STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Health of Portland Rehab & Wellness Cent	215 Highland Circle Drive Portland, TN 37148

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47127 Based on facility policy review, manufacture's guidelines review, printed text message review, medical record review, and interview, the facility failed to protect the resident's right to be free from neglect for 1 of 3 (Resident #1) sampled residents reviewed. The facility failed to provide the necessary structure and processes to meet the care needs of Resident #1, a vulnerable resident with a diagnosis of Paraplegia, when on 7/28/2024, 7/29/2024, 8/11/2024, and 8/12/2024 staff observed the hot water heater located in the Station 2 shower room, leaking/gushing hot water/steam from the tank onto the resident care area. The Station 2 shower room remained in use from 7/28/2024 through 8/1/2024 pending repair and on 8/11/2024 and on the morning of 8/12/2024 staff observed hot water and steam leaking/gushing out of the hot water heater located in Station 2 shower room again. The Station 2 shower room remained in use and on 8/12/2024, at approximately 1:30 PM (six hours later) Resident #1 sustained second degree (partial thickness) burns while being assisted with a shower in the Station 2 shower room, when the malfunctioning hot water tank again began gushing hot water/steam onto the floor underneath Resident #1's left foot. The facility's failure to provide the necessary care and services resulted in an Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) with actual harm for Resident #1. The Administrator was notified of the Immediate Jeopardy for F600 (J) on 8/23/2024 at 8:42 PM in the conference room. The facility was cited at F-600 with a scope and severity of J, which is Substandard Quality of Care. A partial extended survey was completed 8/22/2024-8/23/2024. The Immediate Jeopardy was effective from 7/28/2024 and is ongoing. The facility is required to submit a plan of correction. The findings included: (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: 445306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised 9/15/2023, revealed .It is the organization's intention to prevent the occurrence of .Neglect .The organization will include screening, training, prevention .to provide protection for the health, welfare, and rights of each resident residing in the facility .For purposes of this guidance, Covered Individuals include the owner, operator, employee, manager, agent, or contractor of the facility. Staff would also include caregivers who provide care and services to residents on behalf of the facility .Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .Neglect .Is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .Prevention .Establishing a safe environment that supports, to the extent possible, a resident's safety .Ensuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents . Review of the Operating, Installation and Service Manual for the Station 2 shower room hot water heater revealed, .Hotter water increases the risk of scald injury .Do not use this water heater if it . is not working properly .Water temperature over 125 [degrees] can cause severe burns instantly or death from scalds . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Paraplegia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #1 required substantial/maximal assistance with showers/baths and was dependent for transfers. Review of the Point of Care History for 8/2024 revealed staff documented Resident #1 received a shower on 8/1/2024 and 8/12/2024. Review of the Hospital Emergency Provider Report dated 8/12/2024, revealed Resident #1 had second-degree (partial thickness) burns on his left foot from contact with hot water during his bath (shower). Resident #1 was discharged back to the facility and scheduled for follow up on 8/15/2024 with the hospital's outpatient burn clinic. Review of the comprehensive care plan for Resident #1 revised 8/14/2024, revealed .Resident has a diagnosis of Anxiety .would like to have bed bath hygiene to decrease anxiety . Review of the Hospital Burn and Wound Clinic Report for Resident #1 dated 8/15/2024, revealed .while in the shower chair, the hot water heater burst and his foot was sitting in the water approximately 3-4 minutes . Patient has no feeling below his waist, so he was unaware of the scalding nature of the water .Plan to take patient to OR [Operating Room] tomorrow morning for surgical preparation and application of skin substitute to left lower extremity . Review of the Hospital #1 Operative Note Narrative for Resident #1 dated 8/16/2024, revealed .Surgical preparation and application of skin substitute .to left great toe: 5 x [by] 5 cm [centimeter], left 2nd toe: 3 x 2 cm, left 3rd toe: 2 x 1 cm, left 4th toe: 2 x 2 cm, bottom of left foot: 12 x 3 cm + [plus] 12 x 14 cm .Central area of plantar (sole of the foot) surface of foot with cherry red appearance, significant for area of deeper dermal damage . (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Resident Progress Notes dated 8/16/2024, revealed Resident #1 required a prophylactic [preventative] antibiotic due to risk of infection related to his burn injury. During an interview on 8/16/2024 at 