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

HOMESTEAD HOUSE — Facility Name
0034173 — I.D. Number

905 NORTH JEFFERSON, WEST FRANKFORT, ILLINOIS 62896 — Address

Reviewed By

NOVEMBER 30, 2005 — Date of Survey

ANNUAL — 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 of 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)
350.1060h)
350.1210b)
350.1230b)3)6)
350.1230a)1)2)3)

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.

350.1230e)
350.3030c)4)
350.3240a)b)d)

There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional.

Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

Residents shall be provided with nursing services, in accordance with their needs and which shall include, but are not limited to, the following: The Health Services Supervisor's participation in:

Periodic re-evaluation of the type, extent, and quality of services and programming.

Development of a written plan for each resident to provide for nursing services as part of the total habiliation program.

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Direct care personnel shall be trained in, but are not limited to, the following:

Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

Basic skills required to meet the health needs and problems of the residents.

First aid for accident or illness.

Hot water available to residents at shower bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Sections 2-107 of the Act)

A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (SECTION 3-610 OF THE ACT)

EMPLOYEE AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A REPORT OF SUSPECTED ABUSE OF A RESIDENT INDICATES, BASED UPON CREDIBLE EVIDENCE, THAT AN EMPLOYEE OF THE LONG-TERM CARE FACILITY IS THE PERPETRATOR OF THE ABUSE, THAT EMPLOYEE SHALL IMMEDIATELY BE BARRED FROM ANY FURTHER CONTACT WITH RESIDENTS OF THE FACILITY, PENDING THE OUTCOME OF ANY FURTHER INVESTIGATION, PROSECUTION OR DISCIPLINARY ACTION AGAINST THE EMPLOYEE. (Section 3-611 of the Act)

These regulations were not met as evidenced by the following:

Based on observations, interviews and review of facility's written policy that prohibit mistreatment, neglect or abuse of clients, the governing body neglected to ensure the protection of clients of the facility from harm and to prevent burns from hot water when it failed to develop and provide a system to ensure that water temperatures did not exceed 110 F degrees from all water outlets accessible to residents and to safely monitor individuals who accessed these outlets for:

R5 (one of 16 individuals in the facility) who sustained a large second degree to the top of her right foot while bathing unsupervised by staff.

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R1 - R4; R6-R16 who were at risk for receive burns from hot water that had consistently exceeded 120 F. degrees in all water outlets used by clients for hand washing or bathing.

The facility has failed to develop and implement policies to ensure prompt reporting of allegations of abuse or neglect to the administrator and to the Illinois Department of Public Health, failed to ensure that incidents of possible neglect of individuals, including injuries of unknown origin are thoroughly and immediately investigated, failed to protect residents from further harm during investigation, and failed to provide wound and pain assessments as well as nursing follow-up care for R5 and R6 after injuries, with the potential to impact all individuals in the facility. (R1 - R16)

The facility neglected to ensure the safety needs of clients when it failed to identify the level of supervision needed by R5 during bathing and to assess R5's ability to adjust hot water temperatures independently, with the potential to impact all individuals residing in the facility (R1-4, R6-16).

1) Per physician orders, R5 has diagnoses of Severe Mental Retardation and Schizophrenia Residual Type.

According to the facility's incident report dated 11/3/05, R5 received a burn to her right foot while bathing. The incident report indicates that E1 (RSD/Residential Services Director) was notified of R5's injury at 8:00 P.M. after R5 had informed staff that she had burned her foot.

Per incident report completed by E1 and dated 11/3/05, R5's physician was faxed the incident report and R5 was then seen at the physician's office on 11/4/05 at 1:45 P.M. by Z1 (Physician Assistant.). According to Z1's notes documented on the physician order sheet, R5 sustained a second degree burn to her right foot and was prescribed Silvadene cream to be applied to the affected area covered by a dry dressing twice every day and as needed (PRN) along with pain medication every four hours PRN.

Per review of the facility's documentation, no wound assessments or further pain assessments had been conducted after the incident occurred on 11/3/05 at 8:00 P.M. until R5 was treated at the physician's office on 11/4/05 at 1:45 P.M.

