Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004410	A. BUILDING: ______ B. WING ______	C 06/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RETIREMENT VILLAGE	1740 NORTH CIRCUIT DRIVE ROUND LAKE BEACH, IL 60073

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S 000	Initial Comments Incident Report Investigation to Incident of May 29, 2017 / IL 94624-F309, F323	S 000		
S9999	Final Observations Statement of Licensure Vioaltions: 300.610a) 300.1210b) 300.1210d)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	**Attachment A** **Statement of Licensure Violations**	

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plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.
3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

1).Based on observation, interview, and record review the facility failed to assess and effectively manage pain prior to dressing changes. This failure resulted in R1 experiencing unrelieved pain during two burn wound dressing changes.

This applies to 1 of 3 residents (R1) reviewed for pain in the sample of 3.

The findings include:

R1's computerized diagnoses list shows R1 has

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dementia, depression, chronic subdural hemorrhage, and type II Dens fracture (cervical facture). R1's Minimum Data Set (MDS) dated June 6, 2017 shows moderate cognitive impairment and requires extensive staff assistance with bed mobility, locomotion, dressing, and hygiene. The same MDS shows R1 requires extensive staff assistance of one person with eating and drinking.

R1's computerized physician orders show two medication orders start dated June 23, 2016 for Norco 5-325 mg (milligram), 1 tablet, Q (every) 6 hours prn (as needed for pain) and Acetaminophen 325 mg, 2 tablets, Q 6 hours prn pain.

R1's care plan shows a focus area: 5/29/17 burn on the left and right medial thigh. The intervention section states: Cleanse left and right medial thighs using wound cleanser, apply santyl and cover with dry gauze dressing once daily until resolved. Monitor dressing once every shift, and change if saturation is more than 50%. Date Initiated: 05/31/2017.

On June 13, 2017 at 10:30 AM, R1 was lying in bed while E4 (Wound Care Nurse) was performing dressing changes to her right and left inner thighs. R1's hands were clenched and her face was set in a grimace. R1's right and left inner thighs had egg sized reddened areas with yellow slough in the centers. Clear liquid was oozing out of each wound. R1 was questioned by this surveyor how the thigh wounds occurred and replied she did not know. R1 also stated "I don't know what's going on right now. My leg hurts. Ouch!!" E4 stated she (R1) "got a thermal burn from hot tea". "It happened about two weeks ago." E4 said the burns started as redness,

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S9999	Continued From page 3 progressed to open blisters, and now have necrotic (dead) tissue. E4 was observed cleansing both thigh wounds while R1 continued to moan, "OOOOO" and "Ohhh boy!"" throughout the dressing change. R1 repeatedly said, "Don't hurt me anymore, " and "Both my legs hurt." E4 stated R1 has a prescription for (pain medication) to be given every six hours. E4 stated he did not know when R1 last received pain medication and he did not administer any type of pain medication prior to beginning the dressing changes. E4 stated R1's right and left thigh dressings are changed on a daily basis and more often if needed. E4 completed the dressing changes and exited R1's room without performing any pain level assessment or providing any pain relief treatment. On June 13, 2017 at 1:45 PM, E2 (Director of Nurses) stated signs of pain include, but are not limited to: skin redness, blistering, facial grimacing, restlessness, change in behavior, yelling out, and verbalizing pain itself. E2 said nurses should be assessing resident pain levels and giving medication if pain is present. E2 stated pain medications should be given 30 minutes prior to dressing changes to ensure pain relief can "kick in". E2 said any signs of pain should be addressed as soon as a resident expresses them. R1's June 2017 Medication Administration Record (MAR) shows no administration of Norco or Acetaminophen for the entire month, including June 13, the day of the observed dressing change. R1's MAR also shows R1 is to be assessed for pain on every shift. The pain assessment for June 13, 2017 day shift shows a pain level of zero was obtained while R1 was sleeping.	S9999		

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The facility's Policy for Pain Management dated 2012 states : 1. Resident's complaints of pain (be it Acute, Chronic, Nociceptive, Neuropathic or Incident) will be addressed promptly. Attempts will be made to address the possible cause, and treat when possible thru appropriate measures. 7. The medication and/or treatment will be administered by the nurse for the control of pain and will be monitor by both the nurse and other staff, regarding it's effectiveness.

