STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105881	A. BUILDING _____ B. WING _____	**09/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAWTHORNE HEALTH AND REHAB OF BRANDON	**851 WEST LUMSDEN RD BRANDON, FL 33511**

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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F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** Based on observations, interviews, and record review, the facility failed to promote and facilitate resident self-determination for one (#64) of 15 sampled residents. The facility did not ensure that Resident #64's contracted choice to have a private room was honored. Findings included: An interview was conducted on 9/22/20 at 1:36 p.m. with Resident #64, who stated that she contracted for a private room upon admission on 4/29/20. The resident was admitted to the facility for hospice following acute respiratory disease progression, degeneration of brain disorder, and a history of falling. Following the facility's attempt to mitigate the spread of COVID-19 in the building, Resident #64 was moved to another unit and was placed in a semi-private room. On 09/25/20 at 9:00 a.m., an interview was conducted with Resident #64 who reported not sleeping very well at night following her roommate's restlessness and constant need for staff interventions. Resident #64 was not offered to return to a private room once the isolation precautions were lifted despite room availability. A review of the admission agreement between the facility and Resident #64's Durable Power of Attorney, (POA) signed on 6/07/20, revealed that Resident #64's payer source was private pay with hospice. On 9/25/20 at 10:43 a.m., an interview was conducted with the Admissions Director who confirmed that Resident #64 was charged for a private room even though the isolation precautions for Resident #64 were discontinued and there was ample room availability. The Admissions Director stated a credit was owed to Resident #64 as the semi-private rate is much lower than the private room rate. The Admissions Director stated, I will speak to her about moving to a private room today. 09/25/20 05:03 p.m., a follow up interview and observation was conducted with Resident #64. She was in a private room and said, I am happy now, thank you. An interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) conducted on 09/25/20 at 7:00 p.m., confirmed that Resident #64's room rate should have been reduced for the duration of time that she had to be under isolation for the mitigation of COVID-19. The DON further stated a credit would be issued for Resident #64 related to overpayment of room charges.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**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, interviews with the Nursing Home Administrator(NHA), the Director of Nursing (DON), Assistant Director of Nursing (ADON), nursing staff, the resident's attending physician/Medical Director, and review of clinical records, policies and procedures it was determined that the facility failed to provide an environment that remained as free of accident hazards as possible and ensured residents were safe [MEDICAL CONDITION] scalding hot liquids served during meals. Failure to maintain safe hot liquid temperatures caused hot [MEDICAL CONDITION] two Residents #3 & #57 on 9/2/20, who requested hot liquids. Both residents required supervision of one person for eating and drinking. After learning of the two hot [MEDICAL CONDITION] 9/2/20, the facility failed to investigate the temperatures of scalding hot liquids for 21 days from 9/2/20 until 9/23/20. The facility failed to identify and investigate [MEDICAL CONDITION] on the event log. The facility further failed to document the [MEDICAL CONDITION] detail and have the wound care nurse or physician assess and monitor the scald burns. The facility failed to investigate and identify scalding hot liquid hazards although the event log was updated to reflect the scald burns. The management team to include the Administrator/ Risk Manager, Certified Dietary Manager, Director of Nursing and Assistant Director of Nursing failed to ensure 52 residents, who could request hot liquids, of a total census of 55 residents, were free from potential scalding of hot [MEDICAL CONDITION] 21 days and failed to identify and prevent two vulnerable Residents, #3 and #57, from receiving scalding hot liquid burns. This resulted in the findings of Immediate Jeopardy, occurring on 9/2/20 and removed at 5:00 p.m. on 9/25/20 with the scope and severity reduced to a D. Findings included: 1. On 9/23/20 at 10:00 a.m. Resident #3's electronic progress notes documented by staff member E, Registered Nurse (RN) on 9/2/20 at 11:40 a.m., found that staff member E, RN was called to Resident #3's room for Evaluation of redness to the left thigh. Reddened area noted to left outer thigh, two dry ruptured blisters also noted. Resident states that she had spilled her coffee on it - was unsure of when it had happened. Physician and daughter notified. During an interview on 9/23/20 at 11:50 a.m. with staff member E., RN, she stated Resident #3 spilled her coffee on her left outer thigh. The thigh was red and had a burn. Staff member E, RN stated we document on the progress notes, event logs in the computer and the night shift nurse normally completed progress notes related to skin sweeps. Staff member E, RN stated Resident #3 currently had a red area that was not open. 2. On 9/23/20 at 10:40 a.m., an interview was conducted with the facility's Certified Dietary Manager (CDM) related to who was responsible for the brewing and maintaining of hot liquids to include coffee. The CDM revealed that it was the kitchen's responsibility to make and send out coffee to the floors/units. She further revealed that, since the COVID pandemic, there were only two places to make coffee and hot water, which were 1) In the kitchen, and 2) In the main dining room area. The CDM confirmed that currently, they brew the coffee for residents utilizing a leased coffee machine, which was in the main kitchen. The CDM further confirmed that the leased coffee machine in the main dining room was on and that they used it, but the main machine from the kitchen was only for residents. The CDM was then asked if she could remember any residents in the building being burned by either hot coffee or hot water. She said, I was told by staff maybe a few weeks ago that a resident received too hot of coffee but was never told if that resident received any burn injuries. She further confirmed it had not been brought to her attention from management about coffee serving temperatures, nor did management ever bring to her attention that a resident or residents were burned by hot liquids. The CDM was then asked how she brewed coffee/hot water. She again explained that there was a leased coffee machine that brewed the coffee and the temperature was set within. She was asked how she maintained the coffee machine liquid temperatures and explained that the machine was always on preset temperatures so the coffee would either have to cool by placing it in the walk in refrigerator if too hot, or let sit out in kitchen area near the coffee machine for a period of forty-five minutes to an hour. The CDM was asked how she monitored the coffee and hot water temperatures and was also asked what her and the facility's expectations were when it came to safe coffee/ and or hot water service to residents. The CDM stated that previously, she did not monitor the temperatures of coffee or hot water coming out from the machine, she did not monitor coffee or hot liquids prior to going out to the floor/units, and did not monitor coffee or hot liquids after it reached the floor/units. The CDM was asked if she had any type of log or documentation to show that she had taken temperatures of coffee or hot liquid in the past. She confirmed that was something she had never done and did not have a temperature log of the coffee or hot water temperatures. During this time, the CDM was asked to show what the coffee/hot water temperatures were immediately after brewing and when they reach the floor to be

