STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookshire Post Acute	4660 E Asbury Cir Denver, CO 80222

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for one (#10) of five residents out of 10 sample residents. Resident #1, age less than 65, required total assistance with bathing, was non-verbal and was unable to move his arms and legs. On 10/10/25 at 3:55 p.m. certified nurse aide (CNA) #1 requested a nurse to look at Resident #1's skin in the Summit shower room. CNA #1 stated she was using a washcloth and the resident's skin flaked off. The washcloth was noted to be light brown in color and peeled skin was observed on the shower floor. The licensed practical nurse (LPN) and the assistant director of nursing (ADON) who looked at Resident #1's skin on 10/10/25 did not complete a full body assessment for Resident #1, did not notify the physician about the resident's skin condition upon discovery (see record review and interview below) and did not document their findings until the following day (10/11/25). Resident #1 did not receive a full body skin assessment until the next shift when registered nurse (RN) #1 assessed him, at approximately 7:30 p.m. on 10/10/25, and observed blisters on the resident's skin. The facility called to have the resident sent out and emergency medical services (EMS) arrived to transport the resident to the hospital at 8:54 p.m. At approximately 9:30 p.m. on 10/10/25 Resident #1 was admitted to the emergency room and subsequently diagnosed with second degree burns over 8 percent (%) of his total skin surface including his chest, back and right upper arm. He was assessed by a burn unit team at the hospital who determined that Resident #1 had a full thickness scald burn (skin injury caused by contact with hot liquids such as building water, steam or hot oil). The facility staff continued to use the Summit shower room for resident bathing on 10/11/25 (see ADON interview below) until the hot water was turned off later in the day on 10/11/25. The facility's investigation of Resident #1's burn incident included interviews with residents who also received a bath or shower on 10/10/25. Two residents reported previous sudden changes in water temperature during showers. During an inspection by an outside plumbing vendor on 10/11/25, high water temperatures were discovered in the Summit shower room, 146 degrees Fahrenheit (F), where Resident #1 received a shower on 10/10/25, and in five resident rooms (measured temperatures were 118 degrees F, 122 degrees F, 136 degrees F, 138 degrees F and 150 degrees F - see plumbing timeline below). Review of the facility's water temperature check logs during the survey revealed the facility had not checked water temperatures since 8/15/25 (see documentation below). Staff interviews during the survey further revealed staff had not received education after 10/10/25 and prior to the survey regarding residents' showers and appropriate water temperatures. Specifically, the facility failed to ensure hot water temperatures in residents' rooms and one of two shower rooms did not exceed safe temperatures. This failure resulted in Resident #1 sustaining second degree burns to 8% of his total skin surface, including his chest, back and upper right arm during a shower provided to the resident by CNA #1 in the Summit shower room.Findings include: (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: 065242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2025
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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	I. Immediate jeopardy A. Findings of immediate jeopardy The facility failed to effectively monitor hot water temperatures in residents' rooms and one of two shower rooms to ensure water temperatures did not exceed safe temperature ranges. On 10/10/25 at 3:55 p.m. Resident #1, who was completely dependent on staff for bathing and was non-verbal, was being provided a shower in the Summit shower room by CNA #1. CNA #1 noted the resident's skin was flaking off and alerted a LPN. The LPN and the ADON looked at the resident's skin, however, they did not complete a full body assessment, notify the physician of the resident's skin condition, or document the skin condition until 10/11/25. On 10/10/25 at approximately 7:30 p.m. RN #1 completed a full body skin assessment for Resident #1 and noted blisters on the resident's skin. The resident was subsequently transferred to the hospital for evaluation where he was discovered to have second degree burns over 8% of his total skin surface, including his chest, back and upper right arm. The facility continued to bathe residents in the Summit shower room on 10/11/25 until the water was shut off later that same day to determine if there was a problem with the hot water system. However, the facility failed to educate staff regarding safe hot water temperatures and the potential for burns or