STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to implement its abuse and neglect prohibition policy and procedures related to conducting a thorough investigation of an injury of unknown origin to rule out neglect, to determine if reporting was necessary, and to ensure the safety of 1 of 3 residents reviewed for skin injuries, out of a total sample of 5 residents, (#1). Findings: On 11/01/24 at 2:19 PM, and 11/08/24 at 3:06 PM, in telephone interviews, resident #1's sister stated on 10/02/24, she received notification from the facility that her brother had an extensive skin injury on the back of his thigh. She explained she was not able to visit until about nine days later, and when she spoke with her brother, he told her he accidentally spilled hot coffee on his leg. The resident's sister stated the hot liquid was provided in a Styrofoam cup instead of a cup with a handle which he needed due to his contracted fingers. She recalled she spoke to the Minimum Data Set Coordinator by telephone on 10/17/24 regarding her brother's care plans. The resident's sister said, She kept saying wound and I said, Y'all keep saying it's a wound. It's a burn. Resident #1's sister stated Registered Nurse (RN) B, and the [NAME] 2 Unit Manager (UM) spoke to her about the wounds and plan of care, but no member of the facility management team ever reached out to her regarding an investigation into how the wound occurred. On 11/04/24 at 11:25 AM, the Administrator confirmed she was the facility's Risk Manager and was made aware of resident #1's skin injury in the daily interdisciplinary team (IDT) meeting. She stated she was told the resident was tall and scooted himself down in his wheelchair, and the provider validated the wound was caused by friction. The Administrator explained the Director of Nursing (DON) would be more knowledgeable of the details of the investigation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/04/24 at 12:00 PM, the facility's DON explained she had first-hand knowledge of an incident that involved resident #1 as she was his assigned nurse when injuries were discovered on his left thigh. She stated on 10/02/24 at approximately 5:30 AM, Certified Nursing Assistant (CNA) C called her to resident #1's bathroom. She recalled he had a small blister on his left lateral thigh and a ruptured blister about 12 centimeters long on the back of his thigh. The DON stated the resident informed her he thought it was a scratch from his chair. She explained she examined the chair and noted the cushion was missing and there was a bar with rivets, but no liquid or wound drainage on the seat of the wheelchair. She stated neither the resident's pants nor his bed was wet or soiled. The DON stated the Wound Care Specialist Advanced Practice Registered Nurse (APRN) was in the building that day and she thought the skin injury could have been caused by friction. The DON stated about nine days later, the Administrator called her and asked if she was aware that resident #1's wound was possibly a burn, according to his sister. She stated she again asked resident #1 what caused the wounds, and he denied spilling hot coffee. The DON was unable to explain how the resident could have developed such a significant wound without any visible blood, drainage or moisture in the wheelchair or on his pants. She said, I don't know. I investigated to make sure there was no neglect or abuse. The DON acknowledged although she was directly involved as the assigned nurse at the time the skin injury was discovered, she also conducted the incident investigation. She explained the Administrator, who was the facility's Risk Manager, was also involved in the investigation. The DON stated she obtained statements from the resident, the Dietary Manager, and CNA C. However, she was only able to provide a written statement by the Dietary Manager and her own, a response to the Administrator's communication regarding the allegation of a burn injury. The DON acknowledged although resident #1 was alert and oriented, she did not have a written statement that recorded the details of his interview. She confirmed she did not obtain any written statements from the resident's sister, staff who worked on the unit during that shift or those who cared for the resident during the previous shift. The DON said, Sometimes staff write statements, but if I am already in [the electronic incident report], I just type it in. The DON pointed to a personal coffee maker in her office and explained she sometimes provided coffee for staff but not for residents, and she did not give resident #1 coffee that morning. She stated she was aware Licensed Practical Nurse (LPN) D also had personal coffee maker on the unit, but the Administrator made her take it home. On 11/04/24 at 9:55 AM, the [NAME] 2 UM stated she learned about resident #1's skin injury in the daily IDT meeting on 10/02/24 when the DON reported he had a shearing wound. She stated when she saw the wound a few days later, she was shocked as she only knew about blisters on the lateral thigh. She recalled the large wound on the back of the thigh did not have the appearance of typical shearing. The UM stated RN B said resident #1 reported the wound occurred when he spilled his coffee. She stated to her knowledge, the facility had not initiated an investigation, and she was neither interviewed nor asked to give a statement. On 11/04/24 at 10:08 AM, in a telephone interview, RN B recalled when she toileted resident #1 the day before the wounds were noted, his skin was intact. She stated she was not involved in an incident investigation regarding resident #1 and was never asked to provide a statement. On 11/04/24 at 10:58 AM, the facility's Wound Nurse confirmed on the morning resident #1's wounds were discovered she was rounding with the Wound Care Specialist APRN who determined the injuries were trauma blisters. The Wound Nurse said, To be honest, I do not think we even asked him how it happened. She stated in the following days she heard staff discussing that the injury was a burn. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/04/24 at 11:44 AM, in a telephone interview, LPN A stated she asked resident #1 about his thigh wounds and he told her he spilled hot coffee on his leg. LPN A explained one of the night nurses brought in a coffee maker and residents were able to get hot coffee before the cart came from the kitchen at breakfast time. She stated she was never interviewed or asked to give a statement as part of an incident investigation. On 11/04/24 at 12:43 PM, in a telephone interview, CNA C stated on the morning of 10/02/24 he got resident #1 out of bed and took him to the bathroom where he noticed injuries on his thigh. He stated the resident had been in bed all night, and to his knowledge, had not received any hot liquids. CNA C stated he immediately alerted the DON. He acknowledged there was a coffee maker on the unit and confirmed the following day he heard staff discussing the resident being burned by hot coffee. On 11/04/24 at 1:29 PM, in a telephone interview, LPN D acknowledged she brought in a coffee maker and provided residents, including resident #1, with coffee on the overnight shift. LPN D recalled she was off for two or three days and when she returned, her coffee maker and bag of flavored creamer were not in the usual cabinet at the nurses' station. She said she asked where they were, but nobody would say anything. LPN D explained she unlocked the DON's office, found her coffee maker there, retrieved it, and threw it away. She said, I wasn't about to let them pin anything on me. LPN D stated on 10/02/24 at about 5:30 AM, the DON yelled for help from resident #1's room and CNA C ran to assist her. She was informed that sequence of events differed from the facility's incident report. LPN D stated she never heard about an incident investigation. She verified resident #1 told her he received hot coffee that morning and it burned him. She stated nobody ever asked her to provide either a verbal or written statement about the coffee maker, a coffee spill, or resident #1's burn. On 11/04/24 at 4:15 PM, resident #1 confirmed an incident occurred before he was discharged from the facility. He pointed to his left thigh and said, I got burned with the coffee. Resident #1 explained he got coffee every morning from LPN D. The resident recalled that morning, he got out of bed by himself and sat in his wheelchair. He demonstrated how he reached across his body with his right hand and grasped the white Styrofoam cup. He brought his arm back towards his chest and showed how the cup of coffee tipped and spilled down the left side of his thigh and under his left leg. Resident #1 was informed CNA C stated he assisted him from bed to the bathroom that morning. The resident emphasized he took himself to the bathroom where the DON found him first and then CNA C came in afterwards. Resident #1 confirmed neither the DON nor the Administrator interviewed him about his burn. On 11/05/24 at 5:20 AM, in a telephone interview, CNA C was informed his previous statement conflicted with resident #1's statement regarding the occurrences on 10/02/24. CNA C stated he could not recall the true turn of events of that night. He revised his previous statement to indicate he was not sure whether he got resident #1 out of bed, or if he found him in the bathroom, or if the DON called him to the resident's room. CNA C did not remember if he provided a written statement and stated he was never interviewed as a witness for an investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/24 at 11:40 AM, the Administrator stated the facility's incident investigation process was the nurse would trigger an incident report which was reviewed and investigated by the DON. The Administrator explained her role as Risk Manager was to review the incident report and/or investigation before it was closed and ask any questions that she felt were not answered. The Administrator stated she often completed the review process in conjunction with the DON who provided necessary clinical input. She reviewed the incident report regarding resident #1's injuries and stated it was entered on 10/02/24 at 5:30 AM, by the DON who was the resident's assigned nurse. The Administrator stated the DON's investigation showed resident #1's injuries resulted from friction in the wheelchair. Review of the skin assessment attached to the incident report revealed the document was not completed and closed until 11/04/24 at 9:49 AM, after State Survey Agency (SSA) staff entered the facility. The Administrator was informed that interviews with resident #1 and multiple staff members revealed significantly conflicting information that did not support the facility's findings and