

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Legacy at Jacksonville		STREET ADDRESS, CITY, STATE, ZIP CODE 810 Bellaire St. Jacksonville, TX 75766	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents environment remained as free of accident hazards as is possible for 1 of 5 residents (Resident #1) reviewed for accident hazards. The facility failed to serve coffee at an appropriate temperature resulting in Resident #1 acquiring burns to his left and right inner thighs from a coffee spill. The noncompliance was identified as PNC. The past noncompliance began on 5/22/26 and ended on 5/23/26. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of burns, infection, and hospitalization. Findings included: Record review of Resident #1's face sheet, dated 6/1/26, indicated Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses of unspecified dementia (altered cognition), type 2 diabetes (insulin resistance) with chronic kidney disease, and need for assistance with personal care. Record review of a quarterly MDS assessment, dated 5/20/2026, indicated Resident #1 had a BIMS score of 6 which indicated severely impaired cognition and he required assistance for all ADLs. He required setup or clean-up assistance with eating/drinking. Record review of a comprehensive care plan, dated 11/10/2025, indicated Resident #1 had an ADL self-care performance deficit. Interventions were in place including providing supervision as needed for eating. Record review of Resident #1's comprehensive care plan, revisions on 5/22/26, indicated the resident was at risk of burns due to hot liquids. Resident #1 noted to remove lid at times and did not follow education risks related to hot liquid safety. Interventions were put in place including coffee and other hot liquids should not be served if over 140 degrees, if hot liquid was spilled on resident staff should poor room temperature or lower temperature liquid on the affected area of the resident, and resident reinforced to use a cup with a lid. There were no previous hot liquid safety interventions care planned. Record review of an event note for a burn, dated 5/22/26, indicated Resident #1 received a burn in the dining room to his right and left inner thighs, caused by coffee, tea, or other hot liquid. The description of the event indicated CNA A was taking residents to the dining room and another resident stated that Resident #1 had spilled coffee on himself. The event note indicated the cup of coffee was reportedly sitting too close to the edge of the table and when Resident #1 moved back from the table the coffee spilled on his lap. Redness was noted to right and left inner thighs. Resident #1 complained of a burning sensation and cold compressors were applied and a scheduled pain medication was administered. Interviews were attempted with CNA A on 6/1/26 at 1:28 p.m., 1:40 p.m., 2:23 p.m., and 3:48 p.m. Voice mail was left requesting a return call, but no call was received. Record review of a skin assessment, dated 5/22/26 at 9:07 a.m., indicated Resident #1 had the following new findings: To left inner thigh: reddened area from mid anterior (nearer the front) thigh to inner posterior (nearer the rear) thigh from spilled coffee. To right inner thigh: reddened area from mid anterior thigh to posterior thigh. One fluid filled blister to distal portion (away from center of body or point of attachment) measuring 1X 1 cm Ice water compresses applied and treatment order received for silver ointment until healed. Record review of a skin assessment, dated 5/22/26 at 11:37 a.m., indicated Resident #1 had the following new findings: Additional fluid filled blister # 2 also to distal portion measuring 0.3x 0.3 cm Record review of an 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
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F 0689 Level of Harm - Actual harm Residents Affected - Few	note dated 5/23/26 at 11:57 a.m. indicated Resident #1 had the following noted injury: right thigh intact blister, left thigh (2) small burns Record review of facility Coffee Temperature Log, dated 05/16/26 through 05/22/2026, indicated on 5/22/26 coffee was served with a temperature of 160 degrees by Dietary Aide D's initials. During an observation and interview on 6/1/26 at 9:50 a.m., [NAME] Aide C said she was generally responsible for checking the temperature on the coffee prior to it being served to residents. [NAME] Aid C said she checked the temperature after every pot of coffee that was brewed and added ice to the coffee to reach a desired temperature of 140 or below. [NAME] Aide C said the risk of serving coffee to residents that was too hot could result in burns. [NAME] Aide C was observed calibrating the thermometer