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
	IL6002141	A. BUILDING: ______ B. WING ______	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY HEALTH	2304 C R 3000 N GIFFORD, IL 61847

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S 000	Initial Comments Investigation of Facility Reported Incident of 2/10/22/IL144099 Investigation of Facility Reported Incident of 2/10/22/IL144106	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 1/2 300.3210f) Section 300.3210 General f)The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories. (Section 2-103 of the Act) These regulations were not met as evidenced by: Based on interview and record review the facility failed to prevent misappropriation of property for one (R2) of 39 residents reviewed for abuse in the sample list of 39. This failure resulted in R2's personal money in the amount of $64.00 being taken without permission from R2's purse that was stored in R2's bedroom. Findings include: On 3/1/22 at 8:56 AM R2 stated: About three weeks ago R2 noticed R2's money was gone. R2 had about $66 in R2's purse, and there was only $2 left. R2 had went to therapy that day and left	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 R2's purse in the 3rd drawer of R2's dresser, and later that day R2 had the purse under R2's bed sheets. R2 had last checked R2's money about 3 days prior to the day R2 noticed it was missing. R2 had received $30 cash from family the beginning of August 2021, and a few weeks ago V14 Licensed Practical Nurse (LPN)/R2's Family had given $100 cash to R2 to go out to eat. R2 had money leftover that R2 placed into R2's purse, near the back pocket with R2's wallet. R2 has not had any problems with missing items or money for the last year and a half. R2 said there were two newer staff that R2 suspected may have taken the money. One was an agency Certified Nursing Assistant (CNA) (V38) who gave R2 a shower prior to 2/10/22. (V38) had left the shower room a few times to get towels, and R2's money may have disappeared then. The facility also had a new janitor (V15 Agency Housekeeper) that worked on R2's unit. R2 stated whoever took it must have needed the money more than me (R2.) R2's Minimum Data Set dated 1/24/22 documents R2 is cognitively intact. The facility's Report to Illinois Department of Public Health dated 2/16/22 documents: On 2/10/22 at 8:30 PM R2 reported that R2 was missing $64 from R2's room. "Following Investigation and search of room, reported money is unable to be located. Interview with (R2) reports that (R2) is not sure when the money went missing and is not exactly sure how much money (R2) is missing. Interviews with staff report no one aware of the location of the money. Investigation concluded, however facility staff will continue the search. V16's (LPN) written statement dated 2/11/22	S9999		

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documents: On 2/10/22 at 8:00 PM R2 was going through R2's purse. R2 showed V16 that R2 had $2.00 in R2's wallet. R2 said that R2 had $64.00 that was missing from R2's wallet. R2 said that R2 checks R2's money every couple days and the money was there 2-3 days prior. R2 didn't know where the money went. R2's room was searched and the money was not found.

The undated note with a time of 9:50 AM documents V13 CNA said R2 had money in R2's wallet on Monday (2/7/22), and R2 stated a dark skinned employee gave R2 a shower and cleaned R2's room. R2's Audit Report documents V38 Agency CNA gave R2 a shower on 2/9/22.

On 3/1/22 at 11:51 AM V14 (R2's family) stated: V14 had given R2 $100 cash to go out to eat with family (at an unidentified time.) R2 refused to give V14 the remaining change. R2 may have had $50 left over. R2's family member gave R2 $30 for R2's birthday in August 2021, and R2 kept that money in R2's purse. R2 has not had any prior problems with missing money. R2 told V14 that R2 was missing about $60. R2 thinks it was two agency staff that stole R2's money, and that they had it planned. R2 usually takes R2's purse into the shower, but this time "they whisked (R2) away." R2 left R2's purse behind in the room. R2 is "pretty smart about (R2's) money." R2 told V14 "they didn't take the one dollar bills or (R2's) change."

On 3/1/22 at 2:57 PM V13 CNA stated: On 2/11/22 R2 told V13 that R2 had $64 that was missing. On 2/7/22 R2 pulled out money from R2's wallet to offer to pay V13 for animal wall decor that V13 had given to R2. V13 refused money from R2. V13 was not sure the exact amount that R2 had. R2 told V13 that R2 believed

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a dark skinned employee took R2's money while R2 was out of R2's room during a shower that week. R2 told V13 that R2 had left R2's purse on the floor in R2's room, and R2 usually takes the purse with R2 to the shower.

