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S 000	Initial Comments FRI of 6/13/24/IL175072	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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 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		

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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 interviews, observations and record review, the facility failed to provide adequate supervision to 1 (R4) of 3 (R1, R3 and R4) residents and the physical enviornment review for accidents, this failure resulted in R4 gaining access to the laundry room, that should have been locked, and once R4 gained entry to the laundry room, the facilty's lack of supervision allowed R4 to gain access to a laundry detergent that spilled on his right foot causing a chemical burn that required treament at the local hospital.

Findings include:

R4's electronic medical record indicated resident admitted to facility on 05/01/2023 and has a past medical history not limited to: bipolar type schizoaffective disorder, depression, anxiety, burn of unspecified degree of right foot, iron-deficiency anemia, and age-related physical debility.

Facility final incident report dated 06/29/2024 indicated R4 reported to nurse that he had

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blisters on his right foot. R4 complained of a burning sensation to his right foot after some detergent fell on his shoe while washing some items. R4 was rendered first aide at facility, then sent to a local emergency room and later returned to facility with diagnosis of a chemical burn to his right foot with treatment orders and follow-up to a burn clinic.

Hospital records dated 06/23/2024 indicated R4 presented to local emergency room from facility with complaint of "spilling powered bleach onto right foot". R4 was seen by V12 (Medical Doctor) for a burn follow-up/wound check and was diagnosed with a chemical burn. His foot was irrigated, dressed with wet to dry dressing, then transported back to facility with orders to follow up with primary vision and burn clinic in two days.

Care plan last revised on 06/24/2024 indicated R4 has altered skin integrity related to chemical burn to right great toe tip extending to medial aspect and right medial forefoot extending to dorsal aspect of toes. Same care plan with revision date of 06/25/2024 indicated a focus for R4 to engage in vocational activities with goal to perform duties as discussed with V1 (Administrator) and appropriate department head 5 days per week. Interventions included but not limited to: observe resident during program, and minimize risk factors through interventions such as assessment, team consultation, supervision, observation, structured environment, and peer-buddy system.

Burn outpatient preliminary report dated 06/25/2024 indicated R4 presented to burn clinic for evaluation of chemical burn sustained at facility on 06/23/2024 while working in laundry department where his shoes and socks became

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covered with powdered bleach when it was wasted onto his wet shoes and R4 sustained burn wound to the dorsal, medial foot, and dorsal toes of his right foot with dead skin overlying the burned area. (Report incorrectly indicated left foot.) Treatment was rendered, wound cleaning and healing ointments both applied (see treatment orders below), then covered with gauze dressing and orders to return to the burn clinic in one week.

Treatment orders for R4 with print date of 07/01/2024 showed an order to apply a debridement ointment (removes damaged/dead tissue to promote wound healing) to right great toe tip and right medial foot after normal saline cleanse, then apply an antimicrobial cream to gauze and lay over wound bed and cover with dry dressing daily and as needed.

On 07/01/2024 at 12:06 PM, V4 (Assistant Director of Nursing) said on 06/23/24, R4 went into the laundry room behind the kitchen area on the first floor, but was not allowed to be in this room unsupervised. She also said that she believed the laundry aide was on duty but wasn't present at the time that R4 had entered the laundry room. V4 (ADON) then said R4 saw some detergent in a box on the floor, so he opened the packet and had spilled some onto his shoe when he later felt his foot burning and saw some blisters on his foot. She added that R4 was sent out and returned same day with treatment orders and to follow-up with the burn clinic. V4 added that she was unaware of what specific detergent caused the chemical burn to R4's foot but indicated that V1 (Administrator) was aware of the name.

On 07/01/2024 at 12:48 PM, V1 (Administrator)

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said R4 was allowed to participate in an activities/vocational training program to deal with his anxiety by doing simple tasks that included: scraping plates after meals then taking trays to the doorway of kitchen, mop up a spill on the floor, pick up trash from offices and take the trash to the back door. He added that all chemicals in use for R4 are premixed for him, such as with a cleaning product and water. V1 (Administrator) then said on day of incident (06/23/2024), R4 went into the laundry room per self, saw some detergent stored in a box, opened the box and removed a packet of detergent from the box, and then tried to put the detergent into the washing machine when he spilled some on his foot. V1 added that this occurred at approximately 3:00 PM but R4 did not report the incident and/or the blisters on his feet to his nurse until approximately 4:30PM who sent R4 out for further treatment and evaluation. V1 (Administrator) then said that the detergent was determined to be a whitening detergent that their vendor wanted the facility to try and wasn't previously used by facility. V1 added that the laundry product that caused the burn to R4's foot was in a box near the washers but was removed from the building after incident and will not be used by facility. V1 provided the product safety data sheet (SDS) for review.

Safety data sheet with issue date of 01/26/2024 that indicated the laundry product was a multi-purpose stain blaster reserved for industrial and professional use with no dilution information provided that may cause skin irritation, allergic skin reaction, and/or serious eye damage. SDS sheet indicated to wear personal protective equipment including gloves/clothing/eye and face protection and to store the product locked up.