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) served. On 9/23/20 at 11:00 a.m., the CDM stated that the coffee was ready to go out to the units/floor and was sitting in the metal coffee carafes for about one hour. She did not know what the coffee/hot water temperatures were prior to going out to the floor. Prior to leaving the kitchen area, the CDM was asked how she took temperatures of the hot coffee and hot water. She explained she utilized a regular stick, non-digital thermometer and calibrated it daily. She was asked what the process was in order to calibrate the thermometer. The CDM revealed she stuck the thermometer in a cup of ice and water and waited about 30 seconds to see what the dial read. She indicated the dial should reach 32 degrees Fahrenheit (F). She further explained that if it was not at 32 degrees F., she would then twist the gauge nut until the dial reached 32 degrees F. The CDM revealed that she last calibrated this thermometer earlier today, 9/23/20, prior to the breakfast meal service. The CDM indicated that they only made and served coffee to the residents three times a day, which included, 1. Breakfast meal service, 2. Lunch meal service, and 3. Dinner service. The following was observed: On 9/23/2020 at 11:55 a.m., the CDM pushed a meal cart to the 400 hall. The cart had the coffee and hot water placed on top. The cart reached the 400 hall at 11:57 a.m. The CDM then poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 146 degrees F. The CDM confirmed the temperature at 146 degrees F. At 12:00 p.m., the CDM pushed another tray cart to the 200 hall. At 12:02 p.m., she poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 130 degrees F. The CDM confirmed the temperature at 130 degrees F. At 12:05 p.m., the CDM pushed another tray cart to the 600 transitional unit. At 12:07 p.m., she poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 145 degrees F. The CDM confirmed the temperature at 145 degrees F. At 12:11 p.m., the CDM pushed the final tray cart to the 300 hall. At 12:13 p.m., she poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 165 degrees F. The CDM confirmed the temperature at 165 degrees F. The CDM was asked what the expectations were for serving hot coffee and hot liquids to elderly and compromised residents. She could not give a specific number in degrees but rather stated, Coffee and hot liquids should be at palatable temperatures. The CDM and Surveyor then walked back to the kitchen to observe the coffee machine's liquid service temperatures. The following was observed: 1. The coffee machine in the main dining room had a door on it and had to be unlocked with a key. The key had already been in the lock. The door was opened and there was a digital read out that had a Tank temperature and a Dispense temperature. The dispensing temperature read 193 degrees F. The tank hold temperature read 198 degrees F. The kitchen coffee machine was also observed with a door with a key in the lock. The door was opened and revealed a dispensing temperature of 193 degrees F. The hold temperature read 198 degrees F. (Photographic evidence was taken). The CDM confirmed both machine temperatures and did not know what the temperatures should be and did not know what a safe hot liquid temperature should be for elderly and compromised residents. She also indicated that she could not change or adjust the temperatures but would call the coffee machine company serviceman to come out and look at it. 3. During an interview with Staff member F, Licensed Practical Nurse (LPN) on 9/23/20 at 1:00 p.m., she stated a resident was burned after spilling coffee a few weeks ago. Staff member F, LPN stated it was Resident #57, a recently admitted resident at the time. Staff member F, LPN stated her responsibility and protocol was to create the event report, document progress notes, notify the family and physician, and get orders. Staff member F, LPN stated that all nursing staff and administration could see the event log and that management would review. Staff member F, LPN stated she could print the reports for her residents in case she forgot to get report on someone or give report about an event. She said she would print out an event report for the oncoming nurse to review so they were aware. On 9/23/20 at 1:00 p.m., an interview was conducted with the Nursing Home Administrator and Director of Nursing. They were asked if they could provide information related to hot liquid [MEDICAL CONDITION] occurred on 9/2/20 with regards to Residents #3 and #57. Neither the Nursing Home Administrator nor the Director of Nursing could recall any residents being burned by hot liquids recently. They both indicated that they would look at the incident/accident injury event log. Once they looked at the incident/accident injury event log, they were able to see that both Residents #3 and #57 received hot [MEDICAL CONDITION] 9/2/20. 4. During review of the event log and interview on 9/23/20 at 3:48 p.m., with the ADON, she stated that she created the event log daily. She said, she input the information from the 9/2/20 events into the event log but did not investigate them. Review of the event log found Resident #3's event occurred on 9/2/20 at 2:28 p.m., in her room. She was alert and oriented. Type of event was documented as skin tear/laceration. Possible cause was documented as Spilt hot beverage on lap and investigated cause was documented as Spilt hot beverage on lap. Injury described as left outer thigh- red and small open blister noted. Doctor and family notified. Review of the event log for Resident #57's event found it occurred on 9/2/20 at 2:26 p.m., in her room. She was alert and oriented. Type of event was documented as skin tear/laceration. Possible cause was documented as Spilt hot beverage on lap and investigated cause documented as Spilt hot beverage on lap. Injury described as left upper thigh noted with red area. The ADON stated she did not investigate them since the CDM was made aware by the nurse. 5. During an interview with the NHA, DON, and the CDM on 9/23/20 at 3:55 p.m., the NHA stated the coffee company was contacted and the CDM was notified of the incidents. The Administrator stated the CDM had the coffee carafes sit for 45 minutes prior to serving. The CDM stated she could not recall having a conversation about coffee burns. The Administrator stated that coffee temperatures are quantitative, and the temperatures could not be monitored without taking temperatures of the coffee in the carafe. The Administrator and DON were asked during the conversation, what the facility did from 9/2/20 to 9/23/20 related to [MEDICAL CONDITION] hot liquid. The Administrator stated the facility called the coffee machine company on 9/23/20 and, going forward, temperatures would be taken prior to serving. The Administrator stated the vendor would be coming to adjust the temperature of the coffee machine. During an interview with the DON on 9/23/20 at 4:02 p.m., the DON stated they did not have a policy related to event investigations and would look for one related to hot liquids. 6. During an interview on 9/23/20 at 4:15 p.m., with the CDM she stated that she was unsure how many residents drank hot liquids and would print out a list. The CDM stated she was not sure how many residents preferred coffee. During an interview with the CDM while in the kitchen, she stated the water temperature was 120 degrees after sitting for 20 minutes from the coffee machine. During an interview with Staff member U, dietary aide on 9/23/20 at 4:30 p.m., she stated she had taken the temperature of coffee after dispensing from the coffee machine. The temperature was 165 degrees F. So she put the coffee in the cooler for ten minutes. On 9/23/2020 at 4:25 p.m., the CDM was asked to provide demonstration how the kitchen maintained and served coffee and hot water to residents. She indicated that coffee had already been poured from the machine and that they were sitting on the carts in insulated metal carafes, ready to be taken out to the floor. At 4:30 p.m., a kitchen aide (Employee T) was observed in the kitchen carrying two metal insulated coffee carafes from the walk-in refrigerator to the dining room to place the coffee on the meal carts. Employee T said she had just removed the carafes from the walk-in refrigerator and tested the temperatures. She said, the temperature was 120 degrees F. She further indicated that they now go on the meal carts to be transported to the floor/units. Employee T said that when coffee was poured from the coffee/hot water machine, the temperatures were at 165 degrees F. The CDM was asked to take the temperature of the coffee once it reached the floor/units. Prior to that, the coffee/hot water machine in the kitchen and the coffee/hot water machine in the main dining room were observed for internal liquid temperatures. The machines had a digital read out that included the dispensing temperature and tank holding temperature. At 4:40 p.m. both coffee machines in the kitchen and dining room had the following: 1. Dispensing temperature - 193 degrees F. and 2. Tank holding temperature - 198 degrees F. (Photographic evidence was taken). The following was observed on 9/23/20 during the dinner service: The CDM pushed the meal tray cart from the kitchen at 4:42 p.m., and reached the 600-transition unit at 4:43 p.m. She poured a half cup of coffee into a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 132 degrees F. The CDM confirmed the temperature reached 132 degrees F. The staff was observed serving the coffee to the residents, they provided assistance such as adding cream, sugar, and sugar substitute if requested, and ensured the residents were able to reach the coffee cup. The CDM pushed a meal tray cart from the kitchen and reached the 200 hall at 4:46 p.m. She poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 127 degrees F. She confirmed that the temperature reached 127 degrees F. The CDM pushed a meal tray cart from the kitchen and reached the 400 hall at 4:56 p.m. She poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 139 degrees F. She confirmed that the temperature reached 139 degrees F. The CDM pushed a meal tray cart from the kitchen and reached the 300 hall at 5:15 p.m. She poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 122 degrees F. She confirmed the temperature reached 122 degrees F. The CDM stated, I don't know how the coffee temperature rose as I believed my staff temped the coffee prior to leaving the kitchen at 120 degrees F. During an interview on 9/23/20 at 4:56 p.m., with the Administrator, he confirmed the facility did not have a hot liquid policy, just hot food policy. At approximately 5:30 p.m., the Nursing Home Administrator was interviewed and informed about the lunch meal service coffee temperatures. He stated he understood about the high liquid temperatures and would have an action plan to put in place. 