STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045457	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN LIVING CENTER AT STAGECOACH	6907 HIGHWAY 5 NORTH BRYANT, AR 72022

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** Complaint # (AR 728) was substantiated, all or in part, with a deficiency cited at F689. Complaint # (AR 773) was substantiated, all or in part, with a deficiency cited at F689. Based on observation, record review and interview, the facility failed to provide adequate supervision to prevent accidents for 1 (Resident #1) of 2 (Residents #1 and #2) case mix residents who were at risk [MEDICAL CONDITION] hot liquids. The facility failed to ensure staff provided coffee that was at a safe temperature in order to prevent injury in case of accidental spillage. The facility failed to ensure staff notified the physician after discovering a coffee burn had occurred, which resulted in a delay in treatment to the wound. These failures resulted in past non-compliance and actual harm for Resident #1 when she sustained a second degree burn to her thigh due to spilling coffee in her lap. This failed practice had the potential to affect 32 residents who were at risk [MEDICAL CONDITION] hot liquids according to a list provided by the Director of Nursing (DON) on 8/7/2020 at 2:10 p.m. The facility corrected the deficient practice on 5/11/2020 prior to the survey entrance date. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/03/2019 documented the resident scored 4 (0-7 indicates severe impairment) on the Brief Interview for Mental Status (BIMS), had adequate vision, had no behaviors and had no upper extremity impairment. a. A Nsg (Nursing) Admit/Readmit Assessment with Care Plan effective date 11/12/2019 documented, . Hot Liquid Risk . Care Planning: Resident is at risk [MEDICAL CONDITION] hot liquids. Resident to drink hot liquids while sitting at table only. Resident to use cup with a lid. Temperature of liquids is not to exceed 140 degrees. b. The Care Plan documented in the Focus section, Resident is at risk [MEDICAL CONDITION] hot liquids. Revision on: 11/25/2019 . The Intervention section documented, Resident to drink hot liquids while sitting at table only . Revision on 11/25/2019. c. A Nsg Admit/Readmit Assessment with Care Planning effective date 04/28/2020 documented, .Hot Liquid Risk . Care Planning: Resident is at risk [MEDICAL CONDITION] hot liquids. Resident to drink hot liquids while sitting at table only. Temperature of liquids not to exceed 140 degrees. This assessment was signed by the Care Plan Coordinator on 05/12/2020. d. The Care Plan documented in the Focus section, Resident is at risk [MEDICAL CONDITION] hot liquids. .Revision on 5/12/2020. The Intervention section documented, Resident to use cup with lid for hot liquids. Date Initiated: 05/12/2020. Temperature of liquids not to exceed 140 degrees. Date Initiated: 05/12/2020. The Care Plan also documented in the Intervention section, RESOLVED: Resident to use cup with lid for hot liquids. Resolved 5/12/2020. e. A Late Entry Nurse's Note written on 05/13/2020 by Licensed Practical Nurse (LPN) #1 documented, 5/9/2020 - 10:30 a.m. - Note Text: called to resident room. Resident with burn to left inner thigh. Resident stated that she spilled coffee on her lap while trying to place cup on overbed table. Instructed resident and staff to not drink hot beverages unless they were in a covered container. f. A Late Entry Nurse's Note dated 05/13/2020 by LPN #1 documented, 5/9/2020 - 10:30 a.m. - Hot Rack Charting: called to resident room. Resident with burn to left inner thigh. Resident stated she was trying to place cup of coffee on overbed table and spilled some on her lap. Instructed staff and resident to ensure containers were covered when resident consuming hot liquids. g. A Late Entry Nurse's Note dated 05/15/2020 by LPN #3 documented, 5/15/2020 - 10:47 a.m. Note Text: Resident was noted to have a 2nd degree burn to left lateral thigh r/t (related to) coffee spill. This area was observed by this treatment nurse Monday 5-11-2020. This nurse called (Advanced Practice Nurse) and notified her as well as DON and Administrator. All above noted. Assessed burn and notified POA (power of attorney), this nurse had a video teleconference call with (wound doctor) and received new treatment orders. Today this area is improving ruptured blister has [MEDICATION NAME] tissue and the small clear fluid filled blister is drying out. There is no drainage and resident states it feels a lot better. h. A Division of Medical Service (DMS)-762 dated 05/18/2020 documented, Received a call from . OLTC (Office of Long-Term Care) on 5/18/2020 stating we had an allegation that resident (Resident #1) got a coffee burn one day in May. On 5/8/2020 at approximately 10:15 a.m., (Activity Director) provided coffee in styrofoam cup from her personal coffee maker. Resident was up in chair with bedside table beside her. About 11:30 a.m., Activity Director went and got the resident