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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA CHRISTI VILLAGE - HAYS INC	2225 CANTERBURY DR HAYS, KS 67601

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F 000	INITIAL COMMENTS The following citations represent the results of complaint investigation KS00174159. The 2567 was sent electronically on 09/20/22.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 75 residents. The sample included three residents reviewed for neglect. Based on observation, record review, and interview, the facility failed to follow the care plan and provide the necessary goods and services for Resident (R) 1, which resulted in a second degree burn with fluid filled blisters to R1's upper right thigh. Subsequently, R1 required specialty wound clinic care and suffered from pain that could have been avoided. Findings included:	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/20/2022

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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- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of macular degeneration (progressive deterioration of the retina), hypertension, (high blood pressure), and dysphagia (swallowing difficulty).

R1's "Admission Minimum Data Set (MDS)," dated 06/28/22 documented R1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated R1 was cognitively intact. The MDS further documented R1 required limited to extensive assistance of one to two staff for bed mobility, transfer, ambulation, locomotion, dressing, toilet use, and personal hygiene. The MDS documented R1 required oversight, encouragement, or cueing of one staff for eating.

The "Activities of Daily Living Care Area Assessment (CAA)," dated 06/28/22, documented R1 had poor vision, used a platform walker, and required limited to extensive assistance with all activities of daily living.

The "Vision CAA," dated 06/28/22, documented R1 had poor vision.

The "Nutrition CAA," dated 06/28/22, documented R1 had poor vision and staff would need to explain to R1 where and what foods were on her plate.

The "Hot Liquid Assessment," dated 06/23/22, documented R1 was safe to have hot liquids and documented an intervention for R1 to have a lid with all hot liquids.

The "Cognitive Loss Care Plan," dated 06/25/22, directed staff to provide cues to R1 to promote independence and ensure R1's safety.

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The "Activity of Daily Living Care Plan," dated 06/21/22, directed staff R1 required bilateral hearing aids and was legally blind.

R1's "Care Plan" lacked instruction R1 was to have lids on all hot liquids until 08/18/22, after the incident.

The "Progress Note," dated 08/18/22 at 09:53 AM, documented R1 sustained a 15 centimeter (cm) by 5 cm burn to her right inner thigh after she spilled hot tea water in her lap while eating breakfast. The burned area to R1's right inner thigh contained two blisters that were 1cm wide by 3 and 4 cm's long, respectively. Staff reported the incident to R1's primary care physician and the facility awaited orders for treatment after faxing and calling the primary care physician.

The "Communication with Physician Note," dated 08/18/22 at 10:27 AM, documented R1's primary care physician wanted R1 to be seen in the clinic before treating the burn. R1 was unwilling to go to the clinic as her primary care physician was scheduled to be at the facility the next day for nursing home rounds. Staff administered a needed acetaminophen (pain medication) to R1 as the only available intervention for the pain.

The "Progress Note," dated 08/18/22 at 10:54 AM, documented at the time of the incident staff removed R1's clothing and treated R1 right away. Staff notified R1's primary care physician by phone. A "Hot Liquids Evaluation" was completed for a second time and a new intervention was put in place for R1 to have hot liquids in a cup with a lid for safety.

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The "Skin Evaluation Record," dated 08/18/22 documented R1 had a partial thickness wound. The wound to the right upper thigh had a reddened area measuring 15 cm by 5 cm and two blisters within the reddened area which measured 1 cm by 4 cm and 1 cm by 4 cm.

The "Electronic Medical Administration Record (MAR)," dated 08/18/22 documented R1 rated her pain an "8" on a scale of 0-10 on a numeric pain scale rating with zero being no pain and 10 being the worst pain. Staff administered R1 Tylenol (pain medication) 650 milligrams (mg) at 10:25 AM.

The "Physician Communication Note," dated 08/19/22 at 12:09 PM, documented R1's primary care physician was at the facility to see R1 on rounds and ordered lidocaine 4% cream (pain cream) three times a day as needed for pain to the right thigh burn and instructed staff to keep blisters to right thigh intact if possible; inform R1's primary care physician if the blisters opened. The primary care physician further instructed staff to monitor the burn wound daily until healed or blisters were gone.

