STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004675	A. BUILDING: ______ B. WING ______	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE PAXTON SENIOR LIVING	450 FULTON STREET PAXTON, IL 60957

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S 000	Initial Comments Complaint Investigation 2366660/IL163077	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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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:

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 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 left thigh. The facility also failed to implement an intervention for an adaptive cup for one (R1) of three residents reviewed for accidents in the sample list of three.

Findings include:

R1's Minimum Data Set dated 7/9/23 documents R1 has Dementia with moderate cognitive impairment and requires setup and supervision assistance for eating. R1's Care Plan dated 8/14/23 documents "(R1) has a skin burn of the left lateral thigh/groin r/t (related to) burn from hot coffee spilled at dinner." This care plan includes an intervention to use a spill proof cup for hot liquids during meals.

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R1's Skin Report dated 8/13/23 at 4:30 PM recorded by V11 (Licensed Practical Nurse/LPN) documents a Certified Nursing Assistant (CNA) alerted V11 that R1 had a skin concern to the left outer thigh and R1 stated R1 had spilled coffee on R1's self during dinner. This report documents the area was assessed and describes the wound as a burn on the left hip, but there is no description of the wound or measurements of this burn until 8/14/23. The interdisciplinary team (IDT) note dated 8/14/23 documents the root cause of R1's burn was determined to be R1 spilled hot coffee on R1's lap during dinner and the new intervention was for R1 to use a spill proof container for hot liquids during meals. R1's Skin Assessment dated 8/14/23 at 5:00 PM documents a 6 (centimeter) by 6 by 0.1 new open area to the left hip.

V18 (Certified Nursing Assistant/CNA) written statement dated 8/14/23 documents at 4:30 PM (on 8/13/23) a dietary staff member reported that R1 had spilled coffee and R1's pants may be wet. V18's statement documents V18 went to the dining room and did not notice R1's pants to be soiled. There is no documentation that R1's pants were changed or that R1's skin was immediately assessed for injury. V13 (Certified Nursing Assistant/CNA) written statement dated 8/13/23 documents at 10:30 PM V13 was assisting R1 with toileting and noticed what appeared to be a burn to R1's left thigh. V13 reported this to the nurse. V8 (LPN) written statement dated 8/13/23 documents at 10:30 PM V8 was notified that R1 had a wound to R1's left upper thigh/groin, and R1's wound appeared to be a "scald burn." R1 reported that R1 had spilled coffee on herself. V11's Written Statement, dated 8/13/23, documents at 11:03 PM V8 reported that R1 had

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blistered, red areas to R1's left upper thigh and groin area.

R1's medical record does not document R1 was assessed to determine R1's ability to safely handle hot liquids prior to R1's incident. The 8/13/23 Evening Meal Food Temperature Log documents the coffee temperature was 170 degrees Fahrenheit.

On 8/15/23 at 9:25 AM, V21 (Certified Nursing Assistant/CNA) written transferred R1 onto the toilet and there was a large, reddened area with peeling skin to R1's left upper thigh. V21 stated V21 was told by V2 (Director of Nursing/DON) that R1 burned herself with coffee. V21 stated R1 usually feeds herself and requires only setup assistance. V21 stated R1 has spilled drinks when R1 is really tired.

On 8/15/23 at 10:53 AM, V7 (Registered Nurse/RN) administered R1's left thigh wound treatment. There was a large reddened, raised area from R1's outer thigh that extended across the thigh and down to R1's groin. The center of the wound contained a large, circular, open, moist, shallow wound that contained white, red, and pink tissue. R1 asked V7 "what did I (R1) do there." V7 (RN) told R1 that R1 had spilled coffee there. On 8/15/23 at 11:11 AM, R1 was sitting in the dining room. V21 (CNA) poured R1 coffee that was served in a ceramic coffee mug that did not contain a lid. There was no staff sitting with R1 providing assistance. At 11:15 AM, V23 (Dietary Aide) poured R1's coffee out of the mug and into an adaptive cup with a sipper lid. At 11:24 AM, V21 stated staff were given education following R1's coffee burn, but it did not say anything specific other than dietary is supposed to check the coffee temperature prior to serving.

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V21 stated R1 does not use any specialized or adaptive cups and V21 was unsure what interventions were implemented to prevent R1's burn injury from reoccurring. V21 stated V21 had added ice to R1's coffee today prior to serving.

On 8/15/23 at 11:36 AM, V18 (CNA) stated on 8/13/23 around 4:30 PM, V22 (Dietary Aide) told V18 that R1 spilled coffee on R1's pants. V18 stated V18 went to the dining room and R1 was sitting at the table eating, V18 didn't think anything of it at the time, because V18 thought R1's coffee spilled onto the table and then onto R1's pants. V18 did not think about the coffee burning R1. V18 did not physically check R1's pants nor report the coffee spill to a nurse. V18 stated V18 did not provide any care for R1 that evening. V18 stated R1 does not need assistance with eating, staff just need to keep an eye on R1.

On 8/15/23 at 11:42 AM, V9 (Certified Nursing Assistant/CNA) written stated R1 feeds herself, requires cues, and sometimes R1 places R1's coffee mug between her legs while wandering the facility in R1's wheelchair. V9 stated sometimes R1 would spill coffee while wandering. On 8/15/23 at 12:18 PM, V3 RN stated R1 feeds herself, but occasionally spills food onto her clothes. On 8/15/23 at 1:22 PM V10 CNA stated R1 spills liquids "all the time" and R1 does not use any type of special cups.