to take her to the beauty shop. (Activity Director) stated initially she did not notice the resident was wet. (Certified Nursing Assistant (CNA) #2) was leaving beauty shop as (Activity Director) was pushing resident into the beauty shop. (CNA #2) asked resident did she wet herself and resident stated she spilled something on herself. The resident did not report to them what she spilled. After completing hair, Activity Director took the resident to the hall and reported to (CNA #1) that resident was wet and needed changing. (CNA #1) went and changed the resident and did not note any redness at that time. On 5/9/20 at approximately 9:30 a.m., (CNA #3) removed resident's brief and noted what she initially described as a scratch on her leg. (CNA #3 and CNA #4) were providing resident a shower. (CNA #4) described area as a burn mark. (CNA #4) reports he went to notify (LPN #1) and another resident was telling (LPN #1) of the resident's burn. (CNA #4) confirmed to (LPN #1) that there was a burn mark. (CNA #3) stated she was going to report to the nurse (LPN #1). (CNA #3 and CNA #4) also told (CNA #1). (CNA #4) stated that (CNA #1) also reported to (LPN #1). (LPN #1) reports he was notified of the burn on 5/10/2020 and he assessed the area and applied zinc. On 5/11/2020, (LPN #2) was notified by (CNA #5 and CNA #6) that resident had spilled coffee on her left inner thigh. (LPN #2) notified (LPN #3) treatment nurse of the burn and blisters on resident's leg. (LPN #3) went and assessed the area. The resident had an elongated area where the blister had burst, and a second fluid filled blister intact. The area was described as a second-degree burn measuring 10.4 cm x (by) 5 cm. (LPN #3) then notified Administrator and DON. (LPN #3) notified (APN) and did a teleconference with (wound physician) concerning the burn to the left thigh and received treatment orders at 11:50 a.m. (DON) and (Administrator) went to interview the resident. Resident stated that she spilled the coffee in her lap. She stated she was trying to sit the cup of coffee on the over bed table and missed the table and dropped it in her lap . On 5/11/2020, individual coffee pot was removed from service. Full facility observation completed to ensure there were no other individual coffee pots. (Activity Director) was suspended pending investigation, allowed to return on 5/18/2020. Upon notification from OLTC, the investigation was reopened and (Activity Director) was again suspended pending further investigation. (LPN #1) was suspended pending investigation, allowed to return on 5/13/2020. Pain interview completed on resident. Stated she has had some pain. Did not report how much. Stated it did not keep her awake at night. Rated pain 2/10. (Rated 2 out of 10, indicative of mild pain) All resident's hot liquid assessments were updated by 5/13 with no negative findings. Staff in-serviced that all coffee served to residents must come from the kitchen. Staff in-serviced on abuse and neglect. 1 on 1 in-service with (LPN #1) along with charge nurse in-service on documentation needed for change of condition, treatment order must be obtained for skin impairments with appropriate notifications. 1 on 1 in-service CNA #1) and in-service charge nurses and CNAs, zinc requires physician order [REDACTED]. Upon discovery, the chart was reviewed, and it was determined there was no deviation from the POC (Plan of Care). In conclusion, the facility can't substantiate abuse, however, due to overall job performance and concern in judgement, (Activity Director) was terminated. (Resident #1)

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) has had no complaint of pain. Wound is completely resolved. i. A Late Entry physician progress notes [REDACTED]. Resident is . being seen today for a skin burn to her left inner thigh. Per report, she spilled coffee in her lap. No s/s (signs or symptoms) of infection noted on exam . Skin: Burn to left inner thigh . Wound #1 Date identified: 5/10/2020. Location: Left inner thigh. Type of wound: Burn. Stage: N/A. (not applicable) Measurement/Size: 8.29 cm (centimeters) x 2.05 cm < (less than) 0.1 cm in depth. Undermining/Tunneling: No. Drainage/Exudate: No. Odor: No. Tissue/Wound Bed: Granulation %: 70. [MEDICATION NAME] % 30. Edges: Attached. Peri-wound: Normal. Intact. Progress: Improving . Diagnosis (and) Assessment: 1. Burn to left inner thigh-Silver [MEDICATION NAME] cream 1% to be applied Q shift (every shift) . j. A Late Entry Nurse's Note dated 05/21/2020 by the DON documented, 5/11/2020 - 11:00 a.m. - Spoke with resident's son regarding resident spilling coffee on her leg. Explained the incident, described she had a blister on her left thigh area. (Son) asked was the burn severe enough to require skin grafts. This nurse explained the burn is a second degree and should not require any surgical interventions. He thanked me for the call and stated he appreciates all that we are doing for our residents. k. On 08/05/2020 at 2:50 p.m., the surveyor went