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	IL6006845	A. BUILDING: _____ B. WING _____	C 01/09/2024

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S 000	Initial Comments Complaint Investigation: 2490001/IL168279	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.2210b)1) 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	S9999		

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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 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. (Section 3-202.2a of the Act)

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 300.2210 Maintenance

b) Each facility shall:

1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or

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S9999	Continued From page 2 loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards. These requirments were not met as evidenced by: Based on observation, interview, and record review facility failed to provide a hazard free environment by allowing resident to be exposed to a stationary floor block heater near resident's bed after a fall for 1 of 3 residents (R1) reviewed for accidents/hazards in the sample of three. As a result of this failure, R1 laid on the floor for an undetermined amount of time in contact with the heat source. R1 was emergently sent to the hospital, and treated for second-degree burns and pain management. Findings include: According to R1's face sheet, R1 is a 76 year old female admitted to the facility on 12/02/2021 with diagnosis including but not limited to severe dementia, Alzheimer's disease, anxiety, and diabetes. According to R1's MDS (Minimum Data Set) assessment dated 12/01/2023 under section C, R1 has BIMS (Brief Interview of Mental Status) score of 4 indicating severely impaired cognition. According to R1's MDS (Minimum Data Set) assessment dated 12/01/2023 under section GG, show R1's functional ability is "Dependent - helper does all of the effort, to roll left and right on the bed".	S9999		

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Fall assessments dated 11/24/2023, 11/27/2023, and 01/02/2024 place R1 in category: At Risk For Falls.

R1's fall care plan dated 12/01/2021 reads in part, "Educate resident/family/caregiver of possible negative outcomes r/t (related to) non-compliance; Encourage resident to be compliant with care." Based on R1's MDS assessments, these interventions may have been inappropriate due to R1's lack of cognitive capability.

According to R1's progress note dated 01/02/2024 2:00 AM written by V6 (Licensed Practical Nurse) reads in part, "When (V7 CNA) was doing rounds, (V7 CNA) found the resident on the floor close to the heater and called (V6 LPN) attention. (V6 LPN) went to check on resident immediately, head to toe assessment was done noted resident blister formation and redness of the right side of her body. Resident was unable to describe what happened. (V8 NP) was also made aware with new orders made to send out resident to ER (emergency room) for evaluation."

According to R1's progress note dated 01/02/2024 10:24 AM written by V11 (MDS Registered Nurse) reads in part, "Writer called (local) hospital, and got information that resident was transferred at the Burn Center of (local) Medical Center. The resident is at their Burn Intensive Care Unit."

On 01/02/2024 at 11:10 AM Surveyor observed R1's room. Bed in the lowest position, "scoop" mattress present, fall mat on the left side of the bed, bed placed parallel to the wall underneath the window with radiator adjacent to the right side

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of the bed frame. Radiator warm to touch. Floor block radiator about 4 inch thick with metal, factory cover in place. Bed positioned about 8 inches away from the radiator, creating about 12 inch gap between wall and R1's bed. Radiator exposed to the environment, no additional cover present at this time to prevent any resident from coming in contact with the surface. R1 currently at the hospital, not available for observation or interview during this investigation.

V3 (Plant Operations Manager) presented room and radiator temperature log dated 01/02/2024 (no time) that showed temperature in R1's room at 72 degrees Fahrenheit and radiator temperature at 83 degrees Fahrenheit.

On 01/02/2024 at 11:32 AM Surveyor observed V3 checking radiator temperatures with IRT207 infrared thermometer: R1's room radiator temperature: 81 degrees Fahrenheit.

Operation Manual for IRT207 infrared thermometer reads in part: "The product can only be used to measure body temperature simply for reference."

On 01/02/2023 at 11:18 AM Surveyor interviewed V4 (Registered Nurse) who related the following in summary: When I came in this morning (01/02/2024) at 7:00 AM, V5 (Licensed Practical Nurse) relayed in the hand off report that R1 fell to the right side of the bed. V5 (LPN) said "they" found R1 with superficial redness to the right side and called 911. V5 (LPN) did not specify details of the incident. R1 was sent out to the hospital around 2:30 AM. R1's bed is positioned right against the wall; however, the radiator is somewhat thick and creates a gap between the bed and the wall. R1 has dementia, does not

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speak fluent English, and generally does not talk. Even when we assess R1 for pain, we go by facial grimacing. R1 is not able to use a call light or call for help, that's why she is in the room across from the nursing station to constantly check on her. Nurses check on R1 throughout the shift, during medication administration, blood glucose checks, tray delivery, and feeding assistance. There is no particular schedule for rounding; however, R1 requires more attention, so we check on her more often than every two hours. R1 was doing just fine when I was leaving yesterday (at 7:00 PM)."

