STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155368	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Todd-Dickey Nursing and Rehabilitation	712 W 2nd St Leavenworth, IN 47137

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. 34231 Based on observation, interview, and record review, the facility failed to ensure staff provided effective assistance with drinking in accordance with the plan of care and failed to implement effective interventions to prevent the spillage of hot coffee to a resident with upper extremity tremors for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in the resident spilling the hot coffee and sustaining second degree burns on right lateral chin, right and left thighs; and a third degree burn on right upper inner groin area. Findings include: On 10/1/24 at 10:35 a.m., Resident B was observed resting in bed with her eyes open and watching television. The resident was observed with tremors of persistent movement to the arms, hands, and head. The incident report, dated 9/5/24 at 7:15 a.m., indicated Resident B spilled coffee on her lap with blisters to her right upper thigh and reddened area to her bilateral legs and right lower arm. The facility preventative measures were for staff to provide the resident with a cup with a lid. The clinical record for Resident B was reviewed on 10/1/24 at 10:54 a.m. The diagnoses included, but were not limited to, dementia, anxiety, impulsiveness, and tremors. The significant status changes minimum data set (MDS) assessment, dated 8/5/24, indicated the resident's cognition was moderately impaired. The resident required staff assistance with set up for eating and drinking. The care plan, dated 7/10/24, indicated the resident was a nutritional risk related to a history of malnutrition, tremors, and self-feeding issues. The care plan lacked interventions related to tremors and self-feeding issues. The care plan, dated 7/12/24, indicated the resident required assistance with activities of daily living (ADL's) and staff were to assist Resident B with eating and drinking when needed. The care plan lacked the level of assistance needed related to the number of staff needed or how much assistance Resident B needed with eating and drinking. (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: 155368	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Todd-Dickey Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 712 W 2nd St Leavenworth, IN 47137	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	The nursing to therapy referral, dated 7/23/24 at 2:58 p.m., indicated the resident complained of tremors that refrained her from using eating utensils. The occupational therapy (OT) evaluation, dated 7/26/24, indicated the resident was recently referred to be evaluated by therapy. The resident had an increase in tremors and a decline in fine motor coordination which led to difficulty with self-feeding and ADL tasks. The nursing to therapy referral, dated 8/7/24 at 10:48 a.m., indicated the resident was complaining of difficulty in using her water cup at bedside due to the weight of the water in the cup. The resident continued to have tremors to her hands and arms. The resident's care plan or dietary staff notes lacked any implemented interventions related to the resident's difficulty with holding her cup, after the 8/7/24 therapy referral. The occupational therapy note, dated 9/4/24, indicated the resident and caregiver were educated on the resident's difficulties with self-feeding related to increased difficulty with scooping food onto her utensils. The Certified Occupational Therapy Assistant (COTA) 4 explained the adaptive equipment the resident could use to make self-feeding easier for the resident. The therapist will continue to observe the resident during mealtimes to assess for a scoop plate. The note lacked any documentation related to the resident's difficulties handling liquids or a cup. The progress note, dated 9/5/24 at 7:15 a.m., indicated the resident was up in the dining room and requested a cup of coffee. The resident was given the coffee and dropped the coffee on her lap. The resident was immediately taken to her room and her clothing was removed. The resident's skin was already red and showed signs of blisters (The note lacked where the redness occurred). Cool towels were applied to all the resident's red areas. The facility wound management report, dated 9/5/24 between 1:11 p.m. and 1:14 p.m., indicated the resident had acquired three burned areas related to hot coffee. - Wound 1 was a superficial burn to the resident's right lower inner arm and measured 19 cm (centimeters) in length and 8.2 cm in width with no depth. The area was pink in color with no blisters. Staff were to cleanse the area, apply a thin layer of Silvadene (a cream that treats and prevents wound