STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505183	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Heritage Rehabilitation of Tacoma	7411 Pacific Avenue Tacoma, WA 98408

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 29644 Based on observation, interview, and record review, the facility failed to implement a hot food and beverage policy to protect 2 of 3 sample residents (Resident 1 & 2) reviewed for avoidable burns. Resident 1 experienced harm when they were served hot coffee without securing the lid/top of the coffee cup in a closed or locked position which spilled in their lap resulting in a second-degree burn (involves the first two layers of skin, may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin). Resident 2 experienced harm when they were served hot soup without being temperature checked which spilled in their lap resulting in second-degree burns to their thighs and groin. This failed practice placed residents at risk for accidents and injuries. Findings included . Review of the facility Hot Food and Beverages/Thermal Burns policy, dated 02/27/2001, showed the facility would provide hot food and beverages to residents at a temperature that was palatable but minimized the risk of thermal burns/scalds. Residents would be discouraged from carrying hot drinks in their laps in wheelchairs, hot beverages/liquids would be served at 150 degrees Fahrenheit (dF) or less, hot beverage dispensers from the kitchen would have temperatures obtained by kitchen staff, and if beverages/liquids were warmed in the microwave, facility staff will verify the temperature prior to giving the liquid to the resident and record the temperature on the Resident beverage log. <Resident 1> According to the 09/11/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 1 was assessed with moderate cognitive impairment, bilateral lower extremity limited range of motion, was independent in a motorized wheelchair, had a mechanically altered, and therapeutic diet. Review of the Hot Beverage Safety Evaluation, dated 09/11/2024, showed Resident 1 had a diagnosis of neuropathy or other neurological impairment, and may require set up assistance while consuming hot beverages. Review of the Self Care Performance Care Plan, revised 09/25/2024, showed the resident preferred to feed self independently after set up assist. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a 12/01/2024 Nursing Note showed Resident 1 was at the nurses' station after asking for coffee to be poured into their coffee cup. Resident 1 started traveling in the wheelchair and the coffee cup turned over onto their leg (right lower inner aspect) and the resident complained of a burning sensation (redness noted). The lid/top of the coffee cup was not closed or locked before the resident started to travel in their wheelchair. Record review showed on 12/02/2024, Resident 1 was assessed by the medical provider to have a second degree burn on their right lower medial leg, an intact fluid filled blister with surrounding redness and warmth. Review of a 12/02/2024 Nursing Note showed education was provided to the resident to hand the travel coffee mug to the staff and have them refill the coffee and put the lid back on to prevent the burns. Another Hot Beverage Safety Evaluation was dated as done on 12/02/2024 which showed Resident 1 no longer had neuropathy or other neurological impairment, but did demonstrate poor safety awareness, impaired short term memory, and/or impulsiveness. Resident 1 had a history of injury related to independent consumption of hot beverages and demonstrated non-compliance with awaiting needed assistance with consumption of hot beverages and/or attempts to independently obtain hot beverages. Review of Resident 1's care plan showed on 12/02/2024 it was revised to evaluate the need for adaptive equipment related to hot beverage consumption, Resident has a travel mug, and Resident uses lids for all hot beverages to decrease risk of spills. Review of the facility investigation showed on 12/06/2024 the facility identified the root cause for this event was that resident self directs his own care and insisted on using his personal coffee mug for his coffee, resident placed the cup improperly in his chair, at which point it fell over, and the cup did not close all the way. The facility identified a preventive measure was to educate the resident on the risks of continuing to use the coffee mug and to prevent further burns or another incident like this in the future, to replace his coffee mug with one that closed. During an interview on 12/30/2024 at 10:51 AM, Staff B, Director of Nursing, stated the kitchen staff said they were monitoring beverage temperatures before the