STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675185	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longmeadow Healthcare Center	120 Meadowview Dr Justin, TX 76247

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41211 Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of 105 residents reviewed for supervision. The facility failed to provide a lid which screwed onto the cup per Resident #1's care plan and failed to provide one-person supervision while eating per Resident #1's MDS assessment. This resulted in Resident #1 spilling coffee on himself, which went unwitnessed and unassessed for an undetermined amount of time and Resident #1 sustaining burns to his forearm, hip, and waist on 12/14/2024. The noncompliance was identified as Past Non-Compliance Immediate Jeopardy (IJ). The Immediate Jeopardy began on 12/14/24 and ended on 12/15/2024. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of injury and a decreased quality of life. Findings included: Record review of Resident #1's Face Sheet dated 12/14/24, revealed he was a [AGE] year-old male, admitted to the facility 09/01/17. Diagnoses included Cerebral infarction, hemiplegia and hemiparesis affecting right dominant side, aphasia, and lack of coordination. Record review of Resident #1's Minimum Data Set, dated dated dated [DATE], revealed his brief interview for mental status was 06, which means he was severely impaired. Requires extensive two-person assist for most Activities of Daily Living, total dependence with two-person assist for transfers, and supervision of one-person for eating. Record review of Resident #1's Care Plan dated 10/30/24, revealed Focus: Risk of burns due to hot liquids. Goal: Resident will not suffer any injury related to hot liquids. Intervention: Coffee and other hot liquids should not be served if over 140 degrees. If hot liquid was spilled on self, staff should pour room temperature or lower temp liquid on the affected area of the resident. Resident to use a cup with a screw on lid. Resident will utilize specialized cup for hot liquids. Should be seated in upright position with table or overbed table when hot liquids are being consumed. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Progress Note entered by Nurse B, at 10:46 AM and dated 12/14/24, revealed Note Text: at 1030 (standard time) aide went into the resident room to change the resident and found redness on the right side of the resident body. Right hip, waist (with blisters), and right wrist with a blister. Aide came and got the (Nurse B) then asked for assistance from (Nurse C). nurse found the resident not expressing pain. skin impairment. when the resident was asked when he spilt the coffee he said about 1 hour prior. he was also asked if he told anyone, he shrugged. (Nurse C) called Director of Nursing (DON) while (Nurse B) applied Silvadene to the wounds. (Medical Staff) was also informed of the incident. with the orders stating cleanse with Normal Saline, pat dry, apply silver sulfadiazine to the affected area daily. until healed. on coming nurse will be informed via report. Record review of Resident #1's Progress Note entered by Nurse B, at 11:07 AM and dated 12/14/24, revealed Note Text: Blood Pressure-126/74. Temperature-97.7. Pulse-81. Respiratory-18. Burn to right hip, waist, forearm, and wrist caused by coffee, tea, or other hot liquid, discovered/occurred in Resident Room. Details of injury: upper forearm 2x3 blister wrist 4x4 blister 5x20 redness hip 28x11 buttock 11x2 waist 11x20 right side. Cognition / Behavior at Time of Event: Cognitive Impairment, patient found with burns on his right side by the aide that went to change him. Initial Treatment/New Orders: cleansed normal saline, pat dry, Silvadene applied. orders given cleanse with normal saline, pat dry, apply silver sulfadiazine, until healed Resident Statement: 'spilt my coffee on me' (Medical Staff) notified: 12/14/2024 10:45 AM. (Family) notified: 12/14/2024 10:45 AM. Record review of Resident #1's Progress Note entered by Nurse D, at 12:38 AM and dated 12/21/24, revealed Visit Type: SKIN AND WOUND NOTE Details: Healing Partners Skin and Wound Note PATIENT NAME: Resident #1 DATE OF SERVICE: 12/20/2024 DOB: 06/15/1954 12.20.24: Consult requested due to resident spilling hot coffee on him approximately 5 days ago. He reports 'some' pain to wounds, reports it is tolerable. Educated on ways to decrease risk of spilling coffee on self. Understanding voiced. REVIEW OF SYSTEMS: SKIN: no history of pressure ulcers, no history of chronic wounds MEDICATIONS: . Silvadene External Cream 1 % two times a day . WOUND ASSESSMENT: Wound: 1 Location: right arm Primary Etiology(cause): Second Degree Burn Stage/Severity: Full Thickness [full