10:36 AM, Certified Nursing Assistant (CNA) A stated on 8/12/2024 he assisted Resident #1 with his shower in the Station 2 shower room. CNA A stated during the shower he noticed steam filling the air and hot water pooling in the floor of the shower room. CNA A noticed the water was burning his feet through his shoes and immediately placed towels under Resident #1's feet to get them off the floor. CNA A stated he was unable to remove Resident #1 safely from the shower until the flow of hot water was stopped. CNA A stated if he had been made aware of the malfunctioning hot water heater in the Station 2 shower room and the previous episodes of steam and hot water leaking/gushing from the hot water heater, he would not have taken Resident #1 into the Station 2 shower room on 8/12/2024. During an interview on 8/22/2024 at 11:51 AM, the Director of Nursing (DON) admitted nursing staff had notified her multiple times regarding the Station 2 shower room hot water heater releasing steam and hot water into the shower area. The DON stated on 7/28/2024 at 11:28 PM, she was notified about problems with the Station 2 shower room hot water heater in a text message sent by Registered Nurse (RN) Q. Review of printed text messages provided by the DON revealed, .Leaking blazing hot water .11:28 PM . The DON admitted the Station 2 shower room should have been taken out of service until it was safe for patient care. During an interview on 8/22/2024 at 2:25 PM, the Respiratory Therapist (RT) stated on 8/12/2024 at approximately 7:00 AM she saw steam and water coming from behind the closed door of the Station 2 shower room. The RT stated she helped staff place blankets on the floor to absorb the water. During an interview on 8/22/2024 at 2:37 PM, Licensed Practical Nurse (LPN) B stated Registered Nurse (RN) Q reported that during the previous shift (8/11/2024 7 PM to 7 AM) and again at shift change on 8/12/2024 at 7:00 AM, steam and hot water had leaked out of the Station 2 shower room and the Administrator had told her to turn on the faucet in the soiled utility room when the steam and hot water were present in the shower room. LPN B stated there were blankets on the floor and the soiled utility hot water faucet was running water when she arrived at change of shift report. LPN B was told to leave the water running for about 30 minutes to cool the hot water tank. LPN B confirmed she had never been told to stop using the Station 2 shower room and had never seen an out of use sign posted on the shower room door. LPN B was asked if the incident resulting in Resident #1 being burned in the shower could have been prevented, she replied, I would rather not answer that question. LPN B stated she reported the incidents of steam and hot water coming from the Station 2 shower room to the Administrator and the Maintenance Director on the morning of 8/12/2024, before Resident #1 was burned by the hot water in the shower. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/22/2024 at 3:16 PM, LPN E stated, .That morning, [8/12/2024] during count [change of shift narcotic reconciliation] I saw water and steam coming out into the hall from Station 2 shower room . [Named RN Q] went into the soiled utility room and turned on the water in the sink full blast .I told [Named Administrator] that morning when I saw him that I was concerned about accidents due to the continuing episodes of steam and hot water issues and he just said it was normal for that to happen . LPN E confirmed the Station 2 shower room had not been taken out of service pending repair of the hot water heater. LPN E stated the steam and hot water leaking/gushing out of the Station 2 shower room hot water heater had occurred a few times. LPN E admitted the incident on 8/12/2024 resulting in Resident #1 sustaining a burn injury could have been prevented by not allowing anyone to use the Station 2 shower room. During an interview on 8/22/2024 at 5:40 PM, LPN M stated she was notified by RN Q on 7/29/2024 regarding the Station 2 shower room hot water heater leaking and putting out steam. LPN M stated RN Q told her the Administrator was aware of the issue. LPN M stated on 7/30/2024 she noticed increased heat in the hall in front of Station 2 shower room and observed steam in the air above the hot water heater. LPN M stated she notified the Administrator, and he told her Maintenance would fix the water heater. LPN M stated she followed up with the Administrator on 7/31/2024 and he told her the problem with the heater was fixed. LPN M admitted the Station 2 shower room hot water heater had been worked on several times in the 6 months prior to the 8/12/2024 incident with Resident #1 and the shower room had not been taken out of service at any time. LPN M stated for safety reasons no one should have received care in the Station 2 shower room. During an interview on 8/23/2024 at 10:15 AM, the Regional Plant Operations Manager (RPO) stated the service company had worked on the Station 2 hot water heater multiple times in 2024 due to faulty temperature and pressure issues. The RPO stated on 7/28/2024 the Station 2 shower room hot water heater had released steam and just dribbled water around the tank, then each time the amount of water got worse. The RPO stated the pressure