and checking the temperature of the coffee in the coffee dispenser in the dining room. The temperature of the coffee was observed to be 137.0 degrees. During an interview on 6/1/26 at 10:00 a.m., the DM said all staff who worked in the kitchen were trained in the proper procedures for making coffee. The DM said part of that process included checking the temperature of the coffee and making sure it was below 140 degrees. The DM said the coffee maker brewed coffee at 200 degrees and then ice was added to cool down the coffee to serving temperature. The DM said she audited the coffee temperature logs daily to ensure they were filled out and the temperature was below 140 degrees. The DM said on the day of the incident Dietary Aide D failed to check the temperature of the coffee prior to serving it to the residents. The DM said the coffee temperature was checked after the incident and the temperature was found to be 160 degrees. The DM said the policy was to serve coffee at 140 degrees or below to prevent burns. During an interview on 6/1/26 at 10:10 a.m., Resident #1 said he was sitting in the dining room and his coffee was on the edge of the table. Resident #1 said when someone moved the coffee fell over into his lap. Resident #1 was unable to state who moved causing the coffee to fall over. Resident #1 said he felt pain rated 9/10 on a 0/10 scale from the coffee burn. Resident #1 said staff acted immediately to assist him and applied ice to the burns which was effective at relieving some of the pain. Resident #1 said the burns do not hurt him unless staff were doing wound care, then the pain would be up to 5/10, which he said was okay. Resident #1 said there was no lid on his coffee cup when it spilled, but there were always lids on the coffee cups now. During an observation on 6/1/26 at 10:15 a.m., LVN B completed wound care for Resident #1. Resident #1's skin was observed and an open wound was noted to his right inner thigh along with redness. Discoloration was noted to his left inner thigh, but no redness or blisters. LVN B completed wound care following provided wound care orders of applying alginate calcium once daily and covering with gauze island with border dressing. During an interview on 6/1/26 at 10:15 a.m., LVN B said she was the treatment nurse and she completed an initial wound assessment of Resident #1 after he was burned. LVN B said Resident #1 had redness to both inner thighs and two fluid-filled blisters, one on each thigh. LVN B said the blister had resolved on the resident's left thigh and redness had mostly resolved, only discoloration remained. LVN B said Resident #1 had a nickel sized blister on his right thigh the previous day, but it must have ruptured overnight, because it was now an open wound. LVN B said Resident #1 generally did not complain of pain during his wound care, but he did receive scheduled pain medication. LVN B said Resident #1's left thigh was healed and as of 6/1/26 the most recent wound orders were performed. Record review of Resident #1's wound care physician's orders, dated 6/1/26, indicated for burn wound of the right thigh, add alginate calcium once daily and discontinue silver sulfadiazine 1%. Continue with gauze island with border dressing. During an interview on 6/1/26 at 3:13 p.m., the ADM said immediately following the incident she asked the HS to take the temperature of the coffee. The ADM said the HS went into the kitchen and retrieved the thermometer and checked the temperature of the coffee and it was 106 degrees. The ADM said she then interviewed Dietary Aide D and Dietary Aide D said she did not check the temperature of the coffee prior to serving it to residents on that day. The ADM said Dietary Aide D told her she checked the coffee temperature immediately after the resident was burned and it was 160 degrees. The ADM said Dietary Aide D wrote the 160-degree temperature down on the temperature checking log. The ADM said Dietary Aide D said she added ice to the coffee to cool it (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the dining room reflected coffee temperatures of 137 degrees at 9:50 a.m. and 115 degrees at 3:15 p.m. Sampled temperatures of a coffee dispenser in a separate bistro area at 3:09 p.m. reflected coffee temperature of 130.6 degrees. Record review of coffee temperature log, dated 6/1/26, indicated coffee had been served at appropriate temperatures below 140 degrees. During interviews on 6/1/26 date at 11:15 a.m. to 11:50 a.m. time with sampled residents Resident #2, #3, #4, #5 all indicated the coffee temperature had never been too hot. All residents interviewed indicated they would prefer the coffee to be hotter but were satisfied with the temperatures.		