STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Parkridge	28 S Prospect St Ypsilanti, MI 48198

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to notify the physician of a change in condition for 1 of 3 sampled residents (R101) reviewed for physician notification, from a total sample of 3 residents, resulting in R101 having a delay in treatment of a burn and increased risk for pain and infection. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R101 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included diabetes mellitus, cerebral infarct with hemiplegia affecting right dominant side, hypertension (high blood pressure), chronic kidney disease requiring dialysis, heart failure, atrial fibrillation (irregular heart rate), kidney cancer with removal and weakness. The MDS reflected R101 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact, and he required set-up assist with eating, dependent on staff for dressing, toileting, transferring and bed mobility, and maximal assist (helper does more than half the effort) with hygiene and bathing. Review of the Facility Reported Incident (FRI) report, dated 12/18/24, reflected R101 was his own responsible party. Continued review reflected, On the evening on 12/17/24 at approximately 2045[8:45 p.m.] [R101 initials] asked for CNA to warm up a food item for him (cup of noodles). CNA warmed up the item in the microwave for 3-4 minutes per the residents request and then returned the food item to him and set up per resident request while he was in the bed. The resident was allowing the food to cool down when he reached to throw a napkin away in the trash and he accidentally knocked the food over onto himself . Review of R101 Skin Progress Note, dated 12/17/24 at 8:52 p.m., reflected, Resident has NEW skin issue(s) observed. 1 Abdomen - Open skin wound, Right thigh (front) -Burn skin . Review of R101 Nursing Progress Note, dated 12/17/24 at 8:55 p.m., reflected, Resident accidentally poured hot noodle on himself while eating in bed, and got burned-out with hot noodle. First aids provided, and resident was educated to avoid eating hot meals in bed. Review of R101 Care Plan, dated 4/10/24 through current (1/8/25), reflected interventions that included, Dining: Resident is independent. Requests assistance at times. Setup as needed. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R101 Skin Incident Report, dated 12/18/24 at 12:52 p.m. (over 15 hours after incident), reflected nurse description, Resident was eating cup bowl of noodles, in the action of throwing something away, resident mistakenly knocked off meal unto lap which contained hot liquid. The form included resident description, Resident able to verify and tell how he burned himself. The form included, Injuries observed at time of incident including abdomen, groin and right thigh. The incident report reflected the Physician, Director of Nursing, Nursing Home Administrator and family member were notified 12/18/24 at 2:02 p.m.(over 15 hours after burn incident). Review of R101 Interdisciplinary resident screen, dated 12/24/24, reflected R101 preferred to eat meals with plate on lab. Continued review reflected recommend over the lap tray when in bed with scoop plate and bowl with suction cup for safety with feeding self. During an interview on 1/8/25 at 12:50 p.m. Director of Nursing (DON) B and Nursing Home Administrator (NHA) A reported the FRI for R101 was reported to the State of Michigan on 12/18/24 and immediate plan of correction was implemented. NHA A reported Certified Nurse Aid did not check food temperature after heating R101 single serving of noodles prior to giving to R101 on 12/17/24 that caused burns to R101 abdomen, groin and thigh. NHA A reported there was not a thermometer available for staff to use at that time. NHA A reported the risk to residents was immediately removed 12/18/24 and the facility alleged compliance date was 12/26/24. NHA A reported the facility failed to follow facility reheating policy. DON B was unable to say what was expected of staff for immediate burn treatment other than to remove the source and was unsure if facility had policy to address. Review of R101 facility Skin Observation, dated 12/17/24 at 8:52 p.m., reflected new wound that included open skin wound to abdomen and burn to right thigh. Review of R101 Nursing Progress Note, dated 12/18/24 at 11:14 a.m., reflected, Followed up with patient skin incident to lower right abdomen, right thigh and right groin. Abdomen dermis layer of skin off, pink tissue observed, no drainage or bleeding. Right thigh and groin, blister observed, dark areas surround blister sites. Patient report minimum pain. Areas will remain open to air with aloe vera gel applied to them 3x a day. Patient aware of treatment in place. Patient aware of what occurred in incident and able to tell writer what happened. Patient able to handle hot liquids with no barriers. MD notified. Monitoring in place. Review of R101 Wound Care Consult, dated 12/20/24, reflected, Wound Assessment(s) Wound #1 Right Groin is an acute Partial Thickness Burn 2nd Degree .Initial wound encounter measurements are 4cm length x 4 cm width with no measurable depth, with an area of 16 sq cm .The wound margin is undefined Wound bed has no, granulation; no slough, eschar and no epithelialization present .fluid filled intact blister . Wound #2 Abdomen - RLQ [right lower quadrant] is an acute Partial Thickness Burn 2nd Degree . Subsequent wound encounter measurements are 8cm length x 3cm width x 0.1 cm depth, with an area of 24 sq cm and volume of 2.4 cubic cm .There is moderate amount of serous drainage noted which has no odor . The wound margin is undefined Wound bed has 100%, pink, granulation . Wound #3 Right Thigh is an acute Partial Thickness Burn 2nd Degree .Initial wound encounter measurements are 8cm x 6cm with no measurable depth, with an area of 48 sq cm .The wound margin is attached to wound base .fluid filled intact blister . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan .Wound Cleansing Cleanse wound with Normal Saline Treatments Apply Silvadine (on ABD direct) QDay/PRN[every day and/or as needed]-Right groin, abdomen, right thigh .Secondary Dressing . Review of R101 Physician orders, dated 12/18/24 through 12/27/24, reflected, Apply aloe vera gel to lower abdomen, right groin, and right thigh every shift[three times daily] for wound care. Continued review of R101 Physician orders, dated 12/21/24 through 1/6/25, reflected, Apply silver sulfadiazine to abdomen, right thigh and groin and cover with clean dry dressing every evening shift for burn. Review of the Medication Administration Record (MAR), dated 12/1/24 through 12/31/24, reflected R101 received both aloe vera gel treatment three times daily to three burn areas and silver sulfadiazine every day on 12/20/24 and 12/21/24. Review of R101 Nursing Progress Note, dated 12/21/24 at 11:40 p.m., reflected, At approximately (21:30) treatment was completed on resident burn area. Resident called the nurse and requested for the cream wiped off, upon checking the area, a whitish looking like lotion was on the areas of the burn, that did not match the previous ointment applied to the area, upon querying the resident, a cream Dermasil was noted on the bed and open. Resident asked if he had applied the cream and he did not respond and as the writer cleaned up the sites, resident called 911 stating that the cream had entered his blood stream. [Named ambulance service] arrived, report was given to the attendants. Review of R101 Nurse Progress Note, dated 12/22/24, reflected, Wound care in place from ER visit, and to be kept for one week. Review of the Nurse Progress Note, dated 12/30/24, reflected, Resident burn sites cleansed with normal saline, resident refused for silver to be applied to sites. Collagen with silver material placed over sites with clean dry dressing to cover. Patient reported minimum pain during dressing change. Abdomen site pink and slightly moist. R[right] groin pink/red and moist. R thigh white and moist, no sloth, later of epidermis seen. Review of the facility Wound Assessment Details, dated 12/30/24, reflected R101 had a facility acquired thermal heat partial thickness 2nd degree burn to groin area that measured 5 cm length x 5 cm width with no depth with moderate amount serosanguineous drainage. Continued review of the document reflected the wound was 70% bright pink or red and 30% loose slough with 1/10 pain. Continued review of the document included pictures, dated 12/30/24 at 6:44 a.m., that appeared to have depth to wound (not reflected on assessment.) Review of the facility Wound Assessment Details, dated 12/30/24 at 6:43 a.m., reflected R101 had a facility acquired thermal heat partial thickness 1st degree burn to abdomen that measured 8 cm length x 4 cm width with no depth with scant serous drainage. Continued review of the assessment reflected the wound was 100% bright pink or red. Review of the facility Wound Assessment Details, dated 12/30/24 at 6:54 a.m., reflected R101 had a facility acquired thermal heat full thickness 2nd degree burn to right thigh that measured 8 cm length x 8 cm width x 0 depth with light serous drainage. Continued review of the assessment reflected 100% pale pink or red epithelial tissue. Continued review included pictures that appeared to be 80% pale/white area of slough (non-viable tissue). