STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. BUILDING _____ B. WING _____	**04/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY AT PACIFIC	**916 PACIFIC AVENUE 3RD-5TH FLOORS EVERETT, WA 98201**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure safe hot liquid temperatures for one of three residents (#1) reviewed for accidents and hazards. This failure resulted in harm in the form of a burn to Resident #1 requiring treatment. Findings included . Review of a facility policy, titled, Hot Liquid Safety, dated 09/23/2019, showed the following: - The temperature of hot liquids would be checked in the dietary department prior to distribution to the nursing units. If the temperature was greater than 140-150 degrees Fahrenheit, hold the liquid in the dietary department until it reached a more appropriate temperature; - All residents were assessed for their ability to handle containers and consume hot liquids. Residents with difficulties received appropriate supervision and use of assistive devices in order to consume hot liquids. Interventions would be individualized and noted on the resident's plan of care. Interventions included but not limited to: a. Wide based cups; b. Cups with lids and handles; c. Limit Styrofoam cups to residents with no difficulties; d. Aprons; and e. Disallow hot liquids while lying in bed. - General safety precautions when serving hot liquids included but not limited to: a. Make sure resident was alert and in proper positioning to consume hot liquids; b. Use cups, mugs or other containers that were appropriate for hot beverages; c. Do not overfill containers; d. Regulate temperature of hot liquids to which residents have direct access; e. Place filled containers directly on table. Do not hand them directly to residents; f. Keep hot liquids away from edges of the table; and g. Do not refill containers while the resident is holding the container. - Time and Temperature Relationship to [MEDICAL CONDITION] showed if the water temperature was 155 degrees it would take 1 second for a 3rd degree burn to occur. If the water was 148 degrees, it would take 2 second for 3rd degree burn to occur. If the water was 140 degrees, it would take 5 second for a 3rd degree burn to occur. -[MEDICAL CONDITION] occur even at water temperatures below those identified in the table, depending on an individual's condition and the length of exposure. The policy was updated on 04/16/2020 and showed the following: The temperature of hot liquids would be checked in the dietary department prior to distribution to the nursing units. If the temperature is greater than 140 degrees Fahrenheit plus or minus five degrees, hold the liquid in the dietary department until it reached a more appropriate temperature. Resident #1 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 02/28/2020, showed the resident was independent with eating with set up help only. The MDS showed the resident scored 09/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderate cognitive impairement. Review of a Nutrition Risk Assessment, dated 03/03/2020, showed the resident drank a lot of coffee. A note in the assessment stated, per last assessment: He sometimes eats quite quickly, causing coughing, which then impairs his PO (by mouth) intake overall . The assessment showed the resident was independent/supervision in the dining room with set up. Under the nutritional summary of the assessment, it showed the resident's PO intake was generally fair to poor, and nursing was to provide encouragement of PO intake during meals. Review of a Skin Check- Non-Pressure Weekly assessment, dated 04/08/2020, showed the resident had chronic excoriation/redness to his perineal area and buttocks due to refusing at times to be changed. Review of an incident report, dated 04/10/2020, showed the resident was sitting up in bed for breakfast around 9:30 AM. The incident report showed the resident had placed his coffee cup to his right side on the bed. The resident's coffee spilled and caused a reddened area to the right side of the hip, measuring approximately 13 cm (centimeters) x 13 cm, and later developed into a blister, measuring 3 cm x 2 cm and was noted to be painful to the touch. The incident report showed the coffee cup had a lid on it prior to being spilled. Review of a Skin Check- Non-Pressure Weekly assessment, dated 04/10/2020, showed the resident had a burn to the right thigh (front) measuring 13 cm x 13 cm. The resident's right trochanter (hip) was noted as a site of the burn as well. The notes read approximately 13 cm x 13 cm scattered red right lateral upper thigh, treatment as ordered [MEDICATION NAME] (a topical medication) twice daily. Review of a Skin Check- Non-Pressure Weekly assessment, dated 04/13/2020, showed the right trochanter (hip) had a burn measuring 13 cm x 13 cm. The notes showed the right side of the hip was noted to have a reddened area approximately 13 cm x 13 cm, and later developed a blister to the proximal