STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105252	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackson Memorial Perdue Medical Center	19590 Old Cutler Road Cutler Bay, FL 33157

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	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** 45019 Based on observation, interview and record review the facility failed to ensure the safety and prevent bodily injury for one Resident (#1) out of 3 sampled residents and is determined to be at a level of harm, as evidenced by: Resident #1 sustaining first and second degree burns from hot coffee being spilled on the chest and abdominal area of his body. There were 153 residents residing at the facility at the time of the survey. The findings included: Observation on 09/09/2024; starting at 8:07 AM with the Director of Hospital Operations, Dietary Manager and Director of Nutrition of the Pantry rooms beginning with the South Station Pantry, East Station Pantry, and lastly the North Station Pantry. The coffee and hot water temperatures in the three pantries were checked using a digital thermometer. The results were: South Pantry-1 Coffee Pot, 1 Hot Water Pot Hot water-146.6 Fahrenheit (F) Hot coffee -162.6 F East Pantry-1 Coffee Pot, 1 Hot Water Pot Hot Water-123.8 F Hot Coffee-149 F North Station- 2 Coffee Pots, 1 Hot water Pot Hot Water-143.6 F Hot Coffee #1-156.2 F Hot Coffee #2 140 F (continued on next page)

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.

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	Observation on 9/9/24 at 11:26 AM of the East Station pantry, a digital thermometer was located in the drawer enclosed in a plastic zip bag. Observation on 9/9/24 at 11:47 AM of the South station dining room, staff were serving lunch trays, no hot liquids served to residents from the pantry. Licensed Practical Nurse, Unit Supervisor (Staff H) observed with digital thermometer in her pocket. Observation on 9/9/24 at 11:39 AM with the Director of Nursing (DON) of the North Station Pantry, no thermometer was found in the pantry. Review of the facility policy and procedures titled Serving Hot Liquids reviewed 10/10/23 states: The dietary department will strive to serve hot liquids at temperatures that are safe for residents to handle and palatable for their dining enjoyment. Procedure: item # 6. For dining in the remote dining areas, the kitchen provides all hot beverages and soups for the dining area. Temperature of hot liquids will not exceed 155 degrees at time of delivery to the resident. Review of the facility's policy and procedures titled Safety and Supervision of Residents dated 04/05/2023; documented:: Our facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision and assistance are facility-wide priorities. Procedures: item #8. Implementing interventions to reduce accident risks and hazards are based on resident assessment and observation and shall include the following. a. Communicating specific interventions to all relevant staff b. Assigning responsibility for carrying out interventions c. Documenting Interventions. 9. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently b. Evaluating the effectiveness of interventions c. Modifying or replacing interventions as needed and d. Evaluating the effectiveness of new or revised interventions. Review of the nurse's progress notes dated 08/25/2024 timestamped 11:02 documented-Resident spilled a cup of hot coffee on himself while in the bed. Chest and abdomen red, warm and painful to touch. No open areas or blistering at this time. Advanced Registered Nurse Practitioner (ARNP) notified. Order received for Silvadene cream topically twice a day and wound care evaluation for Monday. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the weekly skin assessment dated [DATE] at 4:30 PM documented chest and left upper abdomen noted with intact blister and redness around status post coffee spilled, treatment in place as ordered, slight tenderness. Record review of the Agency for Health Care Administration (AHCA) Immediate report documented-Date/Time of Incident: 08/25/24; Type of Incident: Neglect/bodily injury; Description of Incident: The resident spilled a cup of hot coffee on himself while in the bed. Chest and abdomen red, warm, and painful to touch. No open areas or blistering at this time. ARNP notified. New ordered Silvadene cream topically twice a day (BID) and wound care evaluation for Monday. On Monday's evaluation by wound care, two blisters were noted on the resident's right abdomen. Record review of the Agency for Health Care Administration (AHCA) Five-Day report documented-Facility Response/Investigation- Head-to-toe assessment was completed on the resident. The provider was made aware, and treatment was provided to the resident as ordered by the provider. Following the event law enforcement was notified on 08/26/2024 at 11:55 AM and arrived at 12:32 PM. The Police Officer arrived at the facility and interviewed Resident #1. Resident #1 reported to the officer that it was an accident. He explained that as he was moving the side table and the coffee tipped