Statement of Licensure Violations

300.610a)
300.1210b)
300.1210d)6)
300.2930c)5)
300.3240a)

Section 300.610 Resident Care Policies
a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

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b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6)All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.2930 Plumbing Systems
c) Water Supply Systems
5)Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

2).Based on observation, interview, and record review the facility failed to ensure resident safety and supervision for cognitively impaired residents when drinking hot tea.

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This applies to 2 of 3 residents (R1 and R2) reviewed for safety and supervision in the sample of 3.

These failures resulted in R1 sustaining second to third degrees burns to her thighs and R2 sustaining a first degree burn to her thigh.

The findings include:

R1's computerized diagnoses list shows R1 has dementia and depression. R1's Minimum Data Set (MDS) dated June 6, 2017 shows moderate cognitive impairment and requires extensive staff assistance with bed mobility, locomotion, dressing, and hygiene. The same MDS shows R1 requires extensive staff assistance of one person with eating and drinking.

R2's computerized diagnoses list shows R2 has Alzheimer's disease. R2's MDS dated May 29, 2017 shows R2 was unable to complete the cognitive assessment and requires extensive staff assistance with bed mobility, locomotion, dressing, and hygiene. The same MDS shows R2 requires limited staff assistance of one person with eating and drinking.

On June 13, 2017 at 10:15 AM, E9 (Dietary Aide) was in the main dining room next to a waist high coffee bar counter. E9 was observed pouring water into the top of a rectangular, insulated container marked "coffee" that was sitting on the coffee bar counter. A second rectangular insulated container was in the area labeled "vanilla coffee" and a third cylinder thermal container was labeled "hot water". E9 stated she was pouring cold water into the containers "because it is too hot when it comes out of the

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kitchen." E9 said about two weeks ago she was directed to begin the cooling down process because some resident was burned on the legs from the hot water used for tea. E9 stated coffee and hot water was being served to residents directly out of the kitchen dispensers before the cooling down process was initiated in the dining room. This surveyor requested E9 to test the temperature of the coffee and hot water in the kitchen dispensers which showed 155 degrees and 174 degrees Fahrenheit respectively. Steam was observed coming out of both mugs while temperatures were recording.

On June 13, 2017 at 10:30 AM, R1 was lying in bed while E4 (Wound Care Nurse) was performing a dressing change to her inner thighs. R1's right and left inner thighs had egg sized reddened areas with yellow slough in the centers. Clear liquid was oozing out of each wound. R1 was questioned by this surveyor how the thigh wounds occurred and she replied she did not know. E4 stated she (R1) got a thermal burn from hot tea. It happened about two weeks ago. E4 said the burns started as redness, progressed to open blisters, and now have necrotic (dead) tissue. E4 stated the burns show full thickness skin loss. E4 was questioned by this surveyor if any other residents have experienced burns from hot water temperatures. E4 stated, "Yes, (R2) was burned before (R1) but her burns weren't as bad. She spilled hot tea on herself too. "

On June 13, 2017 at 11:00 AM, R2 was observed self propelling her wheelchair in the main dining room and down the 500 wing hallway. R2 had a brown mug in her hand with a tea bag hanging out of the side. R2 stated she sustained a burn to her thigh "a few days ago I think". R2 said she got the burn due to a mug of hot tea she dropped

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into her lap. R2 said, "It was too hot."

On June 13, 2017 at 11:05 AM, R4 stated the coffee temperatures were lowered "about two weeks ago" because she heard someone got burned.

On June 13, 2017 at 11:30 AM, R3 stated liquids served in the dining room are served at a lower temperature now because "a couple people got burned." R3 stated she witnessed R2 spill hot tea into her lap while self propelling in her wheelchair. R3 said it was "two or three weeks ago."

On June 13, 2017 at 11:45 AM, E3 (Nurse Supervisor) stated two residents (R1 and R2) sustained thigh burns after spilling hot tea on themselves.
E3 said R1 was seated in the ADL section (staff assist area) of the dining room when the spill occurred. E3 stated that R1 is seated at an assistance table for cueing and supervision. E3 said R1 spilled hot tea on herself during the dinner meal. E3 stated the ADL section is supervised by Certified Nurse Aides (CNAs) during meals. At 12:40 PM, E7 (CNA) stated she was in the ADL dining room but did not see R1 spill the hot tea. At 12:45 PM, E5 (LPN) stated she was passing medication in the ADL dining room but she did not see R1 spill her hot tea. At 2:04 PM, E6 (CNA) stated he was in the ADL dining room but he did not see R1 spill her hot tea.