thickness, permanently destroyed tissue, and painlessness is indicative of 3rd degree burns] Wound Status: New Odor Post Cleansing: None Size: 20.5 cm x 4.1 Location: right hip/thigh Primary Etiology: Second Degree Burn Stage/Severity: Full Thickness Wound Status: New Odor Post Cleansing: None Size: 22 cm x 17 cm x 0.1 cm. Calculated area is 374 sq cm. PROCEDURES: A sharp debridement was not performed today due to patient/family refusal. Record review of Nurse C's written statement, revealed on 12/14/24 at 10:30 AM, she was asked by Nurse B to look at Resident #1. She stated the resident had redness and blistering to right posterior forearm and redness to right outer thigh and redness and blistering to right hip. Resident #1 reported to C.N.A. A that he had spilled his coffee. The aide cleaned the resident up. Nurse C stated she notified the DON and medical staff for treatment orders. She stated she met with the kitchen staff for the coffee temperature which was within range and was less than 140 degrees Fahrenheit. She stated she interviewed the resident and he told her that the coffee was in his water cup with a lid, straw, and handle. The resident told her that he dropped his cup and the lid fell off. She stated the resident said the spill happened about an hour prior to her speaking with him. She stated the resident told her that he did not feel it and he denied pain. Resident #1 told her that he asked for the coffee in the large water jug due to easier use with his poor dexterity and inability to use regular coffee cups without severe difficulty. Nurse C stated Resident #1 had received coffee in this manner since his admission in 2017 and this was his first incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of C.N.A. I's written statement, revealed on 12/14/24 at 9:15 AM, she took Resident #1's breakfast to him. He told her to put his coffee in his cup and she went to the kitchen to get the coffee. She stated she brought the coffee to him and placed it on his table, as he had asked her to do. Observation of Resident #1's wounds on 12/27/24 at 1:46 PM, revealed the resident's wounds were healing. The pink areas had reduced in size. The pink areas were reduced to only the skin which surrounded the wounds which were still draining. Those drainage sites were smaller in size, as well. The measurements of the wounds were as follows: Forearm-3.7 cm x 4 cm, Wrist-3 cm x 4 cm, Waist-4 cm x 4 cm, Hip-9.5 cm x 2. 5 cm. The rest of the wounded skin had resolved. During an interview on 12/27/24 at 2:00 PM with the ADON, revealed reason the measurements from Nurse D's Progress Notes were so large, was because she measured the span of the wounds instead of each individual wound. Observation and interview with Resident #1 on 12/23/24 at 2:54 PM, revealed he had burn wounds on his right forearm, wrist, and at the joint of the thumb. He also had burn wounds on his right hip and waist. The wounds were pinkish red in color. One of the areas on the forearm was about the size of a half dollar and it was draining. The area at the joint of the thumb was about the size of a quarter and it was draining. On his hip and waist area, there was an elongated area which was about three inches long and it was draining. Resident #1 stated the burns occurred when he accidentally knocked over his coffee and it fell on to his right side. He stated when Certified Nurse Aide (C.N.A.) A came in to check if he needed anything, he told her that he had spilled his coffee on himself. He stated he did not know how much time had passed between the spill and him telling the aide about it. He stated he did not remember if the lid was on the cup; however, he stated it usually was on, so he guessed it was on that day. During an interview on 12/27/24 at 3:56 PM with C.N.A. A, revealed she entered Resident #1's room to provide incontinent care and she saw that his skin was red and blistered. She stated, after she changed his brief, she notified Nurse B about the condition of his skin. She stated the reason he did not tell staff about the spill sooner was because he could not feel anything on his right side. She stated Nurse B and Nurse C entered the room, to assess the resident. She stated she replaced the wet linen with clean linen and she changed the resident's clothes, once the nurses were done taking care of his wounds. She stated this was the first time the resident had spilled his drink. She stated he was an avid coffee drinker. She stated she had had a previous talk with the resident and told him that if his coffee was ever too hot, he should let it sit for a while so it could have time to cool off. She stated he said he understood what she told him and agreed to do so. She stated the day after the he spilled his coffee, the