STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515002	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peterson Rehabilitation and Healthcare	20 Homestead Avenue Wheeling, WV 26003

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to protect Resident #39's right to be free from sexual abuse. This was true for one (1) out of five (5) resident-to-resident altercations reviewed during the complaint process. Facility census: 135. Resident identifiers: #39 and #137. The facility's failure to follow their abuse policy and recognize the incident as an occurrence of resident-to-resident sexual abuse placed an unlimited number of residents currently residing in the facility at risk for possible abuse. The state agency determined this was an immediate jeopardy (IJ) situation. a) An electronic medical review, completed on 05/21/24 at 9:45 AM, revealed the following details: -RN Unit Manager #28 documented in a nursing note, dated 02/14/24 at 9:04 AM, At 0150 [1:50] this AM, Staff entered resident's room and observed Resident [#137] on top of roommate [Resident #39] naked, making humping motion, and attempting to remove roommates [roommate's] gown and incontinence brief. -RN Unit Manager #28 documented in nursing note, dated 02/14/24 at 6:59 AM, Aide alarmed this nurse about resident being sexually inappropriate with resident in room. The note also indicated written statements by aides would be given to supervisor on duty. -The only written statement on file was from Nurse Aide (NA) #6 who reported NA #210 requested help in the resident room. NA #6 stated she saw Resident #137 was completely nude and was trying to rip Resident #39's brief off. She also documented she changed Resident #39's bed sheets because Resident #137 had peed on his top sheet. -Review of Resident #137's care plan reflected the facility did not address inappropriate sexual behaviors. -Review of Resident #39's care plan reflected the facility did not address possible trauma from the experience. A record review was completed on 05/21/24 at 9:22 AM. The facility noted the date and time of the incident as happening on 02/14/24 at 1:50 AM. (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility provided the following description of the incident: Resident #137 was observed being sexually inappropriate with roommate (Resident #39). Residents were separated. Resident #39 was moved to a different wing. The facility's five (5) follow-up report outlined the following investigative details: -Resident #137 [the perpetrator] was an [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis of Dementia, Paranoid Personality Disorder, Hallucinations, Depression, and anxiety disorder. He had a Brief Interview for Mental Status (BIMS) score of 09 which is indicative of moderate cognitive impairment. -Resident #39 [the victim] was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease, Dementia, and Depression. He had a BIMS of 01 which is indicative of severe cognitive impairment. -It was reported on 02/14/24 at approximately 2:00 AM a staff member noticed movement in the residents' room. Upon entering the room, the staff member found Resident #137 on top of Resident #39 and appeared to be trying to have sex with him. Resident #39 was dressed in a hospital gown and had an adult brief on. The staff immediately told Resident #137 to get off of him and that it was inappropriate. Staff assisted Resident #137 in getting dressed and removed him from the room to the nurses' station where he could be monitored. -Resident #39 was assessed, and no injuries were found. He showed no signs of emotional distress. -Upon completion of the investigation, the facility did not substantiate abuse occurred because of the incident due to Resident #137 did not have the capacity for intent. Interview with Social Worker -During an interview, completed on 05/21/24 at 10:58 AM, Social Worker #59 when asked to describe sexual abuse described it as, Anything that is uninvited. When asked if he had ever been trained to use the reasonable person concept when investigating complaints, Social Worker #59 stated he had not. By definition, a reasonable person concept would involve a case where a resident was unable to speak for themselves. The investigative team should assess how most people would react to the situation in question. Additionally, Social Worker #59 agreed there could be situations of abuse that do not result in an observable physical injury, or the psychosocial effects of abuse may not be immediately apparent. The social worker agreed that Resident #39 had a BIMS of 01 which would make it unlikely he would be able to speak about how the incident affected him. A resident with such severe cognitive impairment cannot usually recall what has occurred, or may not express outward signs of physical harm, pain, or mental anguish. Social Worker #59 agreed that neither physical marks on the body nor the ability to respond and/or verbalize was needed to conclude that sexual abuse/assault had occurred. During an interview, at approximately 11:20 AM on 05/21/24, the Administrator stated the facility did not substantiate resident-to-resident sexual abuse occurred as a result of the incident due to the fact Resident #137 did not have the capacity for intent. