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	IL6016356	A. BUILDING: _____ B. WING _____	02/20/2025

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690b) 300.690c) 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 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	S9999		

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law enforcement pursuant to Section 300.695, 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.

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.

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This REQUIREMENT is not met as evidenced by:

A. Based on observation, interview, and record review the facility failed to ensure resident coffee was served at a safe temperature. This failure resulted in R57 receiving second degree burns to her right arm. The facility also failed to notify state surveying agency of a serious incident when a resident received second degree burns to her right arm after spilling coffee on herself. This applies to 1 of 6 residents (R57) reviewed for incidents that caused physical harm in the sample of 18 and reviewed for safety and supervision.

The findings include:

The Nurse's Notes for R57 showed, 1/6/25 at 12:19 AM - This writer was called to resident's room by CNA (Certified Nursing Assistant). Resident had spilled coffee on right arm. Right arm noted to have 2 reddened area with shiny skin, no blisters noted. Right forearm open area 3 cm (centimeters) x 2 cm, right elbow 5 cm x 8 cm. Cool water applied to right arm. DON (Director of Nursing) and supervisor made aware. Spoke with...physician assistant. New orders given and endorsed. Tylenol given for pain. Dressing applied per order/change daily. 1/6/25 at 12:23 AM - Dressing clean, dry, and intact. New order per (V9 NP - Nurse Practitioner). Apply bacitracin to right arm burns, apply petroleum gauze, cover with rolled gauze, and change daily. Monitor for signs/symptoms of infection. Wound care consult.

The Provider Progress Note dated 1/5/25 (should have been dated 1/6/25) for R57 showed, patient seen and examined in her room today at the

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request of nursing. Patient has a burn on her right forearm, second degree. No signs/symptoms of infection.

The Initial Wound Evaluation & Management Summary dated 1/8/25 for R57 showed, Patient presents with wounds on her right forearm, right elbow. At the request of the referring provider...a thorough wound care assessment and evaluation was performed today. Focused wound exam (site 1) burn of right elbow; etiology - burn; further etiology detail - hot liquid. Wound size (L x W x D) 7.0 x 6.5 x 0.1 cm. Moderate serous exudate; 100% granulation tissue. Additional wound detail: burn at right elbow and forearm from patient spilling coffee on herself while in bed. Dressing treatment plan: silver sulfadiazine - apply once daily for 30 days. Abdominal pad - apply once daily for 30 days; gauze roll 3.4" apply once daily for thirty days. Focused wound exam (site 2) burn of right forearm; etiology - burn; further etiology detail - hot liquid. Wound size (L x W x D) 2.6 x 3.6 x 0.1 cm. Moderate serous exudate; 5% slough; and 95% granulation tissue. Dressing treatment plan: silver sulfadiazine - apply once daily for 30 days. Abdominal pad - apply once daily for 30 days; gauze roll 3.4" apply once daily for thirty days.

On 2/19/25 at 12:17 PM, the floor where R57 resides had an automatic coffee machine dispenser in the dining room on the counter accessible to anyone.

On 2/19/25 at 12:19 PM, V5 (Dietary Director) filled a cup with coffee from the automatic coffee dispenser machine on the floor where R57 resides dining room. The temperature of the coffee was tested by V5 at the request of the surveyor. The temperature of the coffee from the

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machine was 187.2 degrees Fahrenheit. V5 stated the coffee machines were installed a couple of months ago. V5 stated he doesn't check the temperature of the coffee from the machine on a regular basis. V5 stated the company that services the machine will check the temperature when they come in for a service call and he was unsure of the last time the company was in to provide service. V5 stated the normal temperature that coffee is served is at 180 degrees. V5 stated all coffee comes from the machine and is not made in the kitchen. V5 stated he was told about the incident where someone had burned themselves from the coffee. V5 stated he didn't know who it was that burned themselves. V5 stated he was not part of the correction process for that. V5 stated nursing was a part of the correction process and the dietary department did not do anything for correction.

The last Field Service Update for the coffee machines was dated 7/24/24 and showed it was for the main kitchen machine and the water temperature for that machine was 180 degrees Fahrenheit.

On 2/19/25 at 12:25 PM, V8 (Licensed Practical Nurse/LPN) stated R57 had a burn to her right elbow from coffee. V8 stated R57 asked for coffee and spilled the coffee in bed. V8 stated R57 doesn't have sensation to her right arm and keeps her right arm immobile. V8 stated R57 received a second degree burn from the spilled coffee.

On 2/19/25 at 12:55 PM, V3 (Director of Nursing/DON) stated she received call from nurse and was told R57 was in her room, had finished dinner, and wanted coffee. The CNA

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went and got more coffee and added the coffee to R57's cup. R57 ended up spilling the coffee on herself. R57 had second degree burns from the coffee that were treated right away. V3 stated she had dietary check the temperature of the coffee and it was within normal range. V2 stated she did not know what the temperature of the coffee should be. V2 stated the dietary manager would have been notified by the dietary department. V3 stated she did not report the incident to state surveying agency because there was no need to because she knew how the incident occurred.

