

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/24/2015
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00022974 was initiated on 03/19/15 and concluded on 03/24/15. KY00022974 was substantiated with deficiencies cited at the highest Scope and Severity of a "G".	F 000		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy, it was determined the facility failed to ensure services were provided in accordance with each residents' written Plan of Care for one (1) of four (4) sampled residents (Resident #1). Resident #1's Comprehensive Plan of Care stated the resident had a self-care deficit and required assistance for all Activities of Daily Living (ADLs) with interventions which included one (1) person assistance with meals. Record review revealed Resident #1 was served a meal tray that contained coffee without staff assistance. It was reported to staff by a visitor Resident #1 had spilled his/her coffee which resulted in a burn to the resident's right thigh. (Refer to F-323)	F 282	1. The Social Services Director was educated by the Administrator on serving meals to residents needing meal assistance and following the resident care plan on 3/24/15. 2. Residents were assessed on 3/16/15 to determine if at risk for injury from hot liquid spills using Safety Evaluation for Hot Liquid form. Care plans were updated on 3/19/15 to reflect resident specific interventions if assessed to be at risk for injury from hot liquid spills.	3/29/15
	The findings include: Review of the facility's policy, titled "Care Plans -			

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APR 24 2015
BY: [Signature]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Renee H. Martin</i>	TITLE Administrator	(X6) DATE 4/23/15
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 282 Continued From page 1
Comprehensive", revised October 2010, revealed each resident's Comprehensive Care Plan was designed to incorporate identified problem areas and risk factors associated with the problem areas. Continued review of the "Care Plan Policy" revealed the Comprehensive Care Plan was to aid in preventing or reducing declines in residents' functional status and functional levels, enhance optimal functioning of each resident, and reflect currently recognized standards of practice for problem areas and conditions.

Record review revealed the facility admitted Resident #1 on 02/19/15, with diagnoses which included a recent Intracranial Bleed with a Craniotomy (surgical removal of part of the bone from the skull to expose the brain), Barrett's Esophagus (tissue in the esophagus is replaced with tissue similar to the intestinal lining), Seizure Disorder, Depression and Anxiety. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 02/26/15, revealed the facility assessed the resident to have no Brief Interview for Mental Status (BIMS) score documented. The BIMS score is an indication of the resident's cognitive function. Continued review revealed the facility assessed Resident #1 to be moderately impaired with skills for daily decision making. In addition, Resident #1 was assessed to have poor decision-making skills and to require cues and supervision. Further review of the MDS revealed the facility assessed Resident #1 to require one (1) person physical assist and was totally dependent for eating.

Review of Resident #1's Comprehensive Care Plan, dated 02/27/15, revealed the resident had a self-care deficit care plan and required assistance with all ADLs, related to the presence of Tremors,

F 282
3. Nursing Administration completed education on 3/28/15 for the Nurses, State Registered Nursing Assistants, and Administrative Staff on providing care in accordance with each resident's care plan that was assessed to be at risk from hot liquids. All new staff that has the potential to serve the residents hot liquids will be educated during orientation regarding implementing the care plan interventions of the residents who are at risk for hot liquid.

4. The care plan intervention for residents at risk with hot liquids will be monitored using the Care Plan Audit Tool (CPAT). The CPAT will include the following: observation of staff serving during meal service, observation for lids on hot liquids, observation of dependent residents who are assisted with meals, and compliance that the