On 3/2/22 at 9:01 AM V16 LPN stated: On the evening of 2/10/22 R2 told V16 that R2 was looking through R2's wallet and $64 dollars was missing. R2 showed V16 that R2 had two one dollar bills remaining. R2 told V16 that R2 checks R2's purse every couple of days, and R2 thought the money was gone within the last couple of days.

On 3/1/22 at 12:18 PM V24, Housekeeping Supervisor stated V15, Agency Housekeeper worked on R2's unit on 2/7, 2/8, 2/9 and 2/10/22, and V15 no longer works in the facility. On 3/1/22 at 1:26 PM V2 Director of Nursing reviewed the facility's hall assignments from 2/7-2/10/22. V2 confirmed V38 Agency CNA worked on R2's unit between 2/7/22 and 2/10/22.

On 3/2/22 at 9:58 AM V1 Administrator stated: On 2/10/22 around 8:30 PM, V16 LPN reported that R2 was missing money. R2 said the money went missing a few days ago, and wasn't sure of an exact day or how much money was missing. We searched R2's room and was unable to locate R2's money.

The facility's Abuse Prohibition policy revised 3/15/18 documents the following: "No person shall misappropriate or steal any resident ' s Property."

(C)

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S9999	Continued From page 4 300.1210b) 300.1210d)6) 300.1220b)3) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as	S9999		

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nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure safety of a resident by failing to ensure R1 was assessed for independent safe handling of extremely hot liquids. This resulted in R1 sustaining 2nd degree burns to R1's right thigh. The facility also failed to develop and implement a care plan to include R1's coffee spill and burns, and interventions to prevent reoccurrence. R1 is one of three residents reviewed for accidents in the sample list of 39.

Findings include:

The facility's Report to IDPH (Illinois Department of Public Health) dated 2/16/22 documents the following: On 2/10/22 at approximately 6:15 AM R1 was attempting to get coffee and spilled coffee on R1's right upper thigh. R1 was assessed and there was an open blister to R1's right thigh. After investigation, the facility determined that R1 independently attempted to obtain R1's coffee. When R1 went to apply the lid to the cup, the cup tipped and spilled coffee onto R1's right thigh.

R1's Nursing Note dated 2/10/2022 1:26 PM documents R1 spilled coffee on R1's thigh and burned an area that measured 6.25 cm

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(centimeters) by 5 cm. R1's Progress Note recorded by V11 Nurse Practitioner dated 2/10/22 documents: R1 was evaluated after a coffee spill to R1's right thigh. There was an area with skin peeled away to R1's right inner thigh. R1 had a superficial burn of the right lower extremity.

V12 Physician Progress Note dated 2/17/22 documents R1 has a 2nd degree burn and right thigh injury.

R1's undated Diagnosis List documents R1 has a diagnosis of Hemiplegia/Hemiparesis following Cerebrovascular Disease affecting the right side. R1's Minimum Data Set dated 1/27/22 documents R1 is cognitively intact, R1 requires supervision of one staff person for eating, and R1 has impaired range of motion to one upper and lower extremity. There is no documentation in R1's medical record that R1 was assessed for safe and independent handling of hot beverages.

On 3/1/22 at 2:12 PM V8 Licensed Practical Nurse (LPN) removed R1's dressing to R1's right thigh. There was a large pink/red area with peeled skin, and two small pink areas to R1's right thigh.

On 3/1/22 at 9:46 AM R1 stated R1 had gotten coffee by R1's self that morning (2/10/22) like R1 "usually does." R1 placed the cup on R1's lap to attempt to apply the lid, and the cup tipped and spilled onto R1's lap. The coffee burned and blistered R1's groin.

