STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E613	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LOGAN COUNTY SENIOR LIVING INC	**615 PRICE AVE OAKLEY, KS 67748**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 19 residents. The sample included eight residents with four reviewed for accidents. Based on observation, interview, and record review, the facility failed to notify Resident (R) 12's physician in a timely manner of the facility acquired second degree burn to her left hand. Findings included: - R12's Physician order [REDACTED]. brain by blockage or rupture of an artery to the brain) affecting left nondominant side, and [MEDICAL CONDITION] (progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11, displayed physical behavior directed toward others, and rejected care. The MDS documented R12 required staff supervision with eating, extensive assistance of one staff for hygiene, and extensive assistance of two staff for transfers and dressing. The MDS documented R12 had range of motion (ROM) impairment in one upper extremity, reported no pain, and had two or more non-injury falls. The MDS documented R12 had loss of liquids/solids from her mouth when eating, no skin problems, and received restorative services for eating and swallowing six days per week. The Skin Care Area Assessment (CAA), dated 06/30/20, documented R12 received staff assistance with bed mobility, transfers, ambulation, toileting, and no current skin breakdown. The assessment documented the resident had a [DIAGNOSES REDACTED]. The Nutrition CAA, dated 06/30/20, documented R12 reported loss of liquid or solids from her mouth when eating or drinking and limited functional ROM of her left arm due to a [MEDICAL CONDITION]. The ADL Care Plan, dated 07/01/20, documented the resident required supervision with eating due to swallowing issues. The care plan directed staff to increase ADL assistance as needed and inform all staff of R12's special dietary and safety needs. The care plan documented the resident received a fortified pured (texture of pudding) diet with honey thickened liquids, small portions, and directed staff to cue or assist R12 to eat. The Skin Care Plan, dated 07/01/20, directed staff to follow facility policies and protocols for the prevention and treatment of [REDACTED]. The Nurse's Note, dated 07/25/20 at 03:00 PM, documented R12 refused pain gel treatment to the top of her left hand due to blisters. The Nurse's Note, dated 07/25/20 at 06:56 PM, documented R12 had two water filled blisters, approximately the size of a dime on top side of her left hand. The resident would not allow Licensed Nurse (LN) G to obtain actual measurements of the blisters and told LN G they were okay. The note documented the resident was given hot cereal at breakfast time (cream of wheat) and did not wear a clothing protector. The note documented when LN G went to administer her medications, LN G asked R12 if the cereal was hot and she said, yes. The note documented LN G obtained a clothing protector for R12 and cleaned the cream of wheat off her left hand and her sweater. The note documented the cereal was too hot for R12 to eat, so LN G asked the resident if she could help her with her water or juice, and that would give her cereal time to cool off a little. The note documented LN G did not notice any redness to R12's left hand. The note documented Certified Nurse Aide (CNA) M asked during the evening meal if LN G noticed the two blisters on the top of R12's left hand, LN G related it to the cream of wheat served at breakfast, and the resident's blisters were left open to air. LN G's Witness Statement, dated 08/13/20, documented on 07/26/20, staff brought R12 to the dining room and the cook prepared cream of wheat cereal for her. LN G continued to set up medications (approximately 15-20 feet away) and no one else was in the dining room. The cook served R12 her cereal and thickened liquids and LN G observed the resident started eating on her own. The statement documented some of the cereal fell off R12's spoon onto her left hand, LN G placed a clothing protector on the resident after cleaning her hand, assisted the resident to eat, and asked if the cereal was hot. The resident replied, yes, so LN G administered R12's medications with thickened liquids. LN G documented she stirred some of the Ensure (supplement beverage) into the resident's cereal and occasionally stirred it while she assisted the resident with her drinks. LN G documented CNA M asked her if she noted the blisters on the top of R12's left hand, LN G documented she assessed the resident's left hand and found two fluid filled blisters to the top of the left hand, approximately 0.5 centimeters (cm) x 0.5 cm in size. LN G notified the nurse manager, charted on the blisters, and how they may have occurred. The statement documented LN G forgot to notify the physician and family, documented the blisters were small and thought they could be reported the next day, so she reported the incident to the oncoming nurse. The facility's Incident Investigation, dated 08/13/20, documented R12, who had left sided weakness and lack of sensation, was not wearing