into the kitchen with the Dietary Manager (DM) to observe the dietary department's coffee machine. The DM was asked what temperature the coffee would be when it came out of the machine to give to a resident. She stated, This machine is pre-set to 130-134 degrees. She was asked if she or the kitchen staff could change the temperature range. She stated, No. We don't adjust nothing. If it needs to be adjusted, we have to call the company. At this time, the DM was asked to get a cup of coffee from the machine and check the temperature. She did and the temperature was 135.6. She was asked if she had a routine of checking the temperature of the coffee that comes out of that machine and she stated, I check it pretty much every morning. She was asked if she documented it on a log and she stated, No, I don't write it down. l. On 08/06/2020 at 10:40 a.m., the Care Plan Coordinator was asked what the 'effective date' meant that was located at the top of the Nsg Admit/Readmit Assessment forms, and why it would be different than the date that he signed it. He stated, The effective date .that's the date it's scheduled for or started. The date beside the signature is the date the assessment is locked. He was asked when the hot liquid assessment on Resident #1 was done if the effective date was documented as 04/28/2020 and the date beside his signature was documented as 05/12/2020, with the incident occurring on 05/08/2020. He stated, The assessment could have been done before the incident or after it. It could have been done anytime in that date range. m. On 08/06/2020 at 12:21 p.m., LPN #1 was asked about the incident involving Resident #1 and the coffee burn. He stated, I think it was on a weekend. The aides told me about a spot on her leg. I didn't know about a coffee spill. I put some ointment on it, but I forgot to chart on it, and I had to go back and put some notes in on it. He was asked about the CNAs stating they reported the incident to him on 05/09/2020, yet he documented he assessed the area on 05/10/2020. He stated, The best I can remember is when they told me about it, I went and looked at it. He was asked about giving the CNA Zinc to apply to the wound. He stated, I don't remember if I gave it to her or if she had it available. He was asked about not notifying the physician or the family of the incident. He stated, I didn't. I didn't notify the doctor at that time, but when they talked to me about it, they told me they notified the doctor. He was asked why he did not report the injury to anyone. He stated, The best I can say is maybe I was busy and .I'm not making excuses. I should have stopped what I was doing and taken care of it. n. On 08/06/2020 at 12:55 p.m., CNA #1 was asked what she remembered about Resident #1 and the coffee spill. She stated, I remember putting her on the toilet. It was round time. Her clothes were dry. She had a little red spot on her inner thigh, and I reported it to the nurse. I got her off the toilet. He gave me some cream and I put that on her. She was asked if the nurse looked at the area when she told him about it. She stated, No, he just took my word for it. She was asked what type of cream he gave her, and she stated, I don't remember that. She was asked if she changed the resident's clothes the day the Activity Director asked her to and she stated, No ma'am. By the time I got to her, she already had dry clothes on, and I don't know who changed her. She was asked if she saw the resident anymore that day. She stated, I saw her the next day. My old coworkers got her up for a shower and they saw her leg was blistered up. They came and got me, so I went and found (LPN #1) and he gave them cream that time. I don't know if he looked at it at that point or not. She was asked if the resident complained of any pain. She stated, In the shower room, she was complaining of the inside of her leg hurting. And then on the next round she was complaining about it . o. On 08/07/2020 at 9:18 a.m., LPN #3 was asked what she remembered about the incident involving Resident #1 and the coffee burn. She stated, That Monday, the 11th of May, a CNA grabbed me and told me the resident's leg was hurting from a coffee burn. I didn't know anything about it, so I went down there. It was on her inner thigh and it was blistered in some areas. On the upper portion, the blister had started to seep out. She was asked if she knew how the resident had gotten the burn. She stated, The Activity Director gave her coffee from her personal coffee pot and the resident spilled it. I didn't check the temperature from her coffee pot, but we went and temped the coffee from the kitchen and it wasn't even hot enough to drink in my opinion. She was asked if there had been any other hot [MEDICAL CONDITION] the facility. She stated, Not since I have been here. p. On 08/07/2020 at 9:20 a.m., the Resident's May and June 2020 Treatment Administration Record (TAR) documented treatment to the left thigh started on 05/11/2020 (3 days after the incident) with