STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

ROSEWOOD CARE CENTER OF PEORIA	0035352
Facility Name	I.D. Number
1500 WEST NORTHMOOR ROAD PEORIA, IL 61614	
Address	
02630	08/24/2004
Reviewed By	Date of Survey
COMPLAINT 0423815	15479
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.690a) The facility shall notify the Department of any incident or accident which has, or is likely to

300.1210b)6) have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents

300.3240a) and accidents requiring the services of a physician, hospital, police or fire department,
coroner, or other service provider on an emergency basis shall be reported to the Department.
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.

An Owner, Licensee, Administrator, Employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

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300.690a) Based on record review, interview and observation, the facility neglected to provide treatment
300.1210b))6) for one of three sampled residents (R1). R1 told staff that someone "threw" coffee in his lap,
300.3240a) yet no staff checked for injury until 90 minutes later. R1 was admitted to the hospital with
(Cont=d.) principal admission diagnosis of: Blisters/Epidermal loss due to burn (second degree), multiple sites of lower limb. The facility's initial incident report failed to include pertinent information to inform the Department that appropriate action had been taken regarding this incident.

Findings include:

The initial incident report for R1 was faxed to the regional office on 8/15/04 in the afternoon. Time on the incident for report made is 2 p.m., six hours post time of incident. However, this incident report simply stated that "guest states someone poured coffee and spilled it in my lap. Investigation initiated, final report to follow." , but did not include the information that this resident had large fluid filled blisters on his interior and posterior bilateral thighs and had been sent to the Emergency room. The report also did not include information regarding the resident's cognitive status, nor did it indicate that the facility had immediately implemented practices to prevent further burns from hot beverages.

R1 is an 87 year old resident with diagnoses listed on admission face sheet including: Dementia, Parkinsons, Cerebral Vascular Accident, Macular Degeneration and Peripheral Vascular Disease. This face sheet list admission date as 1/24/04.

R1 was observed on 8/19/04 at 2:00 pm. E7 (Licensed Practical Nurse/LPN) was in the room changing the dressing to R1's burn areas. Two areas were noted on the right inner thigh. The superior area measured 3.5 cm (centimeters) l (length) x 2 cm w (width). The inferior area on his right thigh measured 21.6 (l) cm x 4 cm - 6 cm (w). Both areas were open with the top layer of skin absent, raw appearing and R1 complained of pain when asked. Some loose skin was noted at the edges of the open wounds.

The superior wound on the left inner thigh measures approximately 1.5 (l) cm x 1.5 cm (w) with a fluid filled blister noted. The wound on the outer left inner thigh measured approximately 1.2 cm (l) x 2 cm (w) and was a fluid filled blister as well. The inferior inner thigh wound measured 16.1 cm (l) x 2.4 - 4.8 cm (w). This area was open with the top layer of skin absent, raw appearing and R1 complained of pain when asked. Some loose skin was noted at the edge of the open wound.

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The facility "Level of Care Assessment" completed by E3 (Assistant Director of Nurses) on 7/9/04 under section "Mental Status" describes R1 as "Requires staff supervision to ensure safety in facility due to confusion or lack of orientation. Difficulty communicating personal needs to staff."

Facility "Determination of needs assessment and consent for physical restraint" dated 2/13/04 completed by E10 (Registered Nurse) states, "Safety release belt to remind guest to ask for assistance due to impaired safety judgements secondary to dementia and confusion." The facility "Physical Restraint Review" dated 7/1/04 by E11(LPN) confirms,"(R1) is unable to make judgements regarding safety due to confusion."

The facility "Quarterly Fall Risk Assessment" dated 5/11/04 completed by E12 (LPN) identifies risk factors as: "Confused/Disoriented, Unable to understand/follow directions and poor judgement or decision making." The Care plan for R1 dated 5/12/04 states staff are to: "Monitor guest in dining room...Reorient to his table as needed related to dementia." In interview with E1 on 8/19/04 at 12:00 pm, E1 (Administrator) stated, "There are no CNA (Certified Nursing Assistant) in the dining room during transportation of residents to meals." E1 stated in interview on 8/20/04 at approximately 9:15 am that R1 is confused and thinks another guest is his wife.

