STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105159	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbriar Healthcare Rehabilitation and Nursing C	210 21st Ave W Bradenton, FL 34205

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on interviews and record review, the facility failed to ensure the Physician and Resident Representative were notified of a change in condition in a timely manner for one resident (#1) of two residents sampled. Findings included: Review of the Admission Record for Resident #1 revealed she was admitted to the facility on [DATE]. A review of the contact information showed the resident had a responsible party designated as the POA (Power of Attorney) and Emergency Contact #1. Review of the medical record evaluations tab for Resident #1 revealed there were no assessments, change in condition forms or SBAR (Situation Background Assessment and Recommendations during the time of Resident #1's injury on 07/25/24 and 07/26/24. An SBAR dated 07/27/24 was documented revealing a skin evaluation showed the resident had blisters. On 08/20/24 at 10:24 a.m., a telephone interview was conducted with the facility's Medical Director (MD). He said, I went and saw the resident the day after the incident. I saw she had bruising on her inner thighs that looked linear. I heard she had spilled coffee on herself the day before. I did not hear of it that day. At the time of the assessment, she was sitting in her wheelchair. I saw what looked like an old burn, and the blisters had already deflated. They had been trying to catheterize her as she was having trouble urinating. I saw a linear bruising which at first, I thought was from the irritation during the catheterization. They did not call me when the burn happened. They called me to tell me she was not eating and to follow -up on some labs I had ordered due to the voiding. The MD stated at the time the incident happened, they did not tell him. He stated he was notified the next day around 10 a.m. and when he came in that afternoon, he saw the resident in person and ordered treatment for her. The MD said, Of course they should have notified me at the time of the incident. We could have initiated treatment right away. The MD stated he continued to see the resident probably 6-7 times until her bruising had healed. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/24 at 10:52 a.m., a telephone interview was conducted with Resident #1's Responsible Party (RP). The RP stated she did not know the resident had suffered coffee burns. She said, No one called me about her being burned with coffee. This is the first time I am hearing about it. She stated some time [at the] end of July, she had received a call from a nurse who reported two blisters that could have been from friction. She said, No one mentioned what caused the blisters. The RP stated the resident was not a big person. The friction story did not make any sense to her. She stated the resident's memory comes and goes and she could not count on her to report if she had suffered burns or if she was in pain. On 08/20/24 at 11:16 a.m., an interview was conducted with Staff F, LPN, the nurse assigned to Resident #1. She stated on 07/25/24 at approximately 5:00 p.m., her supervisor, the Assistant Director of Nursing (ADON), had notified her the resident had burned herself with coffee. She said, It was at the end of my shift. The ADON had stated she would notify the physician and family. Staff F confirmed she did not contact the physician or the family herself. She stated the ADON was supposed to do it. She confirmed during her shift she did not initiate any care related to the burn incident. Staff F, LPN confirmed she did not assess the resident herself and she did not document anything in the resident's record. She said, I thought my supervisor was supposed to do it. I did not know that no one called the doctor. We all missed it. I am sorry. On 08/19/24 at 2:58 p.m., an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA stated on 07/25/24 around 10:00 a.m., the resident was served coffee during activities which she spilled on herself. The NHA stated according to an internal document, the physician was notified the resident had suffered a coffee burn. She read the document and stated, CNA stated resident was drinking coffee in the activities room when accidentally she spilled her coffee on her lap. The NHA stated she did not speak to the nurse about why there were no treatment orders initiated at the time of the incident. She confirmed there were no clinical notes in the resident's record. The NHA said, She did not complete the paperwork. Both the NHA and DON confirmed there was no documentation of skin assessments, orders to treat, Change in Condition (CIC) or progress notes on 07/25/24 when the resident suffered burns from coffee. The DON said, I have reviewed the resident's EMR (Electronic Medical Record), you are right, I don't see anything. The DON stated she was not present when the incident occurred. She said, I cannot speak to this incident. I was not here but, I have reviewed the record just like you. I do not see any notes or orders. The DON stated she would have expected staff to ask the resident if she was in pain and to check the skin immediately to see if she had burns. Review of an undated facility policy titled, Changes in Resident's Condition or Status showed the facility shall promptly notify the resident his or her attending physician and representative of changes in the residence medical/mental condition and/or status (e.g., changes in level of care .). 1. The nurse will notify the residents attending physician or physician or call when there has been a(an): Accident or incident involving the resident Discovery of injuries of an unknown source Significant change in the residence physical/emotional/mental condition. Need to alter the residence medical treatment significantly. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Specific instruction to notify the physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident status that: Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. Requires interdisciplinary review and/are revision to the care plan. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR (Situation, Background, Assessment and Recommendation) communication form. 4. Unless otherwise instructed by the resident a nurse will notify the residents representative when The resident is involved in any accident or incident that results in any injuries . There is a significant change in the resident's physical mental or psychosocial status. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Nurses must complete the change of condition evaluation in the [electronic medical record] for any changes of condition. Notify the physician, responsible party or emergency contact of the residents change of condition, and document the notification in the change of condition evaluation form in the [electronic medical record].