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F 282	<p>Continued From page 2</p> <p>Left Sided Hemiparesis (slight paralysis or weakness of the left or right side of the body) and a Seizure Disorder. Continued review revealed Care Plan interventions included a requirement for one (1) person assist with meals and the provision of adaptive/safety equipment as needed. Further review of the Comprehensive Care Plan revealed Resident #1 had a nutritional risk and required total assistance with eating and drinking.</p> <p>Review of the Nurse's Notes, dated 03/11/15 at 12:30 PM, revealed Resident #1 spilled a hot cup of coffee on his/her right leg.</p> <p>Review of the facility's employee incident investigation statements, undated, related to Resident #1 spilling the hot coffee on his/her leg, revealed a staff member served Resident #1 his/her meal without a staff member being present to assist the resident with the meal.</p> <p>Review of the Wound Care Notes, dated 03/11/15, revealed Resident #1 was assessed to have a burn to the right thigh with blisters forming.</p> <p>Interview with State Registered Nursing Aid (SRNA) #1, on 03/23/15 at 8:10 AM, revealed Resident #1 required physical assistance from staff for eating. Per interview, SRNA #1 arrived to the dining room late and observed Resident #1 was sitting in the dining room on 03/11/15 at a table with another resident and a visitor of that resident. Per interview, Resident #1's meal tray had been passed, and the resident had his/her coffee. Further interview revealed no staff were sitting with or assisting Resident #1. Per interview, SRNA #1 did not know who served</p>	F 282	<p>dietary tray card is being followed which contains the information from the resident care plan for hot liquid and dependence with meals. Monitoring will occur during meal services five days/week for four weeks, then biweekly for four, monthly for three by the Quality Assurance Performance Improvement (QAPI) team. The QAPI teams consist of the Administrator, Director of Nursing, Medical Director, Health Information Director, Dietary Director, Assistant Directors of Nursing, Plant Operations Director, Housekeeping Director and Quality of Life Director.</p> <p>Any issues identified will be immediately corrected and staff educated for identified problem with finding brought to the monthly QAPI meeting to ensure the interventions are implemented and compliance maintained.</p>	

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F 282	<p>Continued From page 3</p> <p>Resident #1's meal tray; however, she stated the tray should not have been served to Resident #1 without staff physically present to provide assistance and supervision for the resident.</p> <p>Interview with SRNA #2, on 03/23/15 at 8:50 AM, revealed she was working in the dining room on 03/11/15; however, did not witness the incident with Resident #1. Further interview revealed Resident #1 was assessed to require physical assistance of one (1) staff for meals. Continued interview revealed the meal tray should not have been left at the table without staff assistance and supervision. Further interview revealed the process was to stay with the resident once the tray was served.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 0/23/15 at 8:45 AM, revealed the facility's process for a resident requiring staff feeding assistance was for the resident not to be left without supervision and assistance after the tray was served.</p> <p>Interview with the Social Service Director (SSD), on 03/23/15 at 1:53 PM, revealed she delivered Resident #1's noon meal tray on 03/11/15. She stated she was aware Resident #1 required physical assistance of staff for eating; however, no staff were present at the table when she delivered Resident #1's meal tray. She further stated she did not see that she had done anything wrong because she pushed the meal tray with the hot coffee further back on the table, to a point where she thought it was out of the resident's reach.</p> <p>Interview with the Director of Nursing (DON), on 03/23/15 at 1:13 PM, revealed Resident #1 was</p>	F 282		

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F 282	Continued From page 4 assessed to require staff assistance with eating. Further interview revealed Resident #1 was care planned for staff to assist the resident with meals. Continued interview revealed the care plan was not followed when Resident #1 was served hot coffee and left without assistance. She stated the meal tray should not have been served to Resident #1 without staff present to assist and supervise, per the facility's policy and Resident #1's care plan. Interview with the Administrator, on 03/24/15 at 3:00 PM, revealed Resident #1 had been assessed to require physical staff assistance for meals. Continued interview revealed Resident #1 was care planned to receive physical assistance of one (1) staff for meals. The Administrator stated Resident #1's care plan was not adhered to, and the resident should not have been served the meal tray without the presence of staff for assistance, per the Care Plan and the facility's policy.	F 282		3/29/15	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. Resident #1 was immediately removed from the dining room and taken to her room. Her clothes were removed and a thorough assessment was completed by the wound nurse. The Nurse Practitioner and family were notified. Treatment was applied using Silvadene cream to affected area.		
	This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility				

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F 323 Continued From page 5
failed to ensure residents received adequate supervision to prevent accidents. The facility failed to have an effective system in place, to monitor and/or ensure hot liquids were at a safe temperature.

Resident #1, who the facility had assessed to require physical assist of one (1) staff with meals, was served the noon meal on 03/11/15; however, the resident was not provided the assessed physical assist of one (1) staff. Subsequently, Resident #1 spilled hot coffee on his/her right thigh resulting in burns with blistering (second degree) to the right thigh.

The findings include:

Review of the facility's policy titled, "Safety and Supervision of Residents", revised December 2007, revealed resident safety and supervision and assistance to prevent accidents were facility-wide priorities. Per the Policy, employees would be trained and inserviced on potential accident hazards, how to identify and report accident hazards, and how to prevent avoidable accidents. Further review revealed implementing interventions to reduce accident risks and hazards should include: communicating specific interventions to all relevant staff; assigning responsibility for carrying out the interventions; providing training for staff; and ensuring interventions were implemented and documented.