Silver [MEDICATION NAME] cream every shift and PRN (as needed) and stopped on 06/01/2020 due to the wound being healed. q. On 08/07/2020 at 9:33 a.m., Resident #1 was sitting in her wheelchair in her room. The DON assisted the resident to a standing position so the surveyor could observe her leg. A dark purplish area was observed to the left inner thigh. The resident was asked if she remembered what happened to her leg and she stated, Of course I remember. I was given a cup of coffee and when I went to sit it on my table, I bumped it and it spilled in my lap. I had on thick pants, so it took a little while for it to soak in. It sure did get sore. Somebody said, 'why didn't you holler?' Well there wasn't no need to holler after it already happened. She told me it was hot. It sure itches around the outside edge of it. r. On 08/07/2020 at 12:24 p.m., the DON was asked what she could remember about Resident #1 and the coffee burn incident. She stated, Monday morning (5/11/2020), it was reported to the treatment nurse that she had had a coffee spill with a burn to her leg. So, we began the investigation there. That was the first I heard about it. I went and looked at her leg. She had a blister to her inner left thigh. She told me what happened. She said she had a cup of coffee, reached over to sit it on the table, bumped it on the table and it spilled on her leg. She was asked if there had been any other hot liquid burns. She stated, I'm not aware of any spills prior to that. We went back and searched previous I/As (incident and accidents) and there were no other incidents like that. She was asked about the Nursing Admit/Readmit Assessment forms and the interventions with a box that can be checked. She was asked if a box is checked, did that automatically go over to the care plan as an intervention. She stated, Yes. The system is built to where when you check one of the interventions on the Nursing readmit form, it goes over to the Care Plan. She was asked how an intervention could get removed from a care plan. She stated, You can go edit a Care Plan and delete it, but you can still see that it was there. You can look at resolved interventions. And an intervention is supposed to be current until it is resolved. She was asked why the intervention of having a cup with a lid, that was checked on the 11/29/19 hot liquid assessment, wasn't on the Care Plan at the time of the incident. She stated, I don't know that. It wasn't even on the Care Plan back in November when the assessment was done. s. The facility's Safety of Hot Liquids Policy and Procedure provided by the DON on 8/7/20 documented, Residents will be evaluated for safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions will be implemented to maximize choice of beverages while minimizing the potential for injury . Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include: .Serving hot beverages in a cup with a lid; Encouraging residents to sit at a table while drinking or eating hot liquids . Food service staff will monitor and maintain food temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. t. The facility identified the deficient practice and put corrective action in place on 5/11/2020. The corrective action was as followed: -The Activity Director was placed on administrative leave during investigation. -The coffee maker in activities was removed from service. -Full facility observation to ensure there were no more individual coffee makers. -Occupational Therapy performed a screen to validate hot liquid risk. -All staff were in-serviced that the only coffee that is to be given to residents is to come out of the dietary department. -A list of residents who require a lid for hot liquids was developed and placed in the dietary department, activity department and on each hall cart. -Administrator performed observation rounds 4 days a week x (times) 8 weeks to ensure there were no coffee makers in the department managers offices. -DON/Designee performed observation rounds in resident rooms to ensure there were no coffee makers present. -The Administrator/designee monitored 3 activities a week to ensure hot liquids was provided from the dietary department. -One on one in-services were done with CNA #1 and LPN #1 to educate that CNAs are not to apply zinc oxide. In-service for LPN #1 included documenting on a change in condition and obtaining a treatment order for any skin impairment with proper notification. -LPN #1 was suspended pending investigation. -CNAs and nurses were in-serviced that zinc requires a physician order [REDACTED]. In-service for nurses included documenting on a change in condition and obtaining a treatment order for any skin impairment with proper notification. -The DON/Designee checked zinc storage 3 times a week x 8 weeks. -The DON/Designee monitored clinical alerts 5 days a week to ensure any changes were followed up on. -The DON/Designee did 2 body audits daily x 5 days a week to monitor for possible skin impairments that were not reported.