STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495405	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Square	501 Oak Avenue Waynesboro, VA 22980

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 49456 Based on observations, resident interviews, and staff interviews, the facility staff failed to serve meals in the dining room in a manner to promote dignity affecting three residents (Resident #106, Resident #107 and Resident #108) out of a survey sample of eight residents. The findings included: The facility staff failed to serve the residents sitting at the same table at the same time. On 3/31/25 at 12:00 p.m., an observation was made in the main dining room at lunchtime of the residents being served their meals. Resident #105 was observed at 12:03 p.m., at the table with two other residents, and she received her lunch meal, ate and was leaving the table before Resident #106, and Resident #107 was served their meals. Resident #108 was observed at the table waiting for the other residents to be served before she began eating her meal. On 3/31/25 at 12:10 p.m., Resident #106 was interviewed. Resident#106 said, [Resident#107's name redacted], maybe we will get some more help. Resident #106 said, I am hungry, but patience is a virtue. Registered nurse RN#2 came by the table and said, [Resident #106 name redacted] good, you got your food. On 3/31/25 at 12:25 p.m., an interview was conducted with Resident #108. Resident #108 said, I hate to eat when others don't have their food. Resident #108 was observed with her food served but was sitting and waiting for the others to be served during the lunch service. Resident #108 said, It is supposed to be like family style meals. On 3/31/25 at 2:35 p.m., an interview was conducted with the executive chef, other staff #1 (OS1). OS1 said, The residents deserve dignity in the dining room. So, we try hard to do one table at a time. On 3/31/25 at 3:28 p.m., an interview was conducted with the administrator. The administrator stated if a couple of people were at a table they should serve everyone at the table before going to the next table. When told about the observation made in the dining room, the administrator responded with disappointment. (continued on next page)

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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 10:00 a.m., a meeting was conducted with the administrator, director of nursing and the corporate staff, during which the above concerns were discussed. No additional information was provided prior to the exit conference.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 41449 Based on observation and staff interview, the facility staff failed to post the results of the most recent survey results in a place readily accessible to residents and families having the potential to affect multiple residents on one of one unit. The findings included: On 3/31/25 at 4:45 p.m., observations were conducted on the one healthcare unit. Upon entry to the unit there was a wall pocket that held a three-ring binder. The cover of the binder read, [facility name redacted] 2022-2023 Virginia State Survey Results. Within the binder were survey results, the most recent survey report was dated 11/15/2023. On 4/1/25 at 8:56 a.m., observations were conducted of the survey results binder. There were no results from the survey conducted February 7, 2025, in the binder. On 4/1/25 at 10:36 a.m., an interview was conducted with the facility administrator. When asked about the survey results, the administrator said, [executive director's name redacted] spoke about survey results at his last meeting with all the residents and those minutes were sent to all the resident's family member. When asked about the posting of the survey results, the administrator reported they are in a locked glass cabinet on the wall in the healthcare unit. The surveyor asked the administrator to explain the purpose of posting survey results. The administrator said, so we can be transparent and let them know what we are doing about the tags and to be open with residents and families about what we are working on. The surveyor notified the administrator that the survey results were in a wall pocket on the left side when you enter the unit and did not include the most recent survey results. The administrator confirmed that she had not posted the most recent survey results. The facility was asked to provide the policy regarding survey results, which was not provided prior to conclusion of the survey. No additional information was provided.

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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. 41449 Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide an environment free of avoidable accident hazards and failed to monitor coffee temperatures to prevent burns, resulting in harm for two residents (Resident #4- R4 and Resident #2-R2) in a survey sample of five residents. These findings led to the identification of Immediate Jeopardy (IJ) and the identification of Substandard Quality of Care. The findings included: On 2/5/25, during a review of facility documentation, it was noted that on 6/13/24, Resident #4 (R4) was served coffee which resulted in a burn to her lip and roof of her mouth, requiring hospitalization . On 2/5/25, a closed record review was conducted of R4's chart. This review revealed that a Hot Liquid Risk Assessment had been completed on five occasions in 2023 and four times in 2024. The most recent assessment prior to the burn incident on 6/13/24, was completed on 5/23/24, and noted that R4 had tremors in upper extremities that create risk for spillage and weakness in upper extremities that create a risk for spillage. The recommendations on this form read, Lids on hot beverages and water-resistant clothing protector. According to R4's care plan, an intervention dated 5/28/24 was entered that read, .resident is fed all meals either by husband or by staff. On 6/6/23, a care plan intervention was entered that read, lids on all hot liquids. Dated 6/13/24 at 2:32 p.m., a progress note read, Reported at approx. 1200 by husband [name redacted] that resident burnt the top of her mouth on coffee at breakfast this am. Noted a blister on lower lip. UM [unit manager] in to check on resident. Also has a blister in roof of mouth. Noted resident to have chocked on water with noon medications [sic]. Trying to talk and drink at the same time. Informed ST [speech therapy]. UM placed call/text to NP [name redacted]. Placed resident on MD rounding list for am. No acute distress noted., UM placed note in kitchen to use ice in coffee. Another entry was dated 6/13/24 at 7:27 p.m., that read, I went in to see [R4's name redacted] this afternoon about 2pm. She has a small blister on the right side of her lip, and I noted a blister on the roof of her mouth. [R4's spouse's name redacted] said he gave her coffee this morning which she drinks thru a straw and did not check to see how hot it was. spoke with [nurse practitioner's name redacted], NP and see recommended cool compresses and Tylenol which [R4's name redacted] has a routine and prn order available. reported to [licensed practical nurse #2's name redacted] what [NP name's redacted] said and [NP name redacted] will see her in the morning. According to the nursing progress notes and medication administration record dated 6/13/24, R4 was administered two doses of Tylenol due to pain in and around mouth d/t [due to] coffee burn. According to medication administration notes dated 6/14/24, R4 could not swallow her morning medications. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing note entry dated 6/14/24 at 9:20 a.m., read in part, Undersigned was approached by PT [physical therapist] and SLP [speech language pathologist] and asked to send resident out to ED [emergency department] as SLP had assessed her and found a large blister on palate and lower lip as received yesterday by hot coffee. SLP reports that resident is coughing and having difficulty managing her own secretions. Went to see resident and her spouse and explained that we would like to send her to the ED to be evaluated as airway could be compromised. They agreed and 911 was called for transport with report given to EMS [emergency medical services]. Upon EMS arrival, report was given to EMTs as patient having some difficulty managing secretions and history of Parkinsons. [Nurse practitioner name redacted] was notified, and she states she was the one who asked SLP to evaluate the resident's swallowing ability as she when she was here earlier in the morning, she had noticed some gurgling sounds when she got her to swallow. Resident's spouse states he has notified her family, and they are enroute to ED. Dated 6/14/24 at 1:30 p.m., a nursing progress note read, Spoke with resident's spouse to get an update. He states resident is getting some IV fluid and a decision had been made that she did not need a transport to any other facility. Spouse was tearful and stated that every morning he writes on resident's menu that he wants coffee in a Styrofoam cup, half full, with ice and a straw. He said he lifted the cup to her lips, and she immediately screamed out. The straw became stuck to her lip. He states he mentioned this to the kitchen staff, and they got her ice chips which she indicated helped with the burn and ice cream that he spooned in for her. Undersigned reminded spouse that Styrofoam retains heat, but he stated this was the only kind of cup she could hold onto due to her Parkinsons. He stated he wished he had noticed that there didn't seem to be any ice in the cup and that he hadn't noticed the cup being hot . The discharge summary for R4's hospitalization , from 6/14/24-6/22/24, read in part, . reason for admission: scalded throat from hot coffee, inability to swallow .presented to the emergency department after having issues with swallowing in the setting of drinking hot coffee. Associate with this, she has had mucosal abnormality in her oropharynx and her lips which is causing her not to be able to swallow without significant difficulty due to pain. Burn unit at [name of hospital redacted] was contacted by the ER physician who did not recommend the need for transfer but did recommend supportive care with IV fluids. Discussed this case with GI [gastroenterology] who also did not see any reason to perform any surgical intervention such as endoscopy. Patient was having evaluation and care. She was started on IV antiemetics, IV fluids and IV Zosyn [an antibiotic], CT neck showed thickening of the epiglottis without any other abnormalities . Because of her inability to swallow at all and silent aspirations a PEG [percutaneous endoscopic gastrostomy] tube was placed on 6/20 with some general surgery . Plan is to return to [this skilled nursing facility name redacted] with tube feeds for the near future until her throat heals. Once this heals up, she should be able to return to eating normally and the PEG tube can be removed . On 2/5/25 at 11:40 a.m., an observation was conducted of the on-unit kitchenette where the coffee is prepared. The cook (other employee #1- OE #1) was observed taking the temperature of food items, which included the soup at 174 degrees farenheight and hotdog chili that was 175 degrees farenheight. The cook did not obtain any temperatures of the beverages being served. The coffee maker was noted to have a digital display that read, Ready to Brew. Water temp: 200 degrees. The dietary staff were observed to pour and serve coffee directly from the coffee pot in which it was brewed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/5/25, the food temperature logs for the past week were requested and received. According to the food temperature logs from 1/27/25-2/2/25 and the lunch meal on 2/5/25, there was no evidence that the temperature of the coffee had been obtained. On 2/6/25 at 7:53 a.m., observations of the kitchenette on the unit were conducted. Interviews with the two dietary staff working (other employee #4- OE #4 and other employee #5- OE #5), which revealed that they did not have a protocol to check the temperature of the coffee being served to residents. The food temperature log was reviewed and an interview with the cook confirmed that she only checks the temperature of food items, not beverages. Upon request of the surveyor, a cup of coffee was poured, and the temperature was taken by the cook, which was observed to be 161.2 degrees Fahrenheit (F). The cook said, Oh, I would have thought it would have been hotter than that. It should be, shouldn't it? The dietary staff were observed to pour coffee directly from the pot in which it was brewed. On 2/6/25 at 8 a.m., an interview was conducted with registered nurse #1 (RN #1), who was the unit manager. When asked about R4, RN#1 said, She had Parkinson's and was alert and oriented, was mostly extensive to total assistance with everything. She could feed herself at first but had shoulder issues so her husband would feed her. That morning in the dining room, he sat next to her, and he always gave her coffee. I was at another table feeding and I didn't hear anything unusual. A little while later he called me to the room and complained that she couldn't swallow. I got my flashlight, and her top pallet was pink, but I couldn't really see. That's when we found out he had given her hot coffee through a straw. When asked if R4 normally drank through a straw, RN #1 said, Yes, she normally drank through a straw She had been declining for a while but that was kind of the downward slope for her . On 2/6/25 at approximately 8:40 a.m., an interview was conducted with the dining services director (DSD). The DSD stated that they do not routinely check the temperature of coffee, but that she has periodically checked it and added, It is brewed at about 196 degrees, is held around 160 degrees F, and usually once cream and sugar is added it is around 140 degrees. I've temped it at all stages to ensure it is safe . The DSD reported the last time she had checked it was a few months ago, following R4's incident and added I've done it several times over the years. The DSD also reported that another resident, identified as Resident #2 (R2), had a few incidents where he spilled coffee in his lap. Facility documentation regarding R4's burn incident included a handwritten statement by a dietary server (Other Employee #8- OE #8). This document read, Last Thursday, we had gotten busy, and I was rushing around. I had taken count on drinks and started that morning and noticed [R4's name redacted] had asked for coffee in the right margin. A while later while we were serving, I brought [R4's spouse's name redacted, referred to as Resident #6-R6 going forward] and [R4's name redacted] their food because the counter where [cook's name redacted] was making plates was getting full. Then I grabbed [R6's name redacted] his two waters and [R4's name redacted] a Danimal [yogurt]. Initially forgetting the coffee for [R4's name redacted]. While bringing some plates out for another table [R6's name redacted] called out to me and asked for [R4's name redacted] coffee. In a rush I quickly made her coffee as described on the menu from memory but forgot her ice and straw It wasn't until after lunch when going back through the menus that I realized I had forgotten to put ice in the cup. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/6/25 at 9:29 a.m., a telephone interview was conducted with OE #8. OE #8 explained that R4's menu had requested coffee in a Styrofoam cup and asked for ice. OE #8 said, I forgot to put ice in there. I didn't realize she had been burned until after lunch that day when [DSD's name redacted] asked me. When asked if they check the temperature of coffee before it is served to residents, OE #8 said, Following that incident, we now have the pots that check the temperature. We got them about a week following that incident. We set the temperature, and it keeps it warm but not as warm as the coffee pot itself. OE #8 went on to explain that R4 had always been served coffee, that R4's husband would write on the menu to put ice in it, and that it was not a new request that day. On 2/6/25, a review of R2's clinical record revealed a progress note entry, dated 11/11/24, that read, Resident spilt coffee on right thigh, slight redness noted. Cool compress applied. UM [unit manager] informed, happened around 11:20am. Checked right thigh after lunch, redness resolved. Resident states leg is fine. An additional review of R2's progress notes revealed an entry, dated 1/1/23, that read, Resident requested hot coffee. It was given to him, and he promptly spilled it over on his abdomen and left thigh. The groin area was protected by his brief. I notified Dr. [name redacted] and he ordered Bacitracin / Polymyxin to