room to be changed but he was upset because he wanted the housekeeper to change him, and she was informing him that she could not change him. Around lunch, the CNA notified writer that resd had a blister noted. Upon Assessment, a blister measuring 4.1 cm (centimeters) x 6.0 cm was noted to left inner thigh. Silvadene and dry dressing was applied ... nurse practitioner was notified, and she stated to continue with same treatment daily. Attempted to notify RP (responsible party) but no answer. Resd without any pain noted and tolerated well." A record review of Resident #1's "Progress Note" dated 05/08/24 12:15 PM revealed " ... Resd was seen by NP (nurse practitioner) with wound management specialists today ... Burn blister to left thigh has ruptured and is classified as a 3rd degree burn. New order to clean with NS, apply Medi-honey and Aquacel ag and dry dressing daily. RP notified ..." A record review of Resident #1's "Progress Note" dated 06/06/24 10:48 AM revealed " ... Resd was seen by NP with wound management specialists on 06/05/24. New order for burn to left inner thigh received. Updated orders and notified RP ..." A record review of Resident #1's "Progress Note" dated 07/03/24 11:52 AM revealed " ... Resd was seen by NP with wound management specialists today. No change to orders were made but writer did update treatment orders. Wound assessment	F 689			

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F 689	Continued From page 28 completed as well. RP notified ..." A record review of Resident #1's "Progress Note Details" from Wound Care NP with notes from 01/03/24 through 05/08/24 revealed " ... 04/24/24 ... report of spilling coffee on himself last week. Now has a large third degree burn to left upper thigh, denies pain. Full thickness tissue loss, slough covering wound bed. Plan to start covering with xeroform daily ... 05/01/24 ... Burn to left thigh remains covered with some adherent slough. Provided gentle debridement ... 05/08/24 ... Burn also slowly improving with some pink granulation tissue along edges, continues to have a large area of adherent slough. Plan to start applying Medi-honey daily ..." A record review of Resident #1's "Progress Note Details" from Wound Care NP with notes from 05/08/24 through 06/26/24 revealed " ... 05/15/24 ... Burn to left thigh with similar dimensions, however increased about of pink tissue noted along edges, adherent slough remains in middle. Continue Medi-honey daily ... 05/22/24 ... Burn to left thigh continues to have a large amount of slough to middle of wound bed, pink granulation tissue surrounding. Peri wound moist and macerated. No s/s (signs and symptoms) of infection. Tolerated gentle debridement, was able to remove most of the slough. Plan to start applying collagen plus super absorber dressing daily ... 05/31/24. Burn with slightly smaller dimensions. Continue collagen plus aquacel ag ... 06/05/24 ... No change to burn left thigh-pink wound bed, scant slough, less drainage, no s/s of infection. Resume covering with Xeroform ... 06/12/24 ... Burn to left thigh with similar dimensions. Pink wound bed, moderate amount	F 689			

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F 689	Continued From page 29 of yellow drainage. Peri-wound intact, no erythema. Plan to start covering with Dakins moist dressings daily ... 06/19/24 ... Burn to left thigh improved this week with smaller dimensions, less drainage. Plan to continue covering with Dakins moist dressing daily ... 06/26/24 ... Burn to left thigh unchanged, peri-wound macerated. Plan to start covering with Gentamicin plus Aquacel Ag ..." A record review of Resident #1's "Procedure/Progress Note-Outreach Component" for wounds completed by the wound nurse practitioner revealed measurements of the burn third degree burn to the left thigh for Resident #1 measured 4.5 centimeters (cm) x (by) 5.8 cm x 0.2 cm on 04/24/24 and the area was healed on 07/10/24. The facility submitted the following acceptable Removal Plan on 08/02/24: On 8-2-2024 at 11:15 P.M. the State Survey Agency notified the administrator that the facility failed to ensure adequate supervision when Resident 1, who had diagnoses including Diabetes Mellitus (DM), Hemiplegia (left side), Vascular Dementia, and moderately impaired cognition, spilled hot coffee onto his left thigh, which resulted in a third degree burn. On 4/11/2024 at lunch, after 11:15 a.m., it was reported to the resident care coordinator (RCC) nurse that Resident 1 had spilled coffee on himself and upon assessment it was noted that there was an intact blister to the left medial thigh. The site was cleaned with normal saline and Silvadene and dry dressing applied. The resident care coordinator notified the provider and order to continue the same treatment were received and	F 689			

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F 689	Continued From page 30 to be completed daily. The resident did not complain of any pain at the time. The nurse attempted to notify the resident representative unsuccessfully initially. However, the resident representative did call back and was notified about the burn and the treatments and was updated weekly. After the blister ruptured, the wound care nurse practitioner classified the wound as a third degree burn with new treatment orders. The resident representative was notified and updated. Treatment and care to the burn was ongoing and have since been discontinued as the site has healed. 1. In an effort to immediately protect the residents, the coffee machine was taken out of service on 8-2-2024 so that individuals cannot serve themselves coffee. Individual pots of coffee will be made beginning today, 8-2-2024 and temperatures of the pots will be monitored to ensure that the coffee served is at or below 140 degrees Fahrenheit. Resident #1 will be served coffee at or below 140 degrees Fahrenheit. 2. The root cause of the accident was the hot liquid policy was not followed. This along with the lack of proper supervision resulted in the injury. 3. On 8-2-2024, Coffee Temperature logs were created to indicate the temperature of the beverage prior to serving. This will serve as record of temperatures of coffee being served. 4. Training for all staff prior to working shifts was initiated on 8/2/2024 by the staff development nurse and the Director of Nursing on the following topics: Safety and supervision of residents -Care Plans · Temperature logs for coffee · hot liquids policy No staff will be allowed to work until they	F 689			

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F 689	Continued From page 31 have received appropriate training. 5. Updated the care plans for resident # 1 and identified thirty-three residents that were at risk to include interventions to prevent burns. 6. Weekly body audits were completed for all residents on 8-2-2024 and there were no burns noted. 7. Quality Assurance and Performance Improvement committee meeting was conducted on August 2, 2024, at 12:21 p.m. and the issue was discussed including root cause and appropriate remedies. Attending the meeting: Medical Director, Administrator, Director of Nursing, Resident Care Coordinator/ Infection Preventionist, Dietary Manager, Social Worker, Business Office Manager, Staff Development Nurse, Minimum Data Set Nurse, Medical Records Clerk, Environmental Services Manager, Maintenance Director and the staff scheduler. The facility alleges all corrective actions were completed on 8-2-2024 at 2:00 p.m. and the IJ was removed on 8-3-2024. Validation: The State Agency (SA) validation of the Removal Plan was made on-site during the Complaint Investigation (CI) MS #25877 through record review and interviews on 8/5/24. The SA determined all corrective actions were completed on 8/2/24 and the IJ was removed on 8/3/24.			F 689			