The "Treatment Administration Record (TAR)," dated 08/19/22, directed staff to monitor R1's blisters twice a day until healed and let R1's primary care physician know if the blisters opened. This order was discontinued on 08/24/22.

The "MAR," dated 08/19/22 documented R1 rated her pain a "4" on a scale of 0-10.

The "Skin Evaluation Record," dated 08/20/22, documented R1 had a partial thickness wound to

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her upper right thigh with a reddened area which measured 15 cm by 5 cm with two blisters inside the reddened area that measured 1cm by 4 cm and 1 cm by 3 cm. The facility was directed to keep the blisters intact and let the primary care physician know if the blisters opened.

The "MAR," dated 08/20/22, documented R1 rated her pain a "3" on a scale of 0-10.

The "MAR," dated 08/21/22 documented R1 rated her pain a "2" on a scale of 0-10.

The "Physician Communication Note," dated 08/22/22, documented R1's primary care physician was notified of one of R1's blisters to her right upper thigh broke open and were scabbed over.

The "Skin Evaluation Record," dated 08/22/22, documented R1 had a partial thickness wound to her upper right thigh and recorded two blisters both measuring 5.2 cm by 2.0 cm and the facility was to monitor the fluid filled blisters.

The "MAR," dated 08/22/22 documented R1 rated her pain a "2" on a scale of 0-10.

The "Physician Communication Note," dated 08/24/22, documented the facility contacted R1's primary care physician regarding changing R1's dressing every three days and R1's primary care physician ordered for R1's dressing to be changed every three days.

The TAR, dated 08/27/22, directed staff to cleanse the popped blisters with wound cleanser, apply mupirocin ointment (an antibiotic cream), and to cover with a foam dressing. The order was

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discontinued on 09/12/22.

The "Skin Evaluation Record," dated 08/28/22, documented R1 had a partial thickness wound to her upper right thigh with two blisters that had drained and scabbed over measuring 2.0 cm by 1.0 cm.

The "Skin Evaluation Record," dated 08/28/22, documented R1 had popped blisters to her upper right thigh which measured 6.0 cm by 2.0 cm. The record lacked any description of the wound.

The "Skin Evaluation Record," dated 08/28/22, documented R1 had popped blisters to her upper right thigh which measured 5.5 cm by 2.0 cm. The record lacked any description of the wound.

The "Skin Evaluation Record," dated 08/29/22, documented a popped blister to R1's upper right thigh which measured 5.5 cm by 2.0 cm. The record lacked any description of the wound.

The "Physician Communication Note," dated 08/29/22, documented staff contacted R1's primary care physician and asked to change R1's treatment order to the three burns on her upper right thigh from mupirocin ointment to Silvadene cream (a medication used to treat burns).

The "Physician Communication Note," dated 08/30/22, documented the facility received a signed fax communication for R1's primary care physician directing the facility to have another nurse look at R1's wounds since he could not visualize the wounds and could not advise whether wound care referral was appropriate and suggested an appointment could be scheduled if needed.

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The "Progress Note," dated 09/06/22, documented the facility faxed R1's primary care physician asking for new orders for R1's burn wounds. R1's primary care physician responded that he had asked for another nurse to look at the wound, since he could not assess the wound, and decide if wound referral was needed.

The "Physician Communication Note," dated 09/08/22, documented the facility received a fax from R1's primary care physician ordering a referral to the wound care clinic.

The "Skin Evaluation Record," dated 09/10/22, documented a wound to R1's right upper thigh which measured 6.0 cm by 1.0 cm with treatment to cleanse with wound cleanser and gauze and apply Allevyn (a bordered dressing).

The "Skin Evaluation Record," dated 09/10/22, documented a wound to R1's right upper thigh which measured 5.0 cm by 0.5 cm with treatment to cleans with wound cleanser and gauze and apply Allevyn.

The "Medication Treatment Note," dated 09/12/22, documented new wound care orders received from R1's appointment at the wound care clinic to apply Aquacel Advantage (an antimicrobial dressing for use in acute or hard-to-heal wounds that are infected or are at risk for infection) to the three burns to R1's right upper thigh, cover with Mepilex (a bordered dressing), and change on Wednesdays, Fridays, and as needed. R1 should return to the wound care clinic in one week and all other previous wound care orders were to be discontinued.