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Burn Clinic Consult note, dated 1/6/25, reflected R101 abdomen burn had healed and thigh and groin wound had some eschar on wounds with no signs of infection. Continued review of the note reflected SSD[silver sulfadiazine] daily to groin and thigh burns and follow up with burn unit in one week. Review of R101 facility Wound Assessment Details, dated 1/8/25, reflected the following: ~Groin burn wound-5 cm x 5 cm x 0 cm with 60% red/pink tissue and 40% slough. Review of picture wound bed appeared to have black eschar(dead skin). ~Abdomen burn-healed. ~Right Thigh burn-7 cm x 7 cm x 0 cm with 50% epithelial and 50% slough. Review of picture wound bed appeared to have about 80% yellow slough. During a telephone interview on 1/8/25 at 1:50 p.m., Licensed Practical Nurse(LPN) C reported worked part time at facility and was not working at time of R101 burn. LPN C reported was educated prior to returning to the floor that microwaves had been removed from floors and if residents request for food to be heated/reheated to use microwave in staff breakroom. LPN C reported staff were educated on Heating/Reheating Policy including to check temperature of food prior to giving to residents. LPN C reported had not received education related to Heat/Reheating food prior to R101 incident including new hire education in November of 2024. LPN C reported did not receive education related to immediate response for burn treatment and was unaware of facility had policy. During a telephone interview on 1/8/25 at 2:12 p.m., Certified Nurse Aid(CNA) D reported was made aware of R101 burn incident about a week after when education was received that microwaves had been removed from the each floor and moved to staff breakroom. CNA D reported educated that if residents request food be heated/reheated staff must check the temperature prior to serving to resident. CNA D reported was unsure what temperature to serve resident food or of what the facility policy was. CNA D reported temperatures should be on each resident chart. CNA D reported was a new hire in November 2024 and did not receive education for heating/reheating food at that time. During a telephone interview on 1/8/25 at 2:34 p.m., CNA E reported was not working at the time of R101 incident. CNA E reported was educated upon returned that microwaves had been removed from floors and relocated to staff breakroom. CNA E reported education included heating/reheating resident food including staff required to temp food after heating and policy was on microwave and thermometer was available. CNA E reported R101's hands are stiff and often spilled food so seemed like common sense not to serve hot food in bed. CNA E reported often worked with R101 and had seen burn wounds and R101 had complained of pain at wound sites. CNA E reported R101 would remind CNA E to be careful of burn areas with care and positioning related to pain. CNA E reported did not receive education related to immediate care for burn. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 3:46 p.m., Registered Nurse (RN) H reported was told by CNA I R101 had spilled noodles on himself 9:00 p.m. during medication pass. RN H reported was unsure when R101 spilled food on self but reported immediately went to R101 room and found R101 laying in bed and R101 told her he had spilled hot noodle in lap. RN H reported R101 did not have cloths on and was covered with sheet with no evidence of wet sheet or noodles on R101 and reported was unsure if CNA I had changed sheets. RN H reported R101 reported burned right thigh and abdomen and completed skin assessment. RN H reported R101 was African American and difficult to see if any red areas. RN H reported patted area with damp washcloth, applied petroleum jelly and ABD dressing, and called Nurse Manager J. RN H reported R101 did not report pain and areas were not open. When asked about Skin assessment completed on 12/17/24 for RN H that indicated open abdominal would, RN H reported she did not recall. RN H reported had not received education from facility about heating/reheating food for residents prior to incident but facility provided after. RN H reported did not Notify Physician, Nursing Home Administrator or Director of Nursing. During a telephone interview on 1/8/25 at 4:19 p.m., Nurse Manager J reported was notified by RN H about R101 burn to right thigh and abdomen on the evening of 12/17/24 after she had gone to bed and was unsure of time. Nurse Manager J reported RN H applied normal saline and first aid at the time of the burn. When asked how she knew what RN H did for first aid, Nurse Manager J reported she did not tell her what to do but nurses are trained to clean with normal saline and perform first aid. Nurse Manager J reported observed R101 burn area 12/18/24 with blister noted to right thigh and groin and open skin to abdomen. Nurse Manager J reported would expect staff to perform first aid, contact physician, manager, and Director of Nursing and document in progress notes. Nurse Manager J reported received education 12/18/24 about facility reheating policy and had not received prior. During an observation and interview on 1/8/25 at 5:00 p.m., R101 was laying in bed and appeared able to answer questions without difficulty. R101 reported had burned self with hot noodle soup few weeks prior. R101 reported had own personal single cups of noodle soup and asked CNA I to heat up. R101 reported CNA I brought back to him and placed on hand held mirror in between legs in the bed. R101 reported was too hot so was letting cool down when he accidentally spilled and burned right inner thigh and abdomen area and groin area. R101 reported fortunately groin area was mostly protected by brief because that is a sensitive area. R101 reported he yelled out because it hurt when the soup spilled and used call light to alert staff and reported 10/10 pain on pain scale at time. R101 reported he immediately removed covers but had already burned skin and CNA I answered call light within about two minutes. R101 reported told CNA I what happened she notified RN H who looked at area and covered with dressings. R101 reported at no time did anyone place normal saline or cool cloths on areas. R101 reported no one else looked at burned areas until the next day. R101 reported he told CNA and nurses he had pain and stated, of course that hurt, it is a sensitive area. I told everyone that came in to look at area it hurt. R101 skin tone is black with area on abdomen that appeared scared and healed about 8cm x 4 cm of pink skin. R101 reported on 12/21/24 staff were arguing who was going to complete treatments and R101 lost trust facility was caring for areas appropriately and call 911 and was taken to university burn unit who placed dressing to remain in place for one week. R101 reported facility staff then provided routine treatment after that and followed up with burn unit yesterday with improvements. During an observation on 1/8/25 at 5:20 p.m., observed two microwave in locked first floor breakroom. The facility Heating and Reheating Guidelines were located on the front of one microwave with thermometer and alcohol swabs in area. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/9/25 at 9:50 a.m., R101 denied any concerns and reported planned to leave for dialysis soon. R101 reported staff had provided him with small tray with perimeter that appeared about 12 by 8 inches to use in lap if needed. R101 reported did not like to use bedside table related to mobility. During an observation on 1/9/25 at 10:10 a.m., the third floor pantry had sign on it to keep door locked. This surveyor opened unlocked door and verified no microwave was in pantry. During an interview on 1/9/25 at 10:15 a.m., Licensed Practical Nurse (LPN) L was asked to sign a form after R101 burn incident but was not familiar with R101. LPN L reported was told if heating/reheating resident food to do so in 1st floor breakroom, and not to serve too hot. When queried what was too hot, LPN L reported was unsure and stated, maybe use glove and touch. LPN L reported or lifted temporal thermometer off medication cart and stated, not sure if I should check with this. LPN L reported was unsure of facility policy and where to locate. Review with the facility in-service and, Reheating Foods and Liquids in the Microwave, on 1/9/25 at 10:54 a.m., reflected LPN L met requirements for reheating food/liquids on 12/20/24. Continued review of the FRI investigation reflected Quality Assurance and Performance Improvement (QAPI) past non-compliance sign in dated 12/24/24, did not included the Nursing Home Administrator (NHA) A, Director of Nursing (DON) B or the Medical Director signature. During a telephone interview on 1/9/25 at 11:12 a.m., CNA I reported had worked at the facility for over one year and was present at time of R101 burn incident on 12/17/24. CNA I reported R101 asked her to heat R101's personal single serving cup of [NAME] noodles for 4 minutes in the microwave. CNA I reported R101 requested staff to assist heat meals almost every night. CNA I reported after heating she placed towel on resident lab while laying in bed, with hand held mirror under towel as flat surface, and place cup of hot noodles on surface between R101 legs. CNA I reported R101 turned on light about 45 minutes to one hour later and told her he had spilt noodles on himself and thinks it caused burn. CNA I reported removed wet towel with few noodles on it and threw away empty cup of noodles. reported thinks he burn self. CNA I reported R101 did have open skin on abdomen R101 was pulling back skin. CNA I reported difficult to see if skin discolored because it was so ashy and dry. CNA I reported R101 appeared calm at the time and did not recall complaints of pain. CNA I reported sheet was wet that was on top of R101 and she changed sheet and R101 had brief on. CNA I reported she then exited R101 room and notified RN H what had happened and RN H went to R101. CNA I reported R101 told RN I what had happened, RN I looked at skin and R101 asked for bandaid and RN I told her it needed to dry out with no immediate fist aid observed, including cool compress. CNA I reported had not received prior education at facility for heating/reheating food and received education after R101 burn incident related to heating only not first aid for burns. CNA I reported shift ended on 12/17/24 at 11:00 p.m. and was unable to recall who shift report was given to and reported did not tell oncoming staff about R101 burn incident. CNA I reported did not provide any additional care for R101 on 12/17/24 between 9:00 p.m. and 11:00 p.m. Review of CNA I unsigned witness statement, dated 12/18/24, reflected CNA I saw noodles and liquid on floor when first entering R101 room when R101 reported had spilled soup on himself. CNA I reported management called her 12/18/24 on telephone for statement and did not say noodles and liquid were on the floor and had not seen statements. During an observation on 1/9/25 at 12:15 p.m., during meal service CNA filled coffee cup from insulated drink dispenser in 200 hall took to room [ROOM NUMBER] with no cover. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/9/25 at 12:17 p.m. the 300 pantry had sign posted on door keep door closed. Paper towel was stuffed in door lock to prevent door from locking. This surveyor opened door to pantry and verified no microwave in pantry and no call light. During an interview on 1/9/25 at 12:43 p.m., CNA M reported after resident was burned facility removed microwaves from all of the resident floors. If residents request to have food heated or reheated microwave is located in staff breakroom on first floor. CNA M reported staff should not serve residents food that is too hot. When ask what too hot meant CNA M was unable to answer and reported was unsure what facility policy was. During an interview on 1/9/25 at 1:04 p.m., Assistant Director of Nursing (ADON) O reported had been in position over two years. ADON O reported first heard about R101 burn from 12/17/24 on 12/18/24 at morning meeting after reviewing skin assessment completed by RN H. ADON O was queried what was first aid included for burn and ADON O reported first aid should included cool down area with cool water and non adhesive dressing. ADON O reported would expect staff to provided immediate first aid, notify nurse, who would notify physician, responsible party, DON, NHA for all events including burns and document at time of the event. ADON O reported complete R101 pain and skin assessment 12/18/24 and was first to contact R101 physician on 12/18/24. ADON O reported would not expect petroleum jelly to be used for acute burn treatment. During an interview on 1/9/25 at 2:19 p.m., Wound Nurse (WN) P reported had been in position for two years. WN P reported was notified of R101 burn wound on 12/18/24 and observed two blistered areas to right thigh and right groin and pink open skin to abdomen. WN P reported called R101 physician who ordered aloe vera jell from plant they got from local grocery store daily and not to cover unless out to dialysis. WN P reported would not expect staff to apply petroleum jelly to acute burn. WN P reported completed R101 skin incident/accident report on 12/18/24 that should have been completed at the time of the incident on 12/17/24. WN P reported prior to observing R101 on 12/18/24 had removed foam dressing from right thigh, groin and abdomen. WN P reported staff should have immediately cooled site by adding cool water. WN P would expect staff to immediately cool down burn site, while also notifying nurse, physician, DON and NHA because immediate change of condition. WN I reported R101 had orders for aloe vera three times daily from 12/18/24 until silvadene cream arrived that was ordered 12/20/24 and verified MAR reflected R101 received both between 12/20/24 and 12/21/24 until sent to emergency room . WN P verified R101 had dressing placed at hospital on 12/22/24 that remained in place for 7 days. WN P verified staff had documented R101 was provided dressing changes between 12/22/24 and 12/28/24, however, reported the MAR was not correct because R101 would not allow staff to remove dressing for the ordered 7 days. During an interview on 1/9/25 at 3:31 p.m., DON B and NHA A reported were first notified of R101 burn incident on 12/18/24 at morning meeting by ADON O. NHA A reported would have expected staff to notify them immediately of R101 burn. DON B reported would expect CNA to notify nurse immediately, who would assess, notify physician, DON, NHA and state of Michigan if needed. During an interview on 1/9/25 at 4:45 p.m. DON B reported facility had no evidence of prior education provided to staff for heating/reheating resident food before R101 incident. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review the facility failed to provide the necessary care and services to maintain the highest practical physical level of well being (adequate care after a burn) in 1 of 3 sampled residents (R101) reviewed for accidents, resulting in second degree burns to R101 after spilling hot soup in his lap. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R101 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included diabetes mellitus, cerebral infarct with hemiplegia affecting right dominant side, hypertension (high blood pressure), chronic kidney disease requiring dialysis, heart failure, atrial fibrillation (irregular heart rate), kidney cancer with removal and weakness. The MDS reflected R101 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact, and he required set-up assist with eating, dependent on staff for dressing, toileting, transferring and bed mobility, and maximal assist (helper does more than half the effort) with hygiene and bathing. Review of the Facility Reported Incident (FRI) report, dated 12/18/24, reflected R101 was his own responsible party. Continued review reflected, On the evening on 12/17/24 at approximately 2045[8:45 p.m.] [R101 initials] asked for CNA to warm up a food item for him (cup of noodles). CNA warmed up the item in the microwave for 3-4 minutes per the residents request and then returned the food item to him and set up per resident request while he was in the bed. The resident was allowing the food to cool down when he reached to throw a napkin away in the trash and he accidentally knocked the food over onto himself . Review of R101 Skin Progress Note, dated 12/17/24 at 8:52 p.m., reflected, Resident has NEW skin issue(s) observed. 1 Abdomen - Open skin wound, Right thigh (front) -Burn skin . Review of R101 Nursing Progress Note, dated 12/17/24 at 8:55 p.m., reflected, Resident accidentally poured hot noodle on himself while eating in bed, and got burned-out with hot noodle. First aids provided, and resident was educated to avoid eating hot meals in bed. Review of R101 Care Plan, dated 4/10/24 through current (1/8/25), reflected interventions that included, Dining: Resident is independent. Requests assistance at times. Setup as needed. Review of R101 Skin Incident Report, dated 12/18/24 at 12:52 p.m. (over 15 hours after incident), reflected nurse description, Resident was eating cup bowl of noodles, in the action of throwing something away, resident mistakenly knocked off meal unto lap which contained hot liquid. The form included resident description, Resident able to verify and tell how he burned himself. The form included, Injuries observed at time of incident including abdomen, groin and right thigh. The incident report reflected the Physician, Director of Nursing, Nursing Home Administrator and family member were notified 12/18/24 at 2:02 p.m.(over 15 hours after burn incident). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R101 Interdisciplinary resident screen, dated 12/24/24, reflected R101 preferred to eat meals with plate on lab. Continued review reflected recommend over the lap tray when in bed with scoop plate and bowl with suction cup for safety with feeding self. During an interview on 1/8/25 at 12:50 p.m. Director of Nursing (DON) B and Nursing Home Administrator (NHA) A reported the FRI for R101 was reported to the State of Michigan on 12/18/24 and immediate plan of correction was implemented. NHA A reported Certified Nurse Aid did not check food temperature after heating R101 single serving of noodles prior to giving to R101 on 12/17/24 that caused burns to R101 abdomen, groin and thigh. NHA A reported there was not a thermometer available for staff to use at that time. NHA A reported the risk to residents was immediately removed 12/18/24 and the facility alleged compliance date was 12/26/24. NHA A reported the facility failed to follow facility reheating policy. DON B was unable to say what was expected of staff for immediate burn treatment other than to remove the source and was unsure if facility had policy to address. Review of R101 facility Skin Observation, dated 12/17/24 at 8:52 p.m., reflected new wound that included open skin wound to abdomen and burn to right thigh. Review of R101 Nursing Progress Note, dated 12/18/24 at 11:14 a.m., reflected, Followed up with patient skin incident to lower right abdomen, right thigh and right groin. Abdomen dermis layer of skin off, pink tissue observed, no drainage or bleeding. Right thigh and groin, blister observed, dark areas surround blister sites. Patient report minimum pain. Areas will remain open to air with aloe vera gel applied to them 3x a day. Patient aware of treatment in place. Patient aware of what occurred in incident and able to tell writer what happened. Patient able to handle hot liquids with no barriers. MD notified. Monitoring in place. Review of R101 Wound Care Consult, dated 12/20/24, reflected, Wound Assessment(s) Wound #1 Right Groin is an acute Partial Thickness Burn 2nd Degree .Initial wound encounter measurements are 4cm length x 4 cm width with no measurable depth, with an area of 16 sq cm .The wound margin is undefined Wound bed has no, granulation; no slough, eschar and no epithelialization present .fluid filled intact blister . Wound #2 Abdomen - RLQ [right lower quadrant] is an acute Partial Thickness Burn 2nd Degree . Subsequent wound encounter