

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Fair Oaks Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11300 Fair Oaks Blvd. Fair Oaks, CA 95628	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41206 Based on interviews and record review the facility failed to promptly notify Resident 1's Responsible Party (RP) or Family Member (FM) when Resident 1 experienced burns to two fingers. This failure resulted in Resident 1 feeling as if the facility did not take her injury seriously. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility in May 2020 with diagnoses including parkinsonism (brain conditions that cause tremors) and ataxia (loss of muscle control in arms and/or legs). A review of a nurse progress note dated 4/22/24 at 2:33 p.m. indicated, [Resident 1] was attempting to feed self this AM [morning] without CNA assistance. Due to tremors [Resident 1] spilled hot cereal over and burn 2 fingers to left hand. Index finger blister measuring apprx [approximately] 2.5x1 .middle finger 2x2. [Resident 1] was advised to wait for staff to assist w [with] feeding. NP [Nurse Practitioner] .wrote new orders to monitor site. There was no documented evidence Resident 1's RP or FM was notified of Resident 1's injury when it occurred. During a review of Resident 1's change of condition evaluation (eCOC) dated 4/26/24 at 11:42 a.m., completed by LN 1, the eCOC indicated Resident 1 had a, boil to index (left hand) finger 2.5 x 1, middle finger 2 x 2, burn with hot cereal. Family Member 1 (FM 1) notified on 4/26/24 at 11:25 a.m. During a review of Resident 1's progress Note dated 4/26/24 at 12:15 p.m. indicated Resident 1's FM 1 was concerned Resident 1's fingers were burned and the facility had not notified FM 1 of the incident. During an interview on 6/5/24 at 1:45 p.m. with the Director of Nursing (DON), the DON stated the resident's RP or FM was expected to be notified when an accident or change of condition occurs for the resident. During a telephone interview on 6/11/24 at 12:40 p.m. with the LN 1, the LN 1 confirmed he did not notify Resident 1's FM about the accident with injury. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555153	Facility ID: 555153 If continuation sheet Page 1 of 9

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised February 2021, indicated, Our facility promptly notifies .the resident representative of changes in the resident's medical/mental condition and/or status .A nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury .		

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. 41206 Based on interviews and record review the facility failed to ensure the accuracy of assessments for one resident (Resident 1) when Resident 1 did not receive timely and adequate assessments of her injuries. This failure resulted in Resident 1's inaccurate and inconsistent assessments of her injuries, a lack of diagnosis for her injuries, and a delay in appropriate treatment. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility in May 2020 with diagnoses including parkinsonism (brain conditions that cause tremors) and ataxia (loss of muscle control in arms and/or legs). A review of a nurse progress note dated 4/22/24 at 2:33 p.m. written by Licensed Vocational Nurse 1 (LVN 1) indicated, [Resident 1] was attempting to feed self this AM [morning] without CNA [Certified Nursing Assistant] assistance. Due to tremors [Resident 1] spilled hot cereal over and burn 2 fingers to left hand. Index finger blister measuring apprx [approximately] 2.5x1 .middle finger 2x2. [Resident 1] was advised to wait for staff to assist w [with] feeding. NP [Nurse Practitioner] .wrote new orders to monitor site. A review of Resident 1's nurse progress notes indicated the following: On 4/26/24 at 12:15 p.m., the Assistant Director of Nursing (ADON) who is a Registered Nurse, documented, Informed by Social service director that family member of [Resident 1] had some issues and concern .The writer followed up and did talk to the nurse schedule am [morning] shift on 4/22/24. The writer called the [Family Member] and explained .on 4/22/24 resident was attempting to feed self .without CNA assistance. Due to tremors resident spilled hot cereal over and burn 2 fingers to left hand .The writer update [sic] .the son for the new tx [treatment] to apply .dressing and cover with gauze due to blister already open . On 4/26/24 at 5:11 p.m., the LVN 2 documented, monitoring for left hand boil, no c/o [complaint of] pain or any discomfort, kept clean and dry, will cont. [continue] to monitor. On 4/27/24 at 2:45 p.m., the LVN 3 documented, Patient has a wound on left hand on two fingers due to spilling hot cereal over and burned index finger blister measuring apprx [approximately] 2.5x1 and middle finger 2x2 .Will continue to monitor per order. On 4/29/24 at 6:07 a.m., the LVN 4 documented, pt [Patient] cont monitor for boil to l [left] index hand. Dressing is clean dry and intact, no signs of infection noted at this time . On 4/29/24 at 2:03 p.m., Registered Nurse 1 (RN 1) documented, .No c/o pain or other discomfort. Afebrile [without fever], VSS [vital signs stable]. Wound care completed as ordered by treatment nurse. No s/s [signs and symptoms] of infection noted. (continued on next page)		