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Per telephone interview with Z1 on November 16, 2005 at 12:02 P.M., R5 was treated for a "second degree burn with blisters on top of her foot, some opened". Z1 confirmed that the burn was "pretty bad" and was "a good-sized burn".

Per observation of the wound area by surveyor on 11/16/05, the burn area was approximately two inches by three and a half inches, running across the top of the foot above the instep to the toes, with bruising apparent on the outer edge of the foot. The wound area itselt was deep red in color with flaking, peeling skin noted along the outer edge of R5's foot.

Per review of the facility's report of the incident, the Illinois Department of Public Health/IDPH was not notified of R5's burn until 11/8/05.

Per review of the facility's document titled Abuse/Neglect/Mistreatment Policy and Procedures, Revised 1/5/98, "The Residential Service Director, Program Director shall notify the"Administrator and IDPH "within 24 hours of the incident. Documentation should be made in the Universal notes of notification, to include date and time".

Per interview with E1 on 11/16/05 at 9:30 A.M., E1 stated that she routinely calls the administrator to report things. E1 confirmed that nothing was documented to indicate when she notified the administrator and does not remember when he was informed of R5's injury. E1 also verified that she had not notified IDPH of the incident until 11/8/05.

An additional example of the facility failing to report incidents of possible neglect and/or injuries of unknown origin is available for R6, who according to the facility's incident report of 6/30/05, required eight sutures for a laceration sustained to his "right hand below pinky" which may have occurred when R6 "went for a walk & apparently went through garbage". Per interview with E1 on 11/15/05 at 2:45 P.M., IDPH was not notified of the incident, nor was documentation available to indicate when the administrator had been notified.

Per telephone interview with Z1 on 11/16/05 at 12:02 P.M., R5 was treated on 11/4/05 for a "second degree burn with blisters on top of her foot, some opened". Z1 confirmed that the burn was "pretty bad" and was "a good-sized burn".

Per observation of the wound area by surveyor on 11/16/05, the burn area was approximately two inches by three and a half inches, running across the top of the foot above the instep to the toes, with bruising apparent on the outer edge of the foot. The wound area itself was deep red in color, with peeling/flaking skin apparent along the outer left side of R5's foot.

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Per review of the facility's incident/accident reports, E1 documented that "Resident was getting ready to take a shower turned on water put her Right foot in water. Staff down to check on (R5) heard her say ouch..."

According to the facility's final report of the incident, E1 documented they did not include an investigation into the location of both staff members on duty when the incident occurred nor witness statements from staff and/or residents, where the residents were located in the facility at the time of the incident, what R5 was doing before the incident occurred, etc.

Per entry by E1 in the universal notes dated "11/7/05 late entry for 11/4/05. This writer talked with each staff that worked the shift that R5 had burnt her right foot. R5 stated she burnt it getting in the tub. R5 will readjust the water after it is set by staff".

Per interview with E1 on 11/16/05 at 9:30 A.M., there were two staff on duty when the incident occurred. E1 said staff helps R5 adjust the water temperature then is available if R5 needs assistance. However, as E1 explained, R5 sometimes lets the water from the shower run out, then turns the water back on, preferring to take a bath. E1 said that R5 has never been burned before.

Continuing interview with E1 confirmed since R5 reported she burned her foot while bathing, E1 did record her discussions with staff after the incident, nor did E1 further investigate the incident.

Another examples of the facility failing to conduct thorough a investigations for R5 was per incident report of 11/11/05 documented as having a bruise on her left shoulder possibly attributed to the same incident of the burn on 11/3/05.