relief valve released the steam to prevent pressure from building up in the tank due to abnormal water temperatures. When asked if the pressure relief valve (also known as the pop off valve) was a safety feature, he replied, Yes, definitely, otherwise, the tank would continue to build pressure and explode. The RPO admitted he was not made aware of the staff being told by the Administrator to turn on the faucet in an adjacent room to empty the hot water tank. The RPO confirmed the Station 2 hot water heater should have been turned off and taken out of use pending repair. During a telephone interview on 8/23/2024 at 10:50 AM, RN Q stated on 7/28/2024 the Station 2 shower room hot water heater was leaking extremely hot water and producing steam in the shower room. RN Q stated she notified the Administrator on 7/28/2024 and was instructed to turn on the hot water faucet in an adjacent room whenever the hot water heater produces steam and leaks water into the floor, and it will stop the steam/leaking hot water. RN Q stated she had implemented the process for stopping the leaking hot water multiple times including the early morning hours and at shift change on 8/12/2024. RN Q confirmed she was not instructed to take the Station 2 shower room out of use for patient care pending repair of the hot water heater. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 8/23/2024 at 12:00 PM, CNA V stated on 8/11/2024 she worked the 7 PM to 7 AM shift. CNA V stated, .Sometime during the shift, not sure if it was before or after midnight, there was steam in the hall in front of Station 2 shower room and hot water on the floor .[Named RN Q] turned on the hot water faucet in the soiled utility room and let it run for a long time .[Named RN Q] said that is what [Named Administrator] told her to do when there was a problem with the hot water tank .We had to put towels on the floor to clean up the water and I could feel the heat coming from the water . During a telephone interview on 8/23/2024 at 12:13 PM, CNA F stated, .I worked the night before [Named Resident #1] got burned in the shower [8/11/2024] .I felt heat in the hall in front of the shower room [Station 2] and when I opened the door to the shower room the air was thick with steam, like a sauna [hot, humid steam bath] .[Named RN Q] went into an adjacent room and turned on the hot water faucet to level out the hot water and stop the steam .this has happened many times and [Named RN Q] had been told by the Administrator to turn on the water . CNA F admitted she did not feel it was safe for staff or residents to use the shower room, and confirmed the shower room had never been closed to prevent use. During an interview on 8/23/2024 at 12:42 PM, the Administrator confirmed he was notified on 7/28/2024 regarding the Station 2 shower room hot water heater malfunctioning. The Administrator stated he notified the service company to come out and check the hot water heater. The Administrator stated the service company had been out several times to repair the Station 2 shower room hot water heater due to elevated water temperatures. The Administrator denied the water leaking/gushing from the tank was hot enough to cause harm to anyone. When asked what water temperature would cause steam and water to be expelled from the hot water heater, he replied, .I don ' t know, I am not a Chemist . The Administrator stated the service company came out and fixed the Station 2 hot water heater on 8/1/2024 and denied knowledge of any further problems with the water heater. When asked if he had instructed staff to stop using the Station 2 shower room he replied, There was no need to close it down, [Named Resident #1] was the only resident using that shower room and the leaks usually happened during the night . During separate interviews, previously documented, LPN B and LPN E recalled reporting the on-going episodes of steam and hot water being released from the Station 2 shower room hot water heater to the Administrator and the Maintenance Director on 8/12/2024, prior to Resident #1's incident. During an interview on 8/23/2024 at 6:55 PM, Resident #1 stated the Station 2 shower room on 120 Hall was his preference for showers prior to 8/12/2024 because it was smaller and felt more private. Resident #1 stated since he got burned during his shower, he now has extreme anxiety related to taking showers and can only tolerate a bed bath. Resident #1 stated during his shower on 8/12/2024 the entire room filled up with steam and the tech (CNA A) felt the water burning his feet through his shoes. Resident #1 stated, .