STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235588	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Valley Nursing Home	1086 W. Burdickville Road Maple City, MI 49664

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** 49302 This deficiency pertains to Facility Reported Incident (FRI) MI00145634. Based on observation, interview, and record review, the facility failed to prevent a serious burn injury for one Resident of 3 residents reviewed for accidents and hazards. This deficient practice resulted in a second-degree burn sustained to the upper torso of Resident #1. Findings include: Resident #1 (R1): Review of R1's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including dementia and fibromyalgia (a syndrome causing chronic widespread pain). Review of R1's most recent Brief Interview for Mental Status (BIMS) assessment, dated 5/26/24, revealed a score of 9, indicative of moderate cognitive impairment. Review of the facility investigation summary submitted to the State Agency (SA) read, in part: Date of Alleged Event: 7/1/24 .I was informed by [Certified Occupational Assistant (COTA) C] that [R1] had spilled soup on herself and was burned. I immediately went into [R1's] room. She was in bed lying at a 45-degree angle with her eyes closed and her bowl upside down on her upper abdomen. Her shirt was rolled up away from her skin. I noted a reddened area approximately 3 inches long x 4 inches wide .I interviewed [Certified Nursing Assistant (CNA) B] who delivered the tray. She told me that she brought tray in and left it, because [R1] seemed sleepy. She planned on coming back after she delivered the other trays . [Dietary Director (DD) F] stated that the soup was held at temperature of 173 f [Fahrenheit] in [the] steam table . Investigation determined resident was served soup that was hot enough to burn skin and was left unattended that was in reach of resident who was drowsy and grabbed the bowl to feed herself . On 8/19/24 at 10:30 AM, R1 was observed lying in bed, positioned to toward the right side. CNA D and CNA G were observed re-positioning R1 toward the center of the bed, as R1 was unable to complete the task independently. An interview was attempted and R1 was unable to answer specific questions related to the incident but was able to state, Yes when asked if she experienced a burn on her torso. Review of an incident report, dated 7/1/24, written by CNA B read, in part: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235588	A. Building B. Wing	08/20/2024

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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	I delivered [R1's] dinner .which was soup. I set up her soup to cool, but she was sleepy, so I left to deliver other trays . About five minutes later, the DON [Director of Nursing] grabbed me to inform me that [R1] got burnt by the soup. When we walked back into the room, she [R1] was still very sleepy and lethargic . On 8/19/24 at 12:14 PM, an interview was conducted with COTA C who verified she was treating R1's roommate at the time of the incident. COTA C stated, I was working with [R1's] roommate and the curtain was pulled between the beds, but I heard her [R1] yelling. She was shouting, 'It's hot!' COTA C stated she observed R1 in a reclined position, approximately 45 degrees, with a bowl of soup spilled on her upper torso. On 8/19/24 at 12:14 PM, an interview was conducted with CNA D regarding the proper position to place a resident when choosing to eat in bed. CNA D stated, The resident should be as close as possible to 90 degrees .you want them sitting all the way up. Review of a Skin/Wound Note, dated 7/2/24, written by Registered Nurse (RN) A read, in part: Wound to upper abdomen caused by hot liquid burn today assessed. Pain assessment completed - resident c/o [complains of] 6/10 pain at area, described as burning.Blistering present . On 8/19/24 at 12:21 PM, an interview was conducted with RN A who verified she assessed R1's burn following the incident. RN A confirmed blistering was present upon her assessment which classified the burn as a second-degree [a burn causing damage to the first and second layer of skin]. When asked about positioning expectations for meal consumption in bed, RN A stated, The angle of the bed should be upright to reduce risk of aspiration [choking] or spills. On 8/19/24 at 12:26 PM, an interview was conducted with the DON regarding the burn incident. The DON verified R1 was in a reclined position and a bowl of hot soup was left on a tray table placed over the bed. The DON stated the tray table should have been moved off to the side of the bed before CNA B left the soup unattended. The DON indicated her expectation is to place residents in an upright position should they chose to consume a meal in bed to reduce the risk of accidents. The DON confirmed the presence of blistering classified the burn as second-degree. Review of R1's EMR did not reveal any assessment for burn potential prior to the incident. Review of facility policy titled, Burns, revised 8/7/24, read, in part: [Facility Name] will prevent a burn from occurring . on admission and quarterly an assessment for burn potential will be done for all residents . Review of facility policy titled, Facility Safety Hazards P&P [Policy and Procedures], dated 3/28/24, read, in part: .Foods will be served at safe temperatures to prevent burns .