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S 000	Initial Comments Complaint Investigation 2551961/187749	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690b) 300.690c) 300.1210 b) 300.1210 c) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695,	S9999		

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notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to adjust the type and frequency of interventions and needed level of supervision for a resident with a history of self inflicted burns with hot liquids, and failed to report a burn injury to the Illinois Department of Public Health (IDPH) for one resident (R1) of four residents reviewed for incidents/accidents in the

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sample of four. This failure resulted in R1 spilling hot water onto his groin, sustaining second degree burns to nine percent of his body, causing pain and the need for increased pain medication, and requiring placement of an indwelling catheter to prevent urine from irritating the wounds.

Findings Include:

R1's Face Sheet documented an Admission Date of 4/5/24, and listed Diagnoses including Spinal Stenosis with Fusion of the Lumbar Spine, Schizoaffective Disorder, and Diabetes Type 2.

R1's Minimum Data Set, dated 1/19/25, documented R1 has no deficits in cognition, has impaired range of motion to both lower extremities, requires substantial/maximal assistance from staff for bed mobility, is dependent on staff for transfers, and requires set up or clean up assistance from staff for eating.

R1's Care Plan, dated 12/30/24, documented a problem area, "(R1) displays adverse behaviors. He has been educated to let staff get him hot water to prevent burns and he continues to be non-compliant with this," with corresponding interventions, "Remind (R1) too let staff get his hot water for safety. Educate (R1) about the risk of burns. Provide appropriate non-spill cup for safety."

R1's 2/4/25 Hot Liquid Burn Incident Report documented, "Staff heard resident yelling, staff went in to assess resident, resident continued to yell, 'Help I spilled hot water on myself,' staff noted the bed sheets were wet with hot water. (R1) stated, 'I was trying to take the lid off the water pitcher with hot water in it and the lid popped off and the water went all over me." Injury

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type: Burn(s) to the coccyx, groin, right thigh (rear) and left leg (rear). Intervention: Non spill cup for hot water."

R1's 2/6/25 Wound Evaluation and Management Summary documented, "Patient has wounds on his left posterior leg, right posterior thigh, posterior scrotum, left thigh, left medial foot. Burn on the left medial foot resolved on 2/6/25. Follow up: Evaluation by (V12, Wound Care Physician) weekly, or sooner as needed, with further intervention as indicated based on response to current treatment plan."

R1's 2/4/25 untitled note authored by V14, Nurse Practitioner, documented," Physical Examination: Burn. Acute. Patient spilled hot water for tea into his bed. (V12) has given orders for management."

R1's 2/12/25 Nurses Notes documented: "New order to increase oxycodone (as needed) to every twelve hours." February 2025 Physicians Orders (POS) documented a 1/21/25 order for oxycodone 5 milligrams (mg) one tablet every 24 hours for moderate pain. The same POS documented a 2/12/25 Pain Scale pain level of 7, and a 2/12/25 order to increase the oxycodone to 5mg one tablet every 12 hours for moderate pain.

There was no documentation in R1's record to indicate the 2/4/25 burn incident was reported to IDPH.

On 3/13/25 at 11:30am, R1 was alert and oriented to person, place, and time. R1 was observed to have an indwelling catheter draining clear straw colored urine. R1 stated on 2/4/25 at about 7:30am, he asked V9, Certified Nursing

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Assistant, to heat him up some water so he could make instant coffee. R1 stated V9 took his water pitcher and took it out of the room. R1 stated in a few minutes, V9 returned with hot water in the pitcher. R1 stated he was sitting up in the bed when V9 gave him the pitcher and left the room. R1 stated he was trying to get the lid off, when the lid suddenly came off and steaming hot water was spilled all over his crotch area. R1 stated he was in immediate pain and yelled for help. R1 stated one of the nurses came and got him out of the wet bed linens and assessed his burns. R1 stated he has since been treated weekly by V12. R1 stated he has burned himself previously in similar circumstances, although during those occurrences, he was able to walk to the dining room and microwave hot water himself. R1 stated he had spinal surgery in January, and as a result, has decreased sensation in both lower extremities. R1 stated initially, he did not have a lot of pain, but as time went on he did, and his pain medication had to be increased. R1 stated it has been effective, but has caused him to be more sleepy during the day.

