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

TAYLOR HOUSE	**0035030**
Facility Name	**I.D. Number**

3021 TAYLOR AVENUE
SPRINGFIELD, IL 62703

Date of Survey: 5/18/04

Complaint 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):

350.620a) **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.**

350.810a) **Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents.**

350.1060a) **The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility.**

350.1230d)3) **Direct care personnel shall be trained in, but not limited to, first aid for accident or illness.**

350.2730c)5) **Hot water available to residents at shower, bathing, and handwashing facilities shall not exceed 110**

degrees Fahrenheit.

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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 record verification, the facility neglected to take necessary measures to keep clients of the facility from harm when they failed to implement their policy to prevent neglect when R1 received hot water burns and when they neglected to take steps to protect 15 of 15 remaining clients (R's 2 - 16) to prevent potential further hot water injury when they:

1) Neglected to implement their system procedures for water temperature monitoring as per their policy prior to and following the 4-18-04 incident when R1 was burned.
2) Neglected to implement their policy for medical emergency procedure when R1 was found with hot water burns on her lower body.
3) Neglected to ensure sufficient direct care staff in the facility on the evening of 4-18-04 to supervise and manage the needs of the clients.
4) Neglected to provide programming or service objectives for residents deemed incapable of mixing hot and cold water to a safe temperature.
5) Neglected to ensure staff were trained in implementing the policy and procedure for monitoring water temperatures.

These failures resulted in R1 receiving first and second degree hot water burns that resulted in an emergency hospitalization due to the burns from 4-18-04 until 4-25-04 when R1 died at the hospital.

Findings include:

Per R1's cover sheet, 1-14-04 Individual Service Plan (ISP) and physician order sheet, R1 was a 62 year old female with a diagnosis of Severe Mental Retardation (the team felt the IQ was less than 36), and a Broad Independence score of 2 years 7 months; Type II Diabetes Mellitus;Congestive Heart Failure; Hyperlipidemia; Intraocular Lens Implant; Osteoarthritis right knee; History of benign ovarian cyst; Hemorrhoids; Dorsal Kyphosis; Affective Psychosis; Depression; Hiatal Hernia; and Coronary Artery Disease.

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Per the ISP, R1 had a Broad Independence Score of 2 years 7 months. The cognitive assessment done 2-15-00 showed a full scale IQ of 36 on the revised WAIS-R, although the "CST" (interdisciplinary team) "believes that [R1's] IQ is less than 36...R1's abilities have failed somewhat due to her declining health."

Review of the ISP and assessments show that R1 was "pleasantly confused", according to nursing assessments, and "must be closely supervised due to poor judgement."

- The Social Services / Guardianship section states[R1] did not recognize a stranger, will scrounge through the garbage or go outside with no jacket on if the weather is cool.
Additionally the social service section stated she liked attention from others and did not independently occupy her leisure time. The social services section stated that R1 must be closely supervised due to her poor judgement and needed verbal prompts to close the bathroom door or bedroom door when undressing. R1 served as her own guardian.
- The Leisure section of the ISP states that "[R1] needs constant supervision when out in the community as she exhibits inappropriate behavior around others."
- The Motor Skills area states that, "She had difficulty following verbal instructions."
- The Communication area states that, "Her speech was difficult to understand if the topic was not known...[R1] had limited responses to questions and comments, she was not able to maintain a conversation past social greetings...[R1] demonstrated knowledge of events and activities within her environment... could follow simple directions and routines..."
- The Functional Skills section states at times R1 defecates or urinates on herself, is able to start her bath water and clean herself, but requires assistance with regulating the water temperature. She needs assistance with washing off and thoroughly toweling off. "[R1] requires extensive support."
- The Cognitive Skills section stated that "an IQ of 36 is the lowest measurable score given on the WAIS-R. In reality, [R1's] IQ is much lower than can be accurately

measured...has difficulty identifying her own name from other names" and cannot recognize letters and is not able to pick a particular soda.