identify how consistent monitoring of hot water temperatures in residents' rooms and shower rooms would occur following the incident, until 10/16/25, during the survey. The facility's failure to ensure hot water temperatures in residents' rooms and one of two shower rooms did not exceed safe temperatures created serious harm for Resident #1 and the likelihood of serious harm to other residents if the situation was not corrected immediately. B. Facility notice of immediate jeopardy On 10/16/25 at 11:25 a.m. the nursing home administrator (NHA) on 10/16/25 at 11:25 a.m. was notified that the facility's failure to ensure hot water temperature in residents' rooms and one of two shower rooms did not exceed safe temperatures created a situation of serious harm for Resident #1 and the likelihood of serious harm to other residents if the situation was not immediately corrected. C. Facility plan to remove immediate jeopardy On 10/16/25 at 5:30 p.m. the NHA provided a plan to remove the immediate jeopardy situation. The removal plan read: Immediate action completed: -Resident #1 was discharged to the hospital on [DATE]. -On 10/11/25 the facility stopped use of showers until all water temperatures could be assessed by maintenance staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 10/11/25 the nursing staff completed a skin assessment on all residents to assess further skin concerns. No further concerns were identified. -On 10/11/25 an external plumbing company assessed the hot water system. Based on the assessment, it was determined facility water temperatures were out of range. The hot water was immediately shut off, and a work order was placed to correct work. -On 10/16/25, the water policy was updated to reflect safe bathing temperatures at or below 100 degrees F with monitoring and signage was updated in the facility showers to reflect water temperature range for showers. Facility plan: -A paper audit tool was created and the maintenance director (MTD) or designees will complete temperature readings upon return of hot water in all resident room sinks and shower rooms will be assessed for hot water temperatures. Temperature for sinks will be below 120 degrees F and shower rooms will be at or below 100 degrees F. -Beginning on 10/16/25, the ADON/designee will educate additional staff prior to their next shift on safe bathing temperatures to be at or below 100 degrees F, what to do if a resident skin change was identified, timely notification to a provider for follow up, and Technology Enabled Life Safety (TELS) notification system of abnormal water temperatures. -On 10/16/25 the MTD installed a wireless water temperature monitor in both showers for staff to identify water temperatures prior to and/or during showering residents. -Beginning on 10/16/25, hot water temperatures will be monitored and documented in both shower rooms and four resident rooms twice daily for 30 days; four times per week at various times of the day for 30 days; two times per week at various times of the day for 30 days; and then weekly utilizing the TELS notification system. The NHA will implement a review with the Quality Assurance Performance Improvement (QAPI) committee to review and interpret all data findings. All audit findings will be reviewed at the monthly meeting for at least three months or until the compliance pattern is maintained. The facility provided the following documentation on 10/16/25: Skin assessments were conducted on all residents and were completed by 10/13/25 for all residents in the facility. The updated Safe Water Temperatures policy was provided by regional clinical resource #1 on 10/16/25 at 6:02 p.m. along with signage posted throughout the facility. The policy and updated signage was updated to reflect safe water temperatures at or below 100F. A paper audit tool was provided by regional clinical resource #1 on 10/16/25 at 6:02 p.m. The paper audit tool included a spreadsheet to assess water temperature twice per day for both shower rooms and for four sample resident rooms. Water monitoring audits began on 10/16/25 at 6:02 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Education provided to the staff was provided by regional clinical resource #1 on 10/16/25 at 6:02 p.m. and included information on water temperature versus the time at which it could cause a burn, what changes in the skin to look for when bathing, safe water temperatures at or below 100 degrees F, staff reporting to physician within 30 minutes for any change of condition, and using the TELS system to notify maintenance of any issues. On 10/16/25 between 5:30 p.m. and 6:30 p.m. CNA #2, CNA #6, CNA #7 and LPN #1 were interviewed and confirmed they had received training on safe bathing temperatures and updated temperature monitoring equipment in the shower rooms. D. Removal of immediate jeopardy On 10/16/25 at 6:31 p.m. the NHA was notified that the immediate jeopardy was