be applied to scalded area and cover lightly with a non-stick telfa. Resident is c/o [complaining of] discomfort when the area had bacitracin applied. He was offered a pain pill (oxy 5 mg), and he accepted. He then requested another cup of coffee. We discussed keeping a chux pad over himself when drinking coffee, and to sit upright in the bed. He agreed with this. On 1/2/23, R2 was seen by the medical provider and the note read in part, Chief Complaint / Nature of Presenting Problem: Coffee burn History of Present Illness: I saw the patient today after he spilled coffee on his abdomen and upper thighs. The coffee was quite hot, he had immediate pain. He was noted to have some blistering .The patient has partial-thickness second-degree burns over his lower abdomen and upper left thigh. This encompasses about 2 to 3% of body surface area. They do not appear infected. Barrier ointment will be applied. Careful attention to hygiene will be essential . On 2/6/25, a review of R2's clinical record revealed that a Hot Liquid Risk Assessment had been conducted on 3/7/22, 5/17/22, 8/7/22, 9/13/24, and 11/21/24. Each of the assessments noted the resident was at risk and that interventions were implemented. R2's care plan, which was revised on 1/4/23, had interventions that read in part, [R2's name redacted] has been evaluated by OT [occupational therapy] and will be using a BLUE cup with a white snap-on lid with spout will be used for all hot liquids to prevent further spills and burns. Soups in deep bowls . On 6/14/23, an intervention was added to R2's care plan that read, [R2's name redacted] is encouraged to wear a clothing protector at meals but he will refuse them at times. On 11/21/24, an additional intervention was added that read, use clothing protector with meals when in bed and when up in chair for safety. According to the facility policy titled, Hot Beverages/Liquids, it read in part, 1. On admission/re-admission, quarterly, annually and with significant change, the resident will be assessed for risk of use of hot liquids by a licensed nurse, or dietitian or therapist . 2. If the resident is determined to be at risk of spillage and/or injury from hot liquids, the interdisciplinary team will make recommendations to minimize the resident's risk . 6. The hot beverage dispenser is no higher than 155 degrees; however, soups are dipped from the steam well and served higher than that under the monitoring of the dining staff (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/6/25 at 11:20 a.m., the survey team identified that immediate jeopardy (IJ) was present, as confirmed by the state agency, and was determined to have begun on 1/1/23. A meeting was held with the facility administrator and director of nursing to notify them of IJ findings. On 2/6/25 at 2:40 p.m., the facility submitted an accepted plan of removal that read as follows: All hot liquids served to residents will ONLY come from one central location (Galley Kitchen in HC [healthcare]). [Facility name redacted] will not serve any hot liquid over the following temperatures: Coffee- 155 degrees (There is a temperature regulated pot for coffee). Water- 155 degrees (there is a temperature regulated pot for hot water). Soups/Gravy's/Sauces- hold no higher than 160 degrees- and no less than 140 degrees following food safety guidelines. Temperatures will be taken and documented by the Galley [NAME] for all foods and beverages. The facility will immediately perform a new hot liquid assessment on all current residents. All current staff will be educated on the Hot Beverages/Hot Liquids Policy and any new recommendations based on the hot liquid assessment. Oncoming staff will be educated prior to being permitted to work. The Hot Beverage/Liquid Policy will be reviewed and revised as needed. Complete by Friday, February 7 at 7:00 a.m. On 2/6/25 at 3:10 p.m., an interview was conducted with Resident #6- R6, who was the spouse of R4. R6 said, Every morning she had a cup of coffee . Every day we get a menu for the next day. She always ordered the same thing for breakfast, scrambled eggs, a cup of coffee and I would put with ice, 2 sugars, and creamer. I always wrote that on the menu, this particular day it was a young girl, she brought the coffee in a Styrofoam cup, she [R4] let out a scream, so I knew it was the coffee. All she had was what was in the straw, not a lot. I gave her ice right away and ice cream, she seemed ok except for blistering on her lips. The next day she was not any better and actually her Parkinson's got worse, I think due to trauma. She went to the hospital . They put ice in the coffee so I had assumed they had done it. I didn't feel heat in the cup, so I had no idea they didn't . On 2/6/25 at 3:20 p.m., an interview was conducted with Resident #2- R2. R2 was asked about the two incidents where coffee was spilled which caused injury. R2 had no recall of the incidents. On 2/7/25, to verify implementationof the removal plan, the surveyor reviewed the Hot Liquid assessments to ensure that they were completed on 100% of the residents. No concerns were found. Observations were conducted in the Galley kitchen, which confirmed that temperatures had been obtained for all foods and beverages to include the coffee. The kitchen staff was observed to obtain temperatures of the coffee prior to serving to residents and added ice as needed to ensure that coffee was not served hotter than 155 degrees. It was also observed that the coffee was being held in the temperature regulated carafes. Residents were observed during breakfast to confirm that the interventions identified in the hot liquid assessments were being implemented, to include but not limited to lids on hot beverages and water resistant clothing protectors. The Hot Beverage/Liquid Policy was received and reviewed, which confirmed that the facility had revised the policy on 2/6/25. Interviews were conducted with staff across all departments to ensure they had knowledge of the Hot Beverage/Liquid policy and appropriate serving temperatures of hot liquids. The education/in-service sign in sheets were reviewed and compared to the as-worked schedule to ensure all staff had received education. No concerns were found. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/7/25 at 9 a.m., after having verified that the removal plan had been fully implemented and that facility actions had eliminated the likelihood of serious injury, harm, impairment, or death, the facility was notified that the immediacy had been removed. The scope and severity for the remaining noncompliance was then lowered to a level three, isolated.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 41449 Based on observation, staff interviews and facility documentation, the facility staff failed to post daily staffing information on 1 of 1 unit. The findings included: The facility staff failed to post the daily staffing information for residents and visitors to be able to view. On 2/7/25 at 9:27 a.m. during a walkthrough of the nursing facility the surveyor observed that the daily staffing posting was dated 2/6/25. On 2/7/25 at 9:30 a.m. an interview was conducted with the unit manager, who was a registered nurse (RN #1). When asked about the purpose of the daily staffing posting, RN#1 stated, Because it is regulation and so families know who we have in here. The unit manager identified a staff member as being responsible for it and reported that she posts it daily when she arrives at 7:30 a.m. During the above interview, the facility administrator walked in, was notified of the concern, and was invited to also confirm the finding. On 2/7/25 at approximately 9:35 a.m., the surveyor was accompanied by the unit manager and facility administrator back to the lobby where it was confirmed that the daily staff posting was for the prior day. The unit manager said, Usually she has it up when she comes in, but it's been a crazy day. On 2/7/25 at 10 a.m., during a group meeting with the administrator, director of nursing (DON), and corporate staff, the above findings were discussed. The DON said, She [the assigned employee to post staffing] arrives at 7:30 a.m. every day so it should be done when she gets here. The administrator confirmed that visiting hours are 8 am until 8 pm daily and she would expect it to be posted by the time the visiting hours start. No further information was received prior to conclusion of the survey.

