STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115733	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Eagle Healthcare and Rehab	206 Main Street East Abbeville, GA 31001

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** Based on observation, interview, record review, and review of facility policy, the facility failed to provide supervision to prevent accidents for one of one resident (Resident (R) 47) reviewed for accidents out of a total sample of 18. This failure caused actual harm on 06/9/25 when Certified Nursing Assistant (CNA) 3 gave R47 a bowl of hot ramen noodles and allowed him to go down the hallway with them on his lap to his room, which was on the other hallway. R47 had not been assessed to be able to safely handle hot liquids. R47 spilled the hot noodles on his leg and sustained a burn that resulted in a blister to his upper left thigh. Findings include: Review of a facility policy titled, Use and storage of food brought in by family or visitors, with a copyright date of 2025, revealed, . Foods may be reheated in a microwave and should be stirred during the reheating process and reheated to at least 165 F (Fahrenheit). 5. Ensure that reheated foods are cooled enough to a palatable temperature prior to consuming to prevent burns . Review of a facility policy titled, Incidents and Accidents, dated 01/09/25, revealed, . 'Accident' refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident . Review of R47's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R47 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, difficulty in walking, weakness, and need for assistance with personal care. Review of R47's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/25 and located in the Aspen MDS Viewer, revealed R47 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident was moderately cognitively impaired. It was recorded that R47 had no bilateral upper body impairments and required supervision/touch assistance with activities of daily living. During an observation and interview on 06/09/25 at 2:56 PM, R47 approached the surveyor and Registered Nurse (RN) 1 and raised his left pant leg. R47 exposed a burn to his upper left thigh and stated the burn was caused by soup that he had last night. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R47's Progress Note, dated 06/09/25 at 4:43 PM and located under the Progress Notes tab of the EMR, indicated RN1 documented R47 stated he had burned himself with ramen noodles last night and did not report the incident to anyone. It was recorded that R47 stated he spilled soup onto his left upper leg. The resident was identified with a blister to the upper left thigh. It was documented that the blister was 1.8 long by 1.0 wide, but the unit of measure was not indicated. It was documented the skin was reddened around the blister. It was recorded that the area was cleansed with normal saline and triple-antibiotic ointment (TAO) applied to area. It was recorded that the Nurse Practitioner (NP) was notified and staff was to continue to monitor. Review of R47's entire clinical record failed to indicate an assessment to determine the resident's ability to handle hot liquids had been completed for the resident prior to 06/09/25. During an interview on 06/10/25 at 1:20 PM, R47 stated he had received a package of [NAME] noodles from another resident on 06/08/25 and had asked a staff member to cook them for him. During an interview on 06/10/25 at 2:05 PM, Licensed Practical Nurse (LPN) 1 stated food was being re-heated in the microwave located at the main desk prior to 06/09/25. LPN1 confirmed she had not received training on the reheating of food in a microwave prior to 06/09/25. During an interview on 06/10/25 at 2:14 PM, Infection Preventionist (IP) confirmed she had not received training on taking the temperature of food that was reheated. During an interview on 06/10/25 at 2:25 PM, Registered Nurse (RN) 1 confirmed she had not received training on taking the temperature of food that was reheated. During an interview on 06/10/25 at 3:15 PM, Certified Nurse Aide (CNA) 2 confirmed she had not received training on taking the temperature of food that was reheated. During an interview on 06/10/25 at 3:25 PM, CNA1 confirmed she had not received training on taking the temperature of food that was reheated. During an interview on 06/10/25 at 3:52 PM, the Administrator stated she had been in her position for the past month, and the staff had not been provided with any training on temping water for ramen noodles. The Administrator stated she was not aware of any electronic record assessment used to determine a resident's ability to safely handle hot liquids. During an interview on 06/10/25 at 5:11 PM, CNA3 confirmed she had not received training on taking the temperature of food that was reheated. CNA3 stated she took a bowl of ramen noodles from R47 and entered the nutrition room with the bowl of ramen noodles. CNA3 stated she filled a Styrofoam cup partially with water and placed it in the microwave to heat for 2.5 minutes. CNA3 stated she then exited the nutritional room while waiting for the water to heat. CNA3 stated that she let the water cool off prior to taking the bowl of ramen to R47. CNA3 stated the water was not hot to touch. CNA3 stated she placed the bowl of ramen inside a dome cover used to cover a plated meal. CNA3 confirmed she did not take the temperature of the ramen noodles prior to giving them to the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/10/25 at 1:35 PM, the Administrator provided a policy titled, Hot Liquid Safety Policy, with a revision date of 2025, that read, . All residents are assessed for their ability to handle containers and consume hot liquids. Resident with difficulties will be individualized and noted on the resident's plan of care . Attached to this policy was an in-service/training sheet, dated 06/09/25 and documented as presented by the Assistant Director of Nursing (ADON), with the objectives, . 1. Hot liquid/food (heating) 2. Purple Ther. [thermometer] at microwave to temp food or liquids 3. 140 (degrees mark) is too hot to give to resident . During an interview on 06/11/25 at 2:10 PM, the Assistant Director of Nursing (ADON) confirmed the facility had not assessed all residents who handled hot liquids for safety prior to the incident. The DON stated as of 06/10/25, all residents had been assessed for safety with hot liquids and care plans had been developed. During an interview on 06/11/25 at 2:43 PM, the Dietary Manager (DM) confirmed that the residents had not been assessed for safety with hot liquids before 06/10/25. The DM confirmed all residents had been assessed as of 06/10/25.