removed based on evidence of the facility's implementation of the above plan. However, deficient practice remained at a G level, actual harm that is not immediate jeopardy. II. Facility policy and procedure The Safe Water Temperature policy, revised 2025, was provided by the NHA on 10/15/25 at 9:45 a.m It read in pertinent part, It is the policy of this facility to maintain appropriate water temperatures in resident care areas. Direct care staff will monitor residents during prolonged exposure to warm or hot water for any signs of symptoms and will respond appropriately. Staff will be educated on safe water temperatures upon employment and on a regular basis. Thermometers will be available as needed for use by all staff. Staff will report abnormal findings, such as complaints of water being too cold or too hot, burns or redness, or any problems with water temperature (water is painful to touch or causes redness) to the supervisor and/or maintenance staff. Water temperatures will be set to a temperature of no more than 120 degrees Fahrenheit (F) or the state's allowable maximum water temperature. Maintenance staff will check water heater temperature controls and the temperature of tap water in all hot water circuits weekly and as needed. Documentation of testing will be maintained for three years and kept in the maintenance office. -The facility policy failed to include safe bathing temperatures for residents and safe temperature parameters in all hot water circuits. III. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included cerebral palsy, osteomyelitis of the vertebra, sacral and sacrococcygeal, cardiomegaly, shortness of breath, spastic quadriplegic cerebral palsy, dependence on supplemental oxygen, anxiety disorder, cognitive communication deficit and severe intellectual disabilities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 9/26/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The resident was totally dependent on staff assistance with showers. He required a mechanical lift with two CNAs for transfers. B. Record review The activities of daily living (ADL) care plan, initiated 1/12/24, revealed Resident #1 had an ADL performance deficit related to cerebral palsy. Interventions included total dependence for toileting hygiene, showers, transfer mobility and weekly skin inspection. A skin assessment and a weekly nursing notes, dated 10/4/25 at 12:34 p.m. that Resident #1 had no new skin issues and his skin was clear and intact. A 10/10/25 at 4:00 p.m. late entry nursing progress note, written on 10/11/25 at 10:53 a.m. by the ADON, documented CNA #1 requested that a nurse go into the shower room to assess Resident #1 during the resident's scheduled shower. The ADON noted pink discoloration of the resident's body on his right torso, chest and upper inferior arm. The progress note revealed the ADON immediately checked the water temperature which was documented as comfortably warm. A white washcloth was noted to be light brown in color and peeled skin was noted on the shower floor. The ADON lightly touched the pink area to the resident's chest with no reaction from the resident. She observed CNA #1 for a short time while she resumed the shower with no further evidence of other skin issues. A 10/10/25 at 5:00 p.m. health status note documented Resident #1 had a large skin discoloration noted to his right axillary (space between upper arm and side of the chest wall) area during his shower with no drainage noted. A 10/10/25 at 9:30 p.m. health status note revealed a further assessment of Resident #1 was completed by the floor nurse at 7:30 p.m. and noted blisters at the edges of the resident's skin discoloration drainage. The ADON and the DON were notified. The DON instructed for the resident to be sent out to the hospital. A 10/10/25 at 10:20 p.m. nurses note documented that at approximately 9:45 p.m. the facility received a call from the emergency department (ED) asking questions about Resident #1's injuries. The note documented that it was reported by the day shift nurse that the resident's injuries were discovered during showers. The hospital's concern was why it took the facility so long to send the resident to the ED for evaluation and treatment. A 10/10/25 at 9:48 p.m. ED note documented an ED RN spoke with LPN #3 at the facility. LPN #3 told the ED RN that a day shift nurse reported that during bathing, the CNA on duty had noticed that Resident #1 had skin peeling. LPN #3 stated that upon her assessment at 8:00 p.m. she noted worsening skin discoloration, called the director of nursing (DON) and then transferred the resident to the ED. LPN #3 stated the resident was not taking any new medications and was not on any antibiotics. A 10/11/25 at 1:56 a.m. nursing alert note documented Resident #1 was admitted to the trauma burn intensive care unit at the hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A 10/11/25 