R1's incident report dated May 29, 2017 states: This writer was informed by dining room ADL CNA that resident had spilled hot tea on her lap. Incident was not witnessed however CNA heard her yell .....

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S9999	Continued From page 9 On June 13, 2017 at 11:55 AM, E3 stated R2 spilled hot tea on herself while self propelling in her wheelchair. E3 said R2 is able to fill her own tea mugs with hot water directly from the coffee bar counter in the dining room. At 3:30 PM, E3 stated the dining room is open "24/7" and fully accessible to all residents. E3 stated the dining room should be staffed at all times between 6 AM to 9 PM to ensure resident safety. R2's incident report dated May 23, 2017 states: Res (resident) yelling out in DR (dining room) "Help!" Staff ran in to check on resident. Resident screaming saying that she spilled coffee and its burning ..... The facility's Accident/Incident Tracking Log was reviewed with E3. E3 clarified to this surveyor that R2's burn occurred on May 23, 2017 and R1's burn occurred on May 29, 2017 (6 days later). E3 stated she did not know the temperature of the liquids being served to residents during that time period. E3 said both residents sustained the thigh burns due to the hot water used for tea. On June 13, 2017 at 12:05 PM, E8 (Dietary Director) stated she was first notified that R2 had been burned with hot tea. E8 stated that the time of R2's burn, coffee and hot water were being served to residents at "a temperature of at least 160 degrees (Fahrenheit)." E8 stated she was not performing any temperature checks on the liquids but "knew it was at least that high because it was brewing just fine." E8 said after R2 was burned she attempted to turn the temperature down on the coffee and hot water machines "but it still wasn't going down for the next five days." E8 stated the liquids continued to be available to residents in the 160 degree range. E8 stated, at that time, she did not have any upper	S9999		

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temperature she would consider too hot to serve to residents. E8 said it wasn't until R1 was burned (six days after R2) that the facility began the practice of adding cold water to coffee and tea in order to reach a serving temperature of 130 degrees Fahrenheit.

On June 13, 2107 at 1:00 PM, E1 (Administrator) stated he contacted the coffee/hot water machine manufacturer representative after R2 was burned. E1 stated the water temperature of liquids available to residents remained above 160 degrees because the representative told him brewing will not take place if the temperature is less. E1 said it was not until R1 was burned (6 days after R2) that cold water began to be added to hot tea water and hot coffee after the brew process. E1 stated he did feel that the high water temperatures caused both residents to sustain burns.

On June 14, 2017 at 1:20 PM, Z1 (Wound Physician) stated R1's thigh wounds are a deep partial loss of skin in some areas and a full thickness loss of skin in the worse areas. Z1 stated they are bad burns. Z1 stated R1 is in need of weekly wound visits until the burns are fully resolved. Z1 stated he does not routinely see residents with first degree burns.

Current burn wound classification standards rate partial thickness skin loss as a second degree burn and full thickness skin loss as a third degree burn. Burns resulting in erythema (redness) only are classified as first degree burns.

R1's Progress Note dated May 29, 2017 shows: resident had spilled hot tea on her lap ....escorted resident out of dining room to be assessed .....there was redness and blisters forming to

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S9999	Continued From page 11 bilateral inner thighs near groin. R1's wound observation reports dated May 30, 2017 show: right medial thigh wound measurement of 3.5 cm (centimeter) length, 3.5 cm width and blister is from a burn d/t (due to) spilled hot tea. R1's left medial thigh wound measurement section states: 4.0 cm length and 4.0 cm width. R2's Progress Note dated May 23, 2017 shows: res (resident) screaming saying that she spilled coffee and it's burning .....taken back to her room .....res assessed ...blister to L (left) groin. R2's wound observation report dated May 23, 2017 shows: thermal burn noted on left groin, size: 2 cm length, 2 cm width. The facility's Coffee/Water Temperature Logs were reviewed and showed an initiation date of May 30, 2017 (one day after the second resident burn). The facility was unable to provide any policy relating to coffee or tea temperatures prior to the May 2017 burn incidents. The facility did provide a Food Preparation Policy dated May 30, 2017 that states: water temps. Not to exceed 130 degrees in dining room coffee and tea served. (A)	S9999		