a clothing protector (not care planned and not a policy). The investigation documented the facility failed to timely notify the physician and family when blisters were identified. The Nurse's Note, dated 08/05/20 at 11:34 AM, documented the physician visited R12 during monthly rounds (nine days after blisters noted) and ordered [MEDICATION NAME] (antibiotic ointment) to the resident's left hand for second degree burn to the skin due to hot food falling on the resident's hand several weeks ago. The physician's orders [REDACTED]. The Skin Note, dated 08/18/20 at 09:43 AM, documented a 2 cm in length scab to back of R12's left hand, a second scab measuring 0.5 cm wide, and no drainage or redness. On 08/13/20 at 04:37 PM, observation of R12's left hand revealed a 0.7 cm x 0.2 cm damaged area and a 2 cm x 0.3 cm area, both with dry eschar (dead tissue) in the center and pink skin surrounding. On 08/17/20 at 01:13 PM, LN G verified she did not notify the physician of the blisters from the hot food in a timely manner. LN G stated on 08/05/20, the day the physician came to the facility, the blisters were scabbed. On 08/18/20 at 02:48 PM, Administrative Nurse D verified staff did not notify the physician in a timely manner or call the injury into the state hotline. On 08/19/20 at 04:18 PM, Physician GG's nurse (LN I) stated the facility staff did not report R12'[MEDICAL CONDITION] Physician GG, the physician found the wounds during rounds on 08/05/20, and asked the nursing staff about them. LN I reported Physician GG expected staff to report [MEDICAL CONDITION] same day they occurred. The facility's Change in a Resident's Condition or Status policy, dated May 2017, documented staff would promptly notify the physician and representative of changes in the resident's medical or mental status, including an incident or accident involving the resident, and a discovery of injuries of unknown source. Except in medical emergencies, notifications will be made within 24 hours. The facility failed to notify R12's physician in a timely manner of the facility acquired second degree burn to her left hand, placing the resident at risk for inappropriate treatment and delayed healing.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 19 residents. The sample included eight residents with four residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to report to the state agency Resident (R) 12's second degree burn (partial thickness skin damage causing pain, redness, swelling, and blistering) to the top of her left

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) hand. Findings included: - R12's Physician order [REDACTED]. brain by blockage or rupture of an artery to the brain) affecting left nondominant side, and [MEDICAL CONDITION] (progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11, displayed physical behavior directed toward others, and rejected care. The MDS documented R12 required staff supervision with eating, extensive assistance of one staff for hygiene, and extensive assistance of two staff for transfers and dressing. The MDS documented R12 had range of motion (ROM) impairment in one upper extremity, reported no pain, and had two or more non-injury falls. The MDS documented R12 had loss of liquids/solids from her mouth when eating, no skin problems, and received restorative services for eating and swallowing six days per week. The Skin Care Area Assessment (CAA), dated 06/30/20, documented R12 received staff assistance with bed mobility, transfers, ambulation, toileting, and no current skin breakdown. The assessment documented the resident had a [DIAGNOSES REDACTED]. The Nutrition CAA, dated 06/30/20, documented R12 reported loss of liquid or solids from her mouth when eating or drinking and limited functional ROM of her left arm due to a [MEDICAL CONDITION]. The ADL Care Plan, dated 07/01/20, documented the resident required supervision with eating due to swallowing issues. The care plan directed staff to increase ADL assistance as needed and inform all staff of R12's special dietary and safety needs. The care plan documented the resident received a fortified pured (texture of pudding) diet with honey thickened liquids, small portions, and directed staff to cue or assist R12 to eat. The Skin Care Plan, dated 07/01/20, directed staff to follow facility policies and protocols for the prevention and treatment of [REDACTED]. The Occupational Therapy Screening, dated 06/30/20, documented R12 had a special plastic-coated shallow spoon which helped decrease coughing. The Nurse's Note, dated 07/25/20 at 03:00 PM, documented R12 refused pain gel treatment to the top of her left hand due to blisters. The Nurse's Note, dated 07/25/20 at 06:56 PM, documented R12 had two water filled blisters, approximately the size of a dime on top side of her left hand. The resident would not allow Licensed Nurse (LN) G to obtain actual measurements of the blisters and told LN G they were okay. The note documented the resident was given hot cereal at breakfast time (cream of wheat) and did not wear a clothing protector. The note documented when LN G went to administer her medications, LN G asked R12 if the