

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

LYNWOOD ESTATES

0036004

Facility Name

T.D. Number

301 RODDY ROAD, SALEM, ILLINOIS 62881

Address

Date of Survey: 04/13/2004

COMPLAINTS INVESTIGATION

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):

- 350.610a) The facility's governing body shall exercise general direction of the facility, and shall establish the broad policies and procedures for the facility related to its purpose, objectives, operation, and the welfare of the residents served.
- 350.620a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.
- 350.2730c)5) Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit.
- 350.3240a) 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 observation, interview, and file review, the facility failed:

- 1) Develop policies or procedures and systems to monitor hot water systems in the facility from all water outlets that are accessible to the clients of the facility and to have a system to monitor or replace worn parts for the hot water systems prior to 03/15/04 when a more specific policy was developed.

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"A" VIOLATION(S):

350.610a)
 350.620a)
 350.2730c)5)
 350.3240a)
 (Cont.)

Findings include:

#1 The temperature documentation log from 11/12/03 until 03/15/04 showed that the hot water temperature in the guest bathroom registered from 122 to 132 degrees F. The temperature remained at 122 degrees F on 11 of 11 check dates from 01/05/04 to 03/15/04. The guest bathroom was unlocked and used by clients for hand washing until 03/15/04 when it was recommended that the guest bathroom be locked due to the hot water not being regulated by the mixing valves. This recommendation, however, was not included on the final signed copy of the special staffing for R1 signed by the RSD.

2) R1 received second degree burns over a large area of her right buttocks on 03/14/04, when she independently unclothed herself and sat in a bathtub while the hot water ran into the tub.

Per R1's cover sheet for her 02/23/04 initial Individual Program Plan (IPP) and physician order sheet, R1 is a 64-year-old female with a diagnosis that includes profound mental retardation (IQ of less than 25 and an adaptive behavior score of two years and two months), obesity, cataracts, encephalopathy due to congenital syphilis, aggressive behavior - psychosis, overactive bladder, and retinitis pigmentosa.

R1 was admitted to the facility on 02/23/04 from another group home.

The social service report of the IPP states that R1 is legally blind; but per observation during the survey and staff interview with E2 and E6 on 04/08/04, R1 has functional vision to independently access the facility and independently pick up small items.

According to the incident report of 03/14/04 written by Z4, past direct care staff person, at 11 a.m. on 03/14/04, Z4 heard the water running in the bathroom and found R1 in the bathtub with the water running and sitting backward in the tub "Indian-style" and positioned in the middle of the tub. Per the report, the water was hot to touch and the water was already draining. The report said that Z4 then proceeded to remove R1 from the tub. Per the incident report, there was 1/2 inch of water in the tub.

Based on the facility documented interview in their investigation of the incident, Z4 stated the water was running in the tub when she found R1 in the tub, the water was hot to touch, there was 1/2 to 1 inch of water in the tub and the drain was in the open position. Z4, per the written facility investigation, turned R1 around in the tub and proceeded to give her a bath. The large areas of blistering on R1's right buttocks were not observed until Z4 got R1 out of the tub to dry her. This was verified with E6, direct care staff, interview on 04/08/04 at 2:40 p.m. E6 was working with Z4 on 03/14/04 when R1 received the hot water burn. She said she saw R1 in the bathtub, could hear water running in the tub and could hear R1 talking in the tub when Z4 entered the bathroom. Per E6 when Z4 found R1 in the tub, she said that she may as well give her a bath as long as she was in the tub. Z4 called out for assistance when she found the blisters while drying her.

Per E6, R1 had been found in the shower with the cold water running when she had worked the night shift. She said she had also been found to be sitting in a bathtub with no water in it at times since her admission to the facility. Per E6, R1 did not call out in the instances when she was sitting in hot

water or standing in cold water.