measurements are 8cm length x 3cm width x 0.1 cm depth, with an area of 24 sq cm and volume of 2.4 cubic cm .There is moderate amount of serous drainage noted which has no odor . The wound margin is undefined Wound bed has 100%, pink, granulation . Wound #3 Right Thigh is an acute Partial Thickness Burn 2nd Degree .Initial wound encounter measurements are 8cm x 6cm with no measurable depth, with an area of 48 sq cm .The wound margin is attached to wound base .fluid filled intact blister . Plan .Wound Cleansing Cleanse wound with Normal Saline Treatments Apply Silvadine (on ABD direct) QDay/PRN[every day and/or as needed]-Right groin, abdomen, right thigh .Secondary Dressing . Review of R101 Physician orders, dated 12/18/24 through 12/27/24, reflected, Apply aloe vera gel to lower abdomen, right groin, and right thigh every shift[three times daily] for wound care. Continued review of R101 Physician orders, dated 12/21/24 through 1/6/25, reflected, Apply silver sulfadiazine to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abdomen, right thigh and groin and cover with clean dry dressing every evening shift for burn. Review of the Medication Administration Record (MAR), dated 12/1/24 through 12/31/24, reflected R101 received both aloe vera gel treatment three times daily to three burn areas and silver sulfadiazine every day on 12/20/24 and 12/21/24. Review of R101 Nursing Progress Note, dated 12/21/24 at 11:40 p.m., reflected, At approximately (21:30) treatment was completed on resident burn area. Resident called the nurse and requested for the cream wiped off, upon checking the area, a whitish looking like lotion was on the areas of the burn, that did not match the previous ointment applied to the area, upon querying the resident, a cream Dermasil was noted on the bed and open. Resident asked if he had applied the cream and he did not respond and as the writer cleaned up the sites, resident called 911 stating that the cream had entered his blood stream. [Named ambulance service] arrived, report was given to the attendants. Review of R101 Nurse Progress Note, dated 12/22/24, reflected, Wound care in place from ER visit, and to be kept for one week. Review of the Nurse Progress Note, dated 12/30/24, reflected, Resident burn sites cleansed with normal saline, resident refused for silver to be applied to sites. Collagen with silver material placed over sites with clean dry dressing to cover. Patient reported minimum pain during dressing change. Abdomen site pink and slightly moist. R[right] groin pink/red and moist. R thigh white and moist, no sloth, later of epidermis seen. Review of the facility Wound Assessment Details, dated 12/30/24, reflected R101 had a facility acquired thermal heat partial thickness 2nd degree burn to groin area that measured 5 cm length x 5 cm width with no depth with moderate amount serosanguineous drainage. Continued review of the document reflected the wound was 70% bright pink or red and 30% loose slough with 1/10 pain. Continued review of the document included pictures, dated 12/30/24 at 6:44 a.m., that appeared to have depth to wound (not reflected on assessment.) Review of the facility Wound Assessment Details, dated 12/30/24 at 6:43 a.m., reflected R101 had a facility acquired thermal heat partial thickness 1st degree burn to abdomen that measured 8 cm length x 4 cm width with no depth with scant serous drainage. Continued review of the assessment reflected the wound was 100% bright pink or red. Review of the facility Wound Assessment Details, dated 12/30/24 at 6:54 a.m., reflected R101 had a facility acquired thermal heat full thickness 2nd degree burn to right thigh that measured 8 cm length x 8 cm width x 0 depth with light serous drainage. Continued review of the assessment reflected 100% pale pink or red epithelial tissue. Continued review included pictures that appeared to be 80% pale/white area of slough (non-viable tissue). Review of the Burn Clinic Consult note, dated 1/6/25, reflected R101 abdomen burn had healed and thigh and groin wound had some eschar on wounds with no signs of infection. Continued review of the note reflected SSD[silver sulfadiazine] daily to groin and thigh burns and follow up with burn unit in one week. Review of R101 facility Wound Assessment Details, dated 1/8/25, reflected the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~Groin burn wound-5 cm x 5 cm x 0 cm with 60% red/pink tissue and 40% slough. Review of picture wound bed appeared to have black eschar(dead skin). ~Abdomen burn-healed. ~Right Thigh burn-7 cm x 7 cm x 0 cm with 50% epithelial and 50% slough. Review of picture wound bed appeared to have about 80% yellow slough. During a telephone interview on 1/8/25 at 1:50 p.m., Licensed Practical Nurse(LPN) C reported worked part time at facility and was not working at time of R101 burn. LPN C reported was educated prior to returning to the floor that microwaves had been removed from floors and if residents request for food to be heated/reheated to use microwave in staff breakroom. LPN C reported staff were educated on Heating/Reheating Policy including to check temperature of food prior to giving to residents. LPN C reported had not received education related to Heat/Reheating food prior to R101 incident including new hire education in November of 2024. LPN C reported did not receive education related to immediate response for burn treatment and was unaware of facility had policy. During a telephone interview on 1/8/25 at 2:12 p.m., Certified Nurse Aid(CNA) D reported was made aware of R101 burn incident about a week after when education was received that microwaves had been removed from the each floor and moved to staff breakroom. CNA D reported educated that if residents request food be heated/reheated staff must check the temperature prior to serving to resident. CNA D reported was unsure what temperature to serve resident food or of what the facility policy was. CNA D reported temperatures should be on each resident chart. CNA D reported was a new hire in November 2024 and did not receive education for heating/reheating food at that time. During a telephone interview on 1/8/25 at 2:34 p.m., CNA E reported was not working at the time of R101 incident. CNA E reported was educated upon returned that microwaves had been removed from floors and relocated to staff breakroom. CNA E reported education included heating/reheating resident food including staff required to temp food after heating and policy was on microwave and thermometer was available. CNA E reported R101's hands are stiff and often spilled food so seemed like common sense not to serve hot food in bed. CNA E reported often worked with R101 and had seen burn wounds and R101 had complained of pain at wound sites. CNA E reported R101 would remind CNA E to be careful of burn areas with care and positioning related to pain. CNA E reported did not receive education related to immediate care for burn. During an interview on 1/8/25 at 3:46 p.m., Registered Nurse (RN) H reported was told by CNA I R101 had spilled noodles on himself 9:00 p.m. during medication pass. RN H reported was unsure when R101 spilled food on self but reported immediately went to R101 room and found R101 laying in bed and R101 told her he had spilled hot noodle in lap. RN H reported R101 did not have cloths on and was covered with sheet with no evidence of wet sheet or noodles on R101 and reported was unsure if CNA I had changed sheets. RN H reported R101 reported burned right thigh and abdomen and completed skin assessment. RN H reported R101 was African American and difficult to see if any red areas. RN H reported patted area with damp washcloth, applied petroleum jelly and ABD dressing, and called Nurse Manager J. RN H reported R101 did not report pain and areas were not open. When asked about Skin assessment completed on 12/17/24 for RN H that indicated open abdominal would, RN H reported she did not recall. RN H reported had not received education from facility about heating/reheating food for residents prior to incident but facility provided after. RN H reported did not Notify Physician, Nursing Home Administrator or Director of Nursing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/8/25 at 4:19 p.m., Nurse Manager J reported was notified by RN H about R101 burn to right thigh and abdomen on the evening of 12/17/24 after she had gone to bed and was unsure of time. Nurse Manager J reported RN H applied normal saline and first aid at the time of the burn. When asked how she knew what RN H did for first aid, Nurse Manager J reported she did not tell her what to do but nurses are trained to clean with normal saline and perform first aid. Nurse Manager J reported observed R101 burn area 12/18/24 with blister noted to right thigh and groin and open skin to abdomen. Nurse Manager J reported would expect staff to perform first aid, contact physician, manager, and Director of Nursing and document in progress notes. Nurse Manager J reported received education 12/18/24 about facility reheating policy and had not received prior. During an observation and interview on 1/8/25 at 5:00 p.m., R101 was laying in bed and appeared able to answer questions without difficulty. R101 reported had burned self with hot noodle soup few weeks prior. R101 reported had own personal single cups of noodle soup and asked CNA I to heat up. R101 reported CNA I brought back to him and placed on hand held mirror in between legs in the bed. R101 reported was too hot so was letting cool down when he accidentally spilled and burned right inner thigh and abdomen area and groin area. R101 reported fortunately groin area was mostly protected by brief because that is a sensitive area. R101 reported he yelled out because it hurt when the soup spilled and used call light to alert staff and reported 10/10 pain on pain scale at time. R101 reported he