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F 323	Continued From page 12 related to diagnosis of recent fall with fracture and total hip replacement. R2 was found on the floor by E17 (CNA). August 4, 2013 at 7:45 pm, R2 was found on the floor, lying on left side complaining of left hip pain and headache, unable to move left leg. Transfer to Acute Care Hospital Report: August 4, 2013 at 7:50 pm, E18 (nurse) completed transfer papers to hospital for R2. E18 documented reason for transfer to hospital as followed: "patient got up to walk, un-witnessed, fell to ground "I feel like I cracked my head open" patient unable to extend left leg. Emergency Room Report: Visit Date August 4, 2013 at 10:35 pm, R2 was diagnosed by a physician as a having a coccyx fracture (Tail bone fracture). Fall Care Plan: July 28, 2013 R2 has impaired cognition, is status post left hip fracture and has left hip pain. Impaired/decreased physical activity and mobility related to left total hip replacement. Minimum Data Set (MDS): Admission R2 is scored as a 2 for moderately impaired and decision making skills. R2 requires cues and supervision.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 13 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	F9999		

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F9999	Continued From page 14 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, interviews and record review the facility failed to adequately supervise and protect 3 (R1, R2 and R3) of 3 sampled residents from serious injuries and hospitalization. This failure resulted in; R1 sustained second degree burn to both thighs from hot coffee, R3 sustained a 5X7cm (centimeter) first degree burn to right knee from hot coffee and R2 fell, sustaining a broken tail bone. Findings Include: 1. R1 has diagnosis of dementia, hallucinations, depression, behavioral disorder, osteoporosis and osteoarthritis. R1 is alert but confused and	F9999		

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disoriented. R1's care plan states that R1 needs assistance in all activities of daily living (ADL's). R1's assistance varies from cueing to maximum assistance depending on mood and behavior. Cognitive status: R1 is frequently forgetful and confused. Resident has no awareness to safety.
August 2, 2013 at 1:20 pm., E5 (Restorative Aide) with E6, E7 and E10 (CNA's/Certified Nursing Assistants) were passing lunch trays on the memory care unit. The CNA's picked the trays up from the table as the dietary staff pulled the trays from the cart and placed hot beverages such as coffee and tea into the open cups with no lids. The trays were then taken to the residents with the hot liquids on them and left in front of the unattended residents . E5, E6, E7 and E10 continued to get in line and pass one tray after another until all of the thirty residents received their lunch trays. No one was watching the residents when the trays were placed in front of them. The nurse (E3) was in the medication room.
August 6, 2013 at 12:05 pm, E11 (Dietary Manager) and E12 (Dietary aide), brewed a fresh pot of hot coffee in the main kitchen. Writer asked E11 to obtain a temperature on the fresh coffee after it was completely brewed. The temperature measured at 170 degrees Fahrenheit. The coffee was then transferred into three Ivory carafe containers and placed in the holding unit to be transported to the memory care unit.
August 6, 2013 at 1:00 pm. Surveyor and E11 followed food carts/coffee containers to the memory care unit. The carts were placed in the kitchenette. E11 was asked to obtain coffee temperatures again, the temperature measured at 145 degrees in Fahrenheit.
August 6, 2013 at 1:12 pm, E12 poured the first

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cup of coffee from the carafe into a cup with no cream or sugar. The temperature was taken and measured at 136 degrees in Fahrenheit. The coffee was placed on a tray and set in front of R4 by E5. E7 placed food trays with open hot beverages in front of R5 and R1.

August 2, 2013 at 2:00 pm, E5 (Restorative Aide) stated that on July 30, 2013 at 9:30 am, R1 was in the dining room having breakfast. (E5) was sitting next to R1 providing supervision with meals. R1 called out to staff that her coffee was cold. E5 took the coffee from R1's tray and went into the kitchenette to warm the coffee up in the microwave. E5 stated she changed her mind and did not use the microwave.

