

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024
NAME OF PROVIDER OR SUPPLIER Kendall House Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Grand Blvd. Boerne, TX 78006	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision and assistance to prevent accidents and injury for 1 (Resident #1) of 4 residents reviewed for accidents and supervision as evidenced by:</p> <p>The facility failed to provide adequate supervision and assistance to Resident #1 resulting in Resident #1 receiving a 1st degree burn (a burn affecting the top layer of skin) to her hand and a 2nd degree burn (a burn affecting the top layer of skin, the next layer below it and often causes blisters to the skin) to her thigh after spilling coffee on herself.</p> <p>An Immediate Jeopardy (IJ) was identified on 11/22/2024 at 3:10 p.m. The IJ template was provided to the facility on [DATE] at 3:38 p.m. While the IJ was removed on 11/24/2024 at 5:07 p.m., the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of its Plan of Removal (POR).</p> <p>This failure could place residents who require assistance and supervision at risk for injuries.</p> <p>The findings were:</p> <p>Record Review of Resident #1's undated face sheet revealed she was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included Stroke (occurs when the blood supply to part of the brain is blocked or reduced), Hemiplegia (paralysis of one side of the body), Dysphagia (difficulty swallowing) and Dementia (a general term for impaired ability to remember, think, or make decisions).</p> <p>Record review of Resident #1's hospital discharge progress note, dated 10/26/2024, revealed Resident #1 admitted to the hospital with an acute stroke on 10/04/2024 and had paralysis of the right arm.</p> <p>Record review of Resident #1's progress note titled History and Physical, dated 10/28/2024 by Resident #1's NP stated, patient was previously set up assist to supervision with mobility and ADL's, she is currently total assist with mobility and ADLs. The decision was made to transfer to [facility name] for ongoing monitoring, treatment and SN/PT/OT.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's admission MDS assessment, dated 11/03/2024, revealed a BIMS score of 0, indicating severe cognitive impairment. Section GG Functional Abilities revealed Resident #1 had range of motion limitation that interfered with daily functions or placed the resident at risk for injury with impairment on one side of Resident #1's upper and lower extremity. Section GG Self-Care revealed Resident #1 was dependent (defined on the MDS as the helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for eating (defined on the MDS as the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). Oral hygiene and personal hygiene were coded as dependent. Upper and lower body dressing was coded as substantial/maximal assistance (defined on the MDS as the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). Section I Active Diagnoses included Stroke, Hemiplegia and Dementia. Section K 'Swallowing/Nutritional Status revealed Resident #1 had signs and symptoms of a swallowing disorder that included holding food in mouth/cheeks or residual food in mouth after meals.</p> <p>Record review of a Resident #1's document titled, baseline care plan, and signed by Resident #1's resident representative and a staff member on 10/29/2024, indicated, upon admission, Resident #1's required partial/moderate assistance with eating (defined on the record as the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is place before the resident). The record revealed Resident #1 was cognitively impaired and revealed, BIMS severely impaired. The record revealed Resident #1 was on a regular diet with pureed texture and thin liquid consistency.</p> <p>Record review of Resident #1's comprehensive care plan revealed Resident #1 was not to have any hot beverages per the [resident representative] request, date initiated 11/18/2024 and revised 11/19/2024. The care plan also revealed Resident #1 had a right hand and right outer thigh burn related to a coffee spill and stated per [the resident representative] request, resident is not to have any hot beverages. The care plan was initiated 11/15/2024 and reviewed 11/19/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of 30 day report on PCC, run on 11/21/24, eating record Section GG Eating task documentation report for Resident #1 revealed Resident #1 was documented as independent (defined as resident completes the activity by themselves with no assistance from a helper) on 11/01/2024 at 1:24 p.m. Resident #1 was documented as setup or cleanup assistance with eating (defined as helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) on 10/29/2024 at 11:37 p.m., 10/30/2024 at 3:38 p.m., 11/08/2024 at 5:59 p.m., 11/09/2024 at 2:27 p.m., 11/13/2024 at 12:41 p.m. and 11/18/2024 at 5:59 p.m. Resident #1 had no documentation for supervision or touching assistance