immediately removed covers but had already burned skin and CNA I answered call light within about two minutes. R101 reported told CNA I what happened she notified RN H who looked at area and covered with dressings. R101 reported at no time did anyone place normal saline or cool cloths on areas. R101 reported no one else looked at burned areas until the next day. R101 reported he told CNA and nurses he had pain and stated, of course that hurt, it is a sensitive area. I told everyone that came in to look at area it hurt. R101 skin tone is black with area on abdomen that appeared scared and healed about 8cm x 4 cm of pink skin. R101 reported on 12/21/24 staff were arguing who was going to complete treatments and R101 lost trust facility was caring for areas appropriately and call 911 and was taken to university burn unit who placed dressing to remain in place for one week. R101 reported facility staff then provided routine treatment after that and followed up with burn unit yesterday with improvements. During an observation on 1/8/25 at 5:20 p.m., observed two microwave in locked first floor breakroom. The facility Heating and Reheating Guidelines were located on the front of one microwave with thermometer and alcohol swabs in area. During an observation and interview on 1/9/25 at 9:50 a.m., R101 denied any concerns and reported planned to leave for dialysis soon. R101 reported staff had provided him with small tray with perimeter that appeared about 12 by 8 inches to use in lap if needed. R101 reported did not like to use bedside table related to mobility. During an observation on 1/9/25 at 10:10 a.m., the third floor pantry had sign on it to keep door locked. This surveyor opened unlocked door and verified no microwave was in pantry. During an interview on 1/9/25 at 10:15 a.m., Licensed Practical Nurse (LPN) L was asked to sign a form after R101 burn incident but was not familiar with R101. LPN L reported was told if heating/reheating resident food to do so in 1st floor breakroom, and not to serve too hot. When queried what was too hot, LPN L reported was unsure and stated, maybe use glove and touch. LPN L reported or lifted temporal thermometer off medication cart and stated, not sure if I should check with this. LPN L reported was unsure of facility policy and where to locate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review with the facility in-service and, Reheating Foods and Liquids in the Microwave, on 1/9/25 at 10:54 a. m., reflected LPN L met requirements for reheating food/liquids on 12/20/24. Continued review of the FRI investigation reflected Quality Assurance and Performance Improvement (QAPI) past non-compliance sign in dated 12/24/24, did not included the Nursing Home Administrator (NHA) A, Director of Nursing (DON) B or the Medical Director signature. During a telephone interview on 1/9/25 at 11:12 a.m., CNA I reported had worked at the facility for over one year and was present at time of R101 burn incident on 12/17/24. CNA I reported R101 asked her to heat R101's personal single serving cup of [NAME] noodles for 4 minutes in the microwave. CNA I reported R101 requested staff to assist heat meals almost every night. CNA I reported after heating she placed towel on resident lab while laying in bed, with hand held mirror under towel as flat surface, and place cup of hot noodles on surface between R101 legs. CNA I reported R101 turned on light about 45 minutes to one hour later and told her he had spilt noodles on himself and thinks it caused burn. CNA I reported removed wet towel with few noodles on it and threw away empty cup of noodles. reported thinks he burn self. CNA I reported R101 did have open skin on abdomen R101 was pulling back skin. CNA I reported difficult to see if skin discolored because it was so ashy and dry. CNA I reported R101 appeared calm at the time and did not recall complaints of pain. CNA I reported sheet was wet that was on top of R101 and she changed sheet and R101 had brief on. CNA I reported she then exited R101 room and notified RN H what had happened and RN H went to R101. CNA I reported R101 told RN I what had happened, RN I looked at skin and R101 asked for bandaid and RN I told her it needed to dry out with no immediate fist aid observed, including cool compress. CNA I reported had not received prior education at facility for heating/reheating food and received education after R101 burn incident related to heating only not first aid for burns. CNA I reported shift ended on 12/17/24 at 11:00 p.m. and was unable to recall who shift report was given to and reported did not tell oncoming staff about R101 burn incident. CNA I reported did not provide any additional care for R101 on 12/17/24 between 9:00 p.m. and 11:00 p.m. Review of CNA I unsigned witness statement, dated 12/18/24, reflected CNA I saw noodles and liquid on floor when first entering R101 room when R101 reported had spilled soup on himself. CNA I reported management called her 12/18/24 on telephone for statement and did not say noodles and liquid were on the floor and had not seen statements. During an observation on 1/9/25 at 12:15 p.m., during meal service CNA filled coffee cup from insulated drink dispenser in 200 hall took to room [ROOM NUMBER] with no cover. During an observation on 1/9/25 at 12:17 p.m. the 300 pantry had sign posted on door keep door closed. Paper towel was stuffed in door lock to prevent door from locking. This surveyor opened door to pantry and verified no microwave in pantry and no call light. During an interview on 1/9/25 at 12:43 p.m., CNA M reported after resident was burned facility removed microwaves from all of the resident floors. If residents request to have food heated or reheated microwave is located in staff breakroom on first floor. CNA M reported staff should not serve residents food that is too hot. When ask what too hot meant CNA M was unable to answer and reported was unsure what facility policy was. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 1:04 p.m., Assistant Director of Nursing (ADON) O reported had been in position over two years. ADON O reported first heard about R101 burn from 12/17/24 on 12/18/24 at morning meeting after reviewing skin assessment completed by RN H. ADON O was queried what was first aid included for burn and ADON O reported first aid should included cool down area with cool water and non adhesive dressing. ADON O reported would expect staff to provided immediate first aid, notify nurse, who would notify physician, responsible party, DON, NHA for all events including burns and document at time of the event. ADON O reported complete R101 pain and skin assessment 12/18/24 and was first to contact R101 physician on 12/18/24. ADON O reported would not expect petroleum jelly to be used for acute burn treatment. During an interview on 1/9/25 at 2:19 p.m., Wound Nurse (WN) P reported had been in position for two years. WN P reported was notified of R101 burn wound on 12/18/24 and observed two blistered areas to right thigh and right groin and pink open skin to abdomen. WN P reported called R101 physician who ordered aloe vera jell from plant they got from local grocery store daily and not to cover unless out to dialysis. WN P reported would not expect staff to apply petroleum jelly to acute burn. WN P reported completed R101 skin incident/accident report on 12/18/24 that should have been completed at the time of the incident on 12/17/24. WN P reported prior to observing R101 on 12/18/24 had removed foam dressing from right thigh, groin and abdomen. WN P reported staff should have immediately cooled site by adding cool water. WN P would expect staff to immediately cool down burn site, while also notifying nurse, physician, DON and NHA because immediate change of condition. WN I reported R101 had orders for aloe vera three times daily from 12/18/24 until silvadene cream arrived that was ordered 12/20/24 and verified MAR reflected R101 received both between 12/20/24 and 12/21/24 until sent to emergency room . WN P verified R101 had dressing placed at hospital on 12/22/24 that remained in place for 7 days. WN P verified staff had documented R101 was provided dressing changes between 12/22/24 and 12/28/24, however, reported the MAR was not correct because R101 would not allow staff to remove dressing for the ordered 7 days. During an interview on 1/9/25 at 3:31 p.m., DON B and NHA A reported were first notified of R101 burn incident on 12/18/24 at morning meeting by ADON O. NHA A reported would have expected staff to notify them immediately of R101 burn. DON B reported would expect CNA to notify nurse immediately, who would assess, notify physician, DON, NHA and state of Michigan if needed. During an interview on 1/9/25 at 4:45 p.m. DON B reported facility had no evidence of prior education provided to staff for heating/reheating resident food before R101 incident. Review of the facility, Heating and Reheating Guidelines, dated 2/20/24, reflected, Purpose: The facility will ensure that resident personal food is handled in a safe and sanitary manner to prevent cross contamination and to minimize the risk of food borne illness. The facility will follow any manufactures instructions when preparing food .Guideline 1. Only trained facility staff are authorized to hear and reheat food for residents. 2. Items being heated reheated will be checked for use-be-date .3. Packaged foods will be heated and reheated to microwave following package instructions 4. For reheating precooked food items, microwave to internal temperature of 165 degrees for 15 seconds. 5. Allow heated and reheated food to sit for 2 minutes or according to the manufactures instructions prior to serving to the resident . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility, Accidents Policy, dated 6/29/21, reflected, Accidents refers to any unexpected or unintentional incident, which results or may result in injury of illness to a resident .Avoidable Accident means that an accident occurred because the facility failed to: Identify environmental hazards and/or assess individual resident risk of an accident , including the need to supervision and/or assistive devices. Evaluate/analyze the hazards ad risks and eliminate them, if possible, identify and implement measures to reduce the hazards/risks as much as possible. Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and , if not reduce the risk of an accident . Review of the State of (State Name) Department of Community Health Alert, titled, Scalding Injuries Caused by Excessive Hot Water: Food and Hot Beverage Temperatures, Revised August 5, 2008, revealed, Background: In all age groups, tap water scald injuries have been cited as the second most cause of serious burns. A scald is a burn caused by spills, immersion, splash, or contact with hot water, food and beverages, or steam. The elderly are particularly at increased risk because their skin tends to be less sensitive and reaction times are reduced, causing a tendency to not pull away from hot water quickly enough to avoid scalding. Their thinner skin also burns full depth (through the skin layers and into tissue) more quickly . Although Federal and State agencies do not specify temperatures appropriate to the consumption of hot beverages, facilities should be aware of the risk for harm to a resident from contact or consumption of hot beverages.Scalds can commonly occur from hot food, beverages, or steam . The estimated time for a person to receive second-degree burns was noted as follows: 120 degrees. Time to receive second-degree burn: 8 minutes. 124 degrees. Time to receive second-degree burn: 2 minutes. 131 degrees. Time to receive second-degree burn: 17 seconds 140 degrees. Time to receive second-degree burn: 3 seconds. 150 degrees. Time to receive second-degree burn: Less than one second.

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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** 34705 Based on observation, interview and record review, the facility failed to ensure hot liquid/food was served at a safe and appropriate temperature for one (Resident #101) of three reviewed for accident hazards, resulting in second-degree thermal burn (damage to outer and second layer of skin, causing blisters, pain and discoloration) on R101 abdomen, groin and right inner thigh, open wounds and increased risk for infection. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R101 was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included diabetes mellitus, cerebral infarct with hemiplegia affecting right dominant side, hypertension (high blood pressure), chronic kidney disease requiring dialysis, heart failure, atrial fibrillation (irregular heart rate), kidney cancer with removal and weakness. The MDS reflected R101 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact, and he required set-up assist with eating, dependent on staff for dressing, toileting, transferring and bed mobility, and maximal assist (helper does more than half the effort) with hygiene and bathing. Review of the Facility Reported Incident (FRI) report, dated 12/18/24, reflected R101 was his own responsible party. Continued review reflected, On the evening on 12/17/24 at approximately 2045[8:45 p.m.] [R101 initials] asked for CNA to warm up a food item for him (cup of noodles). CNA warmed up the item in the microwave for 3-4 minutes per the residents request and then returned the food item to him and set up per resident request while he was in the bed. The resident was allowing the food to cool down when he reached to throw a napkin away in the trash and he accidentally knocked the food over onto himself . Review of R101 Skin Progress Note, dated 12/17/24 at 8:52 p.m., reflected, Resident has NEW skin issue(s) observed. 1 Abdomen - Open skin wound, Right thigh (front) -Burn skin . Review of R101 Nursing Progress Note, dated 12/17/24 at 8:55 p.m., reflected, Resident accidentally poured hot noodle on himself while eating in bed, and got burned-out with hot noodle. First aids provided, and resident was educated to avoid eating hot meals in bed. Review of R101 Care Plan, dated 4/10/24 through current (1/8/25), reflected interventions that included, Dining: Resident is independent. Requests assistance at times. Setup as needed. Review of R101 Skin Incident Report, dated 12/18/24 at 12:52 p.m. (over 15 hours after incident), reflected nurse description, Resident was eating cup bowl of noodles, in the action of throwing something away, resident mistakenly knocked off meal unto lap which contained hot liquid. The form included resident description, Resident able to verify and tell how he burned himself. The form included, Injuries observed at time of incident including abdomen, groin and right thigh. The incident report reflected the Physician, Director of Nursing, Nursing Home Administrator and family member were notified 12/18/24 at 2:02 p.m.(over 15 hours after burn incident). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R101 Interdisciplinary resident screen, dated 12/24/24, reflected R101 preferred to eat meals with plate on lab. Continued review reflected recommend over the lap tray when in bed with scoop plate and bowl with suction cup for safety with feeding self. During an interview on 1/8/25 at 12:50 p.m. Director of Nursing (DON) B and Nursing Home Administrator (NHA) A reported the FRI for R101 was reported to the State of Michigan on 12/18/24 and immediate plan of correction was implemented. NHA A reported Certified Nurse Aid did not check food temperature after heating R101 single serving of noodles prior to giving to R101 on 12/17/24 that caused burns to R101 abdomen, groin and thigh. NHA A reported there was not a thermometer available for staff to use at that time. NHA A reported the risk to residents was immediately removed 12/18/24 and the facility alleged compliance date was 12/26/24. NHA A reported the facility failed to follow facility reheating policy. DON B was unable to say what was expected of staff for immediate burn treatment other than to remove the source and was unsure if facility had policy to address. Review of R101 facility Skin Observation, dated 12/17/24 at 8:52 p.m., reflected new wound that included open skin wound to abdomen and burn to right thigh. Review of R101 Nursing Progress Note, dated 12/18/24 at 11:14 a.m., reflected, Followed up with patient skin incident to lower right abdomen, right thigh and right groin. Abdomen dermis layer of skin off, pink tissue observed, no drainage or bleeding. Right thigh and groin, blister observed, dark areas surround blister sites. Patient report minimum pain. Areas will remain open to air with aloe vera gel applied to them 3x a day. Patient aware of treatment in place. Patient aware of what occurred in incident and able to tell writer what happened. Patient able to handle hot liquids with no barriers. MD notified. Monitoring in place. Review of R101 Wound Care Consult, dated 12/20/24, reflected, Wound Assessment(s) Wound #1 Right Groin is an acute Partial Thickness Burn 2nd Degree .Initial wound encounter measurements are 4cm length x 4 cm width with no measurable depth, with an area of 16 sq cm .The wound margin is undefined Wound bed has no, granulation; no slough, eschar and no epithelialization present .fluid filled intact blister . Wound #2 Abdomen - RLQ [right lower quadrant] is an acute Partial Thickness Burn 2nd Degree . Subsequent wound encounter measurements are 8cm length x 3cm width x 0.1 cm depth, with an area of 24 sq cm and volume of 2.4 cubic cm .There is moderate amount of serous drainage noted which has no odor . The wound margin is undefined Wound bed has 100%, pink, granulation . Wound #3 Right Thigh is an acute Partial Thickness Burn 2nd Degree .Initial wound encounter measurements are 8cm x 6cm with no measurable depth, with an area of 48 sq cm .The wound margin is attached to wound base .fluid filled intact blister . Plan .Wound Cleansing Cleanse wound with Normal Saline Treatments Apply Silvadine (on ABD direct) QDay/PRN[every day and/or as needed]-Right groin, abdomen, right thigh .Secondary Dressing . Review of R101 Physician orders, dated 12/18/24 through 12/27/24, reflected, Apply aloe vera gel to lower abdomen, right groin, and right thigh every shift[three times daily] for wound care. Continued review of R101 Physician orders, dated 12/21/24 through 1/6/25, reflected, Apply silver sulfadiazine to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	abdomen, right thigh and groin and cover with clean dry dressing every evening shift for burn. Review of the Medication Administration Record (MAR), dated 12/1/24 through 12/31/24, reflected R101 received both aloe vera gel treatment three times daily to three burn areas and silver sulfadiazine every day on 12/20/24 and 12/21/24. Review of R101 Nursing Progress Note, dated 12/21/24 at 11:40 p.m., reflected, At approximately (21:30) treatment was completed on resident burn area. Resident called the nurse and requested for the cream wiped off, upon checking the area, a whitish looking like lotion was on the areas of the burn, that did not match the previous ointment applied to the area, upon querying the resident, a cream Dermasil was noted on the bed and open. Resident asked if he had applied the cream and he did not respond and as the writer cleaned up the sites, resident called 911 stating that the cream had entered his blood stream. [Named ambulance service] arrived, report was given to the attendants. Review of R101 Nurse Progress Note, dated 12/22/24, reflected, Wound care in place from ER visit, and to be kept for one week. Review of the Nurse Progress Note, dated 12/30/24, reflected, Resident burn sites cleansed with normal saline, resident