infections for burns) topically and wrap with gauze twice daily. - Wound 2 was a partial thickness burn to the resident's right top thigh area and measured 39.5 cm in length and 27 cm in width with no depth. The area was blistered, moist, painful, and reddened. Staff were to cleanse the area, apply a thin layer of Silvadene topically, and wrap with gauze twice daily. - Wound 3 was a superficial burn to the resident's left top thigh area and measured 8 cm in length and 11 cm in width. The area was painful, reddened and blanched with pressure. No blisters were observed. Staff were to cleanse the area, apply a thin layer of Silvadene topically, and wrap with gauze twice daily. The clinical record lacked documentation related to a burn on the resident's right lower facial area. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The physician's order, dated 9/6/24, indicated staff were to continue to cleanse all the resident's burned areas, apply a thin layer of Silvadene cream, and cover with Mepitel (a dressing used to protect the wound and skin). Then apply border gauze (a type of wound dressing that consists of three layers and was used to protect and absorb wounds) to secure. The physician's order, dated 9/11/24, indicated staff were to continue to cleanse all the resident's burned areas, apply a thin layer of Silvadene cream and cover with xeroform dressing (a dressing for low draining wounds). Then apply border gauze to secure. The wound care center history and physical note, dated 9/12/24 at 12:30 p.m., indicated Resident B presented to the wound care center with her family member related to burns acquired in the nursing home from hot coffee. The wound care center detailed assessment, dated 9/12/24 at 12:30 p.m., indicated the resident presented to the center with the following wounds: - Wound 2 involved the resident's right groin area and upper medial leg. The resident had a second-degree burn (involving the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin). The wound measured 25 cm in length, 16 cm in width with a depth of 0.2 cm, full thickness without exposed support structures. The wound had a large amount of serosanguineous (a combination of blood and serum) exudate (drainage), slough (yellow/white material in the wound bed), and with a fat layer exposed. The treatment ordered was Santyl (debriding treatment), staff were to apply a nickel thick amount to wound bed, with a Vaseline gauze over the Santyl and cover with an abdominal pad daily (ABD). The resident's right medial upper leg had a first-degree burn (involving the top layer of skin. These may present as red and painful to touch, and the skin will show mild swelling). The wound measured 2.2 cm in length, 2.4 cm in width with a depth of 0.1 cm, full thickness without exposed support structures, large amount of serosanguineous exudate and slough. The treatment ordered was bacitracin (helps prevent burns from becoming infected) to the wound bed, staff were to apply Vaseline gauze, cover with ABD pad, and secure with gauze daily. - Wound 3 involved the resident's left medial upper thigh. The resident had a second-degree burn. The wound measured 3 cm in length, 4 cm in width with a depth of 0.1 cm, full thickness without exposed support structures. The wound had a medium amount of serosanguineous exudate and with a fat layer exposed. The treatment ordered was bacitracin to wound bed, staff were to apply Vaseline gauze, cover with ABD pad, and secure with gauze wrap. - Wound 4 involved the resident's right lateral chin. The resident had a second-degree burn. The wound measured 0.3 cm in length, 0.5 cm in width with a depth of 0.1 cm, full thickness without exposed support structures, a small amount of serosanguineous exudated. The treatment ordered was bacitracin to the wound bed daily. The wound care center note, dated 9/12/24, lacked any documentation related to the resident's right lower inner arm burn that was identified on 9/5/24 as Wound 1 on the facility wound management note. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility skin and wound note, dated 10/1/24 at 2:47 p.m., indicated the following: -Wound 2 was located on the resident's right groin area. The wound was a third-degree burn (third-degree burns penetrated the entire thickness of the skin and permanently destroy tissue. These present as loss of skin layers, often painless and dry, leathery skin. Skin may appear charred or have patches that appear white, brown, or black). The area measured 4.2 cm in length, 18 cm in width with a depth of 0.2 cm. The wound contained 80% (percent) slough with a heavy amount of serosanguineous exudate. The exposed tissues were the epithelium and dermis. A wound debridement was completed to 100% of the wound and necrotic tissue was removed. The wound was to be cleansed with wound cleanser, patted