[Named CNA A] grabbed towels and put my feet on the towels then yelled for help .I saw the water coming and picked up my right foot [using both hands] to keep it out of the steaming water .I couldn ' t physically pick both feet up and my left foot got burned from the water . During an interview on 8/23/2024 at 7:04 PM, RN CC stated on 8/10/2024 between 2:00-4:00 AM, she felt the heat in front of the Station 2 shower room. She went into the Station 2 shower room, and it was hot and steamy. RN CC stated there was water on the floor and she used towels to clean the area up. RN CC stated she reported the incident in the morning to the on-coming nurse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 47127 Based on facility policy review, hot water heater service manual review, medical record review, facility investigation review, facility Event Report review, Facility Maintenance Logbook Documentation, and interviews, the facility failed to ensure the residents' environment remained free of accident hazards as evidenced by dangerous hot water temperatures in the Station 2 shower room that were measured at 169 degrees Fahrenheit at the time of the incident for 1 (Resident #1) of 10 sampled residents reviewed for accident hazards. On 8/12/2024, Resident #1, a vulnerable resident with a diagnosis of paraplegia was sitting on a shower chair when the hot water tank sprayed scalding hot water on the floor of the shower room where Resident #1 was sitting. Resident #1 sustained second (2nd) degree burns to left plantar area of the left foot. The facility's failure to provide an environment that was free from accident hazards over which the facility had control and prevent avoidable accidents resulted in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) with actual harm for Resident #1. The Administrator was notified of the Immediate Jeopardy on 8/16/2024 at 6:20 PM in the Conference Room. The facility was cited at F-689 with a scope and severity of J, which is a substandard quality of care. The Immediate Jeopardy began on 7/28/2024 and is ongoing. A partial extended survey was done 8/16/2024 - 8/23/2024. The findings included: Review of the facility policy titled, Accidents and Incidents revised on 9/15/2023, revealed .The intent is to ensure the facility provides an environment that is as free from accidents and incidents that are avoidable . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Paraplegia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #1 required maximal assistance with bathing and transfers. Review of the Facility Reported Incident Packet dated 8/12/2024, revealed the hot water heater located in the shower room on Station 2 experienced a mechanical failure and the temperature directly from the hot water heater measured 169 degrees at the time of the event. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility Event Report dated 8/12/2024 at 2:07 PM, revealed Resident #1 sustained second degree (partial thickness burn) burns to his left plantar (sole of the foot) while receiving a shower in the Station 2 shower room at 1:30 PM. The Medical Director was called at 1:38 PM and Resident #1 was assessed by the Nurse Practitioner at 3:40 PM. Review of the facility transfer form dated 8/12/2024 at 8:55 PM, revealed Resident #1 was transferred to the Emergency Department (ED) for treatment related to burns on the left foot. Review of the hospital ED record dated 8/12/2024 at 10:28 PM, revealed Resident #1 had sustained 2nd degree burns on the sole of the left foot. Resident #1 was initially treated in the ED and discharged with orders to follow-up in the outpatient Wound and Burn Clinic on 8/13/2024. During an interview on 8/15/2024 at 1:45 PM, Resident #1 stated, .[Named Certified Nursing Assistant-(CNA) A] was trying to adjust the water temperature, and the shower started to steam up .I could not hardly see because of the steam .I looked down and noticed the water was pooling [rising] on the floor .because of the steam, I knew that the water was hot, so I pulled up my left foot [with both hands] . I was unable to lift both of them [both feet] . Resident #1 stated the hot water did not reach his right foot due to the water drain located between his left and right foot. Review of the hospital Operative Report dated 8/16/2024, revealed Resident #1 had a .Central area of plantar surface of foot [left] with cherry red appearance, significant for area of deeper dermal damage . All burns remain second degree . During a telephone interview on 8/16/2024 at 10:36 AM, CNA A stated, . About 1:30 PM [8/12/2024] I was adjusting the water temperature to start [Named Resident 31]'s shower and noticed the bathroom was becoming steamy and the floor was flooded with water .I felt the hot water through my shoes .I went to the door and yelled for help .the water was too high, and too hot to pull him [Resident #1] through the water to remove him from the shower . During an interview on 8/16/2024 beginning at 3:10 PM, the Administrator was asked about the notifications he received regarding the issues with the hot water tank in the Station 2 shower room. The Administrator communicated he was notified the first time on March 14, 2024 that there was steam in the shower room. The Administrator further communicated he was notified on July 28, 2024 at 11:34 PM from the charge nurse there was steam in the bathroom again, and it could not be duplicated again during the day when showers were being given. The Administrator also stated, .The thermometer read 169 degrees [Fahrenheit] on the day of this incident [8/12/2024] . During an interview on 8/16/2024 at 4:00 PM, the DON stated Registered Nurse (RN) Q notified her about the Station 2 shower room leaking hot water on 7/28/2024 at 11:28 PM. The DON stated she called RN Q back and was told that the problem had already been fixed. The DON stated she was not made aware of the malfunctioning Station 2 shower room hot water