STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105132	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKESIDE OAKS CARE CENTER	**1061 VIRGINIA ST DUNEDIN, FL 34698**

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 -** Minimal harm or potential for 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 observations, staff/resident interviews and medical record review, the facility failed to ensure one (#182) of twenty-five sampled residents was free from hot liquid accident/injury hazard during one (3/10/2020) of four days observed. Findings included: On 3/11/2020, during medical record review for resident #182, a nurse progress note dated 3/10/2020 8:30 p.m. revealed that while a CNA (Certified Nursing Assistant) was helping the resident back into bed and providing peri care to him, she noticed that he had a blister on his left inner thigh. When asked what happened, he told the CNA and nurse that he spilled hot coffee on himself, and didn't think he needed to report it to staff. The physician was notified. This note was documented by Nurse Employee A. On 3/11/2020 at 9:00 a.m. the Dietary Manager, was asked how he and his staff maintain coffee temperatures coming from the kitchen. He indicated that their coffee station/machine in the kitchen made the coffee and heated water. He indicated that coffee and hot water go out on three carts to the west unit, east unit, and dining room. He expressed that the coffee was about 160 degrees Fahrenheit when it came out of the coffee and hot water machine. He further stated that he did not believe there was a log for the temperatures of the coffee and water coming from the machine or when it left the kitchen. He was asked if the coffee machine temperature could be adjusted. He said he did not believe it could. He indicated that water came from the boiler and that maintenance adjusted the temperature from there. Further interview with the Dietary Manager revealed he was unaware of any resident getting burned from coffee in the past and certainly not from last night (3/10/2020). He was told that resident #182 goes out on leave of absences and had been observed with coffee cups from various places in the community. The Dietary Manager further confirmed that he had not been made aware of any residents getting burned with coffee. On 3/11/2020 at 10:00 a.m., the kitchen was toured to conduct coffee and hot water temperatures. The Dietary Manager indicated that coffee went out of the kitchen around 10:00 a.m., daily to both units and the dining room. The Dietary Manager utilized a non-digital stick thermometer and indicated he had calibrated it in water and ice earlier in the morning. He walked over to the coffee service machine and poured a cup of coffee from the spigot. He tested the temperature with the thermometer. The final reading was 142 degrees Fahrenheit. He then got a cup of hot water from the same service station machine and tested it. The final reading was 171 degrees Fahrenheit. The Dietary Manager did not know if the temperatures were too hot for residents and indicated that he could not adjust the temperature on the machine. He said, he believed the water came from the facility boiler, which was adjusted by the Maintenance Director. At this time, the Dietary Manger escorted this surveyor to the Maintenance Office where the boiler was located. The temperature gauge read at 145 - 150 degrees Fahrenheit. An interview with a maintenance employee, Employee C., revealed the boiler that provided hot water to the kitchen was in the laundry room. Employee C. escorted this surveyor to the laundry room where the large boiler was located. He provided visual demonstration of where the temperature gauge was set and read very close to 160 degrees Fahrenheit. Employee C., the Dietary Manager and the Maintenance Director were unaware if the coffee service machine in the kitchen had its own independent heating booster. However, in an interview with the Maintenance Director and the Regional Dietary Manager both indicated that the water came from the boiler in the laundry room to the coffee machine in the kitchen. The coffee machine had a setting and the ability to boost the temperature. They further revealed that the setting on the coffee service machine could not be adjusted by facility staff and that they would have to call the manufacturer to see if there were alternate ways to decrease the temperature. On 3/11/2020 at 10:45 a.m. observation of the the Regional Dietary Manager revealed that he tested coffee temperatures for the coffee that was brought out to the main dining room. The Regional Dietary Manager utilized a digital stick thermometer, which was calibrated earlier in the morning. He poured a cup of hot water from the thermos station. The temperature had a final reading of 158 degrees Fahrenheit. The coffee temperature was at a final temperature of 145 degrees Fahrenheit. The Regional Dietary Manager indicated that the coffee service station manufacturer specified that in order for the coffee to get a good brew, it must get to at least over 180 degrees Fahrenheit. and or higher. He indicated he would