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S 000	Initial Comments Investigation of Facility Reported Incident of 12/1/24/IL182257	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 300.1210d)5)6) 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 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	S9999		

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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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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 observation, interview, and record review the facility failed to serve coffee at a temperature to prevent burns. This failure resulted in R1 receiving a 12-inch, slough filled burn to her left thigh. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 3. This past compliance occurred from 12/1/2024-12/2/2024.

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Findings include:

R1's Admission Record (Face Sheet) showed she was admitted to the facility on 1/8/24 with diagnoses to include but not limited to Parkinson's Disease (degenerative brain disorder leading to tremors and a loss of motor function); tremors; depression; diabetes II; COPD (Chronic Obstructive Pulmonary Disorder, progressive lung disease caused by damage to the lungs); and rheumatoid arthritis.

R1's 10/14/24 Quarterly Minimum Data Set (MDS) showed she was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The MDS showed she used a wheelchair for mobility. The MDS showed R1 required setup or touching assistance for eating and partial/moderate assistance for oral hygiene. The MDS showed she required substantial/maximal assistance to roll left and right in bed; and she required substantial/maximal assistance to go from siting in bed to lying in bed. The MDS showed R1 does not walk.

The facilities incident report from 12/1/24 showed, "[R1] is an alert and oriented resident with a BIMS score of 14 on an all-female behavioral health unit. On 12/1/24 [R1] was wheeling down the hall independently per her baseline when she asked her friend to assist in moving her wheelchair. The friend complied and handed [R1] her coffee with a lid attached to hold while she helped her. Once completed [R1] attempted to hand the coffee back to her friend when she dropped the coffee onto her own left leg. The nursing staff on duty assessed the resident with noted redness to the left leg. NP (Nurse Practitioner) was notified with new treatment orders in place. POA notified of the

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incident and agrees with the current plan of care. [R1] was assessed by wound care MD on 12/2. The investigation started immediately..."

On 12/13/24 at 8:45 AM, R2 stated the councilors office on her locked behavioral unit had a single serving pod-type coffee maker (hereinafter referred to single-serving coffee maker, SSCM). R2 stated, at around 3:30 PM on 12/1/24, she dispensed a cup of coffee by herself then exited the councilors office. R2 said, as she exited the councilors office R1 was in her wheelchair and stuck against the wall. R2 said R1 requested assistance, so she handed her coffee to R1 then moved R1 away from the wall. R2 said when R1 handed the coffee back to her it spilled on R1. R2 said, "...The coffee was fresh. I had just gotten it...The coffee is hot. The stuff I get from the counselors is hot, which is why I like it. The stuff from the kitchen is like bath water. Oh yeah, the stuff from the counselors is hotter, which is why I like it. [R1] yelled out when it spilled on her. After that, I just blanked out. I don't remember who came by; I don't remember who assessed her...[R1] does shake a little (hand tremors) ..."

On 12/13/24 at 9:00 AM, R1 stated "...I was stuck against the wall. I asked [R2] to help and I told her I would hold her coffee and I asked her to push me to the dining room. I dropped the coffee, and it ran down my leg. [R2] felt bad. When the coffee hit my leg, it hurt bad because it was hot and burned my leg...The coffee came from the councilor's office; I don't drink coffee. After it spilled, I screamed...Now they can't get coffee (referring to the SSCM removed from the unit) and they are going to get another coffee maker...I haven't seen my leg since then. They change the dressing every day and the wound nurse checks it twice a week. I still have some

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pain (in that leg). Right now, I would rate it (pain) at a 3 out of 10..."

On 12/13/24 at 10:23, V10 Wound Care Nurse began wound care on R1 with the assistance of V11 MDS nurse. V10 removed the dressing to R1's left thigh exposing R1's wound. The wound was 12 to 14 inches in length beginning at just below the left hip and wrapping behind her thigh to above the back of the knee. At its widest point, the wound was 5 to 6 inches wide. R1's wound was nearly 100 percent yellow/white slough (dead tissue) with the border of the wound being bright red. The wound bed appeared to more than superficial and the slough tissue was below the top layer of skin. R1 was medicated for pain prior to the start of wound care; however, during wound care R1 winced and gasped with pain, especially during the cleaning of the wound.

On 12/13/24 at 10:45 AM, V10 said (with V2 Director of Nursing sitting in on interview), regarding R1's wound, "It was due to the hot coffee." V10 said, "It's a third-degree burn...It started as redness, then blistered, then opened..."

R1's 12/2/24 and 12/9/24 Wound Care assessment completed by V12 Wound Care Physician showed, "Wound Related Diagnosis: Burn of third degree of left thigh..." (All wound assessments were requested, 12/2/24 was the initial provider assessment.)

R1's 12/5/24 Wound Care assessment completed by V13 Wound Care Nurse Practitioner showed, "Wound related diagnosis: Burn of third degree of left thigh..."

R1's 12/12/24 Wound Care Physician assessment (performed by V9 Wound Care

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Physician) showed, "Wound Related Diagnosis: Burn of third-degree of left thigh..." V9's assessment showed the left thigh wound was coded as "T24.312A" (a third-degree burn). The assessment showed, after debridement (removal of dead tissue), the wound was 30 centimeters by 15 centimeters by 0.2 centimeters deep. Prior to debridement the wound measured 30 centimeters by 15 centimeters by 0.1 centimeters deep.

