STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075271	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Healthcare & Rehabilitation Center, LLC	475 High St Mystic, CT 06355

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for injuries of unknown origin, the facility failed to review and revise the plan of care timely following a newly discovered wound and failed to ensure the residents plan of care addressed frequent refusals of care. The findings include: Resident #1's diagnoses included dementia without behavioral disturbances, generalized muscle weakness and polyneuropathy (peripheral nerve disorder that causes multiple nerves throughout the body to malfunction at the same time which can cause numbness, pain, tingling or a burning sensation). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10) and was independent with eating, bed mobility, transfers and ambulation. A. A nurse's note dated 3/17/25 at 12:51 PM identified Occupational Therapist (OT) #1 reported a 16 cm by 7 cm skin tear to Resident #1 ' s right inner thigh, further described the affected area as bright red in color and tender to touch and indicated the nursing supervisor, wound nurse and APRN were notified. The note failed to identify that an intervention was implemented following the discovery of the wound. A skin/wound note dated 3/25/25 at 12:15 PM identified the wound nurse was notified of a new wound discovered to Resident #1 ' s genitals measuring 2 cm by 1 cm by 0.5 cm and was tender to touch. The note reported that the area was cleansed, Silvadene (topical antimicrobial cream used for the treatment of burns) was applied, the area was covered with a dry, clean dressing and Resident #1 was referred to the wound care physician. The facility Reportable Event (RE) Report dated 3/26/25 at 3:00 PM identified that on 3/17/25 at 12:00 PM an injury of unknown origin was discovered to Resident #1's right thigh and was potentially caused by a fall. The RE identified that on 3/25/25, an additional wound was discovered to Resident #1 ' s genitals while OT #1 was performing Activities of Daily Living (ADLs) with Resident #1, and a wound consult was placed. The RE identified the wound physician evaluated the wounds on 3/26/25, classified the wounds to the right thigh and genitals as burns and recommended a burn consult, follow-up with the wound nurse and daily dressing changes. The RCP and Resident Care Card (RCC) were updated to include the use of a sippy cup for drinks at all times. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A RE or Accident and Investigation (A & I) including statements for the 3/17/25 injury of unknown origin could not be located by the DNS. The Resident Care Plan (RCP) dated 3/27/25 (10 days after the initial identification of altered skin integrity on 3/17/25) identified Resident #1 was at risk for alteration in skin integrity and was noted with burns to his/her thigh and genitals on 3/26/25. Interventions included to report any areas of skin redness or breakdown, a sippy cup was to be used with all meals for drinks related to the possibility of a burn and to update the provider and family as needed. Interview with the DNS on 4/17/25 at 3:48 PM identified that an intervention should have been initiated within 24 hours for the right thigh wound discovered on 3/17/25, and RN #4 should have updated the RCP following the incident. The DNS identified the facility Accident Checklist includes updating the RCP with new interventions which should be completed by the nursing supervisor at the time of an incident. Cross reference F689. B. A statement by NA #4 dated 3/28/25 regarding the 3/25/25 injury of unknown origin identified that she went into Resident #1's room on 3/25/25 to provide care and the resident refused. Interview with NA #3 on 4/17/25 at 2:50 PM identified that Resident #1 had a history of refusals to include bathroom assistance, the use of the call bell, personal care and showering. NA #3 identified that she usually had to reapproach Resident #1 several times and encourage him/her to allow help from staff. She identified refusal behavior was Resident #1 ' s baseline and all staff working with Resident #1 was aware of the behavior. NA #3 identified Resident #1 had multiple falls due to refusing to request help from staff. Review of the Resident Care Card failed to identify refusals of care or interventions for refusals to include reapproach. Interview with NA #2 on 4/17/25 at 3:10 PM identified Resident #1 had a history of refusals to include personal care and the use of the call bell and further indicated after multiple attempts at reapproach Resident #1 would eventually allow assistance. Interview with the DNS on 4/17/25 at 3:15 PM identified that Resident #1 was known to refuse care and assistance and indicated Social Worker #1 was responsible for RCPs related to refusals. The DNS inidcated there should have been an RCP for refusals of care. Interview with Social Worker #1 on 4/17/25 at 3:20 PM identified that she is responsible for updating the behavior RCP's, including refusals of care, and indicated she was not aware of care refusals. Although attempted, an interview NA #4 was not obtained. Review of the Care Planning- Interdisciplinary Team policy (undated) directed, in part, that ongoing changes in residents status shall be updated by nursing and/or the Interdisciplinary Team as needed. As care plans are updated, staff shall follow the updated plan of care and as updated on the Care Card as applicable.