conclusion. She stated no staff informed her the resident's injury was a burn and she would have expected them to provide her with that information. She acknowledged the incident investigation did not include documentation of attempted or actual interviews with nursing staff or the resident. The Administrator recalled on around 10/11/24, she was notified resident #1's sister alleged her brother's leg was burned by hot coffee. She stated it might have been close to that time that she discovered LPN D used a coffee maker on the unit, and she immediately instructed staff to remove the appliance. The Administrator acknowledged thorough investigations were not completed at the time of the incident or after the resident's sister made an allegation regarding a burn injury. She confirmed the DON remained adamant that her statement was accurate, but since the investigation was not completed timely, there were discrepancies that may never be resolved. The Administrator explained she did not report the incident as it did not meet the criteria based on the knowledge she had at that time. She verified current investigative findings supported that reporting was required. On 11/05/24 at approximately 11:55 AM, the Regional Clinical Specialist stated her role was to support the facility's DON when necessary. She validated since the DON was involved in resident #1's incident as a witness, she should not have led the investigation. The Regional Clinical Specialist stated the DON never reached out to her for assistance with the investigation and she was not aware of a hot coffee burn allegation until the Administrator notified her after SSA staff entered the facility on 11/04/24. She confirmed she reviewed the initial investigation and said, The paperwork I have does not indicate that all those people were interviewed as I do not have written statements. She explained she conducted preliminary interviews with staff, and they informed her resident #1 was alert and oriented, able to make himself understood, and had situational awareness. She verified that information supported the resident's ability to provide a reliable statement regarding his injuries. The Regional Clinical Specialist stated when the resident's sister made the allegation regarding a burn injury, the facility should have initiated a second investigation and considered reporting at that time. Review of the facility's policy and procedures for Resident Accident and Incidents, dated 4/01/22, revealed the facility would report, document, and investigate all incidents that involved residents. The document defined an incident as an occurrence that was not consistent with routine care of a resident and might be an accident or a situation that could cause an accident. The document indicated an electronic incident report should be completed by the nurse and necessary reports filed according to regulations. The policy indicated statements should be obtained at the time of the incident and should include additional facts and potential contributing factors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedures for Abuse, dated 4/01/22, revealed an injury should be classified as an injury of unknown origin if the source of the injury was not observed or could not be explained by the resident, and the injury was suspicious because of its extent or location. The policy indicated any reports of abuse, neglect, or injuries of unknown origin should be promptly and thoroughly investigated and a root cause analysis would be completed. The document revealed the Administrator and his/her designee would investigate incidents with the assistance of appropriate personnel and obtain statements from involved staff, the resident, and the roommate if possible. During the investigation, the Administrator would keep the resident or the representative informed of the progress of the investigation, investigative findings, and corrective action. The policy revealed serious bodily injuries should be reported immediately, not later than two hours after an allegation was made, to the SSA and Adult Protective Services. If there was no serious bodily injury, reporting should be initiated within 24 hours. The policy indicated a follow-up report with the results of the facility's investigation should be submitted within five days of the immediate report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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** 36489 Based on interview, and record review, the facility failed to promote freedom from an accident hazard, the provision of hot coffee without verifying a safe temperature and/or ensuring the use of appropriate cups, for 3 of 5 residents reviewed for accidents, (#1, #4, and #5); and failed to prevent a burn injury for 1 of 3 residents reviewed for skin injuries, (#1), out of a total sample of 5 residents. The facility's failure to identify the untested temperature of hot coffee as a hazard which posed a risk for burns for residents with cognitive and/or physical impairments resulted in actual harm for resident #1 and placed all residents who received untested hot coffee at risk. Resident #1, a physically and cognitively impaired resident, received hot coffee in a Styrofoam cup and accidentally spilled the liquid on his leg. He suffered blisters and full-thickness skin loss, characteristics of second and third-degree burns, that placed him at risk for infection, a disfiguring scar, and decreased mobility. The resident required ongoing weekly assessments by a wound care specialist and daily dressing changes. Findings: 1. Review of the medical record revealed resident #1, an [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included stroke with left side weakness and paralysis, left elbow contracture (shortening of the muscle that causes a stiff joint), arthritis of both knees, generalized muscle weakness, and a history of falling. Resident #1 was discharged to a nearby Skilled Nursing Facility (SNF) on 10/31/24 at his family's request. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date (ARD) of 9/25/24 revealed resident #1 had adequate hearing, used clear speech with distinct and intelligible words, was able to express his ideas and wants, and had clear comprehension of verbal communication. The resident had impaired vision and did not wear glasses. The document revealed resident #1 did not exhibit any hallucinations, disorganized thinking, or an altered level of consciousness during the look back period. He did not display any behavioral symptoms or reject evaluation or care that was necessary to achieve his goals for health and well-being. Resident #1 had functional limitation in range of motion of his arm and leg on one side and he used a wheelchair for mobility. The resident required set-up or clean-up assistance for eating and partial assistance for mobility and walking short distances. The MDS assessment revealed resident #1 had no pressure ulcers, wounds or skin problems, and he had pressure relieving devices for his bed and chair. Review of the medical record revealed resident #1 had a care plan for activities of daily living self-care performance deficit, initiated on 8/27/19. The interventions indicated he required the supervision of one staff after routine tray set up for eating and needed assistance with opening containers, cutting large items and opening and applying condiments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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	A care plan for the potential for impairment to skin integrity was initiated on 10/03/24. The document revealed resident #1 had blisters on the side and back of his left upper thigh. The interventions instructed nursing staff to monitor and document the location, size and treatment of the skin injury; report any abnormalities, signs of infection, or failure to heal to the physician; and re-direct behavior that could cause open wounds. Review of Weekly Skin Checks from July to September 2024 revealed resident #1 had no skin issues. The Weekly Skin Observation form dated 10/02/24 showed the resident had multiple blisters on the side and back of his left upper thigh. The document indicated the injuries included red open areas from popped blisters. Review of the Wound Care Specialist Advanced Practice Registered Nurse (APRN) Progress Note dated 10/02/24 revealed the provider saw resident #1 for initial evaluation of a left thigh wound with the context described as trauma, blister. The document indicated Wound #1 on the left posterior thigh was a full thickness trauma wound that measured 12.04 centimeters (cm) x 3.7 cm x 0.1 cm and had a scant amount of clear drainage. Wound #2 on the left lateral thigh was a partial thickness trauma wound that measured 1.9 cm x 2.5 cm x no measurable depth. The Wound Care Specialist APRN Progress Note revealed the provider next saw resident #1 on 10/16/24 for follow-up of his left thigh wound. Wound #1 was increased in size and measured 19.29 cm x 7.67 cm x 0.1 cm and had a moderate amount of clear drainage and 51 to 75% slough or soft, dead tissue. Wound #2 measured 1.7 cm x 2.5 cm x 0 cm and had 76 to 100% of eschar or hardened, dead tissue. Review of the Wound Care Specialist APRN Progress Note dated 10/23/24 revealed Wound #1 measured 15.31 cm x 5.61 cm x 0.1 cm and had moderate drainage. Wound #2 measured 1.01 cm x 2.33 cm x 0.1 cm. Both wounds were determined to be full thickness skin loss at that visit. A Progress Note dated 10/30/24 revealed Wound #1 measured 15 cm x 5.0 cm x 0.1 cm and had a moderate amount of clear drainage. Wound #2 measured 1.0 cm x 2.1 cm x 0 cm and was covered with eschar. On 11/01/24 at 2:19 PM, in a telephone interview, resident #1's sister stated on 10/02/24, Registered Nurse (RN) B called to inform her she received change of shift report from the Director of Nursing (DON) regarding a skin issue on her brother's leg. The resident's sister stated RN B explained when she evaluated the area, there were two blisters on the left side of his thigh, but when she fully removed his pants, she discovered there was a large wound that extended from under his buttock down the back of his thigh. The resident's sister recalled she was told the area measured about eight inches and went down to the white meat. She stated she visited her brother a few days later and he informed her the injury was from spilling hot coffee on himself. She stated she was told the coffee was made on the unit at the nurses' station and provided in a Styrofoam cup. The resident's sister explained her brother had a stroke and as a result, his fingers were crooked. She stated he used a special spoon to eat and needed a cup with a handle as he had to place his fingers through the handle to hold it properly. Resident #1's