STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055979	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Post-Acute Care Center	3169 M Street Merced, CA 95348

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(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** 42123 Based on interview and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for one of nine sampled residents (Resident 1), when Resident 1 was diagnosed with dementia (a chronic or persistent disorder of the mental processes marked by memory disorder, personality changes, and impaired reasoning), and a known history of poor safety awareness and muscle weakness and contracture (shortening of muscular or connective tissue that results in deformity) of left hand; and was not supervised while she drank hot tea on 2/16/22, in accordance with comprehensive care plan which indicated Resident 1 was totally dependent on staff to eat and drink. This failure resulted in Resident 1 spilling hot tea onto her chest, suffering avoidable second-degree burns (a burn to the skin characterized by injury to the outer and middle layers of the skin), causing pain and required routine acetaminophen (pain medication) twice daily for pain management, an assessment by the Would Consultant Physician (WCP), and daily dressing changes. Findings: During a review of Resident 1 ' s Admission Record (AR-a document with person identifiable and medical information), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (disrupted blood flow to the brain), clostridium difficile (a germ that causes diarrhea and inflammation of the colon [large intestine]), protein-calorie malnutrition (inadequate intake of food), dementia, transient ischemic attack (TIA- a brief episode of weakness, vision problems, slurred speech resulting from an interruption in the blood supply to the brain), hemiplegia (weakness or partial paralysis on one side of the body) and contracture of muscle left upper arm (fixed tightening of a joint preventing normal movement of the body part). During a review of Residents 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive [pertaining to memory and judgement] and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental Status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 04 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 had severe cognitive impairment. The MDS assessment section G (functional status) dated 1/23/22 indicated Resident 1 required the support of one-person physical assistance for eating. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s progress notes written by the WCP, dated 2/16/22, the notes indicated, . 2 [second degree] burn chest . consistent with hot water . Wound Location . Chest . Type . Trauma . Burn . L x W x D [length by width by depth-measurements] 18 [cm-unit of measurement] x 40 [cm] x 0.2 [cm] . Wound cleanser . silvasorb [wound dressing for partial thickness (outer and middle layer of skin) burns]/alg [alginate-treatment for wound healing] . D [daily] . During a review of Resident 1 ' s Order Summary Report, (OSR-physician orders) dated 2/2022, the OSR indicated, . Cleanse chest with wound cleanser pat dry apply silvasorb gel and leave open to air one time a day related to BURN OF SECOND DEGREE . [brand name] Tablet 325 MG [milligrams-unit of measurement] (Acetaminophen) Give 2 tablet[s] by mouth two times a day related to BURN OF SECOND DEGREE . During a review of Resident 1 ' s IDT Note (Interdisciplinary Team-a group of different healthcare disciplines to plan, coordinate and deliver personalized care) dated 2/17/24 at 2:21 p.m., the IDT note indicated, . IDT met to review redness noted to [Resident 1 ' s] chest on 2/16/22 . Chest injury measurement is 18 [cm] x 40 [cm] x 0.2 [cm] with scant [small amount] drainage . Wound doctor, [WCP ' s name] notified and came in to evaluate [Resident 1] . [WCP] stated the site is a 2nd degree superficial [situated on the skin or immediately beneath it] burn . [Resident 1] stated she spilled tea on her chest . [Resident 1] is also at risk due to fragile skin and a contracture to her left hand . [physician (PHY) 1 ' s name] notified of event and ordered routine pain medication [brand name for acetaminophen] 325 mg 2 tabs PO [by mouth] BID [twice daily] for pain management . During a concurrent interview and record review on 4/2/24 at 1:29 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s medical diagnoses were reviewed. LVN 1 stated Resident 1 ' s diagnoses included cerebral infarction with hemiplegia, weakness and dementia which could affect Resident 1 ' s ability to safely feed herself. Resident 1 ' s ADL [activities of daily living- includes eating, dressing, bathing] care plan dated 1/21/22 was reviewed, the care plan indicated, . [Resident 1] has an ADL self-care performance deficit . Eating: [Resident 1] is totally dependent on (1) staff for eating . The resident has contractures of the left hand . LVN 1 stated the care plan indicated Resident 1 needed a staff member to physically feed her, which would include holding a cup. LVN 1 stated, probably nobody assisted her that day [when Resident 1 was burned]. A color photo of Resident 1 ' s chest dated 2/16/22 at 1:54 p.m., was reviewed. The photo revealed multiple reddened areas on the right upper chest, right breast, mid-chest, and the left inner breast with a few scattered darkened areas. LVN 1 stated the darkened areas in the photo appeared to be scabs (dry protective crust that forms over wounds) which were deeper burns to the skin. During