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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 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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for injuries of unknown origin, the facility failed to ensure a full body skin assessment was performed after the discovery of an injury of unknown origin and failed to document every shift on an injury of unknown origin per physician's orders. The findings include: Resident #1's diagnoses included dementia without behavioral disturbances, generalized muscle weakness and polyneuropathy (peripheral nerve disorder that causes multiple nerves throughout the body to malfunction at the same time which can cause numbness, pain, tingling or a burning sensation). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10) and was independent with eating, bed mobility, transfers and ambulation. A nurse's note dated 3/17/25 at 12:51 PM identified Occupational Therapist (OT) #1 reported a 16 cm by 7 cm skin tear to Resident #1 ' s right inner thigh, further described the affected area as bright red in color and tender to touch and indicated the nursing supervisor, wound nurse and APRN were notified. An OT treatment encounter note dated 3/25/25 identified Resident #1 was grimacing in pain with peri care and stated he/she burned the genitals after spilling hot chocolate in the groin area. The note indicated nursing was notified to address the burn/wound. A skin/wound note dated 3/25/25 at 12:15 PM identified the wound nurse was notified of a new wound discovered to Resident #1 ' s genitals measuring 2 cm by 1 cm by 0.5 cm and was tender to touch. The note reported that the area was cleansed, Silvadene (topical antimicrobial cream used for the treatment of burns) was applied, the area was covered with a dry, clean dressing and Resident #1 was referred to the wound care physician. A physician's order dated 3/25/25 directed to obtain vital signs and document a nursing note every shift for 72-hours (through 3/28/25) following a wound that was discovered to Resident #1 ' s genitals. A wound care physician's note dated 3/26/25 identified wound #1 was located on the right anterior (front), medial (towards the middle) thigh and the genital area and that the largest of the two (2) wounds (right thigh) was measured at 5.5 cm by 11.5 cm by 0.2 cm full thickness burn (a severe burn destroying all layers of skin and may have also damaged underlying tissues). It identified that the wound was compromised of 1-24 percent (%) epithelial tissue (restoration of the skin barrier/growth of new epithelial cells after a damaged skin area), 1-24 % granulation tissue (new pink or red tissue that forms in the healing process of wounds) and 50- 74 % slough (nonhealing tissue that needs to be removed from the wound for healing to take place) with a moderate amount of serous drainage (a clear fluid that drains from wounds and is a sign of healing) and Resident #1 reported a pain level of three (3) out of ten (10) to the area(s), signifying mild pain. The note identified that the treatment recommendations included to cleanse the wound, apply Silvadene to the wound and cover with a dry clean dressing daily. The note identified Resident #1 reported the wounds to the right thigh and genitals were from spilling hot chocolate on him/herself. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Reportable Event (RE) Report dated 3/26/25 at 3:00 PM identified that on 3/17/25 at 12:00 PM an injury of unknown origin was discovered to Resident #1's right thigh and was potentially caused by a fall. The RE identified that on 3/25/25, an additional wound was discovered to Resident #1 ' s genitals while OT #1 was performing Activities of Daily Living (ADLs) with Resident #1, and a wound consult was placed. The RE identified the wound physician evaluated the wounds on 3/26/25, classified the wounds to the right thigh and genitals as burns and recommended a burn consult, follow-up with the wound nurse and daily dressing changes. The RCP and Resident Care Card (RCC) were updated to include the use of a sippy cup for drinks at all times. A nurse's note dated 3/26/25 at 6:06 PM identified the wound physician assessed Resident #1's wounds and determined the wounds were burn related and Resident #1 was referred for a burn consult. The note identified a full body/skin assessment was completed, vital signs were obtained and Resident #1's family and the APRN were notified. The note identified