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	IL6008361	A. BUILDING: _____ B. WING _____	C 11/15/2023

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WYNSCAPE HEALTH & REHAB	2180 MANCHESTER ROAD WHEATON, IL 60187

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S 000	Initial Comments Facility Reported Incident of 10/31/23/IL166589	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to have precautions in place to ensure a resident was free from serious injury after being served hot liquids. This failure resulted in R1 spilling hot coffee onto his lap and sustaining second-degree burns on his right and left inner thighs. This applies to 1 of 3 residents (R1) reviewed for accidents in the sample of 3. The findings include: On November 13, 2023, at 10:15 AM, R1 was sitting in the dining room in his wheelchair. R1's black pants had dried food and a dried white dripped substance over much of R1's bilateral thigh area. R1 was drinking water from a small, uncovered drinking glass. No other food items were present. R1 was not interviewable due to	S9999		

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S9999	Continued From page 2 his cognitive status. R1 was not able to recall the incident where he spilled hot coffee on himself on October 31, 2023. V5 (OT-Occupational Therapist) was standing near R1 and explaining to the resident it was time to receive occupational therapy. R1 required redirection by V5 to go to therapy. R1 kept getting off track while talking, and frequently asked about his newspaper. V5 (OT) said, "[R1's] tremor is minor, but his coordination is worse, especially when bringing items from the table to himself." V5 was not aware of R1's recent burn incident. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on October 26, 2023, with multiple diagnoses including, spinal stenosis, Parkinson's Disease, polyneuropathy, heart disease, generalized anxiety disorder, unsteadiness on feet, dysphagia, muscle wasting and atrophy, lack of coordination, cognitive communication disorder, bladder cancer, and left femur fracture. R1's MDS (Minimum Data Set) dated November 1, 2023, shows R1 has severe cognitive impairment. The MDS continues to show, upon admission to the facility, R1 was able to eat with supervision or touching assistance. The facility's Event Report dated October 31, 2023, at 7:20 AM shows: "Resident Statement: I spilled hot coffee on my thigh. I tried to drink and hold the cup, but I accidentally spilled it." The report shows the incident occurred in the facility's dining room. The report continues to show there were no witnesses to the event. The report shows R1 sustained an approximately 4 x 4 cm. (Centimeter) deflated blister to his left inner thigh and an approximately 2 x 3 cm. deflated blister to his right inner thigh.	S9999		

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S9999	Continued From page 3 The facility's Wound Assessment, completed by V2 (DON-Director of Nursing) on October 31, 2023, at 12:49 PM, shows R1 had a facility-acquired, second-degree burn on his right anterior thigh. The wound assessment continues to show the wound size measurement was 1.50 cm. long by 1.10 cm. wide by 0 cm. deep, with 30 percent intact skin, and 70 percent bright red (beefy) skin. The facility's Wound Assessment, completed by V2 (DON) on November 6, 2023, at 12:24 PM, shows R1's right thigh burn wound size was 11.0 cm. long by 3 cm. wide by 0 cm. deep, with 20 percent intact skin, and 80 percent of the wound bright beefy red. The Wound Assessment continues to show "Wound Note: 3 patches all next to each other. Wound Status: Active. Probable Outcome: Probable decline." The facility's Wound Assessment, completed by V2 ((DON) on October 31, 2023, at 12:58 PM, shows R1 had a facility-acquired, second-degree burn on his left anterior thigh. The wound assessment continues to show the wound size measurement was 3.70 cm. long by 2.50 cm. wide by 0 cm. deep, with 30 percent intact skin, and 70 percent bright red (beefy) skin. The facility's Wound Assessment, completed by V2 (DON) on November 6, 2023, at 12:26 PM, shows R1's left thigh burn wound size was 8.50 cm. long by 2.50 cm. wide by 0 cm. deep, with 35 percent intact skin, and 65 percent of the wound bright beefy red. On November 13, 2023, at 12:59 PM, R1 was lying in bed. V7 (Spouse of R1) was also present in the room. V7 said, "Once in a while, when we	S9999		

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are at home, [R1] drops things while eating. We use a covered mug for all drinks at home." V2 (DON) uncovered R1's legs and showed two large dressings, covering R1's right and left inner thighs. The dressings were dated "11/12/23". V2 removed the dressings and showed the bilateral burn wounds on the inside of R1's right and left thighs. V2 did not measure the wounds or apply treatment. R1 requested the wounds be left open to air and he be allowed to take pain medication prior to V2 administering treatment. The burn wounds were red around the outside of the wounds, with pale, yellow skin towards the center of each wound. There were multiple wounds on R1's right and left inner thighs, all varying shapes and sizes. The largest burn area appeared approximately four inches long by approximately one inch wide.

