

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/24/2007
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NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 324 SS=K	<p>Complaint #12299 substantiated with F324, F490 and F520 cited.</p> <p>483.25(h)(2) ACCIDENTS</p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12299 substantiated (all or in part) with these findings:</p> <p>Based on observation, record review and interview, the facility failed to ensure accurate assessment of residents' ability to handle hot liquids, to ensure spill proof assistive devices were provided, and failed to ensure residents did not receive coffee that was at excessive hot temperatures in order to prevent serious burns for 4 (Residents #1, #2, #3, and #4) of 4 case mix residents who required assistance with hot liquids. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Residents #1, #2, #3 and #4 and had the potential to affect 13 residents in the facility who required assistance with hot liquids according to a list provided by the Assistant Director of Nursing on 1/24/07 at 10:36 a.m. The facility removed the Immediate Jeopardy prior to the survey entrance reducing the scope/severity to "H" (actual harm to Residents #1 and #4 who received burns from spilling hot coffee on themselves), however, the facility did not correct the underlying deficient practices. The facility was informed of the Immediate Jeopardy removed on 1/23/07 at 12:35</p>	F 324		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 324	Continued From page 1 p.m. The findings are: 1. Resident #1 had diagnoses of Dementia, Cerebral Vascular Accident and Insulin Dependent Diabetes Mellitus. The Medicare 14 day Minimum Data Set (MDS) dated 12/12/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, was totally dependent on staff for most activities of daily living and required supervision with eating and drinking. a. A Nurse's Note dated 2/7/06 documented, "Res (Resident) was in D/R (dining room) for evening, up in w/c (wheel chair) at table. A visitor served resident coffee and sat it on the table. Res knocked over coffee and coffee went into her lap. Daughter was present in D/R with res. Res was immediately taken to rm (room)]... clothing removed. Res had large reddened area on top of left mid thigh, approximately size of an adult hand, also very small area on mid right thigh. MD (Medical Doctor) notified..." b. The Care Plan dated 2/7/06 documented, "Use sippy cup for coffee." c. A Hot Liquids Safety Assessment form dated 2/9/06 documented, "Resident to use cup with lid". d. A Weekly Skin Audit Record dated 2/9/06 documented, "Blisters, spilled coffee" and a diagram of body with the left thigh circled. e. An Unusual Occurrence Report dated 3/11/06 at 5:50 a.m. documented, "Summoned to dining room per [name] to look at resident. While [name] was pointing to res (resident's) left upper	F 324			

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F 324	<p>Continued From page 2</p> <p>thigh, observed a 1/2 full coffee cup sitting on res table and hot brown spot on res clothing at left upper thigh area. When asked res where did you get that hot coffee, res pointed at [name] and stated she gave it to me and put it on my table. CNAs assisted res to room and to bed. Removed res bottom pants and upon assessment to extremities, observed a 5 inch x 2 inch red line to res left upper thigh. Skin treatment order, cleanse burn with wound cleanser TAO (Triple Antibiotic Ointment) every shift until healed..."</p> <p>f. The Care Plan dated 3/11/06 documented, "Coffee burn left upper thigh. Res had no sippy cup. 3/13/06 - Insulated cups with lids to prevent burns."</p> <p>g. An Unusual Occurrence Report dated 11/12/06 at 7:30 a.m. documented, "Reported that res up in gerichair in room with tabletop. A.M. meal served, res spilled coffee on chest and abd (abdomen). Res had travel mug with lid in use. Tx (treatment) nurse in room and tx'd (treated). Intervention: Make sure res in dr (dining room) during meal service and travel mug with lid on."</p> <p>h. A Nurse's Note dated 11/14/06 at 2:30 p.m. documented, "... Has blistered area between breast, inside left leg, crease of left leg, resident has irritated area. Treatment nurse notified. Will continue to monitor".</p> <p>i. A Hot Liquids Safety Assessment form dated 11/17/06 documented, "Staff to assist with all hot liquids".</p> <p>j. An Unusual Occurrence Report dated 1/17/07 at 7:15 a.m. documented, "Res was sitting in</p>	F 324		