cereal was hot and she said, yes. The note documented LN G obtained a clothing protector for R12 and cleaned the cream of wheat off her left hand and her sweater. The note documented the cereal was too hot for R12 to eat, so LN G asked the resident if she could help her with her water or juice, and that would give her cereal time to cool off a little. The note documented LN G did not notice any redness to R12's left hand. The note documented Certified Nurse Aide (CNA) M asked during the evening meal if LN G noticed the two blisters on the top of R12's left hand, LN G related it to the cream of wheat served at breakfast, and the resident's blisters were left open to air. The Nurse's Note, dated 07/26/20 at 09:12 AM, documented staff notified LN H of R12's skin integrity concerns, but noted no blisters to R12's left hand that morning. The Weekly Skin Assessments, dated 07/28/20 and 08/04/20, contained no mention of the resident's left hand blisters. LN G's Witness Statement, dated 08/13/20, documented on 07/26/20, staff brought R12 to the dining room and the cook prepared cream of wheat cereal for her. LN G continued to set up medications (approximately 15-20 feet away) and no one else was in the dining room. The cook served R12 her cereal and thickened liquids and LN G observed the resident started eating on her own. The statement documented some of the cereal fell off R12's spoon onto her left hand, LN G placed a clothing protector on the resident after cleaning her hand, assisted the resident to eat, and asked if the cereal was hot. The resident replied, yes, so LN G administered R12's medications with thickened liquids. LN G documented she stirred some of the Ensure (supplement beverage) into the resident's cereal and occasionally stirred it while she assisted the resident with her drinks. LN G documented CNA M asked her if she noted the blisters on the top of R12's left hand, LN G documented she assessed the resident's left hand and found two fluid filled blisters to the top of the left hand, approximately 0.5 centimeters (cm) x 0.5 cm in size. LN G notified the nurse manager, charted on the blisters, and how they may have occurred. The statement documented LN G forgot to notify the physician and family, documented the blisters were small and thought they could be reported the next day, so she reported the incident to the oncoming nurse. CNA M's Witness Statement, dated 07/26/20, documented she walked past R12 and noticed some bumps on her left hand, so she signaled to LN G to come assess them. The facility's Incident Investigation, dated 08/13/20, documented R12, who had left sided weakness and lack of sensation, was not wearing a clothing protector (not care planned and not a policy). The investigation documented the facility failed to timely notify the physician and family when blisters were identified. The physician's orders [REDACTED]. On 08/13/20 at 09:39 AM, observation revealed CNA N used a gait belt and walker, and assisted R12 out of bed. Further observation revealed R12's left hand reddened and bruised with a large tan colored scab. On 08/13/20 at 04:37 PM, observation of R12's left hand revealed a 0.7 cm x 0.2 cm damaged area and a 2 cm x 0.3 cm area, both with dry eschar (dead tissue) in the center and pink skin surrounding. On 08/18/20 at 02:48 PM, Administrative Nurse D stated LN G stood at the med cart and watched the resident from 15-20 feet away as she prepared R12's medications. Administrative Nurse D stated staff did not notify the physician in a timely manner or call the injury into the state hotline. The facility's Abuse/Neglect/Exploitation policy, dated July 2017, documented the Administrator, or his/her designee, will provide the appropriate agencies (local, state and federal agencies) listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. The facility failed to report R12's second degree burn (partial thickness skin damage causing pain, redness, swelling, and blistering) to the top of her left hand to the state agency, placing the resident at risk for further incidents.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 19 residents. The sample included eight residents with four residents reviewed for accidents. Based on observation, interview, and record review the facility failed to assess Resident (R) 12's second degree burn (partial thickness skin damage causing pain, redness, swelling, and blistering) to the top of her left hand. Findings included: - R12's Physician order [REDACTED]. brain by blockage or rupture of an artery to the brain) affecting left nondominant side, and [MEDICAL CONDITION] (progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11, displayed physical behavior directed toward others, and rejected care. The MDS documented R12 required staff supervision with eating, extensive assistance of one staff for hygiene, and extensive assistance of two staff for transfers and dressing. The MDS documented R12 had range of motion (ROM) impairment in one upper extremity, reported no pain, and had two or more non-injury falls. The MDS documented R12 had loss of liquids/solids from her mouth when eating, no skin problems, and received restorative