On 8/15/23 at 12:39 PM, V22 (Dietary Aide) stated on 8/13/23 around 4:30 PM/5:00 PM V22 saw that R1 had spilled coffee on R1's lap and V22 reported this to a CNA. V22 stated R1's coffee is always served in a standard coffee mug and R1 does not use any type of specialized cups. V22 stated V22 did not realize the coffee was hot enough to burn R1 and was unsure what

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the temperature of the coffee was that evening and that they generally start serving coffee around 4:00 PM. V22 stated we now have to check the temperature of the coffee when the first cup is poured and record it on the log. V22 was unsure of any other interventions implemented after R1's incident.

On 8/15/23 at 2:27 PM, V8 (LPN) stated V8 came on duty at 6:00 PM on 8/13/23 and around 10:30 PM V9 (CNA) reported R1's wound. V8 stated R1 had what appeared to be a "splash burn" on R1's left thigh that extended to R1's groin, and the top part had broken skin where the initial contact was made. V8 stated the burn appeared to be a 2nd degree, that was red and blistered. V8 confirmed R1 has spilled liquids previously and stated it was related to R1's age and shaky hands. V8 stated we should either monitor residents while they are drinking coffee or add ice cubes to the coffee.

On 8/15/23 at 12:31 PM, V11 (LPN) stated V11 worked 6:00 PM to 6:00 AM on 8/13/23 and at 11:00 PM V8 (LPN) reported that R1 had an apparent burn with blisters to R1's left upper thigh. V11 stated R1 reported that R1 had spilled coffee at breakfast, but R1's time perception is not always accurate. V11 stated R1's left thigh wound was red with small, raised blisters and one open circular wound. V11 stated none of the staff on evening shift were aware that R1 had spilled coffee on herself earlier that day until the wound was identified.

On 8/15/23 at 12:24 PM, V19 (Social Services Director/Former Dietary Manager) stated V19 was the Dietary Manager for 4 years up until a few weeks ago. V19 stated prior to R1's incident the facility had been checking the coffee temperatures when dispensed from the machine

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S9999	Continued From page 6 and from the carafe when taken to the dining room, and now we are checking the temperature when the first cup is poured from the carafe. The coffee temperature dispensed from the machine was 180 degrees Fahrenheit (F) and the temperature from the carafe was between 160-170 degrees F. V19 stated on 8/14/23 R1 was provided a spill proof cup to use during meals. V19 stated V19 was not aware if the facility has a policy regarding assessing residents for safe handling of hot liquids. V19 stated if residents are noted to have safety concerns it is brought up in the interdisciplinary team meetings, the resident is then assessed to determine if safety interventions are needed. V19 denied that R1 had a history of spilling food/liquids prior to R1's incident. On 8/15/23 at 12:00 PM, V2 (DON) stated V2 is unsure if the facility has a policy regarding the provision of hot liquids and assessing residents for safe handling of hot liquids. V2 stated nursing does not conduct any kind of assessment for that, but maybe dietary does. At 1:35 PM, V2 stated V11 (LPN) reported on the evening of 8/13/23 that R1 had what appeared to be a burn wound to the left thigh/groin area, and R1's incident happened at supper. V2 stated V2 was informed that staff had witnessed R1 spill coffee at dinner, and confirmed this was the cause of R2's burn. V2 stated the incident was reviewed with IDT and we implemented for R1's hot liquids to be in a spill resistant cup. On 8/15/23 at 1:05 PM, V1 (Administrator) stated we prefer the coffee from the dispensary machine to temp between 180-190 F. V1 stated there is no routine assessment done to assess residents for ability to safely handle hot liquids, it is just done on an as needed basis when concerns have	S9999		

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brought them to IDT. V1 stated there had been no prior reported concerns that R1 has spilled hot liquids and R1 has not had any burns previously.

On 8/16/23 at 2:37 PM, V6 (Physician) stated V6 was notified that R1 had a burn on 8/13/23 caused from a coffee spill. V6 stated a burn like that could happen instantly and the damage would have happened within the first few seconds to minutes of the spill. V6 stated V6 thought the facility did ongoing assessments of resident's spill risk. V6 stated it hadn't been reported to V6 that R1 had a history of spilling food/liquids, and if R1 had repeated spilling V6 may have recommended the use of lids or keeping the coffee temperature below a certain range.

The facility's Food Safety: Preventing Burns policy dated 2017 documents the following: "Hot food and beverages will be served at a safe temperature that prevents burns." Hot beverages will be served at 160 (degrees Fahrenheit) F to 185 (degrees) F, the optimum temperature for patient satisfaction." "Hot beverages will be handled carefully during food delivery and meal set-up in an attempt to avoid spills that could cause burns." "Appropriate supervision to obtain hot beverages and/or reheat foods in a microwave will be provided to any individual demonstrating decreased safety awareness and/or anyone who is at risk for burns or scalds based on clinical assessments." "Lap trays, slip guards, or cup holders on wheelchairs may be used to help hot liquids remain upright." This policy includes a chart that documents the following estimated time to receive a 2nd degree and 3rd degree burns based on water temperature: less than 1 second for 2nd degree and 1 second for 3rd degree for 150 degrees, 3 seconds for 2nd degree and 5 seconds for 3rd

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S9999	Continued From page 8 degree at 140 degrees, 17 seconds for 2nd degree and 30 seconds for 3rd degree at 131 degrees, 2 minutes for 2nd degree and 4.2 minutes for 3rd degree at 124 degrees, and 8 minutes for 2nd degree and 10 minutes for 3rd degree at 120 degrees. (B)	S9999		