with eating (defined as helper provides verbal cues and/or touching/steadying and/or contact guard assistance. Assistance may be provided throughout or intermittently). Resident #1 was documented as partial/moderate assistance with eating (defined as helper does LESS THAN HALF the effort. Helper, lifts, holds or supports trunk or limbs, but provides less than half of the effort) on 11/05/2024 at 7:47 p.m. Resident #1 was documented as substantial/maximal assistance with eating (defined as helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) on 10/27/2024 at 7:15 p.m., 10/30/2024 at 8:08 p.m., 10/31/2024 at 1:35 p.m., 10/31/2024 at 11:53 p.m., 11/06/2024 at 9:42 p.m., 11/08/2024 at 8:45 p.m., 11/09/2024 at 11:16 p.m., 11/10/2024 at 7:37 p.m., 11/14. 2024 at 11:29 p.m., 11/16/2024 at 5:59 p.m. and 11/18/2024 at 9:25 p.m. Resident #1 was documented as dependent with eating (defined as helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) on 10/27/2024 at 7:59 p.m., 11/02/2024 at 12:19 a.m., 11/03/2024 at 1:50 a.m., 11/05/2024 at 3:21 a.m., 11/07/2024 at 8:31 p.m., and 11/19/2024 at 8:03 p.m.</p> <p>Record review of Resident #1 record titled, Dehydration Risk Screener, effective date 10/27/2024 at 1:59 p.m. , revealed Resident #1 required extensive physical assistance with fluid intake eating.</p> <p>Record review of Resident #1's Modified Barium Swallow Study (MBS), dated 11/06/2024, revealed an additional active diagnosis code of Dysphagia (difficulty swallowing) following cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced). The MBS's skilled feeding/swallowing plan with the Speech Language Pathologist (SLP) recommendation for liquids stated, ice chips and/or small sips of water with good oral care to practice swallowing with least caustic substance to the lungs (water) as a part of the dysphagia rehabilitation program.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's NP progress note, 11/18/2024, stated, Resident #1 continues with silver sulfadiazine topical for burn sustained by spilling hot coffee on herself. Wound care to consult and treat.</p> <p>Record review of Resident #1's skin/wound note, dated 11/18/2024, revealed a blister to right upper thigh from reported coffee spill. Prescribed ointment applied. Physician and DON aware.</p> <p>Record review of Resident #1's Discharge Plan and Summary, dated 11/18/2024 revealed Resident #1's was planning to discharge to a personal care home on 11/23/2024. The summary listed Resident #1's activities of daily living needs as assistance with shower, assistance with dressing, assistance with meals and assistance with medication management. The discharge summary included directions for applying the silver sulfadiazine cream to the right outer thigh and right hand two times a day.</p> <p>Record review of Resident #1's skin/wound note by the DON, dated 11/19/2024, revealed Resident #1 had a cluster of redness on her right hand measuring 9 x 1 and a blister on her right outer thigh measuring 4 x 2. The note revealed Resident #1 denied pain and the areas were healing well with no signs or symptoms of infection.</p> <p>Record review of Resident #1's wound report by the Wound PA, dated 11/19/2024, revealed wound #1 was a right-hand burn 1st degree with partial thickness measuring 9 x1 x 0.1. The report stated there was no evidence of infection or drainage. Wound #2 was a right hip 2nd degree burn with partial thickness and measuring 4 x 2 x 0.1. Wound #2 had no evidence of infection or drainage.</p> <p>Record review of Resident #1's NP progress note, dated 11/20/2024, stated I was notified yesterday that patient sustained burn to right thigh when she spelt coffee on herself last week. Reported to nursing to apply silver sulfadiazine to R thigh BID x 7 days.</p> <p>Record review of Resident #1's dietary tray card, undated, revealed the following instructions: FEEDING ASSISTANCE. NOT HOT BEVERAGES. No ice in drinks. Lid on ALL drinks.</p> <p>Record review of Resident #1's diet order slip, provided by the Dietary Supervisor, revealed an order dated 11/18/2024 at 5:46 p.m., confirmed by the DON, that stated Special Diet: NCS diet Consistency: PUREED texture, Liquid: THIN consistency, LID TO BE ON ALL DRINKS for NO HOT BEVERAGES TO BE GIVEN UNLESS GIVE UNLESS GIVE BY STAFF. An additional order, date 11/18/2024 at 5:46 p.m., confirmed by the DON, that stated, Special Diet: NCS diet Consistency: PUREED texture, Liquid: THIN consistency, LID TO BE ON ALL DRINKS for NO HOT BEVERAGES TO BE GIVEN UNLESS SUPERVISED and stated to discontinue order created on 11/18/2024 at 5:46 p.m.