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F 324	Continued From page 3 gerichair in dining room, requested coffee, CNA took coffee from dining room window in black mug with lid to resident. CNA turned back to dining room window and heard resident yelling it's burning. Res taken to her room, clothing removed, large area on both upper thighs burned. Staff applied cool wet cloths to areas, tx nurse applied ointment...res continues to moan and cry, gave Percocet per doctors order... dietary manager took coffee temp, coffee temp at 7:25 a.m. 173 degrees. Dietary consultant notified. Consultant stated coffee must be brewed at 180-185 degrees, also stated fragile skin can burn at temp of 110 degrees. Dietary re-inserviced on the importance of checking temp on hot liquids. Staff re-inserviced on handling of hot liquids with assist trays. Inserviced nursing on importance of not giving hot liquids to an assist and walk away. At 9:00 a.m., res continues to moan and call out, pain unresolved. Res skin red with numerous blisters. Dr. [Physicians name] notified again and res sent to ER [Emergency Room]". k. On 1/22/07 at 4:10 p.m., CNA #1 stated, "[01/17/07] I put the coffee mug on the geri chair tray, then I turned around to get some stuff out of the window to pass out trays." The CNA was asked how far she had walked from the table when the resident started yelling. She stated, "I didn't make it to the window. I think I got to the next table and she started saying I'm burning. The mug was in her lap". The CNA demonstrated the incident in the dining room and based on the demonstration, CNA #1 had gotten approximately 12 feet from the resident when the burn occurred. l. A Nurse's Note dated 1/17/07 at 7:15 a.m. documented, "... Res had on bib which protected	F 324			

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F 324	Continued From page 4 chest, coffee ran down front of bib and pooled at thighs, ran between thighs and around to back, numerous blisters, skin bright red, starting to peel...". m. The hospital Emergency Room report dated 1/17/07 documented, "Second degree burns to bilateral thigh with intact blisters noted". n. On 1/22/07 at 4:33 p.m., the Dietary Manager was asked if Resident #1 used that particular travel mug every day. She stated, "She didn't use that particular mug every day. She just used a travel mug in general." She was asked what interventions had been implemented after the previous burns. She stated, "To put coffee in a travel mug. I can't think of any more interventions". She was asked what interventions were implemented since the burn on 1/17/07. She stated, "We pour coffee up in the back and bring the temp down to 140 degrees with water, then it's OK to send out the window. We document in a log for 3 meals what the coffee temp is. Staff has been inserviced". o. On 1/23/07 at 7:10 a.m., CNA #2 was asked what she had been told to do when serving coffee to the residents. She stated, "I'm not sure". She was asked if she was inserviced on hot liquids in the past week. She stated, "I've not been to an inservice about hot coffee, but we were given a piece of paper to read and sign." CNA #2 was asked what information was on the paper. She stated, "I don't know. I have short term memory loss." She was asked what she would do if she gave a resident a cup of hot liquid? She stated, "Make sure it has a lid on it and let them taste it and ask them if it's too hot." She was asked if all coffee cups were supposed to have lids. She	F 324			

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F 324	Continued From page 5 stated, "I don't know." p. On 1/23/07 at 7:18 a.m., CNA #3 was asked what she had been told to do when serving coffee to the residents. She stated, "Make sure it's not too hot." She was asked how she would do that. She stated, "I'd stick my hand over it and stick my pinky in it." CNA #3 was asked what she would do then. She stated, "I'd tell them to be careful with it because it's hot." The CNA was asked if she had been to a recent inservice about hot liquids. She stated, "No, but I'm sure we have one coming up Friday". q. On 1/23/07 at 9:45 a.m., a body audit was conducted the Treatment Nurse with these findings. Resident #1 had burns to the left thigh that extended from the inner portion all the way to the outer thigh. The area was irregular in shape and measured approximately 6 inches long and 2 inches wide. Extending from that burn area on the left outer thigh was more irregular shaped burns going around toward the posterior thigh. The area was open and raw with yellow colored slough. The right inner thigh also had a burned area that measured approximately 3 inches long and 2 inches wide. This area was open and raw with yellow colored slough. 2. Resident #4 had a diagnosis of Multiple Sclerosis. The Quarterly MDS dated 1/10/07 documented the resident had independent cognitive skills for daily decision making, required extensive assistance with most activities of daily living and required supervision with eating and drinking. a. The care plan dated 12/10/05 documented, " Standard Care Plan for skin integrity ... 7/16/06,	F 324			