hospital note documented Resident #1 was brought to the ED and then transferred to a burn unit. The resident's total burn skin area (TBSA) was 8% and the location of the burns were as follows: -Chest 3% TBSA, partial thickness, second degree burns; -Back 3% TBSA, partial thickness, second degree burns; and, -Right upper arm 2% TBSA, partial thickness. A 10/13/25 hospital progress note documented Resident #1 was seen by wound care (on 10/13/25) for an initial wound assessment. Assessment of the wounds revealed the resident's right upper extremity (RUE) and right flank had full thickness burns to areas and the resident's back had partial thickness wounds. The TBSA: 8% and the burn type was a scald. IV. Facility investigation The facility's investigation of the burn incident for Resident #1 was provided by the NHA on 10/15/25 at 9:45 a.m. The investigation included the following timeline of events that occurred on 10/10/15, based on facility camera review and staff interviews: At 3:43 p.m. CNA #1 brought Resident #1 to the Summit shower room. At 3:54 p.m. CNA #1 walked out of the shower room to the nurses' station and spoke to the ADON. LPN # 2 walked back to the shower room with CNA #1. At 3:55 p.m. LPN #2 came back to the nurses' station and the ADON went to the shower room. The shower was running and the ADON took a picture of Resident #1. At 3:57 p.m. the ADON exited the shower room and spoke to a RN and CNA #2. At 4:06 pm. CNA #1 left the shower room with Resident #1. CNA #1 and CNA #2 took Resident #1 to his room and transferred him to bed. At 4:13 p.m. CNA #1 and CNA #2 left Resident #1's room and CNA #1 immediately returned, leaving again at 4:19 p.m and quickly returning to his room again. At 4:22 p.m. CNA #1 left Resident #1's room. She returned at 4:27 p.m. and removed the shower chair from Resident #1's room. -The timeline documented no staff entered Resident #1's room between 4:22 p.m. and 7:29 p.m. At 7:29 p.m. LPN #3 entered Resident #1's room with medications and exited soon after. At 7:39 p.m. LPN #3 documented the resident's vital signs were within normal limits. At 8:12 p.m. CNA #1 entered Resident #1's room with the vital signs machine. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 8:13 p.m. LPN #3 entered Resident #1's room. At 8:14 p.m the ADON called LPN #3 to send the resident out to the ED. At 8:54 p.m. EMS entered the facility and transported the resident to the ED. The facility investigation included a hot water investigation and repairs beginning 10/11/25 to 10/14/25. The investigation included the following timeline of facility plumbing and water testing and repair: On 10/11/25 at approximately 11:00 a.m. an outside plumbing company inspected the facility's boiler system. At approximately 12:30 p.m. it was discovered the facility's hot water temperatures were out of range so the hot water was shut off to determine what steps were needed to correct the water temperatures. The documented water temperatures out of range were as follows: Summit shower room was 146 degrees F (location of Resident #1's shower on 10/10/25); room [ROOM NUMBER] was 150 degrees F, room [ROOM NUMBER] was 138 degrees F, room [ROOM NUMBER] was 136 degrees F, room [ROOM NUMBER] was 122.3 degrees F, and room [ROOM NUMBER] was 118.2 degrees F. On 10/11/25 at 6:00 p.m. the plumbing company determined the mixing valve for the facility's hot water was not functioning properly. At 7:00 p.m. work began to fix the facility's hot water system. On 10/12/25 at 2:00 p.m. the plumbing company found a faulty valve that allowed hot water back into the system without going through the mixing valve and determined that the storage tanks holding water needed to be replaced. At 2:15 p.m. approval was given to replace the faulty valve. On 10/13/25 new storage tanks were delivered and re-piping of the facility's plumbing continued. The facility investigation included resident and staff interviews as follows: Resident #6's interview on 10/11/25 documented that she noticed a sudden change in water temperature previously during a shower. She said while in the shower the water would become too hot or too cold and she did not know if that was reported but it did happen sometimes. Resident #7's interview on 10/11/25 documented he had previously noticed a sudden change in water temperature during a shower and all of a sudden the water became too hot. CNA #4's interview on 10/11/25 documented that CNA #4 said with the new shower, the water got hot and (staff) had to be careful adjusting the water. CNA #8's interview on 10/11/25 documented that CNA #8 said that on full heat, the water was too hot but with an adjustment, the temperature was ok. He said the facility's water temperature fluctuated a lot. CNA #2's interview on 10/11/25 documented that CNA #2 said the facility's water was too hot if not adjusted properly. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