E5 stated she got a fresh cup of coffee out of the kitchenette. E5 stated the coffee was hot because she could see the steam from the cup. E5 stated she placed the hot cup of coffee on the table in front of R1. E5 stated I told R1 that the coffee was hot, to be careful; I left the table of R1 to attend to another resident at a different table. E5 stated she was taking care of another resident when she heard R1 screaming. E5 stated she turned around to see that the coffee was spilled all over R1. E5 stated she tried to help R1 when CNA's E6 and E10 assisted by getting more clothing protectors to place under R1's chest area.

August 2, 2013 at 12:50 pm, E6 stated she was passing trays when E5 started screaming at her that she passed cold coffee to residents. E6 stated she saw E5 go towards the kitchenette to warm up the coffee. E6 stated she continued to pass her lunch trays when she heard R1 screaming "I am burning, I am burning." E6 stated E10 came to the table and took R1 into her room to change her clothes. E6 stated R10 brought R1 back to the table to finish the rest of

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her lunch.
August 2, 2013 at 2:00 pm, E10 stated he was in the dining room when he heard a loud scream coming from R1. E10 said he asked E5 what is going on, E10 said E5 was sitting on the left side of R1 placing clothing protectors under her clothes trying to separate the clothing from R1's skin. E10 said he grabbed some more clothing protectors to give to E5 to place under R1's chest. E10 stated he looked down and saw that R1 was soaked on her lap as well and decided to rush R1 quickly to the room to change her clothes.
E10 stated he told E7 another CNA he was leaving the dining room to change R1's clothes. E10 stated he passed the nurse while taking R1 to her room, the nurse was passing medications; when he told her that R1 had spilled hot coffee all over lap and chest area. E10 stated that E3 (RN/Registered Nurse) told him to put some skin barrier cream on the burned areas.
E10 stated he can tell that R1 was burning so he grabbed top off right away. E10 stated he struggled to get the pants off R1, because R1 was moving all around and screaming "HOT, HOT."
E10 placed the skin barrier cream that is used for incontinent care on R1's chest and thighs. E10 stated after he changed R1's clothes, he immediately took R1 back to the dining room for E5 to finish breakfast.
E10 was asked if E3 (RN) came into the room with him to assess R1's burns. E10 stated No, E3 did not come into the room with him while he was changing and putting skin barrier cream on R1. E10 stated he dressed R1 and put R1 back in wheel chair and rolled R1 into the dining room to finish breakfast.
August 2, 2013 at 3:10 pm, E7 stated she was

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not there to witness the incident. E7 stated she was taking care of another resident when she heard R1 screaming. E7 said she asked E5 and E10 what happened to my resident. E7 said E10 told her that R1 spilled coffee. At about 2:30 pm, I was told by E3 to check R1's thighs and I saw the blisters on the right thigh and I went and told E3.

August 2, 2013 at 3:40 pm, E3 (RN) stated she was passing the morning medications. I heard R1 screaming and I was told that R1 dropped coffee in lap. "E10 was using clothing protectors to blot under clothing and on top." E3 stated, she followed E10 to the room and helped remove the clothes quickly. E3 stated she and E10 placed R1 in the bed and covered R1 with a sheet. E3 was asked if R1 returned to the dining room to finish breakfast. E3 responded No, we put R1 in bed and that is where R1 stayed.

E3 was asked if she assessed R1's wounds and told E10 to place skin barrier cream on the wound. E3 did not answer and kept changing her information of the incident. E3 was asked if she called the physician and E3 stated yes I did twice but was not able to recall what times she called the physician. E3 stated she left the supervisor (E2, Assistant Director of Nursing/ADON) a voice message earlier in the day and that E2 was in a meeting all day. E3 stated she was waiting for E3 to call her back to let her know that R1 had burned herself.

