STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395631	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Zion Retirement Communi	722 Furnace Hill Pike Lititz, PA 17543

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** Based on observation, review of clinical records and facility documentation, and staff interviews, it was determined the facility failed to ensure staff monitored temperature of hot liquids to mitigate the risk of injury. This failure resulted in actual harm to one resident (Resident R1), who sustained burn injuries to the chest and upper thigh.Findings include:Findings include:Review of the facility policy titled Safety of Hot Liquids, dated October 2014, revealed facility interventions to prevent burns included maintaining hot liquid serving temperatures at no more than 180 degrees Fahrenheit.Review of a facility procedure, undated and untitled, stated: All liquids heated in the microwave should be heated at 6 ounces per one beverage setting cycle.Review of information dated January 21, 2026, submitted by the facility to the Department of Health, revealed Resident R1 sustained first- and second-degree burns to the right chest and lateral right thigh from hot tea. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE], with diagnoses including Congestive Heart Failure (heart's inability to pump sufficient amount of blood throughout the body) and muscle wasting and Atrophy (thinning of the muscle mass). Further review of the clinical record revealed Resident R1 was discharged home on January 22, 2026.Review of Resident R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident R1 had a BIMS score of 15, indicating intact cognitive function. The MDS further indicated Resident was independent with eating.Review of Resident R1's clinical record revealed an Occupational Therapy treatment note dated October 2025 which indicated Resident R1 required set-up and clean-up assistance for meals.Review of Resident R1's clinical record including nursing progress note dated January 15, 2026, at 9:50 p.m., revealed Resident R1 spilled hot tea on (his/her) right chest and right hip. Skin slightly red and thin layer of skin peeling off. Resident was reclining the recliner chair, and caught the bottom of the bedside table, tilting the table and spilling the hot tea onto resident.Review of Resident R1's skin evaluation completed by a Wound Specialist on January 20, 2026, identified two burn wounds:Right posterior thigh: full-thickness wound measuring 13.7 cm x 5 cm, depth unmeasurable due to tissue overgrowthRight chest: wound measuring 4 cm x 5.6 cm, depth unmeasurable due to tissue overgrowthWound treatment orders for the right posterior thigh included:Xeroform (non-adhesive) gauze applied three times per week and as needed for 30 daysSterile gauze sponge applied three times per week and as needed for 30 daysRetention tape applied three times per week and as needed for 30 daysWound treatment orders for the right chest included:Xeroform (non-adhesive) gauze applied three times per week and as needed for 30 daysSterile gauze sponge applied three times per week and as needed for 30 daysRetention tape applied three times per week and as needed for 30 daysReview of the facility's investigative report completed by the Director of Nursing (DON) on January 16, 2026, at 9:16 a.m., indicated Resident R1 was provided hot tea of an unknown temperature.Review of facility investigation documents revealed a written statement by Certified Nursing Assistant (CNA) Employee E3 dated January 15, 2026; At change (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
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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	of shift while giving report, approximately 2145 hrs. (9:45 p.m.) Resident R1 requested pretzels, hot tea, and 4 packets of honey. I prepared a ceramic mug of water in the microwave for two minutes with water from the ice and water machine. There was 8-10 oz of water in the mug. I added 4 packets of honey and an [NAME] gray tea bag. I stirred it with a plastic spoon. This process took approximately 3-5 minutes. I placed the mug, saucer, and pretzels in front of (him/her) on the table. The resident took (his/her) recliner remote and began to raise the chair to move (himself/herself) closer to the table. The table upended and the hot tea spilled onto (resident). Gown removed. Nurse alerted. Cold water and cool compress immediately applied.During an interview conducted with the DON on February 4, 2026, at approximately 9:45 a.m., the DON reported the incident occurred after kitchen hours when no dietary staff were present. The DON further revealed that food and beverages prepared by non-dietary staff after hours are not tempted.Observations conducted in the first-floor kitchenette at approximately 11:35 a.m. revealed ceramic mugs with a maximum capacity of 8 fluid ounces.Additional observations of the microwave revealed signage stating: Nursing after hours heating liquids: 6 oz for one beverage cycle only.During an interview conducted with Dietary Aide Employee E4 at approximately 11:45 a.m., Employee E4 reported the microwave signage was placed after Resident R1 sustained multiple burn injuries.Reenactment exercise was conducted on February 4, 2026, at approximately 11:55 a.m. with Dietary Aide Employee E4. One ceramic mug was filled with approximately 8 ounces of cold water (which left no room for honey or tea bags) and heated in the microwave for two minutes. Immediately following the heating cycle, the water temperature measured 187.6 degrees Fahrenheit. During interview conducted with the Director of Nursing (DON) and Nursing Home Administrator (NHA) at approximately 1:35 p.m., both confirmed Resident R1 received a hot beverage of unknown temperature, resulting in multiple burn injuries.The facility failed to ensure staff monitored and controlled the temperature of hot liquids provided to residents, resulting in actual harm to Resident R1.28 Pa Code 201.18(b)(1) Management.28 Pa Code 211.10 (d) Resident care policies.28 Pa Code 211.12 (d)(3)(5) Nursing services.