sister stated the facility suggested her brother's injury was caused by his wheelchair. She expressed disbelief and explained her brother had propelled himself throughout the facility in his wheelchair for years and never had any skin issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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	On 11/04/24 at 9:55 AM, the [NAME] 2 Unit Manager (UM) stated she learned about resident #1's wound in the daily clinical meeting on 10/02/24 when the DON informed the interdisciplinary team that he had a shearing-type wound on his leg. The UM explained she did not evaluate the skin concern that day, but one to two days later, Licensed Practical Nurse (LPN) A asked her to observe the area while she did resident #1's wound care and changed the dressing. The UM recalled the resident had two areas on the side of his thigh that appeared to be popped, draining blisters. She stated LPN A then showed her another wound on the back of resident #1's thigh that was between six and eight inches long and seeping fluid. The UM explained she was shocked, as the DON never mentioned the large wound on the back of his thigh, only that he had shearing on the side. The UM stated the areas did not have the appearance of typical shearing wounds. When asked about the cause of the wounds, the UM stated RN B informed her resident #1 said his coffee spilled. Shearing occurs when forces parallel to the skin stretch and distort internal tissue while there is downward pressure, leading to decreased blood flow and tissue death. Shearing forces contribute to pressure injuries (retrieved from www.merckmanuals.com/professional/dermatologic-disorders/pressure-injury/pressureinjuries#Etiology_v8381516 on 11/18/24). Burn wounds from heat sources such as scalding liquids raise the temperature of the skin and cause tissue death. The classification of burns depends on the depth and severity of penetration of the skin's surface. Second-degree or partial thickness burns involve the first two layers of skin. The burn site may be deep red and/or have blisters and a glossy appearance from leaking fluid, with possible loss of some skin. Third-degree burns penetrate the entire thickness of the skin and permanently destroy tissue. The burn site may appear white, (retrieved from www.hopkinsmedicine.org/health/conditions-and-diseases/burns on 11/18/24). Third degree burns can occur in two seconds with liquids of 148 degrees and in one second with liquids of 155 degrees (retrieved from the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities on 11/18/24). On 11/04/24 at 10:08 AM, in a telephone interview, RN B recalled on the morning of 10/02/24, she received change of shift report from the DON, who told her resident #1 had blisters on his leg. She stated the DON asked her if she was aware of the skin injury. RN B explained she toileted resident #1 the day before and was certain his skin was intact with no blisters, abrasions, shearing, or any other skin issue on his legs. She stated the Wound Care Specialist APRN was in the facility that morning conducting weekly wound rounds, and she assessed resident #1's leg. RN B explained later that shift, she checked the resident's electronic medical record and discovered there was no documentation about the wound. She stated she completed a note regarding the change in condition and notified the Primary Care APRN and the resident's emergency contact, his sister. She then decided to check the resident's skin so she could complete an accurate Skin Observation note and was surprised to discover the areas were worse than described by the DON. She stated when she saw the extent of the wound on the back of resident #1's thigh, she asked the Primary Care APRN who was onsite, to assess the resident's wounds. On 11/04/24 at 10:31 AM, the Primary Care APRN confirmed she was in the facility on 10/02/24 and RN B asked her to assess resident #1. She stated his lateral thigh had a few popped blisters, but she did not remember seeing the wound on the back of the thigh. The Primary Care APRN recalled the Wound Nurse or the Wound Care Specialist APRN had already seen the resident earlier that day. She explained she later learned the injury was a burn from hot coffee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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	Review of the Primary Care APRN's Acute Care Progress Note dated 10/16/24 revealed resident #1's chief complaint was follow-up regarding a wound on his left posterior thigh. The document indicated the resident had a full thickness injury on the back of his left thigh, which according to the unit manager [name of UM], is a burn from coffee. On 11/04/24 at 11:44 AM, in a telephone interview, LPN A recalled she was assigned to care for resident #1 on the day following the discovery of his skin injury. She confirmed he had no prior skin issues. LPN A explained she was the night shift nurse and although the dressing change was scheduled for the day shift, she did it as the dressing was soiled from a large amount of dark-colored wound drainage. She recalled showing the wound to the UM who appeared shocked when she saw it as she thought it was just shearing. LPN A said, I asked him what happened, and he said he spilled coffee. LPN A stated the coffee cart from the kitchen arrived on the unit between 7:30 AM and 8:00 AM, but one