STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106074	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KEYSTONE REHABILITATION AND HEALTH CENTER	**1120 W DONEGAN AVE KISSIMMEE, FL 34741**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure assistance and supervision were provided to prevent an avoidable accidents for 1 of 5 sampled residents, (#1). Findings: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A nursing progress note dated 9/13/20 at 6:28 PM read, at approximately dinner time resident #1 asked her Certified Nursing Assistant (CNA A) to warm her soup for her. By trying to feed herself the soup fell on her thigh and the resident was burnt on two different places, assessment was done, MD made aware, treatment given, resident is alert and oriented request that she prefer to talk to her guardian herself. The CNA was removed from the assignment, safety measures in place, will continue to observe resident. A physician's progress note dated 9/16/20 indicated that resident #1 had [MEDICAL CONDITION] to spilt hot soup. Two burned areas were identified on the right anterior thigh and the right lateral thigh. The two burnt areas measured 5 cm (centimeters) x 7 cm x 0.1 cm and 3 cm x 2 cm x 0.1 cm, respectively. On 9/17/20 at 2:15 PM, resident #1 stated her family brought in food/soup to the facility and it was stored in the refrigerator that was located in the unit's pantry. She stated that on 9/13/20 at dinner time, she asked CNA A to warm up her soup that was in the refrigerator. Resident #1 said CNA A brought her the soup in a Styrofoam cup with a lid. She said she could see steam coming up from the straw. The resident explained that CNA A told her the soup was hot and she set it on the table to cool. The resident stated that her hands were shaky that day and she picked up the soup and it spilled on her leg. She stated the soup had never been that hot before even after I had let it sit. Resident #1 said her pants were covered with hot soup. She said she pressed her call light and a nurse arrived but she left to get another staff to help. The resident recalled that CNA A came into her room after she had been burnt. She said the CNA told her, 'this is all your fault.' The resident stated, It's painful, even now. When I stretch, I can feel that my skin is ripping apart. Review of the admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/3/19 noted the resident scored 14 out of 15 on the Brief Interview for Metal Status which indicated she was cognitively intact. Section G of the MDS assessment for Activities of Daily Living (ADLs) assessed resident #1 as 2/2 for eating which indicated assistance by 1 staff person was required to eat safely. Review of the Occupational Therapy (OT) progress notes indicated resident #1 was certified for therapy from 8/26/20 to 9/8/20. The OT progress note dated 9/8/20 indicated the resident required supervision for eating/feeding. The resident's ADL Care Plan was initiated on 12/5/19 and was last reviewed on 7/10/20. The eating section of the ADL Care Plan remained the same since 12/5/20. It noted, 'The resident requires assistance from staff to eat as necessary. After the resident was burnt by the hot soup the physician gave orders dated 9/14/20 that read the resident, is assist to feed with all meals. Although the physician ordered the resident to be assisted with her meals to ensure resident safety, the resident's ADL Care Plan was not updated to reflect the physician's new order. Further medical record review noted that the resident was cared planned for resistive/refusing care. This Care Plan noted, 'If resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again. However, the resident's care plan did not instruct staff on how to re-heat food/soup and to ensure she would not be scalded or burned. On 9/17/20 at 2:45 PM, CNA A confirmed she was working when resident #1 was burnt by the hot soup. CNA A stated she was passing out dinner trays when the resident asked her to heat up her soup. CNA A stated she put the soup in a Styrofoam cup and placed it in the microwave for 2 minutes. She said the soup was still cold so she continued heating it for 1 more minute. There was no indication that CNA A was aware or had been trained that food needed to be rapidly re-heated to 165 degrees and served at a palatable temperature while minimizing the risk of scalding or burns. CNA A stated there was no thermometer in the pantry to measure the temperature of the re-heated soup. CNA A stated that the resident needed total assistance with some things and assist with other. CNA A stated after she delivered the soup, she instructed the resident to call her if she needed help. Then CNA said she left resident #1's room and assisted another resident with eating. There was no indication that CNA A assisted resident #1 with eating or provided supervision during the meal. CNA A stated, it's not my fault, because resident #1 did not wait. CNA gave no time frame as to how long the resident should have waited for assistance or why she left hot soup with the resident even though she did not provide any supervision or assistance as per the resident's plan of care. On 9/17/20 at 3:12 PM, Licensed Practical Nurse (LPN) B confirmed she responded to the resident's call light when she spilled the soup. LPN B stated when she entered the room, she saw the spilled soup on the resident's lap. She said there was a red mark on the resident's upper thigh. She stated the resident's meal tray was in the room with the white Styrofoam cup. The resident told her that she was burned by the soup. LPN B explained that the CNAs were responsible for re-heating the residents' personal food that family brought in. LPN B stated there had been no prior training for re-heating food. LPN B stated that resident #1 was sometimes able to feed herself and sometimes needed assistance to feed. LPN B did not explain who or how they assessed whether resident #1 was able to feed herself at each meal. LPN B did not provide an answer when asked if resident #1 was assessed to be able to eat the hot soup independently on 9/13/20 at dinner time. When asked if there was a process to ensure residents were not burned from hot food or soup, LPN B stated, it should be at the normal temperature. LPN B was not able to define 'normal temperature' so that residents were not burned or scalded from hot food. On 9/17/20 at 3:34 PM, the contracted Certified Dietary Manager (CDM) stated that facility staff, not the contracted dietary staff, were responsible for re-heating residents' food. He stated the kitchen staff do not allow food from the outside to be brought into the kitchen. He explained that food that was brought in by family was stored in the refrigerator in the pantry. The CDM stated he had instructed the kitchen staff on how to re-heat food but had not provided training to the CNAs. Observation of the pantry with the CDM noted a sign on the wall that instructed staff to re-heat coffee and food to 135 degrees Fahrenheit. The CDM stated he did not post the sign. He stated the correct way to re-heat food was to rapidly re-heat it to 165 degrees Fahrenheit. When asked what could be done to prevent residents being burned by hot food, the CDM said at his last job, they used 'thermal sticks' which turn a certain color depending on the temperature of the food. He stated thermal sticks were not used at this facility. On 9/17/20 at 4:18 PM, a meeting was conducted with the Administrator and Director Of Nursing (DON). The DON stated that after resident was burned, the staff were in-serviced on re-heating food. The DON did not provide a reason as to why signs in the pantries instructed staff to re-heat food to 135 degrees Fahrenheit. She reviewed the Policy and Procedure provided by the CDM. She stated that food needed to be rapidly reheated to 165 degrees Fahrenheit. When asked about the Root Cause of why resident #1 was burned, the DON stated that she did not have a Root Cause Analysis as they were still investigating and working on staff in-services. The DON added that the CNA should not have left the resident alone with the hot soup. The DON did not explain why resident #1 was not given assistance and supervision during meals as noted in the plan of care and therapy notes.

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