August 2, 2013 at 11:45 am, E2 (ADON) stated, R1 is alert but disoriented for the most part. R1 is not able to make her own decisions. E2 stated R1 is care planned for poor safety and depends on staff to make all safety awareness decisions. E2 stated that on July 30, 2013 at about 1:45pm-2:15 pm, not certain of time; E3 asked if I got her voice message that R1 spilled coffee on

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lap and there are blisters. I told E3 I was in a meeting all day and had not checked my voice mail messages. E2 stated when E3 said blisters she did not allow E3 to finish the telephone conversation; that she rushed upstairs to check on R1's condition.
E2 was asked if E3 notified the physician and if any orders were carried out by any nurses for R1 prior to E2 coming up to assess R1's thermal burns. E2 responded I was not aware of any orders being implemented by the nurse per the physician. E2 stated she immediately told E3 to call the physician for special foam to help heal blisters and drainage of the blisters. E2 stated she asked R1 if there is any pain but that she is also aware that R1 is not able to respond appropriately to that question.
Facility's Policy for Medical Emergencies:
2. All residents will receive timely assessment and care in the event of a medical emergency. Emergency situations include, but are not limited to: cardiac arrest, acute seizures, Shock, Trauma, such as burns, fractures, lacerations, poisoning, etc.
In all emergency situations the immediate needs of the resident(s) will be assessed and treated, and the on-call and/or attending physician will be notified as soon as possible for further orders.
D. Acute Trauma (e.g., burns, severe lacerations, fractures or other trauma), Nurse's duties are to:
1. Assess results of trauma and maintain patent airway.
2. Administer routine first aid as necessary; cover wounds with dressing; apply wet compresses to burns, applies splits and flushes chemical burns with water, etc.)
8. Notify the attending physician, physician on call, or Medical Director as indicated.

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Physician Statement:
August 6, 2013 at 9:30 am, Z1 (Physician) was asked what time he was made aware of R1's injury. Z1 stated around 2:45pm, because he was in his vehicle headed to his other facility. Z1 stated he was left a voice message without a number or any general information as to the urgency of the call. Z1 stated he had to wait until he arrived to his facility and then he googled the facility phone number and called to find out that R1 had spilled coffee on her.
Z1 stated he visited R1 at the facility on August 5, 2013 and was asked by the facility why he did not come to see R1 related to the incident. Z1 stated "no one asked me to come out to the facility or told me the severity of the phone call or about any blisters on my patient."
Wound Assessment Detail Report:
July 30, 2013 at 2:18 pm, report ordered by E2 and completed by E3 documents R1's wounds as active thermal-burn with partial thickness.
Wound report pictures show different views of formed blisters and redness of the right groin area. The documentation and the wound certified nurse indicated the burn to be a second degree burn.
Physician Order Sheet:
July 30, 2013 at 9:30 pm., order to the pharmacy for R1's wound treatment to the burn area was not carried out until 9:30 pm for a special silver cream to the burn site. R1 went the entire day without any treatment or pain medication for the second degree burn. E2 was asked if she was aware that R1 was not treated for burns, E2 stated she was not aware until the PM shift nurse made her aware.
Nursing Notes and Medication Administration Record:
July 30, 2013 at 3:44 pm E3 documented that R1