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F 0804 Level of Harm - Actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41449 Based on observation, resident interview, staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide beverages at a safe temperature to prevent injury, which resulted in harm for two residents (Resident #4 - R4 and Resident #2 - R2) in a survey sample of five residents. The findings included: 1. For Resident #4 (R4), the facility staff served coffee at a temperature that resulted in significant burns and scalding, which developed into a life-threatening injury that required hospitalization and the surgical placement of a feeding tube. On 2/5/25, during a review of facility documentation, it was noted that on 6/13/24, Resident #4 (R4) was served coffee which resulted in a burn to her lip and roof of her mouth, causing hospitalization . On 2/5/25 a closed record review was conducted of R4's chart. This review revealed a Hot Liquid Risk Assessment completed on 5/23/24, which noted R4 had tremors in upper extremities that create risk for spillage and weakness in upper extremities that create a risk for spillage. The recommendations documented on this form read, Lids on hot beverages and water-resistant clothing protector. Dated 6/13/24 at 2:32 p.m., a progress note read, Reported at approx. 1200 by husband [name redacted] that resident burnt the top of her mouth on coffee at breakfast this am. Noted a blister on lower lip. UM [unit manager] in to check on resident. Also has a blister in roof of mouth. Noted resident to have chocked on water with noon medications [sic]. Trying to talk and drink at the same time. Informed ST [speech therapy]. UM placed call/text to NP [name redacted]. Placed resident on MD rounding list for am. No acute distress noted., UM placed note in kitchen to use ice in coffee. Dated 6/13/24 at 7:27 p.m., another entry read, I went in to see [R4's name redacted] this afternoon about 2pm. She has a small blister on the right side of her lip, and I noted a blister on the roof of her mouth. [R4's spouse's name redacted] said he gave her coffee this morning which she drinks thru a straw and did not check to see how hot it was. spoke with [nurse practitioner's name redacted], NP and she recommended cool compresses and Tylenol which [R4's name redacted] has a routine and prn order available. Reported to [licensed practical nurse #2's name redacted] what [NP name's redacted] said and [NP name redacted] will see her in the morning. According to the nursing progress notes, R4 was administered two doses of Tylenol due to pain in and around mouth d/t [due to] coffee burn. According to medication administration notes dated 6/14/24, R4 could not swallow her morning medications. (continued on next page)

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F 0804 Level of Harm - Actual harm Residents Affected - Few	Dated 6/14/24 at 9:20 a.m., a nursing note entry read in part, Undersigned was approached by PT [physical therapist] and SLP [speech language pathologist] and asked to send resident out to ED [emergency department] as SLP had assessed her and found a large blister on palate and lower lip as received yesterday by hot coffee. SLP reports that resident is coughing and having difficulty managing her own secretions. Went to see resident and her spouse and explained that we would like to send her to the ED to be evaluated as airway could be compromised. They agreed and 911 was called for transport with report given to EMS [emergency medical services]. Upon EMS arrival, report was given to EMTs as patient having some difficulty managing secretions and history of Parkinsons. [Nurse practitioner name redacted] was notified, and she states she was the one who asked SLP to evaluate the resident's swallowing ability as she when she was here earlier in the morning, she had noticed some gurgling sounds when she got her to swallow. Resident's spouse states he has notified her family, and they are enroute to ED. Dated 6/14/24 at 1:30 p.m., a nursing note entry read, Spoke with resident's spouse to get an update. He states resident is getting some IV fluid and a decision had been made that she did not need a transport to any other facility. Spouse was tearful and stated that every morning he writes on resident's menu that he wants coffee in a Styrofoam cup, half full, with ice and a straw. He said he lifted the cup to her lips, and she immediately screamed out. The straw became stuck to her lip. He states he mentioned this to the kitchen staff, and they got her ice chips which she indicated helped with the burn and ice cream that he spooned in for her. Undersigned reminded spouse that Styrofoam retains heat, but he stated this was the only kind of cup she could hold onto due to her Parkinsons. He stated he wished he had noticed that there didn't seem to be any ice in the cup and that he hadn't noticed the cup being hot . For the admission from 6/14/24-6/22/24, R4's hospital discharge summary read in part, . reason for admission: scalded throat from hot coffee, inability to swallow . presented to the emergency department after having issues with swallowing in the setting of drinking hot coffee. Associate with this, she has had mucosal abnormality in her oropharynx and her lips which is causing her not to be able to swallow without significant difficulty due to pain. Burn unit at [name of hospital redacted] was contacted by the ER physician who did not recommend the need for transfer but did recommend supportive care with IV fluids. Discussed this case with GI [gastroenterology] who also did not see any reason to perform any surgical intervention such as endoscopy. Patient was having evaluation and care. She was started on IV antiemetics, IV fluids and IV Zosyn [an antibiotic], CT neck showed thickening of the epiglottis without any other abnormalities . Because of her inability to swallow at all and silent aspirations a PEG [percutaneous endoscopic gastrostomy] tube was placed on 6/20 with some general surgery . Plan is to return to [this skilled nursing facility name redacted] with tube feeds for the near future until her throat heals. Once this heals up, she should be able to return to eating normally and the PEG tube can be removed . (continued on next page)

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F 0804 Level of Harm - Actual harm Residents Affected - Few	On 2/6/25 at 8 a.m., an interview was conducted with registered nurse #1 (RN #1), who was the unit manager. When asked about R4, RN #1said, She had Parkinson's and was alert and oriented, was mostly extensive to total assistance with everything. She could feed herself at first but had shoulder issues so her husband would feed her. That morning in the dining room, he sat next to her, and he always gave her coffee. I was at another table feeding and I didn't hear anything unusual. A little while later he called me to the room and complained that she couldn't swallow. I got my flashlight, and her top pallet was pink, but I couldn't really see. That's when we found out he had given her hot coffee through a straw. When asked if R4 normally drank through a straw, RN #1 said, Yes, she normally drank through a straw . She had been declining for a while but that was kind of the downward slope for her . On 2/6/25 at approximately 8:40 a.m., an interview was conducted with the dining services director (DSD). The DSD stated that they do not routinely check the temperature of coffee, but that she had periodically checked it. The DSD said, It is brewed at about 196 degrees, is held around 160 degrees F, and usually once cream and sugar is added it is around 140 degrees. I've temped it at all stages to ensure it is safe . The DSD reported the last time she had checked it was a few months ago, following R4's incident and added I've done it several times over the years. The DSD also reported that another resident, identified as Resident #2 (R2), had a few incidents where he had spilled coffee in his lap. Included with the facility documentation regarding R4's injury from the hot coffee was a handwritten statement by a dietary server (Other Employee #8 - OE #8). This document read, Last Thursday, we had gotten busy, and I was rushing around. I had taken count on drinks and started that morning and noticed [R4's name redacted] had asked for coffee in the right margin. A while later while we were serving, I brought [R4's spouse's name redacted, referred to as Resident #6-R6 going forward] and [R4's name redacted] their food because the counter where [cook's name redacted] was making plates was getting full. Then I grabbed [R6's name redacted] his two waters and [R4's name redacted] a Danimal [yogurt]. Initially forgetting the coffee for [R4's name redacted]. While bringing some plates out for another table [R6's name redacted] called out to me and asked for [R4's name redacted] coffee. In a rush I quickly made her coffee as described on the menu from memory but forgot her ice and straw It wasn't until after lunch when going back through the menus that I realized I had forgotten to put ice in the cup. On 2/6/25 at 9:29 a.m., a telephone interview was conducted with OE #8. OE #8 explained that R4's menu had requested coffee in a Styrofoam cup and asked for ice. OE #8 said, I forgot to put ice in there. I didn't realize she had been burned until after lunch that day when [DSD's name redacted] asked me. When asked if they check the temperature of coffee before it is served to residents, OE #8 said, Following that incident, we now have the pots that check the temperature. We got them about a week following that incident. We set the temperature, and it keeps it warm, but not as warm as the coffee pot itself. OE #8 went on to explain that R4 had always been served coffee and the resident's husband would write on the menu to put ice in it; this was not a new request that day. (continued on next page)