services for eating and swallowing six days per week. R12's Skin Care Area Assessment (CAA), dated 06/30/20, documented no current skin breakdown. The assessment documented the resident had a [DIAGNOSES REDACTED]. The Nutrition CAA, dated 06/30/20, documented R12 reported loss of liquid or solids from her mouth when eating or drinking and limited functional ROM of her left arm due to a [MEDICAL CONDITION]. The Skin Care Plan, dated 07/01/20, directed staff to follow facility policies and protocols for the prevention and treatment of [REDACTED]. The Nurse's Note, dated 07/25/20 at 03:00 PM, documented R12 refused pain gel treatment to the top of her left hand due to blisters. The Nurse's Note, dated 07/25/20 at 06:56 PM, documented R12 had two water filled blisters, approximately the size of a dime on top side of her left hand. The resident would not allow Licensed Nurse (LN) G to obtain actual measurements of the blisters and told LN G they were okay. The note documented the resident was given hot cereal at breakfast time (cream of wheat) and did not wear a clothing protector. The note documented when LN G went to administer her medications, LN G asked R12 if the cereal was hot and she said, yes. The note documented LN G obtained a clothing protector for R12 and cleaned the cream of wheat off her left hand and her sweater. The note documented the cereal was too hot for R12 to eat, so LN G asked the resident if she could help her with her water or juice, and that would give her cereal time to cool off a little. The note documented LN G did not notice any redness to R12's left hand. The note documented Certified Nurse Aide (CNA) M asked during the evening meal if LN G noticed the two blisters on the top of R12's left hand, LN G related it to the cream of wheat served at breakfast, and the resident's blisters were left open to air. The Nurse's Note, dated 07/26/20 at 09:12 AM, documented staff notified LN H of R12's skin integrity concerns, but noted no blisters to R12's left hand that morning. The Weekly Skin Assessments, dated 07/28/20 and 08/04/20, contained no mention of the resident's left hand blisters. The Nurse's Note, dated 08/05/20 at 11:34 AM, documented the physician visited R12 during monthly rounds (nine days after blisters noted) and ordered [MEDICATION

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) NAME] (antibiotic ointment) to the resident's left hand for second degree burn to the skin due to hot food falling on the resident's hand several weeks ago. The Nurse's Note, dated 08/06/20 at 04:28 AM, documented R12 tolerated application of [MEDICATION NAME] ointment to [MEDICAL CONDITION] the back of her left hand, affected area scabbed, and currently open to air without redness or drainage. The Nurse's Note, dated 08/08/20 at 02:04 PM, documented a large scab to the back of R12's left hand with redness to edges around the scab. The Nurse's Note, dated 08/12/20 at 07:58 PM, documented a second degree burn to top of R12's left hand, the scab partially came off, and had rough edges. R12 refused to allow nursing to trim the scab to prevent it from getting pulled off, but allowed nurses to apply [MEDICATION NAME] ointment two times that day. The physician's orders [REDACTED]. LN G's Witness Statement, dated 08/13/20, documented on 07/26/20, CNA M asked LN G if she noted the blisters on the top of R12's left hand, LN G documented she assessed the resident's left hand and found two fluid filled blisters to the top of the left hand, approximately 0.5 centimeters (cm) x 0.5 cm in size. LN G notified the nurse manager, charted on the blisters, and reported the incident to the oncoming nurse. The Skin Note, dated 08/18/20 at 09:43 AM, documented a 2 cm in length scab to back of R12's left hand, a second scab measuring 0.5 cm wide, and no drainage or redness. On 08/13/20 at 09:39 AM, observation revealed CNA N used a gait belt and walker, and assisted R12 out of bed. Further observation revealed R12's left hand reddened and bruised with a large tan colored scab, approximately one inch wide by two inches in length. On 08/13/20 at 04:37 PM, observation of R12's left hand revealed a 0.7 cm x 0.2 cm damaged area and a 2 cm x 0.3 cm area, both with dry eschar (dead tissue) in the center and pink skin surrounding. On 08/17/20 at 01:13 PM, LN G stated nursing staff did not complete skin treatments and assessments of the resident's left hand blisters prior to the physician's visit ten days after the blisters noted. On 08/18/20 at 02:48 PM, Administrative Nurse D verified nursing did not assess the burn/damaged skin routinely prior to the physician visit 10 days after the incident. On 08/19/20 at 04:18 PM, Physician GG's nurse (LN I) stated the facility staff did not report R12'[MEDICAL CONDITION] Physician GG, the physician found the wounds during rounds on 08/05/20, and asked the nursing staff about them. Upon request the facility did not provide a policy for the routine, ongoing assessment of wounds or injuries. The facility failed to routinely assess Resident (R) 12's second degree burn to the top of her left hand, placing the resident at risk for delayed healing and infection.