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350.620a) **R1 received first and second degree burns on her feet, buttocks, and legs on the evening**
350.810a) **of 4-18-04 when she independently unclothed herself after 3 residents (R's 2, 3, and 4)**
350.1060a) **assisted her in coming to the bathroom, running hot bathwater and bathing her based on**
350.1230d)3) **facility incident report and staff and client interviews.**
350.2730c)5)
350.3240a) **According to the GP-15 report (report of incident) written by E4, between 8 - 8:15 PM**
(Cont'd.) **on 4-18-04, R1's clothing was put in R2 and R4's bedroom and adjoining bathroom (Room 1 according to facility diagram) on a chair [in preparation] to give R1 a bath after [E4 gave] R16 a bath. E4 wrote she saw R1 in the living room. E4 wrote that she went to get R16 off of the toilet to put her [R16] "in chair" [wheelchair], answered the phone, and pushed R16 into her room (room 7 per the diagram). When E4 came out of the dining room, R4 was in the hallway and said ,"that girl needs help out of tub." Per the report, when E4 got to the room, R1 was in the bathtub. Her skin was red and there was no water in the tub. Per the report, R's 2, 3, and 4 were all in the bathroom with R1 and R1 was laying on her left side and could not get out [of tub]. E4 saw that R1's feet had blistered and she had burns on both feet, the back of her left leg, her left buttock cheek and on the inside of her right thigh.**

The final report by the emergency department of the hospital dated 4-18-04 at 9:00 PM states that R1 was seen at 8:33 PM. The presenting problem was "Major burn" with the occurrence noted as "a few minutes prior to arrival". The location of the burns were noted to be on her "back, abdomen, right hand, left hand, right leg, left leg, right foot and the left foot. Quality; blisters and erythema. The degree of severity is moderate...Prior skin problems; negative. Risk factors; negative. The

location where the accident occurred was at group home."

Other symptoms noted were moderate erythema and moderate pain. Morphine Sulfate (MS) 6 mg was given. The examination of the skin showed blisters, circumferential burn, first degree burns 20% and 2nd degree burns 15%. The impression and plan stated, "Burn, major, Diagnosis of burn and burn of the abdominal wall; Second degree burn of the back; Burn of the hand; Blisters with epidermal loss due to burn (second degree) of foot."

Her condition was listed as "stable but guarded".

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R1's hospital expiration flow sheet stated that she died at 6:55 PM on 4-25-04.

Phone interview with Z1, physician on 4-29-04 at 2:45 PM indicated that R1 died from multi organ system failure in the burn unit of the hospital on 4-25-04. Per Z1, R1's heart had 1/3 of the function of a normal person's heart. She said that when R1 went into renal failure and had to undergo renal dialysis at the hospital, that it could have been caused by the cardiac condition, but that the condition could have been exacerbated by her burns on her body. She said it was difficult to do fluid replacement for burns with someone with a compromised cardiac condition due to possibility of overloading the heart.

Z1 said when she spoke with the facility director, she questioned how R1 could have gotten burned and was not informed that the skin was off of her feet. Z1 said that the facility told her that her burns were not that bad. Z1 said she did not tend to R1's medical care while she was in the hospital.

Z3, physician, said per phone interview on 5-4-04 at 11:35 AM that he saw R1 in the hospital, that she had 1st and 2nd degree burns and was tended to by the plastic surgeon in the hospital burn unit and her chronic medical conditions were exacerbated by her burns.

Z2, physician, said per phone interview on 5-4-04 at 12:20 PM that she saw R1 in the burn unit of the hospital and worked on the sidelines with the physicians in the burn unit.

She said that renal failure is common for those with burns and was exacerbated by R1's congestive heart failure.

She said that reading some of the physician progress notes, she thought R1 had 1st and 2nd degree burns on 37 % of her body and that some of the burns were bad enough and not healing so that skin grafting was considered. She thought that the back of her thighs and feet were being considered as sites needing grafting.

