STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maristhill Nursing & Rehabilitation Center	66 Newton Street Waltham, MA 02453

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** 40702 Based on records reviewed and interviews, for one of three sampled residents, (Resident #1), who required assistance from staff with personal hygiene, the Facility failed to ensure that during the provision of personal care that staff took necessary steps to maintain his/her safety to prevent an incident resulting in an injury, when on 01/22/25, a Certified Nurse Aide (CNA) used an electric curling iron to curl Resident #1's hair, he/she sustained a second-degree burn (partial thickness, involves both the outer (epidermis) and underlying layer (dermis) of skin, they cause pain, redness, swelling, and blistering) to the upper left side of his/her forehead, which required treatment. Findings Include: Review of the Facility's Policy titled, Electric Safety for Residents, dated as revised January 2011, indicated that the resident will be protected from injury associated with the use of electric devices, including electrocution, burns and fire. Review of the Facility's Policy titled, Activities of Daily Living (ADLs), Supporting, dated as revised March 2018, indicated the following: -residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal hygiene -appropriate care and services will be provided for residents who are unable to carry out ADLs independently, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care) Resident #1 was admitted to the Facility in January 2025, diagnoses included polyosteoarthritis (arthritis in five or more joints), hypertension, atrial fibrillation, weakness, and hyperlipidemia (high cholesterol). Review of Resident #1's Admission Minimum Data Set (MDS), dated [DATE], indicated that he/she was alert, oriented, cognitively intact, able to make his/her own decisions and required staff assistance with personal hygiene. (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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(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 Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/26/25, indicated that on 01/22/25 Resident #1's nursing assistant brought her curling iron to work and at approximately 11:30 A.M. the nursing assistant proceeded to comb and curled Resident #1's hair, while in the process he/she sustained a burn on the left upper side of his/her forehead measuring 2.0 centimeters (cm) by 0.3 cm. Review of Resident #1's Nurse Progress Note, dated 01/23/25, (written by Nurse #2), indicated that around 4:00 P.M. Nurse #2 noticed skin redness with peeled skin on Resident #1's left upper forehead measuring 2. 0 cm by 0.3 cm. The Note indicated that Nurse #2 asked Resident #1 what happened, he/she stated that the morning Certified Nurse Aide (CNA) (later identified as CNA #1) accidentally touched the curling iron to his/her forehead yesterday (01/22/25), when she (CNA #1) was curling his/her hair. The Note further indicated that the on-call provider was notified and gave an order to apply Vaseline to the affected area (left upper forehead) daily for seven days. During an interview on 02/24/25 at 10:25 A.M., Resident #1 said CNA #1 had brought her own curling iron to work (could not recall exact date) to curl his/her hair and said he/she got a burn mark on his/her forehead from the curling iron. Resident #1 said he/she felt the curling iron burn his/her forehead, did a little jump and said, ouch, that hurts, and CNA #1 stopped curling his/her hair the minute it happened. Resident #1 said the skin on his/her forehead peeled off, got crusty, and the nurses were putting some type of cream on the burn to his/her forehead. During an interview on 02/25/25 at 2:25 P.M., Nurse #3 said she worked the 7:00 A.M. to 3:00 P.M. shift on 01/22/25 and 01/23/25 and was assigned to Resident #1 on both days. Nurse #3 said on 01/22/25 she was not aware that CNA #1 had curled Resident #1's hair with a curling iron. Nurse #3 said she did not notice a red area on Resident #1's forehead either day (01/22/25 or 01/23/25) because Resident #1's hair covered his/her forehead and that he/she had not complained of any pain or discomfort. During an interview on 02/24/25 at 2:52 P.M., (which included review of her written statement) Nurse #2 said on 01/23/25 around 4:00 P.M. she went to take Resident #'1 vital signs, noticed that he/she had an area of redness on the upper left side of his/her forehead with a piece of skin peeling off and measured the red area to be 2.0 cm by 0.3 cm. Nurse #2 said she asked Resident #1 if he/she fell or bumped his/her head and said Resident #1 told her that CNA #1 had touched his/her forehead with a curling iron yesterday (01/22/25). Nurse #2 said she notified the on-call provider and obtained an ordered to apply Vaseline daily for seven days to the affected area. During an interview on 02/24/25 at 1:54 P.M., CNA #1 said she worked the 7:00 A.M. to 3:00 P.M. shift on 01/22/25 and was