a telephone interview on 4/11/24 at 6:31 a.m. with LVN 2, LVN 2 stated she was the day shift charge nurse on 2/16/22. LVN 2 stated at approximately 1:00 p.m., the Director of Nursing (DON) had called for her to Resident 1 ' s room. LVN 2 stated when she entered Resident 1 ' s room, she observed redness across Resident 1 ' s chest area. LVN 2 stated Resident 1 reported she had spilled hot tea on herself. LVN 2 stated Resident 1 complained she had a burning pain of eight out of 10 on the numeric pain scale (1-3 no pain to mild pain, 4-6 moderate pain, 7-10 severe pain). LVN 2 stated Resident 1 was assessed by the WCP who was in the facility at the time of the incident. LVN 2 stated the WCP indicated Resident 1 had 2nd degree burns to her chest and ordered wound care. LVN 2 stated Resident 1 ' s PHY 1 ordered acetaminophen 325 mg two tablets twice daily for pain management. Resident 1 ' s ADL care plan was reviewed, LVN 1 stated the care plan indicated Resident 1 was totally dependent on one staff member for eating. LVN 2 stated totally dependent meant Resident 1 required a staff member to provide physical assistance to eat and drink. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/17/24 at 10:15 a.m. with CNA 5, CNA 5 stated if a resident required assistance to eat, they were not safe to handle a hot beverage without assistance. CNA 5 stated, they could burn themselves. During a concurrent interview and record review on 4/17/24 at 10:42 a.m. with LVN 3, Resident 1 ' s NSG [nursing] Hot Beverage Safety Evaluation (HBSE- an assessment to determine the level of supervision needed for safe consumption of hot beverages) dated 1/21/22 was reviewed. The HBSE indicated, . score 3 [out of 5] . May require set up assistance . A. Resident demonstrates impaired orientation . yes . B. Resident has a diagnosis of Neuropathy [disease of the peripheral nerves causing numbness or weakness] or other neurological impairment . yes . C. Resident demonstrated one or more of the following cognitive impairments: Poor safety awareness, Impaired short term memory, Impulsiveness . Yes . score . 1-3 points: Resident may require set up assistance while consuming hot beverages . 4-5 points . Resident is unable to consume hot beverages safely independently. Resident requires supervision while consuming hot beverages . LVN 3 stated the HBSE indicated Resident 1 may require set up assistance with hot beverages but did not indicate she needed supervision. LVN 3 stated Resident 1 ' s diagnoses of cerebral infarction, dementia and weakness should be considered when evaluating if Resident 1 was safe to drink hot beverages independently. LVN 3 stated, I would question the results [of the HBSE]. LVN 3 stated Resident 1 ' s diagnoses placed her at a higher risk of burning herself if left unsupervised with a hot beverage. During a concurrent interview and record review on 4/17/24 at 11:23 a.m. with the DOR (Director of Rehabilitation), Resident 1 ' s Occupational Therapy OT Evaluation & Plan of Treatment, dated 1/24/22 was reviewed. The evaluation indicated, . Musculoskeletal System [bones, muscles and joints] Assessment . RUE [right upper extremity (arm)] Strength = Impaired [weakened or damaged] . LUE [left upper extremity] Strength = Impaired . General RUE Strength = 3/5; Shoulder = Impaired . Elbow/Forearm = Impaired . Wrist = Impaired . LUE Strength = 2+/5; Shoulder = Impaired . Elbow/Forearm = Impaired . Wrist = Impaired . Self Feeding=Patient requires assistance . Evaluation Summary . Physical/Cognitive/Psychosocial [evaluation of mental health and social well-being] Performance . presents with impairments in balance, dexterity [performing tasks with hands], fine motor coordination [small exact movements], gross motor coordination [large movements], mobility [movement], strength . limitations and/or participation restrictions in the areas of general tasks and demands . The DOR stated the evaluation indicated Resident 1 had an impairment in the strength and mobility to both arms. The DOR stated the evaluation indicated Resident 1 ' s daughter assisted with all care and mobility needs before facility admission. During a concurrent interview and record review on 4/17/24 at 12:14 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 1 ' s MDS Section G dated 1/23/22, was reviewed. The MDS indicated, . H. Eating-how resident eats and drinks, regardless of skill . ADL Support Provided . code 2 [One-person physical assistance] . The MDSC stated the MDS indicated Resident 1 needed one person to physically assist her to eat. The MDSC reviewed Resident 1 ' s ADL care plan and stated the care plan indicated she was totally dependent on staff to eat. The MDSC stated it was unsafe for Resident 1 to drink a hot beverage without assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/17/24 at 12:45 p.m. with the Director of Staff Development (DSD), the DSD stated she remembered Resident 1. The DSD stated she was not working the day Resident 1 had a burn incident but had seen Resident 1 ' s wound after the incident. The DSD stated an HBSE was done for all residents on admission, quarterly and if there was an incident. The DSD reviewed Resident 1 ' s HBSE dated 2/16/22 and stated it indicated there was a cognitive impairment, poor safety awareness, impaired short-term memory, and impulsiveness. The DSD reviewed Resident 1 ' s ADL care plan and stated one person should have stayed with her the entire time she was drinking the hot beverage. The DSD stated Resident 1 was not safe to drink