speak with the coffee service station company and have them come out to adjust the temperatures as it may be too hot still. But in doing so, the coffee may not brew correctly. On 3/11/2020 at 11:20 a.m. an interview with the Nursing Home Administrator, who was also the Risk Manager, revealed that she was just made aware of the incident that occurred last night and she was in the process of doing an investigation. She indicated she was not communicated with verbally by the nurse, Employee A. who documented the note of resident #182 having a blister on his leg. The Administrator indicated that she received information about it through the kitchen staff just moments ago. This incident was only brought to her attention as a result of this surveyor speaking to kitchen staff about resident #182 and the alleged burn. Review of the medical record revealed resident #182 was admitted to the facility for long term care on 5/7/2012 and readmitted recently from the hospital on [DATE]. Review of the advance directives revealed resident #182 was his own decision maker and had multiple family members listed as contacts. Review of the MDS (Minimum Data Set) assessments revealed: - 2/19/2020 (Quarterly) - Cognition/Brief Interview Mental Summary score 15 of 15, which meant the resident was cognitively intact. Activities of Daily Living with Eating - Independent, no set up. - 2/26/202 (Discharge) - Cognitive/Brief Interview Mental Summary score - no score but indicated memory ok and independent with decision making skills. Activities of Daily Living with Eating - Independent. Other assessments included and revealed: - Functional status evaluation Admission assessment dated [DATE] revealed: resident requires no assistance with eating and drinking; no sensory impairment; no safety risks documented. - Interdisciplinary Therapy Screen dated 3/12/2020 revealed: Review of the nurse progress notes dated from 12/2/2019 through to 3/12/2020 revealed: Patient stated his cup of hot liquids spilled due to a broken lid. Occupational Therapy observed him drinking out of cup with lid. No spills or upper extremity tremors noted which would increase risk of spills. He is safe with hot liquids with lid. He does not want an Occupational Therapy official evaluation at this time. 12/4/2019 8:51a.m. (Activity note) Loves gardening, loves to take care of the patio. Participates in coffee social and some of the parties. 12/13/2020 9:52 p.m. (Activity note) Likes to drink coffee 3/11/2020 11:35 a.m. (Nurse Progress Note) Resident continues to refuse treatment much of time. Has recently thrown staff out from room. Refuses to let this nurse assess his burn but later accepted. There are blisters on inner thigh and intact. See non pressure wound assessment The Change of Condition, Situation, Background, Assessment, and Recommendation, (SBAR) incident note dated 3/10/2020, revealed: Resident spilled hot coffee on self, it wasn't reported to staff. CNA found blister inner left thigh and reported it to nurse. Treatment: Wound care consult, Anacept gel topically daily, until healed; Skin evaluation: Blister and Burn; No pain; Appearance: Resident spilled hot coffee on self, a blister came afterward. Physician notified and treatment in place. Review of the current care plans with next review date 6/8/2020 revealed the following areas, but not limited to: 1. Requires assist with Activities of Daily Living related to a spinal injury, impaired, non ambulatory related to [MEDICAL CONDITION]. He is able to propel himself, able to feed self, with interventions in place to include, but not limited to: EATING: able to feed self

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105132	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKESIDE OAKS CARE CENTER	**1061 VIRGINIA ST DUNEDIN, FL 34698**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and set up as needed. 2. Resistive to care, non compliant with care and treatment. Does not like to shower, will not off load and go back to bed, feels he knows what is best. Often refuses wound treatments, removes dressings, will not keep lid on coffee cup (as of 1/14/2019). 3. New care plans as of evening of 3/11/2020: Resident has impairment to skin integrity of the related burn with interventions to include: Observe/document location, size and treatment of [REDACTED]. to Physician, and Therapy screen for motor function. On 3/12/2020 at 9:32 a.m. in an interview with the DON (Director of Nursing) and the NHA (Nursing Home Administrator) both revealed that they were now aware that resident #182 spilled coffee on his left leg and received a burn. The DON revealed that on 3/10/2020, an aide reported to the nurse, Employee A. that a blister was observed on resident #182's left thigh. She indicated that the resident never reported it to staff and it was only found when the aide was assisting with the resident during care and services. The DON revealed that resident #182 was his own decision maker and was independent with most to all Activities of Daily Living to include eating and drinking. The DON indicated that resident #182 had never spilled hot liquids on himself