CNA #1's interview on 10/11/25 documented that CNA #1 said as soon as Resident #1's skin started peeling, she notified a nurse. CNA #1 said she let the shower water warm up, and then began showering and washing Resident #1 with a washcloth. She said she checked the water prior to each time she rinsed the resident. She said the resident had been in the shower approximately 10 minutes when she noticed his skin starting to slough off.

-The staff interviewed for the facility's investigation did not notify facility staff or management that the water was too hot if not adjusted properly (see interview below).

V. Facility's water temperature monitoring and documentation

The facility's water temperature check log was provided by the NHA on 10/15/25 at 3:45 p.m. The logs documented weekly monitoring of water temperatures in both facility showers, eight resident rooms, a mixing valve, two public restrooms, the kitchen and the laundry room.

-The last hot water temperature checks were recorded on 8/15/25, and there were no hot water checks or temperatures recorded after 8/15/25.

A 10/15/25 Temperature Audit Sheet was provided by the NHA on 10/15/25. Recorded water temperatures were as follows: Summit shower room was 114 degrees F, Summit shower room sink was 114 degrees F, Aspen shower room was 118 degrees F, Aspen shower room sink was 115 degrees F, room [ROOM NUMBER] was 117 degrees F , room [ROOM NUMBER] was 118 degrees F and room [ROOM NUMBER] was 117 degrees F.

VI. Observations of facility water temperatures on 10/16/25

Water temperatures from random resident rooms and common areas were checked on 10/16/25. The findings revealed the following:

At 11:10 a.m. the hot water temperature of the sink at the Summit nurses' station was measured and found to be 112.6 degrees F.

At 11:15 a.m. the hot water temperature in the secured unit shower room was measured and it was found to be 109.6 degrees F.

At 11:20 a.m. the hot water temperature of resident room [ROOM NUMBER] was found to be 104.4 degrees F.

At 11:20 a.m. the hot water temperature of Resident room [ROOM NUMBER] was found to be 107.6 degrees F.

VII. Staff interviews

(continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ADON said that Resident #1's skin was something she had not seen before. The ADON said she had not been notified of any changes to Resident #1's skin prior to seeing him in the shower and he still had soap on his body. The ADON said CNA #1 told her she did not use a different facility soap for Resident #1's shower and the water was running when she (the ADON) went into the shower room. The ADON said Resident #1 was not making any noises, and if the resident was uncomfortable he would make noise. The ADON said the pitch of the noises the resident made indicated how he was feeling. The ADON said she put on a glove and lightly touched Resident #1's skin to see if he hurt or if it was bleeding, and in one area she lightly rubbed where the pink area ended to see if any more skin would come off. The ADON said CNA #1 finished the resident's shower and she asked CNA #1 to show her what she was doing when the resident's skin sloughed off. The ADON said she observed CNA #1 rub the resident with the towel and no more skin came off. The ADON said she wanted to talk to another nurse on duty to get another opinion, ask what she should do about it and ask if another nurse had seen something similar. The ADON said she documented her assessment of Resident #1 in the shower the next day as a late entry. The ADON said she thought the resident's issue was not urgent because the resident was not bleeding and she conveyed that to the assigned nurse on duty. The ADON said she did a full body skin check at that time she went into the shower. -However, the ADON did not document the assessment until 10/11/25, after Resident #1 had been sent to the hospital on the evening of 10/10/25 (see progress notes above). The ADON said the staff used non-verbal resident's reactions to their comfort level in the shower and the staff watched for those reactions. The ADON said there was one more resident shower provided on 10/11/25 before the facility knew there was an issue with the hot water temperature. Regional clinical resource #1 said Resident #1's skin issue was a discoloration and a skin discoloration did not require urgent notification to the provider. Regional clinical resource #1 said the residents interviewed during the facility investigation were interviewed because they also had a shower on 10/10/25 (the same day as Resident #1). The NHA said there should be weekly water logs completed and the MTD was responsible for completing the logs. The NHA said he was not sure if the facility was currently completing water temperature monitoring but the previous MTD used to complete that task (prior to 8/15/25). The MTD and the NHA were interviewed together on 10/15/25 at 3:42 p.m. The MTD said he had monitored water temperatures at the facility. The MTD said he went into the shower or residents' rooms, he waited a minute or two after turning on the water and then took the water temperature. The MTD said he waited and when the water started to get hot, he would hold the thermometer in the water until the temperature stopped rising. The MTD said he checked the water temperature in residents' rooms by randomly checking different rooms and he tried not to check the same room each week. He said he checked water temperatures in residents' rooms once weekly. The MTD said he checked the shower room water temperatures once a week. The MTD said he usually checked three to four rooms in different sections of the building. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER: Brookshire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 4660 E Asbury Cir Denver, CO 80222	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-However, there was no documentation of water temperature checks since 8/15/25 (see above). The MTD said he wanted the water temperature in residents' rooms to be between 106 degrees F to 110 degrees F and in the shower rooms he might let it go to 112 degrees F or 113 degrees F or a little bit warmer. The MTD said the investigation of Resident #1's burn incident was the first time he had heard the water suddenly became hot during a resident's shower. The NHA said there were 34 resident rooms in the facility and three to four rooms was 10 percent of the total to monitor. The NHA said the facility investigation was the first time he had heard the water suddenly became hot during a resident's shower. The NHA said any staff member could use the TELS system to put a maintenance work order in. RN #1 was interviewed on 10/15/25 at 4:27 p.m. RN #1 said at approximately 7:30 p.m. (on 10/10/25) she was completing an assessment of another resident. RN #1 said she finished assessing the other resident and LPN #3 asked RN #1 to go into Resident #1's room. RN #1 said she entered Resident #1's room and LPN #3 asked her to tell her what she (RN #1) saw. RN #1 said she looked at Resident #1's right side and observed an open wound bed. RN #1 said LPN #3 said she had to take a picture of the resident. RN #1 said she continued to assess the resident and noticed the resident had an open wound bed from his right nipple to just above the groin area, going all the way back and an irregular shaped wound that went toward the middle of his spine toward his incision. RN #1 said she noticed the outer edges of the wound of the skin were rolled, like the skin had just come off and had some blisters on it. RN #1 said an unidentified CNA told her an agency nurse was previously informed about Resident #1's skin issue earlier in the day. RN #1 said she was told by the same CNA that she thought the resident was really dirty, so when his skin started coming off in the shower, she started scrubbing harder. RN #1 said she was told by the CNA that she called the nurse into the shower and the nurse informed her there was nothing wrong. RN #1 said she told LPN #3 Resident #1 needed to be sent out immediately to the hospital. She said LPN #3 was consulting the AD

