

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  Brookestone of Papillion		STREET ADDRESS, CITY, STATE, ZIP CODE  610 South Polk Street Papillion, NE 68046	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45641</p> <p>Licensure Reference Number 175 NAC 12.006.09(I)</p> <p>Based on observation, interview, and record review, the facility staff failed to ensure interventions were implemented to prevent hot liquid burns for 2 (Residents 1 and 2) of 3 sampled residents that had been identified as at risk for injury from hot liquids to prevent potential accidents. The facility census was 89.</p> <p>Findings are:</p> <p>A record review of the facility's Hot Liquid Management Guidelines dated 03/2016 revealed hot liquids could increase a resident's risk of injury if hot liquids are not maintained within point of service temperature. Coffee, tea, and hot chocolate are commonly served at 160-180 degrees Fahrenheit (F). This temperature can cause instantaneous burns. A 3rd degree burn can happen at 155 degrees F in 1 second. Identify a resident at high risk and reduce temperature, communicate as needed, use adaptive equipment/clothing as necessary, and update the care plan. Residents with hot liquids should not be left unsupervised.</p> <p>A record review of the facility's Hot Liquid Risk Management training assigned to the facility staff following Resident 1's hot liquid accident on 08/11/2024 revealed coffee, hot tea, hot cocoa, soup, gravy and sauces and liquid with vegetables are liquids that create a burn risk. Skin contact time for a 3rd degree burn to occur in 1 second if the hot liquid temperature was 156 degrees F, 2 seconds if the hot liquid temperature was 149 degrees F, 5 seconds if the hot liquid temperature was 140 degrees F, and 15 seconds if the hot liquid temperature was 133 degrees F.</p> <p>A record review of the facility's Enrollments &amp; (and) Completions with multiple dates revealed 1 of 13 dietary staff and 14 of 107 nursing staff had completed the Hot Liquid Risk Management training. It did not reveal that Culinary Assistant (CA)-A or CA-B completed the education.</p> <p>A.</p> <p>A record review of Resident 1's Clinical Census dated 09/04/2024 revealed the resident was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 1's Medical Diagnosis dated 09/04/2024 revealed the resident had diagnoses of Transient Cerebral Ischemic Attack (a medical emergency that occurred when blood flow to the brain was interrupted), Syncope and Collapse (passed out), Other Lack Of Coordination, Muscle Weakness, History Of Falling, and Dysphagia (trouble swallowing).</p> <p>A record review of Resident 1's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 06/27/2024 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) of 15 of 15 that indicated the resident was cognitively aware. The resident needed set up assistance for eating and oral hygiene (teeth brushing), needed substantial/maximal assistance for toileting, dressing, footwear, and personal hygiene (body cleaning), and was dependent on staff for bathing.</p> <p>A record review of Resident 1's Care Plan with an admitted [DATE] revealed the resident was at risk for potential impaired nutritional status and had interventions of: hot liquids risk, cool before serving, accidental hot liquids spill if resident awake for meals place towel on lap and if the resident is asleep do not leave hot liquids on tray, lids to coffee cups as needed to avoid hot liquid spills.</p> <p>A record review of Resident 1's Hot Liquids Risk assessment dated [DATE] revealed the resident was at risk for injury from hot liquids, and interventions were to see the Care Plan. Therapy, Dietary, licensed nurses, and direct care staff had been updated on the resident's risk status.</p> <p>A record review of Resident 1's Incident Investigation/Interdisciplinary Team Review Meeting dated 08/11/2024 revealed the resident had been burned from spilled soup and interventions put in place to prevent future incidents was to use lids and education.</p> <p>A record review of Resident 1's Breakfast-Day 11 diet sheet dated 09/04/2024 revealed the resident was to get coffee and had a note of cool hot liquids.</p> <p>In an observation on 09/04/2024 at 7:10 AM revealed Resident 1 was seated in a wheelchair in the resident's room with an uncovered cup of coffee in front of the resident.