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On 09/13/22 at 12:15 PM, observation revealed R1 slept in her recliner with her legs elevated. R1's lunch tray was on a tray table in front of her, was not set up for her to eat as evidenced by her utensils were still rolled up in a napkin at the tip of the tray, and the tray had no liquids for R1 to drink. R1 woke up upon hearing the knock on the door.

On 09/13/22 at 12:17 PM, R1 stated she had burns on her leg from several weeks ago. R1 stated she did not have the hot tea water in her hand when it spilled. R1 stated she did not have a bed side table and used her walker that had a tray on it for meals. R1 stated that whoever put the tray on her walker tray did not make sure the walker tray was all the way attached and the tray with the hot tea spilled in her lap. R1 stated the burned area to her upper right thigh hurt very bad at first and then it just kind of went numb. R1 stated she went to the wound care clinic the previous day and was there for three hours while they took all of the dead skin out of the burn wounds and that was very painful. R1 pulled up her shorts and showed the dressing on her upper right thigh. R1 further stated, "I am legally blind. I didn't know it [her lunch tray] was there. Can you tell me what I am eating?" R1 stated her family took her walker home.

On 09/13/22 at 12:30 PM, Dietary Staff (DS) BB stated she worked in the kitchen area the day that R1 was burned with the hot tea water. DS BB stated the whole tray had ended up in R1's lap and all of her fluids on the tray had spilled. DS BB stated when she took the tray into R1, she noticed that the right side of R1's walker with the tray was notall of the way down but she did not think anything about it. DS BB stated she did not

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set up R1's breakfast tray that morning when she placed the tray in front of R1. DS BB stated she set up R1's tray sometimes when she brought the tray to R1, but it depended on how busy she was. DS BB stated she put R1's hot tea water in the microwave and when she took it out it was about 160 degrees Fahrenheit (F) but she would let it sit for a bit and let it cool down to around 130 degrees F.

On 09/13/22 at 12:45 PM, Certified Nurses Aide (CNA) M stated R1 ate her meals off her walker with a tray since her admission. CNA M stated that the walker with the tray was not stable and CNA R reported to the charge nurses that it was not safe.

On 09/13/22 at 01:00 PM, Licensed Nurse (LN) G stated R1 had been eating her meals off her walker with a tray since her admission. LN G stated that the walker with the tray was not stable enough to eat off and she had reported to administrative staff that it was not safe. LN G stated R1 had a tray table in her room now.

On 09/13/22 at 03:00 PM, Administrative Staff A stated she did not know R1 did not have a tray table in her room and no one had informed her the walker with the tray on it was not safe, as she would have ensured a tray table was placed in R1's room. Administrative Staff A stated R1 was legally blind and could have easily knocked the food tray off her walker tray by accident and received the burn.

The facility's "Safety of Hot Liquids" policy, revised December 2017, documented residents will be evaluated for safety concerns and potential for injury from hot liquids on admission,

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readmission and on change of condition. Appropriate precautions will be implemented to maximize choice of beverage while minimizing the potential for injury. The potential for burns from hot liquids is considered an on-going concern among residents with weakened motor skills, balance issues, and nerve or musculoskeletal conditions. Resident with these or other conditions may suffer from accidental burns and related complications stemming from thinner, more fragile skin that may burn quickly and severely and take longer to heal. Residents who prefer hot beverages with meals will not be restricted from these options. Associates should complete a Hot Liquid Safety Evaluation as indicated and document the risk factors in the care plan. Once risk factors for injury are identified, appropriate interventions will be implemented to minimize the risk from burns. Such intervention may include: serving hot beverages with a lid, encouraging residents to sit at a table while drinking or eating hot beverages, protective lap covering or clothing to protect skin from accidental spills, and associate supervision or assistance with hot beverages. Food service staff will monitor and maintain food temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding and maintain a palatable temperature. Person Centered Care Plan will be updated for those at risk with appropriate interventions.

The facility failed to follow the care plan and provide appropriate care and services for R1, which resulted in R1 obtaining a burn causing fluid filled blisters (second degree burns) to her upper right thigh which required specialty wound clinic care and caused avoidable pain.

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