end that measured approximately 4 cm x 4.5 cm x 0.1 cm. No other skin issues identified. Review of the Hot Beverage Temperature Log, dated April 2020, showed on 04/10/2020 the hot beverage temperature for breakfast was 140 degrees. The log showed the temperatures of hot beverages were consistently between 140 degrees Fahrenheit and 150 degrees Fahrenheit for 04/01/2020 - 04/14/2020. Review of an occupational therapy note, dated 03/06/2018, showed the resident had no difficulty feeding himself, but did not mention handling of hot fluids or beverage containers. Review of the comprehensive care plan, review date 04/16/2020, showed the resident had the potential to be verbally aggressive related to dementia with poor impulse control. The care plan showed the resident had impaired cognitive function/dementia or impaired thought process related to dementia caused by [MEDICAL CONDITION]'s (stokes). Interventions included providing the resident with necessary cues, and the resident needed assistance with all decision making. The care plan indicated under the fall care plan focus area interventions that the resident had no or poor safety awareness, and that the resident did not use his call light. Review of the medical record, review date 04/17/2020, showed that prior to 04/14/2020, the resident did not have an assessment for his ability to handle containers and consume hot liquids. In an interview on 04/16/2020 at 10:27 AM, Resident #1 stated when asked about the coffee spill incident, that his coffee cup did not have a lid on it. The resident stated when he spilled the coffee it burned him and it was painful. The resident was observed to have steady hands with no concerns for dexterity. In an interview on 04/16/2020 at 10:33 AM, Staff B, Nursing Assistant Certified (NAC), stated she had never been asked to heat up coffee for a resident. In an observation on 04/16/2020 at 10:38 AM, with Staff A, Registered Nurse (RN)/Resident Care Manager (RCM), showed the 3rd floor nourishment cart with coffee poured into a coffee cup and the temperature was observed to test at 157 degrees Fahrenheit. Staff A stated the coffee was made in a separate machine on each floor in the nourishment room. In an observation and interview on 04/16/2020 at 10:45 AM, Resident #1's coffee burn wound was observed with Staff A. The wound was observed to be covered with a 4 inch x 4 inch white dressing. The wound was on the lateral right hip and upper right thigh. An open area measuring approximately 5 cm x 4 cm was observed to be red and raw. An area adjacent to the open area was observed to be red and measuring approximately 3 cm x 3 cm. Staff A stated they were using [MEDICATION NAME] ointment to treat the burn. In an observation on 04/16/2020 at 10:55 AM, Staff A took the temperatures of the liquids on the 3rd floor nourishment carts. Cart 1 was observed to have two coffee pots. The coffee temperature was measured at 155 degrees Fahrenheit and 151 degrees Fahrenheit and the hot water temperature was 140 degrees Fahrenheit. Cart 2 was observed to have one coffee pot temperature at 155 degrees Fahrenheit, a pot of decaf coffee temperature at 140 degrees Fahrenheit, and hot water temperature of 130 degrees Fahrenheit. The temperature log for the carts only allowed for one temperature to be recorded. Staff A was asked how she knew which temperature was recorded on the log, she stated she did not know specifically, but did state all of the hot water came out of the same coffee maker. In an observation and

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

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) interview on 04/16/2020 at 11:10 AM, Staff C, Dietary Manager, stated she wrote a new hot drinks policy in January 2020 and that hot drinks were supposed to be between 140-150 degrees Fahrenheit. Staff C took the temperature of the coffee thermos container on the 5th floor nourishment room, and the temperature read 150 degrees Fahrenheit. Staff C made a fresh pot of coffee and took the temperature, which read 150 degrees Fahrenheit. Staff C stated she knew Resident #1 liked his coffee hot, and prior to COVID closing the dining rooms, the resident would ask staff to heat up his coffee for him. In an interview on 04/17/2020 at 11:14 AM, Staff D, CNA, stated sometimes residents ask for their coffee to be heated up and they use the microwave. Staff D denied temping the fluids after microwaving, and stated she would feel the cup with her hand to check temperature and inform the resident it was hot. Staff D stated they typically only put lids on coffee if the resident is traveling for example from the dining room to their room, but if serving from the drink cart right outside of a resident room, they would not necessarily put a lid on it unless the resident asked for a lid. In an interview on 04/17/2020 at 11:19 AM, Staff E, NAC, stated the NAC's do not check the temperatures of fluids, but the dietary aides did. Staff E stated they