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F 324	<p>Continued From page 6</p> <p>Resident to be given coffee at table by staff . To be given in a sippy cup. ... "</p> <p>b. An Unusual Occurrence Report dated 7/16/06 at 6:45 a.m., documented, "Resident states she requested coffee from a dietary staff member. When she got the coffee she lifted up on lid and spilled the cup in her lap. Upper right and left thighs are pink in color and tender to touch. 7:15 a.m. - Bilat upper thighs very red with blisters noted on inner upper thighs ... Travel mug, lid on cup and inservice dietary about giving out hot liquid. Check and monitor temp of liquid."</p> <p>c. On 1/23/07 at 10:40 a.m., the DON stated there was no documentation that the temperature of coffee had been monitored, and that the Dietary Manager couldn't remember if they did or not.</p> <p>d. A Hot Liquids Safety Assessment dated 1/12/07 documented the resident was able to manage hot liquids independently.</p> <p>3. Resident #3 had diagnoses of Dementia and Glaucoma. The Quarterly MDS dated 12/11/06 documented the resident had moderately impaired cognitive skills for daily decision-making, required extensive assistance with most activities of daily living and required assistance with eating and drinking.</p> <p>a. An Unusual Occurrence Report dated 8/21/06 at 8:30 a.m. documented, "Dropped coffee cup at table and spilled coffee in her lap. Initially skin on inner thighs slightly pink. Resident denies pain. 9:20 a.m. - Rechecked inner thighs. Res continues to deny pain. No blistering noted. 12:00 p.m. - Per CNA, res has area left inner</p>	F 324			

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F 324	Continued From page 7 thigh, res c/o stings a little. Saf Gel applied... Intervention: Coffee with ice chips in travel mug". b. A Hot Liquids Safety Assessment dated 8/22/06, 9/12/06 and 12/15/06 documented the resident was at risk for injury from spills of hot liquids. 4. Resident #2 had diagnoses of Dementia and Anxiety. The Quarterly MDS dated 12/1/06 documented the resident had modified independent cognitive skills for daily decision making and required supervision with eating and drinking. a. An Unusual Occurrence Report dated 8/27/06 at 12:00 p.m. documented, "CNA reported that res spilled coffee on herself in DR. Left thigh area of pants cold/wet. Skin had no redness or warmth. No obvious injury. Intervention: Cup with lid for hot liquids. " b. A Hot Liquids Safety Assessment dated 6/4/06 documented the resident was not at risk for injury from spills of hot liquids. An assessment dated 8/27/06 and 12/7/06 documented the resident was at risk but could drink hot liquids with supervision. 5. On 1/22/07 at 2:40 p.m., the Administrator provided the following documentation of corrective action that was initiated on 1/17/07 which removed the Immediate Jeopardy: - Inservice dietary about monitoring coffee temps - Hot liquids assessment completed on all residents - Review all residents currently with hot liquids to ensure they are getting correct safety measures	F 324			

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F 324	Continued From page 8 - Reviewed all I&As from past year for other coffee burns and reviewed interventions. - Daily monitoring of tray and supervision during meals.	F 324		
F 490 SS=K	6. On 1/22/07 at 5:30 p.m., during an evening meal observation, on 1/23/07 at 7:15 a.m., during the breakfast meal observation and 11:46 a.m., during the lunch meal observation, the dietary staff checked the temperature of the coffee before it was sent out the window to the residents. None of the temperatures were above 140 degrees. 483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #12299 substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility's administration and nursing administration failed to ensure an effective system was in place to accurately assess and reassess residents' ability to handle hot liquids, to intervene in an effective manner, and to monitor staff's implementation of interventions to prevent burns from hot liquids. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Residents #1, #2, #3 and #4 and had the potential to affect 13 residents in the facility who	F 490		