hot tea unsupervised. During a concurrent interview and record review on 4/17/24 at 1:10 p.m. with the DON, the DON stated on 2/16/22 at approximately 1:00 p.m. she answered Resident 1 ' s call light. The DON stated she noticed Resident 1 ' s neck was wet and there was redness across her chest. The DON stated called for the charge nurse. The DON stated she asked Resident 1 what had happened, and Resident 1 told her she spilled tea on herself. The DON stated the WCP was in the facility and assessed Resident 1. The DON stated the WCP diagnosed Resident 1 with 2nd degree burns to her chest. Resident 1 ' s ADL care plan dated 1/21/22 was reviewed, and the DON stated the care plan indicated Resident 1 was totally dependent on staff for eating. The DON stated totally dependent meant staff would set up meals, cut the food and feed the resident. The DON stated care plans were important because they provided individualized care for the residents. The DON stated Resident 1 ' s MDS Section G dated 1/23/22 indicated Resident 1 was assessed as needing one-person physical assistance to eat. The DON stated somebody should have stayed with Resident 1 while drinking hot tea. The facility ' s policy and procedure (P&P) titled Quality of Care, dated 7/2018 was reviewed. The P&P indicated, . provide an environment that is free from controllable accident hazards and provision of supervision and devices needed to prevent avoidable accidents . Efforts to minimize risk to residents will include individualized, resident-centered interventions to reduce individual risks related to hazards in the environment . The DON stated Resident 1 ' s individualized care plan was not followed according to P&P, and it may have prevented the accident from occurring. During a review of Resident 1 ' s NSG [nursing] Admission/Readmission Evaluation, dated 1/21/22, at 5:24 p. m., the evaluation indicated, .ADLs . Eating . The resident has an ADL self-care performance deficit . [box checked] Eating: the resident is dependent on (1) staff for eating . Impairments . [box checked] cognitive . Forgetfulness and confusion noted . During a review of Resident 1 ' s History and Physical, (H&P-complete assessment), dated 1/23/22, at 6:13 p. m., written by Physician (PHY) 1, the H&P indicated, . past medical history significant for generalized weakness, Dementia, CVA [Cerebrovascular Accident-loss of blood flow to part of the brain] with left sided weakness and left hand contracture . Dementia; Monitor behavior and help with ADL . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P), titled Quality of Care, dated 7/2018, the P&P indicated, . provide an environment that is free from controllable accident hazards and provision of supervision and devices needed to prevent avoidable accidents . Efforts to minimize risk to residents will include individualized, resident-centered interventions to reduce individual risks related to hazards in the environment. Interventions will be modified when necessary . Individualized interventions will be developed to reduce the potential for accidents .Interventions will be consistent with professional standards . Resident specific interventions will be reflected in the resident ' s person-centered, individualized care plan . Monitoring and modification process may include . verifying that interventions are implemented . evaluating the effectiveness of interventions . The facility may use supervision as an intervention to mitigate accident risk . Risks and Environmental Hazards . In order to be considered hazardous, a potentially hazardous item or situation must be accessible to a vulnerable resident . Hot water may reach temperatures that are hazardous for residents, putting them at risk for burns caused by scalding [injury from hot liquid or steam] . During a review of a professional reference retrieved from https://nursinghomesabuse. org/nursing-home-injuries/burns/ titled Burn Injuries in Nursing Homes, dated 4/30/23, the reference indicated, . Burn injuries are a common occurrence in nursing homes, with elderly residents being at higher risk due to factors such as decreased mobility, sensory deficits [loss, absence, or marked impairment of vision, hearing taste, touch or smell] and cognitive impairment . Burn injuries can be cause by hot surfaces, scalding liquids . are often preventable with proper staff training and safety protocols . following factors make elderly individuals more vulnerable to scalds . Impaired sensation that prevents elders from reacting quickly to heat . Thinner skin, which burns to its full depth more readily . Nursing home residents could come into contract with hot liquids if the nursing home fails to take protective measures . Hot coffee and the steam from hot foods can cause painful and severe burns. Health conditions common to the elderly . can increase the risk of elders spilling coffee on themselves . Nursing homes should always ensure food and coffee are served at safe temperatures, and that coffee is served in cups with secured lids . older adults with the following characteristics face the highest risks of experiencing burns . limited mobility Slow reaction times . Sensory impairment . Decreased coordination . Cognitive decline . When nursing homes accept patients, they accept responsibility for any harm that comes to patients while under their care . has the duty to provide a safe, hospitable environment for residents . Their duties include . protect patients . supervise patients . Take proactive measures to prevent injuries .