heater on 8/12/2024 at 7:00 AM. The DON stated she expects staff to make her aware of any adverse incidents that occur immediately. The DON acknowledged since the incident on 8/12/2024, she had become aware of multiple episodes of the hot water heater malfunctioning prior to Resident #1 being burned in the Station 2 shower room. The DON stated if she had been made of aware of the concerns with the hot water heater on 8/12/2024 at 7:00 AM, she would have shut down the Station 2 shower room on the 120 Hall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/19/2024 at 11:15 AM, Licensed Practical Nurse (LPN) B stated on 8/12/2024 at approximately 1:30 PM, CNA A called for help in the Station 2 shower room. LPN B stated, .I went to the door [of the shower room] and the steam was so thick you could not see anything but the silhouette of [Named Resident #1] . LPN B stated she turned on the water in the soiled utility room to lessen the supply of hot water as she had been instructed to do previously to resolve the episodes of steam and hot water issues in the Station 2 shower room. LPN B stated staff had to wait until the hot water and steam resolved before removing Resident #1 to prevent additional injury because the shower chair did not have a place for Resident #1's feet to be off the floor. During an interview on 8/19/2024 at 11:30 AM, LPN E stated, .[Named CNA A] stuck his head out of the shower room and yelled for assistance .water was gushing out of the hot water heater .all we could do was monitor [Resident #1] because of all the hot water and it was unsafe for us to enter the shower room . LPN E stated there had previously been issues with the hot water heater leaking and on 8/12/2024 at 7:00 AM, the hall had steam with hot water pouring out into the hallway. LPN E stated it [hot water and steam come from the hot water heater] happens a lot on night shift, and [Named RN Q] told us what to do when this happens . When asked to describe the amount of water present in the shower room LPN E replied, .the water flow [from the hot water heater] in the shower room was more than what the drain could handle, and [Named RN Q] went into the soiled utility room and turned the water on full blast like [Named Administrator] had told her to do . LPN E stated the Station 2 shower room hot water tank had malfunctioned multiple times within the past 6 months. During a telephone interview on 8/19/2024 at 11:56 AM, the Medical Director stated on 8/12/2024 the DON notified her about Resident #1 sustaining an injury due to a mechanical failure with the hot water heater located in the Station 2 shower room. The Medical Director stated the DON denied the need for intervention at the time of notification. During a phone interview on 8/19/2024 at 6:16 PM, CNA V stated the problems with hot water leaking out of the hot water heater located in the Station 2 shower room happened multiple times during the night shift. CNA V stated the most recent episode occurred the previous weekend (8/10/2024-8/11/2024). CNA V stated, .When this happened [hot water leaking from the hot water heater] [Named RN Q] would turn on the hot water in another room to stop it . During an interview on 8/20/2024 at 10:35 AM, the Regional Plant Operations Manager (RPO) stated the steam and hot water coming out of the hot water tank located in the Station 2 shower room was a result of the pop off valve (a pressure relief valve) opening up. The RPO stated the pop off valve acts as a safety mechanism to prevent pressure from building up in the hot water tank due to abnormally high temperatures. The RPO stated, .The pop off valve releases the pressure, otherwise, it [hot water heater] would explode . The RPO stated the Station 2 shower room hot water heater was plumbed to empty the hot water onto the floor rather than directly into a drain. During an interview on 8/22/2024 at 2:37 PM, LPN B stated on 8/12/2024 at approximately 7:00 AM, staff noticed steam and hot water coming from the Station 2 shower room. LPN B stated RN Q turned on the hot water in the soiled utility room and said to leave it on for about 30 minutes to stop the hot water leaking out. LPN B stated she was distracted immediately following the episode of steam and hot water coming from the hot water heater located in the Station 2 shower room at 7:00 AM and did not immediately report the incident to the Administrator. LPN B stated she saw the Administrator in the hallway later and told him about the malfunctioning hot water heater. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Health of Portland Rehab & Wellness Cent	215 Highland Circle Drive Portland, TN 37148