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When explaining if there was an instance where a resident did not wish to engage in sexual activity with another resident that the facility must respond to it as an alleged violation of sexual abuse, the DON questioned how the facility would know if it was unwanted since they had no way of knowing Resident #39's sexual preference prior to his cognitive decline. The Surveyor explained that the expectation was if the resident did not have capacity to consent to sexual activity, the facility should always respond to it as an alleged violation of sexual abuse. Using a reasonable person concept, it could be assumed that a nude person climbing on top of you in the middle of the night, humping you, and attempting to remove your clothing would be considered sexually inappropriate and would reasonably cause anyone to have psychosocial harm. The Administrator and DON confirmed that neither resident's care plan had been updated to reflect the need to monitor Resident #137 more closely or to offer Resident #39 any trauma services. The resident-to-resident sexual abuse occurred on 02/14/24 at 1:50 AM. The facility was notified of the IJ on 05/21/24 at 12:10 PM. The State Office approved the facility's Plan of Correction (POC) at 5:54 PM on 05/21/24. After observation, staff interview, review of facility documentation, and record review determining the implementation of the POC, the IJ was abated at 1:00 PM on 05/22/24. The IJ started on 2/14/24 at 1:50 AM and ended on 05/22/24 at 1:00 PM. The facility's approved abatement POC consisted of the following: On 05/21/24 at 1:45 P.M. one on one education for staff present and via phone call for staff not present was provided related to the facility abuse policy, which included what abuse was and reporting requirements, including sexual and verbal abuse was initiated by the Director of Education for all 175 employees. The education consisted of the different types of abuse, whether it is physical and what this entails (hitting, slapping, punching, pinching, etc.), sexual and what that entails (unwanted physical touch, groping of private areas of the body, attempted intercourse, unwanted advances), emotional/verbal (making fun, degrading jokes, putting someone down, derogatory comments, yelling, cursing). A plan for any staff member not educated to not work until education was completed and implemented. On 05/21/24 from 1:45 P.M. to 3:30 P.M. interviews were completed by Management staff comprised of the Social Work, Social Service Designee, Business Office Manager, Assistant Business Office Manager, Human Resource Director, and the Admissions Director for 48 residents who have capacity using the Resident Ause Questionnaire with questions consisting of: How are you doing today?, How is your care?, Do you feel safe here?, Have you ever felt threatened by another resident or uncomfortable?, Do you have any issues with staff here?, Have staff ever made you feel afraid? No new concerns were identified by the facility following these interviews. On 05/21/24 from 1:45 P.M. to 3:15 P.M. skin inspections were performed by RN Unit Manager #1, RN Unit Manager #1, RN Skin Nurse, and ADON for 87 residents who do not have capacity. No abnormalities were found by the staff completing the inspections. On 05/21/24 at 2:03 P.M. the Chief Operating Officer for [NAME] Rehabilitation and Healthcare Center re-educated the Administrator and Director of Nursing on the facility abuse policy, including reporting and substantiating allegations of abuse regardless of capacity of the residents involved. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/21/24 at 2:40 P.M. the Facility Quality Assessment and Assurance Committee ADHOC meeting was held by phone with the Facility Medical Director, Administrator, and Director of Nursing regarding incident of abuse involving Resident #39 and Resident #137 which occurred on 02/12/24 and what corrective action measures were being taken. On 05/21/24 at 2:25 P.M. to 3:10 P.M. the Registered Nurse Assessment Coordinator #1 and Registered Nurse Assessment Coordinator #2 completed an audit of resident care plans and identified those who exhibited possible inappropriate sexual behaviors. These were reviewed and updated to ensure that appropriate interventions are in place. Beginning 05/22/24, during the morning Interdisciplinary team (IDT) meeting the facility will discuss if any new allegations or concerns of abuse have been brought to anyone staff members' attention as well as reviewing the 24-hour report. The facility will ensure any/all allegations will be thoroughly investigated, and actions will be taken to ensure the facility is following the abuse policy. The facility identifies the deficient practice occurred related to a failure to identify the potential psychosocial harm from the occurrence and the failure to identify the incident as sexual abuse regardless of capacity. Beginning 05/22/24 the Administrator or her designee will forward any new reportable allegations to the Chief Operating Officer to review to ensure that the facility conducts a thorough investigation with accurate conclusions. Beginning 05/22/24 the Director of Nursing or her designee will conduct an audit of 10 residents using the Resident Abuse Interview Tool and skin assessment. The audit will be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality Assurance and Performance Improvement Committee for ongoing compliance. Beginning 05/22/24 the Director of Education or her designee will conduct an audit of 10 employees using the Staff Abuse Questionnaire. The audit will be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality Assurance and Performance Improvement Committee for ongoing compliance. Review of the facility's Abuse/Neglect policy revealed the following details regarding the definition of sexual abuse: -Sexual abuse was defined as, but was not limited to, non-consensual sexual harassment, sexual coercion, contact, or sexual assault. -Anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must take steps to ensure that the resident is protected from abuse.