Z2 said that R1 had started to go into multi system failure prior to Thursday, 4-22-04. Z2 said she felt that the burns contributed to R1's death. Z2 said that R1's medical condition had been stable prior to her receiving burns from hot water at the facility. Z2 said in interview on 5-11-04 at 9:58 AM per phone regarding transferring R1 to the hospital per car with slippers and clothing, that one would have to worry about clothing and shoes / slippers sticking to the burns and the risk of infection.

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Z9, physician, said per phone interview on 5-11-04 at 8:40 AM that he cared for R1's cardiac condition in the hospital and he had not seen her prior to hospitalization. He said that he did not feel that R1 had a heart attack - that there was no blocked artery in the heart, but that rather her heart problems were due to severe cardio-myopathy and congestive heart failure (CHF). Z9 said that there was more of a fluid build-up (CHF) and that her heart was a severe underlying medical problem when seen in the hospital following R1's burns.

Z9 said R1's heart condition worsened from the stress of the burn injury.

1. Water temperatures were not monitored in client bathrooms according to facility policy prior to and following the 4-18-04 incident when R1 was burned. The facility failed to follow it's Hot Water Policy (of 10-01-84 / revised 10-19-88) that states, "Hot water available to residents at shower, bathing, and hand washing facilities shall not

exceed 110 degrees F. and the procedure that states, "Hot water outlets shall be monitored in residents' bathrooms one time weekly."

1.a. The facility neglected to monitor hot water in resident shower / tub / bathrooms prior to 4-18-04 when R1 was burned with hot water.

Prior to R1's hot water burns, the facility maintenance person weekly checked only 4 water outlets in the facility [one reading for men's wing, one reading for woman's wing, staff bathroom and kitchen] according to the water temperature log (form GA-26 of 11-02) and verified by interview with E5, maintenance person on 4-27-04.

The most recent hot water check prior to R1's burn was documented on the log on 4-16-04.

The log stated the kitchen and men's (unspecified bathroom on wing) and the women's (unspecified bathroom on wing) and staff bathroom water temperatures were checked.

The note at the margin of the 4-16-04 date on the log stated "turned down".There is no indication what was turned down or to what degree it was turned down.

E5 said during an interview on 4-27-04 at 12:10 PM that the notation "turned down" meant that he turned the hot water heater down and did not specify to what degree the water heater was turned down.

350.620a)	**E5 stated on 4-27-04 that only one bathtub water outlet was checked on each wing at the**
350.810a)	**farthest end from the hot water heater one time per week. E5 acknowledged that there**
350.1060a)	**were 5 client shower / tub rooms, the kitchen and staff bathroom (for a total of 7 areas of**
350.1230d)3)	**hot water) but he only checked 4 areas (water outlets) of the building.**
350.2730c)5)	
350.3240a)	**E5 said that he started maintenance for the building on October 2003 and this was how**
(Cont'd.)	**he was taught to check hot water temperatures and he was not aware of a facility hot water policy.**

E5 said he was not told to check every bathroom / shower room accessible to clients. Per interview with E2 on 4-27-04, the mixer valve had been replaced last year.

1.b. Following R1's hot water burn of 4-18-04, the facility neglected to follow its Hot Water Policy (of 10-01-84 / revised 10-19-88.)

1.b.1. Following R1's burn on the evening of 4-18-04, there is no evidence the water temperature was checked by facility staff.

Increased monitoring of the water temperature was not initiated until 7 AM on 4-19-04, according to the water temperature log. 7 of 7 areas checked exceeded 110 degrees F:
Staff bathroom - - 120 degrees
Room 1 bathroom - 120 degrees (bathroom where R1 was burned the previous evening)
Room 2 bathroom - 120 degrees
Room 3 bathroom - 120 degrees
Room 4 bathroom - 115 degrees
Room 5 bathroom - 115 degrees
Kitchen - 115 degrees
Per the facility diagram, E5 showed surveyor on 4-27-04 that bathroom where R1 received the hot water burns was located in room 1.

E5 stated in his 4-27-04 interview that the mixer valve was adjusted by the plumber on
4-19-04, who then showed E5 how to adjust the mixer valve. The mixer valve was determined to be faulty and was ordered. It was not installed until 4-29-04 due to the valve not being in stock, according to E5.