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** The facility had a census of 19 residents. The sample included eight residents with four reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision with meals for one of four sampled residents, Resident (R) 12, who received a second degree burn (partial thickness skin damage causing pain, redness, swelling, and blistering) to the top of her left hand. Findings included: - R12's Physician order [REDACTED]. brain by blockage or rupture of an artery to the brain) affecting left nondominant side, and [MEDICAL CONDITION] (progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11, displayed physical behavior directed toward others, and rejected care. The MDS documented R12 required staff supervision with eating, extensive assistance of one staff for hygiene, and extensive assistance of two staff for transfers and dressing. The MDS documented R12 had range of motion (ROM) impairment in one upper extremity, reported no pain, and had two or more non-injury falls. The MDS documented R12 had loss of liquids/solids from her mouth when eating, no skin problems, and received restorative services for eating and swallowing six days per week. The Skin Care Area Assessment (CAA), dated 06/30/20, documented R12 received staff assistance with bed mobility, transfers, ambulation, toileting, and no current skin breakdown. The assessment documented the resident had a [DIAGNOSES REDACTED]. The Nutrition CAA, dated 06/30/20, documented R12 reported loss of liquid or solids from her mouth when eating or drinking and limited functional ROM of her left arm due to a [MEDICAL CONDITION]. The ADL Care Plan, dated 07/01/20, documented the resident required supervision with eating due to swallowing issues. The care plan directed staff to increase ADL assistance as needed and inform all staff of R12's special dietary and safety needs. The care plan documented the resident received a fortified pured (texture of pudding) diet with honey thickened liquids, small portions, and directed staff to cue or assist R12 to eat. The Skin Care Plan, dated 07/01/20, directed staff to follow facility policies and protocols for the prevention and treatment of [REDACTED]. The Occupational Therapy Screening, dated 06/30/20, documented R12 had a special plastic-coated shallow spoon which helped decrease coughing. The Nurse's Note, dated 07/25/20 at 03:00 PM, documented R12 refused pain gel treatment to the top of her left hand due to blisters. The Nurse's Note, dated 07/25/20 at 06:56 PM, documented R12 had two water filled blisters, approximately the size of a dime on top side of her left hand. The resident would not allow Licensed Nurse (LN) G to obtain actual measurements of the blisters and told LN G they were okay. The note documented the resident was given hot cereal at breakfast time (cream of wheat) and did not wear a clothing protector. The note documented when LN G went to administer her medications, LN G asked R12 if the cereal was hot and she said, yes. The note documented LN G obtained a clothing protector for R12 and cleaned the cream of wheat off her left hand and her sweater. The note documented the cereal was too hot for R12 to eat, so LN G asked the resident if she could help her with her water or juice, and that would give her cereal time to cool off a little. The note documented LN G did not notice any redness to R12's left hand. The note documented Certified Nurse Aide (CNA) M asked during the evening meal if LN G noticed the two blisters on the top of R12's left hand, LN G related it to the cream of wheat served at breakfast, and the resident's blisters were left open to air. The Nurse's Note, dated 07/26/20 at 09:12 AM, documented staff notified LN H of R12's skin integrity concerns, but noted no blisters to R12's left hand that morning. The Weekly Skin Assessments, dated 07/28/20 and 08/04/20, contained no mention of the resident's left hand blisters. LN G's Witness Statement, dated 08/13/20, documented on 07/26/20, staff brought R12 to the dining room and the cook prepared cream of wheat cereal for her. LN G continued to set up medications (approximately 15-20 feet away) and no one else was in the dining room. The cook served R12 her cereal and thickened liquids and LN G observed the resident started