typically only put lids on hot beverages if the resident was travelling with it, for example from the dining room to the resident's room, but if serving the resident in their room, they do not usually put a lid on it unless the resident asked. In an interview on 04/17/2020 at 11:50 AM, Staff A stated the floor staff do not warm up beverages, but dietary prepared the hot beverages and took the temperatures. Staff A stated the temperature should be between 140 degrees Fahrenheit and 150 degrees Fahrenheit, and on 04/10/2020, the day of the incident, the temperature log for the morning hot beverages was 140 degrees Fahrenheit. In an interview on 04/17/2020 at 12:01 PM, Staff F, weekend dietary supervisor, stated when coffee comes out of the coffee machine, it usually comes out at 150-160 degrees Fahrenheit, and with the lag time before going on the floor, it was usually 150 degrees Fahrenheit by the time it was being served. Staff F stated there was no hard rule on what a safe temperature was to prevent scalding. Staff F stated there were a few residents that on occasion would ask staff to heat their hot beverages up because they preferred the hotter temperatures. Staff F stated when she did this, she would check the temperature with great care to make sure it was not too hot, and inform the resident that it was hot. Staff F stated if taking the nourishment cart/beverage cart to the floor and serving to residents in their rooms, they do not typically put lids on hot beverages unless the resident asks or will be traveling with their fluids, for example going from the dining room to the resident's room. In an interview on 04/17/2020 at 12:37 PM, Staff G, Dietary Aide, stated the process was to brew the coffee in the nourishment room and the temperature was typically 150 degrees Fahrenheit or higher. In an interview on 04/17/2020 at 12:53 PM, Staff H, Dietary Aide, stated when making hot beverages like coffee or preparing the hot water, the temperature was usually between 150 - 155 degrees Fahrenheit. Staff H stated she put lids on hot beverages if a resident had shaky hands, or if the resident requested one. In an interview on 04/20/2020 at 10:49 AM, Staff I, CNA, stated that on the morning Resident #1 spilled his coffee and burned himself, he was working with the resident. Staff I stated he had helped the resident to prepare for breakfast, brought the resident his breakfast tray, and the resident requested coffee. Staff I stated he provided the resident with coffee in a cup with a lid on it, and proceeded to go help other residents. Staff I stated a short time later he went to collect Resident #1's breakfast tray, and the resident stated calmly that he had accidently burned himself with his coffee. Staff I stated the resident's coffee cup still had the lid on it but was upside down on the bed on the resident's right side. Staff I stated the resident stated he did not feel it at first. Staff I stated he immediately got a cold cloth and the nurse to assess the resident. Staff I stated the resident does not usually remember his name and can be forgetful, but was mostly alert and oriented. Staff I denied hearing the resident call out in pain or using call light to call for help. Staff I stated the resident was calm following the incident, and stated the next day the resident had forgotten about the incident when Staff I asked about it. In an interview on 04/20/2020 at 2:32 PM, the Director of Nursing (DNS), stated the resident was alert and oriented and able to express needs. The DNS stated she found out from staff interviews the resident preferred his coffee hot. The DNS stated the resident was able to move all extremities, and that his [MEDICAL CONDITION]/[MEDICAL CONDITION] did not impact the resident's movement. The incident report for Resident #1's burn and the hot liquid policy were reviewed with the DNS. The DNS acknowledged based on the way the policy was written, the appropriate temperature of the coffee was confusing. The DNS stated the resident was assessed for handling hot beverages upon admission. The facility policy stated hot liquid temperatures should be cooled if between 140-150 degrees Fahrenheit, and staff stated that the appropriate temperatures were between 140-150 degrees. The morning of the incident, the temperature log showed hot beverages were at a temperature of 140 degrees Fahrenheit. The resident reported the coffee cup had no lid, and Staff stated they do not typically place a lid on hot beverages unless transporting or a resident requests a lid. The incident report indicated there was a lid on the coffee cup. The resident received a burn forming into a blister as a result of a coffee burn. The facility failed to ensure safe and appropriate temperatures for hot fluids, failed to implement the hot fluid policy, and failed to assess the resident for handling container and consuming hot fluids resulting in harm in the form of a burn, requiring treatment. Reference: (WAC) 388-97-1060 (3) (g)