over and fell on to his upper abdomen, the lid popped off and spilled the contents of the cup on him causing the burn. No charges or allegations were made by Resident #1 to law enforcement or the facility. [local community-based agency notified] was notified by the Risk Manager at noon and the call was answered at 12:56 PM the report was given and [the local community-based agency] did not take the case. Initial attempt to report online but the system was not working. Resident #1 assigned nurse stated just before lunch, on Sunday 8/25/2024, the resident requested a cup of coffee. I got him a cup of coffee from the floor coffee dispenser and covered it with a lid to bring to the resident's room. I placed the cup of coffee with a lid that was secured and tightened on the table next to a cup of water on the resident's table. The table was otherwise clear, no garbage or clutter on the table or surrounding area. I left the resident's room. When I returned to the nurses' station the resident had his call light on. I returned to the room and the resident had spilled the coffee on himself. The gown was saturated with coffee. I removed his gown and cleaned him up. The chest and upper abdomen were red, and very painful when touched. There were no open areas or blisters at this time. I reported to the supervisor immediately and then called the provider on call. Provider ordered Silvadene cream to be applied and a wound care consult. When the resident was interviewed, he stated that as he was moving the overbed table, the coffee tipped over and fell on to his upper abdomen, the lid popped off and spilled the contents on him causing the burn. The resident denied any abuse by the staff. The resident had a wound care assessment and is receiving treatment. The allegation of abuse/Neglect was unsubstantiated the resident denied any abuse and the staff acted within proper practice and procedure. The resident is alert and oriented X 4 with full function of his upper extremities and capable of feeding himself. The event was not within the facility control and procedures post-event were appropriate. According to the Florida Agency for Health Care Administration (AHCA), hot beverages like coffee, tea, and hot chocolate are typically served at a temperature of 160-180 F (71-82 C) after the facility (continued on next page)

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	105252	A. Building B. Wing	09/10/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	investigation, all of our coffee Dispenser temperatures were tested and was serving coffee at 151 F, below the typical serving temperature on the AHCA website. Interview on 9/10/24 at 9:16 AM Licensed Practical Nurse (Staff I) stated: On 8/25/24 I was the assigned nurse for [Resident #1] the resident requested a cup of coffee, I gave the coffee to the resident with a lid on the cup, I sat the coffee on the resident's overbed table and left the room, when I was walking to the nurses' station the call light for the resident's room came on, I went back to the resident's room, the resident told me he had spilt his coffee, I started cleaning the resident and took his gown off, I noticed the skin on his left abdomen was red and sensitive to touch. I notified the supervisor and called the ARNP that was on call, I received an order to apply Silvadene twice a day and a wound care consult. I checked on the resident afterwards several times during my shift, the resident was doing well and had no complaints of pain. Interview on 9/10/24 at 9:59 AM Registered Nurse, Wound Care (Staff K) stated: I completed a skin check on 8/26/24 on the resident. I observed redness on the abdomen with an intact blister, I did not do measurements because it was not a pressure ulcer, I assessed the resident for pain to touch, the resident said he was ok. The resident had an order for Silvadene starting on 8/25/25-apply a thin layer of Silvadene to chest and abdomen twice a day, leave open to air. The resident went to the hospital for a wound evaluation on the thigh unrelated to the redness and blister, at the time the treatment was ongoing for the redness and blister, the area still had some redness, and the blister was still intact. Because of the blister the burn would be classified as a second-degree burn, initially on 8/25/24 the area was just red, the redness would be classified as a first-degree burn. Interview on 9/10/24 at 10:32 AM the Director of Nursing (DON) stated she is aware of the incident that happened to the resident. On 8/28/24 the in-service the Certified Nursing Assistants (CNAs) received was a part of the AHCA Five-day investigation and was about safety and hot liquids-for example, if staff. give a cup of coffee to a resident they should put a lid on it, feel the hotness of the coffee, determine if it is safe to serve to the residents. Future trainings will include starting next week-testing of the coffee in the kitchen and recording the temperatures, thermometers on the floor for staff use to check the temperatures of the coffee, making sure staff have and know the correct temperature range for hot liquids, training