eating on her own. The statement documented some of the cereal fell off R12's spoon onto her left hand, LN G placed a clothing protector on the resident after cleaning her hand, assisted the resident to eat, and asked if the cereal was hot. The resident replied, yes, so LN G administered R12's medications with thickened liquids. LN G documented she stirred some of the Ensure (supplement beverage) into the resident's cereal and occasionally stirred it while she assisted the resident with her drinks. LN G documented CNA M asked her if she noted the blisters on the top of R12's left hand, LN G documented she assessed the resident's left hand and found two fluid filled blisters to the top of the left hand, approximately 0.5 centimeters (cm) x 0.5 cm in size. LN G notified the nurse manager, charted on the blisters, and how they may have occurred. 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R12 refused to allow nursing to trim the scab to prevent it from getting pulled off, but allowed nurses to apply [MEDICATION NAME] ointment two times that day. The physician's orders [REDACTED]. The Nurse's Note, dated 08/15/20 at 07:24 PM, documented pink areas on the resident's left hand, scabs were gone, and her hand appeared healthy and healing. The Nurse's Note, dated 08/17/20 at 11:51 AM, documented the resident's left hand partially healed,, skin to the top of her left hand clean and pink in color, with no open areas. The Skin Note, dated 08/18/20 at 09:43 AM, documented a 2 cm in length scab to back of R12's left hand, a second scab measuring 0.5 cm wide, and no drainage or redness. On 08/13/20 at 09:39 AM, observation revealed CNA N used a gait belt and walker,

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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	(continued... from page 3) and assisted R12 out of bed. Further observation revealed R12's left hand reddened and bruised with a large tan colored scab, CNA N carefully handled that hand and assisted the resident to the bathroom. On 08/13/20 at 09:50 AM, observation revealed LN G cleansed the back of R12's left hand with soap and water and applied [MEDICATION NAME] ointment via a cotton swab. Observation revealed the scab was very loose over most of the wound with pink skin underneath. On 08/13/20 at 10:04 AM, observation revealed LN G assisted the resident with her thickened liquids, Dietary Staff (DS) BB brought R12 hot cereal and LN G instructed the resident to take a small bite first to see if it was too hot. Observation revealed R12 held her left hand to her chest under the clothing protector and spilled some of the cereal onto her clothing protector. On 08/13/20 at 04:37 PM, observation of R12's left hand revealed a 0.7 cm x 0.2 cm damaged area and a 2 cm x 0.3 cm area, both with dry eschar (dead tissue) in the center and pink skin surrounding. On 08/17/20 at 01:13 PM, LN G stated nursing staff did not complete skin treatments and assessments of the resident's left hand blisters prior to the physician's visit. LN G verified she did not notify the physician of the blisters from the hot food in a timely manner. LN G stated on 08/05/20, the day the physician came to the facility, the blisters were scabbed. On 08/18/20 at 02:48 PM, Administrative Nurse D stated LN G stood at the med cart and watched the resident from 15-20 feet away as she prepared R12's medications. Administrative Nurse D stated staff did not notify the physician in a timely manner or call the injury into the state hotline. On 08/19/20 at 04:18 PM, Physician GG's nurse (LN I) stated the facility staff did not report R12'[MEDICAL CONDITION] Physician GG, the physician found the wounds during rounds on 08/05/20, and asked the nursing staff about them. LN I reported Physician GG expected staff to report [MEDICAL CONDITION] same day they occurred. The facility's Accident and Incidents policy, dated July 2017, documented all accidents or incidents involving residents, occurring on our premises shall be investigated and reported to the Administrator. The Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The facility failed to provide R12 adequate supervision with meals to prevent a second degree burn to the top of her left hand from hot food, placing the resident at risk for a serious skin injury and infection.