</p> <p>In an observation on 09/04/2024 at 9:04 AM revealed CA-A poured steaming hot coffee from an insulated carafe (container), delivered it on a food tray uncovered to Resident 1, placed the tray on the overbed table in front of the resident, and left the room.</p> <p>In an observation on 09/04/2024 at 9:06 AM , using a thermometer revealed the temperature of the coffee in the carafe that was served to Resident 1 was 163 degrees F.</p> <p>In an interview on 09/04/2024 at 7:10 AM, Resident 1 confirmed the resident is served hot coffee in an uncovered cup and the staff does not place a towel over the lap when eating or drinking hot liquids.</p> <p>In an interview on 09/04/2024 at 9:55 AM, Resident 1 confirmed the resident is served steaming hot coffee all the time and had to add creamer and wait for it to cool before drinking it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/04/2024 at 9:13 AM, CA-A confirmed that when the Resident 1's diet ticket said cool hot liquids, that meant the staff was to put ice in the cup of coffee. CA-A confirmed that was not done for Resident 1 prior to being served, but then said CA-A put ice in the pot this morning. CA-A confirmed CA-A did not know what the safe temperature was to prevent scalding (burn).</p> <p>In an interview on 09/04/2024 at 9:17 AM, the facility's Administrator confirmed the coffee temperature of 163 degrees F was too hot to prevent scalding and should not have been served to at risk residents.</p> <p>B.</p> <p>A record review of Resident 2's Clinical Census dated 09/04/2024 revealed the resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 2's Medical Diagnosis dated 09/04/2024 revealed the resident had diagnoses of Cerebral Infarction Due To Unspecified Occlusion or Stenosis (stroke), Unspecified Dementia (confusion), Memory Deficit following Cerebral Infarction, Other Lack Of Coordination, Weakness, and Dysphagia (trouble swallowing).</p> <p>A record review of Resident 2's MDS dated [DATE] revealed the resident had BIMS of 9 of 15 which indicated the resident was moderately cognitively impaired. The resident independent for eating, need partial/moderate assistance with oral hygiene and upper body dressing, needed substantial/maximal assistance for lower body dressing and footwear, and was dependent on staff for toileting.</p> <p>A record review of Resident 2's Care Plan with an admitted [DATE] revealed the resident was at risk for potential impaired nutritional status and had interventions of set up assist with meals in room or dining room per choice and hot liquids risk, cool before serving.</p> <p>A record review of Resident 2's Hot Liquids Risk assessment dated [DATE] revealed the resident was at risk for injury from hot liquids, and interventions were to see the Care Plan. Therapy, Dietary, licensed nurses, and direct care staff had been updated on the resident's risk status.</p> <p>A record review of Resident 2's Breakfast-Day 11 diet sheet dated 09/04/2024 revealed the resident was to get coffee and had a note of cool hot liquids.</p> <p>In an observation on 09/04/2024 at 9:02 AM revealed CA-B poured steaming hot coffee from an insulated carafe (container), delivered it uncovered to Resident 2, placed it on the overbed table in front of the resident, and left the room.</p> <p>In an observation on 09/04/2024 at 9:06 AM, using a thermometer revealed the temperature of the coffee in the carafe served to Resident 2 was 163 degrees F.</p> <p>In an interview on 09/04/2024 at 12:35 PM, Resident 2 confirmed the coffee is normally delivered really hot. The resident confirmed the resident had to wait to drink it and hold the cup correctly. The resident confirmed the coffee is not delivered with a lid and only a napkin is placed on the resident's lap when eating or drinking hot liquids.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/04/2024 at 9:15 AM, CA-B confirmed that when the Resident 2's diet ticket said cool hot liquids, that meant the staff was to put ice cubes in the cup of coffee. CA-B confirmed CA-B did not place ice cubes in Resident 2's coffee before CA-B delivered the coffee to Resident 2. CA-A confirmed CA-A did not know what the safe temperature was to prevent scalding (burn).</p> <p>In an interview on 09/04/2024 at 9:17 AM, the facility's Administrator confirmed the coffee temperature of 163 degrees F was too hot to prevent scalding and should not have been served to at risk residents.</p>		