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(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** 43453 Based on observations, interviews, record review, and policy review, the facility failed to ensure one (#1) of four residents sampled were free from burn hazards during activities coffee social hour. Findings included: Review of the Resident Admission Record dated 08/19/24, showed Resident #1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The resident was admitted with diagnoses that included but not limited to Dementia unspecified severity, without behavioral disturbance, weakness, need for assistance with personal care, cognitive communication deficit, muscle weakness, and encephalopathy. Review of a quarterly MDS (Minimum Data Set) dated 06/03/24, section C showed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 06 which indicated severe cognitive impairment. Section GG showed the resident required moderate assistance for eating, meaning the helper did less than half the effort. Review of a care plan initiated 07/09/20, showed an Activities of Daily Living (ADL) focus for ADL self-care performance deficit related to ADL needs. Participation varied due to Dementia, limited mobility and weakness. Interventions included staff to offer and assist with meals. A second focus showed Resident #1 had impaired cognitive function or impaired thought processes related to dementia, impaired decision-making, long-term memory loss, and short-term memory loss. Interventions included to cue, reorient, and supervise as needed. Review of a document titled, Occupational Therapy (OT) Evaluation and Plan of treatment dated 08/01/24, showed Resident #1 was referred to OT for services. Reason for Referral: Patient is a [AGE] year-old female Long Term Care (LTC) resident within facility is referred to skilled occupational therapy services for update functional review with recent history of hot liquid injury. Patient presents at prior level of ADL and positioning function, recent downgrade to puree foods. Residents continues to demonstrate fluctuations in self-care levels 2/2. Patient changes in cognitive function and confusion with advancement of dementia, requiring frequent maximum are self-feeding. Patient provided eval assessment only to update self-care and self-feeding assistant requirements. Patient able to demonstrate ability to drink cold liquids from a cup with a straw but unable to demonstrate ability to cognitively execute self-feeding for bringing foods to mouth using fork and or spoon requiring mode/Max cell feeding assist. Patient recommended for use of Thermos sip cup with lid and handle for drinking of warm liquids with staff assistance patient not recommended for drinking of hot liquids 2/2 patient level of cognitive decline with safety awareness and fine gross motor coordination deficits. On 08/19/24 at 10:45 a.m., an observation and interview was conducted with Resident #1. She was observed in the activities room. The resident was appropriately dressed. Resident #1 was not interviewable. She did not respond to any questions or greetings. (continued on next page)

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(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	On 08/20/24 at 10:52 a.m., a telephone interview was conducted with Resident #1's Responsible Party (RP). The RP stated she did not know the resident had suffered coffee burns. She said, No one called me about her being burned with coffee. This is the first time I am hearing about it. She stated some time at the end of July, she had received a call from a nurse who reported two blisters that could have been from friction. She said, No one mentioned what caused the blisters. The RP stated the resident was not a big person. The friction story did not make any sense to her. She stated the resident's memory comes and goes and she could not count on her to report if she had suffered burns or if she was in pain. On 08/20/24 at 11:54 a.m., a telephone interview was conducted with Staff A, Certified Nursing Assistant (CNA) who was working with Resident #1 in the activities room. She stated she was familiar with the resident and worked with her before. She stated the resident had declined and required extensive assistance. She stated on 07/25/24, she had roughly eight residents in the activities room. She stated Resident #1 asked for coffee. She stated they had a [brand name of coffee machine] in the activities room. She was assisting the Activities Director (AD) who told her to make coffee. She said, I brewed the coffee, put creamer and sugar and handed it to [Resident #1]. She stated