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/24 at 6:34 p.m., the LVN 5 documented, .Pt monitored for left land/finger burned by oatmeal. Pt has bandades [sic] on 2 fingers Pt skin pink moist mucous membranes . On 4/30/24 at 6:52 a.m., the LVN 4 documented, Pt cont monitor for boil to L [left] index hand. On 5/17/24 at 4:21 p.m., the LVN 6 documented, left 2ndand 3rd finger popped blisters have resolved. On 5/19/24 at 8:48 a.m., the LVN 6 documented, written NP [Nurse Practitioner] updated tx order for left 2nd and 3rd fingers. There was no documented assessment or evaluation of Resident 1's injuries on the day Resident 1 obtained the injuries to her left hand by an RN, NP or Physician. During a telephone interview on 6/11/24 at 12:40 p.m. with LVN 1, LVN 1 confirmed performing a physical assessment was not within an LVN's scope of practice. The LVN 1 stated assessments are supposed to be completed by the RN. The LVN 1 also stated LVNs cannot diagnose an injury or condition. The LVN 1 stated he was responsible for gathering information of what occurred and providing his findings to the NP or Physician. The LVN 1 verified there was no documented assessment as to the type of burn (first, second or third degree) Resident 1 had received from the hot cereal. During a telephone interview on 6/11/24 at 1 p.m. with the Director of Nursing (DON), the DON stated, The RN completes the assessments, it would be expected that the RN would come to the floor and complete the assessment. A review of the Nursing Practice by the California Nurses Association, undated, stipulates, The RN is legally responsible for analyzing, synthesizing and evaluating data collected on patients through the RN direct observation .only the RN can perform assessments, which includes analysis and formulation of a nursing diagnosis .this responsibility cannot be delegated or assigned to an LVN. A review of the Vocational Nursing Practice Act, undated, stipulates, The LVN may use and practice ' basic assessment (data collection)' .the LVN is required to report and/or refer abnormal values to the RN .the LVN cannot analyze, synthesize and evaluate data.		

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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. 41206 Based on interviews and record review the facility failed to revise Resident 1's care plan within a timely manner after Resident 1 sustained an injury after an accident. This failure decreased the facility's potential to ensure residents receive appropriate and person-centered care. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility in May 2020 with diagnoses including parkinsonism (brain conditions that cause tremors) and ataxia (loss of muscle control in arms and/or legs). A review of a nurse progress note dated 4/22/24 at 2:33 p.m. indicated, [Resident 1] was attempting to feed self this AM [morning] without CNA assistance. Due to tremors [Resident 1] spilled hot cereal over and burn 2 fingers to left hand. Index finger blister measuring apprx [approximately] 2.5x1 .middle finger 2x2. [Resident 1] was advised to wait for staff to assist w [with] feeding. NP [Nurse Practitioner] .wrote new orders to monitor site. During a review of Resident 1's care plan initiated on 4/26/24 indicated, [Resident 1] has actual impairment to skin integrity of the left index and middle finger r/t [related to] burn with hot cereal. During a interview with the Director of Nursing (DON) and concurrent record review on 6/5/24 at 1:45 p.m. of Resident 1's care plan regarding the burns she obtained on 4/22/24, the DON confirmed the care plan had not been revised in a timely manner. The DON stated, I expect the care plans to be updated the day of or the next day at the latest; this one [care plan] was updated late. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41206 Based on interviews and record reviews the facility failed to ensure physician orders were followed when Resident 1 did not receive wound care treatment as ordered. This failure decreased the facility's potential to assist Resident 1's wound to heal. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including open wounds to right and left lower legs, diabetes mellitus (inadequate control of sugar in the blood stream) and atherosclerosis of arteries (narrowing and hardening of the blood vessels) in the legs and feet. During a review of Resident 1's Order Summary Report (OSR, physician orders) printed on 6/5/24, Resident 1 had orders for the following wound care: 1. Starting on 4/15/24, licensed nurses were to monitor Resident 1's left and right lower extremities, lower leg to toes, diabetic foot ulcer for sing or symptoms of infection, every shift. 