On 3/1/22 at 11:17 AM R1 was sitting in the assisted dining room in a wheelchair, feeding R1's self with R1's left hand. R1's right hand/arm was positioned at R1's side. R1 was drinking from a coffee cup with a sipping lid. The coffee

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S9999	Continued From page 7 machine was located on the counter of the dining room, near the edge, and within access of the residents. On 3/1/22 at 12:05 PM the coffee was sampled from the dispenser in the assisted dining room. The coffee tasted very hot. The February 2022 Coffee Temperature Log documents the coffee temperature ranged from 166-171 degrees Fahrenheit (F.) On 3/1/22 at 9:42 AM V7 Certified Nursing Assistant (CNA) stated: If they (residents) are "with it" (cognitively intact) they go and get coffee themselves. Most of the time the residents ask staff to get coffee for them and we put a lid on it. R1 does go and get coffee independently. On 3/1/22 at 11:31 AM V5 Dietary Aide stated: The facility used to have a coffee machine that had an on/off switch. We could turn it off to prevent residents from getting their own coffee. We got a new machine about two months ago. We haven't been able to figure out a way to turn it off like the last one. R1 does get R1's own coffee. On 3/1/22 at 12:00 PM V6 Dietary Manager stated: Usually the coffee temperature ranges from 158-170 degrees F. Yesterday the coffee was 169. V6 obtained coffee from the machine located in the dining room near the administrative hall. V6 calibrated V6's thermometer and obtained a temperature of 171 degrees F. In general staff get coffee for the residents, but sometimes the residents "sneak in" to the dining room and get coffee. The coffee machine in this dining room is on 24 hours per day for staff to get coffee. V6 has heard that R1 comes into the dining room and gets coffee on R1's own. Following R1's coffee spill we monitored the	S9999		

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temperature of the coffee for 4 days. Other than that I'm (V6) not aware that we have done anything different.

On 3/1/22 at 2:49 PM V9 LPN stated: R1 often gets up at 3:00 AM and gets R1's own coffee in the dining room. On 2/10/22 shortly after 6:00 AM, R1 told V9 that R1 had spilled coffee on R1's lap and R1 said "it burns." V9 assessed R1, and R1 had ripped open a blister to R1's right thigh and had applied barrier cream to the area. V9 measured the burn. R1 reported to V9 that R1 had attempted to get the coffee by R1's self. The cup spilled when R1 attempted to apply the lid. R1 can only use the left hand, due to a stroke. R1 can only grasp with R1's right fingers.

On 3/2/22 at 10:30 AM V10 Certified Occupational Therapy Assistant (COTA) stated: V10 had treated R1 for OT previously in November 2021. R1 had no functional range of motion to R1's right upper extremity upon R1's discharge from OT. R1 would use R1's left hand to feed R1's self. It would require two hands to safely apply a coffee lid. V10 was not aware that R1 had been getting R1's own coffee. The facility has been using sipping lids for the coffee cups. If V10 was aware that R1 was independently getting coffee, V10 wouldn't have recommended anything other than R1 may not have required the use of the lid.

On 3/2/22 at 10:51 AM V11 Nurse Practitioner stated V11 was asked to evaluate R1 on 2/10/22 following a coffee spill. V11 stated the coffee burned R1's right thigh. V11 was asked if V11 had any concerns regarding R1's ability to safely and independently obtain coffee. V11 stated V11 would have recommended for R1 to be re-evaluated by OT. On 3/3/22 at 9:46 AM V11

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stated: V11 assessed R1's right thigh burn today. V11 is referring R1 to a wound clinic. V11 was told that R1 had gotten coffee, and while attempting to put the lid on the cup, the coffee spilled onto R1's lap. V11 thought the burn looked a little worse today, and a couple areas are starting to blister. V11 agreed with V12's assessment, that the burn is a 2nd degree burn. Scarring would be based on the healing process, and R1 is a diabetic so healing will take longer.

On 3/2/22 at 11:00 AM V2 Director of Nursing stated R1 was not assessed for the ability to safely and independently obtain R1's coffee since R1 is alert and oriented.

On 3/2/22 at 9:36 AM V1 Administrator stated R1 reported to the nurse that R1 had spilled coffee on R1's lap. R1 had attempted to get the coffee by R1's self. We have now instructed staff and R1 that staff are to get R1's coffee. R1 still tries to get R1's coffee independently, and staff continue to re-educate R1. At 9:56 AM V1 Administrator stated the facility does not use an assessment tool to determine a resident's ability to safely and independently obtain hot beverages. At 1:05 PM V1 Administrator stated the facility does not have a policy for the provision of hot beverages or accident prevention regarding hot beverages.

(B)