Review of the facility's policy titled, "Assistance with Meals", revised October 2013, revealed residents would receive assistance with meals in a manner which met the individual needs of each resident. The Policy revealed staff would serve

F 323 2. On 3/16/15 all Residents were assessed to determine if at risk for injury from hot liquid spills using the newly implemented Safety Evaluation for Hot Liquids form which was implemented after the deficient practice.

The following interventions were instituted to prevent the deficient practice from reoccurring: lids added to all hot liquids served to residents beginning 3/23/15, dependent residents are assisted with hot liquids during meals and as needed. The Plant Operations Director inspected the coffee maker for proper functioning on 3/12/15 and found it to be working properly. The Plant Operations will continue weekly inspections. The Dietary Director checked coffee temperatures to ensure that coffee is within proper temperature range per policy on 3/12/15 and found to be within normal limits. The Dietary Director will continue to monitor temperatures daily.

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F 323	Continued From page 6 resident trays and help residents who required assistance with eating. Continued review revealed residents who could not feed themselves would be fed with attention to safety, comfort and dignity. Review of the facility's policy titled, "Meal Service - In Dining Room", dated July 2002, revealed the meal tray should be served to the resident whose dietary card was on the meal tray. Per the Policy, residents incapable of feeding themselves were "dependent dined", which indicated staff assistance was required. Continued review revealed should a resident require assistance with eating, staff was to help the resident as necessary. Review of the facility's policy titled, "Food Temperatures", updated October 2008, revealed acceptable serving temperatures for coffee, tea or other hot beverages should be equal to or greater than one hundred forty (140) degrees Fahrenheit and no higher than one hundred fifty-five (155) degrees Fahrenheit. Record review revealed the facility admitted Resident #1 on 02/19/15, with diagnoses which included a recent Intracranial Bleed with a Craniotomy (surgical removal of part of the bone from the skull to expose the brain), Barrett's Esophagus (when tissue in the esophagus is replaced with tissue similar to the intestinal lining), Seizure Disorder, Depression and Anxiety. Review of the Nutritional Evaluation, dated 02/19/15, revealed the facility assessed Resident #1 to have difficulty swallowing, inadequate food and fluid intake, and difficulty with chewing and feeding self. Further review revealed Resident #1	F 323	Current and new Residents will be assessed/reassessed upon admission/readmission and quarterly and as needed to determine if at risk for injury from hot liquid spills using the Safety Evaluation for Hot Liquids form to ensure compliance and continued safety for the residents. 3. The Administrative Staff was educated by the Director of Nursing on 3/24/15 regarding meal service tray pass and Hot Liquid Procedure to ensure residents adequate supervision to prevent accidents. On 3/28/15 the remainder of the staff was educated on the Hot Liquid Procedure by Nursing Administration to follow the dietary tray ticket which will reflect the residents' individual interventions regarding hot liquids including lids and dependence at meal service to ensure residents receive adequate supervision with hot liquids to prevent accidents.		

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F 323	<p>Continued From page 7</p> <p>had disorganized thinking and memory problems and was dependent on staff for feeding. Review of Resident #1's dietary directive card revealed he/she should sit at table 13 B and required staff assist with eating.</p> <p>Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 02/26/15, revealed the facility assessed the resident to have no Brief Interview for Mental Status (BIMS) score documented. Continued review revealed the facility assessed Resident #1 was moderately impaired with skills for daily decision making, made poor decisions and required cues and supervision. Further review of the MDS revealed the facility assessed Resident #1 to require one (1) person physical assist and to be totally dependent for eating.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 02/27/15, revealed the resident had a self-care deficit problem and required assistance with all activities of daily living (ADL's) related to Tremors, Left Sided Hemiparesis (slight paralysis or weakness of the left or right side of the body) and a Seizure Disorder. Continued review revealed interventions noting the resident required one (1) person assist with meals and should be provided adaptive/safety equipment as needed. Further review of the Comprehensive Care Plan revealed Resident #1 was a nutritional risk and required total assistance with eating and drinking.</p>	F 323	<p>All new staff that has the potential to serve the residents hot liquids will be educated during orientation that all residents have the potential to be at risk with hot liquids. The new staff will be educated to follow the dietary tray ticket which will reflect the residents' individual interventions regarding hot liquids including lids and need for supervision related dependence at meal service. All current or new staff will be monitored by the Administrator, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator regarding following interventions on dietary tray tickets.</p> <p>Residents will be assessed/reassessed upon admission/readmission and quarterly and as needed to determine if at risk for injury from hot liquid spills using the Safety Evaluation for Hot Liquids form to ensure compliance and continued safety for the residents. This information will be added/changed on the dietary tray ticket to ensure staff is knowledgeable of resident</p>	
	<p>Continued record review of a Nurse's Note, dated 03/11/15 at 12:30 PM, revealed during the noon meal Resident #1 spilled a hot cup of coffee on his/her right leg.</p>		<p>interventions.</p>	