350.620a)
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350.1230d)3)

Per the water temperature log, the water temperatures were not checked again until 3 PM
on 4-19-04 when some of the bathrooms continued to exceed 110 degrees F:
Staff bathroom - 111 degrees
Room 1 bathroom - 112 degrees

350.2730c)5)
350.3240a)
(Cont'd.)

Room 2 bathroom - 111 degrees
Room 3 bathroom - 111 degrees

Following R1's burn of 4-18-04 and prior to 4-27-04, per interview with E5, he checked the hot water with a thermometer twice a day around 7 AM and 3 PM Monday through Friday and E2 checked the hot water sometimes.

On Saturday and Sunday (4-24-04 and 4-25-04), documentation on the water temperature log shows that only one [unidentified] water outlet in the facility was checked on each day by the Qualified Mental Retardation Professional (QMRP), E2, which was documented as follows:

4-24-04 check was at 8 AM and 5:15 PM.
4-25-04 check was 10:30 AM and 7:45 PM.
Per interview with E2 on 5-4-04 at 10:30 AM only one water outlet was checked in a resident bathroom at the far end on one hall. The mixer valve had not been replaced at this time.

Per observation of the facility on 4-27-04, there are 2 wings for client bedrooms and bathrooms. The floor plan for client rooms is an "L" shape. The water outlet checked by E2 was at the far end on one side of the "L".

The hot water continued to be poorly regulated prior to the replacement of the mixer valve on 4-29-04 as evidenced by documentation on the temperature log of the following water temperatures on 4-27-04 at 6:45 AM:
Staff bathroom - 111 degrees
Room 4 bathroom - 115 degrees
Room 5 bathroom - 114 degrees
Kitchen - 115 degrees

350.620a)
350.810a)
350.1060a)
350.1230d)3)

"Turned down" is written in the margin of the log next to this date/time.

The log has notes of turned up or down on the following dates / times following R1's burn on 4-18-04:

350.2730c)5)
350.3240a)
(Cont'd.)

4-22-04 - 6:30 AM turned up
4-27-04 - 6:45 AM turned down
4-27-04 - 3:00 PM turned up
4-28-04 - 6:45 AM turned down

There is no documentation if the mixer valve or water heater was turned up or down or to what degree the adjustment was made.

1.b.2. There is no evidence the facility immediately ensured the safety of clients 2 to 16 who were at risk for burns after R1's hot water burn on the evening of 4-18-04.

Based on observation of clients at the facility and verified by E4 and E8, R's 2 - 15 ambulate independently. Only R16 is in an wheelchair and needs staff assist for toileting and mobility.

After 8 PM on 4-18-04 clients had independent access to hot water in sinks and tubs and were at risk to receive burns until the water no longer exceeded 110 degrees F. There is no evidence that the facility checked the temperature of the water or prevented access to outlets with hot water until 7:00 AM on 4-19-04 (approximately 11 hours after the burn occurred) when the water temperatures checked by the maintenance person showed all water sources checked exceeded 110 degrees.

After R1 was burned on the evening of 4-18-04, direct care staff who worked, E4 and E8 per interview on 4-27-04, did not check the water temperatures or secure bathrooms to prevent possible burns to other clients (R's 2 -16) who remained at the facility after R1 was taken to the hospital with first and second degree hot water burns.

2. The facility failed to follow its Policy No. 5.57 for Physical Injury and Illness related to Abuse and Neglect by failing to implement the policy for medical emergencies.

350.620a)

The policy states, "Individuals served by the agency shall receive timely and

	effective
350.810a)	**medical service for physical injuries and illnesses" and defines neglect as ,"Failure to**
350.1060a)	**provide ...services necessary to avoid physical harm, mental anguish..." with the purpose**
350.1230d)3)	**being to "provide guidance to staff in securing timely and effective medical service for**
350.2730c)5)	**individuals".**
350.3240a)	
(Cont'd.)	**Staff failed to call 911 when R1 was burned in the bathtub on the evening of 4-18-04.**

Per interview with E4 on 4-27-04 at 4:50 PM, E4 was giving R16 a shower in the bathroom adjoining her bedroom on 4-18-04. R16 needed total assistance for bathing, dressing and transferring. E4 said that she could not find a disposable diaper for R16. E4 looked in R16's and R1's bedroom, linen closet and laundry room. E4 said she finally found a diaper in the laundry room. During this time, E4 asked R2 to "keep an eye on R16" who was on the toilet while E4 looked for a diaper. Per E4, R16 is a total transfer and will try to get up on her own and has fallen in the past.