the resident had right side weakness and could barely move her right hand. She said, the resident was facing the TV at first, after I served her the coffee, I turned her around to face the sitting bar area. I poured the coffee into a [Brand name] cup. I said it is hot. She did not touch the coffee at first, I was sitting there charting, then I heard something spill, I looked over and saw the cup on the floor. She had some on herself. A little bit on the sweater and on pants. She did not yell or cream. She said 'Oooh!' She did not say she was in pain. I asked did you spill coffee on yourself? She did not answer. I got the napkins and started to clean her up. [Staff C, CNA] came to the room, and she went to get real towels. She helped to clean her up. Staff A stated it was approximately 15 - 20 minutes before lunch. She stated she told the resident's aide (Staff B, CNA) she had spilled coffee on herself. She stated the resident went to the dining room right after the incident and she was not changed immediately. Staff A stated they would normally serve coffee in [Brand name] cups during activities social hour. She confirmed it was not in a mug, it did not have a lid, and it did not have handles. Staff A said, No one said that I needed to check the coffee temperature before serving. Staff A said, I did not notify the nurse. I figured the assigned Aide would go get the nurse. She stated the assigned Aide (Staff B) wheeled her to the dining room. Staff A stated after lunch she saw the resident in her bed and a nurse was in the room. She said, I assumed she was aware. I did not know it was for other reasons. Staff A stated she had notified Staff D, Licensed Practical Nurse (LPN)/ MDS. She stated Staff D had walked in to the activities room to tell her to push fluids for Resident #1. Staff A said, I said Okay , she just spilled coffee on herself. She stated she did not know what Staff D, LPN did with that information as the nurse did not say anything. Staff A said, Looking back, I should have gone to tell the assigned nurse myself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/20/24 at 11:54 a.m., an interview was conducted with Staff C, CNA. She stated she was not assigned to Resident #1. She was taking another resident to activities at approximately 10:30 a.m. when she noticed the resident had dropped her coffee. She said, I heard her making sounds. She is not loud, she does not speak up. I saw she had [spilled] her coffee on herself. I went and got towels from the resident's room and saw the CNA who was assigned [Staff B,CNA] in her room, making the bed. I told the CNA she had spilled coffee. We both walked back to the activities room and found Staff A trying to clean what she could with the napkins. I helped finish wiping down the area. I left and went back to my assigned area. I did not notify anyone other than the CNA who was assigned. Staff C said, It is an expectation that I should report, I assumed Staff A and Staff B would let the nurse know. In hindsight, it was a mistake. Once they asked, I was surprised. The next day I told them she was burned with coffee. On 08/20/24 at 12:32 p.m., an interview was conducted with Staff B, CNA (Assigned to Resident #1 on 7/25/24). She worked 7:00 a.m. to 7:00 p.m. on 07/25/24. She said, I was not in the activities room when she dropped the cup. I was in her room making her bed. [Staff C, CNA] came and got a towel and said the resident had [spilled] coffee on herself. I was in the room with another resident at the time and I could not leave right away. When I was done, I found they had cleaned her up. They wiped the coffee off her. When I got ready to lay her down after lunch, around 12:30 p.m. I put her to bed and noticed some bruises on her thigh, it was not bubbled yet. I thought it was from her brief. It was not there when I showered her earlier. When I went to check her later around 5:30 p.m., I saw she had blistered on her left thigh. I did not tell the Assistant Director of Nursing (ADON). It flipped (sic) my mind when I saw the blisters. I said to myself, she had burnt herself. I told her nurse [Staff F, LPN]. Staff B stated Resident #1 would not remember if she had spilled coffee on herself or not. Staff B stated she would not tell if she was in pain. Staff B said, She expresses with her face. She did not have any facial expressions. Staff B stated she did not report the burn incident to the nurse because she assumed the people that were in there should have told the nurse. On 08/19/24 at 9:59 a.m., an interview was conducted with the ADON/Unit Manager. She stated Resident #1 was alert, spoke very little and made