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life, and resident safety.Specifically, the quality assurance and performance improvement (QAPI) program committee failed to identify and address concerns related to accidents and safety of residents in which the facility failed to ensure hot water temperatures did not exceed safe temperature ranges that rose to the level of immediate jeopardy and created a situation that a serious adverse outcome was likely.Findings include:I. Cross-reference citationCross-reference F689: The facility failed to ensure safe water temperatures, conduct and document a thorough assessment of a resident with a new skin condition and notify the resident's provider timely.II. Staff interviewsThe nursing home administrator (NHA) and regional clinical resource #2 were interviewed together on 8/16/25 at 6:00 p.m.The NHA said the maintenance director (MTD) was a newer staff member and started working at the facility in August 2025. The NHA said at that time, the Summit shower room was down and not working. The NHA said the Summit shower not working impacted the facility because the facility only had one working shower instead of two. The NHA said the MTD did take the temperature of the Summit shower on approximately 9/4/25 or 9/5/25, prior to the residents using the shower.Regional clinical resource #2 said she preferred the facility include water management to their QAPI minutes and review them at the QAPI meeting then further review everything submitted in TELS. The NHA said the QAPI committee met monthly. The NHA said each interdisciplinary team (IDT) member was to submit assigned information that he, the NHA, reviewed prior to the QAPI meeting. The NHA said the medical director attended the QAPI meeting and the IDT was required to attend. Regional clinical resource #2 and the NHA were interviewed together a second time on 10/16/25 at 6:00 p.m. The NHA said the paper audit tool created to monitor water temperatures was to be turned into him for review. The NHA said he would then scan the audit into the computer for an electronic record and keep the paper copy in the facility's plan of the correction binder. The NHA said all temperature monitoring would be sent to him for review. The NHA said the MTD knew he was supposed to be monitoring water temperatures but he did not record them. The NHA said facility staff could enter a work order into the TELS system (electronic submission system) that would be sent to maintenance to accept.