Per E4, R2 was visiting R3 in her bedroom where they had visual access to R16's adjoining toilet / shower room.

E4 said that she asked R2 for permission to use the tub in R2's bathroom to give R1 a tub bath since R1 only had a shower in her adjoining bathroom and R1 preferred a tub bath.
E4 said she was also trying to get things ready for R1's bath.
E4 said when she was looking for a diaper, answering the phone and preparing things for R1's bath, she did not know where E8 was - that maybe he was in the kitchen preparing snacks. E4 said that while she was going through the building, she saw R1 in the living room on the sofa asleep with her head on R10's shoulder.

After answering the phone in the dining room, E4 said that R4 was in the hall and told her, "That girl needs help out of the tub." E4 said she did not know what girl R4 was talking about.

Per E4's interview, E4 said that when she got to the bathroom, R's 2, 3, 4 were in the bathroom of Room #1 (R2 and R4's room).

350.620a)
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350.1060a)
350.1230d)3)
350.2730c)5)
350.3240a)
(Cont'd.)

E4 found that R1 was in the tub with no water. R1 normally turned onto her knees to get out of the tub. Per E4, R1 was on her left side and she saw that R1's hip was a little red. When E4 asked what she was doing there, she said that she did not know. E4 said that R1 could not roll over and get up as she normally did. E4 put towels in the bottom of the tub and got into the tub to help R1 up. At that time she saw a "piece of skin on outer left foot, then I saw skin off of her feet...Skin (yellow substance) was in tub, skin was thin, just didn't think - [it] looked like toilet paper."

E4 was not aware 3 clients had helped R1 into the bathroom / tub. E4 said that the staff monitors all clients with access to water but admitted that this was not possible if a staff was busy in a bathroom with another client. E4 did not know where the other direct care staff co-worker, E8, was during the time R's 2, 3, and 4 were putting R1 in the bathtub.

E4 said that R1 can get in and out of the tub, dress and undress and wash her own hair. Per E4, R1 needed numerous prompts to undress, but enjoyed taking a bath.

Per E4, she called for E8 when she found R1 in the bathtub and he assisted her to get R1 on the edge of the tub. E8 said in his 4-27-04 interview that on 4-18-04, he went to the bathroom after R2 and R3 told him that E4 needed his help in R4's bathroom.

E8 said he had just stepped outside to smoke a cigarette when the clients called for his help.

Per E8, there was no water in the tub, but towels in the tub, "maybe to soak up water". E8 saw R1 in R4's bathroom sitting undressed on the side of the tub with her feet on the floor. She was pink from the waist town. E8 said he told E4 to get a robe [for R1] and he sprayed R1 with cold water. E8 indicated that he thought you should put cold on a burn. He asked E4 if they should call 911. Per E8, E4 told him that they do not usually call 911.

E4 and E8 stated they put slippers on R1's feet (with skin off of her feet) , put a robe on her, walked her to a car, "then [E4] took her in [her] car to ER." E4 said that when they arrived at the hospital, she picked her up and put her in a wheelchair to go into the ER. E4 said that R1 never complained of pain until she was in the burn unit - then she "could hear her holler".

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E4 said in her 4-27-04 interview that she panicked. She called E2 at home, told her what happened and told E2 that she [E4] was taking R1 to the hospital and hung up. E4 said that she probably did not give E2 a chance to respond or give directions. E4 said that 911 was not called.

E4 said that she only called 911 one time since she started work at the facility (12-8-00 per employee roster) when a client had a seizure. She said that usually the staff took clients to the emergency room by themselves. E4 said afterwards she was told to call 911.