The undated Mayo Clinic website titled "Burns" showed three levels of burns. The website showed the final and most severe burn was a third-degree burn. The website showed a third-degree burn was a burn which "involves all of the layers of skin and sometimes the fat and muscle tissue under the skin..."

On 12/13/24 at 9:17 AM, V5 Psychiatric Rehab Services Coordinator (PRSC, working on the locked women's unit) stated she was working when R2 made her coffee. V5 stated she was assisting another resident when R2 entered the office and made the coffee. V5 stated the SSCM was no longer in the office and had been removed. V5 said R1 does not have any self-harm behaviors.

On 12/13/24 at 9:50 AM, V5 stated she does not monitor the temperature of the SSCM.

On 12/13/24 at 11:23 AM, V7 Dietary Manager stated the facility has temperature regulated coffee machines in the kitchen which are used to fill carafes for the residents. V7 stated the kitchen's coffee makers dispense coffee at 165 degrees Fahrenheit (F) which ends up being 160 F in the cup. V7 stated, "We check the coffee temperature. We check it every time it (coffee) goes out. We check the coffee temperature to

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avoid burns. We send it out at 145-150 F. We use ice to cool it down and label the pots. Some residents are on 'cool down' so their food and hot beverages must be at a lower temperatures, so we label the coffee if it's 'cool down' which is 135F maximum." V7 said, "As far as I know they are not allowed to have coffee pots on the units and if they do, we don't monitor them. I was asked to get the coffee [temperatures] lower because there have been burns at other facilities. I didn't lower temperatures on coffee pots on other units because I didn't know about them. If coffee is hot, it can cause burns, which is part of the reason why we are looking at new coffee machines [for the kitchen.] We were not monitoring the women's unit [SSCM]."

On 12/13/24 at 11:18 AM, V6 Psychiatric Unit Manager stated, "We don't have any process in place to measure the coffee temperature (from the SSCM). We were not monitoring the coffee temperature. The locked men's unit also had an [SSCM], but we removed that one also."

On 12/13/24 at 11:23 AM, V8 Cook was preparing coffee for the noon meal. V8 stated, "I add ice to get the coffee down to 145F. I have worked here for 11 years, and we have been checking coffee temperatures for several years. The 145 F is for regular coffee, 'cool down' coffee is 135 F."

On 12/13/24 at 2:00 PM, V7 stated, "I'm not sure where the 145-150 F [coffee temperature] came from. Not able to find it [in a policy] it's just the temperature we always serve the regular coffee at as a safe temperature." V7 then retrieved the "At RISK Hot Food and Beverage Temperature Service policy (dated 5/2019). V7 stated, while referencing the section of the policy "Water Temperature and Time Reference Guide for third

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degree burn for Elderly;" "we might have gotten it [150 F maximum coffee temperature] from this chart."

The facility's policy, At RISK Hot Food and Beverage Temperature Service policy (dated 5/2019) showed, "Food and beverages will be served at a temperature that is safe and palatable. Purpose: To reduce the risk of injury." The policy showed liquids at 155 F can cause a third-degree burn in as little as one second and 140 F liquids can cause third degree burn in 3 seconds.

On 12/13/24 at 11:15 AM, V1 Administrator stated they were not able to locate the SSCM from the locked women's unit. V1 and V7 Assistant Administrator found another SSCM, same brand, and dispensed coffee from this SSCM unit into a Styrofoam cup. The coffee measured 174.2 F using a facility thermometer. Approximately 2 minutes later, the coffee was 166 F.

On 12/13/24 at 11:42 AM, V9 Wound Care Physician said, "The best answer right now is it's an unclassified burn degree because I cannot see the whole wound. This wound will take about three months to heal. I see coffee burns all the time; it is something they (the facility) should be aware of. She does have Parkinson's which can affect her grip strength." V9 said, for normal people, a burn would occur at 160 F.

The Consumer Protection Safety Commission publication titled "Avoiding Tap Water Scalds" showed "Most adults will suffer third-degree burns if exposed to 150 degree water for two seconds..."

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S9999	Continued From page 8 Prior to the survey date of 12/17/24, the facility had taken the following action to correct the noncompliance: 1. On 12/1/24 V1 directed staff to cease the use of SSCM machines on both the men's and women's locked units. 2. On 12/1/24 V1 developed a plan of correction. 3. On 12/124 training for staff regarding the safe administration of hot liquids and cool liquid program was initiated. 4. On 12/2/24 R1 was assessed by the therapy department, for safe handling of hot liquids. 5. On 12/2/24 Quality Assurance audits for serving hot liquids in the dining room was initiated for both high risk and low risk resident. The audits will be reviewed at the next scheduled QA Committee meeting. 6. On 12/2/24 an emergency resident council meeting was held and residents were educated on not handing liquids to other residents as well as residents pushing other residents in wheelchairs. 7. New residents are assessed for mealtime safety and their ability to handle hot beverages. 8. The facility will maintain a current list of all residents requiring the cool liquid program. (A)	S9999		