DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

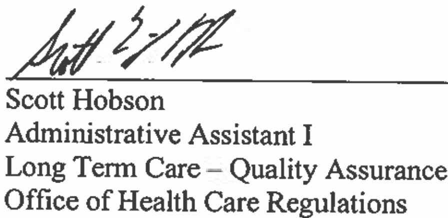
THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. DUPAGE COUNTY BOARD, D/B/A, DUPAGE CARE CENTER, Respondent.	))))))))))	Docket No. NH 21-C0440

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Daniel Cronin
Licensee Info:	Dupage County Board
Address:	421 County Farm Road Wheaton, Illinois 60187

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 28 day of July, 2021.



Scott Hobson
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002612	A. BUILDING: ______ B. WING ______	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUPAGE CARE CENTER	400 N COUNTY FARM RD WHEATON, IL 60187

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S 000	Initial Comments Complaint Investigation: 2172908/IL133367	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1010i) 300.1210b) 300.1210d)3)6) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be	S9999		

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to immediately assess and provide treatment to a resident with burn injuries after spilling coffee.

This failure resulted in R1 (who is paraplegic) having a delay in treatment to his second degree burns requiring surgical debridement.

This applies to 1 of 4 residents (R1) reviewed for incident/accidents in a sample of 11.

Findings include:

The review of R1's EHR (Electronic Health Record) shows R1 a 70 years old was admitted to the facility on 8/24/18 with diagnoses that included injury at C5 level of spinal cord, anxiety disorder, paraplegia, hypertension, orthostatic hypotension, depression, neurogenic bladder. R1's MDS (Minimum Data Set) dated 4/21/21 showed R1 required extensive assistance of one staff with bed mobility, transfer, and toilet use.

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The MDS shows R1 with impairment to one part of the upper extremities.

On 5/7/21 at 8:55 A.M., R1 stated on 4/26/21, he spilled hot coffee on himself because the coffee mug lid was not properly screwed to the mug. R1 stated on 4/26/21 he was assisted by V5 (Certified Rehab Nursing Assistant, CRNA) in his room during breakfast. R1 stated V5 brought coffee to him in his mug that he has used for over two years. R1 stated as he picked the mug up from his bedside table and was about to drink the coffee, the lid came off and the hot coffee spilled out of the mug. R1 stated the entire coffee spilled over his right lower abdomen and thigh area. R1 stated he did not realize how bad the burn was immediately following the coffee spill. R1 stated he could not feel from his waist down related to his paraplegia. R1 stated V9 (CRNA) removed his shirt, mopped his right upper abdomen area. R1 stated V5 brought linen to change his bed later. R1 stated no treatment was received to the burn area until the next day. According to the MDS (Minimum Data Set) dated 4/21/21, R1 is cognitively intact.

Review of R1's POS (physician order sheet) shows an order dated 4/26/21 at 9:00 P.M.: "apply ice pack for 20 minutes, loose clothing, apply silvadene cream to open area, right upper lateral leg twice daily until healed."

R1's medical record dated 4/26/21 shows R1 obtained secondary degree burns to his right lower abdomen and right lateral thigh around 9 A.M., R1's skin was not assessed for injuries until around 8:30-9:00 P.M. (approximately 12 hours after the incident). The facility also failed to inform the physician about R1's incident until 9:00 P.M. (12 hours after the incident). R1 did not receive

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any treatment to the burn areas until 11:00 P.M., on 4/26/21 (14 hours after the incident).

Review of R1's initial daily wound documentation dated 4/27/21 shows R1 with burn to right lateral lower abdomen that measured 22cm (centimeter) in length (L) x 15.00cm in width (W) x 0.00cm in depth (D). The wound base was noted with 1.5cm x 1.5cm collapsed blister. The second burn wound site was the right lateral thigh which measured 38cm (L) x 20cm (W) x 0.10cm (D) with 100% granulation tissue.

R1's wound treatment order was changed on 4/28/21. The new wound treatment shows to clean the right upper lateral thigh with normal saline, pat it dry then apply Vaseline gauze and a thin layer of silvadene and cover it with gauze and ABD (Army Battle Dressing) pad daily in the morning. Change only ABD pad if saturated in the evening shift and as needed. Clean the right lower lateral abdomen with normal saline, pat it dry then apply silvadene and cover with ABD pad daily.

Review of R1's wound evaluation and management summary dated 5/5/21 shows R1 with burn wound to the right hip that measured 24.0cm (L) x 14.0cm (W) x not measured (D) with 50% slough and 50% granulation. The report shows R1's wounds were noted with heavy serous exudates. The report also shows R1 had surgical excisional debridement procedure done to the burn wounds. The report also shows to administer multivitamins once daily, vitamin C 500mg twice daily, and zinc oxide 220mg once daily for 14 days.

On 5/7/21 at 11:20 AM, V10 (Wound Care Nurse) stated she saw R1 on 4/27/21 and did a skin

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assessment. V10 stated redness and lots of drainage were noted from R1's wound sites and due to the amount of drainage coming out of R1's wounds, she called V17 (Wound Care Doctor) to inform her of the findings. V10 stated V17 changed R1's treatment orders to reflect the current condition of R1's wounds at the time. V10 stated there was a debridement done on 5/5/21 by V17 to R1's right lateral thigh.

