STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on observation, interview, and record review the facility failed to ensure resident coffee was served at a safe temperature. This failure resulted in R57 receiving second degree burns to her right arm. The facility also failed to ensure fall preventative measures were in place for a resident. This applies to 2 of 6 residents (R57 & R28) reviewed for safety and supervision in the sample of 34. The findings include: 1. The Nurse's Notes for R57 showed, 1/6/25 at 12:19 AM - This writer was called to resident's room by CNA (Certified Nursing Assistant). Resident had spilled coffee on right arm. Right arm noted to have 2 reddened area with shiny skin, no blisters noted. Right forearm open area 3 cm (centimeters) x 2 cm, right elbow 5 cm x 8 cm. Cool water applied to right arm. DON (Director of Nursing) and supervisor made aware. Spoke with . physician assistant. New orders given and endorsed. Tylenol given for pain. Dressing applied per order/change daily. 1/6/25 at 12:23 AM - Dressing clean, dry, and intact. New order per (V9 Nurse Practitioner/NP). Apply bacitracin to right arm burns, apply petroleum gauze, cover with rolled gauze, and change daily. Monitor for signs/symptoms of infection. Wound care consult. The Provider Progress Note dated 1/5/25 (should have been dated 1/6/25) for R57 showed, patient seen and examined in her room today at the request of nursing. Patient has a burn on her right forearm, second degree. No signs/symptoms of infection. The Initial Wound Evaluation & Management Summary dated 1/8/25 for R57 showed, Patient presents with wounds on her right forearm, right elbow. At the request of the referring provider .a thorough wound care assessment and evaluation was performed today. Focused wound exam (site 1) burn of right elbow; etiology - burn; further etiology detail - hot liquid. Wound size (L x W x D) 7.0 x 6.5 x 0.1 cm. Moderate serous exudate; 100% granulation tissue. Additional wound detail: burn at right elbow and forearm from patient spilling coffee on herself while in bed. Dressing treatment plan: silver sulfadiazine - apply once daily for 30 days. Abdominal pad - apply once daily for 30 days; gauze roll 3.4 apply once daily for thirty days. Focused wound exam (site 2) burn of right forearm; etiology - burn; further etiology detail - hot liquid. Wound size (L x W x D) 2.6 x 3.6 x 0.1 cm. Moderate serous exudate; 5% slough; and 95% granulation tissue. Dressing treatment plan: silver sulfadiazine - apply once daily for 30 days. Abdominal pad - apply once daily for 30 days; gauze roll 3.4 apply once daily for thirty days. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/19/25 at 12:17 PM, the floor where R57 resides had an automatic coffee machine dispenser in the dining room on the counter accessible to anyone. On 2/19/25 at 12:19 PM, V5 (Dietary Director) filled a cup with coffee from the automatic coffee dispenser machine on the floor where R57 resides dining room. The temperature of the coffee was tested by V5 at the request of the surveyor. The temperature of the coffee from the machine was 187.2 degrees Fahrenheit. V5 stated the coffee machines were installed a couple of months ago. V5 stated he doesn't check the temperature of the coffee from the machine on a regular basis. V5 stated the company that services the machine will check the temperature when they come in for a service call and he was unsure of the last time the company was in to provide service. V5 stated the normal temperature that coffee is served is at 180 degrees. V5 stated all coffee comes from the machine and is not made in the kitchen. V5 stated he was told about the incident where someone had burned themselves from the coffee. V5 stated he didn't know who it was that burned themselves. V5 stated he was not part of the correction process for that. V5 stated nursing was a part of the correction process and the dietary department did not do anything for correction. The last Field Service Update for the coffee machines was dated 7/24/24 and showed it was for the main kitchen machine and the water temperature for that machine was 180 degrees Fahrenheit. On 2/19/25 at 12:25 PM, V8 (Licensed Practical Nurse/LPN) stated R57 had a burn to her right elbow from coffee. V8 stated R57 asked for coffee and spilled the coffee in bed. V8 stated R57 doesn't have sensation to her right arm and keeps her right arm immobile. V8 stated R57 received a second degree burn from the spilled coffee. On 2/19/25 at 12:55 PM, V3 (Director of Nursing/DON) stated she received call from nurse and was told R57 was in her room, had finished dinner, and wanted coffee. The CNA went and got more coffee and added the coffee to R57's cup. R57 ended up spilling the coffee on herself. R57 had second degree burns from the coffee that were treated right away. V3 stated she had dietary check the temperature of the coffee and it was within normal range. V2 stated she did not know what the temperature of the coffee should be. V2 stated the dietary manager would have been notified by the dietary department. On 2/20/25 at 11:21 AM, V9 (Nurse Practitioner/NP) stated the facility called telehealth the evening that it happened and got a treatment order. V9 stated she saw R57 the following day. R57 had a second degree burn to her arm. V9 stated she ordered Silvadene. The family refused that treatment and wanted bacitracin because they had a doctor friend that told them that is what they use for burns. V9 state she was not sure if R57 needed assistance with meals; however, R57 had been declining. V9 stated she believed R57 needed assistance. V9 stated this could have been prevented from happening by checking the temperature of the coffee and making sure it is not too