On 2/20/25 at 11:21 AM, V9 (Nurse Practitioner/NP) stated the facility called telehealth the evening that it happened and got a treatment order. V9 stated she saw R57 the following day. R57 had a second degree burn to her arm. V9 stated she ordered Silvadene. The family refused that treatment and wanted bacitracin because they had a doctor friend that told them that is what they use for burns. V9 state she was not sure if R57 needed assistance with meals; however, R57 had been declining. V9 stated she believed R57 needed assistance. V9 stated this could have been prevented from happening by checking the temperature of the coffee and making sure it is not too hot.

The Care Plan dated 6/28/24 - Present for R57 showed, R57 is at risk for impaired skin integrity. Offer staff assistance with hot beverages. Encourage use of clothing protector to protect skin for accidental spills. Encourage resident to sit up right at a table while drinking hot liquids. Serve hot liquids in a cup with a lid.

The Face Sheet dated 2/19/25 for R57 showed diagnoses including Alzheimer's disease,

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depression, osteoporosis, hypertension, atherosclerotic heart disease, spinal stenosis, gastro-esophageal reflux disease, anxiety disorder, edema, osteoarthritis, abnormal posture, and muscle weakness.

The MDS (Minimum Data Set) dated 12/20/24 for R57 showed severe cognitive impairment; dependent for eating; substantial/maximal assistance needed for toileting hygiene, bathing, upper body dressing, and personal hygiene.

The facility's Accidents and Incidents - Investigating and Reporting (July 2017) showed, all accidents or incidents involving residents, employees, visitors, etc., occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a report of incident/accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. The director of nursing services shall ensure that the administrator receives a copy of the report of incident/accident form for each occurrence. The facility's policy did not show anything regarding reporting to state surveying agency.

The facility's Safety of hot Liquids policy (October 2014) showed, Appropriate precautions will be implemented to maximize choice beverages while minimizing the potential for injury. The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions. Residents with these or other conditions may suffer from accidental burns and related complications stemming from thinner, more

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fragile skin that may burn quickly and severely and take longer to heal. Residents who prefer hot beverages with meals (i.e., coffee, tea, soups, etc.) will not be restricted from these options. Instead, staff will conduct regular hot liquids safety evaluations as indicated and document the risk factors for scalding and burns in care plan. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include a. maintaining hot liquids serving temperature of not more than 180 degrees Fahrenheit: e. staff supervision or assistance with hot beverages.

B. Based on observation, interview, and record review the facility failed to ensure fall preventative measures were in place for a resident. This applies to 1 of 6 residents (R28) reviewed for safety and supervision in the sample of 34.

R28's face sheet printed on 2/20/25 showed diagnoses including but not limited to heart failure, chronic obstructive pulmonary disease, chronic kidney disease, anxiety, and dementia. R28's facility assessment dated 1/24/25 showed severe cognitive impairment.

R28's fall risk assessment dated 2/3/25 showed a high risk of falls. The same assessment showed a history of falls in the last three months, weakness with gait and transfers, and forgets her limitations.

R28's care plan showed a focus area related to the high risk for falls. Interventions included staff to place floor mats beside the bed and bed in lowest position when she is in it.

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On 2/18/25 at 12:27 PM, R28 was lying in bed with her eyes closed. R28's bed was low to the ground but there were no fall mats next to the bed.

On 2/19/25 at 9:31 AM, R28 was in bed and was yelling out for help. R28 did not have any fall mats next to the bed. The mats were folded up and leaning against the wall at the foot of the bed. V7 and V10 (RN-Registered Nurses) responded to R28 and entered the room. V7 stated R28 has fallen out of bed in the past. About one month ago, she rolled out and hit her eye on the side rail. V7 was asked if the bed was in the lowest position and stated no. V7 lowered the bed further to the ground. At 9:54 AM, R28 was yelling out for help again and outwardly agitated. The fall mats were still not next to the bed and remained folded up against the wall.

On 2/19/25 at 9:45 AM, V10 (RN) stated R28 has fallen out of bed several times in the past. She can get herself to the side of the bed and rolls herself out. She ends up on the floor. That is why the fall mats are important. V10 said R28 gets agitated and excited, like she is right now. She is highly confused and frequently ends up on the floor.

On 2/19/25 at 12:06 PM, R28 was in bed and V11 (Certified Nursing Assistant) was in the room. The bed was not in the low position and the fall matts were folded up against the wall by the window. V11 stated she needs the mats next to her bed anytime she is in it. She falls out of bed a lot and they keep her from getting hurt.

On 2/20/25 at 11:07 AM, V3 (Director of Nurses) stated R28 has had several falls out of bed related to her behaviors. She is confused, gets

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S9999	Continued From page 9 agitated, and rolls herself out of bed. She will try to get up by herself frequently. The low bed and fall mats need to be in place at all times. They both help minimize any potential for injury. She absolutely needs the interventions in place. The facility's Falls and Fall Risk Managing policy revision dated 3/2018 states: "1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling." "B"	S9999		