Per review of the facility's water temperature logs on the night of the incident of 11/3/05 when R5 received a second degree burn while bathing, the women's west bathroom had a recorded temperature of 122 F. degrees. Following the incident the water temps for the women's west bathroom were recorded as follows:

11/04/05 - 120 degrees
11/05/05 - 122 degrees
11/06/05 - 122 degrees
11/07/05 - 122 degrees

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350.620a)	11/08/05 - 124 degrees
350.1060h)	11/09/05 - 132 degrees
350.1210b)	11/10/05 - 130 degrees
350.1230b)3)6)	11/11/05 - 130 degrees
350.1230a)1)2)3)	11/12/05 - 128 degrees
350.1230e)	11/13/05 - 110 degrees
350.3030c)4)	11/14/05 - 122 degrees
350.3240a)b)d)	11/15/05 - 126 degrees
(Cont.)	

The water temperatures for this bathroom were recorded in excess of 120 degrees for the entire months of September and October preceding the incident of 11/3/05. Per review of the water temperature logs for women's east, men's west, men's east, and the staff bathroom which is accessible to residents, the water temperatures consistently were documented in the 120 degree range.

Per review of the facility's final report of the burn incident, dated 11/8/05, "water temperatures were checked for completion and a plumber came out to check the water heaters on both the North and South end of the facility. It was found that the water heater on the South end, where (R5) had taken a shower the thermostat was sticking. The water heater was repaired at this time."

Per interview with E1, RSD (Residential Services Director) on 11/15/05 at 2:45 P.M., the plumber came to the facility on 11/4/05 and "checked all bathrooms, sinks, etc. and they checked O.K." around 120 degrees. E1 said that maintenance had also checked the water temperatures and the temps were "O.K." around 120 degrees.

E1 explained that when the plumber came to the facility on 11/4/05, he initially checked the water temperatures, then re-checked the water temperatures again later and reported that the water was even hotter. Per E1, the plumber said that the water temperature for the women's west (also referred to as the south end) bathroom was "160 degrees and if the thermostat was broken could have been even hotter." E1 said the plumber changed the thermostat on the water heater located on the southwest end of the facility and was going to return the next day to install a new water heater.

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Per interview with E1 on 11/16/05 at 3:30 P.M., E1 said that the plumber was supposed to come back on 11/6/05 but had called the facility to tell them he had another emergency and would return the next day. However, the plumber did not return to the facility to replace the water heater(s) until 11/17/05. E1 also confirmed that the maintenance man had not adjusted the water temperature settings to 110 degrees until 11/17/05.

Per continuing interview with E1, E1 said that the plumber, maintenance staff, as well as she all though the water temperatures were safe at 120 degrees and believed everything was all right after the thermostat was replaced.

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Per interview with E1 on 11/15/05 at 2:45 P.M., E1 said that corrective action taken after the incident of 11/3/05 consisted of telling staff not to use the women's bathroom after the incident on 11/3/05 and through 11/4/05 until the water heater was repaired, having staff administer basic first aid to R5 per the facility's policy and taking R5 to the physician's office the day after the incident occurred. E1 confirmed that the women's bathrooms were reopened after plumber fixed the thermostat on 11/5/05.

Per continuing interview with E1, E1 said that the nurse consultant had not been contacted after the incident of 11/3/05, that staff did not document assessments of R5's wound nor pain assessments such as vital signs for R5 and did not re-assess R5's ability to adjust the hot water temperatures independently, nor the level of supervision that R5 required during bathing. E1 further confirmed that none of the residents had been re-assessed as to their level of supervision needed during bathing, nor had any of the residents been re-assessed as to their ability to independently regulate water temperatures.

Per interview with E4, (Direct Support Person) on 11/21/05 at 4:05 P.M., E4 stated that after R5 brought the burn to E4's attention on 11/3/05, E4 wrapped R5's right foot in a cool towel, took her vital signs and called the RSD (E1) around 8:00 P.M. E4 said she gave R5 some over the counter pain medication and that E1 had instructed E4 to give basic first aid per the facility's policy which E4 had already done. E4 said that she didn't think it was a third degree burn and that R5 "didn't act like she was in pain."

E4 confirmed that she had not documented the status of R5's wound and did not take R5's vitals after the initial vitals taken when the burn occurred. E4 stated that she knows she should have documented better but thought the other staff on duty had taken care of it on the incident report.