the trainer on the guidelines of food safety and temperatures, to present to the staff at the trainings, providing guidance to direct care staff on the floor and the other components of the improvement plan. Currently based on the information provided by the nutrition staff, the temperature range for hot liquids is 155-165 F. I am aware our facility policy presented to you (the surveyor) states temperature of hot liquids will not exceed 155 degrees at time of delivery to the residents. The burns the resident sustained on his chest and abdomen were initially redness and the next day blisters appeared, because of the blisters the burns were classified as second-degree burn. Review of the medical records for Resident #1 revealed resident was admitted to the facility on [DATE]. Clinical diagnoses included but not limited to: Contusion of right thigh, Unspecified cirrhosis of liver, Pressure ulcer of sacral region stage 2, Unspecified open wound right thigh. Resident #1 was discharged on [DATE] to the hospital. Review of the Physician's Orders Sheet for August-September 2024 revealed Resident #1 had orders that included but not limited to: 8/25/24- silver sulfadiazine cream; 1 %; amount: thin layer; topical, Special Instructions: Apply a thin layer to chest and abdomen Twice a Day. (continued on next page)

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	105252	A. Building B. Wing	09/10/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident # 1's Discharge Return Anticipated Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented Brief Interview for Mental status Score unable to be determined. Section GG for Functional Abilities and Goals documented set or clean up assistance for eating. Section M for Skin Conditions documented stage 2 pressure ulcer, present on admission. Section N for medications documented resident is taking antibiotics, anticoagulants and Opioid. Record review of Resident #1 's Care Plans Reference Date 08/23/2024 revealed: Focus: Resident has a Potential for alteration in skin integrity and skin breakdown related to: 08-23-24 Resident currently has pressure ulcer on admission. Resident is at risk for sign and symptoms of wound infection. On 08-25-24 Resident spilled a cup of hot coffee on himself while in the bed. Noted redness on the chest and abdomen area, warm and painful to touch. No open areas or blistering at this time. ARNP notified. Order received for Silvadene cream topically twice a day. Goal: Resident will be free from further skin breakdown thru next review date. Pressure ulcer will be free from sign and symptom of infection through next review date. Interventions: Nursing assistant to check skin during routine care and report to the nurse for any changes. Heel checks/Body/skin audit weekly. Monitor and Document in matrix changes in skin integrity every week. Wound consultation if needed. Care Plans Reference Date 8/28/24 revealed: Resident's Chest and left upper abdomen noted with an intact blister and redness around, coffee spilled incident, treatment in place as ordered with slight tenderness as noted. Goal: Resident blister formation on the chest and left upper abdomen will remain intact and will not develop signs of infection through next review date. Interventions: Apply treatment to chest and left upper abdomen blister as ordered. Observe site for signs of infection during dressing changes, notify provider at once if abnormalities are noted. Ensure safety at all times, supervise when handling beverages at all times. Review of the Facility's Grievance Log from June 2024-August 2024 revealed Resident #1 was not listed on the grievance log. Review of the Abuse/ Neglect Log from June 2024-August 2024 revealed Resident #1 was listed on abuse log on August 2024. Resolution: Unsubstantiated. Review of the In-service on 08/28/24 revealed all Certified Nursing Assistants received training on safe food/liquid temperatures. Education included-always check food/drink temperature before offering to residents, communicate to residents to be careful as the food may be hot before they start to eat and drink, food/liquid drinks temperature is important for food safety, and it is important to keep food out of high temperatures that might cause harm. Review of the Kitchen Daily Temperature Logs starting 8/25/24-9/9/24-revealed temperatures of coffee and hot water are being checked daily before being placed in the pantries on the units. Reviewed the Facility Performance Improvement Plan (PIP) in place to ensure resident s do not sustain burns from hot liquids starting 8/28/24. The components are: (continued on next page)