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F 323	<p>Continued From page 8</p> <p>Review of the facility's employee incident investigation statements, undated, related to Resident #1 spilling the hot coffee on his/her leg, revealed a staff member had served Resident #1 the noon meal without staff being present to assist the resident with the meal.</p> <p>Review of the Wound Care Note, dated 03/11/15 at 12:30 PM, revealed Resident #1 was assessed to have a burn to the right thigh with blisters forming. The Note revealed the initial wound assessment measured 16.6 centimeters (cm) in length by 20.3 cm in width by 0.1 cm in depth for the "right thigh whole burn" area, labeled Wound #1. Continued review revealed the left lower quadrant of Resident #1's abdomen was also assessed to have three (3) newly-identified areas observed with serous fluid filled blisters (Wounds #2, #3 and #4). Further review revealed the wounds were documented as follows: Wound #2 measured 0.5 cm in length by 0.7 cm in width by 0.0 cm depth; Wound #3 measured 0.8 cm in length by 0.7 cm in width by 0.0 cm in depth; and Wound #4 measured 0.4 cm in length by 1.2 cm in width by 0.0 cm in depth.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1, on 03/23/15 at 8:10 AM, revealed Resident #1 required physical assistance from staff for eating. Per interview, Resident #1 was sitting in the dining room on 03/11/15 at a table with another resident and a visitor of the other resident. Continued interview revealed SRNA #1 observed Resident #1's meal tray had been passed, and the resident had his/her coffee with no staff sitting with or assisting the resident. Continued interview revealed the visitor reported to staff Resident #1 had spilled his/her coffee. According to SRNA #1, she did not know who</p>	F 323	<p>On 3/12/15 the Dietary Director in-serviced the dietary staff on the Coffee Procedure. On 3/19/15 the Coffee Procedure was revised and dietary staff educated by the Dietary Director to ensure that hot liquids are served at a safe temperature and an effective monitoring system was put in place. Dietary Director shall maintain a daily temperature audit and log for hot liquids.</p> <p>Plant Operations will maintain a weekly check on coffee maker/ hot beverage appliance to ensure compliance with required temperature.</p> <p>4. Adequate supervision to prevent accidents and maintain safety and to ensure care plan interventions are followed for residents at risk with hot liquids will be monitored using the Care Plan Audit Tool (CPAT). The</p>	
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F 323	Continued From page 9 served Resident #1's meal tray; however, she stated the tray should not have been served to the resident without staff physically being present to provide assistance and supervision for the resident. Interview with SRNA #2, on 03/23/15 at 8:50 AM, revealed she was working in the dining room on 03/11/15. She stated she did not witness the incident involving Resident #1, but explained the facility's process for managing residents who required assistance with eating. SRNA #2 further stated she was aware Resident #1 was assessed to require the physical assistance of one (1) staff person for meals. Continued interview revealed the meal tray should not have been left at Resident #1's table without staff being present to provide assistance and supervision. Further interview revealed the process was for staff to stay with the resident once the tray was served. Interview with SRNA #3, on 03/23/15 at 12:45 PM, revealed she was working in the dining room during the noon meal service on 03/11/15. Further interview revealed she was assisting another resident and had her back to Resident #1 when the incident occurred. Continued interview revealed she observed Resident #1 in the dining room, sitting with another resident and the other resident's visitor. Per interview, SRNA #3 heard the other resident's visitor report Resident #1 had spilled his/her coffee. SRNA #3 stated she transported Resident #1 to his/her room via wheelchair and assisted the resident into the bed and with undressing, for the nurse to assess the resident. Interview with Licensed Practical Nurse (LPN) #1, on 03/23/15 at 8:45 AM, revealed the facility's	F 323	CPAT will include the following: observation of staff serving during meal service, observation for lids on hot liquids, observation for adequate supervision for dependent residents needing assistance with meals, and maintain compliance that the dietary tray card is being followed which contains the information and provides the staff with the knowledge from the resident care plan for hot liquid and dependence with meals. The staff will be monitored during meal services five days/week for four weeks, then biweekly for four weeks, monthly for three months by the Administrator, Director of Nursing, Assistant Directors of Nursing and Staff Development Coordinator.		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/24/2015
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NAME OF PROVIDER OR SUPPLIER MAYFAIR MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 TATES CREEK ROAD LEXINGTON, KY 40502
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323 Continued From page 10
process for a resident who required staff feeding assistance was for the resident not to be left without supervision and assistance after the tray was served.

