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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Heights Nursing & Rehabilitative Center	302 E Iowa Street Hiawatha, KS 66434

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** The facility identified a census of 50 residents. The sample included three residents with three residents reviewed for hot liquid safety. Based on observations, record review, and interviews, the facility failed to ensure an environment free from accident hazards when on 02/15/26 Dietary Staff CC provided cognitively impaired Resident (R) 1 with coffee in a lidded cup, without obtaining the temperature of the coffee prior to giving it to her, and R1 spilled the coffee on herself. After the spill, the staff obtained the temperature of the coffee, which was 151 degrees Fahrenheit. R1 sustained second degree burns from the hot liquid spill. Findings included:- R1 admitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness, dementia (a progressive mental disorder characterized by failing memory and confusion), dysphagia (difficulty swallowing), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R1's Quarterly Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of eight which indicated moderate cognitive impairment. R1 required set up or clean-up assistance with eating. R1 had a mechanically altered diet. R1's Significant Change MDS dated 02/26/26, documented R1 had a BIMS score of three which indicated severe cognitive impairment. R1 was independent with eating. R1 had a mechanically altered diet. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 02/26/26, documented R1 had a BIMS of three. The Nutritional Status CAA dated 02/26/26, documented R1 readmitted to the facility after a hospitalization for burns. R1 had second-degree burns to her right and left lower limbs. R1 continued with a regular diet with soft, bite sized texture and thin liquids. R1's 10/18/24 Care Plan documented R1 was alert to self only, due to dementia, but she was familiar with her surroundings. The Care Plan documented the following interventions: Initiated 10/18/24, Resolved 02/23/26: R1 had some increased weakness, and she could have regular mugs without lids for hot liquids per her request. R1 had no history of spillage or other issues related to the matter. R1's 10/29/25 Care Plan documented R1 had a swallowing problem related to dysphagia. The plan documented the following interventions: Initiated 01/19/26, Resolved 02/19/26: Dietary and nursing staff provided all hot liquids in a hydro-jug, non-spill cup. Initiated 01/26/26, Created on 02/23/26: R1 refused hydro-jug, non-spill thermal cup. Staff provided all hot liquids in a mug with a lid. Initiated 02/19/26, Revised 03/09/26: Staff used a mug with a lid for all hot liquids or non-spill thermal mug if R1 agrees. Staff placed a clothing protector on R1's chest and lap area during meals. R1 only drank hot liquids at the table or with staff supervision. Initiated 02/21/26: Per family request, staff placed two ice cubes in R1's hot liquid beverages and soups. R1's EMR documented the following: A Hot Liquids Safety Evaluation dated 04/12/25, documented R1 had upper extremity weakness and loss or reduced mobility. The evaluation documented an intervention for a cup with a lid. A diet order, dated 11/25/25 and discontinued 02/20/26, revealed R1 had a regular diet with soft and bite-sized texture and thin liquids. The order instructed staff to provide a mug with a lid for all hot liquids or a non-spill thermal mug if she agreed; staff placed a clothing protector on R1's chest and lap area during meals; and R1 only drank hot liquids at the table or with (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	staff supervision. A Nurses Note on 02/15/26 at 10:15 AM, documented at 09:40 AM staff alerted the nurse that R1 spilled hot coffee on herself in the dining area. The nurse performed an immediate assessment and noted erythema (redness or inflammation of the skin) from below R1's belt line to her groin. R1 appeared tired and repeatedly stated she was tired. R1 reported pain in her groin and bilateral thighs, stating it hurt. R1 had blistering present on her medial/inner thighs, consistent with a burn injury. The facility notified the on-call provider and received orders to send R1 to the emergency room (ER) for further evaluation and treatment. The facility notified R1's representative who agreed to the transfer. R1 departed from the facility with Emergency Medical Services (EMS) at 10:05 AM. A Nurses Note on 02/15/26 at 11:45 AM, documented at 11:36 AM, the ER nurse called the facility to report they were transferring R1 to the Burn Center Hospital. The facility notified R1's representative. An Emergency Department Note on 02/15/26, documented R1 ate breakfast that morning and spilled her coffee in her lap. She finished eating breakfast and staff took her to the shower to clear her up, when they noticed significant firmness in her lap with peeling skin, believed to be second-degree burns. R1's skin assessment revealed 3% total body surface area (TBSA-the percentage of body surface affected by partial or full-thickness burns), partial thickness (potentially painful burn that affects the first and second layer of the skin) burns to her inner groin area, and bilateral medial (inner) thighs. An admission History and Physical Examination note on 02/15/26, documented R1 presented to the burn center with partial thickness scald burns to her bilateral thighs and perineum (the area between the anus and the genitalia) after spilling 157-degree F coffee in her lap that morning at breakfast. The facility's reportable investigation documented on 02/15/26 at 09:40 AM, R1 sat in the dining room for breakfast. The kitchen staff and nursing staff heard R1 holler out and Dietary Staff BB looked out of the serving window to see coffee on the floor. Dietary Staff BB asked Certified Nurse Aide (CNA) M, who assisted another resident with breakfast, to check on R1. CNA M got up and observed coffee on R1's lap, then started to pat it dry. CNA M asked Dietary Staff BB to call for a nurse in charge to assess R1. Licensed Nurse (LN) G arrived and began his assessment. LN G's assessment revealed redness and blistering to R1, so LN G called the on-call provider and requested R1 to be sent to the ER for evaluation. R1 transferred to the ER for evaluation and the ER later notified the facility they transferred R1 to a burn center for further evaluation. The burn center treated R1 for second-degree burns and a new onset of atrial flutter (a heart arrhythmia where the upper chambers of the heart, beat too quickly) with bradycardia (low heart rate, less than 60 beats per minute). The investigation conclusion noted: After investigation, the facility felt the incident was accidental and was caused by R1's health condition. R1 told the nurse she was tired, and her blood pressure was low. R1 had a lid on her coffee cup per her care plan but when she dropped the cup, the lid came off. R1 had no history of dropping her coffee prior to that incident. In a notarized witness statement on 02/15/26, Dietary Staff CC stated R1 asked him to refill her coffee mug. He went to the kitchen and brought the coffee pot to the table. Dietary Staff CC stated he filled her cup and took it over to the counter to put sweetener in it. He put the lid on and sat the cup on the table for R1. On 03/19/26 at 11:50 AM, R1 sat in her wheelchair at a dining room table. She wore a clothing protector and had a thermal coffee mug with a lid and straw positioned in front of her on the table. On 03/19/26 at 11:52 AM, Dietary Staff DD filled a coffee cup with coffee from an automatic machine in the serving room. Dietary Staff DD obtained the temperature of the coffee and noted the temperature to be 134.9 degrees Fahrenheit (F). On 03/19/26 at 10:12 AM, Administrative Nurse D stated Dietary Staff BB obtained the temperature of what remained in R1's coffee cup on 02/15/26, after the spill, and reported the temperature was 151 degrees F. On 03/19/26 at 11:52 AM, Dietary Staff BB stated on 02/15/26, she served residents from the serving room and heard R1 holler. She stated she looked up and noticed coffee on the floor. Dietary Staff BB told CNA M, who was behind R1, to check on R1. She stated she obtained the temperature of the coffee that remained in R1's cup and noted the temperature as 151 degrees F. Dietary Staff BB stated staff put ice in R1's coffee and she used a cup with a lid. She stated staff obtained the temperature of every cup and did not send it out if it was over (continued on next page)

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