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	IL6013361	A. BUILDING: _____ B. WING _____	C 07/13/2015

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LEXINGTON OF LAGRANGE	4735 WILLOW SPRINGS ROAD LA GRANGE, IL 60525

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a)b)d)6 300.1220b)3 300.3240 a)d) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999	Attachment A Statement of Licensure Violations	

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provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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. Restorative measures shall include, at a minimum, the following procedures:

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders,

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S9999	Continued From page 2 and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to follow their policy for monitoring and serving hot beverages to prevent burns, failed to monitor residents requiring assistance with activities of daily living, and failed to report 2 incidents of burns for 2 of 3 (R2,R3) residents reviewed for incidents and accidents. This failure resulted in R2 and R3 sustaining 1st and 2nd degree burns after spilling hot beverages on themselves. Findings include: On 7/7/15 at 12:45pm in the second floor dining room, E26(Server) took the temperatures of the coffee and hot water for tea being served to the residents. The coffee was 149 degrees	S9999		

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Fahrenheit (F) and the hot water was 163 degrees F. When the hot water was poured into the plastic cup, small bubbles formed around the inside of the cup and steam continuously billowed from the surface of the water. The hot water temperature was very uncomfortable and too hot to tolerate during 3 seconds of submersion of surveyor's right index finger. E26 stated the hot water was "too hot" to serve. E26 stated this is the second carafe of hot water being served to residents and the temperature was not checked prior to serving. Review of 2nd floor dining room temperature log documents a temperature for the first carafe of hot water and none for the second. This was verified and confirmed by E26.
On 7/7/15 at 1:05pm in the kitchen after lunch service, the coffee containers and hot water carafes for both dining rooms were brought into the kitchen. E28(Server) took the temperatures of the coffee and hot water from the 1st floor dining room. The coffee measured 120 degrees F and the hot water measured 165 degrees F. Review of 1st floor dining room temperature log documents the hot water temperature to be 154 degrees F and 156 degrees F. E27(Dishwasher) stated he prepared and brought the coffee and hot water to the floors before lunch. Before leaving the kitchen, the temperature of the hot water was 150 degrees F, but E27 did not document it anywhere. E27 stated the temperature of the water should have been measured and recorded upon arrival to the floor, before serving to residents. E26, E27, E28, and E5(Food Service Supervisor) could not explain or account for the increase in the temperature of the hot water.

Closed record documents R2 was admitted to the facility on 6/3/15 with a diagnosis of generalized muscle weakness. Minimum Data Set (MDS)

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6/15/15 Section C Cognitive Patterns documents R2 is alert and oriented; Section G Functional Status documents R2 needs limited assistance with one person physical assist for locomotion in the wheelchair around the unit, supervision with one person physical assist for eating, and uses a wheelchair; Section I Active Diagnoses document general muscle weakness as an active diagnosis. Care Plan Report documents R2 requires extensive assistance with activities of daily living due to weakness, poor endurance, and impaired mobility. Interventions include to supervise/assist R2 during mealtimes one to one and as needed. R2's entire care plan was reviewed and there is no care plan regarding the right thigh burn sustained on 6/18/15 or when treatment started on 6/23/15.

Nurse Note 6/19/15 4:10am, late entry for 6/18/15 1:15pm, R2 reported hot tea spilled on the right thigh, assessment notes a "5.5 in area appeared red with no blistering." An ice pack was given to R2 and Z2(Nurse Practitioner) was notified. Nurse Note 6/19/15 2:18pm documents no changes in the right thigh burn. The next nurse note assessing the right thigh burn is 4 days later on 6/23/15 at 1:12am, E29(Nurse) documents the right thigh burn is an open wound and the physician was notified. Skin Eval 6/23/15 12:35pm documents E4(Wound Nurse) was asked to see R2 for the right thigh burn. The burn is assessed as 7 x 12 centimeters (cm) with wound bed covered in "yellowish slough throughout", reddened around the wound, scant amount of drainage, and R2 had discomfort during assessment. Z2 was notified and assessed R2. Nurse Practitioner Progress Note 6/19/15 9:03am, documents R2 spilled hot tea on the right thigh by accident, reports mild pain and discomfort. Right thigh burn is documented as