2. Starting on 4/16/24, licensed nurses were to clean Resident 1's left lower extremity to toes with normal saline, pat dry, paint with betadine (antiseptic used for skin disinfection), cover with abdominal pad (sterile, highly absorbent dressing), wrap in kerlix (fast wicking and absorbent) dressing daily, or as needed due to multiple injuries. 3. Starting on 4/22/24, licensed nurses were to clean Resident 1's right lower extremity to toes with normal saline, pat dry, paint with betadine (antiseptic used for skin disinfection), cover with abdominal pad (sterile, highly absorbent dressing), wrap in kerlix (fast wicking and absorbent) dressing daily, or as needed due to multiple injuries. A review of Resident 1's Treatment Administration Record (TAR), dated April 2024, indicated the following: 1. There was no documented evidence of monitoring of Resident 1's left and right lower extremities for 20 out of 70 shifts. On the morning shift on 4/18/24 and 4/24/24 staff documented a 9 on the treatment record. A review of the TAR chart codes indicated a 9 represented, Other, See Progress Notes. A review of Resident 1's progress notes dated 4/18/24 and 4/24/24 indicated no reason why the monitoring was not completed. 2. There was no documented evidence wound treatment was conducted on Resident 1's left lower extremity to toes for 5 out of 11 shifts. On 4/18/24 and 4/24/24 a 9 was annotated on the TAR. A review of Resident 1's progress notes dated 4/18/24 and 4/24/24 indicated no reason why the wound treatment was not conducted. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. There was no documented evidence wound care treatment was conducted on Resident 1's right lower extremity to toes for 3 out of 5 shifts. On 4/18/24 a 9 was annotated on the TAR. A review of Resident 1's progress notes dated 4/18/24 indicated no reason why the wound treatment was not conducted. On 6/5/24, a review of a skin observation tool, dated 4/18/24 (four days after Resident 1's admission), was reviewed. The document indicated Resident 1 had a right lower leg diabetic ulcer (a serious complication caused by a combination of poor circulation, susceptibility to infection and nerve damage from high blood sugar levels) which measured 9.5 cm (centimeters, a unit of measurement) by 3 cm and a left lower leg diabetic ulcer which measured 15.5 cm by 4 cm. During a concurrent interview and record review on 6/5/24 at 11:42 a.m. with Licensed Nurse 1 (LN 1), the LN 1 confirmed the missing dates on Resident 1's April 2024 TAR and stated, The empty dates on the TAR either indicate the treatment wasn't done or maybe the nurse forgot to check it off .either way, there is no documentation to verify if the treatment was done. The LN 1 verified there were no progress notes written in Resident 1's chart to indicate why the treatments were not completed. During a review of Resident 1's records on 6/5/24 at 2:03 p.m., Resident 1's admission skin assessment was requested. The facility failed to provide the surveyor with a copy of Resident 1's admission skin assessment. During a concurrent interview and record review on 6/5/24 at 3:40 p.m. with the Director of Nursing (DON), the DON confirmed there were missing and blank dates on Resident 1's April 2024 TAR. The DON stated, The nurse either didn't do the treatment or they didn't initial that they did it, I'm unable to determine if the treatment had been completed or not. The DON explained a 9 on the TAR indicated the treatment was not done and there should be a progress note associated with the specific date; the DON confirmed there were no progress notes in Resident 1's chart to indicate why treatments were not completed. A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised July 2017, indicated, All services provided to the resident .shall be documented in the resident's medical record .The following information is to be documented in the resident medical record .Treatments or services performed. Documentation in the medical record will be .complete, and accurate. A request for the facility's P&P regarding the standard for following physician orders was requested on 6/11/24 at 3:53 p.m. The facility was not able to provide an appropriate P&P. A review of the California Nursing Act indicated licensed nurses have a legal duty to carry out physician's orders as written.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41206 Based on observation, interviews, and record review the facility failed to ensure the safety for one resident (Resident 1) when Resident 1 did not receive adequate supervision and assistance during breakfast. This failure resulted in burns and blisters to two of Resident 1's fingers and pain to the affected area. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted to the facility in May 2020 with diagnoses which included parkinsonism (brain conditions that cause tremors) and ataxia (loss of muscle control in arms and/or legs). A review of a nurse progress note dated 4/22/24 at 2:33 p.m. indicated, [Resident 1] was attempting to feed self this AM [morning] without CNA assistance. Due to tremors [Resident 1] spilled hot cereal over and burn 2 fingers to left hand. Index finger blister measuring apprx [approximately] 2.5x1 .middle finger 2x2. [Resident 1] was advised to wait for staff to assist w [with] feeding. NP [Nurse Practitioner] .wrote new orders to monitor site. During a concurrent observation and interview on 6/5/24 at 9:50 a.m. with Resident 1, in Resident 1's room, Resident 1 was observed sitting up in bed, with tremors noted to her right hand. Resident 1 stated she needed assistance with eating due to her tremors because she was not able to hold the utensils steady. Resident 1 stated the Certified Nursing Assistant 1 (CNA 1) was assisting her the day of the incident and had taken the hot cereal to heat it in the microwave. When the CNA 1 returned with the hot cereal, Resident 1 stated the CNA 1 then stepped away from the bedside. Resident 1 stated she picked up her fork to check the temperature of the hot cereal, brought the hot cereal to her lips, dropped the fork because the cereal was so hot, the hot cereal spilled on her left hand and the bowl fell to the floor. Resident 1 stated, I screamed bloody murder, it was the most painful thing. I let out a blood curdling yell, but I don't think staff took it seriously. The charge RN (Registered Nurse) never came to evaluate me or the wound nurse until a few days later. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/5/24 at 10:22 a.m. with CNA 1, the CNA 1 stated she was not familiar with Resident 1's care, although she did know Resident 1 needed assistance with her meals. On the day of the incident, it was the second time CNA 1 had been assigned to care for Resident 1. The CNA 1 stated she microwaved Resident 1's hot cereal that morning. The CNA 1 stated, I put the cereal in the microwave and set the timer for one minute, but I took it out before the timer went off. I admit it, it was my fault, it was probably too hot. The CNA 1 stated she placed the hot cereal on Resident 1's tray and then stepped away, approximately four feet, behind the curtain to get Resident 1's coffee. Resident 1 yelled out and CNA 1 turned back around to check on Resident 1. The CNA 1 stepped around the curtain and noticed Resident 1's left hand between the third and fourth fingers were red. The CNA 1 stated she reported the incident immediately to the Licensed Vocational Nurse 1 (LVN 1). The CNA 1 stated, I assumed she would wait to let me help her with the cereal, I'm supposed to help her. She [Resident 1] was screaming, I noticed her hand immediately, her fingers blistered between one to two hours after [the spill]. During an observation on 6/5/24 at 11:35 a.m. the microwave across from the nursing station on D unit was observed. Taped to the top of the microwave was a laminated sign which stated, Re-Warming Liquids, Temperature Should Not Exceed 145 Degrees. Test all liquids with a thermometer before giving to your resident/patient. To the left of the microwave a digital thermometer was hanging in a black pouch on the wall. A cup from the kitchen with approximately 1.5 in (inches, a unit of measure) of water was placed inside the microwave and the microwave was set to one minute. At 41 seconds the cup, which did not feel hot, was removed from the microwave. The thermometer was placed into the cup of water and was held in place for 15 seconds. When the thermometer was removed the temperature on the thermometer read 166.4 degrees Fahrenheit (F, a unit of measurement). During an interview on 6/5/24 at 12:05 p.m. with CNA 2, the CNA 2 stated, There's a thermometer in there [room next to nursing station] but I don't use it. The cereals in the morning are already nice and warm, there's no reason to reheat them. During an interview on 6/5/24 at 12:43 p.m. with CNA 3, the CNA 3 stated, Resident 1 will end up spilling her food because she shakes, she gets food everywhere, we [CNAs] have to assist her. CNA 3 stated Resident 1 attempts to use her spoon or fork, but she shakes and the food drops everywhere. During a concurrent observation and interview on 6/5/24 at 12:57 p.m. with CNA 2 and CNA 3 (CNA 1 was unavailable) the microwave and thermometer was observed. The CNA 2 and CNA 3 confirmed they were aware of the sign and the thermometer, and they have received education in the past on how to use the microwave and thermometer. During an interview on 6/5/24 at 1:45 p.m. with the Director of Nursing (DON), the DON confirmed CNA 1 should not have left Resident 1 unattended during breakfast. The DON stated Resident 1 needed assistance and supervision with meals, she has tremors and is unable to feed herself. A review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, revised July 2017, the P&P indicated, Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.		