</p> <p>Record review of Resident #1's BIMS completed on 11/22/2024 at 9:10 a.m. revealed a BIMS score of 3, indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation, 11/21/2024 at 11:10 a.m., Resident #1 was observed sitting in a wheelchair in her room. The door to her room had 2 laminated signs on the door and 2 signs on the bathroom door. One sign said, no hot drinks and the other sign had an image of a coffee cup with a line through it, indicating no coffee. Resident #1 was positioned in her wheelchair with a wedge cushion on the right side of her seat and her right arm was resting on the wedge cushion. Resident #1 had an overbed table in front of her that had a Styrofoam cup with a straw and lid and a television remote on the top of the table. Resident was observed picking up the Styrofoam cup with her left hand and bringing the straw to her mouth. Observation of this movement revealed Resident #1's left hand exhibited a visible tremor causing the cup to shake as Resident #1 moved the cup with the straw up toward her mouth and a tremor as she sat the cup back down on the overbed table. Resident #1 had a large area of darkened redness on the top of her right hand.</p> <p>During an observation, 11/21/2024 at 12:20 p.m., Resident #1 was observed sitting at a dining room table by herself. Resident #1 had a lunch plate in front of her with pureed consistency and one plastic cup of water with a closed lid and no straw. Resident #1 was observed with pureed food smeared on the side of her face while attempting to feeding herself.</p> <p>During an observation, 11/22/2024 at 8:00 a.m., Resident #1 was observed in the dining room at a table with 3 other residents. Resident #1 had a clothing protector over the front of her clothing. CNA A brought Resident #1 a breakfast tray that consisted of pureed eggs, potato, and sausage. CNA A asked Resident #1 if she wanted apple juice and Resident #1 said yes. CNA A got the apple juice in a glass with a lid and straw and then sat down at the table and fed Resident #1 her breakfast including assisting her with drinking the apple juice. Resident #1 was observed picking up her apple juice and bringing the cup with a straw to her mouth and setting it back down on the table. During this movement, Resident #1 had a visible tremor causing the cup to shake while lifting the glass up and down. CNA A fed Resident #1 all of her meal and assisted her with fluid intake.</p> <p>During an observation, 11/22/2024 at 9:45 a.m., RN B was observed performing wound care by applying silver sulfadiazine to Resident #1's right hand and right outer thigh. Resident #1 was lying her in bed with the television on. RN B asked Resident #1 if she was having any pain and Resident #1 said 'no. Resident #1's right hand was observed to have a darkened redness on the top of the hand. Resident #1's right thigh burn revealed a reddish pink area, approximately the size of a quarter, that appeared raw and was surrounded by redness. RN B stated Resident #1 had a blister in that area for the last several days that had been intact and stated it must have popped earlier in the day. RN B administered the medication without Resident #1 indicating any signs or symptoms of pain.</p> <p>During an observation of a photograph on 11/22/2024 at 4:49 a.m. of Resident #1, taken on 11/19/2024 at breakfast by the resident's representative, the photograph revealed Resident #1 sitting at the dining room table in the facility with a Styrofoam cup of coffee with a plastic lid with an open tab on her breakfast tray, no clothing protector and visible liquid spills in two areas on the front of Resident #1's shirt.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator, 11/21/2024 at 8:58 a.m., the Administrator stated he became aware of the incident on 11/19/2024 when Resident #1's resident representative discussed the incident with the DON. The Administrator stated when he was informed of the incident, he asked staff to stop serving hot beverages immediately, in-serviced nurses and CNAs on hot liquids, reporting injuries, how to treat minor burns and resident rights and reported the incident to HHSC. The Administrator stated he also discussed not serving hot beverages with the Dietary Supervisor and stated he was reaching out to the manufacturer of the coffee machine to see if the coffee machine can be recalibrated to reduce the temperature of the coffee and was waiting for a response. The Administrator stated he believed the coffee temperature from the coffee maker was 160 degrees and that the facility cannot recalibrate the temperatures. The Administrator stated the facility was not serving coffee until the machine was recalibrated.