On 5/7/21 at 10:15 AM, V5 (CRNA) stated she filled R1's mug with coffee during breakfast. V5 stated she was in another resident's room when she heard R1's scream. V5 stated she went to R1's room and found R1 had spilled the coffee on himself. V5 stated V9 (CRNA) was also present in the room. V5 stated R1's shirt was removed by V9 while she went out of R1's room to obtain linen. V5 stated she did not inform V3 (Nurse) right away because R1 asked her not to inform V3. V5 stated she went back to R1's room about two hours later to change his linens and got R1 up. V5 stated she informed V3 in the afternoon before the end of her shift but V3 stated she would see R1 later.

On 5/7/21 at 10:30 A.M, V9 (CRNA) stated she was taking R3's breakfast tray out on 4/26/21 when R1 screamed out. V9 stated she went to R1's side and found out R1 had spilled the entire coffee on himself. V9 stated V5 rushed into the room and they both removed R1's shirt. V9 stated R1 was very upset and started cursing out. V9 thought V5 went to get the nurse (V3) but V3 did not come into R1's room before V9 left R1's room.

On 5/7/21 at 12:55 P.M., V3 (Nurse) stated she cared for R1 on 4/26/21 (during the day shift). V3 stated she was alerted by V5 around 2:00 P.M.,

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that R1 had spilled coffee on himself earlier during the shift. V3 stated she was told by V5 that there was no injury and that R1 did not want her informed. V3 stated she went to see R1 later around 3:15 P.M., but R1 was in an activity program. V3 stated she did not perform a skin assessment on R1 nor relate the incident to oncoming nurse or the supervisor on duty. V3 stated she took V5's words that R1 had no injuries, so she went home. V3 stated she should have done a thorough skin assessment on R1. V3 further stated she should have informed the oncoming nurse about the incident and should have documented the incident. V3 stated she was made aware of R1's injuries the next day.

On 5/8/21 at 3:06 P.M., V8 (Evening Supervisor) stated he was called on 4/26/21 at around 8:30 P.M., by V21 (Nurse) about the coffee spill on R1 that occurred during the day shift. V8 stated he was informed by V21 that "it was a burn and it was big." V8 stated he immediately went with V12 (Supervisor) to assess R1. V8 stated R1's abdominal skin was noted with redness and blisters, the thigh area was also noted with open wounds and blisters. V8 stated he called V19 (Doctor) to inform him. V8 stated he obtained treatment orders for the wounds. V8 stated he did not personally do the initial treatment on R1's wounds.

On 5/10/21 at 1:38 P.M., V22 (Evening Nurse) stated that on 4/26/21 at around 8:30 P.M., she was called by V23 CNA (Certified Nursing Assistant) to see "something important" with R1. V22 stated when she arrived in R1's room, she saw a huge redness to R1's lower abdomen and right thigh. V22 stated she called V8 right away to report the incident. V22 stated V8 obtained treatment orders for R1's burn wounds. V22

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stated R1 refused the ice pack application but she went back to apply silvadene on R1's right thigh while R1 was sleeping. V22 stated she did not get any assistance from staff to turn R1 for proper application of the silvadene cream because it was close to 11:00 P.M., and staff was getting ready to go home. V22 stated she informed V8 that R1 refused the ice pack but was not sure if R1's physician was informed.

On 5/7/21 at 3:02 P.M., V2 (Director of Nursing, DON) stated she expected the nursing staff to notify the nurse on duty immediately after the coffee spill. V2 also stated when the nurse was eventually notified, the nurse should have performed a visual assessment of R1's skin, administered first aid treatment, notified the physician, and passed the report to the oncoming nurse.

On 5/10/21 at 2:15 P.M., V17 (Wound Care Physician) stated she was asked to see R1's wounds on 5/5/21 because "they were not getting better." V17 stated R1's burn wounds had lots of superficial layer of slough and would not heal. V17 stated a debridement was needed and carried out to the right thigh burn wound to help promote wound healing. V17 stated she modified the initial physician order by adding Vaseline gauze to keep the wound moist and allow passage of drainage. V17 stated she added multivitamin regimen and zinc sulfate to help improve wound healing.

On 5/10/21 at 2:35 P.M., V19 (R1's Attending Physician) stated he was notified of R1's incident on the night of 4/26/21. V19 stated he was informed that the incident occurred during the day. V19 stated he would have preferred to be notified of the incident immediately and he would

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have instructed nursing staff to loosen R1's clothings, apply cool compress and use silvadene treatment on the wounds. V19 stated the cool compress would have decreased the burn area of the skin. V19 further stated he was not informed R1 refused the ice packs but he saw R1 the following day after the incident with second degree burns.

The facility's policy titled, "Accident/Incident Reporting" dated 10/03/2019 showed: "To ensure prompt and appropriate treatment to any resident sustaining an incident or accident...Report event/occurrence to supervisor, head nurse, or department manager...complete appropriate documentation on the shift that the accident or incident occurred and provide this information to the supervisor". Further review of the policy showed: The license nurse shall..examine all accident/incident victims...assess the extent of the injury...administer first aid for minor cuts or abrasions..

"B"