E4 said that she thought it took about 10 - 15 minutes to take R1 to the emergency room.

With R1's medically compromised diagnosis of diabetes and congestive heart failure, there was the potential that R1 could have had a medical emergency in the car due to the burns to her body and could have suffered additional discomfort from walking on burned feet, having slippers on the burned feet, having clothing on and sitting on a burned buttocks and legs in the car ride to the hospital.

The facility policy for physical injury states that staff on duty should take appropriate action consistent with the following: "If the individual must be taken to the emergency room, Notify the local ambulance [911] service to transfer unless directed otherwise by QMRP or administrator".

3. The facility neglected to ensure that there was sufficient direct care staff to meet clients' needs when:

a. One direct care staff (E4) was left alone with 15 clients around the time R1 was burned when 1 of 2 direct care staff (E8) on duty left to take one client to the store;
b. One (new) staff (E8) was left alone with 15 clients when 1 of 2 direct care staff on duty (E4) left to take R1 to the emergency room and stayed at the hospital until 1:30 AM, when she returned to the facility to work the night shift

c. 5 clients stated they helped staff by assisting in other clients' care or monitoring to prevent falls.

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3.a. E8 said per interview on 4-27-04 at 3:30 PM that he "wasn't here for most of it incident of 4-18-04 when R1 got burned]. E8 said "it was after supper and...the cook was gone. Took a resident, R12, to [name of a grocery store] for a soda." Per E8, R12 wanted to get a soda, so he took her by herself in the van to the grocery store to buy a soda.

When E8 got back to the facility, he went to the back of the facility for a cigarette when R2 and R3 called him to help E4 with R1.

Per time records (punch sheets) for 4-18-04 when R1 was burned, after 7 PM when the time records indicate that E7, the cook, left for the day, the only direct care staff on duty were E4 and E8. E4 was an experienced, trained staff.

E8 started at the facility on 2-17-04 and had not completed all of his training, according to E8.

During the time E8 was away from the facility, E4 was bathing R16 and attempting to find a diaper for R16 in various places through the building. She was also trying to get things ready for R1's bath. E4 said that R16 was not to be left alone and she asked a client (R2) to watch R16 while she was on the toilet. Per E4, R2 was visiting R3 in her bedroom where they had visual access to R16's adjoining toilet / shower room.

E4 was not aware 3 clients were helping R1 into the bathroom / tub. E4 said that the staff monitors all clients with access to water but admitted that this was not possible if a staff was busy in a bathroom with another client.

3.b. E8 was left alone with clients from approximately 8 - 8:15 PM on 4-18-04 until 1:35 AM 4-19-04 while E4 was at the hospital with R1.

Per employee roster, E8 started work at the facility as a direct support person (DSP) / hab tech on 2-17-04.

Per the schedule, 2 direct care staff were to be at the facility until 10:30 PM. When E4 stayed at the hospital, no replacement staff was sent to work with E8. E2, QMRP, was notified by phone by E4 that she was taking R1 to the hospital about 8 - 8:15 PM per the incident report. There is no evidence other staff was called in to work with R8. Since E4 was scheduled to work a double shift (evenings and nights), E8 stayed at the facility on his evening shift until 1:35 AM 4-19-04 when he said E4 returned to the facility to work the night shift.

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350.1230d)3)
350.2730c)5)
350.3240a)
(Cont'd.)

3.c. R's 2, 3, 4, 8, and 12 stated they helped staff out with other clients:

During an interview with R2 on 4-28-04 at 3:12 PM in her bedroom, she said that if water was hot, she would turn down the water. She said that she helped the staff out and put R1 in the bathroom (on 4-18-04). She said nobody asked her to do this. R2 said that she asked R1 if she was ready for her bath - "come with me". Per R2, she thought R4 put the water in the tub.

R4 is a 60 year old female with an adaptive score of 3 years 4 months and moderate level of functioning per resident roster. Also per resident roster, E2 indicated R4 needed assistance with bathing.