Resident #1 stated he/she may have spilt hot chocolate on his/herself. The burn center consultation dated 4/2/25 identified that the genital wound was noted with a 1 cm by 0.7 cm by 0.1 cm superficial burn which was very tender to touch. The right medial thigh burn was identified as a 11 cm by 4.5 cm by 0.1 cm full thickness burn with yellow and brown devitalized tissue (non-functional, essentially dead tissue) noted at the surface and pink tissue was noted to the base and the devitalized tissue was debrided (removal of dead/damaged tissue) with a blade. The note reported that the full thickness burns to the right thigh and to the genitals would benefit from a moist topical treatment, debriding agent to the right thigh and pain control. The burn center consultation dated 4/14/25 identified that the genital wound was healed but the right thigh revealed a deep burn wound with adherent (stuck to, hindering the healing process) yellow and black eschar (dead tissue). The note reported operative (surgical) management of the wounds was discussed with Resident #1, but he/she preferred to continue with local wound care and avoid surgery. a. Review of the clinical record failed to identify a full body skin assessment was completed for Resident #1 following the discovery of the right thigh wound to ensure no further skin injuries were present. The first full body skin assessment identified after the discovery of the wound on 3/17/25 was dated 3/20/25 and identified that no new, unidentified wounds were noted. Interview with LPN #1 on 4/17/25 at 11:19 AM identified he was the charge nurse on the 7:00 AM to 3:00 PM shift responsible for Resident #1 on both 3/17/25 and 3/25/25. He identified that when he observed the right thigh wound on 3/17/25, he was unsure of what kind of wound it was and indicated he did not perform a full body skin assessment following the discovery of the right thigh wound. He further identified he notified the wound nurse (RN #1) and thought she would complete the assessment for Resident #1. LPN #1 identified that on 3/25/25, OT #1 notified him of the wound to the genitals and indicated he notified RN #4 (Nursing Supervisor) and RN #1 but did not observe the area himself. He identified that he did not perform a full body skin assessment following notification from OT #1 because he thought RN #4 or RN #1 would complete the assessment. Interview with RN #1 on 4/17/25 at 12:55 PM identified that when she assessed the right thigh wound on 3/17/25 she did not perform a full body skin assessment and that the charge nurse (LPN #1) should have then completed a full body skin assessment and documented the assessment in the clinical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/17/25 at 1:25 PM identified that charge nurses are responsible for completing a full body skin assessment, following an accident (fall, injury) or the identification of any new wounds, to ensure additional wounds are not present and further indicated LPN #1 should have completed a full body skin assessment following the 3/17/25 right thigh wound discovery. Interview with APRN #1 on 4/17/25 at 2:11 PM identified that she was on her way out of the building on 3/17/25 when she was asked to see the wound to Resident #1's right thigh. She identified she directed the staff to monitor the area. b. Review of nurse's notes dated 3/25/25 through 3/28/25 failed to identify that nurse's notes had been documented on the 3:00 PM to 11:00 PM shift on 3/25/25, the 11:00 AM to 7:00 AM shift on 3/25/25, the 7:00 AM to 3:00 PM shift on 3/26/25, the 11:00 PM to 7:00 AM shift on 3/26/25, 7:00 AM to 3:00 PM shift on 3/27/25, the 3:00 PM to 11:00 PM shift on 3/27/25, the 11:00 PM to 7:00 AM shift on 3/27/25, the 7:00 AM shift on 3/28/25 and the 3:00 to 11:00 PM shift on 3/28/25 per the 3/25/25 physician's order. Interview with the DNS on 4/17/25 at 9:25 AM identified that following the 3/25/25 discovery of the wound to the genitals, she entered an order for nursing to write a note every shift, and indicated a note should have been documented every shift per physician's order. Interview with APRN #1 on 4/17/25 at 2:11 PM identified that she was on her way out of the building on 3/17/25 when she was asked to see the wound to Resident #1's right thigh. She identified the nursing staff should have performed a full body skin assessment following the incident to ensure no additional wounds were present. Review of the Investigating Injuries of Unexplained Injuries policy dated 5/2006 