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F 490	Continued From page 9 required assistance with hot liquids according to a list provided by the Assistant Director of Nursing on 1/24/07 at 10:36 a.m. The facility removed the Immediate Jeopardy prior to the survey entrance reducing the scope/severity to "H" (actual harm to Residents #1 and #4 who received burns from spilling hot coffee on themselves), however, the facility did not correct the underlying deficient practices. The facility was informed of the Immediate Jeopardy removed on 1/23/07 at 12:35 p.m. The findings are: 1. From February 2006 - January 2007, Resident #1 received burns from spilling hot coffee on herself on 4 separate occasions: a. A Nurse's Note dated 2/7/06 documented, "Res (Resident) was in D/R (dining room)] for evening, up in w/c (wheel chair) at table. A visitor served resident coffee and sat it on the table. Res knocked over coffee and coffee went into her lap. Daughter was present in D/R with res. Res was immediately taken to rm (room) ... clothing removed. Res had large reddened area on top of left mid thigh, approximately size of an adult hand, also very small area on mid right thigh. MD (Medical Doctor) notified ..." A Weekly Skin Audit Record dated 2/9/06 documented, "Blisters, spilled coffee" and a diagram of body with the left thigh circled. 1) The Care Plan dated 2/7/06 documented, "Use sippy cup for coffee." 2) A Hot Liquids Safety Assessment form dated 2/9/06 documented, "Resident to use cup with lid".	F 490		

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F 490	<p>Continued From page 10</p> <p>b. An Unusual Occurrence Report dated 3/11/06 at 5:50 a.m. documented, "Summoned to dining room per [name] to look at resident. While [name] was pointing to res (resident's) left upper thigh, observed a 1/2 full coffee cup sitting on res table and hot brown spot on res clothing at left upper thigh area. When asked res where did you get that hot coffee, res pointed at [name] and stated she gave it to me and put it on my table. CNAs assisted res to room and to bed. Removed res bottom pants and upon assessment to extremities, observed a 5 inch x 2 inch red line to res left upper thigh. Skin treatment order, cleanse burn with wound cleanser TAO (Triple Antibiotic Ointment) every shift until healed..."</p> <p>1) The Care Plan dated 3/11/06 documented, "Coffee burn left upper thigh. Res had no sippy cup. 3/13/06 - Insulated cups with lids to prevent burns."</p> <p>c. An Unusual Occurrence Report dated 11/12/06 at 7:30 a.m. documented, "Reported that res up in gerichair in room with tabletop. A.M. meal served, res spilled coffee on chest and abd (abdomen). Res had travel mug with lid in use. Tx (treatment) nurse in room and tx'd (treated). Intervention: Make sure res in dr (dining room) during meal service and travel mug with lid on."</p> <p>1. A Nurse's Note dated 11/14/06 at 2:30 p.m. documented, "... Has blistered area between breast, inside left leg, crease of left leg, resident has irritated area. Treatment nurse notified. Will continue to monitor".</p> <p>2. A Hot Liquids Safety Assessment form dated 11/17/06 documented, "Staff to assist with all hot</p>	F 490			

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F 490	Continued From page 11 liquids". d. An Unusual Occurrence Report dated 1/17/07 at 7:15 a.m. documented, "Res was sitting in gerichair in dining room, requested coffee, CNA took coffee from dining room window in black mug with lid to resident. CNA turned back to dining room window and heard resident yelling it's burning. Res taken to her room, clothing removed, large area on both upper thighs burned. Staff applied cool wet cloths to areas, tx nurse applied ointment...res continues to moan and cry, gave Percocet per doctors order... dietary manager took coffee temp, coffee temp at 7:25 a.m. 173 degrees. Dietary consultant notified. Consultant stated coffee must be brewed at 180-185 degrees, also stated fragile skin can burn at temp of 110 degrees. Dietary re-inserviced on the importance of checking temp on hot liquids. Staff re-inserviced on handling of hot liquids with assist trays. Inserviced nursing on importance of not giving hot liquids to an assist and walk away. At 9:00 a.m., res continues to moan and call out, pain unresolved. Res skin red with numerous blisters. Dr. [Physicians name] notified again and res sent to ER (Emergency Room)". A Nurse's Note dated 1/17/07 at 7:15 a.m. documented, "... Res had on bib which protected chest, coffee ran down front of bib and pooled at thighs, ran between thighs and around to back, numerous blisters, skin bright red, starting to peel..." The hospital Emergency Room report dated 1/17/07 documented, "Second degree burns to bilateral thigh with intact blisters noted". 1) On 1/22/07 at 4:33 p.m., the Dietary Manager was asked if Resident #1 used that particular travel mug every day. She stated, "She didn't use	F 490			

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F 490	<p>Continued From page 12</p> <p>that particular mug every day. She just used a travel mug in general." She was asked what interventions had been implemented after the previous burns. She stated, "To put coffee in a travel mug. I can't think of any more interventions".</p> <p>2) The Dietary Manager was asked what interventions were implemented since the burn on 1/17/07. She stated, "We pour coffee up in the back and bring the temp down to 140 degrees with water, then it's OK to send out the window. We document in a log for 3 meals what the coffee temp is. Staff has been inserviced."</p> <p>3) On 1/23/07 at 7:10 a.m., CNA #2 was asked what she had been told to do when serving coffee to the residents. She stated, "I'm not sure". She was asked if she was inserviced on hot liquids in the past week. She stated, "I've not been to an inservice about hot coffee, but we were given a piece of paper to read and sign." CNA #2 was asked what information was on the paper. She stated, "I don't know. I have short term memory loss." She was asked what she would do if she gave a resident a cup of hot liquid? She stated, "Make sure it has a lid on it and let them taste it and ask them if it's too hot." She was asked if all coffee cups were supposed to have lids. She stated, "I don't know. "</p> <p>4) On 1/23/07 at 7:18 a.m., CNA #3 was asked what she had been told to do when serving coffee to the residents. She stated, "Make sure it's not too hot." She was asked how she would do that. She stated, "I'd stick my hand over it and stick my pinky in it." CNA #3 was asked what she would do then. She stated, "I'd tell them to be careful with it because it's hot." The CNA was asked if</p>	F 490			

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F 490	<p>Continued From page 13</p> <p>she had been to a recent inservice about hot liquids. She stated, "No, but I'm sure we have one coming up Friday".</p> <p>2. Resident #4 suffered burns from spilling hot coffee in her lap in July 2006:</p> <p>An Unusual Occurrence Report dated 7/16/06 at 6:45 a.m., documented, "Resident states she requested coffee from a dietary staff member. When she got the coffee she lifted up on lid and spilled the cup in her lap. Upper right and left thighs are pink in color and tender to touch. 7:15 a.m. - Bilat upper thighs very red with blisters noted on inner upper thighs ... Travel mug, lid on cup and inservice dietary about giving out hot liquid. Check and monitor temp of liquid."</p> <p>1) On 1/23/07 at 10:40 a.m., the DON stated there was no documentation that the temperature of coffee had been monitored, and that the Dietary Manager couldn't remember if they did or not.</p> <p>2) A Hot Liquids Safety Assessment dated 1/12/07 documented the resident was able to manage hot liquids independently.</p> <p>3. Resident #3 spilled hot coffee in her lap in August 2006:</p> <p>An Unusual Occurrence Report dated 8/21/06 at 8:30 a.m. documented, "Dropped coffee cup at table and spilled coffee in her lap. Initially skin on inner thighs slightly pink. Resident denies pain. 9:20 a.m. - Rechecked inner thighs. Res continues to deny pain. No blistering noted. 12:00 p.m. - Per CNA, res has area left inner thigh, res c/o stings a little. Saf Gel applied..."</p>	F 490		