The facility final investigation report dated 8/20/04 states the coffee brewer heats the coffee to a temperature of 190 degrees Farenheit (F). The temperature measured by the facility at the point of service (directly from the coffeepot) was 183 degrees (F). During observations on 8/23/04 from 7:15 am until 7:45 am, residents were in the main dining room unattended except for activity staff. E13 (Activity Director) was interviewed at 7:30 am on 8/23/04. E13 stated, "On the weekends, the activity staff does not come in until 10:30 am or 11:00 am." The coffee was measured on 8/23/04 at 7:44 am at the

point of service with a temperature of 174 degrees (F) recorded. E14 (Dietary Aide/Cook) was present during the measurement.

E4 (laundry aide) was interviewed on 8/19/04 at 1:20 pm at the facility. E4 stated,"(R1) was sitting in the dining room. I pushed (R1) to the table (in his wheelchair) about 7:35 am. I got (R1) some coffee and told (R1) to be careful because it was hot. When I left the dining room, (R1) was sipping on it."

300.690a) E5 (dietary aide/cook) was interviewed on 8/19/04 at 1:30 pm. E5 stated, "I usually come out
300.1210b)6) to pass coffee/drinks at 7:40 am to 7:45 am. On Sunday (8/15/04) (R1) was at his table. I
300.3240a) noticed a coffee cup sitting in front of (R1). (R1) usually doesn't drink coffee. At about 7:50
(Cont-d.) am - 7:55 am, (R1) told me someone threw coffee on him. I said I would find a CNA (Certified Nursing Assistant). I told (E8)/(CNA) that (R1) was wet, wanted to be changed and (R1) said someone threw coffee on him. (E8) took (R1) and that was the last I saw (R1) that morning (about 8:00 am)."

E8 (CNA) was interviewed on 8/20/04 at 10:58 am. E8 stated, "I was pushing guests to the dining room when a dietary aide (E5) said (R1) had spilled coffee and needed to be changed. I couldn't find a CNA on his hall. About 8:00 am (R1) was back near the dining room. The CNA (E6) was by (R1) and I told her (R1) had spilled coffee or something and needs to be changed. I didn't tell the nurse but did tell (E6)."

E6 (CNA) was interviewed on 8/19/04 at 1:37 pm. E6 stated, "After breakfast we toilet the residents. As I stood (R1) up, I saw he was wet. I pulled (R1's) pants down and saw some huge blisters. I asked (R1) if he had spilled coffee because it smelled like coffee. (R1) said 'yeah.' I had (E9/CNA) go tell the nurse and I stayed with (R1). No one CNA/Nurse/Dietary told me (R1) was wet or spilled coffee on (R1) that morning."

E9 was interviewed on 8/20/04 at 11:06 am. E9 stated, "We (E6 and E9) took (R1) to his room. We could smell the coffee on (R1). When we stood (R1) up we saw (R1) was wet. When his pants were pulled down I saw the blisters in his groin area. We told the nurse right away. No one told me before I saw the blisters that (R1) had spilled

anything."

E7 (Licensed Practical Nurse/LPN) was interviewed on 8/19/04 at 1:10 pm. E7 stated, "I was first notified at 9:30 am. The minute I saw it, I ran and called the doctor and family immediately. No one had told me (R1) had spilled coffee. After talking to the doctor, I gave (R1) Tylenol and placed ice on it."

Facility transport records documents R1 left for the hospital emergency room at 9:55 on 8/15/04 by ambulance.

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The emergency room physician's report states, "The patient was noted to have burns over his thighs bilaterally with significant amount of discomfort. No pre-transport treatment was provided by the nursing home to the patient. The patient was apparently burned by hot liquid. The patient obviously sat in this for a period of time enough to cause burning over the posterior thighs as he (R1) sat in the hot liquid and did not have any treatment initiated at the extended care facility."

Z2's (Attending physician of R1) admission physical to the local hospital on 8/15/04 states, "Acute burns occurring some time this morning to groin and perineal area with thigh and buttock burns after a spill. I was contacted at approximately 9:50 am this morning from the home and notified that there had been a burn which had been unidentified until that time. I said (R1) needed some pain treatment as well as ice to his burns as this had not been initiated and she (nurse) said she was too busy calling the doctor and family. In emergency room I saw (R1) and he stated some employee spilled something on him. (R1) complained about it but no intervention was performed. ((R1) had been doing much better until this incident and this will be a major setback for him."

Z2 was interviewed on 8/23/04 at 2:08 pm by phone. Z2 verified the history and physical dated 8/15/04 to the hospital was accurate. Z2 also stated, "I was very concerned the facility did not address the first aid issue. (R1) has a lot of medical issues and was finally getting somewhat better. I had just changed his office

appointment to every month instead of every two weeks. Now, (R1) has other medical issues added."