her needs known through eye contact. Every now and then you could get her to speak. The ADON/UM, stated on 07/25/24, Resident #1 spilled coffee on herself during activities. The coffee was brewed in the activities room. She stated she was not sure they checked the temperatures. The ADON stated at approximately 12:00 p.m., herself and Staff D, LPN had gone into the resident's room to catheterize her. She said, At that time, we had noted what appeared to be old areas of irritation to her skin, we did not know about the burn incident. She had some irritation near her groin. Later that day, roughly 3 hours later, the CNA, [Staff B] came and said the resident had blistered areas. She said she did not know where the blisters came from. The ADON stated she notified Staff E, LPN who was assigned to the resident. She stated she thought Staff E had assessed the resident, called the doctor and put treatment in place. She said, I did not become aware of the burn incident until later in the day, sometime after 5 p.m. I notified the assigned nurse, Staff E. The ADON confirmed she did not assess the resident or call the doctor. She stated the assigned nurse should have. She stated she assessed Resident #1 the following morning and observed a blistered area to her left upper thigh area and one on the right inner middle thigh, lower than the brief area. She said, the resident did not express any pain. I called the doctor and received orders. The doctor came in later in the afternoon. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/19/24 at 2:43 p.m., a follow-up interview was conducted with the ADON. She said, I became aware of blisters at approximately 5 p.m. Staff B, CNA spoke to me. I went to the nurse and told her the CNA had notified me that the resident had blisters. I told her to do a CIC (Change in Condition), call the doctor and notify the family. I can't confirm if it was done or not. I did not ask. I did not follow up. She completed the risk form which does not prompt you to do any other documentation. The ADON confirmed Staff F did not document in the medical record. The ADON said, I did not call the doctor the day of the incident. I expected the nurse who was assigned to the resident to do it. I don't know why she did not. Yes, I am her supervisor. I did not review the record to see what she did. The resident did not receive any treatment that day. I don't know why there is no documentation. On 08/19/24 at 12:52 p.m., a telephone interview was conducted with Staff F, LPN assigned to Resident #1 on 07/25/24. She said, I was told by [Staff B, CNA] around maybe 6:45 p.m. She said the resident spilled coffee on herself. I asked her when. She said it happened earlier in the day. I asked why she did not tell me she said she forgot. I went to look at her [Resident #1]. She had two blisters in her thighs. She had one on her left side, a little bit under the groin area. The following day she had one on the right side too. I told [the ADON]. She was assessed by the ADON. The ADON called the doctor and made the notes. Staff F stated Staff B had reported the resident was in the activities room and they were having coffee when she spilled it on herself. Staff F stated she would have expected the CNAs to notify her if the resident had any incident. She stated she could not remember if she had documented in the resident's record. Staff F stated Resident #1 expressed pain through facial grimacing. She stated the resident did not normally talk but spoke only sometimes. On 08/20/24 at 11:16 a.m., a second in-person interview was conducted with Staff F, LPN, the nurse assigned to Resident #1. She stated on 07/25/24 at approximately 5 p.m., her supervisor, the ADON had notified her the resident had burned herself with coffee. She said, It was at the end of my shift. The ADON had stated she would notify the physician and family. Staff F confirmed she did not contact the physician or the family herself. She stated the ADON was supposed to do it. She confirmed during her shift she did not initiate any care related to the burn incident. Staff F, LPN confirmed she did not assess the resident herself and she did not document anything in the resident's record. She said, I thought my supervisor was supposed to do it. I did not know that no one called the doctor. We all missed it. I am sorry. On 08/20/24 at 10:24 a.m., a telephone interview was conducted with the facility's Medical Director (MD). He said, I went and saw the resident the day after the incident. I saw she had bruising on her inner thighs that looked linear. I heard she had spilled coffee on herself the day before. I did not