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redness involving epidermis noted on the upper/anterior thigh measuring 12 x 6 cm, no visible blisters at this time, however the skin over is very fragile and it is unclear whether the blisters won't form later today. Documented 1st degree burn, no blisters at this time, however, "?" 2nd degree due to presentation of the skin. If blisters noted later today, will order silvadene cream. Physician Order Sheet June 2015 documents an order for antibiotic ointment to the right thigh 6/23/15. There are no other orders for treatments to R2's right thigh burn. June 2015 Treatment Record documents a treatment of topical antibiotic ointment initiated on 6/23/15 to the right thigh. Wound Assessment dated 6/22/15 (locked 6/23/15 12:45am) documents a right thigh burn wound as 3rd degree was identified on 6/19/15, it has 10% non-granulating tissue and 90% slough, measuring 7 x 12 cm, and related to coffee spilled on thigh 4 days ago and the area is now open. Nurse Practitioner Progress Note 6/23/15 documents R2 was seen upon nursing staff request, R2 had a 1st degree burn last week that turned out now to be an open wound. Right thigh large open wound, center covered with yellow slough. Physician was notified by nurse Practitioner, antibiotics started orally and topical to the wound. Nurse Practitioner Note 6/29/15 documents R2 will be discharged home 6/30/15, the right thigh burn is getting smaller and does not hurt anymore. Initial/Final Report 6/25/15, 2 days after the wound was noted as a change in condition and 6 days after the incident occurred on 6/18/15, documents R2 was in the dining room for lunch, poured self a cup of tea and some of the tea spilled on the right upper thigh. R2 returned to the room, seen by the nurse practitioner, identified with a first degree burn, treatment ordered, wound care nurse to monitor, care plans and assessments updated. The report

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does not include information to clearly identify a timeline or dates of orders to clarify a sequence of events.

On 7/7/15 at 3pm, R3 stated the burn from the hot tea was "a whole story itself", the tea "was very, very hot, too hot!" Grievance Form 6/16/15 documents a concern about treatments to a burn on R3's leg. Nurse Practitioner Note 5/24/15 documents a 1st and 2nd degree burn lower abdomen and right inner thigh. Nurse Note 5/24/15 documents R3 reporting spilled tea at lunchtime. There is no additional documentation of the burns. No accident/incident report has been completed or reported to the Illinois Department of Public Health (IDPH). Presentation of Incident Accident Report 7/7/15 from incident of 5/24/15 documents R3 spilled tea on self during lunch. Inservices 7/7/15 for incident and accident investigations presented along with witness statements.

The following interviews tookplace on 7/7/15:
At 12:30pm, E4(Wound Nurse) stated R2 spilled hot tea on 6/19/15. The burn was red and did not blister right away, it blistered 2 days later. The nurse Practitioner was notified and treatments started 6/23/15.
At 1:45pm, E5(Food Service Supervisor) stated an inservice was conducted on 6/25/15 after the burn to remind staff to check the temperature of hot liquids before serving. Another inservice was conducted on 7/7/15. E5 stated lids are available to put on the cups if residents take them out of the dining area. E5 did not have an explanation for the discrepancy in hot water temperatures on 7/7/15.
At 4:30pm, E2(Director of Nursing) stated staff is instructed to fill out incident reports for any

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unusual occurrence that hurts the resident. "A burn would be reportable to IDPH."