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. 42120 Based on record review and interview the facility failed to keep Resident #38 free from a chemical restraint imposed for purposes of discipline when an antipsychotic medication was given without a physician order. The deficient practice put all one (1) resident that exhibit behaviors currently residing in the facility at risk for serious injury, serious harm, serious impairment, or death. Resident identifier: #38. Facility Census: 135. Findings included: a) Resident #38 During a complaint survey a review of Resident #38's nursing progress notes found: Nursing note dated 05/5/24 4:35 AM Came onto wing at 2:20, patient (pt) came out screaming and chasing the staff down the hallway because they wanted a regular diet, was told to go back to their room, patient went into the room and laid down on the bed. Patient was held down and given 5mg/1ml IM shot of haldol. pt came back out and charged at staff again. pt charged at nurses station and fell into soiled room door. pt tried to get up and attack nurses again but wasn't able to get up. pt scooted into their room. pt came back out, charged at the nurses desk again. pt was trying to grab this nurse, this nurse held his hands and tried to get him off me. supervisor helped him back off of this nurse and he fell on the floor and laid there as the cops and the ambulance came to take him to the hospital. During a confidential interview (CI) #1, on 05/22/24 with an individual present on the day noted, the nurse administering the IM injection, was unable to readily report the dose given. CI #1 stated Licensed Practical Nurse (LPN)#1 discarded the Haldol bottle, and she provided medication from a zip lock bag. Continued record review of Resident #38's Physicians orders found there was no active order for Haldol on 05/05/24. The facility was notified of the Immediate Jeopardy (IJ) at 3:10 PM on 05/22/24. The facility submitted their first abatement plan of correction (POC) at 5:44 PM on 05/22/24. The abatement POC was accepted by the state agency at 6:00 PM on 05/22/24. After observation of the implementation of the abatement POC, the IJ was abated at 11:40 AM on 05/23/24. The IJ started on 05/22/25 and ended on 05/23/24. The facility's approved abatement POC consisted of the following: Correction action for area of concern- (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/22/24 at 3:21 PM one on one education for licensed nursing staff present and via phone call for staff not present was provided related to the facility medication administration policy, the six rights of medication administration, and not administering a medication without an order was initiated by the Director of Education for all 39 licensed nurses. The education consisted of the right patient, the right drug, the right time, right dose, right route, and right documentation. It also consisted of verifying the order prior to administering the medication. A plan for any staff member not educated to not work until education was completed and implemented. On 05/22/24 at 3:25 PM the Facility Quality Assessment and Assurance Committee ADHOC meeting was held by phone with the Facility Medical Director, Administrator, and Director of Nursing regarding incident administering a medication without an order to Resident #38 which occurred on 05/05/24 and what corrective action measures were being taken. On 05/22/24 from 3:35 PM to 5:00 PM an audit of PRN (as needed) medications given for the last seven days for all 136 residents were performed by RN Unit Manager #1 and the DON. The audit will ensure that any PRN medications that were given had a reason and the effectiveness of the medication was documented. This report was then audited against the nursing documentation for the last seven days to ensure that no PRN medication was given without an order. Any discrepancies found were corrected and if needed provider notified and new orders obtained if given. On 05/22/24 at 3:45 P.M. the Six Rights of Medication Administration signs were made and laminated and then secured to the seven medication carts in the facility as a visual reminder to the licensed nursing staff. On 05/22/24 from 4:00 P.M. to 5:00 P.M. an audit of the medication carts were conducted by RN Unit Manager #2, RN Wound Nurse, and the ADON to ensure that any discontinued PRN medication were not on the carts. If any were found they were removed and disposed of according to policy. Beginning 05/23/24, during the morning Interdisciplinary team (IDT) meeting the facility will review the PRN medication administration report from the previous day and review the 24-hour report to ensure that no PRN medications were given without an order. The facility will run a report of discontinued medications and ensure that the medications have been removed from the medication carts. The facility identifies the deficient practice occurred related to a medication being administered without an order, as the medication was a PRN. order that had previously been in place but had ended on 04/29/24 and not pulled from the medication cart. Beginning 05/23/24 the Director of Nursing or her designee will conduct an audit of 10 residents using the Unnecessary Drug Review audit to ensure that no residents are receiving medications without an order. The audit will be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality Assurance and Performance Improvement Committee for ongoing compliance. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning 05/23/24 the Director of Education or her designee will conduct an audit of 10 employees using the Medication Administration Audit tool to ensure that the licensed nursing staff are following the six rights of medication administration. The audit will be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality Assurance and Performance Improvement Committee. During an interview, with LPN #1 on 05/21/24 at 9:24 AM via phone, she stated, resident was so aggressive he was chasing staff down the hall multiple times. She stated, she administered an intermuscular Haldol 5ml per 1 ML in Resident #38's arm. She stated, she did try to administer the injection in the back of his arm, but it was administered in the middle of his arm due to him swinging his arms. She stated that five (5) staff members were present at this time. During an Interview on 05/22/24 at 1:48 PM, Nurse Practitioner #211 confirmed, she did not authorize an order for Haldol 5ml per 1 ML until 05/06/24 after he returned from the emergency room . During an Interview on 05/22/24 about 2:10 PM the director of Nursing verified Resident #38 did not have an active Haldol order when he was administered the drug.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to ensure all alleged violations involving abuse were reported in a timely fashion to all appropriate state agencies. This was true for one (1) out of five (5) resident-to-resident altercations reviewed during the complaint process. Facility census: 135. Resident identifiers: #39 and #137. Findings include: a) The Facility's Abuse/Neglect Policy Review of the facility's Abuse/Neglect policy revealed the following reporting requirements: -All alleged violations of abuse are to be reported by the facility to the SA (State Agency) and Adult Protective Services (APS). b) Alleged Resident-to-Resident Sexual Abuse An electronic medical review, completed on 05/21/24 at 9:45 AM, revealed the following details: -RN Unit Manager #28 documented in a nursing note, dated 02/14/24 at 9:04 AM, At 0150 [1:50] this AM, Staff entered resident's room and observed Resident [#137] on top of roommate [Resident #39] naked, making humping motion, and attempting to remove roommates [roommate's] gown and incontinence brief. -RN Unit Manager #28 documented in nursing note, dated 02/14/24 at 6:59 AM, Aide alarmed this nurse about resident being sexually inappropriate with resident in room. The note also indicated written statements by aides would be given to supervisor on duty. -The only written statement on file was from CNA #6 who reported CNA #210 requested help in the resident room. CNA #6 stated she saw Resident #137 was completely nude and was trying to rip Resident #39's brief off. She also documented she changed Resident #39's bed sheets because Resident #137 had peed on his top sheet. c) Facility Investigation and Reporting A record review was completed on 05/21/24 at 9:22 AM. The facility noted the date and time of the incident as happening on 02/14/24 at 1:50 AM. The facility provided the following description of the incident: Resident #137 was observed being sexually inappropriate with roommate (Resident #39). Residents were separated. Resident #39 was moved to a different wing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This incident was reported to Adult Protective Services (APS) and the Long-Term Care Ombudsman. There was no report made to the State Agency (Office of Health Facility Licensure and Certification.) d) Interview with Administrator During an interview, at approximately 11:30 AM on 05/21/24, the Administrator stated it was an oversight that the Office of Health Facility Licensure and Certification did not receive an immediate fax reporting of the allegations of resident-to-resident sexual abuse on 02/14/24.