</p> <p>During an interview with the DON, 11/21/2024 at 9:15 a.m., the DON stated she was notified by RN A on 11/14/2024 around 4:00 p.m. that Resident #1 had spilled coffee on her hand and had redness, RN A had notified the resident representative, NP and wound care. The DON stated there was not an order or in-service completed at the time of the incident to stop providing hot liquids to Resident #1 until 11/19/2024, after meeting with the resident's representative. The DON stated she started an in service on 11/15/2024 for staff to encourage residents to have lids on their coffee and stated the NP gave orders on 11/15/2024 for a medicated treatment for the burns. The DON stated on 11/19/2024, Resident #1's resident representative met with the DON and stated the resident representative observed coffee on Resident's #1's breakfast tray on 11/19/2024 and was upset. The DON said the Resident #1's resident representative stated she had previously told RN A that the representative she did not want Resident #1 to have hot beverages. The DON stated RN A said the resident representative told her Resident #1 never drank coffee at home and should not be drinking hot liquids at the facility. The DON stated Resident #1 had a sign on her door that said no hot beverages, but the DON was not aware of how and when the sign was placed on the door but said she thought a nurse placed it on the door at the request of the resident's representative. The DON said residents were not assessed for hot liquid safety and stated they would follow any recommendations from therapy and if a resident had tremors, they would use a lid on the coffee or try and discourage hot liquids.</p> <p>During an interview with Resident #1, 11/21/2024 at 11:10 a.m., Resident #1 was only able to answer basic questions. Resident #1 said she did not know what happened to her hand, denied spilling coffee, and denied having any pain. Resident #1 was unable to accurately answer questions about where she was, the date or day of the week, etc. Resident #1 presented with a calm and pleasant demeanor and did not exhibit any nonverbal signs of distress or pain during the interview.</p> <p>During an interview with LVN A, 11/21/2024 at 11:19 a.m., LVN A stated Resident #1 can use her left hand to drink independently but there are times that she needs queuing and needs help and stated I do not know when asked if Resident #1 was able to drink hot beverages independently. LVN A said a resident's cognitive level and how well a resident can handle drink cups would determine if a resident should be served hot beverages and said she received training last week about being more mindful about which residents should get hot liquids. LVN A stated Resident #1 typically needed assistance with dressing, toileting and meal intake. LVN A stated she was not aware of a system to identify residents who might be at risk for hot liquid burns.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2024
NAME OF PROVIDER OR SUPPLIER Kendall House Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Grand Blvd. Boerne, TX 78006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with Dietary Aide A, 11/21/2024 at 11:30 a.m., Dietary Aide A stated she usually arrived for her shift at 6 a.m. and stated coffee temperatures were not normally taken or recorded in the morning before breakfast service. Dietary Aide A stated she was told the coffee was tested today and it was around 160-165 as long as the coffee was placed in the blue ceramic mugs. Dietary Aide A said the dietary department was not providing coffee from the coffee makers in the satellite kitchens in the facility and still have those coffee makers out of order. Dietary Aide A said coffee was being provided in coffee urns from another kitchen on the continuum of care campus where the facility was located. Dietary Aide A said coffee was provided to residents on the morning of 11/21/2024 and the coffee was served in ceramic mugs instead of Styrofoam cups. Dietary Aide A said Resident #1 was not provided coffee on the morning of 11/21/2024 and said she was educated on the risk of burns from hot liquids by the DON on 11/21/2024 around 9:15 a.m.</p> <p>During an interview with the Dietary Supervisor, 11/21/2024 at 11:42 a.m., the Dietary Supervisor stated coffee temperatures were usually done on a daily basis but the machine dispenses at the same temperature on a daily basis so they would check the temperatures if someone complained that the coffee was too hot or too cold. The Dietary Supervisor said the coffee temperatures were not documented. The Dietary Supervisor said the dietary department was only serving coffee now in blue ceramic mugs instead of Styrofoam cups because the ceramic mugs do not hold temperature like the Styrofoam cups. The Dietary Supervisor said the coffee machine temperatures were tested several times yesterday and said the temps ranged between 170-180 degrees. The Dietary Supervisor stated the facility did stop serving coffee from the coffee machines in the kitchens in the facility but transported coffee from another kitchen on the campus to the facility to serve the residents on 11/20/24 and 11/21/2024. The Dietary Supervisor said his understanding from the Executive Chef that it was the Executive Director over the campus who made the decision to start serving coffee again using coffee from another kitchen on the campus. He stated, I questioned it because my understanding was the machines were to be shut down and I was told since the coffee was being transported and was at a regulated temperature it was approved. The Dietary Supervisor said he did not know which kitchen the coffee was being transported from on the campus. The Dietary Supervisor said the coffee was tested on [DATE] when it was dispensed into the blue mugs and the temperature was 160 degrees. The Dietary Supervisor said he was notified of diet or order changes by receiving a diet communication slip and said he received a diet communication form for Resident #1 stating Resident #1 was to have lids on all cups regardless of hot or cold and no hot beverages but said he did not recall what day he received the diet communication. The Dietary Supervisor said Resident #1 did not receive coffee on 11/20/2024 or 11/21/2024.