hot. The Care Plan dated 6/28/24 - Present for R57 showed, R57 is at risk for impaired skin integrity. Offer staff assistance with hot beverages. Encourage use of clothing protector to protect skin for accidental spills. Encourage resident to sit up right at a table while drinking hot liquids. Serve hot liquids in a cup with a lid. The Face Sheet dated 2/19/25 for R57 showed diagnoses including Alzheimer's disease, depression, osteoporosis, hypertension, atherosclerotic heart disease, spinal stenosis, gastro-esophageal reflux disease, anxiety disorder, edema, osteoarthritis, abnormal posture, and muscle weakness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The MDS (Minimum Data Set) dated 12/20/24 for R57 showed severe cognitive impairment; dependent for eating; substantial/maximal assistance needed for toileting hygiene, bathing, upper body dressing, and personal hygiene. The facility's Safety of hot Liquids policy (October 2014) showed, Appropriate precautions will be implemented to maximize choice beverages while minimizing the potential for injury. The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions. Residents with these or other conditions may suffer from accidental burns and related complications stemming from thinner, more fragile skin that may burn quickly and severely and take longer to heal. Residents who prefer hot beverages with meals (i.e., coffee, tea, soups, etc.) will not be restricted from these options. Instead, staff will conduct regular hot liquids safety evaluations as indicated and document the risk factors for scalding and burns in care plan. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include a. maintaining hot liquids serving temperature of not more than 180 degrees Fahrenheit: e. staff supervision or assistance with hot beverages. 34891 2. R28's face sheet printed on 2/20/25 showed diagnoses including but not limited to heart failure, chronic obstructive pulmonary disease, chronic kidney disease, anxiety, and dementia. R28's facility assessment dated [DATE] showed severe cognitive impairment. R28's fall risk assessment dated [DATE] showed a high risk of falls. The same assessment showed a history of falls in the last three months, weakness with gait and transfers, and forgets her limitations. R28's care plan showed a focus area related to the high risk for falls. Interventions included staff to place floor mats beside the bed and bed in lowest position when she is in it. On 2/18/25 at 12:27 PM, R28 was lying in bed with her eyes closed. R28's bed was low to the ground but there were no fall mats next to the bed. On 2/19/25 at 9:31 AM, R28 was in bed and was yelling out for help. R28 did not have any fall mats next to the bed. The mats were folded up and leaning against the wall at the foot of the bed. V7 and V10 (RN-Registered Nurses) responded to R28 and entered the room. V7 stated R28 has fallen out of bed in the past. About one month ago, she rolled out and hit her eye on the side rail. V7 was asked if the bed was in the lowest position and stated no. V7 lowered the bed further to the ground. At 9:54 AM, R28 was yelling out for help again and outwardly agitated. The fall mats were still not next to the bed and remained folded up against the wall. On 2/19/25 at 9:45 AM, V10 (RN) stated R28 has fallen out of bed several times in the past. She can get herself to the side of the bed and rolls herself out. She ends up on the floor. That is why the fall mats are important. V10 said R28 gets agitated and excited, like she is right now. She is highly confused and frequently ends up on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/19/25 at 12:06 PM, R28 was in bed and V11 (Certified Nursing Assistant) was in the room. The bed was not in the low position and the fall matts were folded up against the wall by the window. V11 stated she needs the mats next to her bed anytime she is in it. She falls out of bed a lot and they keep her from getting hurt. On 2/20/25 at 11:07 AM, V3 (Director of Nurses) stated R28 has had several falls out of bed related to her behaviors. She is confused, gets agitated, and rolls herself out of bed. She will try to get up by herself frequently. The low bed and fall mats need to be in place at all times. They both help minimize any potential for injury. She absolutely needs the interventions in place. The facility's Falls and Fall Risk Managing policy revision dated 3/2018 states: 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on observation, interview, and record review the failed to ensure controlled substances were disposed of in a safe manner for 3 of 3 residents (R22, R296, R297) reviewed for controlled medications in the sample of 34. The findings include: 1.) R296's face sheet documents she was admitted to the facility on [DATE] for aftercare following joint replacement. The February 2025 Physician Order Sheet shows and order for Tramadol (a controlled pain medication) 50 milligram (mg) tablet every 6 hours as needed for pain. R297's face sheet documents she was admitted to the facility on [DATE] for a fracture of unspecified part of the neck of the right femur. The February 2025 Physician Order sheet shows an order for oxycodone (a controlled pain medication) 5 mg every 6 hours as needed for pain. On 2/20/25 at 9:28 AM, the medication cart on 3 west was reviewed for narcotic controlled medications. V6 (Registered Nurse/RN) opened the locked narcotic box. Medication cards for R296 and R297 were observed to have controlled medications taped back into their medication cards. R296 had a card of Tramadol 30 tablets. The pill in the card in the number 30 bubble was taped in place. R297's controlled medication card of oxycodone, had a pill taped back into the card in the number 29 bubble. V6 said controlled medications should not be taped back into the bubble cards. If a resident refuses the medication, it should be destroyed. 