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F 0804 Level of Harm - Actual harm Residents Affected - Few	On 2/6/25 at 3:10 p.m., an interview was conducted with Resident #6 - R6, who was the spouse of R4. R6 said, Every morning she had a cup of coffee . Every day we get a menu for the next day. She always ordered the same thing for breakfast, scrambled eggs, a cup of coffee and I would put with ice, 2 sugars and creamer. I always wrote that on the menu, this particular day it was a young girl, she brought the coffee in a Styrofoam cup, she [R4] let out a scream, so I knew it was the coffee. All she had was what was in the straw, not a lot. I gave her ice right away and ice cream, she seemed ok except for blistering on her lips. The next day she was not any better and actually her Parkinson's got worse, I think due to trauma. She went to the hospital . They put ice in the coffee so I had assumed they had done it. I didn't feel heat in the cup, so I had no idea they didn't . 2. For Resident #2 (R2), who had two instances of spilling coffee, resulting in injury, the facility staff failed to ensure coffee was served at a safe temperature to prevent burns. On 2/6/25, a review of R2's clinical record revealed that a Hot Liquid Risk Assessment had been conducted on 3/7/22, 5/17/22, 8/7/22, 9/13/24, and 11/21/24. Each of the assessments noted the resident was at risk and interventions were implemented. Last revised on 1/4/23, R2's care plan read in part, [R2's name redacted] has been evaluated by OT [occupational therapy] and will be using a BLUE cup with a white snap-on lid with spout will be used for all hot liquids to prevent further spills and burns. Soups in deep bowls . On 6/14/23, an intervention was added to R2's care plan that read, [R2's name redacted] is encouraged to wear a clothing protector at meals but he will refuse them at times. On 11/21/24, an additional intervention was added that read, use clothing protector with meals when in bed and when up in chair for safety. Dated 11/11/24, a progress note entry read, Resident spilt coffee on right thigh, slight redness noted. Cool compress applied. UM [unit manager] informed, happened around 11:20am. Checked right thigh after lunch, redness resolved. Resident states leg is fine. An additional review of R2's progress notes revealed an entry dated 1/1/23, that read, Resident requested hot coffee. It was given to him, and he promptly spilled it over on his abdomen and left thigh. The groin area was protected by his brief. I notified Dr. [name redacted] and he ordered Bacitracin / Polymyxin to be applied to scalded area and cover lightly with a non-stick telfa. Resident is c/o [complaining of] discomfort when the area had bacitracin applied. He was offered a pain pill (oxy 5 mg), and he accepted. He then requested another cup of coffee. We discussed keeping a chux pad over himself when drinking coffee, and to sit upright in the bed. He agreed with this. On 1/2/23, R2 was seen by the medical provider and the note read in part, Chief Complaint / Nature of Presenting Problem: Coffee burn History of Present Illness: I saw the patient today after he spilled coffee on his abdomen and upper thighs. The coffee was quite hot, he had immediate pain. He was noted to have some blistering .The patient has partial-thickness second-degree burns over his lower abdomen and upper left thigh. This encompasses about 2 to 3% of body surface area. They do not appear infected. Barrier ointment will be applied. Careful attention to hygiene will be essential . On 2/6/25 at 3:20 p.m., an interview was conducted with Resident #2 - R2. When asked about the two incidents when spilled coffee caused him injury, R2 had no recall of the incidents. (continued on next page)

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F 0804 Level of Harm - Actual harm Residents Affected - Few	On 2/5/25 and 2/6/25, observations were conducted in the on-unit kitchenette, where the coffee was brewed and served from. The coffee was observed being poured directly from the pot in which it was brewed, not the temperature controlled caraffe. Observations of the coffee maker revealed a digital display that read, ready to brew, water temp 200 degrees. According to facility staff interviews and according to the temperature logs, the temperature of hot beverages was not checked or monitored by facility staff prior to serving. Titled, Hot Beverages/Liquids, this facility policy read in part, .6. The hot beverage dispenser is no higher than 155 degrees; however, soups are dipped from the steam well and served higher than that under the monitoring of the dining staff . On 2/6/25 and again on 2/7/25, the facility administrator and director of nursing were made aware of the above findings.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41449 Based on observation, staff interview, clinical record review and facility documentation reviews, the facility staff failed to effectively administer in the facility in a manner to prevent accident hazards, which resulted in the identification of immediate jeopardy and substandard quality of care during the survey, that had been identified during a prior survey and not corrected, having the potential to result in more than minimal harm for many residents residing on one of one units. The findings included: The facility administrator, who was responsible for monitoring and ensuring ongoing compliance to provide an environment free of accident hazards, failed to effectively administer the facility in a manner to ensure residents were not at risk for injury from hot liquids. During the survey conducted 2/5/25-2/7/25, the facility was determined to be in immediate jeopardy due to the lack of monitoring of the temperature of hot liquids, which resulted in harm when two residents suffered injury from spilled coffee. One of the residents required hospitalization for the severe injuries sustained and underwent multiple surgical procedures as a result. Following the abatement of immediate jeopardy during that survey, the facility submitted a plan of correction to ensure ongoing compliance, in which the facility administrator had a direct role. The approved plan of correction read in part, . Temperature checks will be performed by the cook on extension sheets during mealtimes of any hot liquid (coffee, hot water, reheated beverages) Coffee / Hot Water will not exceed 155 degrees (serving temp). Soups/Gravy/Sauces will be held between 140-160 degrees. Not to exceed 160 degrees (serving temp) . The Administrator will provide oversight for an environment free of avoidable accidents and safe monitoring of hot liquid temperatures. This will be reviewed in the daily leadership meeting. Audits will be conducted to monitor whether hot liquid temperatures are served at the appropriate temperatures and ensure that residents at risk have the appropriate interventions and assistive devices in place to prevent burns. Audits will be conducted three times per week for 30 days and then one time per week for an additional 60 days . On 3/31/25 at 12 noon, observations were conducted in the kitchen and dining room of the lunch meal. In the dining room, a sign was posted that read, [facility name redacted] will not serve any hot liquid over the following temperatures: Coffee- 155 degrees (there is a temperature regulated pot for coffee). Water- 155 degrees (there is a temperature regulated pot for hot water). Soups/Gravies/Sauces- hold no higher than 160 degrees- and no less than 140 degrees following food safety regulations. It was observed that the cook (OE#2) measured the temperature of the soup as 163 degrees Fahrenheit (F). It was then observed that Resident #101 (R101) was served soup in a regular bowl and was observed eating the soup. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #102 (R102) was observed being served a cup of hot chocolate without a lid on the cup. The facility staff had not taken temperatures of the hot water prior to preparing the hot chocolate for R102. After the resident was served the hot chocolate, the dietary aide (OS #2) was questioned about the source for the hot water used to make the hot chocolate. OS#2 stated that she had obtained the water directly from the coffee maker and confirmed that she had not taken the temperature of the hot water prior to serving R102 the hot chocolate. OS#2 then checked the temperature of the water from the coffee maker/dispenser, and it measured 178.5 degrees F. On 3/31/25 at 12:25 p.m., following R101 being served and observed consuming the soup, the surveyor returned to the kitchen. When asked if she had rechecked the temperature of the soup, the cook (OE #2) said, No. When asked to recheck the temperature of the soup, OE #2 demonstrated that the thermometer indicated 159.9 degrees F. When asked about the safe temperature, OE #2 said, I don't know what the temperature should be, 160 something. Do I need to go get my paper? It was observed that there was no posted signage in the kitchen on heating or serving hot liquids. On 3/31/25, a clinical record review was conducted of R101's chart. The review revealed that on 2/13/25, R101 had a Hot Liquid Risk Assessment completed, which indicated she was at risk for injury from hot liquids and the facility documented interventions that included lids on hot beverages and soups in mugs. According to R101's care plan, the intervention of lids on hot liquids, soups in mugs was added to the care plan on 2/13/25. According to the clinical record, R102 was admitted to the facility on [DATE], at which time a Hot Liquid Risk Assessment was completed. The assessment noted R102 had . weakness in upper extremities that create risk for spillage. The intervention documented was lids on hot beverages. R102's care plan was initiated on 3/21/25 and noted the intervention for lids on hot liquids. On 3/31/25 at 3:40 p.m., an interview was conducted with the facility administrator. The administrator explained that coffee, hot water, and hot tea are to be served at 155 degrees F or less. Soups and gravy are to be at 160 degrees F or less. The administrator said, We don't want any repeats of spills or burns, we don't want any accidents. The facility administrator went on to say that the food temperature logs are to indicate what temperature they are serving foods at. I was looking at them and I think some folks measured when they took out [referring to the transport insulated box that food is transported from the main kitchen to the unit kitchenette in], rather than when served. When asked, how are you monitoring compliance? The administrator said, I had not gone and looked at this last week, I was planning to do it today and y'all came. When notified of the above findings, including that foods were being held at temperatures higher than the facility identified as being safe temperatures and residents' interventions were not being followed, the administrator said, I think I definitely need to do some survey education with some things. We have done education with all the staff, including dining. I've been periodically going down and asking what's the hottest you can serve a hot liquid at. When asked if OE#2 had been questioned on safe temperatures, the administrator said, No. When asked if she checked the temperature of hot liquids and soups, the administrator said, I don't actually check the temperatures; it was an observation thing. On 3/31/25 at 4:56 p.m., observations were conducted in the dining room of the evening meal. Resident #105 was served coffee without a lid. According to R105's meal ticket, she was to have a lid with hot liquids. The administrator was present in the dining room, and this was brought to her attention. The administrator confirmed the observations and then went to the kitchen and had the dietary aide provide R105 a mug with a lid for the coffee. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to R105's clinical record, a risk assessment for hot liquids was completed on 2/6/25, and the recommendation noted, lids on hot beverages. According to R105's care plan an intervention dated 5/2/24 read, All staff to be informed of resident's special dietary and safety needs. On 2/12/25, another intervention had a revision, and it read, Lids on hot liquids. Review of the food temperature logs revealed that following the removal of the prior immediate jeopardy on the morning of 2/7/25, during the lunch meal on 2/7/25, the tomato bisque soup was recorded as having been at a temperature of 183 degrees F, which exceeded the allowable holding temperature according to the facility policy for resident safety. During the evening/dinner meal on 2/7/25, they recorded that the tomato bisque soup was 183.7 degrees F, and the [NAME] stew was 181.2 degrees F. There was no indication that the recorded temperatures were holding temperatures or serving temperatures, nor any measures taken to correct the unsafe temperatures. According to the food temperature logs for the lunch and evening meal on 2/10/25, the soup was recorded as having had a temperature of 190 degrees and 181.2 degrees F, respectfully. On 2/13/25, the chicken noodle soup at lunch had a holding temperature of 166 degrees recorded. From 2/14/25-3/17/25, there were 26 instances where the soup was recorded as having been held at a temperature above 160 degrees F. Multiple instances recorded the temperature as having been at or above 190 degrees and had no indication that the temperature was checked prior to serving to residents. There were multiple instances of meals where there was no evidence of food temperatures or the hot liquid temperatures being checked and/or monitored. On five occurrences, 2/16/25, 3/10/25, 3/15/25 for breakfast and lunch, and 3/16/25, the coffee was recorded at a temperature that exceeded the facility's identified safe temperature of 155 degrees F. On 3/31/25 at 3:40 p.m., an interview was conducted with the facility administrator. The administrator explained that coffee, hot water, and hot tea are to be served at 155 degrees F or less. Soups/gravy/sauces are to be at 160 degrees F or less. The administrator said, Following temps is important so we don't have a repeat accident. We don't want any accidents. The facility administrator went on to say that the food temperature logs are . to indicate what temperature they are serving foods. I was looking at them and I think some folks measured when they took it out [referring to the transport insulated box that food is transported from the main kitchen to the unit kitchenette], rather than when served. When asked how is she monitoring compliance, the administrator said, I had not gone and looked at the temperature logs last week. I was planning to do an audit today and y'all came. I think I definitely need to do some survey education with some things. We have done education with all of the staff down there, including dining. I've been going down periodically and asking what's the hottest you can serve a hot liquid. When asked if OE #2 had been questioned, the administrator stated, No. On 4/1/25 at 1 p.m., after consulting with the state survey agency, the survey team determined the facility was again in immediate jeopardy (IJ) regarding accident hazards related to hot liquids and that the immediacy began with the very next meal served following the removal of IJ on the morning of 2/7/25. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 11:14 a.m., a follow-up interview was conducted with the facility administrator. When asked to explain and describe her role, the administrator stated, My title is Administrator of Resident Life. I oversee health care, resident services department, activities, the front desk . the day-to-day operations for the healthcare center . The administrator explained that she makes rounds within the facility and attends morning meetings. She explained that during morning meetings, the following are reviewed, We talk about census, incidents, falls and things that have happened in the last 24 hours. When asked what the purpose of reviewing incidents is, the administrator said, We want to be proactive or reactive to incidents and implement interventions to prevent reoccurrence, pinpoint things that could be a performance improvement issue. That way if any questions are among the departments, we can communicate and have a multidisciplinary approach and communication. When asked if she was responsible for resident safety and wellbeing, the administrator said, Yes. The facility provided a policy titled, Hot Beverages/Liquids with a revision date of 03/2025. According to the policy, it read in part, [Facility name redacted] will establish and maintain policies and protocols to ensure resident safety and minimize resident harm from hot beverages/liquids. Burns related to hot water/liquids may also be due to spills and/or immersion 1. On admission/re-admission, quarterly, annually and with significant change, the resident will be assessed for risk of use of hot liquids i.e. beverages, soups, etc. by a licensed nurse, or dietitian, or therapist . 2. If the resident is determined to be at risk of spillage and/or injury from hot liquids, the interdisciplinary team will include preventative measures in the resident's care-plan to minimize the resident's risk . 5. The following safe temperatures will be monitored for hot liquids: Coffee- 155 degrees, water- 155 degrees, soups/gravy/sauces- hold no higher than 160 and no less than 140 for compliance with food safety guidelines . According to the job description for the administrator, the job description read in part, Job Summary: The primary responsibilities of the administrator of resident life is to oversee daily operations in the nursing and life enrichment departments and function as the administrator of record for . health care center. The document went on to read, Essential Job Duties: . Ensure . healthcare center remains in compliance with all applicable state and federal regulations . In conjunction with the department team members- develop, interpret, and initiate policies and procedures for the overseen departments. Makes appropriate policy or procedure changes to comply with state and federal regulations . Researches and develops plans of action for dealing effectively with important resident problem areas . During the meeting with the administrator, she was made aware of the survey team's concern that the facility was not effectively administered to ensure the previously cited deficiency was corrected to ensure residents were free from accident hazards. No additional information was provided.

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F 0865 Level of Harm - Actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record reviews, and facility documentation review, the facility staff failed to implement and maintain an effective quality assurance and performance improvement (QAPI) program, and failed to provide evidence necessary to demonstrate compliance with these requirements, which resulted in harm for two residents (Resident #2 and Resident #4) in a survey sample of five residents. The findings included: On 2/5/25 at 11:40 a.m., an observation was conducted of the on-unit kitchenette where the coffee is prepared. The cook (other employee #1- OE #1) was observed taking the temperature of food items, which included the soup at 174 degrees farenheight and hotdog chili that was 175 degrees farenheight. The cook did not obtain any temperatures of the beverages being served. The coffee maker was noted to have a digital display that read, Ready to Brew. Water temp: 200 degrees. The dietary staff were observed to pour and serve coffee directly from the coffee pot in which it was brewed. The food temperature logs for the past week were requested and received. According to the food temperature logs from 1/27/25-2/2/25 and the lunch meal on 2/5/25, there was no evidence that the temperature of the coffee had been obtained. On 2/5/25 and 2/6/25, clinical record reviews of Resident #2 (R2) and Resident #4's (R4) progress notes revealed several instances where the residents sustained burns due to hot coffee. Dated 1/1/23, R2's progress notes revealed an entry that read, Resident requested hot coffee. It was given to him, and he promptly spilled it over on his abdomen and left thigh. The groin area was protected by his brief. I notified Dr. [name redacted] and he ordered Bacitracin / Polymyxin to be applied to scalded area and cover lightly with a non-stick telfa. Resident is c/o [complaining of] discomfort when the area had bacitracin applied. He was offered a pain pill (oxy 5 mg), and he accepted. He then requested another cup of coffee. We discussed keeping a chux pad over himself when drinking coffee, and to sit upright in the bed. He agreed with this. On 1/2/23, R2 was seen by the medical provider, who documented in part, Chief Complaint / Nature of Presenting Problem: Coffee burn History of Present Illness: I saw the patient today after he spilled coffee on his abdomen and upper thighs. The coffee was quite hot, he had immediate pain. He was noted to have some blistering .The patient has partial-thickness second-degree burns over his lower abdomen and upper left thigh. This encompasses about 2 to 3% of body surface area. They do not appear infected. Barrier ointment will be applied. Careful attention to hygiene will be essential . According to another progress note entry dated 11/11/24, in R2's chart that read, Resident spilt coffee on right thigh, slight redness noted. Cool compress applied. UM [unit manager] informed, happened around 11:20am. Checked right thigh after lunch, redness resolved. Resident states leg is fine. R4's progress note entry dated 6/13/24 at 2:32 p.m., read in part, Reported at approx. 1200 by husband [name redacted] that resident burnt the top of her mouth on coffee at breakfast this am. Noted a blister on lower lip. UM [unit manager] in to check on resident. Also has a blister in roof of mouth. Noted resident to have chocked on water with noon medications [sic] . (continued on next page)

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	495405	A. Building B. Wing	02/07/2025

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F 0865 Level of Harm - Actual harm Residents Affected - Few	A nursing note entry dated 6/14/24 at 9:20 a.m., read in part, Undersigned was approached by PT [physical therapist] and SLP [speech language pathologist] and asked to send resident out to ED [emergency department] as SLP had assessed her and found a large blister on palate and lower lip as received yesterday by hot coffee. SLP reports that resident is coughing and having difficulty managing her own secretions. Went to see resident and her spouse and explained that we would like to send her to the ED to be evaluated as airway could be compromised. They agreed and 911 was called for transport with report given to EMS [emergency medical services]. Upon EMS arrival, report was given to EMTs as patient having some difficulty managing secretions and history of Parkinsons. [Nurse practitioner name redacted] was notified, and she states she was the one who asked SLP to evaluate the resident's swallowing ability as she when she was here earlier in the morning, she had noticed some gurgling sounds when she got her to swallow. Resident's spouse states he has notified her family, and they are enroute to ED. According to a nursing note entry dated 6/14/24 at 1:30 p.m., it read, Spoke with resident's spouse to get an update. He states resident is getting some IV fluid and a decision had been made that she did not need a transport to any other facility. Spouse was tearful and stated that every morning he writes on resident's menu that he wants coffee in a Styrofoam cup, half full, with ice and a straw. He said he lifted the cup to her lips, and she immediately screamed out. The straw became stuck to her lip. He states he mentioned this to the kitchen staff, and they got her ice chips which she indicated helped with the burn and ice cream that he spooned in for her. Undersigned reminded spouse that Styrofoam retains heat, but he stated this was the only kind of cup she could hold onto due to her Parkinsons. He stated he wished he had noticed that there didn't seem to be any ice in the cup and that he hadn't noticed the cup being hot . According to the hospital discharge summary for R4's hospitalization from [DATE]-[DATE], it read in part, . reason for admission: scalded throat from hot coffee, inability to swallow .presented to the emergency department after having issues with swallowing in the setting of drinking hot coffee. Associate with this, she has had mucosal abnormality in her oropharynx and her lips which is causing her not to be able to swallow without significant difficulty due to pain. Burn unit at [name of hospital redacted] was contacted by the ER physician who did not recommend the need for transfer but did recommend supportive care with IV fluids. Discussed this case with GI [gastroenterology] who also did not see any reason to perform any surgical intervention such as endoscopy. Patient was having evaluation and care. She was started on IV antiemetics, IV fluids and IV Zosyn [an antibiotic], CT neck showed thickening of the epiglottis without any other abnormalities . Because of her inability to swallow at all and silent aspirations a PEG [percutaneous endoscopic gastrostomy] tube was placed on 6/20 with some general surgery . Plan is to return to [this skilled nursing facility name redacted] with tube feeds for the near future until her throat heals. Once this heals up, she should be able to return to eating normally and the PEG tube can be removed . (continued on next page)