R1 was in the bathroom of R2 and R4's room to take her bath.

Per R2, R1 said the water was hot when she got into the tub. R2 did not state how much water was in the tub when R1 got in, but said during the bath the water was up to her waist and pointed to the waist on her own body.

R2 said again, that the water was "very hot" and did not know why it was not cool water.
R2 said that R3 washed her (R1), and R2 took the water out of the tub - the water "was hot". R2 then said that she asked R4 to get E4 and then waited for E4. This corresponds with E4's account that R4 came to get her help.

R2 said that she accidentally helped staff out.

Per interview with R3 on 4-28-04 at 3 PM in her bedroom, she said that R1 was her roommate and she would help put her shoes on in the morning. R3 said that R1 could take her clothes off by herself and liked to use the bathtub in R2's bedroom since there was a [roll in] shower in their (R1 and R3's) bedroom.

R3 said that R4 turned the water on in the tub for R1 and it "was hot". "I washed her back and water was very hot. I turn my water down if hot." R3 said that E4 helped get R1 out of the tub.

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TAYLOR HOUSE	0035030
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350.620a)
350.810a)
350.1060a)
350.1230d)3)
350.2730c)5)
350.3240a)
(Cont'd.)

When asked if clients were ever asked to help staff with other clients, R2 said in the 4-28-04 interview that E4 asked her to watch R16 for a minute.

R3 said in interview on 5-5-04 at 2:20 PM that she was asked to watch another client [R16 when she was on the toilet] only "that one time" (referring to when R1 was in tub and got burned in the 4-18-04 incident).

R8, a verbal male who functions in the moderate level of functioning per resident roster, said in interview on 5-5-04 at 2:25 PM that one time E11 asked him to watch R16 in her wheelchair in the living room so she would not get up. He said that he would have called staff if R16 was falling and he would have helped her if she got up.

R12, a verbal female with a mild level of functioning per resident roster, said in interview on 5-5-04 at 3:39 PM that no staff asked her to watch clients, but she takes it upon herself to watch R16, her roommate, if she is on the toilet alone since one time she was trying to put her diaper in the waste basket and leaned over and fell on the floor of the bathroom and hurt her shoulder. A written progress note on a GP-15 form dated 4-10-04 at 3:03 PM stated that R16 attempted to get off (toilet) alone and fell hitting her right shoulder and right side of her head on the sink cabinet. The note was

written by E11.

Per E4 and per R16's record, she was admitted to the facility on 3-12-04. Z5 stated in phone interview on 5-4-04 at 3:07 PM that R16 was transferred from her previous placement due to increased falls and insufficient staff to monitor to prevent falls.

The initial health and history assessment for R16 written 3-12-04 states that R16 is a high risk for falls.

The admission summary written by the social work consultant states that R16 had falls from her wheelchair when she would try to retrieve an item out of her reach and was very dependent in the area of toileting.

Progress notes verified that R16 was at risk for falls per documentation that R16 fell at the workshop on 4-5-04 and at the facility 4-10-04.

4. The facility neglected to provide programming or service objectives for residents deemed incapable of mixing hot and cold water to a safe temperature.

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350.3240a)
(Cont'd.)

R1 was burned in a bathtub with hot water when R's 2, 3, and 4 put her in the bathtub and bathed her. R's 2 and 3 stated that the water was "very hot" , but there is no evidence they cooled the water, immediately called staff to assist with the hot water or immediately took steps to prevent injury to R1.

Per resident roster given by E2, R's 2 and 3 are totally independent in bathing, including regulating hot water temperature. Although R2 and 3 were deemed independent in regulating water temperature, they made no attempt to cool the bath water for R1 when they stated the water was "very hot."
Per interview with E2 on 4-27-04 at 2:40 PM, the assessment tool used to determine if clients can regulate water temperature is the SIB (Scales of Independent Behavior) assessment.
E2 stated no client is in a training program to regulate water temperature.

a. R2 is a 29 year old female with an adaptive behavior score of 8 years,1 month (per SIB) and mild level of functioning per resident roster. R2 failed to cool hot water in R1's bath water on 4-18-04. She is in no training program to regulate water temperature.
b. R4 is a 60 year old female with an adaptive score of 3 years 4 months and moderate level of functioning per resident roster. Also per resident roster, E2 indicated R4 needed assistance with bathing.

