

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER Emerald Care		STREET ADDRESS, CITY, STATE, ZIP CODE 209 North Ahtanum Avenue Wapato, WA 98951	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to provide hot liquids at a safe drinking temperature for 1 of 4 residents (Resident 1) reviewed for accident hazards. Resident 1 experienced harm in which they sustained burns on their right thigh from hot coffee. This failed practice placed the residents at risk for burn injuries, pain, and adverse health conditions. Findings included. Review of a policy titled, Free of Hazards/Supervision and Devices, dated 02/2025, showed the facility would ensure each resident received adequate supervision and assistive devices to prevent avoidable accidents and injuries. The facility would implement a systemic, interdisciplinary approach for identifying, evaluating, and mitigating risks, while maintaining resident safety, dignity, independence, and choice. Review of the Washington State Department of Labor and Industries guidance titled, Burn Injury Facts, dated 04/01/2009, showed scald burns occurred when skin comes in contact with hot liquids or steam. Water at a temperature of 155 degrees Fahrenheit [(F) a temperature measurement] would cause a third-degree burn (a burn that destroys the entire depth of the skin, damaging fat, muscle, organs, or bones) in one second. Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including quadriplegia (a loss of control of both arms and legs), heart failure, and anxiety. The 01/08/2026 comprehensive assessment showed Resident 1 required set-up assistance of one staff member for eating and dependent on one to two staff members for all other activities of daily living (ADLs). The assessment also showed Resident 1 had an intact cognition. Record review of a nursing progress note (PN) dated 03/22/2026 at 9:20 AM, showed Staff C, Registered Nurse, completed an assessment of Resident 1's wound. There was an area of redness that measured 4.5 centimeters (cm - a unit of measure) long by 13.0 cm wide, with three fluid filled blisters in the reddened area. Resident 1 reported to Staff C that they had spilled coffee on their lap the day before. Resident 1 stated they did not report the incident at the time because they had decreased sensation in their legs and did not feel the burn. Resident 1's provider was notified and the facility received orders to monitor the area and apply skin prep (a liquid film dressing used to protect skin from friction and trauma) daily. Record review of the facility investigation report, dated 03/21/2026 at 2:00 PM, showed Resident 1 had a red area with two blisters in the reddened area. Resident 1 stated they spilled hot cocoa (Resident 1's interview and record review show the hot liquid was coffee) on themselves earlier in the day but had forgotten about it until receiving cares at night. During a concurrent observation and interview on 03/24/2026 at 10:12 AM, showed Resident 1 sitting in the dining/activities room in their motorized wheelchair. Resident 1 had a cup of coffee with a lid on the cup sitting on the table next to them. They had a sweatshirt over their lap. Resident 1 stated they had a cup of coffee from the front coffee station a few days ago. They stated they were unable to get it for themselves; someone had gotten it for them. Resident 1 stated they usually have a tumbler with a lid but left it in their room that day. They stated they used a regular cup with a lid that had just tipped over while they were drinking it. Resident 1 stated they were burned by the coffee but didn't feel it because they had decreased sensation in their legs. Resident 1 stated they did not lay down during the day and stated they preferred not to show the burn to the State Agency investigator. During an interview on 03/24/2026 at 10:16 AM, Staff D, (continued on next page)</p>

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Dietary Staff, stated the kitchen refilled the resident coffee pots at scheduled times during the day: 6:00 AM, 9:00 AM, 11:00 AM, 1:30 PM, 3:30 PM, and 6:30 PM. They stated they refilled them more often than the scheduled times. Staff D stated they ensured the brewed coffee was at 155 degrees F before they took the coffee cart to the resident's area. They stated they kept logs of the temperature of the coffee to make sure it was not over 155 degrees F. During a concurrent observation and interview on 03/24/2026 at 12:25 PM, Staff B, Director of Nursing, obtained a cup of coffee from a coffee pot located on the coffee cart in the resident's common area. There was steam rising from the coffee in the cup. Staff B obtained the temperature of the coffee using the facility thermometer, which read 168.8 degrees F. Staff B stated the coffee was too hot and removed the coffee cart from the resident area. During a concurrent interview and record review on 03/24/2026 at 2:18 PM, Staff E, Dietary Manager, reviewed the coffee temperature log with Staff B present. Staff E stated the kitchen staff were only taking the temperature of one of the four pots on the coffee cart prior to leaving the kitchen. Review of the coffee temperature log entry for 03/21/2026 (the date of the incident) showed an entry at 4:40 AM with a temperature of 152 degrees F, 7:15 AM with a temperature of 155 degrees F, and 11:00 AM with a temperature of 155 degrees F. They stated they were unsure if the kitchen staff were taking the temperature directly from the pot or from a pitcher of coffee. Staff E stated the kitchen staff should be taking the temperature and recording the temperature of all the pots prior to leaving the kitchen. Staff B stated the kitchen staff needed to check the temperature of all coffee pots before the coffee cart left the kitchen and if the temperature was over 155 degrees F, they would need to ensure it was at a safe temperature before allowing residents access to it. During an interview on 03/24/2026 at 2:24 PM, Staff B stated the facility did not complete assessments or have a process in place to ensure residents were safe with handling hot liquids. During an interview on 03/24/2026 at 2:58 PM, Staff A, Administrator, stated the process for ensuring residents were safe with the coffee cart included checking the temperatures of the coffee in the dispensers before sending them from the kitchen. Staff should complete a second check before providing the coffee to the resident. There should be a thermometer located on the coffee cart to complete the temperature check. Reference: WAC 388-97-1060(3)(g)</p>		