directed, in part, that should a resident be observed with unexplained injuries, the nurse on duty must assess the resident and complete an accident/incident form and record such information into the resident's clinical record. Residents must be assessed immediately and an investigation initiated. A written report will be filed with DPH within 72 hours. The results of the investigation will be reported to DPH within five (5) working days of the allegation or occurrence. Every effort is made to determine the cause of an injury of unknown origin and so documented. The Weekly Skin Audit policy (undated) directed, in part, that Certified Nursing Assistants will perform skin checks on a daily basis while performing morning, evening and incontinent care, and notify of any alteration in skin integrity. Licensed nurses will perform skin body audits on a weekly basis, on assigned shower day and as needed. The weekly head-to-toe check of the resident's skin includes: The surface of the skin that comes in contact with the bed and chair, bony prominences and surfaces of the skin that comes in contact with any orthotic devices, tubes, braces or positioning devices and skin folds. The nurse will initiate the Skin Evaluation in the clinical record. The Registered Nurse Supervisor will be notified when a newly developed area is identified and will assess. The skin evaluation will be completed, including the site and measurements.

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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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for injuries of unknown origin, the facility failed to ensure the resident was free from accidents resulting in sustaining several burn wounds from a hot beverage spill and the failure to implement an ordered intervention to prevent further injury. The findings include: Resident #1's diagnoses included dementia without behavioral disturbances, generalized muscle weakness and polyneuropathy (peripheral nerve disorder that causes multiple nerves throughout the body to malfunction at the same time which can cause numbness, pain, tingling or a burning sensation). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10) and was independent with eating, bed mobility, transfers and ambulation. A nurse's note dated 3/10/25 at 3:03 AM identified Resident #1 had an unwitnessed fall in his/her bathroom. The note did not identify alterations in skin integrity related to the fall. A nurse's note dated 3/14/25 at 9:00 AM identified Resident #1 was found sitting upright on the floor next to his/her bed and a 1.25 cm superficial scrape to the base of the left thumb. The note did not identify any further alterations in skin integrity related to the fall. Review of the clinical record identified no further falls from 3/14/25 through 3/16/25. A nurse's note dated 3/17/25 at 12:51 PM identified Occupational Therapist (OT) #1 reported a 16 cm by 7 cm skin tear to Resident #1 ' s right inner thigh, further described the affected area as bright red in color and tender to touch and indicated the nursing supervisor, wound nurse and APRN were notified. Review of the clinical record failed to identify the cause of the inner thigh wound, wound treatment and monitoring or preventative interventions initiated after the discovery of the right thigh wound. Review of the March 2025 Documentation Survey Report (Nurse Aide flowsheets/ documentation) identified Resident #1 received a shower on 3/24/25 by NA #4 and no skin areas were observed. An OT treatment encounter note dated 3/25/25 identified Resident #1 was grimacing in pain with peri care and stated he/she burned the genitals after spilling hot chocolate in the groin area. The note indicated nursing was notified to address the burn/wound. A skin/wound note dated 3/25/25 at 12:15 PM identified the wound nurse was notified of a new wound discovered to Resident #1 ' s genitals measuring 2 cm by 1 cm by 0.5 cm and was tender to touch. The note reported that the area was cleansed, Silvadene (topical antimicrobial cream used for the treatment of burns) was applied, the area was covered with a dry, clean dressing and Resident #1 was referred to the wound care physician. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A wound care physician's note dated 3/26/25 identified wound #1 was located on the right anterior (front), medial (towards the middle) thigh and the genital area and that the largest of the two (2) wounds (right thigh) was measured at 5.5 cm by 11.5 cm by 0.2 cm full thickness burn (a severe burn destroying all layers of skin and may have also damaged underlying tissues). It identified that the wound was compromised of 1-24 percent (%) epithelial tissue (restoration of the skin barrier/growth of new epithelial cells after a damaged skin area), 1-24 % granulation tissue (new pink or red tissue that forms in the healing process of wounds) and 50- 74 % slough (nonhealing tissue that needs to be removed from the wound for healing to take place) with a moderate amount of serous drainage (a clear fluid that drains from wounds and is a sign of healing) and Resident #1 reported a pain level of three (3) out of ten (10) to the area(s), signifying mild pain. The note identified that the treatment recommendations included to cleanse the wound, apply Silvadene to the wound and cover with a dry clean dressing daily. The note identified Resident #1 reported the wounds to the right thigh and genitals were from spilling hot chocolate on him/herself. Review of the facility Reportable Event (RE) Report dated 3/26/25 at 3:00 PM identified that on 3/17/25 at 12:00 PM an injury of unknown origin was discovered to Resident #1's right thigh and was potentially caused by a fall. The RE identified that on 3/25/25, an additional wound was discovered to Resident #1 ' s genitals while OT #1 was performing Activities of Daily Living (ADLs) with Resident #1, and a wound consult was placed. The RE identified the wound physician evaluated the wounds on 3/26/25, classified the wounds to the right thigh and genitals as burns and recommended a burn consult, follow-up with the wound nurse and daily dressing changes. The RCP and Resident Care Card (RCC) were updated to include the use of a sippy cup for drinks at all times. A physician's order dated 3/27/25 directed for Resident #1 to utilize a sippy cup with all meals for all drinks. The burn center consultation dated 4/2/25 identified that the genital wound was noted with a 1 cm by 0.7 cm by 0.1 cm superficial burn which was very tender to touch. The right medial thigh burn was identified as a 11 cm by 4.5 cm by 0.1 cm full thickness burn with yellow and brown devitalized tissue (non-functional, essentially dead tissue) noted at the surface and pink tissue was noted to the base and the devitalized tissue was debrided (removal of dead/damaged tissue) with a blade. The note reported that the full thickness burns to the right thigh and to the genitals would benefit from a moist topical treatment, debriding agent to the right thigh and pain control. The burn center consultation dated 4/14/25 identified that the genital wound was healed but the right thigh revealed a deep burn wound with adherent (stuck to, hindering the healing process) yellow and black eschar (dead tissue). The note reported operative (surgical) management of the wounds was discussed with Resident #1, but he/she preferred to continue with local wound care and avoid surgery. Observation of Resident #1 on 4/17/25 at 8:58 AM identified Resident #1 in his/her room, laying in bed with an over the bed table positioned to the right side of the bed. A maroon mug was on the table without a cover displaying a brown liquid inside, an open cup of orange juice with a straw was next to the mug, a red liquid was noted all over the floor and LPN #2 was in the doorway and stated she was waiting for housekeeping to clean up the spill. Further observation at 11:50 AM identified two (2) open maroon mugs on the over the bed table containing a brown liquid filled to about 0.5 inches from the top, which Resident #1 identified as hot chocolate, and an open cup of a brown carbonated beverage with a straw, which Resident #1 identified to be cola. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with LPN #2 on 4/17/25 at 11:52 AM identified that she was not aware Resident #1 was care planned to have all liquid beverages in a sippy cup and that her assignment sheet did not indicate the need for a sippy cup. Interview and observation with NA #1 on 4/17/25 at 11:52 AM identified he provided Resident #1 with hot chocolate and cola for lunch and was unaware Resident #1 required a sippy cup for all meals, and reported the intervention was not on the RCC. NA #1 was observed taking the drinks off Resident #1's over the bed table and obtaining the correct cups. Review of the RCC failed to identify Resident #1 required a sippy cup for all fluids during all meals. Interview with OTA #1 (Rehab Director) on 4/17/25 at 12:00 