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F 490	<p>Continued From page 14</p> <p>Intervention: Coffee with ice chips in travel mug".</p> <p>A Hot Liquids Safety Assessment dated 8/22/06, 9/12/06 and 12/15/06 documented the resident was at risk for injury from spills of hot liquids.</p> <p>4. Resident #2 spilled hot coffee in her lap in August 2006:</p> <p>An Unusual Occurrence Report dated 8/27/06 at 12:00 p.m. documented, "CNA reported that res spilled coffee on herself in DR. Left thigh area of pants cold/wet. Skin had no redness or warmth. No obvious injury. Intervention: Cup with lid for hot liquids. "</p> <p>A Hot Liquids Safety Assessment dated 6/4/06 documented the resident was not at risk for injury from spills of hot liquids. An assessment dated 8/27/06 and 12/7/06 documented the resident was at risk but could drink hot liquids with supervision.</p> <p>5. On 1/22/07 at 2:40 p.m., the Administrator provided the following documentation of corrective action that was initiated on 1/17/07 which removed the Immediate Jeopardy:</p> <ul style="list-style-type: none"> - Inservice dietary about monitoring coffee temps - Hot liquids assessment completed on all residents - Review all residents currently with hot liquids to ensure they are getting correct safety measures - Reviewed all I&As from past year for other coffee burns and reviewed interventions. - Daily monitoring of tray and supervision during meals. <p>6. According to the DON on 1/23/07 at 9:00 a.m.,</p>	F 490		

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F 490	Continued From page 15 19 facility nursing employees had worked since the incident on 1/17/07, but had not been inserviced regarding the serving of hot liquids.	F 490		
F 520 SS=K	7. On 1/22/07 at 5:30 p.m., during an evening meal observation, on 1/23/07 at 7:15 a.m., during the breakfast meal observation and 11:46 a.m., during the lunch meal observation, the dietary staff checked the temperature of the coffee before it was sent out the window to the residents. None of the temperatures were above 140 degrees. 483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		

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F 520	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12299 substantiated (all or in part) with these findings:</p> <p>Based on observation, interview and record review, the facility's Quality Assessment and Assurance Committee (QA&A) failed to ensure that quality issues were identified and corrective actions were implemented after Resident #1 received 4 burns from hot coffee in an 11 month period. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Residents #1, #2, #3 and #4 and had the potential to affect 13 residents in the facility who required assistance with hot liquids according to a list provided by the Assistant Director of Nursing on 1/24/07 at 10:36 a.m. The facility removed the Immediate Jeopardy prior to the survey entrance reducing the scope/severity to "H" (actual harm to Residents #1 and #4 who received burns from spilling hot coffee on themselves), however, the facility did not correct the underlying deficient practices. The facility was informed of the Immediate Jeopardy removed on 1/23/07 at 12:35 p.m. The findings are:</p> <p>1. From February 2006 - January 2007, Resident #1 received burns from spilling hot coffee on herself on 4 separate occasions:</p> <p>a. A Nurse's Note dated 2/7/06 documented, "Res (Resident) was in D/R (dining room) for evening, up in w/c (wheel chair) at table. A visitor served resident coffee and sat it on the table. Res knocked over coffee and coffee went into her lap. Daughter was present in D/R with res. Res</p>	F 520		

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F 520	<p>Continued From page 17</p> <p>was immediately taken to rm [room]... clothing removed. Res had large reddened area on top of left mid thigh, approximately size of an adult hand, also very small area on mid right thigh. MD (Medical Doctor) notified..." A Weekly Skin Audit Record dated 2/9/06 documented, "Blisters, spilled coffee" and a diagram of body with the left thigh circled.</p> <p>1) The Care Plan dated 2/7/06 documented, "Use sippy cup for coffee."</p> <p>2) A Hot Liquids Safety Assessment form dated 2/9/06 documented, "Resident to use cup with lid".</p> <p>b. An Unusual Occurrence Report dated 3/11/06 at 5:50 a.m. documented, "Summoned to dining room per [name] to look at resident. While [name] was pointing to res [resident's] left upper thigh, observed a 1/2 full coffee cup sitting on res table and hot brown spot on res clothing at left upper thigh area. When asked res where did you get that hot coffee, res pointed at [a resident 's name] and stated she gave it to me and put it on my table. CNAs assisted res to room and to bed. Removed res bottom pants and upon assessment to extremities, observed a 5 inch x 2 inch red line to res left upper thigh. Skin treatment order, cleanse burn with wound cleanser TAO [Triple Antibiotic Ointment] every shift until healed..."</p> <p>1) The Care Plan dated 3/11/06 documented, "Coffee burn left upper thigh. Res had no sippy cup. 3/13/06 - Insulated cups with lids to prevent burns."</p> <p>c. An Unusual Occurrence Report dated</p>	F 520			