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sustained three 2nd degree burns to her right groin and one 1st degree burn to her left groin area.
July 31, 2013 at 4:30 am, R1 was awake and calling out "mother " with facial grimacing, R1 was medicated with Norco 5/325 mg. (milligrams) for comfort.
2. R3 has a diagnosis of degenerative Joint Disease (DJD), Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), chronic back pain and Peripheral Vascular Disease (PVD). R3 is care planned for generalized weakness due to limited mobility.
Incident Report:
February 20, 2013 at 8:40 am, R3 was eating breakfast in the dining room when hot coffee was spilled onto right leg. R3 sustained a chemical burn with pinkish discoloration on the right knee.
Skin Detail Report:
R3 sustained a 1st degree burn to the right knee.
Nursing Notes
Feb. 20, 2013 at 3:56 pm, R3's right knee noted to be pink and measured site at 5cm x 7 cm (centimeters). Resident states 6/10 pain of burning sensation. No blisters noted and ice pack applied. Physician and family made aware of incident.
3. R2 has a diagnosis of dementia, DJD, glaucoma, osteoporosis and a new hip fracture/replacement on 07/25/13. R2's Minimum Data Set (MDS) scores R2 as alert but confused, not able to make own decisions. R2 is care planned for previous injuries and lack of safety awareness for self. R2 requires total assistance of ADL's from staff and does exhibit moods and behaviors.
Admission Report:
R2 was admitted to the facility on July 28, 2013 at 4:30 pm. R2 was received via paramedics after

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being discharged from the local hospital where R2 had a total hip replacement as a result of a fall on July 25, 2013. R2 fell while outside and broke the left hip. Admitting Diagnosis: Difficulty in walking related to fracture of the femur, new hip replacement, history of falls and generalized muscle weakness. R2 's care plan does not have any type of alarm device intervention to alert staff of attempts to get out of chair.
Admission Nursing Assessment/Nursing Notes:
July 28.2013 at 4:30pm, E13 (nurse) documented R2 was received from the local hospital via stretcher and paramedics with spouse. R2 was transferred to bed with a three person extensive assist. R2 was in significant pain but was unable to describe the pain. Patient is alert to name only, spouse answers all questions. R2 is unaware of the year, season or President.
July 29, 2013 at 8:45 am, (E14) nurse documented R2 as alert but confused to her surroundings. R2 was very fidgety in bed and continually tried to sit on edge of bed. R2 had torn off left hip dressing from left hip surgical site.
August 6, 2013, at 11:00 am, E2 (Assistant Director of Nursing) was asked why R2 did not have an alarm attached since the facility was aware that R2 had fallen a few days ago and just had a new hip replacement. (E2) stated the alarms startle our residents on the Dementia unit so we just decided sometime in June or July of 2013 not to use the alarms. We use them in the facility but not on the Dementia unit.
Fall Risk Screen Assessment:
July 28, 2013 in the section of Mobility when rising from chair: E13 stated that R2 made multiple attempts and was successful in rising from the chair. The risk factor increase tool documented by E13 states that R2 is (4 times more likely to fall than if R2 stands with a single

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F9999	Continued From page 23 movement). R2 is unable to rise without assist. Incident/Occurrence Report: Type = Falls August 2, 2013 at 6:50 pm, R2 was noted to be sitting at the very edge of her wheelchair, the seat cushion was sliding off the chair. R2 was trying to reposition self. The wheel chair was unlocked which made it difficult for R2 to get back in the chair. R2 has impaired balance and coordination with generalized weakness and poor safety awareness. R2 is on psychotropic drug use, related to diagnosis of recent fall with fracture and total hip replacement. R2 was found on the floor by E17 (CNA). August 4, 2013 at 7:45 pm, R2 was found on the floor, lying on left side complaining of left hip pain and headache, unable to move left leg. Transfer to Acute Care Hospital Report: August 4, 2013 at 7:50 pm, E18 (nurse) completed transfer papers to hospital for R2. E18 documented reason for transfer to hospital as followed: "patient got up to walk, un-witnessed, fell to ground "I feel like I cracked my head open" patient unable to extend left leg. Emergency Room Report: Visit Date August 4, 2013 at 10:35 pm, R2 was diagnosed by a physician as a having a coccyx fracture (Tail bone fracture). Fall Care Plan: July 28, 2013 R2 has impaired cognition, is status post left hip fracture and has left hip pain. Impaired/decreased physical activity and mobility related to left total hip replacement. Minimum Data Set (MDS): Admission R2 is scored as a 2 for moderately impaired and decision making skills. R2 requires cues and supervision. (B)	F9999		

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