dry, apply Santyl cream and covered with ABD/bordered gauze daily. - Wound 3 was located on the resident's left thigh. The wound was a third-degree burn. The wound measured 0.5 cm in length, 1.5 cm in width with a depth of 0.1 cm with a small amount of serosanguineous exudate. The exposed tissue was epithelium. The wound was to be cleansed with wound cleanser, apply xeroform and bordered gauze daily. The facility wound note, dated 10/1/24, lacked documentation related to the resident's Wound 1 identified on the facility wound note, dated 9/5/24; or Wound 4 identified on the Wound Care Center assessment, dated 9/12/24. During an interview on 10/1/24 at 10:35 a.m., the resident's family member indicated the wound nurse had been in that morning for treatment to her family member's burn wounds. The resident had a third-degree burn to her right upper thigh and a second-degree burn to her left upper thigh. The resident had severe tremors, and the family member was unsure why there was no lid on the coffee cup to prevent spillage. On 10/1/24 at 11:00 a.m., during an observation of the coffee maker in the facility kitchen, the industrial coffee maker was observed to be set at 200 degrees Fahrenheit. The ED indicated they do not individually temp the coffee. The industrial coffee maker was set at 200 degrees Fahrenheit. The standard was between 205 to 215 degrees Fahrenheit and they set their' s below the standard at 200 degrees Fahrenheit. The industrial coffee maker was observed to be set at 200 degrees Fahrenheit. On 10/1/24 at 11.07 a.m., during an observation of the coffee temperatures in the two residents' dining rooms, the coffee being served by staff was tempted to be at 140 degrees Fahrenheit. On 10/1/24 at 11:30 a.m., a request was made for the facility policy on hot liquids. On 10/1/24 at 12:30 p.m., the Executive Director (ED) indicated the facility did not have a policy on hot liquids. The ED and Director of Nursing (DON) indicated they did not do hot liquid evaluations. The ED indicated that the resident, had always drank coffee. The DON indicated Resident B was able to eat and drink with no issues. The resident had a couple of hospital stays. After her second hospital stay, they had therapy take a look at the resident. She would not eat; she was paranoid and had mental status changes. Speech could not evaluate her because she refused. The family member could get her to eat. They sent her to neurology, and they put her on Gabapentin for her tremors. She had lethargy and increased tremors. They decreased the Gabapentin. There was no need for an evaluation as the family member was assisting the resident with meals. She was up for meals, still having tremors and staff were supervising. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/2/24 at 9:16 a.m., the Executive Director (ED) indicated the resident was seen by the occupational therapist assistant on 9/4/24 for assistive devices and felt at that time a lid was not needed. The facility staff were aware the resident had tremors; however, the tremors were inconsistent. The ED provided a typed noted completed on 10/2/24 and dated 9/4/24 from COTA 4. The typed noted indicated the following: The resident and resident's caregiver were educated on the different types of adaptive equipment. Adaptive equipment suggested were a scoop plate, weighted silverware, and lids on cups. The resident observed on 9/4/24 with a plastic lid on a regular cup. The resident completed drinking tasks without problems. The resident demonstrated minimum tremors during treatment session. At this time, due to the resident's alertness and minimum tremors, lids on cups were not recommended. On 10/2/24 at 9:42 a.m., an observation of the resident's wound was made with the DON and Licensed Practical Nurse (LPN) 8. The resident's area to her right groin wound (Wound 2) was observed to be 18 cm in length, 4 cm in width with a depth of 0.1 cm. Scar tissue was observed around the peri-wound. Approximately 70% of the wound was covered with yellow slough. There was no odor. The left thigh wound (Wound 3) was observed to be 2 cm in length and 2 cm in width with no depth. The wound bed was observed to be pink with no slough. Scar tissue was observed to the top of the wound. The resident denied any pain or discomfort. During an interview 10/2/24 at 9:45 a.m., Certified Nursing Aide (CNA) 5 indicated the day of the incident, she heard someone crying and another CNA 6 was taking the resident to her room. Resident B shakes really bad, and it comes and goes. She could not recall if the resident had tremors that day, but some days she had them and some days she did not. There were plenty of days that she needed a lid for her cup to prevent her from spilling the liquid. She was aware the resident had tremors. During an interview on 10/2/24 at 