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350.610a) Per the facility investigation report and verified by interview with E2, service coordinator, on 04/08/04
 350.620a) at 2 p.m. as soon as the burn was discovered, staff were told to call E9, maintenance person, who
 350.2730c)5) came to the facility and adjusted the thermostat on the hot water heater. About one hour later, E2
 350.3240a) checked the hot water temperature in the tub and sink of the bathroom. The temperature registered
 (Cont.) 130 degrees F. E2 said that she took the water temperature with a food thermometer since there
 was not a calibrated water-testing thermometer at the facility. E2 said that she was told that the food
 thermometer was not accurate/ calibrated, but she wanted to have some idea how hot the water was
 that had caused the burn to R1.

The facility had no system in place to ensure hot water would not exceed 110 degrees F. Based on
 interview with E2 on 04/08/04, prior to 03/14/04, the facility policy only stated that the facility would
 check water temperatures. There were no written protocols or procedures how, when, or by whom
 this was to be done. The previous maintenance person was the designated person to check water
 temperatures, according to E2.

Prior to 03/14/04, the maintenance person kept the calibrated thermometer to check water
 temperatures and checked the water temperature at one unspecified faucet on the women's and
 men's side of the facility as well as the guest bathroom and the kitchen sink. There is no evidence
 that consistent hot water temperatures (122 F. degrees) in the guest bathroom sink were regulated,
 nor is there evidence that the facility attempted to determine or correct the cause of the excessive hot
 water. The guest bathroom was used by clients to wash their hands per E6.

Per the facility investigation of the 03/14/04 incident, Z3, past direct care person, said that he
 adjusted the hot water heaters or mixing valves the week prior to the incident because "they" were
 complaining that the water was too hot. Z3 said in an interview on 04/08/04 at 3:45 p.m. that one
 night he checked the water in the parker tub located on the men's wing, and it measured 115
 degrees F. Z3 said the parker tub had its own thermometer. He said that he turned the mixing valve
 down on the men's side thinking it controlled the hot water for the entire facility. He said that the
 water temperature cooled down after adjusting the valve. Z3 said that he reported this to his co-
 worker but could not recall who was told. Z3 said he took it upon himself to check the water
 temperatures in the parker tub but never documented his readings.

Per observation on 04/08/04 at 2 p.m. with E2, the bathtub that R1 sat in with the hot water was
 located on the women's wing across from her bedroom. The tub was a few feet from the bathroom
 door and next to the toilet. The tub had a one handled water control. By leaning on the water control
 handle (if it would be used to hold while getting into the tub), the handle turned very easily to the hot
 water setting. The observation was done with E2 who concurred that the handle turned easily to the
 hot setting by leaning on the handle. R1's burn was consistent with the curve of the tub below the
 faucet.

The nurse's notes written by E4, RN consultant, on 03/14/04 stated that she was called at 11:25 a.m.
 on 03/14/04 regarding R1's injury. E4 said in interview on 04/07/04 at 11:00 a.m. that she came to
 the facility immediately.

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350.610a) The nurse's notes written by E4 state that she found R1 to be fully dressed and sitting on the sofa in
 350.620a) the living room and appeared to be in no discomfort. E4's assessment indicated that R1 has an area
 350.2730c)5) from the coccyx extending horizontally across the right buttock distally toward the outer right thigh.
 350.3240a) The area was "approx.
 (Cont.) 12 - 13 inches across, four inches wide for approx. six inches then tapering to 1/4 inch at the outer
 thigh with open area the size of a dime at the coccyx and a fluid filled blister approx. 6 X 4 inches to
 the right of the open area. The remainder of the 12 - 13 in. area, red skin intact."

Per the emergency room record and nurse's notes, R1 was sent to the emergency room on 03/14/04 at approximately 12 noon, where the burn was identified as a second degree burn. The burn was treated and R1 was released to go back to the facility.