Based on interview with R2 and R3, R4 put very hot water in R1's bathwater for her bath in which R1 received first and second degree burns. R4 is in no training program to regulate water temperature.

c. R3 is a 39 year old female with an adaptive behavior score of 6 years 8 month and moderate level of functioning per resident roster. R3 washed R1 while she sat in hot water in the bathtub. R3 is in no training program to regulate water temperature. Although the roster deemed the clients were independent in regulating hot and cold water. They did not practice these skills when hot water was used when they bathed another client.

5. The facility neglected to ensure staff were trained in implementing the policy and procedure to monitor water temperatures.

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350.3240a)
(Cont'd.)

Staff were not retrained as to how to accurately check water temperature with a thermometer prior to client use for bathing or hand washing until 4-27-04 when the complaint investigation was initiated related to the incident of 4-18-04 when R1 received first and second degree burns due to bathing in hot water.

E2 said in interview on 4-27-04 at 2:40 PM that direct care staff do not document hot water temperatures, that the maintenance person and herself checked and documented the hot water.

Per "In-Service Education / Meeting Report" dated 4-19-04 and signed by E2 as the instructor, training was given the day after R1's burn. E2, however, stated not all staff were trained at the same time: Staff were instructed as they came to work from 4-19-04 to 4-20-04.

The instructions state: "Staff will understand that no resident can take a bath until staff checks water temp. Have resident also check water temp with staff so resident understands what proper water temp should feel like. If staff feels water is hot to touch then staff will take the thermometer and check for exact water temp."
E2 said the inservice did not train staff specifically in how to use a thermometer and that direct care staff do not document water temperatures.

Per E2's 4-27-04 interview, staff were told to put their hand under the water in the bath to see if it was too hot and then clients were to put their hand under the water to check for comfort. The hot water temperature checked on 3 of 17 checks from 4-19-04 to 4-27-04 exceeded 110 F degrees at 7 of 7 hot water outlets checked. There were 12 water outlets in the facility that clients has access to. The water mixer valve was not replaced until
4-29-04 (when the part was available). No thermometers were used by direct care staff to ensure the hot water did not exceed 110 degrees.

E4 and E8 both said in their 4-27-04 interview that they were to check hot water with their hand.

Neither staff could say where the facility thermometer was located to check hot water. E4 thought she would use a cooking thermometer to check water temps if it felt too hot.
Neither E4 or E8 said they could feel the difference between 110 and 112 degrees.

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350.620a)	**E8, who's start date was 2-17-04, according to the employee roster, said he learned the**
350.810a)	**usage of a thermometer for hot water in his training class.**
350.1060a)	**E6, direct care staff, said that she worked at the facility for 15 years and knew the**
350.1230d)3)	**thermometer was on the door at the front (time clock closet) and could probably tell by**
350.2730c)5)	**her hand if the water temperature was above 110 degrees.**
350.3240a)	
(Cont'd.)	**E1 verified that the thermometer was in an envelope on a bulletin board under some papers on the inside of the time clock closet. The envelope was labeled as thermometer with a yellow highlighter and was difficult to easily read and find**

among other papers on the bulletin board.

Direct care staff were not instructed to check water temperatures with a thermometer until 4-27-04.

Illinois Department of Public Health Institutional Health and Safety Section Technical Procedure #9 dated May 1, 1989 titled "Thermal Burn Hazards" stated that time / temperatures required to produce full-thickness (second and third degree) scald burns in the elderly can occur at 3 minutes at 124 degrees F. The notice stated that burns to elderly may be especially serious and could possibly result in death due to a decrease in the skin thickness which allows the burn to penetrate to deeper layers of tissue, and due to impaired cardiovascular function and other biological impairments. (R1 had impairments of Congestive Heart Failure and Diabetes.)

(A)