2.) R22's face sheet documents she was admitted on [DATE] with multiple diagnoses including Alzheimer's disease, anxiety, and diarrhea. On 2/20/25 at 10:00 AM, the 2 west medication cart was reviewed with V7 (RN). The controlled medication/narcotic box had a card for R22 of diphenoxylate/atropine with 2 tablets remaining. The pill in the number 2 bubble on the card was taped back into place. V7 said the pill should have been destroyed, with 2 nurses and both nurses would sign the medication count sheet. She said the controlled medication should not have been taped back into the package. On 2/20/25 at 10:20 AM, V2 (Director of Nursing) said if a resident refused a narcotic medication, the nurses are to put it in the sharps box with 2 nurses to witness and sign the count sheet. The pill should never be taped back into the card because it is already dispensed. If the pill is not taken it should be destroyed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's November 2022 policy for controlled substances documents the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Dispensing and Reconciling Controlled Substances: 6. Unless otherwise instructed by the director of nursing services, when a resident refused a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose ampules (or it is not given) the medication is destroyed and may not be returned to the container. 7. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31615 Based on interview and record review the facility failed to ensure food temperatures were monitored for meals prior to service for all 76 residents residing in the facility. The findings include: The CMS (Centers for Medicare and Medicaid services) form 671, dated 2/18/25, documents 76 residents reside in the facility. On 2/18/25 at 10:00 AM, V7 (Dining Director) said the food temperatures are initially taken by the dietary aide in the kitchen. The food is then sent up to the 2nd and 3rd floors to be placed on a steam table and then plated directly before giving to the residents. V7 said the temperatures are logged into the book on each of the pantry log books and the temps are transferred to the main logbook. Each of the food items should have 2 temperature readings, one is done in the kitchen, and the second temperature from the pantry. The temperature monitoring sheets were reviewed for the week of 2/2/25 to 2/8/25 for the 2nd and 3rd floor pantries. The 2nd floor readings show on 2/2/25 only 1 temperature for dinner, 2/6/25 no dinner temperatures, 2/7/25 lunch 1 temperature, no dinner temperatures, and 2/8/25 no dinner temperatures recorded. The pantry floor 3 log shows on 2/2/25 dinner no floor temperatures, 2/4/25 no floor temperatures for lunch or dinner, 2/6/25 and 2/8/25 had no dinner temperatures recorded. On 2/18/25 at 10:15 AM, V7 said it is important for the temperatures to be taken before meals to ensure the food is cooked properly, no chance of food poisoning, and the residents are getting hot food. The facility's 2005 policy for food temperatures documents it is the policy of the community to ensure the proper serving temperature of food through the use of a temperature monitoring system. Procedure: 1. Hot food temperatures will be taken three times throughout each meal service. Hot food temperatures will be taken prior to leaving the heath center kitchen, prior to meal service, and after completion of meal service for each meal. Temperatures will be recorded each time in a temperature log form.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34891 Based on observation, interview, and record review the facility failed to ensure PPE (Personal Protective Equipment) was worn in a manner to prevent cross contamination for 1 of 1 resident (R28) reviewed for infection control in the sample of 34. The findings include: On 2/18/25 at 12:27 PM, R28 had signs on her door stating she was on droplet precautions. The signs showed full PPE was needed in the room including gowns, gloves, face shields, and N95 masks. The signs showed the correct manner to don and doff the PPE items. The signs stated to remove the gown, gloves, N95 mask, and eye protection after exiting the room. On 2/19/25 at 9:31 AM, R28 was in bed and yelling out for help. V7 and V10 (RN-Registered Nurses) donned gowns, gloves, face shields, and N95 masks then entered the room. R28 was confused and agitated. V10 exited room and removed her gown and gloves at the room door. V10 continued to wear her face shield and N95 mask down the hallway. V10 was interviewed while leaning on the wound treatment cart and again in the nurse's charting room. V10 stated R28 was on isolation for covid, and full PPE is needed whenever staff go into the room. V10 said the PPE should be removed and put into the red bins near the room exit. Wearing the dirty PPE outside of the room can contaminate things. On 2/20/25 at 11:07 AM, V3 (Director of Nurses) stated staff need full PPE when entering a resident room that is on isolation for covid. Staff need to remove the PPE when exiting the room to protect themselves and stop the spread of covid. There is the potential for the spread of germs between residents. PPE worn outside of the isolation room has the potential to contaminate the outside environment and common areas. Cross contamination to others is a definite concern. The facility's Coronavirus Disease (COVID-19)-Using Personal Protective Equipment policy revision dated 5/2023 states: Disposable respirators are removed and discarded after exiting the resident's room or care area and closing the door .Eye protection is removed after leaving the resident room or care area. .