CITATION NUMBER: 020011701

Date: 9/1/2015 12:00:00 AM

Type Of Visit: Complaint Investig.

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00438405

Licensee Name: Alameda Healthcare & Wellness Center LLC
Address: 430 Willow Street Alameda, CA 94501
License Number: 020000268 Type of Ownership: Limited Liability Company

Facility Name: Alameda Healthcare & Wellness Center
Address: 430 Willow Street Alameda, CA 94501
Telephone :
Facility Type: Skilled Nursing Facility Capacity: 166
Facility ID: 020000043

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
	CLASS: B CITATION: Patient Care	$1,500.00	9/14/2015

F323

CLASS B **CITATION --** Patient Care

F323 483.25(h): FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The facility violated the aforementioned regulation by failing to prevent hot water from being spilled onto Resident 1. A CNA placed a cup of very hot water on Resident 1's bedside table, which was cluttered with her items. While moving the clutter to make more room on the bedside table, the cup tipped over, spilling hot water onto Resident 1. As a result of this failure, Resident 1 received first degree burns (involves the upper layer of the skin and is usually red and very painful) and second degree burns (partial thickness burn which involves the entire outer layer of skin and upper layers of the dermis which contains the nerve endings. The burn will be pink or red in color, and painful.) Resident 1 experienced a pain level of 8 out of 10 (pain scale where zero is no pain and 10 is the worst pain imaginable,) and a delay in her rehabilitation therapy due to the location and extent of the burns.In an interview on 5/7/15 at 11:40 a.m., Resident 1 stated on 4/9/15, she was still in bed when Certified Nursing Assistant (CNA) 1 brought her breakfast tray into her room. Resident 1 stated she was on contact isolation precautions (used when a resident has a type of bacteria or virus that could be transmitted by touching contaminated areas). The meal was set up on disposable paper products. There was no room for the tray on the over bed table. CNA 1 put the cup of very hot water on the over bed table and began moving objects, when the hot water spilled onto Resident 1's upper, inner thighs and extended to her buttocks. Resident 1 stated after the hot water spilled on her the pain was, "Out of this world." Resident 1 stated as of 5/7/15, she was still having continuous pain on her upper thigh, especially during dressing changes, 29 days after the incident.Review, on 5/7/15, of Resident 1's admission documentation dated 1/15/15, showed Resident 1 was admitted to the facility on 1/15/15, with multiple diagnoses that included rehabilitation therapy to address a fall, lower leg injury, and

generalized muscle weakness.Resident 1's Dietary Questionnaire form dated 1/15/15, as part of dietary's admission assessment, showed Resident 1 preferred not to have any hot drinks such as coffee, decaffeinated coffee, or tea served to her for breakfast, lunch, and dinner. There was no update to the assessment to show Resident 1 now preferred hot water with her meals.Record review of the Physician Assistant's notes, dated 4/9/15, showed, "Pt. (patient) had boiling water spilled on her legs this am. Multiple bullae (blisters) formed in medial (inner) thigh and have since ruptured ... significant pain of burn; uncontrolled with current pain rx (prescription medication)... Medial thigh burn: applying sulfadiazine 1% and cover with silvaderm (medications to control infection and promote healing) contact layer q (every) shift. Will increase Norco (narcotic pain reliever) prn (as needed) for pain." Review of the form used by nursing staff to facilitate an efficient and accurate communication between nurses and physicians, dated 4/9/15 at 8:30 a.m., showed Resident 1 had, "1st and 2nd degree burn, secondary to hot water spilled on upper inner bilateral thighs". At 10:00 a.m., "Noted Resident's c/o (complaint) of pain at site of second degree burn rated as 10/10 on pain scale. Medicated with 2 tablets Norco 5/325, as prescribed; will assess within one hour" (pain scale of 0 to 10; with 0 indicating no pain and a score of 10 on the pain scale, as the most severe pain imaginable.)Resident 1's Patient Wound Assessment dated 5/5/15, showed the following notation for her right inner thigh wound: "Burn had a measurement of "Length 21 centimeter (8-1/4 inches) X Width of 8.5 cm X Depth 0.2 cm (8-1/4 inches X 3-1/2 inches)." Left inner thigh wound burn had a measurement of "7.0 cm X 5.0 cm X .02 cm (2-3/4 inches X 2 inches)." Resident 1 complained of having pain at a level of 8 out 10, during the dressing change.During a dressing change observation and concurrent interview on 5/7/15 at 12:25 p.m., Licensed Vocational Nurse (LVN) 1 confirmed the wounds on Resident 1's left and right upper thighs were due to the scalding by hot water on 4/9/15. LVN 1 stated the wound was, "Better now; you should have seen it (wound) before it started healing. The right upper thigh wound extends all the way to Resident 1's buttock area."During an observation and concurrent interview of the Dietary Supervisor (DS), while in the presence of the Administrator on 5/7/15 at 12:50 p.m., she confirmed that once the hot water was poured into the cup, it would take 20 minutes until it was delivered to the resident in her room. The temperature of hot water immediately after it was poured from the hot water dispenser/coffee maker was 180 degrees Fahrenheit (F). Five minutes later (at 12:55 p.m.,) the water temperature was 163 degrees F; 10 minutes later the water temperature was 152.6 degrees, and by 20 minutes after pouring, the water temperature was 144.3 degrees F. According to the Burn Foundation, a hot water temperature of 140 degrees F. can cause a third degree burn (full thickness) in as little as 5 seconds of exposure to hot water. A hot water temperature of 149 degrees F can cause a second degree burn in as little as 2 seconds. (http://www.burnfoundation.org/programs/resource.cfm?c=1&a=3) During an interview and concurrent record review on 5/7/15 at 1:05 p.m., Licensed Vocational Nurse (LVN) 1 stated right after the accident on 4/9/15, she assessed Resident 1. LVN 1 stated nursing staff used a "Skin Sheet" to record the wound measurements. Nursing staff obtained a physician's order for wound treatment and pain medications because Resident 1 was having pain. LVN 1 was unable to locate Resident 1's "Skin Sheet" from 4/9/15 for Resident 1's initial burn wound measurement.In an interview on 5/7/15 at 1:25 p.m., Certified Nursing Assistant (CNA) 1 stated when she brought a disposable breakfast tray to Resident 1 on 4/9/15. Her bedside tray was cluttered with multiple items, so there was not room for the breakfast tray. She set the hot water cup on the bedside table, and began helping Resident 1 clear space on the tray. While she was assisting Resident 1 clear a space for the tray, her attention was diverted, and that was when the water spilled onto Resident 1. She did not see the cup tip over, or how it tipped over.There was no documentation to show a care plan for clutter on the bedside table. There was no documentation to show staff identified possible spill hazards due to clutter on the bedside table. In an interview on 5/7/15 1:55 p.m., the Occupational Therapist stated before Resident 1 suffered the hot water burn, she was able to walk along the hallway for up to 100 feet and she was getting stronger. When Resident 1 was put on contact isolation, she was able to do PT/OT activities in her room. Since the burn incident, she began doing her exercises mostly in bed two to three times per day. She had to learn to move her leg a certain way so it would not rub against the other injured leg while getting

out of bed in order to avoid more pain. The Occupational Therapist stated the burn and the pain delayed Resident 1's recovery by at least one and a half months. Therefore, the facility failed to provide adequate supervision to prevent an accident. This failure had a direct or immediate relationship to the health, safety or security of patients.

Name Of Evaluator:
Maria Nevarez

Evaluator
Signature:_____

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature:_____

Name:_____

Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE