STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335653	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menorah Home & Hospital for Aged & Infirm	1516 Oriental Blvd Brooklyn, NY 11235

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** 43285 Based on observation, record review, and interviews conducted during an abbreviated survey (NY00337987), the facility failed to adequately supervise a resident to prevent accidents. This was evident in 1 out of 3 residents sampled (Resident #1). Specifically, on 04/02/2024 at 2:20 pm, during recreational social hour in the dining room, Resident #1, accidentally spilled hot tea on their person. Subsequently, Resident #1 was assessed to have redness to two areas on the left side of the lower abdomen and left upper inner thigh. This resulted in actual harm to Resident #1 that was not immediate jeopardy. The findings are: The facility's Policy and Procedure on Resident's safety during recreation programs involving food and beverages dated 04/03/2024, documented this facility is committed to providing each resident with safety during recreational programs involving food and beverages. Also, documented Recreation staff to check diet orders and confirm with nursing staff that residents can feed themselves. Resident #1 was admitted to the facility on [DATE] with diagnoses of Diabetes (high blood sugar) with peripheral neuropathy (weakness to the legs) and impaired cognition (memory loss, difficulty understanding). The Minimum Data assessment dated [DATE] documented Resident #1 had severely impaired cognition. Resident #1 required setup assistance with eating and can feed themself. The Facility's Investigation documented on 04/02/2024 at 2:20 pm, during recreational social hour in the dining room, Recreation Leader #1 placed a Styrofoam cup with tea on a table in front of Resident #1. Resident #1 attempted to pick up the cup and spilled the tea. Resident #1 was evaluated by Registered Nurse #1 and first aid treatment of cool compresses were placed on the red areas of the left side of the lower abdomen and left inner upper thigh. The Medical Doctor assessed Resident #1 and ordered wound care treatment and pain management. Resident #1's skin was treated daily by the Registered Nurse/ Wound Care Nurse #1 and was completely healed on 04/16/2024. The Medical Doctor's progress note dated 04/02/2024 at 3:15 pm, documented Resident #1 spilled hot tea on the left side of their abdomen. During the physical exam erythema (redness) of the abdomen and left upper inner thigh with burns of the skin was observed. The Treatment Care Plan was to apply cream for burns to the affected area daily. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nursing progress note dated 04/03/2024 at 1:57 pm, documented by Licensed Practical Nurse #1 on 04/02/2024, at around 2:20 pm, Resident #1 spilled hot tea on their stomach area (abdomen) and left upper inner thigh. Recreational Therapist #1 stated while they were serving tea and cookies to the residents, Resident #1 took the cup and the hot tea spilled on themselves. On assessment, Resident #1 was observed with redness to left side of low abdomen 9-centimeter by 11-centimeter by 0.1 centimeter with 30 percent of open skin and redness 2-centimeter x 10.8-centimeter x 0.1 centimeter to left upper thigh with peeling of the outer skin. Cold compresses were applied until the Medical Doctors evaluation. Pain management with Acetaminophen 650 milligram was provided. Resident #1 was seen by the Medical Doctor and treatment started. During an interview on 4/16/2024 at 10:42 am, Recreation Leader #1 stated they served tea to Resident #1 at the time of the incident. An electric kettle was used to boil the water. The water was boiled in the recreation's staff office and not used until 15-20 minutes later. A Styrofoam cup with tea was placed on a table in front of Resident #1. The tea bag was not hot to touch when removed from the cup therefore they gave it to Resident #1. The cup of tea was placed in front of Resident #1 when they heard Resident #1 make some noise ow and Resident #1 said they got tea on them. They took Resident #1 to the nursing station. During an interview on 04/16/2024 at 1:00 pm, Registered Nurse #1 stated on 04/02/2024 at approximately 2:22 pm they were informed by Licensed Practical Nurse #1 that hot tea spilled on Resident #1. Registered Nurse #1 stated a body assessment was done. Resident #1 was observed with redness and an open area to left lower abdomen and left inner thigh. Registered Nurse #1 stated they immediately applied a cold compress. The Medical Doctor was in the facility and was notified. The Medical Doctor examined, treated and Resident #1 received pain medicine for pain. Registered Nurse #1 stated Resident #1 received acetaminophen for pain. Registered Nurse #1 stated all staff members were in-serviced on handling of hot beverages and all Styrofoam cups were removed from the unit and replaced with insulated plastic mugs with lids. During an interview on 04/16/2024 at 1:30 pm, the Medical Doctor stated they were at the facility when they received a call from Registered Nurse #1 informing them about Resident #1's burn. The Medical Doctor stated they immediately went to assess Resident # 1, performed a body assessment, and observed Resident # 1 with redness on the abdomen and left inner thigh with some of the skin peeled off. The Medical Doctor stated they ordered a cream for treatment of the burns. The Medical Doctor stated Resident #1 did not complain of any pain or discomfort to the area, however, Resident #1 was on acetaminophen for pain. The Medical Doctor stated the incident was discussed extensively in an interdisciplinary team meeting and the team decided to replace the Styrofoam cups with insulated plastic mugs with lids. The Medical Doctor also stated the team decided to stop serving hot beverages in between meals on all the units. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/22/2024 at 10:30 am, the Director of Nursing stated they were informed by the Registered Nurse #1 on 04/02/2024 at approximately 2:25 pm, Resident #1 spilled their hot tea on themselves. Director of Nursing stated that first aid, and a cold compress was applied immediately. The Director of Nursing stated they immediately stopped the tea and cookies program. The Director of Nursing stated Resident #1 was assessed and the Medical Doctor was called. The Medical Doctor was in the building and immediately went and examined Resident #1, ordering to apply a cream daily to treat the burns. Resident #1 was to be followed by wound care per the Medical Doctor order. The Director of Nursing stated an interdisciplinary team meeting was held and they agreed to discontinue the Styrofoam cups off all the units and replaced them with insulated mugs with covered lids. A facility wide in-service was provided to staff members on burns and safe handling of hot foods and hot beverages. The Director of Nursing stated they informed the Facility's Administrator of the incident, and they continued to monitor Resident #1. The Director of Nursing stated Resident #1's burns were completely healed. During an interview on 04/22/2024 at 11:00 am, the Assistant Administrator stated they were informed of Resident #1's burns on 04/02/2024 at approximately 3:30 pm. The Assistant Administrator stated they immediately started an investigation. The Assistant Administrator stated an interdisciplinary team meeting was held on 04/03/2024 where the burn was discussed. The Assistant Administrator stated they implemented new interventions and an in-service with the staff members on safe handling of hot foods and hot beverages. Immediate Jeopardy was not identified, Facility Past Noncompliance was identified on 04/16/2024. Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the Past noncompliance and was in substantial compliance for this specified regulatory requirement prior to surveyor's onsite visit on 04/16/2024. The facility implemented the following correction action prior to surveyor entrance date on 04/16/2024. Interdisciplinary team meeting was conducted on 04/04/2024, and the incident was discussed. New interventions were implemented to include: Discontinue usage of all Styrofoam cups for serving hot beverages. Use insulated plastic cups for all hot beverages. Inservice of staff across all disciplines for safe handling of hot beverages. The facility in-service staff members on safe handling food and beverages as follows. Administration 3 staffs = 100 %, Housekeeping 31/44 = 70 %, Dietary 34/48 = 71 % Plant operation 10/10 = 100 %, Recreation 10/10 = 100%, Human Resource 3/4 = 75% Nursing-Certified Nursing Assistant = 88, Licensed Practical Nurse =38, Registered Nurse = 46, a total of 172/319 = 53%. In-services ongoing, any staff members out on vacation will be in-service upon return. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Three residents were interviewed on the use of Styrofoam cups on the unit. The residents stated the Styrofoam cups were removed and were replaced with insulated plastic cups. Seventeen staff members were interviewed, and they all stated that they received in-service on safe handling of food and beverages two weeks ago. They are knowledgeable on where to find the thermometer on the unit to test the hot foods. They are also knowledgeable of the acceptable temperature for hot beverages. Quality Assurance and Performance Improvement meeting is schedule for 4/18/2024, however, an interdisciplinary team meeting was held on 04/04/2024 on resident sustained burns during recreation program. The in-service coordinator will in-service staff members who are out on vacation on safe handling food and beverages upon return to work. 10 NYCRR 415.4(b)(1)(i)