On 01/02/2024 at 12:01 PM Surveyor interviewed V3 (Plan Operations Manager) who related the following in summary: Our heating system contains of a boiler that is set to ambient temp of 73-80 degrees Fahrenheit. There is a differential of 7 degree, for example, if the temperature outside drops, the differential will go up by 7 degrees. Boiler temperature never goes over 80 degrees Fahrenheit or below 73 degrees Fahrenheit, that's how temperature is maintained in the whole building. When I came in this morning (01/02/2024), and measured temperatures in the whole building, radiator temperatures were somewhere between 75 - 79 degrees Fahrenheit. We just started monitoring radiator temperatures today.

On 01/02/2024 at 12:48 PM Surveyor interviewed R2 (R1's roommate) who related the following in summary: R1 moved around in the bed a lot, that's why they have this mat on the floor. R1 can barely talk, and if she does, it's very soft and hard to hear. Even if R1 called for help, I wouldn't be able to hear her. I didn't hear R1 fall, but I had TV on, so that's probably why. I don't remember if there was anybody coming into the room

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throughout the night to check on us."

On 01/02/2024 at 3:02 PM Surveyor requested to review video of the hallway adjacent to R1's room from the night of the incident to verify frequency of monitoring R1 by night staff, V1 (Administrator) said, "I cannot let you access our system; you can't review the recording."

On 01/03/2023 at 10:05 AM Surveyor interviewed V6 (Licensed Practical Nurse) who related the following in summary: I worked night shift 01/01/2024 to 01/02/2024, at the time of the incident. I worked with one CNA that night. Normally we have two CNA's at night. We had no chance to take a break and neither of us fell asleep that night. I initially saw R1 around 7.30 PM during my rounds. I then saw R1 around 9:00 PM during blood glucose check and insulin administration, and then again around 00:15 AM when I assisted R1's roommate back to bad. At all times, R1 was laying on her back in the middle of the mattress. Generally, R1 sleeps overnight and doesn't move around that much; however, R1 has enough strength to roll off the bed. R1 is at risk for falls, so her bed was in the lowest position. V7 (Certified Nursing Assistant) was doing rounds around 2 AM that night and told me that R1 fell. I went into R1's room and I saw her laying on the floor, on the right side of the bed, between the bed and the radiator with her right side touching the radiator. V6 (CNA) and I pushed the bed further away and moved R1 to prevent her from touching the radiator. I assessed R1 while she was on the floor. I saw redness and blisters on her right side. I quickly notified V2 (DON) and V8 (Nurse Practitioner), and I was instructed to call 911. I also notified R1's Power of Attorney while waited for the ambulance. I don't remember the exact time of

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911 call, but it was immediately after I assessed R1 and spoke to V8 (NP). The ambulance arrived around 3:00 AM. There was nothing unusual about positioning of R1's bed on my shift. We always had some space between the bed and the radiator to make sure the bed is not touching it. I'm not sure why the bed was supposed to be away from the radiator. I am not sure how hot was the radiator that night, but we don't control its temperature.

On 01/03/2024 11:01 AM Surveyor interviewed V7 (Certified Nursing Assistant) who related the following in summary: I have been working in the facility for five years now. R1 was admitted about 3 years ago. R1 has never been able to talk, and she prefers to speak Polish. Generally, R1 sleeps at night but she has tendency slide off the bed. That is why, R1's bed is always in the lowest position with fall mat on the left side of the bed. There is not enough space on the right of the bed to place a fall mat. The bed is not too close to the wall on the right side because there was a concern that R1 might get burnt from the radiator, that is to the right of the bed. When I came in (on 01/02/2024) at 11:00 PM, R1 was in bed. Then I checked on her around 1:00 AM was in the bed. Both times R1 was in the middle of the bed, laying her back. At around 2:00 AM, I found R1 laying on the floor with her right side touching the radiator. I called V5 (LPN), we picked her up and put her back in the bed. V5 (LPN) then did his assessment and notified V2 (DON), V8 (NP), and R1's Power of Attorney. I am not sure what time the ambulance came, I don't remember; I saw R1's injury, the redness, and imagined the pain she must have been in. I burnt myself while I was cooking, so I know how painful that is.