of the other night nurses had a personal coffee maker that was used on the unit. On 11/04/24 at 12:43 PM, in a telephone interview, Certified Nursing Assistant (CNA) C confirmed he was regularly assigned to care for resident #1 on the night shift. He stated on the morning of 10/02/24, he was in the bathroom with the resident and noted he had skin sloughing on the back of his thigh. CNA C stated he immediately notified the assigned nurse, the DON. He acknowledged there was a coffee maker on the unit, but he did not know if someone provided resident #1 with hot coffee that day. On 11/04/24 at 1:29 PM, in a telephone interview, LPN D confirmed she provided a coffee maker and flavored creamers for use on the unit during the overnight shift. She explained there were residents who got up early, between 5:30 AM and 6:00 AM, and she normally brewed a pot of coffee at about 5:00 AM to accommodate them. She stated sometimes she even had to make two pots if they were all drinking it. LPN D said, It became almost a full-time job. She acknowledged neither she nor other staff checked the temperature of the coffee before they provided it to residents. She stated resident #1 usually got up at 6:30 AM and she routinely made his coffee early and left it in his room, to ensure it was ready for him. LPN D recalled on the morning of 10/02/24, at about 5:30 AM, she stood at her medication cart and heard the DON yell for help from resident #1's room. She stated CNA C ran into the room and she followed behind, but the DON looked out and said she didn't need her. LPN D explained she thought resident #1 fell as he often got up in the morning by himself, without calling for help. LPN D stated when she later asked CNA C what happened in resident #1's room, he acted like he did not know what she was talking about. LPN D verified resident #1 eventually told her he was burned that morning when he spilled hot coffee on himself. On 11/05/24 at 1:46 PM, in a telephone interview, CNA E stated about a day or two after the incident, she heard resident #1 was burned by hot coffee. She validated staff brewed coffee in the unit's pantry in the early morning. CNA E confirmed she observed LPN D distributing coffee to residents on many occasions. She verified LPN D usually made resident #1's coffee and left it on a table in his room. CNA E explained soon after this incident occurred, someone removed the coffee pot and staff were instructed not to give the residents hot liquids anymore. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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	On 11/05/24 at 1:07 PM, in a telephone interview, the Wound Care Specialist APRN confirmed on 10/02/24, the DON approached her in the hallway and asked her to see resident #1 as he had a large blister on the back of his thigh. She stated she determined the wound was caused by trauma and surmised it could have been caused by constant rubbing on the seat of his wheelchair. The Wound Care Specialist APRN was informed resident #1 reported the wounds were the result of a hot coffee spill. She said, I am not 100% sure it was not a burn. It is a possibility that it is a burn injury and full thickness would be a third-degree burn. She expressed doubts that the resident would have tried to drink coffee that was hot enough to scald his leg. She added that she usually saw dietary staff arrive on the unit with coffee at about 7:30 AM while she was rounding. The Wound Care Specialist APRN was told residents on the unit received coffee prepared by staff at about 5:30 AM and safe temperatures were not verified before serving the hot liquid. She acknowledged she did not have access to that information at the time she assessed resident #1's wounds. On 11/04/24 at 4:15 PM, resident #1 confirmed an incident occurred before he was discharged from the facility to his current SNF. He pointed to his left thigh and said, I got burned with the coffee. Resident #1 explained he got coffee every morning from LPN D. He said, She makes it for me special, every morning. She knows how I like it. She's the best one. The resident recalled on that morning, he got out of bed by himself and sat in his wheelchair. He demonstrated how he reached across his body with his right hand and grasped the white Styrofoam cup. He brought his arm back towards his chest and showed how the cup of coffee tipped and spilled down the left side of his thigh and under his left leg. Resident #1 stated he then went to the bathroom to remove his clothes, and the DON found him there. He confirmed CNA C entered the room soon afterward. On 11/05/24 at 4:11 PM, the UM at resident #1's current SNF stated he completed the admission assessment on 10/31/24. Joint review of the document revealed the resident was admitted with a burn wound to the rear left thigh. The UM recalled he received the information from the resident and his family. He verified resident #1 clearly stated the etiology of the wound and although his speech was sometimes soft and a little slow, he was able to communicate well, make his needs known, and easily participate in conversation. The UM showed the resident's current Brief Interview for Mental Status (BIMS) Evaluation tool which had a score of 8/15, indicating moderate cognitive impairment. The UM explained he was also the facility's Wound Care Nurse and once informed the wound was a burn, he realized the orders from the previous facility were more appropriate for a pressure-type wound, not a burn, so he obtained new physician orders. 