PM identified she was unaware Resident #1 had a new order (dated 3/25/25) for a sippy cup at all times. She identified she should have been notified of the order so she could have notified the kitchen to ensure Resident #1 received adaptive equipment. She identified that the order did not go through the proper process and was not showing up on the RCC so the NA's would not be aware of the intervention. Interview with the DNS on 4/17/25 at 12:08 PM identified that following the new intervention of the sippy cup, the Dietary Director told her she needed a physician's order and that the order was entered incorrectly. She reported she did not think to notify the therapy department. Interview with the Director of Dietary on 4/17/25 at 12:18 PM identified that coffee and hot water are placed into the designated carafes for about thirty (30) minutes prior to them being served and they should be served between 160 and 190 degrees Fahrenheit. The temperature obtained from the beverage cart on the B wing identified the hot water to be 161.5 degrees Fahrenheit and the coffee to be 156 degrees Fahrenheit. He identified an adaptive feeding equipment list is generated from orders that are entered into the electronic health record, and then the adaptive equipment (cups and silverware) are added to meal delivery carts for NA's to utilize as ordered. He identified he did not recall the DNS notifying him that Resident #1 required an adaptive cup and reported Resident #1 was not on his list. Review of the Adaptive Equipment Tally Report dated 4/17/25 failed to identify Resident #1 on the list for adaptive meal equipment. Interview with OT #1 on 4/17/25 at 12:25 PM identified she discovered the right thigh and genital wounds during therapy sessions. She reported that on 3/17/25, she assisted Resident #1 to the bathroom and observed a large, open, reddened wound to the right inner thigh. She indicated she was aware Resident #1 had recent falls but thought a skin tear was unlikely due to the location of the wound. She identified she documented a skin tear due to not knowing what to call the wound and indicated she immediately reported the wound to LPN #1 and RN #1. She identified Resident #1 ' s sheets were soiled but was unsure if that was due to a spill or stool. OT #1 identified she did not observe the area to the genitals on 3/17/25. OT #1 identified that on 3/25/25 she was assisting Resident #1 with a sponge bath and Resident #1 said, ouch and stated the area hurt due to spilling hot chocolate. (continued on next page)

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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	Interview with the DNS on 4/17/25 at 3:48 PM identified the burns should not have occurred on 3/17/25 or 3/25/25 and that a full investigation into the injuries of unknown origin should have been completed after each incident. The DNS reported that a full body skin assessment should have been completed after the 3/17/25 incident and the charge nurse should complete an assessment after a change in condition/accident. She identified the intervention for Resident #1 to utilize a sippy cup at all meals should have been followed but she was unaware of the process for implementing adaptive equipment at the time she entered the order. Although attempted, interviews with MD #2 (wound physician), RN #3 (prior DNS) and NA #4 were not obtained. Although requested, a facility Accident and Investigation (A & I) dated 3/17/25 was not provided. Review of the Investigating Injuries of Unexplained Injuries policy dated 5/2006 directed, in part, that any allegation of occurrence of an injury of unknown origin will be reported immediately but no later than within 24 hours of the allegation or occurrence to the Department of Public Health (DPH). An investigation will be initiated and conducted by the Administrator or his/her designee. Should a resident be observed with unexplained injuries, the nurse on duty must assess the resident and complete an accident/incident form and record such information into the resident's clinical record. Residents must be assessed immediately and an investigation initiated. A written report will be filed with DPH within 72 hours. The results of the investigation will be reported to DPH within five (5) working days of the allegation or occurrence. Every effort is made to determine the cause of an injury of unknown origin and so documented. Although requested, a policy on hot beverage serving temperatures was not obtained.