On 01/03/2023 at 12:40 PM Surveyor interviewed

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V8 (Nurse Practitioner) who related the following in summary: Facility staff called me on 01/02/2024 around 2.30 - 2.45 AM. They said that R1 had fallen out of the bed but had no head injury. I decided to send her to the hospital for further evaluation because, in the past couple of weeks, R1 was dehydrated, needed some IV fluids, and her conditioned declined all together. I wanted to stay on the safe side. I wasn't made aware R1 sustained 2nd degree burns during the fall incident, this is the first time I hear about it. R1 could have sustained 2nd degree burns from touching radiator within 10-15 minutes or even less. R1 had extra fat tissue but not a lot of muscle which would make her more at risk to sustain severe burns.

On 01/03/2024 2:32 PM Surveyor interviewed V9 (Burn Intensive Care Unit Nurse Practitioner) who related the following in summary: I have been taking care of R1 since she was admitted to the burn unit earlier today (01/02/2024). R1 was admitted with diagnosis of burn - 2.5% of body surface area. R1 had to be transferred from the local hospital to higher level of care due to the burn injury itself. R1 sustained partial thickness with some full thickness burns and had to be evaluated in our burn unit. R1 has scattered burns to her back side and chest, including right armpit, right breast area, right upper and lower flank. Majority of those are partial thickness with some full thickness burns. R1 did not need to be exposed to the radiator for extended period of time, her age alone and limited mobility would increase her risk to sustain 2nd degree burns.

R1's hospital record dated 01/02/2024 reads in part, "R1 was taken via ambulance to the emergency room on 1-2-2024 at 3:48 am and was diagnosed with superficial partial thickness

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burn of the abdominal wall, upper extremity: right shoulder, right arm, right flank, right breast, and right lower flank. Approximately 10% partial thickness thermal burns, (R1) found near the radiator. Pain management:1. At 4:51 am with fentanyl solution 50mcg (micrograms), 2. At 7:28 am Morphine Sulfate 2mg/ml (milligrams/milliliter). R1 was transfer to a local hospital (2) burn Intensive Care Unit at 8:35am (higher level of care)."

On 01/03/2024 at 2:58 PM Surveyor interviewed V10 (Nurse Consultant/ acting DON) who related the following in summary: I came into the facility on the morning of 01/02/2024. V1 (Administrator) and I spoke to both, V6 (LPN) and V7 (CNA) who were both working at the time of the incident. Our investigation included: log sheet of all radiator and room temperatures including audits; statements from V6 (LPN), V7 (CNA), and family; risk management; facility wide fall risk audit; and blueprint of all the rooms and bed placements. Based on initial investigation there is no conclusion that pertains to what had happened. I have been a nurse for 15 years and I have never come across anything similar in my career. We had R1's bed in low position, fall mat, scoop mattress, and round on her; therefore, interventions that were implement were satisfactory, but something still went wrong. I think it is a tragic accident, but staff fulfilled my expectations. I don't think this is anything we could have been predicted. We try to keep beds away at safe distance from the radiators. If R1 returns to the facility, she will be placed in another room. R1's bed was moved for contractor to have access to the radiator. The family is very upset and doesn't want R1 to come back to the facility.

On 01/03/2024 at 3:28 PM Surveyor interviewed

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S9999	Continued From page 10 V1 (Administrator) who related the following in summary: The incident was brought to my attention yesterday (01/02/2024) at 8:00 AM. I was told that V2 (former DON) was involved and R1 was sent out to the hospital. It was a terrible accident. We don't have any conclusion to our investigation; however, we cannot be in the residents' room all the time or have heat off in the wintertime. I don't think this could have been prevented. My expectation for staff is to continue to monitor residents and radiators' temperatures to make sure this doesn't happen again. V1 (Administrator) said that there is no "Radiator Safety" and/or "Heating System" policy per surveyor's request. V1 (Administrator) presented "Fall Prevention Program" policy dated 11/21/2017 that reads in part, "The resident will be checked approximately every two hours, or as according to the care plan, to assure they are in a safe position. The frequency of safety monitoring will be determined by the resident's risk factors and plan of care." (A)	S9999		