refused for silver to be applied to sites. Collagen with silver material placed over sites with clean dry dressing to cover. Patient reported minimum pain during dressing change. Abdomen site pink and slightly moist. R[right] groin pink/red and moist. R thigh white and moist, no sloth, later of epidermis seen. Review of the facility Wound Assessment Details, dated 12/30/24, reflected R101 had a facility acquired thermal heat partial thickness 2nd degree burn to groin area that measured 5 cm length x 5 cm width with no depth with moderate amount serosanguineous drainage. Continued review of the document reflected the wound was 70% bright pink or red and 30% loose slough with 1/10 pain. Continued review of the document included pictures, dated 12/30/24 at 6:44 a.m., that appeared to have depth to wound (not reflected on assessment.) Review of the facility Wound Assessment Details, dated 12/30/24 at 6:43 a.m., reflected R101 had a facility acquired thermal heat partial thickness 1st degree burn to abdomen that measured 8 cm length x 4 cm width with no depth with scant serous drainage. Continued review of the assessment reflected the wound was 100% bright pink or red. Review of the facility Wound Assessment Details, dated 12/30/24 at 6:54 a.m., reflected R101 had a facility acquired thermal heat full thickness 2nd degree burn to right thigh that measured 8 cm length x 8 cm width x 0 depth with light serous drainage. Continued review of the assessment reflected 100% pale pink or red epithelial tissue. Continued review included pictures that appeared to be 80% pale/white area of slough (non-viable tissue). Review of the Burn Clinic Consult note, dated 1/6/25, reflected R101 abdomen burn had healed and thigh and groin wound had some eschar on wounds with no signs of infection. Continued review of the note reflected SSD[silver sulfadiazine] daily to groin and thigh burns and follow up with burn unit in one week. Review of R101 facility Wound Assessment Details, dated 1/8/25, reflected the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	~Groin burn wound-5 cm x 5 cm x 0 cm with 60% red/pink tissue and 40% slough. Review of picture wound bed appeared to have black eschar(dead skin). ~Abdomen burn-healed. ~Right Thigh burn-7 cm x 7 cm x 0 cm with 50% epithelial and 50% slough. Review of picture wound bed appeared to have about 80% yellow slough. During a telephone interview on 1/8/25 at 1:50 p.m., Licensed Practical Nurse(LPN) C reported worked part time at facility and was not working at time of R101 burn. LPN C reported was educated prior to returning to the floor that microwaves had been removed from floors and if residents request for food to be heated/reheated to use microwave in staff breakroom. LPN C reported staff were educated on Heating/Reheating Policy including to check temperature of food prior to giving to residents. LPN C reported had not received education related to Heat/Reheating food prior to R101 incident including new hire education in November of 2024. LPN C reported did not receive education related to immediate response for burn treatment and was unaware of facility had policy. During a telephone interview on 1/8/25 at 2:12 p.m., Certified Nurse Aid(CNA) D reported was made aware of R101 burn incident about a week after when education was received that microwaves had been removed from the each floor and moved to staff breakroom. CNA D reported educated that if residents request food be heated/reheated staff must check the temperature prior to serving to resident. CNA D reported was unsure what temperature to serve resident food or of what the facility policy was. CNA D reported temperatures should be on each resident chart. CNA D reported was a new hire in November 2024 and did not receive education for heating/reheating food at that time. During a telephone interview on 1/8/25 at 2:34 p.m., CNA E reported was not working at the time of R101 incident. CNA E reported was educated upon returned that microwaves had been removed from floors and relocated to staff breakroom. CNA E reported education included heating/reheating resident food including staff required to temp food after heating and policy was on microwave and thermometer was available. CNA E reported R101's hands are stiff and often spilled food so seemed like common sense not to serve hot food in bed. CNA E reported often worked with R101 and had seen burn wounds and R101 had complained of pain at wound sites. CNA E reported R101 would remind CNA E to be careful of burn areas with care and positioning related to pain. CNA E reported did not receive education related to immediate care for burn. During an interview on 1/8/25 at 3:46 p.m., Registered Nurse (RN) H reported was told by CNA I R101 had spilled noodles on himself 9:00 p.m. during medication pass. RN H reported was unsure when R101 spilled food on self but reported immediately went to R101 room and found R101 laying in bed and R101 told her he had spilled hot noodle in lap. RN H reported R101 did not have cloths on and was covered with sheet with no evidence of wet sheet or noodles on R101 and reported was unsure if CNA I had changed sheets. RN H reported R101 reported burned right thigh and abdomen and completed skin assessment. RN H reported R101 was African American and difficult to see if any red areas. RN H reported patted area with damp washcloth, applied petroleum jelly and ABD dressing, and called Nurse Manager J. RN H reported R101 did not report pain and areas were not open. When asked about Skin assessment completed on 12/17/24 for RN H that indicated open abdominal would, RN H reported she did not recall. RN H reported had not received education from facility about heating/reheating food for residents prior to incident but facility provided after. RN H reported did not Notify Physician, Nursing Home Administrator or Director of Nursing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 1/8/25 at 4:19 p.m., Nurse Manager J reported was notified by RN H about R101 burn to right thigh and abdomen on the evening of 12/17/24 after she had gone to bed and was unsure of time. Nurse Manager J reported RN H applied normal saline and first aid at the time of the burn. When asked how she knew what RN H did for first aid, Nurse Manager J reported she did not tell her what to do but nurses are trained to clean with normal saline and perform first aid. Nurse Manager J reported observed R101 burn area 12/18/24 with blister noted to right thigh and groin and open skin to abdomen. Nurse Manager J reported would expect staff to perform first aid, contact physician, manager, and Director of Nursing and document in progress notes. Nurse Manager J reported received education 12/18/24 about facility reheating policy and had not received prior. During an observation and interview on 1/8/25 at 5:00 p.m., R101 was laying in bed and appeared able to answer questions without difficulty. R101 reported had burned self with hot noodle soup few weeks prior. R101 reported had own personal single cups of noodle soup and asked CNA I to heat up. R101 reported CNA I brought back to him and placed on hand held mirror in between legs in the bed. R101 reported was too hot so was letting cool down when he accidentally spilled and burned right inner thigh and abdomen area and groin area. R101 reported fortunately groin area was mostly protected by brief because that is a sensitive area. R101 reported he yelled out because it hurt when the soup spilled and used call light to alert staff and reported 10/10 pain on pain scale at time. R101 reported he immediately removed covers but had already burned skin and CNA I answered call light within about two minutes. R101 reported told CNA I what happened she notified RN H who looked at area and covered with dressings. R101 reported at no time did anyone place normal saline or cool cloths on areas. R101 reported no one else looked at burned areas until the next day. R101 reported he told CNA and nurses he had pain and stated, of course that hurt, it is a sensitive area. I told everyone that came in to look at area it hurt. R101 skin tone is black with area on abdomen that appeared scared and healed about 8cm x 4 cm of pink skin. R101 reported on 12/21/24 staff were arguing who was going to complete treatments and R101 lost trust facility was caring for areas appropriately and called 911 and was taken to university burn unit who placed dressing to remain in place for one week. R101 reported facility staff then provided routine treatment after that and followed up with burn unit yesterday with improvements. During an observation on 1/8/25 at 5:20 p.m., observed two microwave in locked first floor breakroom. The facility Heating and Reheating Guidelines were located on the front of one microwave with thermometer and alcohol swabs in area. During an observation and interview on 1/9/25 at 9:50 a.m., R101 denied any concerns and reported planned to leave for dialysis soon. R101 reported staff had provided him with small tray with perimeter that appeared about 12 by 8 inches to use in lap if needed. R101 reported did not like to use bedside table related to mobility. During an observation on 1/9/25 at 10:10 a.m., the third floor pantry had sign on it to keep door locked. This surveyor opened unlocked door and verified no microwave was in pantry. During an interview on 1/9/25 at 10:15 a.m., Licensed Practical Nurse (LPN) L was asked to sign a form after R101 burn incident but was not familiar with R101. LPN L reported was told if heating/reheating resident food to do so in 1st floor breakroom, and not to serve too hot. When queried what was too hot, LPN L reported was unsure and stated, maybe use glove and touch. LPN L reported or lifted temporal thermometer off medication cart and stated, not sure if I should check with this. LPN L reported was unsure of facility policy and where to locate. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review with the facility in-service and, Reheating Foods and Liquids in the Microwave, on 1/9/25 at 10:54 a. m., reflected LPN L met requirements for reheating food/liquids on 12/20/24. Continued review of the FRI investigation reflected Quality Assurance and Performance Improvement (QAPI) past non-compliance sign in dated 12/24/24, did not included the Nursing Home Administrator (NHA) A, Director of Nursing (DON) B or the Medical Director signature. During a telephone interview on 1/9/25 at 11:12 a.m., CNA I reported had worked at the facility for over one year and was present at time of R101 burn incident on 12/17/24. CNA I reported R101 asked her to heat R101's personal single serving cup of [NAME] noodles for 4 minutes in the microwave. CNA I reported R101 requested staff to assist heat meals almost every night. CNA I reported after heating she placed towel on resident lab while laying in bed, with hand held mirror under towel as flat surface, and place cup of hot noodles on surface between R101 legs. CNA I reported R101 turned on light about 45 minutes to one hour later and told her he had spilt noodles on himself and thinks it caused burn. CNA I reported removed wet towel with few noodles on it and threw away empty cup of noodles. reported thinks he burn self. CNA I reported R101 did have open skin on abdomen R101 was pulling back skin. CNA I reported difficult to see if skin discolored because it was so ashy and dry. CNA I reported R101 appeared calm at the time and did not recall complaints of pain. CNA I reported sheet was wet that was on top of R101 and she changed sheet and R101 had brief on. CNA I reported she then exited R101 room and notified RN H what had happened and RN H went to R101. CNA I reported R101 told RN I what had happened, RN I looked at skin and R101 asked for bandaid and RN I told her it needed to dry out with no immediate fist aid observed, including cool compress. CNA I reported had not received prior education at facility for heating/reheating food and received education after R101 burn incident related to heating only not first aid for burns. CNA I reported shift ended on 12/17/24 at 11:00 p.m. and was unable to recall who shift report was given to and reported did not tell oncoming staff about R101 burn incident. CNA I reported did not provide any additional care for R101 on 12/17/24 between 9:00 p.m. and 11:00 p.m. Review of CNA I unsigned witness statement, dated 12/18/24, reflected CNA I saw noodles and liquid on floor when first entering R101 room when R101 reported had spilled soup on himself. CNA I reported management called her 12/18/24 on telephone for statement and did not say noodles and liquid were on the floor and had not seen statements. During an observation on 1/9/25 at 12:15 p.m., during meal service CNA filled coffee cup from insulated drink dispenser in 200 hall took to room [ROOM NUMBER] with no cover. During an observation on 1/9/25 at 12:17 p.m. the 300 pantry had sign posted on door keep door closed. Paper towel was stuffed in door lock to prevent door from locking. This surveyor opened door to pantry and verified no microwave in pantry and no call light. During an interview on 1/9/25 at 12:43 p.m., CNA M reported after resident was burned facility removed microwaves from all of the resident floors. If residents request to have food heated or reheated microwave is located in staff breakroom on first floor. CNA M reported staff should not serve residents food that is too hot. When ask what too hot meant CNA M was unable to answer and reported was unsure what facility policy was. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/9/25 at 1:04 p.m., Assistant Director of Nursing (ADON) O reported had been in position over two years. ADON O reported first heard about R101 burn from 12/17/24 on 12/18/24 at morning meeting after reviewing skin assessment completed by RN H. ADON O was queried what was first aid included for burn and ADON O reported first aid should included cool down area with cool water and non adhesive dressing. ADON O reported would expect staff to provided immediate first aid, notify nurse, who would notify physician, responsible party, DON, NHA for all events including burns and document at time of the event. ADON O reported complete R101 pain and skin assessment 12/18/24 and was first to contact R101 physician on 12/18/24. ADON O reported would not expect petroleum jelly to be used for acute burn treatment. During an interview on 1/9/25 at 2:19 p.m., Wound Nurse (WN) P reported had been in position for two years. WN P reported was notified of R101 burn wound on 12/18/24 and observed two blistered areas to right thigh and right groin and pink open skin to abdomen. WN P reported called R101 physician who ordered aloe vera jell from plant they got from local grocery store daily and not to cover unless out to dialysis. WN P reported would not expect staff to apply petroleum jelly to acute burn. WN P reported completed R101 skin incident/accident report on 12/18/24 that should have been completed at the time of the incident on 12/17/24. WN P reported prior to observing R101 on 12/18/24 had removed foam dressing from right thigh, groin and abdomen. WN P reported staff should have immediately cooled site by adding cool water. WN P would expect staff to immediately cool down burn site, while also notifying nurse, physician, DON and NHA because immediate change of condition. WN I reported R101 had orders for aloe vera three times daily from 12/18/24 until silvadene cream arrived that was ordered 12/20/24 and verified MAR reflected R101 received both between 12/20/24 and 12/21/24 until sent to emergency room . WN P verified R101 had dressing placed at hospital on 12/22/24 that remained in place for 7 days. WN P verified staff had documented R101 was provided dressing changes between 12/22/24 and 12/28/24, however, reported the MAR was not correct because R101 would not allow staff to remove dressing for the ordered 7 days. During an interview on 1/9/25 at 3:31 p.m., DON B and NHA A reported were first notified of R101 burn incident on 12/18/24 at morning meeting by ADON O. NHA A reported would have expected staff to notify them immediately of R101 burn. DON B reported would expect CNA to notify nurse immediately, who would assess, notify physician, DON, NHA and state of Michigan if needed. During an interview on 1/9/25 at 4:45 p.m. DON B reported facility had no evidence of prior education provided to staff for heating/reheating resident food before R101 incident. Review of the facility, Heating and Reheating Guidelines, dated 2/20/24, reflected, Purpose: The facility will ensure that resident personal food is handled in a safe and sanitary manner to prevent cross contamination and to minimize the risk of food borne illness. The facility will follow any manufactures instructions when preparing food .Guideline 1. Only trained facility staff are authorized to hear and reheat food for residents. 2. Items being heated reheated will be checked for use-be-date .3. Packaged foods will be heated and reheated to microwave following package instructions 4. For reheating precooked food items, microwave to internal temperature of 165 degrees for 15 seconds. 5. Allow heated and reheated food to sit for 2 minutes or according to the manufactures instructions prior to serving to the resident . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility, Accidents Policy, dated 6/29/21, reflected, Accidents refers to any unexpected or unintentional incident, which results or may result in injury of illness to a resident .Avoidable Accident means that an accident occurred because the facility failed to: Identify environmental hazards and/or assess individual resident risk of an accident , including the need to supervision and/or assistive devices. Evaluate/analyze the hazards ad risks and eliminate them, if possible, identify and implement measures to reduce the hazards/risks as much as possible. Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and , if not reduce the risk of an accident . Review of the State of (State Name) Department of Community Health Alert, titled, Scalding Injuries Caused by Excessive Hot Water: Food and Hot Beverage Temperatures, Revised August 5, 2008, revealed, Background: In all age groups, tap water scald injuries have been cited as the second most cause of serious burns. A scald is a burn caused by spills, immersion, splash, or contact with hot water, food and beverages, or steam. The elderly are particularly at increased risk because their skin tends to be less sensitive and reaction times are reduced, causing a tendency to not pull away from hot water quickly enough to avoid scalding. Their thinner skin also burns full depth (through the skin layers and into tissue) more quickly . Although Federal and State agencies do not specify temperatures appropriate to the consumption of hot beverages, facilities should be aware of the risk for harm to a resident from contact or consumption of hot beverages.Scalds can commonly occur from hot food, beverages, or steam . The estimated time for a person to receive second-degree burns was noted as follows: 120 degrees. Time to receive second-degree burn: 8 minutes. 124 degrees. Time to receive second-degree burn: 2 minutes. 131 degrees. Time to receive second-degree burn: 17 seconds 140 degrees. Time to receive second-degree burn: 3 seconds. 150 degrees. Time to receive second-degree burn: Less than one second. The facility put into place processes implemented to prevent further occurences. Utilizing the facilities guidelines on heating and reheating food/saftey of hot liquids. Monitoring was inititated with audits and results reported to Quality Assurance. The facility was determined to be in compliance with the action plan as of 12-26-24.