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No documentation of R5's wound area was found in the facility's staffing notes, nursing notes or universal notes chowing showed assessments of the wound and R5's response to treatment either before or after seeing the physician's assistant on 11/4/05; nor was documentation found regarding any type of pain assessment, such as vital signs, reaction to touch, etc after the initial staff notes on 11/3/05.

Per staff notes recorded by E4, dated 11/3/05, R5 "needs to stay home tomorrow, her right foot is blistered and swollen. @ 8:00 pm staff gave her Tylenol for pain. She needs to keep her sock off. We used the wheelchair to she wouldn't be walking on it one of the blisters has already popped and is draining."

The next entry in the staff notes is also dated 11/3/05, initialed by E5, and states "Staff called QRMP about the blistered foot of R5." Vital signs were recorded, per entry by E5, with blood pressure of 146/82, pulse of 76 and temperature of 98.2 degrees.

When asked by surveyor for documentation of wound and pain assessments after the initial entry noted above, E1 could not provide evidence that R5's wound was assessed by facility staff or consulting nurse as to color, size, blisters, drainage, bruising, swelling, etc. Nor could the facility provide evidence that R5 was assessed for pain by the nurse or facility staff.

Per review of the Medical Administration Record and universal notes, no subsequent vital signs were documented after 11/3/05 when the injury occurred.

In addition, compliance with the physician orders for R5, including soaking the affected area, covering the wound with a dry dressing, keeping the foot elevated, observing for signs and symptoms infection, redness, swelling, etc. also was not documented by facility staff or consulting nurse.

Per interview with E1, on 11/15/05 at 2:45 P.M., E1 confirmed that the facility's nurse was not called about R5's burn. E1 also verified that the facility did not have a policy to address when the nurse should be called. E1 stated that their procedure has always been for staff to call her first and she would tell them what to do. E1 also confirmed that there were on nursing notes available to indicate that the facility's nurse had monitored R5's burn between physician's visits.

Per review of universal notes of 11/14/05, R5 returned to the physician's office with staff notes indicating that "the swelling has gone down some and her foot is not as discolored as it was." Z1 notes said to continue soaking her foot and putting the Silvadene on it and giving her the Antibiotic."

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Per review of the documentation presented to the surveyor, however, no pain assessments nor wound assessments were documented by facility staff or consulting nurse. In addition, compliance with the physician orders for R5, including soaking the affected area, covering the wound with a dry dressing, keeping the foot elevated, observing for signs and symptoms of infection, redness, swelling, was not documented by facility staff.

Per review of the facility's Medical Emergency Procedures, revised 7/13/98, in the case of ACUTE TRAUMA, which per policy includes burns, if it is a first or second degree burn staff are to "flush with cool water; monitor vital signs for shock, rapid pulse and lower blood pressure." The policy does not specify when or if the consulting nurse is to be notified in the event of a medical emergency defined as "one in which the medical status of a person is in imminent jeopardy or thought to be. Medical emergencies can include, but are not limited to: cardiac arrest, acute trauma, convulsions, choking, shock, poisoning, etc."

Per continuing interview with E1 on 11/15/05, E1 stated that she couldn't find documentation vitals were taken after the incident, the physician orders were implemented as written and any type of wound assessments were done. E1 confirmed staff should have documented better and confirmed the only documentation available was the Medical Administration Record (MAR) which indicated that Silvadene cream had been initiated at the 4:00 P.M. medication pass on 11/5/05, Tylenol #3 was started at Noon on 11/5/05 and Keflex was given beginning on 11/12/05 at the 4:00 P.M. medication pass.

2) An additional example is available for the facility not having contacted the nurse and not having documented follow-up nursing care for R6. According to the facility's incident report dated 6/30/05, R6 required eight sutures after receiving a cut on his finger which may have occurred when R6 "went for a walk & apparently went through the garbage." However, no documentation of treatment, wound and/pain assessments after the incident occurred was available for surveyor to review.

Per interview with E1 on 11/15/05 at 2:45 P.M., IDPH was not notified, nor was there documentation that the administrator had been notified. R6's IP was not dated after the incident.

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