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F 520	<p>Continued From page 18</p> <p>11/12/06 at 7:30 a.m. documented, "Reported that res up in gerichair in room with tabletop. A.M. meal served, res spilled coffee on chest and abd (abdomen). Res had travel mug with lid in use. Tx (treatment) nurse in room and tx'd (treated). Intervention: Make sure res in dr (dining room) during meal service and travel mug with lid on." A Nurse's Note dated 11/14/06 at 2:30 p.m. documented, "... Has blistered area between breast, inside left leg, crease of left leg, resident has irritated area. Treatment nurse notified. Will continue to monitor".</p> <p>1) A Hot Liquids Safety Assessment form dated 11/17/06 documented, "Staff to assist with all hot liquids".</p> <p>d. An Unusual Occurrence Report dated 1/17/07 at 7:15 a.m. documented, "Res was sitting in gerichair in dining room, requested coffee, CNA took coffee from dining room window in black mug with lid to resident. CNA turned back to dining room window and heard resident yelling it's burning. Res taken to her room, clothing removed, large area on both upper thighs burned. Staff applied cool wet cloths to areas, tx nurse applied ointment...res continues to moan and cry, gave Percocet per doctors order... dietary manager took coffee temp, coffee temp at 7:25 a.m. 173 degrees. Dietary consultant notified. Consultant stated coffee must be brewed at 180-185 degrees, also stated fragile skin can burn at temp of 110 degrees. Dietary re-inserviced on the importance of checking temp on hot liquids. Staff re-inserviced on handling of hot liquids with assist trays. Inserviced nursing on importance of not giving hot liquids to an assist and walk away. At 9:00 a.m., res continues to moan and call out, pain unresolved. Res skin red</p>	F 520			

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F 520	<p>Continued From page 19</p> <p>with numerous blisters. Dr. [Physicians name] notified again and res sent to ER [Emergency Room]". A Nurse's Note dated 1/17/07 at 7:15 a.m. documented, "... Res had on bib which protected chest, coffee ran down front of bib and pooled at thighs, ran between thighs and around to back, numerous blisters, skin bright red, starting to peel..." The hospital Emergency Room report dated 1/17/07 documented, "Second degree burns to bilateral thigh with intact blisters noted".</p> <p>1) On 1/22/07 at 4:33 p.m., the Dietary Manager was asked if Resident #1 used that particular travel mug every day. She stated, "She didn't use that particular mug every day. She just used a travel mug in general." She was asked what interventions had been implemented after the previous burns. She stated, "To put coffee in a travel mug. I can't think of any more interventions".</p> <p>2) The Dietary Manager was asked what interventions were implemented since the burn on 1/17/07. She stated, "We pour coffee up in the back and bring the temp down to 140 degrees with water, then it's OK to send out the window. We document in a log for 3 meals what the coffee temp is. Staff has been inserviced."</p> <p>3) On 1/23/07 at 7:10 a.m., CNA #2 was asked what she had been told to do when serving coffee to the residents. She stated, "I'm not sure". She was asked if she was inserviced on hot liquids in the past week. She stated, "I've not been to an inservice about hot coffee, but we were given a piece of paper to read and sign." CNA #2 was asked what information was on the paper. She stated, "I don't know. I have short term memory</p>	F 520			