Interview with the Social Service Director (SSD), on 03/23/15 at 1:53 PM, revealed she had been employed at the facility for approximately six (6) or seven (7) weeks. The SSD revealed she had received basic education upon hire related to meal service and setting up the tray for the resident. Continued interview revealed she delivered Resident #1's noon meal tray on 03/11/15. Per interview, she was aware Resident #1 required physical assistance of staff for eating; however, no staff were present when she delivered Resident #1's meal tray. She stated she did not see that she had done anything wrong because she pushed the meal tray with the hot coffee further back on the table, to a position she thought was out of Resident #1's reach. The SSD further stated she did not know how Resident #1 obtained the hot coffee from the meal tray. Further interview revealed the SSD received education after the incident on 03/11/15 regarding not leaving residents unattended at meals if they had been assessed by the facility to require staff assistance with eating.

Interview with the Dietary Manager (DM), on 03/26/15 at 3:26 PM, revealed on 03/11/15 after the incident, the temperature of the coffee was obtained and was noted to be between one hundred fifty-five (155) degrees Fahrenheit and one hundred sixty (160) degrees Fahrenheit, an acceptable temperature for coffee. The DM stated the appropriate temperatures for serving coffee should be between one hundred forty (140) degrees Fahrenheit and one hundred sixty

F 323 All audit tools developed for plant operations, CPAT, and dietary services will be reviewed weekly for 4 weeks, then biweekly for four weeks, then monthly for 3 months by members of the Quality Assurance Performance Improvement (QAPI) committee. The QAPI teams consist of the Administrator, Director of Nursing, Medical Director, Health Information Director, Dietary Director, Assistant Directors of Nursing, Plant Operations Director, Housekeeping Director and Quality of Life Director.

Any issues identified will be immediately corrected and staff educated for identified problem and finding brought to the monthly QAPI meeting to ensure the interventions are implemented and compliance maintained.

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F 323	Continued From page 11 (160) degrees Farenheit. Continued interview revealed the Dietary Department did not have a process in place, prior to the incident, to monitoring to ensure correct serving temperatures for hot beverages. According to the DM, the Dietary Department had since implemented a new process for coffee. Further interview revealed the new process included once the coffee was brewed at the station, it was placed in a holding container and remained in the holding container and cooled until the coffee "temped" at the appropriate temperature. Interview with the Director of Nursing (DON), on 03/23/15 at 1:13 PM, revealed the facility did not have a risk assessment tool for hot beverages. Continued interview revealed a meal tray should not have been served to a resident who required physical assistance of staff without staff present to provide the assistance and supervise the resident, as per the facility policy. The DON stated the appropriate temperature for coffee was between one hundred forty (140) degrees Farenheit and one hundred fifty-five (155) degrees Farenheit. She stated the facility's process was not adhered to on 03/11/15, when staff served a meal tray to Resident #1, who was assessed to require assistance, and the tray was left without ensuring staff were present to assist and supervise the resident. Interview with the Administrator, on 03/24/15 at 3:00 PM, revealed the facility did not have an assessment tool in place for screening residents at risk for hot beverages. Further interview revealed the facility's process included staff assigned to the dining room were to ensure meals were served timely and residents were assisted and supervised per the policy. Further	F 323			

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F 323	Continued From page 12 interview revealed management and administrative staff was also scheduled in the dining room to assist and monitor residents. Continued interview revealed Resident #1 had been assessed to require physical staff assistance for meals; however, the facility's policy was not followed. The Administrator stated Resident #1 should not have been served hls/her meal tray until staff could be present to assist with eating according to the facility's policy. Further interview revealed her expectation for residents requiring assistance with eating, was they should not be served the meal tray without staff being present to provide the assessed assistance, as per the facility's policy.	F 323			