assigned to provide care to Resident #1. CNA #1 said on 01/22/25 she had extra time and decided to curl Resident #1's hair because she wanted him/her to look pretty. CNA #1 said she went to her car to get her curling iron and brought it into the Facility. CNA #1 said she curled the sides and back of Resident #1's hair first then curled his/her bangs downward towards his/her forehead with the curling iron. CNA #1 said she held the curling iron in place for about two seconds because Resident #1's hair was very fine and thin. CNA #1 said the curling iron was hot and close to Resident #1's forehead, but she did not see or realize that the curling iron had touched his/her forehead and said that Resident #1 did not flinch or say anything while she curled his/her hair. CNA #1 said she was assigned to Resident #1 the following day (01/23/25), said she did not notice any redness or burn mark on his/her forehead, and that if she had seen an area on his/her forehead she would have told the Unit Manager immediately. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said she did not know that she could not bring a curling iron into the Facility to curl a resident's hair and said if she had known she would not have brought the curling iron into work to curl Resident #1's hair. Review of Resident #1's Physician Progress Note, dated 01/24/25, indicated Resident #1 was seen after he/she experienced some kind of burn on his/her forehead and the burn mark had blistering. Review of Resident #1's Physician Orders, dated 01/24/25, indicated to discontinue Vaseline and to apply Silver Sulfadiazine (a topical antibiotic used to treat and/or prevent infection to second and third-degree burns) to forehead twice daily. Review of Resident #1's Nurse Progress Note, dated 01/24/25, (written on the 3:00 P.M. to 11:00 P.M. shift by Nurse #2), indicated that Resident #1 had a burn on his/her upper left forehead with visible redness, and little swelling measuring 2.0 cm by 0.3 cm. Nurse #2 said on 01/24/25 Resident #1's burn to his/her forehead still had redness with some swelling and a small area that was yellow in color. Nurse #2 said that Resident #1 was seen by the Physician earlier that day (01/24/25) and the treatment order to his/her forehead was changed to Silver Sulfadiazine twice a day. During an interview on 02/25/25 at 11:59 A.M., the Physician said he saw Resident #1 on 01/24/25, he/she had sustained a second-degree burn to his/her forehead. The Physician said Resident #1's burn was red with a blister, and said he gave an order to apply Silver Sulfadiazine twice a day. Review of Resident #1's Nurse Practitioner Progress Note, dated 01/27/25, indicated that Resident #1 had a scabbed (dry, crusty layer that forms over a wound) abrasion to his/her forehead (hairline) after he/she was noted to have a burn. During an interview on 02/24/25 at 12:15 P.M., the Nurse Practitioner (NP) said when she saw Resident #1 on 01/27/25, the burn to his/her forehead was pink with a scabbed over appearance and that she gave an order for a wound consult to be done as a second set of eyes. Review of Resident #1's Physician Orders, dated 01/27/25, indicated for nursing to arrange for a wound consult for his/her forehead wound. Review of Resident #1's Initial Wound Evaluation and Management Summary, dated 01/30/25 (written by the Wound Physician), indicated Resident #1 had a burn wound with undetermined thickness to his/her forehead from a curling iron, measuring 1.0 cm in length by 2.0 cm in width, depth was un-measurable due to the presence of dried fibrinous exudate (type of inflammatory fluid that forms in response to tissue injury), and the scabbed area measured 1.70 cm. The Summary indicated that Resident #1's wound was undergoing autolytic debridement (method of wound care that uses the body's own enzymes to remove dead tissue) and to apply Silver Sulfadiazine once daily for 30 days. During an interview on 02/25/25 at 11:33 A.M., the Wound Physician said he saw Resident #1 on 1/30/25 for a burn to his/her forehead which had a scab over it. The Wound Physician said if there is a scab over a wound, he cannot determine the depth or thickness of the wound and said that Resident #1's burn was a second-degree burn because first-degree burns do not scab over. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 02/25/25 at 1:17 P.M., the Director of Nursing (DON) said Resident #1 sustained a second-degree burn to his/her forehead from a curling iron that CNA #1 used to curl his/her hair. The DON said CNA #1 should not have brought in her own personal curling iron into the Facility to curl Resident #1's hair because it was not in her (CNA #1) scope of practice and said that CNA #1 was not a licensed hairdresser. The DON said that CNAs should only be washing residents' hair, towel drying, and brushing and combing their hair. The DON said it is her expectation that all nursing staff abide to the Facility's policy for providing ADLs to residents and not to use electric hair styling devices on residents.