DON brought him a new insulated cup which had a screw-on lid. She he had also been provided with a preventative apron; however, he refused to use it. She stated he was very vocal how he wanted things to be and if things were not to his liking. She stated staff were in-serviced on how certain residents must use specific no-spill cups or mugs. She stated the residents who have to use those cups were the residents who had shaky hands. She also stated staff were to obtain coffee for the residents, from the temperature regulated coffee machine. She stated she would put a towel over the resident whenever she assisted him with eating or drinking. She stated he doesn't like the towel, but he will allow it over the apron. (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 on 12/23/24 at 3:23 PM with Nurse B, revealed she was notified by C.N.A. A Resident #1 had spilled coffee and his skin was red and blistered. She stated she assessed the resident and called for Nurse C. She stated she and Nurse C assisted the resident out of bed, so his linen could be changed. She stated the resident's skin was red and blistered. She stated she and Nurse C cleansed the resident's wounds and dressed them. She stated once they completed the dressings, C.N.A. A dressed the resident in clean clothes. She stated she notified the medical staff, DON, Administrator, and family. She stated the medical staff ordered Silvadene and pain medication. She stated once the medications were received, they were applied to the wounds. She stated after assessment and consultation with the medical staff, they determined that Resident #1's wounds did not require for him to go to the hospital to be treated. During an interview on 12/23/24 at 3:34 PM with Nurse E, revealed the regulated temperature machine was purchased in December of 2022, after the facility's first burn incident. During an interview on 12/27/24 at 10:45 AM with the Dietary Manager, she stated she learned about Resident #1's injury from Nurse C, who told her that C.N.A. I had gotten coffee from the temperature regulated machine, and she wanted the coffee from that machine to be checked. She stated when she checked the temperature of the coffee, it was 136.2 degrees Fahrenheit. She stated it was about 10:30 AM, at that time. She stated the temperature regulated coffee machine was set not to exceed 138 degrees Fahrenheit prior to 12/14/24. She stated she began logging the temperature of the coffee from the machine on 12/14/24, after the Resident #1 was injured from spilling coffee on himself, as a precautionary measure. During an observation, interview, and record review on 12/27/24 at 11:00 AM with the DON, revealed the facility provided a standard mug which has a snap-on lid and flexible straw to all residents who when they are admitted to the facility. She showed me the supply of the mugs in the storage closet. The mugs were similar to the ones issued in hospitals; except they were smaller in size. She stated all residents use cups or mugs which have some form of lid affixed to them, to prevent spills. She stated all staff were in-serviced, after Resident #1's injury. She stated a Hot Liquid Assessment was completed on all residents. A call was made to C.N.A. I on 12/27/24 at 1:25 PM, in an attempt to interview them. A message could not be left as no opportunity to leave a message was offered. A call was made to the Medical Staff on 12/27/24 at 1:28 PM, in an attempt to interview them. A message was left on their voicemail. A call was made to Nurse D on 12/27/24 at 1:33 PM, in an attempt to interview her. A message was left on her voicemail. During an interview on 12/27/24 at 4:44 PM with the Administrator, revealed the facility had made preventative changes prior to Resident #1's injuries and due to a similar incident with another resident in 2022. He stated Resident #1's incident was his first of this kind, so they used the same interventions which were in place for the previous resident. He stated all staff were in-serviced, following the resident's accident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's undated Guidelines on Serving Coffee, reflected 1. As there is no published federal regulation for minimum or maximum coffee temperature, the decision as to the temperature at which to serve the coffee rests with the administration .the safety of their individual residents and their physical and mental limitations. 3. Any residents who have risk factors for coffee burns, such as significant cognitive impairment or extreme shaking may be evaluated for additional safety precautions using a hot beverage risk assessment. Safety precautions may include but are not limited to additional supervision when consuming coffee, insulated or non-insulated coffee mugs with sippy lids, coffee services at lower temperatures, or restricted coffee availability. 