STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505255	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Othello Post Acute	495 North Thirteenth Street Othello, WA 99344

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. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and use of assistance devices when consuming hot beverages, and to consistently assess hot beverage temperatures for safety prior to serving to prevent accidents for 1 of 3 sample residents (Resident 1). Resident 1, who was severely cognitively impaired, experienced harm when they were provided a cup containing a hot beverage that had not been checked for temperature without a lid and unsupervised which the resident spilled in their lap and resulting in a third-degree burn.According to the American Burn Association, thinner skin of older adults burns faster and deeper, and a serious burn can occur within five seconds of exposure to a liquid at a temperature of 140 degrees Fahrenheit (F).Per the assessment dated [DATE], Resident 1 was severely cognitively impaired, required assistance with activities of daily living including set up of food and drink before eating and/or drinking, and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (loss of strength or paralysis in the right side of the body due to a stroke, lack of sufficient blood flow to the brain), and aphasia (a language disorder that affects a person's ability to communicate).Review of the care plan dated 06/02/2025, documented Resident 1 was to be encouraged to drink hot cocoa while seated at a table in the dining room, and that Resident 1 required supervision and possible assistance when consuming hot beverages.Review of the facility incident investigation, showed Resident 1 was seated in their wheelchair in the hallway when Staff A, Nursing Assistant (NAC) gave the resident a cup of hot cocoa from the snack cart that came from the kitchen a short time before. Staff A walked down the hallway away from the resident. Into another resident's room and heard Resident 1 scream and saw the resident had spilled the hot cocoa on their lap.Review of Resident's 1's electronic medical record, showed they sustained a burn to their right and left thighs on 7/26/2025 at 6:01pm when they spilled hot cocoa on their lap. Staff B, Registered Nurse (RN) documented the burn initially resulted in reddened skin and on 07/28/2025 a blister developed on the back of the right thigh.Review of progress note dated 07/28/2025, Staff C, Physician Assistant (PA), documented Resident 1 had third degree burns (damage to the top and middle layers of skin and the fatty layer) on their inner thighs with a blister between right thigh and buttocks, approximately 6 centimeters (cm) x 2 cm in size, because of having spilled hot cocoa on their lap on 07/26/2025.During an interview on 07/29/2025 at 3:15pm, Staff D, evening cook, stated the evening snack cart was scheduled to go out at 7:00pm but often was taken out early. They stated they didn't check the temperatures of the hot liquids on evening snack, Staff D explained that temperatures of the hot liquids were required.In an interview on 07/29/2025 at 3:24pm, Staff E, Dietary Manager, stated the evening snack cart hot liquids temperatures are supposed to be checked and stated there was no record of the temperature checks for the evening snack cart. They also stated Resident 1 had a large mug with a heavy lid that would not come off if dropped and it was supposed to be used when giving Resident 1 hot liquids. They stated it had not been used on 07/26/2025, when the resident spilled hot liquid on their thighs.Review of the care plan showed no documentation, prior to 07/30/2025, that Resident 1 used a particular mug for hot beverages.Review of the Facility's July 2025 hot liquids temperature log documented hot liquids were not to be served unless the temperature was within 123-155 degrees F. The temperature log the facility provided for July 2025 started with July 19th, 2025, only documented 10:00am and 3:00pm snack cart temperatures. Further review from 07/19/2025 through 07/27/2025, showed all temperatures for hot water and hot coffee were documented 158 degrees F or higher.Reference: WAC 388-97-1060 (3)(g)