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F 0865 Level of Harm - Actual harm Residents Affected - Few	On 2/7/25, a review of the facility's QAPI program was conducted with the facility Administrator and Chief Operating Officer (COO). When asked about the QAPI response to the three serious burn incidents, the administrator stated that the QAPI program reviewed the incidents in June 2024 and November 2024, when R4 and R2 sustained the burns, respectively. The QAPI Action Plan with a date of 6/14/24, read in part, Goals/Objectives/Expected Outcome: Inservice conducted on 6/14/24 with all dining staff to review beverage safety and confirm understanding of policy and practice . Temperature defined by 155 degrees or below. Temperature controlled dispensers will be implemented to ensure acceptable temperature of beverages. There were no other entries or evidence that ongoing monitoring had occurred after the plan was initiated in June 2024. No evidence was provided that there had been any QAPI response to the the serious burns that R2 sustained in [DATE]. During the above meeting, the facility administrator was then asked to explain the process used by the QAPI program to ensure on-going compliance. The administrator did not answer. When the discussion shifted to the another incident in November 2024, when R2 again spilled hot coffee, which caused redness, the administrator was asked what had been the response of QAPI. The administrator provided a QAPI Action Plan dated 11/11/24, in which the actions were noted as, .verbal warning and education presented to CNA [certified nursing assistant] and hot liquid assessments performed on all new residents on admission and quarterly with MDS [minimum data set] [an assessment tool]. All new staff oriented to the policy and practice There were no other entries or evidence that ongoing monitoring had occurred since the plan was initiated. The surveyor informed both the administrator and COO that during the survey, each time observations were conducted on 2/5/25 and 2/6/25, the facility staff were not utilizing the temperature-controlled coffee dispensers, nor were staff monitoring the temperature of the coffee being served. The facility administrator was asked to explain how the QAPI program is effective in ensuring the ongoing compliance with the action plans implemented to promote resident safety and to prevent future occurrences. Instead of directly answering, the administrator and COO both verbalized understanding how it could be viewed that their QAPI program is not effective. A review of the facility document titled, Quality Assurance/Performance Improvement Plan for 2025, was conducted, noting that it read in part, QAPI at [facility name redacted] involves a comprehensive approach to utilizing information, data, reports and benchmarking to improve the quality of life, care and services. It is meant to identify opportunities for improvement, address gaps in systems; implement improvements; and continuously monitor effectiveness of interventions . The above findings were discussed during a meeting with the facility administrator, director of nursing and corporate staff on 2/7/25. No additional information was provided.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 41449 Based on staff interviews and facility documentation, the facility staff failed to provide effective communications training for one employee (the social worker), in a survey sample of nine employee records reviewed. The findings included: The facility staff failed to have credible evidence of effective communication training for the social worker. On 2/6/25, a sample of nine employees was selected for review of training requirements, as part of the extended survey. The list of employees was given to the facility administrator, and they were asked to provide evidence of the staff training to include the area of effective communication. On 2/7/25, the employee records were reviewed. It was noted that the facility's social worker had no evidence of having received training for effective communication. On 2/7/25 at approximately 10:35 a.m., the above findings were reviewed with the facility administrator, director of nursing and corporate staff. On 2/7/25, in the afternoon, the facility administrator stated they had nothing further to provide the survey team. No additional information was provided prior to exit conference.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 41449 Based on staff interview and employee record reviews, the facility staff failed to provide QAPI (Quality Assurance and Performance Improvement) training to 9 of 9 sampled employees reviewed for educational requirements. The findings included: On 2/6/25, a sample of nine employees was selected from a listing of current staff. The sample included management staff, CNAs (certified nursing assistants), LPNs (Licensed practical nurses) and RNs (registered nurses). The facility administrator was given the names of the nine sampled staff and was asked to provide all education and in-service training for those employees to include evidence of QAPI training. On 2/7/25, the facility provided a transcript for an electronic training system for the sampled employees. These documents were reviewed and revealed that none of the 9 sampled employees had received any training with regards to the elements and goals of the facility's QAPI program. During a meeting held at approximately 10:35 a.m., on 2/7/25, the facility Administrator, Director of Nursing, and corporate staff were made aware that there was no evidence that any of the sampled staff had received training on the elements and goals of the QAPI program. On 2/7/25, at approximately 12:30 p.m., the Administrator and DON stated that the facility did not have any additional information to provide.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 41449 Based on staff interview, staff record review, and facility documentation review, the facility staff failed to provide behavioral health training to two of nine employees. The findings included: For other employee #1 (OE #1) and other employee #6 (OE #6), the facility staff had no credible evidence of the employees having received behavioral health training. On 2/6/25, a sample of nine employees was selected for review of educational requirements as part of the extended survey review. The facility administrator was given the list of employees selected for review and was asked to provide evidence of their educational training to include behavioral health training. On 2/7/25, the facility provided the surveyor with the employee training records. This review revealed no evidence that either OE #1 or OE #6 received any behavioral health training. According to the facility assessment, which was last reviewed on 2/4/25, the facility provides care for residents with mental health and behavioral needs. Section 2: Services and Care We Offer Based on Residents' Needs read in part, . Mental Health and Behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities, SUD, traumatic brain injury Section 3 of the facility assessment, titled Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, included a statement that read in part, . We utilize the following competencies: This is not an all-inclusive list . Behavioral Health- includes caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions . On 2/7/25, the above findings were reviewed with the facility administrator, director of nursing and corporate staff. They reported they had nothing additional to provide.