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	105252	A. Building B. Wing	09/10/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	8/28/24-Review incidents and accidents and falls in morning and weekly meetings. 8/28/24-8/30/24-Review requirements for hot liquids 9/4/24-obtain thermometers to be given to the floors 9/11/24-develop a process to minimize resident injury related to hot liquids to floors and report to QAPI (Quality Assurance and Performance Improvement) . 9/11/24-Kitchen to monitor temperatures on distribution 9/16/24-Educating staff regarding the new process monitoring temperatures for food/liquid items. Interview on 9/9/24 at 11:17AM Registered Nurse (Staff A) east unit stated the kitchen brings the coffee in the dispensers every morning on a cart and they take it back with them when we are finished, the nurses and the CNAs served the coffee to the residents from the cart, we do not check the temperatures of the coffee before serving. The coffee is usually hot when we serve the coffee to the resident. Interview on 9/9/24 at 11 25 AM Registered (Staff B), unit manager east wing stated, coffee comes from the kitchen in dispensing coffee pots and is picked up from the floor by the kitchen. Any staff, the CNAs or nurses serve the coffee to the residents, if the residents request coffee, we have thermometers available in the Pantry to check the temperature of the hot beverages before serving. Surveyor went with Unit manager to the pantry room; a thermometer was observed in the drawer in a plastic bag. Interview on 9/9/24 at 11:26 AM Certified nursing Assistant (Staff C) East wing stated: when I serve coffee to residents I go into the pantry, the coffee is in dispensing coffee pots on a black rack in the pantry, I washed my hands, pour the coffee, if the coffee is really steaming, I would use the thermometer located in the drawer to test the temperature before serving to the resident. The acceptable temperature for the coffee is below 155 degrees Fahrenheit. On 9/9/24 at 11:35 AM Registered Nurse (Staff D) North wing stated: I do not serve coffee to the residents, usually the CNAs on the unit serve the coffee to the residents. On 9/9/24 at 11:30 AM CNA. (Staff E) North unit stated: When I serve coffee to the residents, I get the coffee from the pantry and serve the coffee to the residents, the coffee is usually warm to hot and it comes fresh from the kitchen, I just serve the resident the coffee, I am not checking the temperature with any device. We do not heat up the coffee for the resident, we serve the coffee directly from the coffee pot in the pantry. On 9/9/24 at 11:35 AM CNA. (Staff F), North unit stated: I prepare the coffee the way the resident likes it, I make sure the coffee is not too hot, I feel the outside of the coffee cup and look at the amount of steam to estimate the hotness of the coffee, I let the resident know to be careful and then I serve the resident, I do not check the temperature of the coffee with a thermometer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/9/24 at 11:39 AM the surveyor asked the DON to be shown the thermometer in the North unit pantry room, The DON stated after looking in the drawers that she did not find a thermometer in the north pantry. On 9/9/24 at 11:49 AM, CNA. (Staff G) South unit, when asked by surveyor to walk through the steps of preparing and serving coffee to the residents stated: When I serve coffee to the residents, I get the coffee from the pantry, I put the coffee in a cup, put a lid on the coffee and gave it to the resident. The kitchen checks the temperature before the coffee is placed in the pantry. On 9/9/24 at 12:01 PM Licensed Practical Nurse (Staff H) Unit supervisor reported: the coffee for the residents is dispensed by staff in the pantry and the served to the resident, the coffee comes from the kitchen in dispensing coffee pots and is placed in the pantry, the temperatures are checked by the kitchen staff before the coffee is placed in the pantry but we have a thermometer in the pantry to check the temperature if the staff thinks the coffee is too hot. Staff H took the thermometer out of her pocket and showed the surveyor, at the time the surveyor and supervisor were standing inside the South unit pantry. Staff H stated the coffee is served to residents at a temperature below 155 degrees Fahrenheit. On 9/10/24 at 7:40 AM the Assistant Director of Nursing (ADON)/Risk Manager/ADON revealed; this incident occurred on 8/25/24 at 11:30 AM, the resident requested coffee, Licensed Practical Nurse (Staff I) got a coffee from the coffee dispenser, covered the coffee cup with a lid and placed the cup of coffee on the resident's overbed table. There was only a cup of water on the resident's overbed table at the time. After Licensed Practical Nurse (Staff I) left the room, she went to the nurses' station, she noticed the resident's call light was on, she went back to the room and observed the resident's gown was saturated with coffee. Staff I removed the resident's gown and cleaned the resident, she observed the resident's chest and upper abdomen skin was red, she reported her observations and what occurred to her supervisor and the resident's physician. Staff I received an order for Silvadene to apply to the reddened areas and a wound consult. On 8/26/24 the wound care nurse conducted a skin assessment and observed two intact blisters on the upper left abdomen with mild sensitivity to the area, the treatment orders were as previously prescribed. The ADON stated: I initiated the day one report after the blisters were identified on 8/26/24 at 12:04 PM, the