STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175456	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria	116 S Central Ave Mulvane, KS 67110

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 - Minimal harm or potential for 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** The facility reported a census of 57 residents; the sample included three residents. Based on observation, interviews, and record review, the facility failed to ensure an environment free from accidents when staff failed to assess Resident (R) 1's ability to safely manage hot liquids resulting in a hot liquid spill. This deficient practice placed R1 at risk for burns and pain.Findings included:- R1's Electronic Health Record (EHR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), and Parkinsonism (a clinical syndrome characterized by a group of symptoms including resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).R1's 01/06/25 Annual Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. The MDS documented R1 required set-up assistance for eating and oral care. The MDS documented R1 was dependent for toileting, bathing, dressing, and transfers. The MDS documented R1 had no skin conditions present.R1's 01/21/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R1required assistance with activities of daily living (ADL) and mobility. The CAA noted the care plan would address her need for assistance with personal care and mobility.R1's 06/24/25 Quarterly MDS documented R1 had disorganized thinking and an altered level of consciousness. The MDS documented R1 required moderate assistance for eating, oral care, and personal hygiene. The MDS documented R1 was dependent for toileting, bathing, dressing, wheelchair mobility, and transfers. The MDS documented R1 had no skin conditions present.R1's Care Plan dated 04/19/23 instructed staff to provide assistance with meals as needed. The plan directed staff to set up R1's tray and assist her with bites and sips as she was not consistently feeding herself. R1's Care Plan did not address the handling or management of hot liquids.R1's EHR lacked evidence the facility assessed R1's ability to safely manage hot liquids.The 06/08/25 Villa [NAME] Physician Communication documented R1 had declined and was unable to eat on her own again. On 06/11/25, the physician responded, Labs pending.R1's Progress Note dated 06/15/25 at 04:37 PM documented at approximately 10:25 AM, R1 lay in bed while staff cleaned her neck; there was a family member in the room. The note documented Licensed Nurse (LN) G assessed R1 and noted a large burn to her neck, shoulder, and ear on her right side. LN G noted a sticky substance on R1's neck, ear, and in her hair, along with a brown wet spot on the pillowcase that looked like coffee. At 10:50 AM, R1 requested a pain pill. The note documented staff were educated about not leaving hot drinks in reach of residents who were not able to safely handle them or who needed assistance with them.R1's Physician Orders dated 06/15/25 ordered Silvadene external cream (topical antibiotic medication primarily used to prevent and treat wound infections in patients with burns), apply topically two times a day to burns on the neck, shoulder, and ear. The Silvadene was discontinued on 06/18/25.R1's Physician Orders dated 06/18/25, ordered A&D ointment (a topical skin protectant ointment containing vitamins A and D, typically used to help heal and protect minor cuts, and burns) to (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the area of dryness on the right shoulder/neck and up into the hairline two times a day for exacerbation of skin condition.The 06/18/25 Physician Progress Note documented R1 sustained a burn to her right neck while trying to drink coffee in bed. The note documented orders were received for Silvadene topically, and the burn appeared to be improving at that time. The note documented that Administrative Nurse D had a discussion with the nursing staff regarding hot beverages and R1. The note documented that the burn appeared to be a first-degree burn (a burn that affects the first layer of the skin).R1's Skin/Wound Evaluation dated 06/18/25 at 04:28 PM documented a red scaly pink area measuring 13.61 centimeters (cm) by 5.85 cm and an area dimension of 59.59 cm.R1's Progress Note dated 6/18/25 at 05:16 PM documented after a review of updated pictures of the burn area with the physician and finding the area to be dry and scaly with no appearance of a burn, it was believed that the area might be more of an underlying skin condition that the resident had and not a burn. R1 will no longer get Silvadene cream on the area and will now get A&D ointment on the area per the physician, who agreed the area was not a burn at all.During an observation on 07/30/25 at 12:30 PM, CNA N picked up a cup of coffee that sat on the counter next to the coffee carafe, put a lid on the cup, and placed it on a resident's room tray. CNA N then started to walk out of the dining area. CNA N hesitated and then stated that she obtained a temperature reading of 120 degrees Fahrenheit (F.) prior to the service. Upon request, CNA N obtained a thermometer from a small cup on the counter and placed the thermometer in the coffee without sanitizing the thermometer. The coffee was 100 degrees F. Further observation of the dining area revealed a large sign with instructions for staff to obtain temperature readings of all hot liquids prior to service, and that the hot liquid temperature could not exceed 120 degrees F.On 07/30/25 at 10:10 AM, Certified Nurse Aide (CNA) M reported that she gave R1 her breakfast tray while R1 was in bed the morning of 06/15/25. CNA M reported the coffee mug had a lid on it. CNA M said she was not aware that R1 required assistance with meals. CNA M reported that she noted R1's sheets had a brown stain on them near the resident's head when she assisted R1 with care. CNA M reported that she then observed the coffee mug had no lid on it; there was coffee in the cup, and the lid was on the table. CNA M said she noted reddened skin on the right side of R1's neck and her right ear, so she got the nurse. CNA M stated that all confused residents required lids on their hot beverages, and should be in the dining room to eat, but if a resident refused, the staff would assist the residents. CNA M reported that R1 had become more confused in the past month.On 07/30/25 at 10:19 AM, CNA N reported that if a resident was not fully aware of their surroundings, shaky, and/or confused, the resident would have a lid on their hot beverage. CNA N reported some residents were care planned for covered hot beverages.On 07/30/25 at 10:25 AM, LN H stated she was unsure what the policy was regarding hot liquids before R1 spilled the hot coffee, but stated now every resident would have a lid placed on all hot beverages. LN H said if a resident was alert and oriented, they could take the lid off themselves.On 07/30/25 at 12:40 PM, Administrative Staff A and Administrative Nurse D acknowledged that none of the staff signed that they received education regarding hot liquids, except for the immediate education provided on 06/15/25, signed by the four staff members on duty at the time. Administrative Staff A reported they sent out an alert on 06/15/25 via text and email to all staff, which directed that, effective immediately, all hot liquids must have a temperature taken prior to serving and the liquid must be 120 degrees F. or lower before placing the lid on the cup and serving. Administrative Staff reported that the facility did not have a policy implemented for hot beverages yet, as she had to finish it after she completed her research. Administrative Staff A reported that there was a posting of the education for all the staff about temperatures and lids in the facility in several locations.On 07/30/25 at 01:00 PM, Administrative Nurse D reported she (continued on next page)

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