On November 13, 2023, at 2:00 PM, V8 (Son of R1) said, he was upset R1 sustained burns on his legs from spilling coffee on himself. V8 said, "Who gives a confused man with Parkinson's disease a cup of hot coffee without a lid on it?"

On November 15, 2023, at 9:11 AM, V12 (Dietary Aide) said, "On October 31, 2023, [R1] was sitting in his wheelchair at a table in the dining room. It was early in the morning, before breakfast was even served. He was sitting closer to the area we call the pantry which has a large window between the dining room and the kitchen. He was not near the nurse's station. It is hard to see the nurse's station from where [R1] was sitting. [V14] (Cook Helper) was in the pantry. No other staff were present in the dining room with me. I believe there were two other residents in the dining room at the time. They both asked for coffee, so I served them coffee also. That day was the first time I met [R1]. I did not know him. He asked

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me for a cup of coffee. I used the coffee dispenser in the dining room. The dispenser makes one cup of coffee at a time, and we serve the coffee in a coffee mug. I served the coffee to [R1] black. I did not add cream or sugar. I did not put the coffee in a covered mug. After I served the coffee to the resident, I left the dining room. No other staff took over for me or stayed in the dining room with the residents. When I came back to the dining room, [R1] had already spilled the coffee on his lap and two nurses were taking care of him."

On November 13, 2023, at 2:16 PM, V4 (ADON-Assistant Director of Nursing) said, "I was the nurse working when [R1] spilled the coffee on himself on October 31, 2023. I was sitting in the nurse's station waiting for the nurse from the next shift to take over for me. I had worked the night shift. [R1] was up around 6:30 AM. I was the night nurse, and I know I gave him his medication around that time. The dietary staff served the coffee to [R1]. The dietary staff was there to prepare the food and serve the liquids to residents. Dietary staff do not supervise the residents. No staff was in the dining room supervising the residents when [R1] spilled the hot coffee. I saw him flinch and I ran to him right away. He had spilled hot coffee in his lap. I got a towel and put it inside his pants. We took him to his room and changed him right away. When we removed his pants there were already blisters on his thighs and some open skin areas."

On November 13, 2023, at 11:07 AM, V2 (DON) said, "[R1] is new to us. The morning that he spilled the coffee (October 31, 2023), [V4] (ADON) was here. He asked for a cup of coffee. He was given the coffee by a dietary aide. He spilled the coffee on his lap. [V4] removed his

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S9999	Continued From page 6 pants and saw he had blistering on his thighs right away. I want to say they applied cool cloths to his skin. Maybe an hour or two later I came, and I assessed him. The blisters were red and opened at that point. I applied a treatment. His physician came the next day and saw him. His wife comes here every day after breakfast. She was not here when he spilled the coffee because it was before breakfast. He was in the dining room when it happened." On November 13, 2023, at 3:13 PM, V11 (Therapy Director) said, "I am familiar with [R1]. He usually lives in our independent living area, and I have been to his apartment in the past to provide therapy. He is very confused at times. At times he needs cues and supervision that everything is safe. He needs to have eyes on him and make sure he is doing well. He has some coordination deficits. For instance, when we give him a cone during therapy, and ask him to place it on the table in front of him, sometimes he cannot do that due to his lack of coordination. He isn't really a person with tremors. There are just times where there is inattention and a coordination thing. Sometimes he misjudges something, and he loses his coordination a bit. Because of the variance in his cognition, he needs supervision and cues at times. He needs more supervision, and that is why he cannot eat alone in his room. His motor impairment has become more pronounced. He has decreased motor control of his left leg. He cannot move his left leg out of the way, if, for instance, he was spilling something and trying to avoid the spill." On November 14, 2023, at 1:13 PM, V1 (Administrator) said, "We do not have a policy on hot liquids handling."	S9999		

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S9999	Continued From page 7 On November 14, 2023, at 1:43 PM, V9 (Physician) said he knows R1 well and has known him for a few years. V9 said he has seen R1 at his independent living apartment prior to coming to the facility. V9 continued to say R1 spilled coffee on himself in the dining room and sustained second-degree burns on his inner thighs from the coffee. On November 15, 2023, at 11:25 AM, V15 (Territory Sales Manager) said, it is up to the facility to have their own safety system in place to ensure no one gets burned from hot coffee. "I think it is a known thing that hot coffee is coming from the coffee machine. Usually nursing homes have a CNA (Certified Nursing Assistant) working or someone watching to keep residents safe from burns. Other options are to set the coffee cups off to the side and let them cool five minutes or so and the coffee temperature will drop ten to twenty degrees before it is served. Sometimes facilities point fingers at us or blame the machine. It is a hot beverage, and the facilities need to have precautions in place, and train and educate their staff when serving to nursing home residents." (B)	S9999		