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42120 Based on record review, and staff interview, the facility failed to ensure one (1) of three (3) residents had a person-centered comprehensive care plan implemented to meet his/her other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Failure to implement Resident #72's care plan resulted in her sustaining a burn to her abdomen which required physician intervention. Resident #72 sustained actual harm due to the facility's failure to implement her care plan. Resident identifiers: #27. Facility census: 135. Findings included: a) Resident #27 Review of facility documentation during a Facility Reported Incident (FRI) investigation showed a reportable dated 10/30/23. The incident occurred on 10/30/23 when Resident #27 sustained a burn injury to the right side of her abdomen after spilling coffee on herself that had been reheated. Continued review revealed a Physician treatment order for Silvadene External Cream to be applied to the right side of the abdomen topically every day for burn. A care plan review found a care plan focus area initiated on 09/23/22 and revised on which included a potential for safety concerns and injury from hot liquids. A care plan goal initiated on 04/23/20 and revised on 09/13/22 included Minimize risk for injury from hot liquids. Interventions included: Encourage resident to be out of bed and in sitting position for consumption of hot liquids. Temp of liquids not to exceed 180 degrees. Initiated 07/06/21. Subsequent review of the 10/30/23 statement from Nurse Aide #202 found: Resident #27 requested her coffee to be re-heated with most meals. Resident #27 was in bed. Coffee was in a regular coffee cup with no lid or straw. The five (5) day follow up found incident reported as failure to follow plan of care resulting in injury, the whole house education completed on hot liquid safety and observation audits to be completed of staff reheating foods/liquids to ensure instructions are followed, temperature of item is checked and verified temperature is within range and properly logged. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview with Staff Development #27 it was revealed, Resident #27 had at least two (2) burns from hot coffee at different times. Also, she confirmed the care plan was not followed during the 10/30/23 incident that contributed to Resident #27 getting burned.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to revise residents care plans after an occurrence of resident-to-resident sexual abuse. This was a random opportunity for discovery throughout the complaint survey process. Resident identifiers: #137 and #39. Facility census: 135 Findings included: a) Resident #137 An electronic medical review, completed on 05/21/24 at 9:45 AM, revealed the following details regarding Resident #137. -RN Unit Manager #28 documented in a nursing note, dated 02/14/24 at 9:04 AM, At 0150 [1:50] this AM, Staff entered resident's room and observed Resident [#137] on top of roommate [Resident #39] naked, making humping motion, and attempting to remove roommates [roommate's] gown and incontinence brief. -RN Unit Manager #28 documented in a nursing note, dated 02/14/24 at 6:59 AM, Aide alarmed this nurse about resident being sexually inappropriate with resident in room. -A written statement from Nurse Aide (NA) #6 stated NA #210 requested help in the resident room. NA #6 stated she saw Resident #137 completely nude and was trying to rip Resident #39's brief off. She also documented she changed Resident #39's bed sheets because Resident #137 had peed on his top sheet. -Review of Resident #137's care plan reflected the facility did not address inappropriate sexual behaviors. b) Resident #139 Review of Resident #39's care plan reflected the facility did not address possible trauma from the experience. Interview with Administrator and Director of Nursing (DON) During an interview, at approximately 11:20 AM on 05/21/24, the Administrator and DON confirmed that neither resident's care plan had been updated to reflect the need to monitor Resident #137 more closely due to his inappropriate sexual behaviors or to offer Resident #39 any trauma services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515002	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peterson Rehabilitation and Healthcare	20 Homestead Avenue Wheeling, WV 26003

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 - 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. 42120 Based on observation and staff interview the facility failed to ensure the residents environment over which it had control was free from accident hazards related to Resident # 27 received a burn after spilling reheated hot coffee on herself. The deficient practice put all residents that drink coffee currently residing in the facility at risk for serious injury, serious harm, serious impairment, or death. Resident identifiers: #27. Facility census: 135. Findings included: a) Hot Liquids Review of facility documentation during a Facility reported Incident investigation (FRI) showed a reportable dated 10/30/23. The incident occurred on 10/30/23 when Resident # 27 sustained a burn injury to the right side of her abdomen after spilling coffee on herself that had been reheated. Continued review revealed a physician treatment order for Silvadene External Cream to be applied to the right side of the abdomen topically every day for burn. A care plan dated 04/23/20 with a revision date of 09/13/22 review found: A focus area for potential safety concerns and injury from hot liquids. The goal was to Minimize risk for injury