before and was not assessed as unsafe with hot liquids. She indicated that the nurse, Employee A. identified and assessed resident #182 and found a blister/burn, reported it to the doctor, and received orders for treatment. The Administrator, who was also the Risk Manager, revealed that it had not been brought to her attention yet, but it was less than 24 hours ago. She confirmed that staff were still within the timeframe to report the incident to the Risk Manager. She also confirmed that Resident #182 was not in need of a transfer to a higher level of care to include the emergency room /Hospital. The DON and Administrator revealed that they had started an immediate investigation and interviewed and re-reassessed Resident #182. The DON and Administrator said that upon interview with resident #182, he indicated that he had spilled some coffee from out of the cup and felt that the lid or cup was cracked. The DON and Administrator had the cup with the plastic lid that was used by the resident. Observations revealed the cup did not have any cracks or chips. The lid was secured tightly, also with no cracks or chips. The only place liquid could come out was through the small sip hole. Note, Photographic evidence was taken of the actual coffee cup used by resident #182. The DON and Administrator both confirmed that the kitchen staff and or nursing had not logged hot liquid temperatures prior to 3/10/2020. They indicated that there had not been a need or concern in the past and basically were unaware that the coffee machine produced high liquid temperatures. The NHA and DON both revealed that there had not been any other resident with skin burn injuries, related to hot liquids. On 3/13/2020 at 9:00 a.m. and during the afternoon at 12:04 p.m. attempts were made to interview Resident #182. He did not want to discuss his coffee burn and indicated there was Too much of a big deal Resident #182 was pleasant with surveyor but kept changing the subject and indicated that he had been talking with so many people about it and he was done. He started to talk about his paintings/pictures on the wall. He was asked more than three times about the coffee spill and he indicated he did not want to talk about it again. On 3/10/ during lunch meal observations in the dining room, there were over four residents seated at one table who directed an aide, Employee B., to reheat their coffee as it was very cold. Steam had been observed coming off the tops of the coffee cups. On 3/11/2020 during both the breakfast and lunch meal observations in the main dining room with six random and interviewable residents, all indicated that the coffee temperatures were fine and that they have never burned themselves with hot liquids. On 3/12/2020 at 10:30 a.m. interviews with ten random residents, who were all in their rooms on the West and East units, all indicated that they have never been burned by the coffee or water, and feel that coffee temperatures were satisfactory. They also confirmed that they have never heard of any residents being burned by hot liquids. Review of the Coffee Service Station manufacturer specification manual, titled Curtis Wilbur Curtis Company, Inc. Service Manual - ThermoPro Twin Brewer, dated with print date 9/2006, revealed the following information: a. Following are Factory Settings for your G3 Coffee Brewing Systems: Brew Temperature = 200 degrees Fahrenheit. b. Set up Steps to include: #5; The heating tank will require 20 to 30 minutes to reach operating temperature (200 degree Fahrenheit.) as indicated by the READ-TO-BREW indicator. The specifications sheet continued to indicate: Water will fill the tank approximately 2-3 minutes depending on water flow rate. When the proper level is reached, Wilbur Curtis Heating will appear on the screen. It takes approximately 20 minutes to reach set point temperature of 200 degrees Fahrenheit. Further, control will display, Wilbur Curtis Ready to Brew when temperature reaches the set point 200 degrees F. Unit is now ready to brew. The diagram grid of the specifications sheet revealed the brew temperature setting is within a range of 174 to 204 degrees F. Review of the facility's policy and procedure titled, Re-Heating Resident Food and Beverages, with effective date 11/30/2014 revealed: Policy: To reduce the risk of [MEDICAL CONDITION] hot beverages, liquids and food, and to provide guidance on re-heating resident food and/or liquids. Staff members only are to re-heat resident food and or liquids in the microwave to temperatures that are safe and palatable for residents. The procedure section of this policy revealed, The staff member is to use the dial thermometer to ensure the item or liquid reaches 165 degrees F. to prevent foodborne illness. The staff member is to use the dial thermometer provided to ensure a maximum temperature of the item is not greater than 140 degrees F. at the time of service. Interview with the Dietary Manager and the Nursing Home Administrator both confirmed that hot liquids should not go out to residents over 165 degrees Fahrenheit and that coffee should be cooled if reaches that degree of heat or higher.