2. Review of the medical record revealed resident #4, a [AGE] year-old male, was admitted to the facility on [DATE] with diagnoses including stroke with right side weakness and paralysis, difficulty walking, and seizures. The MDS Quarterly assessment with ARD of 8/22/24 revealed resident #4 had a BIMS score of 15/15 which indicated he was cognitively intact. The resident used a walker for mobility. Resident #4 had a care plan for physical mobility deficits related to a stroke with right sided weakness, initiated on 3/05/24. The interventions indicated the resident was able to ambulate with a rolling walker. A care plan for risk for falls related to stroke with right sided weakness, seizures, and a history of falling was initiated on 3/07/24. The interventions instructed staff to anticipate and meet the resident's needs and reorient him regarding safety reminders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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	On 11/05/24 at 10:31 AM, resident #4 confirmed he was one of the residents who received coffee early in the mornings before the kitchen was open. He explained LPN D was a great nurse as she made coffee for the residents who were up early. Resident #4 stated his routine was to go to the nurses' station and LPN D would pour the hot coffee into his cup. He pointed to a personal stainless steel insulated cup that was in a cup holder attached to his walker. Resident #4 explained LPN D even bought cup holders for some residents so they would not have to carry the hot coffee. The resident shared that LPN D no longer provided hot coffee since the incident that involved a resident #1 who was burned when he spilled hot coffee on himself. Resident #4 said, He hardly had use of his hands. He has a really rough time holding things sometimes. He was in his room when it happened. He told me about it the next day. 3. Review of the medical record revealed resident #5, a [AGE] year-old male, was readmitted to the facility on [DATE] with diagnoses including stroke with left side weakness and paralysis, repeated falls, generalized muscle weakness, chronic pain, and left foot drop. The MDS Quarterly assessment with ARD of 8/09/24 revealed resident #5 had a BIMS score of 12 which indicated moderate cognitive impairment. He required set-up assistance for eating and supervision or touching assistance for mobility. Resident #5 had limitation in functional range of motion of one leg and used a wheelchair. Resident #5 had a care plan for activities of daily living self-care performance deficit related to left side paralysis following a stroke, impaired mobility and balance, and a history of falling, revised on 2/21/24. The interventions included set-up assistance of one staff member before eating. A care plan for risk for falls, revised on 5/29/24, revealed resident #5 had gait and balance problems, left side weakness, poor trunk control, and poor safety awareness. The goals included minimizing the risks of incidents and injury. The interventions instructed nursing staff to anticipate and meet his needs and therapy staff were to evaluate for wheelchair modifications as indicated. On 11/05/24 at 10:25 AM, resident #5 verified he was one of the residents who received early morning cups of coffee from LPN D. He explained he was a retired roofer, and for many years he woke up at about 4:30 AM to go to work. The resident stated he still could not sleep later than that. Resident #5 described the cup as white Styrofoam with a lid. When asked about the temperature of the coffee, he said, I've got to let it sit to cool it off a little before I can drink it. On 11/04/24 at 12:02 PM, the Dietary Manager stated the facility's process to ensure safety and prevent burns was to check the temperatures of all food and beverages in the kitchen before the items were served to residents. He explained after temperatures were checked, coffee and hot water for tea were poured into containers for service. He confirmed hot coffee and tea should be served in diner-type plastic cups with a handle and covered with a plastic lid. The Dietary Manager stated the facility's maximum allowed temperature for hot liquids was 145 degrees Fahrenheit. He verified kitchen staff arrived at 6:00 AM so it should not be possible for residents to get coffee earlier. According to the National Coffee Association the optimal temperature for brewing coffee is approximately 200 degrees Fahrenheit and the preferred serving temperature is between 140 and 155 degrees Fahrenheit (retrieved from www.ncausa.org on 11/18/24). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor	1550 Jess Parrish CT Titusville, FL 32796

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	Review of the facility's policy and procedure for Hot Liquids, updated on 7/29/24, revealed residents would receive hot liquids at a palatable temperature that would not burn the skin if spilled. The guidelines indicated coffee would be brewed at the recommended temperature and leave the kitchen at a temperature between 140 and 158 degrees. The policy revealed coffee served to residents outside of mealtimes should be checked to ensure the temperature was not above 145 degrees and it should never be served in Styrofoam cups.