five day was submitted on 8/29/24 at 11:58AM. On 8/26/24 law enforcement was notified, they came to the facility and interviewed the resident (Resident #1), [Resident #1] stated the nurse (Staff I) brought him coffee and as he was moving the table when the coffee fell on his abdomen, it was an accident, the resident did not press any charges or made any allegations to the officer. [local community-based agency] was notified, and the case was not accepted. The resident was interviewed by me (ADON)-stated the same explanation of the incident as he told to the Police Officer and denied any abuse by any staff, he stated that it was an accident caused by him. The allegation of neglect and abuse was unsubstantiated. There was no delay in care, the coffee temperature was checked on 8/26/24, it was at 151 F, the resident is alert and oriented and fed himself, he did not require any help with eating and drinking, he was independent. On 8/28/24 the staff (All CNAs) were educated on safe food temperature. Education included always check food/drink temperature before offering to residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/10/24 at 8:26 AM the Assistant Director of Nursing (ADON)/Risk Manager stated on 8/28/24 the staff (All CNAs) were educated on safe food/liquid temperatures. Education included always check food/drink temperature before offering to residents. There was no direct information on how to check the temperatures. The in-service to the CNAs was facilitated by (IT/education staff). Our policy states temperature of hot liquids will not exceed 155 degrees at time of delivery to the resident. Review of the performance improvement Plan (PIP) with the ADON/Risk manager revealed the next training date for staff on food/liquid temperatures will be on 9/16/24. On 9/10/24 at 8:56 AM Education/training Staff (Staff L) stated on 8/28/24 I provided training to the CNAs about food safety-proper temperatures of food, cold food served old and hot food served hot. Specifically for coffee, when they serve the coffee to the resident, if it is too hot, let the coffee sit for at least 5 minutes before serving to the resident. Visually check the food or the liquid being served to the resident and determine if it is safe to serve to the resident. For example-if the plate or cup is too hot for the CNAs to hold or handle it is probably too hot for the resident. In the training, I did not go over any information with the CNAs about testing the temperatures with a thermometer. Checking temperatures of the food and liquids is done in the kitchen. On 9/10/24 at 9:29 AM the Dietary Manager stated: The coffee is made in the kitchen and taken to the pantry on the units and placed on the countertops. The temperature of the coffee is taken right before it goes on the floor, the range is between 150-160 degrees Fahrenheit and is usually taken an hour before the coffee goes on the floor. We started recording the temperature readings of the coffee on the daily temperature logs starting on 8/25/24, prior to 8/25/24 we did not record the temperature of the coffee before sending the coffee out to the unit pantries. Fresh coffee is made three times a day for each meal and placed in the pantry on each unit. If the temperature is lower than 150 degrees, we would rebrew the coffee, if the temperature is higher than 160 degrees, we would either add ice to cool the coffee down or let it sit for a while and then recheck the temperature. Once we transport the coffee to the units, the staff get the coffee from the pantry when requested by the resident or if it is on the meal ticket. I am aware that the facility policy states temperature of hot liquids will not exceed 155 degrees at time of delivery to the resident. On 9/10/24 at 9:40 AM The Nutrition Director stated: Currently the kitchen does the testing of the temperature of coffee after it is brewed and before it is delivered to the floor. This started once the incident occurred on 8/25/24 and I was notified of the incident. We make coffee for breakfast, lunch and dinner and check the temperatures before the coffee goes out on the floor. The temperature range of the coffee should be between 155-165 degrees Fahrenheit, if the coffee is below 155, we toss and remake the coffee, if the temperature is above 165 we add ice or let it sit for a while and recheck the temperature. If a resident complains the coffee is too hot or cold, the floor staff have access to a thermometer that they can use to check the temperatures. These thermometers are usually kept with the nursing manager on duty. The staff should be aware of the acceptable temperature range for the coffee 155-165, we are in the process of training all nursing staff and kitchen staff. I am aware that the facility policy states temperature of hot liquids will not exceed 155 degrees at time of delivery to the resident, we are working on revising our policy. On 9/10/24 at 10:12 AM the facility's Administrator revealed the performance Improvement plan was started on 8/28/24, and in-services started after the incident involving Resident #1,. Regarding food/liquid temperatures.