The following interviews took place on 7/8/15:
At 10:10am, E2 stated she was not aware of R2's burn until 7/7/15. An investigation was started and the staff were inserviced on filling out incident and accident reports. Care plans should be initiated and updated for injuries or new treatments, only residents that are alert and oriented were able to serve themselves. Now only staff can serve hot liquids. E2 stated the temperatures of liquids should be checked prior to service. Water temperature should decrease over time, not increase. E2 stated R2 was carrying a cup of hot tea while self propelling the wheelchair with her feet.
At 11:30am, E13(Nurse) stated on 6/19/15 the area on R2's right thigh was 3-4 cm red, not open, and without blisters.
At 11:35am, E12(Nurse Aide) stated R2 got her own cup of tea, no one saw her getting it. R2 propelled herself in the wheelchair, the tea spilled and burned her leg. Residents are not allowed to get their own hot beverages anymore.
At 12:40pm by phone, Z1(Nurse Practitioner) stated R3's burn blistered right away, it was a 2nd degree burn from the hot temperature of the liquid spilled. R3 had fragile skin and a longer sustained contact time of the hot liquid affected the extent of the burn. With a very hot beverage plus fragile skin, it does not take a long time to sustain a burn like R3. Z1 stated the facility should have and follow safety checks to monitor and serve hot beverages.
At 1:10pm, Z2(Nurse Practitioner) stated R2 initially had a 1st degree burn measuring 12 x 6 cmto the right thigh. Due to the large area affected and the condition of the burn, Z2 suspected blisters could occur. Z2 instructed staff

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to monitor the burn for worsening signs such as blisters, open areas, or increased redness, and notify her right away for treatment orders. Z2 did not see the burn until 4 days later when it appeared as a worsening burn, open, and covered in yellow slough. Z2 notified the physician that the burn looked "much worse" and ordered a topical treatment, oral antibiotics, and blood work to check for infection. Z2 stated R2 does not have fragile skin, malnutrition, or other factors that would make her more susceptible to burn from hot liquids. R2's burn was severe due to the temperature of the beverage and the length of time on the skin. Z2 stated R2 has physical limitations, R2 should not have been carrying the hot liquid while self propelling in the wheelchair. Z2 stated the facility should be monitoring and serving the liquids according to their policy.
At 3:05pm, E20(Nurse) stated R2's burn was unchanged on 6/20/15. E20 was instructed to monitor the burn for infection, worsening condition, blisters, or open areas.
At 3:55pm, E18(Nurse) stated when she first took care of R2 and saw the burn on the right thigh, it was already open and covered with white slough. R2 told E18 that it happened "a few days ago". E18 stated she did not do a treatment on her shift and no one else did one either. Review of the schedule documents E18 was assigned to R2 on 6/20/15, 2 days after the burn occurred but 3 days before any treatment was ordered.

Inservice titled "Hot Beverages 135-155 degrees" was conducted on 6/25/15 and Inservice titled "Food and Beverage Temperatures" was conducted on 7/7/15.
Flyer in the kitchen is titled "Reminder! Take Your Temperatures!!! All Hot Beverages & Soup 135-155 degrees F".
Food Temperatures policy - Hot beverages and

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S9999	Continued From page 9 soups will be held between 135-155 degrees F. Areas where coffee will be served will be monitored. Wound Documentation Best Practices policy - Wound Nurse or designee assesses wounds within 24 hours of admission, nurses note as needed for worsening wound, full wound assessment weekly. Skin Management policy - The care plan is developed based on the individual risks and needs of the resident. Interventions are developed based on the assessment information and are interdisciplinary in content. Accident and Incident Documentation and Investigation policy - The investigation process assists the interdisciplinary team to develop plans or programs to prevent further incidents. The circumstances surrounding the event will be documented in the medical record. Determine what changes, if any, need to be taken to prevent another event and make changes in the plan of care as necessary. Report to IDPH as required. Change in Condition policy - Notification of the physician, legal representative, or interested family member should occur promptly when there is a change in the resident's condition, such as, a change in the resident's physical, mental, or psychosocial status or a need to alter treatment. The plan of care is altered to reflect a change in condition and new goals and approaches being considered when indicated. (C)	S9999		