Based on emergency room records, nursing notes, and an incident report, R1 was returned to the emergency room with bleeding from the burn area. Per interview with E7, direct care staff who was working at the time, R1 was crying in the bathroom and a large amount of blood was seen in the toilet, on the bathroom floor, and all over R1's pants. E7 said that blood was "squirting" from a little hole in the burn area. E7 said that when R1 independently pulls down her pants, the pants could have rubbed over the bandaged burn area. Per interview with the physician on 04/08/04, it is possible that a superficial blood vessel could have been bleeding in the open burn area.

As of 04/08/04, the burn was still not healed and a wound care nurse was providing treatment in addition to the facility treatments of the burn. Whirlpool baths were also ordered to treat the burn.

Per observation of the burn in R1's bedroom on 04/08/04 at 3:10 p.m. with E6, the wound was covered with a large dressing and was saturated with green-yellow drainage. The dressing was removed by E6. The wound was a full thickness depth with bright red open area covering the entire crest of R1's right buttock. The area measured 14 inches across the crest from the coccyx to the outer thigh. The widest part of the burned area was two inches wide over the majority of the burn. There was no skin growth observed over the large burned area. The area was measured by E6 at the surveyor's request.

Z1, physician, said in phone interview on 04/08/04 at 9:50 a.m. that he did not know how R1 could have been burned and that a second degree burn is going to take a long time to heal.

3) After 03/14/04, when the facility initiated closer monitoring of hot water temperatures, the clients remained at risk for hot water burns from 03/14/04 until 03/18/04 due to excessive hot water temperatures in the bathrooms.

Per interview with E2 on 04/07/04, and E5, direct care staff, on 04/08/04 at 11:35 a.m., water temperatures were checked on each shift prior to baths. If the water was too hot, the bathroom was not to be used. Per the interviews and inservices, all clients were to have staff assistance for bathing until it could be determined that the water temperatures were regulated.

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350.610a) Review of the water temperature logs (following R1's burn from hot water at 11:30 a.m. on 03/14/04)
 350.620a) indicated the following dates and times faucets exceeded 110 degrees F:
 350.2730c)5)
 350.3240a) 03/14 at 11 p.m. - Men's shower 112 F. degrees. Sink in men's shower room 111 F. degrees.
 (Cont.) Guest bathroom sink 111 F. degrees.

3/15 at 7 a.m. - Women's sink in shower room 120 F. degrees. Men's parker tub 115 F. degrees.
 Sink in the tub room 121 F. degrees. Men's shower 120 F. degrees. Sink in shower room 119 F.
 degrees. Guest bathroom sink 120 F. degrees.

As of 7 a.m., there were no safe areas for clients to wash their hands and yet there was no evidence
 that further temperatures were taken until 32 hours later on 03/16/04 at 3:11 p.m..

For the documented 03/11 measurements on 03/16 of the hot water temperatures, three of four
 water sources on the men's wing had 120 F. degrees hot water readings: The sink in the parker tub
 room, the shower, and the sink in the shower room. The guest bathroom sink had a reading of 120
 degrees.

Although staff were to assist clients with bathing, there was the potential for clients to independently
 enter the tub or shower, as R1 had done 03/14/04. Additionally there was no way to safeguard
 clients who washed hands in the sinks with the excessive hot water. If bathrooms were to be closed
 if the water was too hot on 03/15/04 at 7 a.m., there would have only been one sink in the facility for
 client hand washing.

E2 said in interview on 04/08/04 that the facility thought they could control the hot water by adjusting
 the hot water tank/mixing valve thermostat and found when this did not ensure regulation, that it was
 felt that the mixer valves were faulty. Per a copy of a work order from a plumbing and heating
 company, on 03/18/04, two existing mixing valves were replaced due to hot water problems.
 Following the replacements of the valves, the water temperatures remained below 110 degrees.

The new facility policy states the facility will check water temperatures weekly at all taps and water
 outlets accessible to clients, but does not give procedures as to what staff are to do if the
 temperature exceeds 110 degrees.

The facility failed to ensure client safety when the hot water temperatures were not monitored and/or
 remained too hot prior to needed plumbing repairs.

(A)