On 3/13/25 at 12:00pm, R4, R1's Roommate/Family Member, who was alert and oriented to person, place, and time stated she was woken up on 2/4/25 by R1 yelling that he had been burned. R4 stated R1 later told R4 that V10, Hall Monitor, had been the staff member who brought him the hot water.

On 3/13/25 at 2:55pm, V12 stated R1 sustained second degree burns over nine percent of his body. V12 stated R1's wounds are healing, there were no signs of secondary infection, and R1 will not require skin grafts. V12 stated he has previously treated R1 for non intentional self inflicted burns in similar circumstances. V12

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stated he has repeatedly told R1 to not handle hot water, but R1 will not comply. V12 stated R1 temporarily requires an indwelling catheter to prevent urine from irritating the wounds.

On 3/14/25 at 8:40am, V9 denied giving R1 the hot water, and stated she does not know who did. V9 stated, "I would not give him a pitcher of hot water and not supervise him with it." V9 stated she did not think there was any staff re-education after the incident.

On 3/14/25 at 9:00am, V4, CNA Supervisor, stated after R1's 2/4/25 burns, staff were educated to make sure R1 is sitting up in his chair and not in bed when given hot water.

On 3/14/25 at 10:40am, V10 stated she did not give R1 the hot water, and does not know who did. V10 stated, "I wouldn't have, because everybody knows he spills it and he's not supposed to have it." V10 stated she did not recall getting re-educated after the incident.

On 3/14/25 at 12:30pm, V3, Assistant Director of Nurses, stated on 2/4/25 at about 7:30am, she heard R1 yelling for help, and she and V1, Regional Nurse/Director of Nurses, responded. V3 stated they got R1 into dry linens and V3 assessed R1, noting he had areas of redness, peeling skin to his left posterior leg,right posterior thigh, posterior scrotum, left thigh, and left medial foot. V3 stated she notified V12 and sent him pictures of the burns, and V12 responded with treatment orders. V3 stated R1 has burned himself on hot liquids previously, and was treated by V12. V3 stated she does not know who gave R1 the hot water. V3 stated R1 did not have complaints of pain that morning past the time of the burn itself. V3 stated several days after the

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burns occurred, R1 complained of increased pain, and V15, Primary Care Physician, increased R1's pain medication.

On 3/14/25 at 2:20pm, V1 corroborated V3's account of the incident as stated above. V1 stated when he investigated the incident, no staff members took responsibility for giving R1 the hot water. V1 stated staff should have put the water in a handled cup with a lid, not a water pitcher. V1 stated R1 has burned himself on hot liquids several times, when he ambulated to the dining room and microwaved the water himself. V1 stated as a result, the microwave was removed from the dining room, and R1 has been educated numerous times about the need for staff assistance with hot liquids. V1 stated on 2/5/25, staff were re-educated R1 is to get hot water in the handled cup with lid. V1 stated he was unaware he needed to report this incident to IDPH. V1 stated the facility does not have a policy about reporting incidents to IDPH, but they go by the State of Illinois licensure regulations.

A 2/5/25 State of Education for Employees Sign In Sheet documented, "The following area of instruction were covered: We have got (R1) adult sippy cups for him to use. There is 2 cups-clear, with handles."

The facility's Safety and Supervision of Residents Policy, dated July 2017, stated," Systems approach to safety: The facility oriented and resident oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk. factors, and then adjusts interventions accordingly. Resident supervision is a core component of the systems approach to safety.

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S9999	Continued From page 7 The type and frequency of resident supervision is determined by the individual residents assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment. (such as construction) or if there is a change in the residents condition." (B)	S9999		