7. On 9/24/20 at 6:10 a.m. the building was entered in order to observe coffee/hot water service prior to breakfast meal service. At 7:08 a.m., the CDM and two cooks revealed that this a.m. at 5:00 a.m. they prepared coffee. The CDM related that the coffee machines were always on in the kitchen and the main dining room. She revealed that she and her staff poured coffee from the coffee machine in the kitchen and took it directly to the freezer to cool. The CDM indicated that the pour temperature was 167 degrees F. and coffee/hot water after pour was taken to the walk-in freezer to sit for an unspecified time. She added that the coffee was then removed from the freezer and tested with a calibrated thermometer. She reported that the temperatures reached 120 degrees F. The CDM was asked to take coffee/hot liquid temperatures once they reached the floor/units. The process was as follows. A meal tray cart left the main dining room/kitchen area at 7:08 a.m. and reached the 200 hall at 7:10 a.m. The CDM poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 110 degrees F. She confirmed the temperature reached 110 degrees F. A meal tray cart left the main dining room/kitchen area at 7:13 am. and reached the 600-transition hall at 7:15 a.m. The CDM poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 110 degrees F. She confirmed the temperature reached 110 degrees F. A meal tray cart left the main dining room/kitchen area at 7:18 a.m. and reached the 400 hall at 7:20 a.m., The CDM poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 125 degrees F. She confirmed the temperature reached 125 degrees F. A meal tray cart left the main dining room/kitchen area at 7:35 a.m. and reached the 300 hall at 7:35 a.m. The CDM poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 120 degrees F. She confirmed the temperature reached 120 degrees F. 8. A review of the American Burn Association Scald Injury Prevention, Educator's guide, ameriburn.org/wp-content/uploads/2017/04/scaldinjuryeducatorsguide.pdf, revealed: General background information on [MEDICAL CONDITION]- Although [MEDICAL CONDITION] happen to anyone, young children, older adults and people with disabilities are the most likely to incur such injuries. Most scald burn injuries happen in the home, in connection with the preparation of hot food or beverages, or from exposure to hot tap water in bathtubs or showers. Both behavioral and environmental measures may be needed to protect those vulnerable to scalds because of age or disability, or because they do not have control of the hot water temperature in multi-unit residential buildings. The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. The most common regulatory standard for the maximum temperature of water delivered by residential water heaters to the tap is 120 degrees F. At this temperature, the skin of adults requires an average of five minutes of exposure for a full thickness burn to occur. When the temperature of a hot liquid is increased to 140 degrees F. it takes only five seconds or less for a serious burn to occur. Coffee, tea, or other hot beverages are usually served at 160 degrees F. to 180 degrees F., resulting in almost [MEDICAL CONDITION] will require surgery. Since immediate removal of the hot liquid from the skin may lessen the severity, splash and [MEDICAL CONDITION] not be as deep [MEDICAL CONDITION] in a bathtub. High Risk Groups Older Adults - Older adults, like young children, have thinner skin so hot liquids cause [MEDICAL CONDITION] even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. Because they have poor microcirculation, heat is removed from burned tissue rather slowly compared to younger adults. People with Disabilities or Special Needs - Individuals who may have physical, mental or emotional challenges or require some type of assistance from caregivers are at high risk for all types of burn injuries including scalds. The disability may be permanent or temporary due to illness or injury and vary in severity from minor to total dependency on others. Mobility impairments, slow or awkward movements, muscle weakness or fatigue, or slower reflexes increase the risk of spills while moving hot liquids.[MEDICAL CONDITION] the lap are common when a person attempts to carry hot liquids or food while seated in a wheelchair. Moving hot liquids can be extremely difficult or someone who uses a can or walker. Sensory impairments can result in decreased sensation, especially to the hands and feet, so the persona may not realize if something is too hot. Changes in a person's intellect, perception, memory, judgement or awareness may hinder the person's ability to recognize a dangerous situation (such as a tub filled with scalding water) or respond appropriately to remove themselves from danger. While the basic principles of scald prevention apply to the general population the additional concerns affecting these high risk groups must be addressed. Scald injuries result in considerable pain, prolonged treatment, possible lifelong scarring, and even death. Prevention of scald injuries is always preferable to treatment and can be largely accomplished through simple changes in behavior and in the home environment. Time and Temperature Relationship to [MEDICAL CONDITION] temperature Time for a third degree burn to occur 155 degrees F. 68 degrees C. 1 second 148 degrees F. 64 degrees C. 2 seconds 140 degrees F. 60 degrees C. 5 seconds 133 degrees F. 56 degrees C. 15 seconds 127 degrees F. 52 degrees C. 1 minute 124 degrees F. 51 degrees C. 3 minutes 120 degrees F. 48 degrees C. 5 minutes 100 degrees F. 37 degrees C. safe temperature for bathing 9. During interview and observation of Resident #3 after readmission on 9/25/20 at 6:30 p.m., the resident stated she spilled her coffee on herself, but it no longer hurts and It's healed now. Resident #3 consented to observation and revealed a pink left outer thigh area measuring approximately 5 centimeters long by 1 centimeter wide. Resident #3 rubbed her hand over the area and again stated, It's healed now. Review of the electronic record for Resident #3 revealed a Brief Interview for Mental Status (BIMS), dated 8/17/20, of 12 indicating moderate impairment. Section G, from Minimum Data Set (MDS) functional status, H. eating - how resident eats and drinks regardless of skill revealed a self- performance of 1. Supervision - oversight, encouragement or cueing and support of 1 indicated set up help only. Review of Resident #3's physician order: Regular diet dated 8/12/20. Resident on hospice dated 8/12/20. Skin sweep once a day on Thursday from 6:00 p.m. to 6:00 a.m., dated 8/17/20. Monitor burn to left upper thigh until resolved twice a day dated 9/2/20. Review of physician telehealth visit on 9/2/20 revealed limited exam due to COVID 19. Skin checked as intact no [MEDICAL CONDITION], rash, ulcer. Review of Resident #3's nursing progress notes revealed on: 9/2/20 at 9:02 p.m., the RN documented Resident #3's left outer hip remains pink, painless per resident. No signs or symptoms of infection. 9/4/20 at 12:26 a.m., the RN documented weekly skin sweep. No new areas noted on resident. 9/5/20 at 10:11 p.m., the RN documented burn on left outer hip remains pink painless per resident. No signs or symptoms of infection. 9/6/20 at 10:20 p.m., the RN documented burn on left outer hip remains pink painless per resident. No signs or symptoms of infection. 9/7/20 at 10:54 p.m., the RN documented burn on left outer hip remains pink painless per resident. No signs or symptoms of infection. 9/8/20 at 9:20 p.m., the RN documented burn on left outer hip remains pink painless per resident. No signs or symptoms of infection. 