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F 520	<p>Continued From page 20</p> <p>loss." She was asked what she would do if she gave a resident a cup of hot liquid? She stated, "Make sure it has a lid on it and let them taste it and ask them if it's too hot." She was asked if all coffee cups were supposed to have lids. She stated, "I don't know. "</p> <p>4) On 1/23/07 at 7:18 a.m., CNA #3 was asked what she had been told to do when serving coffee to the residents. She stated, "Make sure it's not too hot." She was asked how she would do that. She stated, "I'd stick my hand over it and stick my pinky in it." CNA #3 was asked what she would do then. She stated, "I'd tell them to be careful with it because it's hot." The CNA was asked if she had been to a recent inservice about hot liquids. She stated, "No, but I'm sure we have one coming up Friday".</p> <p>2. Resident #4 suffered burns from spilling hot coffee in her lap in July 2006:</p> <p>An Unusual Occurrence Report dated 7/16/06 at 6:45 a.m., documented, "Resident states she requested coffee from a dietary staff member. When she got the coffee she lifted up on lid and spilled the cup in her lap. Upper right and left thighs are pink in color and tender to touch. 7:15 a.m. - Bilateral upper thighs very red with blisters noted on inner upper thighs ... Travel mug, lid on cup and inservice dietary about giving out hot liquid. Check and monitor temp of liquid."</p> <p>1) On 1/23/07 at 10:40 a.m., the DON stated there was no documentation that the temperature of coffee had been monitored, and that the Dietary Manager couldn't remember if they did or not.</p>	F 520		

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F 520	<p>Continued From page 21</p> <p>2) A Hot Liquids Safety Assessment dated 1/12/07 documented the resident was able to manage hot liquids independently.</p> <p>3. Resident #3 spilled hot coffee in her lap in August 2006:</p> <p>An Unusual Occurrence Report dated 8/21/06 at 8:30 a.m. documented, "Dropped coffee cup at table and spilled coffee in her lap. Initially skin on inner thighs slightly pink. Resident denies pain. 9:20 a.m. - Rechecked inner thighs. Res continues to deny pain. No blistering noted. 12:00 p.m. - Per CNA, res has area left inner thigh, res c/o stings a little. Saf Gel applied... Intervention: Coffee with ice chips in travel mug".</p> <p>A Hot Liquids Safety Assessment dated 8/22/06, 9/12/06 and 12/15/06 documented the resident was at risk for injury from spills of hot liquids.</p> <p>4. Resident #2 spilled hot coffee in her lap in August 2006:</p> <p>An Unusual Occurrence Report dated 8/27/06 at 12:00 p.m. documented, "CNA reported that res spilled coffee on herself in DR. Left thigh area of pants cold/wet. Skin had no redness or warmth. No obvious injury. Intervention: Cup with lid for hot liquids. "</p> <p>A Hot Liquids Safety Assessment dated 6/4/06 documented the resident was not at risk for injury from spills of hot liquids. An assessment dated 8/27/06 and 12/7/06 documented the resident was at risk but could drink hot liquids with supervision.</p> <p>5. On 1/22/07 at 2:40 p.m., the Administrator</p>	F 520		

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NAME OF PROVIDER OR SUPPLIER BEEBE RETIREMENT CENTER, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 709 MCAFEE LANE BEEBE, AR 72012		
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F 520	<p>Continued From page 22</p> <p>provided the following documentation of corrective action that was initiated on 1/17/07 which removed the Immediate Jeopardy:</p> <ul style="list-style-type: none"> - Inservice dietary about monitoring coffee temps - Hot liquids assessment completed on all residents - Review all residents currently with hot liquids to ensure they are getting correct safety measures - Reviewed all I&As from past year for other coffee burns and reviewed interventions. - Daily monitoring of tray and supervision during meals. <p>6. On 1/22/07 at 5:30 p.m., during an evening meal observation, on 1/23/07 at 7:15 a.m., during the breakfast meal observation and 11:46 a.m., during the lunch meal observation, the dietary staff checked the temperature of the coffee before it was sent out the window to the residents. None of the temperatures were above 140 degrees.</p> <p>7. On 1/23/07 at 12:03 p.m., the facility's Administrator was asked to provide documentation to indicate the QA&A Committee had intervened with the coffee burns over the past 11 months. As of 1/24/07 at 10:00 a.m., the Administrator had not provided any QA&A documentation.</p>	F 520			