</p> <p>During an interview with the Administrator, 11/21/2024 at 11:57 a.m., the Administrator stated he did not find out about the coffee being served until after our conversation earlier in the day and said he was surprised to hear that coffee was still served on 11/20/1014 and 11/21/2024 after he requested no coffee to be served to residents on 11/19/2024 until the machines could be calibrated.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kendall House Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1050 Grand Blvd. Boerne, TX 78006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Dining, 11/21/2024 at 12:19 p.m., the Director of Dining stated his role was to oversee all food operations for the entire campus, including this facility. The Director of Dining stated coffee was usually prepared at the facility using the coffee machines provided by a vendor. The Director of Dining stated the Administrator did ask for the coffee machines to be shut down until they could be recalibrated and stated the Director of Dining reached out the manufacturer and was told the lowest the coffee machine could be calibrated to was 180 degrees and said they did some testing of different cups yesterday and stated he thought the actual problem was the Styrofoam cup. The Director of Dining stated during the test, the coffee from the machine was dispensed into a Styrofoam cup and ceramic cup at 180 degrees. The coffee was then tested in the two cups after three minutes and the coffee in the Styrofoam cup was 178 degrees and the coffee in the ceramic cup was 150 degrees. The Director of Dining stated residents were still requesting coffee and they did not want to deny any residents their right to have coffee so the coffee was being prepared in another kitchen and transported to the facility. He stated the coffee tempted at 170 degrees prior to transport to the facility and was 152 degrees when dispensed into resident ceramic mugs yesterday. The Director of Dining stated his understanding was Resident #1 had a Styrofoam cup with coffee on 11/14/2024 when she received the 1st and 2nd degree burns and stated they are no longer using Styrofoam cups for resident coffee.</p> <p>During an interview with LVN B, 11/21/2024 at 12:45 p.m., LVN B stated Resident #1 was able to feed herself but needed some specialty things like her pudding needs to be in a glass bowl because it is not heavy enough in a paper container and she cannot eat out of it. LVN B stated Resident #1 could drink fluids but stated I don't think she can pick up a cup and sip off of it without a straw in it. She would have a hard time drinking off of the rim of a cup. LVN B stated Resident #1 could drink out of a Styrofoam cup if it had a straw in it. LVN B stated she had to help feed Resident #1 pudding sometimes and stated that Resident #1 should not be given coffee unless it was cooled down due to her diagnosis of hemiplegia, dysphagia, and a BIMS of 0. LVN B stated she determined which residents were able to have hot beverages based on the resident being alert and oriented x 3, full use of movement of their hands and if they can recognize sensory. LVN B stated Resident #1's resident representative told LVN B on 11/11/2024 that she did not want Resident #1 to have any hot beverages.</p> <p>During an interview with the OTA, 11/21/2024 at 2:00 p.m., the OTA stated she had been working with Resident #1 on upper and lower body dressing and toilet transfers. The OTA stated, in her experience, Resident #1 would be stand by assist with supervision meaning someone would have had to be right next to Resident #1 if she was holding a cup of coffee or hot liquids. She requires lots of ques for initiation and sequencing.</p> <p>During an interview with the ST, 11/21/2024 at 2:17 p.m., the ST stated Resident #1 had a severe cognitive deficit and moderate to severe dysphagia. The ST stated, it would depend on how hot and how full the cup was when asked if Resident #1 could safely hold and drink from a cup of hot liquid.</p> <p>During an interview with RN A, 11/21/2024 at 2:30 p.m., RN A stated she was informed by CNA D on 11/14/2024 around lunch time, Resident #1 had spilled coffee on herself. RN A stated, Resident #1 probably should not have go[TRUNCATED]</p>		