9/9/20 at 11:14 a.m., the RN documented resident is alert and oriented times two with confusion, able to make needs known. Assist of 2 for transfers and one for activities of daily living. Reddened area to outer left thigh pink and painless per resident. 9/9/20 at 9:30 p.m., the RN documented burn on left outer hip remains pink painless per resident. No signs or symptoms of infection. 9/10/20 at 8:28 p.m., the RN documented skin sweep performed on resident. No new areas of concern. 9/13/20 at 11:09 a.m., the LPN documented patient alert and oriented times 3, hard of hearing. Assist of one with activities of daily living. 9/16/20 at 9:03 p.m., the RN documented Burn on left outer hip healed; painless per resident. No signs or symptoms of infection. 9/18/20 at 5:11 a.m., the RN documented a weekly skin sweep- no new areas noted on resident. Burn on left outer thigh area is light pink. 9/23/20 at 7:56 a.m., the RN documented a note and edited the note on 9/23/20 at 11:57 a.m. to add: reddened area to left outer thigh remains, skin intact. Review of the telemedicine wound care visit dated 9/8/20 at 11:37 a.m., 9/15/20 at 11:40 a.m. and 9/22/20 at 10:05 a.m. did not discuss left outer thigh. Review of Resident #3's treatment administration record revealed, on 9/2/20, an order to monitor burn to left upper thigh until resolved twice a day. Completed. Review of Resident #3's treatment administration record found, on 8/17/20, skin sweeps documented on Thursdays. Completed. Review of Resident #3's care plan with last revision date 8/19/20, identified problem start date on 10/11/18 of impaired vision related to [DIAGNOSES REDACTED]. Goal date of 11/19/20, resident will not experience negative consequences of vision loss as evidenced by; remaining physically safe, and participating in social, and self-care activities. Review problem dated 9/23/20, revealed resident at risk for spilling her coffee related to shaking. Approach dated 9/23/20, resident to have a cup of coffee to be provided and nursing to

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) evaluate. During an interview on 9/25/20 at 1:41 p.m. with Director of Rehab (DOR), she stated Resident #3's biggest issue was her vision loss. Review of the occupation therapy evaluation, dated 6/19/20 to 7/18/20, found self-feeding underlying impairments as low vision. 10. Review of Resident #57's electronic nursing progress notes on 9/2/20 at 12:04 p.m. found the LPN documented, She was summoned to resident's room by therapist. The nurse made aware of quarter size red area to upper left thigh. Therapist informed the nurse that she observed coffee stain on resident's gown. Resident unaware of what happened. Resident does complain of area burning. The nurse spoke with the resident's son and notified him of the area on the left upper thigh red area. During a phone interview with Staff member Z, RN on 9/25/20 at 1:00 p.m., She confirmed she completed the wound care for the facility. Staff member Z, RN stated Resident #57's nurse contacted her on 9/22/20 and asked her to assess the burn as the nurse thought the wound may be infected. Staff member Z, RN stated the wound was not infected. Staff member Z, RN stated Resident #57 was not on the wound list to be seen and had not been assessed by the wound nurse prior to 9/22/20. During an interview with the DOR (Director of Rehabilitation) on 9/25/20 at 1:08 p.m., she confirmed she observed Resident #57 sitting in a big puddle of coffee on the floor under her wheelchair and cleaned up the floor. The Director of Rehab stated she could not see anything on Resident #57's clothes but halfway through therapy the resident started complaining the inside of her leg felt weird. The DOR stated she looked at Resident #57's left inner leg. It was a red long oval shaped area. The DOR stated she went to get the nurse and she could see the top layer of skin was peeling (like a sunburn). The nurse went to get a dressing. The DOR stated the residents in the building had not been assessed for safety and handling hot liquids, It's not something we usually do. Review of the nursing progress notes, dated 9/9/20 at 1:33 p.m., and documented by the LPN revealed an area to left upper thigh is no longer red in color. Color is brownish. No complaints offered. Review of the nursing progress notes dated 9/12/20 at 5:52 a.m., documented by the LPN revealed Resident #57 complaining of itching on the red area on her left upper thigh. When checked, the area appears to be scabbing. Site is cleansed and covered with dressing to avoid unconscious scratching and reopening of the scabs. Resident tolerated it well throughout the night. Review of the nursing progress notes, dated 9/13/20 at 2:26 a.m., and documented by the LPN revealed no new skin issues noted during skin check. Existing skin concerns have treatments in place. Review of the nursing progress notes dated 9/13/20 at 1:07 p.m. and documented by the LPN revealed Resident #57's observed dressing on left upper thigh. Dressing removed observed drainage on dressing. Observed area with slough. Area cleaned with normal saline, triple antibiotic ointment and dressing applied. Resident denies pain to area. Review of the nursing progress notes dated 9/18/20 at 4:48 p.m., documented by the RN revealed the resident with open area located to left upper thigh. Observed redness around the area, hot to touch. Resident referred itching and discomfort. Treatment completed as ordered with triple antibiotic ointment during the shift. Physician notified. Waiting for wound care evaluation. Oncoming nurse notified. Continues monitoring. Review of the social services note dated 9/22/20 at 1:11 p.m., revealed poor safety awareness. Review of the nursing progress notes dated 9/24/20 at 11:29 a.m., documented as late entry-9/22/20, read as follows. Nurse requested that wound nurse assess wound on left medial thigh as she voiced concern it was infected. Scant serous drainage. Dime size open area, the rest of the area is scabbed and open to air. No signs and symptoms of infection. Advised nurse to continue with current treatment and notify physician with wound assessment when it has no further drainage for orders. Will continue to monitor. Review of the physician orders [REDACTED]. Start date 9/13/20, cleanse left upper thigh with normal saline, apply triple antibiotic ointment and cover with dressing daily. Start date 9/7/20, skin sweep once a day on Saturday. Review of physician telehealth visit, dated 9/9/2
F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with the Nursing Home Administrator (NHA)/Risk Manager, Director of Nursing (DON), and Assistant Director of Nursing (ADON), Nursing staff, the attending Physician/Medical Director, record review of resident #3 and #57's medical record, review of the facility's policies, the facility's Administration failed to utilize its resources effectively by failing to investigate and act on two documented burn injuries for residents #3 and #57. A total of 52 out of 55 residents had the potential to request hot liquids. The facility documented the hot [MEDICAL CONDITION] 9/2/20 on the event log for September then failed to investigate and remove the burn risk potential for 52 of 55 residents. Further, the facility's Administration failed to identify, and decrease the risk for hot [MEDICAL CONDITION] failed to monitor the temperatures for the hot liquids for 21 days from 9/2/20 to 9/23/20. The Administration further failed to provide education/in servicing to kitchen staff and care staff related to identification of residents presenting with scald burn injuries and related to the identification of liquids being too hot for compromised and elderly residents. This resulted in the findings of Immediate Jeopardy, occurring on 9/2/20 and removed at 5:00 p.m. on 9/25/20 with the scope and severity reduced to a D. Findings included: 1. Review of the job description titled Nursing Home Administrator, last revised 11/28/2017 revealed Job Function: Responsible for directing the overall operation of the facility's activities with current applicable federal, state, local and corporate standards, guidelines and regulations ensuring the highest degree of quality resident care is always provided. Primary Responsibilities: Assure that the goals of the Nursing Home are being met - the provision of quality resident care in a highly respectful, highly regulated, well managed, and caring environment and billing and collection for these services. Complete other duties as assigned by supervisor Specific Duties: Responsible for training all Department Heads, by following Personal Policies, management training and budgeted hours. Participation in orientation-training program for new employees and monitor all training including, but not limited to, OJT, and in-services, monitor staff training period for all employees. Quality