9:47 a.m., CNA 6 indicated it was breakfast time and CNA 7 handed Resident B a cup of coffee. The coffee was really hot that day. She heard something drop. She walked over and saw that the coffee had spilled on Resident B. She took the resident to her room, removed her clothing and put cold wash cloths on the reddened areas. Her skin was red when she removed the resident's clothing. She did not recall if the resident was having tremors that day, but she was aware the resident did have tremors. During an interview on 10/2/24 at 11:00 a.m., COTA 4 indicated she had spent time with the resident on 9/4/24. When she went in the room, the resident was abed, and her family member was at her bedside. The resident had a couple of hospital stays and after she came back from her second one, she was very paranoid. She quit eating and thought the staff were poisoning her food. On 9/4/24, when she saw the resident, she was coming out of showing signs of paranoia. The family member asked her about assistive devices, and she spoke with her about a scoop plate, weighted utensils, and a lidded cup if it came to that. On 9/4/24, the resident's tremors were minimal, and she was alert and oriented. When her lunch tray came, her cup had a lid on it. She put a straw in the top of the lid and the resident did fine drinking. She was aware the resident had tremors, and the tremors would come and go and were very inconsistent. It was a very short time when the incident occurred that the resident could feed herself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 10/2/24 at 11:09 a.m., CNA 7 indicated on the morning of the incident, they were getting the breakfast trays ready. She asked Resident B if she wanted coffee, and she said yes. She poured the resident some coffee and it was hot. She placed the coffee on the residents' table, out of the resident's reach, because it was hot. She went back to the food cart and was told the resident had spilled her coffee. She and CNA 6 took the resident to her room, got her undressed and placed cold cloths on the reddened areas. After that she left the resident's room to finish the meal service. She had never seen the resident with a lid on her cup. She had no idea how the resident reached the coffee cup or if someone else gave it to her. The resident's tremors were not as bad that day as they usually were. She was aware the resident had tremors. The resident had always gotten coffee before when she wanted it, without a lid on her cup, and she did not recall the resident ever having a lid on her coffee. On 10/2/24 at 12:38 p.m., the resident was observed resting in bed with her eyes closed and her call light in reach. Tremors were observed ongoing to the arms, hands, and head. Resident B's family member indicated the day before the incident occurred, COTA 4 came in and told her she was getting ready to put an order in for her family member to have a lid on her drinks. COTA 4 told her that her family member had eaten her meal well the day before. Her family member could not handle the weight of cups because she was shaking so badly. Burn Exposure Chart, www.antiscald.com, indicated .that a person will receive a second degree burn in 3 seconds of exposure and third degree burn in 5 seconds of exposure to water of 140 [degrees Fahrenheit] . Occupational-Therapy-Scope-of-Practice, www.research.aota.org/practice, 2024 American Occupational Therapy Association, .Occupational therapy services may be provided by two levels of practitioners: (1) the occupational therapist and (2) the occupational therapy assistant, as well as by occupational therapy students under appropriate supervision (AOTA, 2018). Occupational therapists function as autonomous practitioners, are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. The occupational therapy assistant delivers occupational therapy services only under the supervision of and in partnership with the occupational therapist (AOTA, 2020b). When the term occupational therapy practitioner is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2015a) . The Past noncompliance began on 9/5/24. The deficient practice was corrected by 9/12/24 after the facility implemented a systemic plan that included the following actions: All staff were educated on assist to feed which included all residents that needed assistance were assisted timely, temperature of fluids were appropriate and to resident preference, and the use of specialty cups/lids appropriately (9/11/24); Coffee temperature monitoring was implemented (9/5/24); All residents were observed to ensure no issues with cups and eating (9/5/24); Drink lids provided to all units and on hydration carts (9/8/24); Vendor completed inspection of coffee maker and ensured no temperature malfunctions (9/12/24). This Citation relates to Complaint IN00442615 3.1-45(a)(2)