beverages left the kitchen. Staff B was unable to state when, on 12/01/2024 the coffee was brought out from the kitchen, or what the temperature was prior to being sent out to the floor. Review of the Kitchen Weekly Hot Beverage Temp Log showed dietary staff were documenting the temperatures of coffee and hot water once for breakfast, once for lunch, and once for dinner. Review of the log dated 11/04/2024 through 12/01/2024 showed no temperatures were obtained for the dinner time hot beverages. On 12/01/2024 staff documented at breakfast the coffee was 157 dF and the hot water was 189 dF. After the incident on 12/02/2024 and 12/03/2024 it was 160 dF and 190 dF, and on 12/04/2024 169 dF and 193 dF. Review of education documents showed on 12/05/2024 staff were educated on proper drink temps for residents and the need to properly temp all hot beverages to 165 dF before leaving the kitchen. Temps were to be taken before each meal service and documented. Lids and stir straws should be readily available and utilized. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/30/2024 at 11:42 AM, Staff E, Dietary Aide, stated they checked the coffee and hot water temperatures first thing in the morning, around 6:00 A.M. Staff E stated the hot beverages cannot leave the kitchen if they were over 165 dF. <Resident 2> According to the 09/20/2024 Annual MDS, Resident 2 was assessed as alert and oriented, with bilateral lower extremity impaired range of motion, and required set up assistance to eat. Review of a 09/20/2024 Hot Beverage Safety Evaluation Resident 2 had a diagnosis of neuropathy or other neurological impairment so they may require set up assistance while consuming hot beverages. Review of Resident 2's Care Plan showed a 08/20/2024 revision that resident was able to hold cup, feed self, and eat finger foods independently. Review of 12/08/2024 Nurses Note showed the resident spilled hot soup on their groin area while in bed. Resident 2 was assessed with burns to upper inner left and right thighs and groin where blisters had started to form. During an interview on 12/30/2024 at 12:00 PM, Resident 2 stated they had a cup of noodle soup and spilled it in their lap, the soup was hot and burnt their leg. Resident 2 stated at the time the burn hurt at a level 10 (on a scale of 1-10). Resident 2 stated the burn still hurt, at a 7, not all the time, but when the dressing was changed or when the area was bumped into. Review of the facility 12/12/2024 incident investigation showed a Certified Nursing Assistant (CNA) heated up a cup of soup, for 2 minutes in the microwave. CNA brought it to resident and told her, Be careful (Resident 2), it's hot! And set it on their table. Resident picked up the cup and realized the cup was warm and went to set it back down. When this occurred, Resident 2 splashed a little soup from the cup on themselves, which they reacted to and due to neuropathy, ended up spilling the whole cup in their lap. Resident was dependent on staff for care, meals, and mobility. Resident 2 was assessed with two blisters in their groin\thigh area measuring 3" x 3 and the blister on their right thigh had some fluid build up in it along the edge. The facility identified the root cause for this event as related to resident's neuropathy and impaired mobility. During an interview on 12/30/2024 at 11:09 AM, Staff B stated the CNA was from a staffing agency and did not temp the soup before giving it to the resident because they were unaware they needed to. Education to prevent burn incidents was dated 12/09/2024 and included review of the Hot Food and Beverages Policy. Observation on 12/30/2024 at 11:15 AM of the area where the microwave was located showed a thermometer and a binder with instructions to complete prior to giving resident's heated food/beverage items. Inside the binder was a Food Temperature Log with instructions, Food and beverages must NOT be served over 150 dF! If measured above it must be cooled PRIOR giving it to the resident. During an interview at 12/30/2024 at 11:18 AM Staff D, Staff Development, stated staff were instructed if an item was over 150 dF, they were to cool and recheck. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the food temperature log showed the first entry was dated 12/09/2024. During an interview on 12/30/2024 at 11:18 AM. Staff B stated the food temperature log was not implemented prior to Resident 2's incident. Further review of the log showed on 12/12/2024 staff documented mashed potatoes were 160.5 dF, on 12/19/2024 a cup of noodles was 175 dF. Neither entry had a recheck temperature logged. During an interview at 12/30/2024 at 11:18 AM, Staff B stated, They're not following policy. REFERENCE: WAC 388-97-1060(3)(g).