Assurance Committee including Pharmaceutical and Infection: Control Committees, Safety Committee, Department Head Meeting, Census and Medicare Meeting, Abuse Investigations and any required notifications, HIPPA Compliance Officer, Developing Implementing Plans of Correction, Risk Management Concerns I.e. Sentinel Events, Grievance Officer, Responsible for the Food Service Program, Monitor and control all contractual services and outside agencies. Review of job description titled Director of Nursing, last revised 4/3/2018, revealed: Job Function: Coordinate and direct all health care services provided to Resident. Supervises: Shift Coordinators, CNAs, MDS coordinators, Shift Nurses, Medical Services, Medical Records, Pharmacist. Reports to: Administrator Primary Responsibilities: Implement and monitor Facility Policies and Procedures to ensure that the facility is in compliance with all Federal and State Minimum Standards as they apply to nursing and medical services, Supervise all documentation of services provided to residents, interview, hire, train and supervise all employees under your supervision and review staff competency in dealing with medical issues and provide training on a regular and as needed basis, perform other duties as assigned by administrator. Specific Duties: Make rounds to check all aspects of resident care. Plan the day's medical activities, provide on-the-job training for new staff that works under your supervision, Supervise and conduct monthly meetings and other meetings as needed. Provide in-service training as scheduled. Develop an annual training calendar in advance to meet regulatory requirements, Complete weekly Accident and Incident Reports and compile a monthly report to be submitted to the Safety and QAPI Committees. Review numbers of Accidents and Incidents in facility to determine areas of concern. Develop a plan to correct and avoid reoccurrence of areas identified, Schedule and complete QAPI audits based on assessed resident' needs. Provide reports of findings, plans of actions and results at quarterly QAPI meetings, monitor completion of weekly measurements and documentation of wounds, Assist the Administrator with completion of Sentinel Events as needed, Spot check all nurses documentation by randomly auditing charts daily. 2. On 9/23/20 at 1:00 p.m., an interview was conducted with the Nursing Home Administrator and Director of Nursing. They were asked if they could provide information related to hot liquid [MEDICAL CONDITION] occurred on 9/2/20 with regards to Residents #3 and #57. Neither the Nursing Home Administrator nor the Director of Nursing could recall any residents being burned by hot liquids recently. They both indicated that they would look at the incident/accident injury event log. Once they looked at the incident/accident injury event log, they were able to see that both Residents #3 and #57 received hot [MEDICAL CONDITION] 9/2/20. Neither the Nursing Home Administrator nor the Director of Nursing could provide any further information. The Nursing Home Administrator and Director of Nursing (DON) both confirmed they never investigated either of the hot liquid burn incidents. At this time the Nursing Home Administrator (NHA) and DON were asked how they monitor hot liquid temperatures to ensure residents do not get burned or injured. They both indicated that it was the Certified Dietary Manager's (CDM) responsibility and they could not speak to exactly how that was done. The NHA and DON were both made aware that since they did not know how hot liquids were monitored for resident safety, that a coffee and hot water temperature demonstration would need to be conducted immediately and prior to the next meal service. During an interview on 9/25/20 at

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	105881	A. BUILDING _____ B. WING _____	09/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAWTHORNE HEALTH AND REHAB OF BRANDON	851 WEST LUMSDEN RD BRANDON, FL 33511

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) 1:47 p.m., with the Administrator and the DON, the DON stated the event log and the corresponding progress note in the computer were to be discussed in the morning meeting every day. However, on 9/2/20 the DON stated no events were discussed in the morning meeting and could not elaborate on the reason they were missed. The DON again confirmed the events were not discussed on 9/2/20 and did not have an answer why [MEDICAL CONDITION] not reviewed or investigated for 21 days from 9/2/20 to 9/23/20. The NHA confirmed the best practice would be to discuss events at the morning meeting but [MEDICAL CONDITION] 9/2/20 were missed. The NHA said the DON was responsible to review the events with the morning meeting management team. The DON was asked where the facility failed and she stated, It was with the date 9/2/20 because [MEDICAL CONDITION] it to the log but were never reviewed at the morning meeting. The DON stated she thought they failed to discuss [MEDICAL CONDITION] stated they need to evaluate why at the morning meeting they did not discuss the burns. The DON stated she was not sure why she was not notified about [MEDICAL CONDITION] would have expected the RN or LPN to notify her immediately. The DON stated once the facility was notified of [MEDICAL CONDITION] 9/23/20 the staff were trained on palatable coffee and if the resident requested hotter coffee, staff would need to go to the kitchen and only get the coffee from the dietary staff and not heat up the coffee. Dietary would do all temps on coffee before all meals. During review of the event log for September and interview on 9/23/20 at 3:48 p.m., with the ADON, she stated she created the event log from the event reports that are initiated by the nurses in the computer. The ADON confirmed she added Resident #3 and #57 to the event log related to [MEDICAL CONDITION] did not investigate the events as she thought the CDM was made aware by the nurse. Review of the event log for September found Resident #3's event occurred on 9/2/20 at 2:28 p.m., in her room. She was alert and oriented. Type of event was documented as skin tear/laceration. Possible cause was documented as Spilt hot beverage on lap and investigated cause was documented as Spilt hot beverage on lap. Injury was described as left outer thigh- red and small open blister noted. Doctor and family notified. Review of the event log for September for Resident #57's event found it occurred on 9/2/20 at 2:26 p.m., in her room. She was alert and oriented. Type of event was documented as skin tear/laceration. Possible cause was documented as Spilt hot beverage on lap and investigated cause was documented as Spilt hot beverage on lap. Injury was described as left upper thigh noted with red area. During an interview with the NHA, DON, and CDM on 9/23/20 at 3:55 p.m., the NHA stated the coffee machine company was contacted and the CDM was notified of the incidents. The Administrator stated the CDM had the coffee carafes sit for 45 minutes prior to serving. The CDM stated she could not recall having a conversation about coffee burns. The Administrator stated, That coffee temperatures are quantitative, and the temperatures could not be monitored without taking temperatures of the coffee in the carafe. The Administrator and DON were asked during the conversation, what the facility did from 9/2/20 to 9/23/20 related to [MEDICAL CONDITION] hot liquid. The Administrator stated the facility called the coffee machine company on 9/23/20 and, going forward, coffee and hot liquid temperatures would be taken prior to serving. The Administrator stated the vendor would be coming to adjust the temperature of the coffee machine. During an interview with the DON on 9/23/20 at 4:02 p.m., the DON stated they did not have a policy related to event investigations and would look for one related to hot liquids. During an interview with the DON on 9/24/20 at 12:19 p.m., she stated that she and the ADON were responsible for investigating events and she would have to look and see if she had any other documentation related to [MEDICAL CONDITION] than the event log. During an interview on 9/25/20 at 1:08 p.m. with the Director of Rehab (DOR), she stated, the residents in the building had not been assessed for safety and handling hot liquids, It's not something we usually do. 3. On 9/23/20 at 10:00 a.m. Resident #3' s electronic nursing progress notes documented by staff member E, Registered Nurse (RN) on 9/2/20 at 11:40 a.m., revealed that staff member E, RN was called to Resident #3's room for Evaluation of redness to the left thigh. Reddened area noted to left outer thigh, two dry ruptured blisters also noted. Resident states that she had spilled her coffee on it - was unsure of when it had happened. Physician and daughter notified. During an interview on 9/23/20 at 11:50 a.m. with staff member E., RN, she stated Resident #3 spilled