STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005706	A. BUILDING: _____ B. WING _____	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY MAPLE CREST	4452 SQUAW PRAIRIE ROAD BELVIDERE, IL 61008

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S 000	Initial Comments Complaint Investigation #2417743/IL178472	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999		

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meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

These Requirements were not met evidenced by:

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Based on observation, interview, and record review the facility failed to monitor temperatures of hot beverages prior to serving to residents, resulting in R1 sustaining full thickness (third degree) and partial thickness (second degree) burns to her thighs. This failure had the potential to affect 50 out of 75 residents residing in the facility that drink hot beverages.

The findings include:

The facility's Resident who drink hot liquids form dated 9/30/24 shows 50 out of 75 residents drink hot liquids.

On 9/30/24 at 8:25 AM, residents were observed drinking coffee at the breakfast meal.

On 9/30/24 at 8:27 AM, V3 (Dietary Manager) showed this surveyor the hot water machine. The digital temperature reading on the hot water machine showed 155 degrees Fahrenheit (F).

On 9/30/24 at 8:27 AM, V3 (Dietary Manager) said the facility uses instant coffee packets which are put into a carafe, hot water from the machine is poured into carafe, and then the carafe is sent out to the dining room to serve the residents. V3 said hot water for tea is put into a carafe as well and served.

On 9/30/24 at 9:50 AM, V4 (Dietary Aid) said the coffee is pre-made in a packet which is dumped into a carafe and then you pour water from the machine into the carafe. V4 said all coffee for the facility is made from this machine. V4 said the coffee temperature is not checked before putting the carafes out in serving area for staff to serve the residents. V4 said there is no temperature log for hot beverages.

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S9999	Continued From page 3 On 9/30/24 at 9:55 AM, V3 (Dietary Manager) said they do not check temperature of coffee or hot water before it is served to the residents. V3 said she has never temped the coffee since she started at the facility in July of 2024. V3 said she was not aware of any issues with the hot water machine and there were no work orders for it. At 10:05 AM, V3 said a resident (R1) recently got burned from the coffee and V1 (Administrator) had her turn the machine down to 135 degrees F. V3 said prior to the resident getting burned the machine was set at 165 degrees F. V3 said after she turned it down to 135 degrees F the residents complained and so she turned it back up to 155 degrees F. V3 said she doesn't have a owner's manual for the hot water machine, she just Googled what temperature to set the machine to. V3 was not aware of what temperature to serve hot liquids at. V3 said when R1 got burned it was a Sunday, and she came in and temped the coffee but she didn't document it. V3 said there was no process change for making coffee after the incident and she did not start temping the coffee or hot water before serving. On 9/30/24 at 9:55 AM, V3 (Dietary Manager) poured hot water from the machine and temped the water. The thermometer read 146.9 degrees F. On 9/30/24 at 10:15 AM, V5 (Assistant Maintenance Director) with this surveyor, calibrated his thermometer with ice water and got a temperature of 33 degrees F. V5 then poured hot water from the hot water machine into a coffee cup (used to serve residents) and got a temperature of 143.2 degrees F. V5 said he is not aware of any problems with the hot water machine.	S9999		

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On 9/30/24 at 11:05 AM, V6 (Licensed Practical Nurse/LPN) said on 9/15/24, R1 had coffee in an insulated metal to go cup that her family supplied and had spilled the coffee on her lap. V6 said V7 (Certified Nursing Assistant/CNA) had brought R1 from the dining room to the resident hallway outside of R1's room. V6 said she heard R1 yell "it's burning!" V6 said she had V15 (CNA) lay R1 down in bed to remove her pants. V6 said R1 had redness to her left inner thigh area. V6 said R1's family was at the facility and wanted R1 to get back up to her chair and go the the dining room. V6 said she notified V2 (Director of Nursing), V9 (Nurse Practitioner), and V11 (hospice nurse). V6 said she worked on R1's section for the morning shift and then worked in another section for the PM shift. V6 said V10 (LPN) (who was taking care of R1's section for the PM shift) called her over to look at R1's legs. V6 said both legs around the inner thigh were blistered. V6 said she didn't measure the burns at the time, but the left inner thigh was about the size of a softball and the right inner thigh had multiple blisters of all sizes from just below the groin down her thigh to about 4 inches above her knee.

On 9/30/24 at 11:22 AM, V7 (CNA) said she had brought R1 back from the dining room to her hallway and R1 started pulling on her pants and yelling "it's hot!" V7 said at that time she noticed R1's pants were wet on her inner thighs.

On 9/30/24 at 1:48 PM, V1 (Administrator) said when she was notified of R1's burns on 9/15/24, she had V3 (Dietary Manager) tell her the temperature that the hot water machine was set at, and had her lower it. V1 said she didn't have any one check temperatures of the hot water at that time or have had kitchen staff monitoring the

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temperatures of the hot water since.

R1's most recent Care Plan shows R1 has diagnoses of spinal stenosis, unspecified dementia, Parkinson's disease with dyskinesia, and unspecified neuropathy of lower limbs. This same Care Plan shows R1 has severe impaired cognitive function related to dementia, has Parkinson's with tremors, neck contracture, and decreased safety awareness.

R1's Progress Note dated 9/15/24 at 9:14 AM, by V6 (LPN) shows resident spilled coffee on her left leg, redness and irritation.

R1's Wound Summary dated 9/16/24 by V8 (Wound LPN), shows "right medial thigh, burn, 2nd degree, facility acquired, measuring 13.0 x 6.0 x 0.1 cm (centimeters)." R1's Wound Summary dated 9/16/24 by V8 shows "left medial thigh, burn, second degree, facility acquired, measuring 18.0 x 18.0 x 0.1 cm."

R1's Physician Wound Evaluation and Management Summary dated 9/18/24 (3 days after sustaining burns) shows: "Burn of the left anterior thigh full thickness (3rd degree), etiology: hot liquid, wound size: 2.7 x 7.5 x 0.1 cm. Burn of the right medial thigh partial thickness (2nd degree), etiology: hot liquid, wound size: 7.5 x 6.0 x 0.1 cm. Burn of the left medial thigh, etiology hot liquid, wound size: 2.5 x 4.0 x not measurable cm, fluid filled blister."

The facility's undated Hot Beverage Policy shows "hot beverages are provided to the clients in a safe manner. There is no specific temperature at which hot beverages should be served. Palatability versus the risk of scalding are factors the community takes into consideration when

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S9999	Continued From page 6 serving hot beverages." On 10/1/24 at 1:12 PM, V1 (Administrator) said she reached out to the kitchen provider for safe temperatures for serving hot liquid and the preferred temperature for consuming is 120-135 degrees F, which they will be implementing. 10/1/24 at 1:05 PM, V17 (Dietitian) said she didn't know the safe temperature range to serve hot beverages at, she would need to consult her manual. V17 said the kitchen should have a policy on temperatures, how to monitor temperatures and by whom. (A)	S9999		