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/22/2024 at 3:16 PM, LPN E stated she spoke to the Administrator the morning of 8/12/2024 and told him she was concerned about safety of staff and residents due to the malfunctioning hot water heater in the Station 2 shower room. LPN E stated the Administrator told her the episodes of steam and hot water being released was a normal process. During an interview on 8/23/2024 at 12:42 PM, the Administrator confirmed he was notified on 7/28/2024 regarding the Station 2 shower room hot water heater malfunctioning. The Administrator stated the water leaking/gushing from the tank was not hot enough to cause harm to anyone. When asked what water temperature would cause steam and water to be expelled from the hot water heater, he replied, .I don't know, I am not a Chemist . The Administrator acknowledged instructing nursing staff to turn on the hot water in an adjacent room and cool off the Station 2 hot water heater to stop the steam and hot water gushing from the malfunctioning hot water heater. The Administrator stated, .Turning on the faucet drains all the hot water from the heater tank and lets cold water fill the tank .When the temperature of water in the hot water tank increases, it causes pressure to build up and the pop off valve [pressure relief valve] triggers to release pressure . When asked if the pressure relief valve was a safety mechanism, the Administrator replied, Yes. When asked if he should have turned off the hot water heater after the pressure relief valve was triggered multiple times due to increased water temperatures instead of instructing staff to drain excessively hot water from the tank, to temporarily stop the steam and hot water being dispersed, the Administrator refused to answer. The Administrator stated the service company came out and fixed the Station 2 hot water heater on 8/1/2024 and denied knowledge of any further problems with the water heater. When asked if he had instructed staff to stop using the Station 2 shower room he replied, There was no need to close it down, [Named Resident #1] was the only resident using that shower room and the leaks usually happened during the night . During an interview on 8/22/2024 at 2:20 PM, the Respiratory Therapist (RT) stated on the morning of 8/12/2024 she saw steam coming out of the Station 2 shower room door above eye level and water coming out at the threshold. During an interview on 8/22/2024 at 3:50 PM, CNA Y stated on 8/12/2024, during report (AM shift change) she was told there had been a problem with the shower over the weekend with episodes of hot water and steam coming out of the Station 2 shower room. CNA Y stated the Station 2 shower room should not have been used that day [8/12/2024] due to resident safety. During an interview on 8/22/2024 at 5:40 PM, LPN M (the on-call nurse) stated on 7/28/2024, the weekend supervisor (RN Q) called her and stated the hot water heater was steaming, and water was leaking out of the hot water heater onto the floor in the shower room. LPN M contacted the Administrator and requested that he call RN Q, and he said that he would take care of it. LPN M stated the Administrator said that someone was scheduled to come repair it. On 7/30/2024, LPN M saw steam in the shower room coming from the top of the hot water heater and could feel the heat outside in the hall. LPN M stated she notified the Administrator, and he told her the Maintenance Director would fix the water heater. LPN M stated she followed up with the Administrator on 7/31/2024 and he told her the problem with the water heater was fixed. LPN M agreed for safety reasons, no one should have received care in the Station 2 shower room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 8/23/2024 at 10:50 AM, RN Q stated on 7/28/2024 at 11:38, there was condensation dripping onto the floor from the hot water heater and she notified the DON, and the Administrator. RN Q stated she also contacted LPN M, the on-call nurse. RN Q stated the Administrator called and instructed her to turn on the faucets in the soiled utility room and let it run until the steam cleared. RN Q disclosed on 8/12/2024 the mechanical failure occurred again at approximately 7:00 AM during the change of shift and the Station 2 shower room floor was flooded with hot water. Refer to F600 and F835

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47127 Based on the Board of Examiners of Nursing Home Administrators (BENHA) review, job description review, and interview, Administration failed to provide the oversight and supervision of staff to protect the resident's right to be free from neglect and failed to meet the care needs of residents in a safe environment when staff continued to provide Resident #1's showers in the Station 2 shower room which contained a malfunctioning hot water heater. Administration failed to provide oversight and supervision to provide an environment free from hazards and prevent an avoidable accident when the hot water heater in Station 2 shower room experienced a mechanical failure causing scalding hot water to [NAME] onto the floor where Resident #1 was receiving a shower resulting in a major burn injury to Resident #1's left foot. Administration's failure to provide oversight and supervision resulted in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, serious impairment, or death to a resident) with actual harm to Resident #1. The Administrator, Regional Nurse, Director of Nursing (DON), and Regional Plant Operations Manager were notified of the Immediate Jeopardy (IJ) for F-835 on 8/23/2024 at 8:42 PM in the Conference Room. The facility was cited at F-835 with a scope and severity of J. The Immediate Jeopardy was effective from 7/28/2024 and is ongoing. The facility was also cited F-689 and F-600 with a scope and severity of J, which is substandard quality of care. The facility is required to submit a Plan of Correction (POC). The findings include: Review of the BENHA form revealed the facility had the same Administrator for the last 22 months. The Administrator upon entrance into the facility was hired on October 1, 2022. Review of the facility's unsigned job description for the Administrator dated 3/2021, revealed, .Lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies .Verify that the building and grounds are maintained appropriately, and that equipment and work areas are clean, safe, and orderly, and any hazardous conditions are addressed .ensure resident needs are being addressed .assist in eliminating/correcting problem areas, and/or improvement of services . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's unsigned job description for the Director of Nursing dated 3/2021, revealed, .manage the overall operations of the Nursing Department in accordance with Company policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all residents ' needs .develop, and direct the administration and resident care of the nursing service department .Assure residents a comfortable, clean, orderly and safe environment . During an interview on 8/22/2024 at 11:51 AM, the DON acknowledged since the incident on 8/12/2024, she had become aware of multiple episodes of the hot water heater malfunctioning prior to Resident #1 being burned in the Station 2 shower room. The DON stated on 7/28/2024 at 11:28 PM, she was notified about problems with the Station 2 shower room hot water heater in a text message sent by Registered Nurse (RN) Q. Review of the printed text messages provided by the DON revealed, .Leaking blazing hot water .11:28 PM . The DON admitted the Station 2 shower room should have been taken out of service until it was safe for patient care. During an interview on 8/22/2024 at 2:37 PM, Licensed Practical Nurse (LPN) B stated RN Q reported that during the previous shift (8/11/2024 7 PM to 7 AM), and again at shift change on 8/12/2024 at 7:00 AM, steam and hot water had leaked out of the Station 2 shower room. LPN B stated she reported the incidents of steam and hot water coming from the Station 2 shower room to the Administrator and the Maintenance Director on the morning of 8/12/2024, before Resident #1 was burned by the hot water in the shower. During an interview on 8/22/2024 at 3:16 PM, LPN E stated, .That morning, [8/12/2024] during count [change of shift narcotic reconciliation] I saw water and steam coming out into the hall from the Station 2 shower room .[Named RN Q] went into the soiled utility room and turned on the water in the sink full blast .I told [Named Administrator] that morning when I saw him that I was concerned about accidents due to the continuing episodes of steam and hot water issues and he just said it was normal for that to happen . During an interview on 8/23/2024 at 12:42 PM, the Administrator confirmed he was notified on 7/28/2024 regarding the Station 2 shower room hot water heater malfunction. The Administrator stated the water leaking/gushing from the tank was not hot enough to cause harm to anyone. When asked what water temperature would cause steam and water to be expelled from the hot water heater, he replied, .I don't know, I am not a Chemist . The Administrator admitted to instructing nursing staff to turn on the hot water in an adjacent room and cool off the Station 2 hot water heater to stop the steam and hot water gushing from the malfunctioning hot water heater. The Administrator stated, .Turning on the faucet drains all the hot water from the heater tank and lets cold water fill the tank .When the temperature of water in the hot water tank increases, it causes pressure to build up and the pop off valve [pressure relief valve] triggers to release pressure . When asked if the pressure relief valve was a safety mechanism, the Administrator replied, Yes. When asked if he should have turned off the hot water heater after the pressure relief valve was triggered multiple times due to increased water temperatures instead of instructing staff to drain excessively hot water from the tank, to temporarily stop the steam and hot water being dispersed, the Administrator refused to answer. The Administrator stated the service company came out and fixed the Station 2 hot water heater on 8/1/2024 and denied knowledge of any further problems with the water heater. When asked if he had instructed staff to stop using the Station 2 shower room he replied, There was no need to close it down, [Named Resident #1] was the only resident using that shower room and the leaks usually happened during the night . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN B and LPN E stated they reported malfunctioning of the Station 2 shower room hot water heater to the Administrator on 8/12/2024 before Resident #1 was scalded by water gushing from the hot water heater in the Station 2 shower room. Administration failed to provide the oversight and supervision of staff to protect the resident's right to be free from neglect and failed to meet the care needs of residents in a safe environment Refer to F-600 Administration failed to provide oversight and supervision to provide an environment free from hazards and prevent an avoidable accident. Refer to F-689