her coffee on her left outer thigh. The thigh was red and had a burn. Staff member E, RN stated we document on the progress notes, event reports in the computer and the night shift nurse normally completed progress notes related to skin sweeps. Staff member E, RN stated Resident #3 currently had a red area that was not open. 4. Review of Resident #57's electronic nursing progress notes on 9/2/20 at 12:04 p.m. found the LPN documented, She was summoned to resident's room by therapist. The nurse made aware of quarter size red area to upper left thigh. Therapist informed the nurse that she observed coffee stain on resident's gown. Resident unaware of what happened. Resident does complain of area burning. The nurse spoke with the resident's son and notified him of the area on the left upper thigh red area. During an interview with Staff member F, Licensed Practical Nurse (LPN) on 9/23/20 at 1:00 p.m., she stated a resident was burned after spilling coffee a few weeks ago. Staff member F, LPN stated it was Resident #57, a recently admitted resident at the time. Staff member F, LPN stated her responsibility and protocol was to create the computer event report, document progress notes, notify the family and physician, and get orders. Staff member F, LPN stated that all nursing staff and administration could see the event log and that management would review. Staff member F, LPN stated she could print the reports for her residents in case she forgot to get report on someone or give report about an event. She said she would print out an event report for the oncoming nurse to review so they were aware. 5. On 9/23/20 at 10:40 a.m., an interview was conducted with the facility's Certified Dietary Manager (CDM) related to who was responsible for the brewing and maintaining of hot liquids to include coffee. The CDM revealed that it was the kitchen's responsibility to make and send out coffee to the floors/units. She further revealed that, since the COVID pandemic, there were only two places to make coffee and hot water, which were 1) In the kitchen, and 2) In the main dining room area. The CDM confirmed that at this point and currently, they brew the coffee for residents utilizing a leased coffee machine, which was in the main kitchen. The CDM further confirmed that the leased coffee machine in the main dining room was on and that they used it, but the coffee machine from the kitchen was only for residents. The CDM was then asked if she could remember any residents in the building being burned by either hot coffee or hot water. She said, I was told by staff maybe a few weeks ago that a resident received too hot of coffee but was never told if that resident received any burn injuries. She further confirmed it had not been brought to her attention from management about coffee serving temperatures, nor did management ever bring to her attention a resident or residents were burned by hot liquids. The CDM was then asked how she brewed coffee/hot water. She again explained that there was a leased coffee machine that brewed the coffee and the temperature was set within. She was asked how she maintained the coffee machine liquid temperatures and explained that the machine was always on preset temperatures so the coffee would either have to cool by placing it in the walk in refrigerator if too hot, or sit out in kitchen area near the coffee machine for a period of forty-five minutes to an hour. The CDM was asked how she monitored the coffee and hot water temperatures and was also asked what her and the facility's expectations were when it came to safe coffee/ and or hot water service to residents. The CDM stated that previously, she did not monitor the temperatures of coffee or hot water coming out from the machine, she did not monitor coffee or hot liquids prior to sending them out to the floor/units, and did not monitor coffee or hot liquid temperatures after they reached the floor/units. The CDM was asked if she had any type of log or documentation to show that she had taken temperatures of coffee or hot liquid in the past. She confirmed that was something she had never done before. During this time, the CDM was asked to show what the coffee/hot water temperatures were immediately after brewing and when they reach the floor to be served. On 9/23/20 at 11:00 a.m., the CDM stated that the coffee was ready to go out to the units/floor and was sitting in the metal coffee carafes for about one hour. She did not know what the coffee/hot water temperatures were prior to going out to the floor. Prior to leaving the kitchen area, the CDM was asked how she took temperatures of the hot coffee and hot water. She explained she utilized a regular stick, non-digital thermometer and calibrated it daily. The CDM said that she last calibrated this thermometer earlier today, 9/23/20, prior to the breakfast meal service. The CDM indicated that they only made and served coffee to the residents three times a day, which included, 1. Breakfast meal service, 2. Lunch meal service, and 3. Dinner service. The following was observed: On 9/23/2020 at 11:55 a.m., the CDM pushed a meal cart to the 400 hall. The cart had the coffee and hot water placed on top. The cart reached the 400 hall at 11:57 a.m., The CDM then poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 146 degrees F. The CDM confirmed the temperature at 146 degrees F. At 12:00 p.m., the CDM pushed another tray cart to the 200 hall. At 12:02 p.m., she poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 130 degrees F. The CDM confirmed the temperature at 130 degrees F. At 12:05 p.m., the CDM pushed another tray cart to the 600 transitional unit. At 12:07 p.m., she poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 145 degrees F. The CDM confirmed the temperature at 145 degrees F. At 12:11 p.m., the CDM pushed the final tray cart to the 300 hall. At 12:13 p.m., she poured a half cup of coffee in a white

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F 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 165 degrees F. The CDM confirmed the temperature at 165 degrees F. The CDM was asked what the expectations were for serving hot coffee and hot liquids to elderly and compromised residents. She could not give a specific number in degrees but rather stated, Coffee and hot liquids should be at palatable temperatures. The CDM and Surveyor then walked back to the kitchen to observe the coffee machine's liquid service temperatures. The following was observed: 1. The coffee machine in the main dining room had a door with a key. The key had already been in the lock. The door was opened and showing a digital read out that had a Tank temperature and a Dispense temperature. The dispensing temperature read 193 degrees F. The tank hold temperature read 198 degrees F. The kitchen coffee machine was also observed with a door with a key in the lock. The door was opened and revealed a dispensing temperature of 193 degrees F. The hold temperature read 198 degrees F. (Photographic evidence was taken). The CDM confirmed both machine temperatures and did not know what the temperatures should be and did not know what a safe hot liquid temperature should be for elderly and compromised residents. She also indicated that she could not change or adjust the temperatures but would call the coffee machine company serviceman to come out and look at it. On 9/23/2020 at 4:25 p.m., the CDM was asked to provide demonstration how the kitchen maintained and served coffee and hot water to residents. She indicated that coffee had already been poured from the machine into insulated metal carafes, ready to be taken out to the floor. At 4:30 p.m., a kitchen aide (Employee T) was observed in the kitchen carrying two metal insulated coffee carafes from the walk-in refrigerator to the dining room to place on the meal carts. Employee T said she had just removed the carafes from the walk-in refrigerator and tested the temperatures and said the temperature was 120 degrees F. She said that they now go on the meal carts to be transported to the floor/units. Employee T said that when the coffee was poured from the coffee/hot water machine, the temperatures were at 165 degrees F. The CDM was asked to take the temperature of the coffee once it reached the floor/units. Prior to that, the coffee/hot water machine in the kitchen and the coffee/hot water machine in the main dining room were observed for internal liquid temperatures. The machines had a digital read out that included the dispensing temperature and tank holding temperature. At 4:40 p.m. both coffee machines in the kitchen and dining room had the following: 1. Dispensing temperature - 193 degrees F. and 2. Tank holding temperature - 198 degrees F. (Photographic evidence was taken). The following was observed on 9/23/20 during the dinner service: The CDM pushed the meal tray cart from the kitchen at 4:42 p.m., and reached the 