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On 07/01/2024 at 1:24 PM, V6 (Social Services Director) said R4's cognition is always intact, but he can be anxious at times so facility explored therapeutic interventions and activities that were appropriate for R4 to perform. She added that R4 enjoyed cleaning, so she referred him to the appropriate department heads who only inquired about R4's mental state/cognition and did not include V6 in the planning. V6 (SSD) then said she has never been done this type of intervention/activities in the past with any other resident and indicated that no type of safety contract was initiated for R4 related to the activities/duties he would be performing.

On 07/01/2024 at 1:51 PM, R4 said that he takes himself into the laundry area because the laundry doors are not locked and there's no code to unlock the door. R4 added that he's washed clothes and operated the machines before to help the laundry staff. R4 said on day of incident, there was no one present of working in the laundry room. He then said after loading the washer with soiled white linens and incontinence pads, he saw a box filled with packets of a bleach detergent, opened it, then spilled some to the top of his right shoe when he tried to add packet into the washer. R4 then said that he felt a burning sensation to his right foot, so he had removed his shoe, took off his sock, then put his shoe back on. R4 added that he stayed in the laundry room for a while longer to finish what he was previously doing and at no time did any staff come to the laundry room while he was there. R4 then said a few hours later, he informed his nurse during medication administration about the incident and of the burning sensation. He said the nurse (V9) put a dressing on his foot and said R4 had to be sent to local hospital. R4 said he went to the emergency room, they cleaned his foot, applied a dressing

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then sent him back to the facility. R4 added that he followed up with the burn clinic on the next day and has a second appointment on 07/02/2024. R4 said at times, he still feels a burning sensation to his right foot that comes and goes.

On 07/01/2024 at 2:24 PM, observed V10 (Wound Care Nurse) provide wound care to R4's right foot prior to applying a new dressing. During wound care, observed open areas to tip of great toe and lateral side extending to medial aspect. Also observed open area to top of foot from medial base of great toe through dorsal aspect (fourth toe) and noted edema throughout R4's right foot. V10 said the areas are considered two wounds, with one cluster extending from great toe to fourth toe and from side of great toe and around to front. She added that R4's wounds are documented as full thickness wounds with slough, with red smooth areas throughout wounds.

On 07/01/2024 at 2:50 PM, toured laundry area that is across from dietary department in back hallway with V1 (Administrator). Observed a lock on laundry doorknob and the door propped open with an armchair placed in the doorway. Upon entering the laundry room, a laundry staff member removed the chair from the doorway and placed it against the wall next to door. V1 then said the laundry door should always be locked when no staff is present.

On 07/02/2024 at 10:51 AM, V2 (Assistant Administrator) said the laundry department is closed from 2:00 PM until 4:00 PM so on the day of R4's incident, the laundry department was closed. Reviewed working schedule and hours worked provided by V2 that showed no laundry staff were working on day of incident

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(06/23/2024) between the hours of 1:30 PM through 4:13 PM.

On 07/02/2024 at 11:31 PM, V3 (Director of Nursing) said R4 he was not allowed to be in the laundry room because this is not included on his list of activities to do. V3 added that no resident is allowed in the laundry room, and the door should be locked if no staff is present. She also said that no door should be propped open at any time.

On 07/02/2024 at 11:38 AM, V9 (Licensed Practical Nurse) said at approximately 8:30 PM on day of incident, he was preparing medications when R4 came to the nurse's station and said something fell on his right foot. V9 said he and R4 went to his room, R4 removed his shoe and sock to his right foot and V9 saw what looked like blisters to his first four toes, were not fluid-filled. V9 added that R4 complained of a burning sensation to the foot that did not look like a recent injury. R4 informed V9 (LPN) that some bleach fell on his gym shoe while he was in the laundry room. V9 called the treatment nurse, manager on duty and the administrator then cleaned R4's wound with normal saline and applied a wet to dry dressing. He then spoke to the physician and received order to send R4 to the hospital where he stayed for a few hours then returned with a dressing in place and orders to follow up with the burn clinic.

On 07/02/2024 at 01:32 PM, V1 (Administrator) said no one stands over R4 to watch him perform his duties that have since been discontinued post R4's incident. V1 then said that R4 was able to access the laundry room because it was found during investigation that the lock to the laundry room door was not functioning properly and required the lock to be changed out with new

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S9999	Continued From page 8 keys reissued to laundry staff. Reviewed vendor sales receipt dated 06/24/2024 that showed the purchase of a new lock system and copies made for four additional keys. Reviewed supervision and safety policy dated "03/15" that reads in part: policy strives to make the environment as free from hazards as possible. Safety risks and environmental hazards are identified on an ongoing basis through employee training conducted upon hire, annually and as needed. Resident supervision is a core component to resident safety. Staff to make visual rounds on residents minimally every two hours and more often if necessary based on resident's assessment needs. (B)	S9999		