from hot liquids. Interventions included: Encourage resident to be out of bed and in sitting position for consumption of hot liquids. Initiated 04/23/20. Temp of liquids not to exceed 180 degrees. Initiated 07/06/21. Subsequent review of the 10/30/23 statement from Nurse Aide #202 found: Resident #27 requested her coffee to be re-heated with most meals. Resident #27 was in bed. The coffee was in regular coffee cup with no lid or straw. The five (5) day follow up found Incident reported as failure to follow plan of care resulting in injury, the whole house education completed on hot liquid safety and observation audits to be completed of staff reheating foods/liquids to ensure instructions are followed, temperature of item is checked and verified temperature is within range and properly logged. Review of in- serviced/educated on Safety of Hot Liquids date 10/30/23 found only NA #202 was educated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Staff Development #27 it was revealed that Resident #27 had at least two (2) burns from hot coffee at different times. Also, she confirmed that only one staff member was educated after the 10/30/23 burn on Resident #27. Interviews on 05/21/24 at12:10 PM with Registered Nurse #120, Helping Hands #74 and Licensed Practical Nurse #58 revealed they were unaware of the facility policy/ procedure for reheating food and liquids. The facility was notified of the Immediate Jeopardy (IJ) at 4:37 PM on 05/21/24. The facility submitted their first abatement plan of correction (POC) at 5:41 PM on 05/21/24. The abatement POC was accepted by the state agency at 6:12 PM on 05/21/24. After observation of the implementation of the abatement POC, the IJ was abated at 1:00 PM on 05/22/24. The IJ started on 05/21/25 and ended on 05/22/24. The facility's approved abatement POC consisted of the following: Correction action for area of concern- On 05/21/24 at 4:53 P.M. one on one education for staff present and via phone call for staff not present was provided related to the facility Safety of Hot Liquids policy and that if food needs to be reheated, it will be discarded and the kitchen will send up new as well as after-hours things can be reheated in one central location and temperatures are to be taken and recorded and no higher than 140 degrees was initiated by the Director of Education for all 175 employees. A plan for any staff member not educated to not work until education is completed and implemented. On 05/21/24 from 4:55 P.M. to 6:00 PM Hot liquid risk screening tool were completed by RN Unit Manager #1 and RN Unit Manager #2 on all residents and care plans updated as needed to reflect the assessment. On 05/21/24 at 5:00 P.M. Maintenance Man #1 removed microwaves from the unit pantries. One microwave will be kept in the conference room area in the event that something needs to be heated after hours. A sign will be placed there to instruct staff how to heat food and beverages, including taking the temperature and recording. The liquids are to be no hotter than 140 degrees. On 05/21/24 at 5:05 P.M. the Facility Quality Assessment and Assurance Committee ADHOC meeting was held by phone with the Facility Medical Director, Administrator, and Director of Nursing regarding incident of Accident Hazard involving Resident #27 which occurred on 04/06/23 and again on 10/30/23 and what corrective action measures were being taken. On 05/21/24 at 5:30 P.M. the physician was notified, and orders received for Occupational Therapy evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Beginning 05/22/24, during the morning Interdisciplinary team (IDT) meeting the facility will discuss if any new injuries have occurred related to hot liquids through reviewing the risk as well as reviewing the 24-hour report. Any new injuries from hot liquids will be investigated and new interventions in place to prevent future episodes. The facility identifies the deficient practice occurred related to a staff member not following the resident's plan of care and adhering to the facility policy as it relates to hot liquids. Beginning 05/22/24 the Administrator or her designee will forward any new reportable allegations to the Chief Operating Officer to review to ensure that the facility conducts a thorough investigation with accurate conclusions. Beginning 05/22/24 the Director of Nursing or her designee will conduct an audit of 10 residents using the Resident Skin Assessment tool. The audit will be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality Assurance and Performance Improvement Committee for ongoing compliance. Beginning 05/22/24 the Director of Education or her designee will conduct an audit of 10 employees using the Staff Questionnaire as it relates to how to reheat liquids and by demonstration. The audit will be completed twice a week for four weeks and then as determined necessary. Findings will be referred to the Quality Assurance and Performance Improvement Committee for ongoing compliance.