600-transition unit at 4:43 p.m. She poured a half cup of coffee into a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 132 degrees F. The CDM confirmed the temperature reached 132 degrees F. The staff was observed serving the coffee to the residents, they provided assistance such as adding cream, sugar, and sugar substitute if requested, and ensured the residents were able to reach the coffee cup. The CDM pushed a meal tray cart from the kitchen and reached the 200 hall at 4:46 p.m. She poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 127 degrees F. She confirmed that the temperature reached 127 degrees F . The CDM pushed a meal tray cart from the kitchen and reached the 400 hall at 4:56 p.m. She poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 139 degrees F. She confirmed that the temperature reached 139 degrees F . The CDM pushed a meal tray cart from the kitchen and reached the 300 hall at 5:15 p.m. She poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 122 degrees F. She confirmed the temperature reached 122 degrees F. The CDM stated, I don't know how the coffee temperature rose as I believed my staff temped the coffee prior to leaving the kitchen at 120 degrees F. During an interview on 9/23/20 at 4:56 p.m., with the Administrator, he confirmed the facility did not have a hot liquid policy, just a hot food policy. On 9/23/20 at approximately 5:30 p.m., the Nursing Home Administrator was interviewed and informed about the lunch meal service coffee temperatures. He stated he understood about the high liquid temperatures and would have an action plan put in place. On 9/24/20 at 6:10 a.m. the building was entered in order to observe coffee/hot water service prior to breakfast meal service. At 7:08 a.m., the CDM and two cooks revealed that this a.m. at 5:00 a.m. they prepared coffee. The CDM related that the coffee machines were always on in the kitchen and the main dining room. She revealed that she and her staff poured coffee from the coffee machine in the kitchen and took it directly to the freezer to cool. The CDM indicated that the pour temperature was 167 degrees F. and coffee/hot water after pour was taken to the walk-in freezer to sit for an unspecified time. She added that the coffee was then removed from the freezer and tested with a calibrated thermometer. She reported that the temperatures reached 120 degrees F. The CDM was asked to take coffee/hot liquid temperatures once they reached the floor/units. The process was as follows. A meal tray cart left the main dining room/kitchen area at 7:08 a.m. and reached the 200 hall at 7:10 a.m. The CDM poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 110 degrees F. She confirmed the temperature reached 110 degrees F. A meal tray cart left the main dining room/kitchen area at 7:13 am. and reached the 600-transition hall at 7:15 a.m. The CDM poured a half cup of coffee in a white disposable cup, from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 110 degrees F. She confirmed the temperature reached 110 degrees F. A meal tray cart left the main dining room/kitchen area at 7:18 a.m. and reached the 400 hall at 7:20 a.m., The CDM poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 125 degrees F. She confirmed the temperature reached 125 degrees F. A meal tray cart left the main dining room/kitchen area at 7:35 a.m. and reached the 300 hall at 7:35 a.m. The CDM poured a half cup of coffee in a white disposable cup from one of the metal coffee insulated carafes. After the thermometer was in the cup for about thirty seconds, the temperature reached 120 degrees F. She confirmed the temperature reached 120 degrees F. During an interview on 9/23/20 at 4:15 p.m., with the CDM she stated that she was unsure how many residents drank hot liquids and would print out a list. The CDM stated she was not sure how many residents preferred coffee. She provided a beverage roster that revealed eight residents preferred hot tea, coffee or cocoa. However, she said any resident can request coffee, but those eight were the only residents she had documented. At 5:30 p.m. the NHA and DON were asked how many residents had the likelihood to drink hot liquids. The NHA and DON provided the list on 9/24/2020 at approximately 11:00 a.m. During an interview with the CDM while in the kitchen, she stated the water temperature was 120 degrees after sitting for 20 minutes from the coffee machine. During an interview with Staff member U, dietary aide on 9/23/20 at 4:30 p.m., she stated she had taken the temperature of coffee after dispensing from the coffee machine. The temperature was 165 degrees F. So, she put the coffee in the cooler for ten minutes. 6. During an interview with the coffee machine representative on 9/24/20 at 3:54 p.m., he stated that all the coffee machines come from the company with a stock temperature of 190 degrees which could be adjusted to as low as possibly 110 degrees. The representative stated I can't tell anyone what to set the temperature to. However, I could tell someone how to reduce the temperature. The representative stated he was told the scald point is about 150 degrees and stated the Administrator told him to set the machine at 135 degrees. The representative stated he was not contacted to adjust the coffee temperatures until today but could have walked the CDM through it over the phone. He stated the machine would take a while to drop the temperature of the coffee and recommended the facility place the coffee in the chiller for about 10 minutes to drop the temperature down 20 to 30 degrees. 7. During an interview and observation of Resident #3 after readmission on 9/25/20 at 6:30 p.m., the resident stated she spilled her coffee on herself, but it no longer hurts, it's healed now. Resident #3 consented to observation which revealed a pink left outer thigh area measuring approximately 5 centimeters long by 1 centimeter wide. Resident #3 rubbed her hand over the area and stated again stated, It's healed now. Review of the electronic record for Resident #3 revealed a Brief Interview for Mental Status (BIMS), dated 8/17/20, of 12 indicating moderate impairment. Section G, from Minimum Data Set (MDS) functional status, H. eating - how resident eats and drinks regardless of skill revealed a self- performance of 1. Supervision - oversight, encouragement or cueing and support of 1 indicated set up help only. Review of Resident #3's physician order: Regular diet dated 8/12/20. Resident on hospice dated 8/12/20. Skin sweep once a day on Thursday from 6:00 p.m. to 6:00 a.m., dated 8/17/20. Monitor burn to left upper thigh until resolved twice a day dated 9/2/20. Review of Resident #3's care plan with last revision date 8/19/20 identified problem start date on 10/11/18 of impaired vision related to [DIAGNOSES REDACTED]. Goal date of 11/19/20, resident will not experience negative consequences of vision loss as evidenced by; remaining physically safe, and participating in social, and self-care activities. Review problem dated 9/23/20 revealed resident at risk for spilling her coffee related to shaking. Approach dated 9/23/20 resident to have a cup of coffee to be provided and nursing to evaluate. During an interview on 9/25/20 at 1:41 p.m., with Rehab Director, she stated Resident #3's biggest issue was her

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HAWTHORNE HEALTH AND REHAB OF BRANDON	**851 WEST LUMSDEN RD BRANDON, FL 33511**

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 0835 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) vision loss. Review of the occupation therapy evaluation, dated 6/19/20 to 7/18/20, found self-feeding underlying impairments as low vision. 