hear of it that day. At the time of the assessment, she was sitting in her wheelchair. I saw what looked like an old burn, and the blisters had already deflated. They had been trying to catheterize her as she was having trouble urinating. I saw a linear bruising which at first, I thought was from the irritation during the catheterization. They did not call me when the burn happened. They called me to tell me she was not eating and to follow up on some labs I had ordered due to the voiding. The MD stated at the time the incident happened, they did not tell him. He stated he was notified the next day around 10 a.m. and when he came in that afternoon, he saw the resident in person and ordered treatment for her. The MD said, Of course they should have notified me at the time of the incident. We could have initiated treatment right away. The MD stated he continued to see the resident probably 6-7 times until her bruising had healed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/19/24 at 2:39 p.m. an interview was conducted with Staff D, LPN/MDS. She stated she became aware of the burn incident in the evening. She denied having been notified by the CNA earlier. She confirmed she went to the activities room earlier in the day approximately 10:30 a.m. when she observed Resident #1 sitting in her wheelchair. She said, She had some dampness on her clothes to the side of her left leg, I touched it, and it was moist, like her clothes had touched something wet. I knew she had just come out of the shower. I did not see any appearance of coffee spilled on the floor or on the resident. The CNA was over at the table charting. Staff D stated she saw the skin irritation around 12:30 p.m. when they were trying to catheterize the resident. She stated she thought it was caused by her brief or something. She stated she did not investigate the irritation. She said, the CNA applied barrier cream. On 08/19/24 at 2:58 p.m., an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA stated on 07/25/24 around 10 a.m. the resident was served coffee during activities which she spilled coffee on herself. The NHA stated according to an internal document, the physician was notified the resident had suffered a coffee burn. She read the document and stated, CNA stated resident was drinking coffee in the activities room when accidentally she spilled her coffee on her lap. The NHA stated she did not speak to the nurse about why there were no treatment orders initiated at the time of the incident. She confirmed there were no clinical notes in the resident's record. The NHA said, She did not complete the paperwork. Both the NHA and DON confirmed there was no documentation of skin assessments, orders to treat, change in condition (CIC) or progress notes on 07/25/24 when the resident suffered burns from coffee. The DON said, I have reviewed the resident's EMR (Electronic Medical Record), you are right, I don't see anything. The DON stated she was not present when the incident occurred. She said, I cannot speak to this incident. I was not here but, I have reviewed the record just like you. I do not see any notes or orders. The DON stated she would have expected staff to ask the resident if she was in pain and to check the skin immediately to see if she had burns. Review of the July 2024 physician orders for Resident #1 showed treatment orders started 07/27/24 with an end date 08/10/24. Treatment as follows: apply skin prep to left inner thigh fluid blisters every shift for preventative skin care for 14 days. The review showed treatment orders dated 07/26/24, discontinued 07/27/24 to cleanse closed blister to upper left inner thigh, pat dry, apply skin prep and cover with dressing, change dressing daily AM and PM every day shift. The review confirmed there were no orders entered on 07/25/24 when Resident #1 suffered burns. Review of the EMR evaluations tab for Resident #1 revealed there were no assessments, change in condition forms or SBAR (Situation Background Assessment and Recommendations during the time of Resident #1's injury on 07/25/24 and 07/26/24. An SBAR dated 07/27/24 was documented revealing a skin evaluation showed the resident had blisters. There was no other information available. Review of Resident #1's EMR showed there were no documented progress notes or skin assessments related to the resident's burn or treatment plans from 07/25/24 at 10:30 a.m. to 07/26/24 at 4:38 p.m. Review of a progress note dated 07/26/24 at 4:38 p.m. showed The MD assessed blisters to left inner thigh and gave orders for treatment . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A physician note dated 07/27/24 at 02:13 p.m., marked [late entry, entered 07/29/24] showed There was a reported spilling over coffee on her thigh, but the upper part of the thigh has no burn marks on it at all which would be very unusual this may be friction from trying to insert a Foley or a scratch with movement. We are monitoring there is no surrounding redness. Review of an IDT (Interdisciplinary team) progress note dated 07/29/24 showed, Resident noted to have fluid filled blisters to left upper thigh and right lower inner thigh and closed blistered area to left lower thigh. Treatment in progress. Review of the only skin and wound note dated 08/08/24, signed by the Nurse Practitioner showed, New recommendations: Facility requests to assess patient's inner thigh s/p (status post) burn. Resolved blisters noted. Recommend skin prep area daily to protect. No open wounds at this time of visit. On 08/19/24 at 10:20 a.m., an interview was conducted with the Kitchen Manager (KM). The KM stated they were not testing coffee temperatures. He stated the NHA informed him a resident was served coffee by a staff member in the activities room. He stated every day at 10 a.m., they brewed a special pot for the activities group. He said, I will add the activity coffee temperature check in the log. During the time of the interview, a temperature of the coffee poured into serving carafe's was tested . It read 165 . He said, The coffee is brewing at temperatures that are higher. A second temperature check of coffee brewed for the activities group on 08/19/24 at 10:26 a.m. revealed a temperature of 163.4 . He stated their plan was to add ice cubes until it was at the proper temperature prior to serving. Review of a facility policy titled, Accidents and Incidents, revised July 2017 showed all accidents or incidents involving residents, employees, visitors ,vendors etc., occurring on our premises shall be investigated and reported to the administrator. Policy interpretation and implementation. 1. The nurse supervisor/charge nurse/end or the department director or supervisor shall promptly initiate a document investigation of the accident or incident. 2. The following data is applicable shall be included on the report of incident/accident form: The date and time the accident or incident took place. The nature of the injury/illness. The circumstances surrounding the accident or incident. Where the accident or incident took place. The name(s) of witnesses and their accounts of the accident or incident. The injured person's account of the accident or incident. The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105159	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbriar Healthcare Rehabilitation and Nursing C	210 21st Ave W Bradenton, FL 34205

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(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	The date/time the injured person's family was notified and by whom. The condition of the injured person, including his/her vital signs. The disposition of the injured. Any corrective action taken. Follow up information. Other pertinent data as necessary or required. The signature and title of the person completing the report. 5. The nurse supervisor/charge nurse and or the department director or supervisor shall complete a report of incident/accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. 6. The director of nursing shall insure that the administrator receives a copy of the report of incident accident form for each occurrence. 7. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. Review of a facility policy titled, Meal Distribution - Hot Beverage Considerations, dated October 2022 showed, it is the center policy that hot beverages will be served at proper temperatures to allow for resident palatability as well as safety. Older adults have delayed response time, skin sensitivity, and pre-existing health conditions that can cause damage to skin if heart beverages come in contact with skin. Action steps 1. The dining service director will ensure the coffee temperatures from the coffee machine do not exceed 155 . 2. The dining service director will ensure that coffee temperatures of hot beverages will arrive for service at a temperature range of 140-155 F. 3. (c). This staff will be provided with a probe thermometer and alcohol wipes to sanitize the thermometer staff who take the temperature will have adequate training on the proper sanitizing and use of a probe thermometer. (d). If the temperature exceeds 140 the beverage shall remain under the direction of the person reheating until the beverage is within the 120 to 140 degrees temperature range.