5. An investigation and evaluation will be performed for any resident who receives a coffee burn, and a plan to reduce this resident's risk of receiving future burns will be developed and implemented. The Administrator and DON were notified on 12/27/24 at 5:45 PM, that a past non-compliance IJ situation had been identified due to the above failures. It was determined these failures placed Resident #1 in an IJ situation on 12/14/24. The facility implemented the following interventions: Record review of the hot liquid assessments revealed all residents were assessed. The dates on the report ranged from 12/14/24 - 12/19/24. Record review of the December 2024 Coffee Temperature Log for the Regulated Machine revealed the temperatures from 12/14/24 through 12/27/24, all temperatures were below 140 degrees Fahrenheit. Observation of the dining room on 12/23/24 at 1:24 PM, revealed a resident was getting coffee from the temperature-regulated machine. The resident was ambulating independently and was able to hold their mug steadily. The resident's mug was made of a clear plastic with blue measured lines and a snap-on blue cap. It also had a handle. During an interview on 12/23/24 at 3:17 PM with Resident #2, he stated he was told by another resident that everyone needed to have a cup or mug which had a screw-on lid. He stated he was happy with the mug, which the facility provided when he was admitted to the facility. He stated he had no problem with the mug and that he knew the screw-on lid was for residents who could not handle their cups well, on their own. He stated he did not need assistance with getting his coffee. He stated he gets his coffee from the machine in the dining room. He stated the coffee from that machine is always warm, but for him, it was never hot enough. Observations on 12/27/24 between 11:22 AM and 2:00 PM, revealed residents were carrying or drinking from cups which had lids affixed to them. Three residents in wheelchairs were observed with the cups, which had the screw-on lids. Residents in their rooms were observed to have the facility-provided mugs within their reach. Residents who were drinking coffee in the dining room, during lunch, received their coffee in the plastic coffee cups from the kitchen, and there were plastic lids in place. Record review of the in-services conducted on 12/14/24. The topics of the in-services were Hot Liquids/Food Spills, Coffee, Hot Liquids Serve Temps, and Acceptable Mugs for Serving Coffee. During an interview on 12/23/24 at 3:23 PM with Nurse B, revealed staff were in-serviced on making sure hot liquids are served in cups which have lids on them and making sure the coffee comes from the temperature regulated machine. (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 on 12/23/24 at 3:34 PM with Nurse E, revealed all staff were in-serviced on ensuring residents are being served coffee from the temperature regulated machine, in the dining room. She stated all warm or hot liquids have During an interview on 12/27/24 at 10:45 AM with the Dietary Manager, revealed staff received an in-service about residents were to be served hot drinks in cups with lids on them. She stated residents can only get coffee from the temperature regulated machine in the dining room and if coffee is retrieved from staff, from the brewing machine in the kitchen, it has to come from kitchen staff who have ensured its cooled down to 140 degrees Fahrenheit or below. During an interview on 12/27/24 at 11:00 AM with the DON, revealed all staff were in-serviced on hot liquids, food spills, serving temperatures for hot liquids, and acceptable mugs for hot liquids. During an interview on 12/27/24 at 3:56 PM with C.N.A. A, revealed staff received an in-service on what to do if a resident spills hot coffee, coffee is to be retrieved from the temperature regulated machine in the dining room, for residents, and residents have to have a lid on their coffee cups. During an interview on 01/09/25 at 9:52 PM with C.N.A. G, revealed staff received an in-service on making sure residents are not served excessively hot drinks. She stated coffee is to be served to residents in cups that have lids on them. She stated they are to be mindful of where they placed the resident's drinks to ensure the residents can reach the drinks without knocking them over. During an interview on 01/10/25 at 12:13 AM with Nurse H, revealed staff received an in-service on hot drinks, focused on coffee. She stated the coffee it to come from the machine in the dining room. She stated coffee is to be served to residents in cups that have lids. She stated they talked about spill prevention.