8. During an interview with the Director of Rehab (DOR) on 9/25/20 at 1:08 p.m., she confirmed she observed Resident #57 sitting in a big puddle of coffee on the floor under her wheelchair and cleaned up the floor. The Director of Rehab stated she could not see anything on Resident #57's clothes but halfway through therapy the resident started complaining the inside of her leg felt weird. The DOR stated she looked at Resident #57's left inner leg. It was a red long oval shaped area. The DOR stated she went to get the nurse and she could see the top layer of skin was peeling (like a sunburn). The nurse went to get a dressing. Review of the physical therapy daily treatment notes, dated 9/2/20 at 6:23 p.m., revealed the Director of Rehab documented Resident #57 received for therapy this date sitting up in wheelchair with large puddle of (what appeared to be) coffee on floor underneath/behind her chair. Empty cup was sitting on tray table; however; patient had no recollection of spilling it. This therapist cleaned up spill and commenced treatment without incident. About halfway through session, patient with complaints of a burning sensation at inner thigh. Skin was inspected with a small red streak and slight peeling of top layer of skin evident at left inner thigh. Nurse F, LPN was made aware. Performing skin inspection and topical treatment at the end of the physical therapy session. Plan for next session. Review of the nursing progress notes for Resident #57, dated 9/9/20 at 1:33 p.m., and documented by the LPN revealed an area to left upper thigh is no longer red in color. Color is brownish. No complaints offered. Review of the nursing progress notes, dated 9/12/20 at 5:52 a.m., documented by the LPN revealed Resident #57 complaining of itching on the red area on her left upper thigh. When checked, the area appears to be scabbing. Site is cleansed and covered with dressing to avoid unconscious scratching and reopening of the scabs. Resident tolerated it well throughout the night. Review of the nursing progress notes, dated 9/13/20 at 2:26 a.m., and documented by the LPN revealed no new skin issues noted during skin check. Existing skin concerns have treatments in place. Review of the nursing progress notes dated 9/13/20 at 1:07 p.m. and documented by the LPN revealed Resident #57's observed dressing on left upper thigh. Dressing removed observed drainage on dressing. Observed area with slough. Area cleaned with normal saline, triple antibiotic ointment and dressing applied. Resident denies pain to area. Review of the nursing progress notes dated 9/18/20 at 4:48 p.m., documented by the RN revealed the resident with open area located to left upper thigh. Observed redness around the area, hot to touch. Resident referred itching and discomfort. Treatment completed as ordered with triple antibiotic ointment during the shift. Physician notified. Waiting for wound care evaluation. Oncoming nurse notified. Continues monitoring. Review of the physician orders [REDACTED]. Start dated of 9/13/20 revealed to cleanse left upper thigh with normal saline, apply triple antibiotic ointment and cover with dressing daily. Start date 9/7/20 skin sweep once a day on Saturday. Review of care plan, with revision date 9/23/2020 revealed Resident #57's problem start date on 9/23/20 for risk for spilling coffee. Goal to have decreased episodes of spilling coffee. Approach dated 9/23/20 to provide cup of coffee to be provided to resident and Occupation therapy to evaluate. Problem start date 9/3/20 Cognitive loss/Dementia, impaired cognition/memory issues as evidenced by BIMS assessment. Review of the MDS section C. BIMS dated
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and policy review, the facility did not ensure an effective infection prevention program as evidenced by 1) failing to ensure non-critical equipment used for three (#3, #50, and #38) of eight residents on transmission-based precautions was cleaned and disinfected appropriately between uses on one (600 hallway) of two transmission-based precaution hallways, and 2) failing to ensure one staff member (Staff S) cleaned Personal Protective Equipment (PPE) of a face shield between contact with three (#3, #50, and #38) of eight residents on transmission-based precautions. Findings Included: On 9/22/20 at 12:07 p.m., Staff member S, Certified Nursing Assistant (CNA) was observed coming from Resident #38's room wearing a KN95 mask covered by surgical mask, face shield, and gown with plastic disposable arm covers. CNA S was holding a reusable thermometer and pulse oximeter in her left ungloved hand. Resident #38 was on isolation precautions to include droplet and contact. Staff member S, CNA donned one glove and placed it on her right hand and used the ungloved left hand to hold the thermometer and pulse oximeter while she cleaned them with the bleach wipe. She then placed them on the back-right side of the medication cart with Staff member R, Registered Nurse (RN) standing at the cart. With the gloved right-hand Staff member S, CNA opened the soiled utility room, keeping her leg stretched out to prop the door open, disposed of the wipe and washed her hands. Staff member S, CNA was not observed cleaning her face shield or changing it. Staff member S, CNA picked up the same thermometer and pulse ox and went to Resident #50's room at 12:13 p.m. Resident #50 was on isolation precautions to include droplet and contact. Staff S exited Resident #50's room and came back to the nurse's medication cart next to the soiled utility room holding the thermometer and pulse oximeter with ungloved hands. Staff member S, CNA donned a glove in the right hand and used the ungloved left hand to hold the thermometer and pulse oximeter while cleaning them with the bleach wipe. Staff member S, CNA used the ungloved left hand to open the soiled utility room after placing the thermometer and pulse on the back-right side of the medication cart. She washed her hands, picked up the thermometer and pulse oximeter and went to Resident #3's room at 12:15 p.m. Resident #3 was on isolation precautions to include droplet and contact. Staff S exited the room with the thermometer and pulse oximeter in her left ungloved hand and donned a glove on the right hand. She used a bleach wipe to clean the thermometer and pulse oximeter. She placed the thermometer and pulse oximeter on the back-right side of the medication cart and went into the soiled utility room. During all three observations, Staff S, CNA was not observed to clean her face shield. During an interview with Staff member R, Registered Nurse (RN) on 9/22/20 at 12:18 p.m., she stated, At this time we don't have any disposable equipment in the isolation rooms. I don't know why we don't have any disposable equipment right now Staff R continued on to state that the thermometer and pulse oximeter belong to Staff S, CNA, and not the facility. During an interview with Staff member S, CNA on 9/22/20 at 12:20 p.m., she stated the equipment observed was her personal medical equipment that she brought into the facility and that she did not have disposable equipment at this time. Staff member S, CNA stated that she cleaned the reusable equipment with a bleach wipe and confirmed that she was observed using shared equipment on three residents who were on isolation precautions for suspected COVID-19, [MEDICAL CONDITION], and observation precautions. Staff member S, CNA stated she was not in-serviced on the need to clean her face shield when leaving the isolation rooms and confirmed she did not clean her face shield or change her surgical mask after leaving the suspected COVID 19 room. During an interview on 9/22/20 at 12:43 p.m. with the Assistant Director of Nursing (ADON) she stated staff need a mask, face shield or goggles, and gown when entering Residents #3, #38 or #50's room. Staff had to double gown in Resident #38 and #50's room and they were expected to clean their face shield after leaving a resident room on the 200 and 600 hallways as those were the transitional and observation halls. Residents in the 200 and 600 hallways were on contact and droplet precautions. Staff were to use disposable equipment or dedicated equipment on those units and should not be sharing equipment. The ADON stated her expectation for cleaning equipment such as the pulse oximeter and thermometer would be to clean them with a bleach wipe. The ADON then stated two Residents, #38 and #50, should have disposable equipment only in their room. The ADON stated she set up the isolation caddy and monitors them. The ADON stated some staff did use personal equipment to take vital signs and the facility was aware but did not have a policy for personal equipment. The staff clean the equipment with bleach wipes. The ADON stated staff were to use the disinfectant spray to clean the face shield or the goggles. The disinfectant was in the soiled utility room and not kept at the point of use outside the resident rooms in the isolation caddy. Review of facility policy Infection Control revised 11/28/19, 7 pages revealed: All residents with known or suspected infectious conditions will be cared for using the most appropriate nursing care determined for the benefit and safety of the resident concerned, the other residents in the facility, and the safety of the employees. Review of the facility policy Categories of transmission-based precautions revised 9/18, 5 pages revealed: It is the policy of the facility to follow nationally recognized standards and guidelines for transmission-based (isolation) precautions. Contact precautions must be implemented, in addition to standard precautions, for resident known to be infected or colonized with organisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. 2. [MEDICAL CONDITION] C. Gloves and Hand hygiene 4. After glove removal and hand hygiene, ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room. e. Resident care equipment 1. When possible, dedicate that use of non-critical resident care equipment items. Avoid sharing between residents. 2. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. Photographic evidence was obtained.