STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146186	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates Cts of Huntley	12140 Regency Parkway Huntley, IL 60142

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39537 Based on observation, interview, and record review the facility failed to ensure measurements were obtained and tracked for a resident with burns from spilled coffee for 1 of 3 residents (R1) reviewed for quality of care in the sample of 11. The findings include: On 10/1/24 at 11:33 AM, R1 was sitting on the toilet. R1 was wearing a long-sleeved shirt, but was exposed from the waist down. V8 (Wound Care Nurse) and V17 (CNA) assisted him to a standing position. R1's left inner thigh had a dark red area, the size of an irregularly shaped baseball. The skin was peeling and there were open areas. V8 said R1 had a change to his wound today and she had ordered a Wound Care Consult. V8 said coffee was spilled on R1 and he had redness to his left forearm and left inner thigh. V8 said R1's forearm had healed, but his thigh wound was worsening. R1 said the server guy spilled coffee on the table and it went on me and burned me. R1 stated, It wasn't my fault, I can't move that fast any more and boy did it hurt. My arm doesn't hurt anymore, but his leg does. R1's dressing came off during the transfer and V8 (Wound Care Nurse) obtained more supplies. When V8 applied the Medi-honey treatment, R1 complained of pain. V8 administered Tylenol. At 12:08 AM, V8 non-pressure wounds are assessed weekly to assess the wound's progress and determine if the treatments are effective. V8 said R1's burns would be considered a non-pressure wound. V8 said the wound appearance should be described. V8 said initially R1's left inner thigh wound was not opened, it was just redness, but now it is opened. V8 said she called the doctor and obtained an order for a Wound Care Consult and new treatments orders because R1's wound was not open and had slough in the wound bed. V8 said she did not perform measurements on R1's burns because they were not open. The surveyor asked V8 how she was able to track the progress of R1's wounds without wound measurements. V8 did not provide an answer. The surveyor asked what degree R1's burns were considered. V8 said she was not sure. The surveyor asked if the facility had a policy for care of a burn. V8 said she wasn't sure. V8 said the Wound Care consult was entered 10/1/24 (R1's burns occurred 9/20/24). V8 said the Wound Care Provider had not seen R1 prior, but would see him the next time rounds were completed. R1's Facesheet showed diagnoses to include, but no limited to: right side weakness following a stroke; dysarthria; congestive heart failure; pulmonary hypertension; chronic atrial fibrillation; epilepsy; and Brown-Seguard Syndrome (rare spinal disorder resulting from injury to one side of the spinal cord). R1's BIMS (Brief Interview Mental Status) assessment completed 9/25/24 showed he was cognitively intact. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Physician Order Sheet dated 10/1/24 showed an order for Silver Sulfadiazine cream (used for treatment of burns) started on 9/20/24. This document showed new orders for Medihoney Wound/Burn Dressing Paste to left inner thigh daily started on 10/1/24. R1's Care Plan initiated 10/1/24 showed R1 had an open area to his left inner thigh. This care plan showed R1 was at increased risk for delay in wound healing due to need for assistance with care, impaired mobility, occasional incontinence, and contributing medical conditions. This R1's Progress Notes dated 9/20/24 at 8:48 PM showed, Staff reported he slipped the coffee cup and opened the lid of hot coffee on the table and it (dripped) down onto the resident. Resident stated, It was not my fault, I could not get up fast enough . This note showed R1 had redness to his left forearm and left inner thigh. There were no measurements of the wounds. R1's Progress Notes showed on 9/21/24 R1 had redness to his left upper arm; and had redness and blistering to his left inner thigh. These notes do not contain any wound measurements. On 9/23/24 V8 completed a Skin/Wound Note. This assessment does not contain wound measurements. R1's 9/27/24 Skin/Wound Progress Note does not include measurements. This notes showed that R1 does refuse treatment at times and his POA was notified. R1's Skin/Wound Progress Note dated 10/1/24 did not contain wound measurements, but showed, While administering treatment ordered, noted with open area to left inner thigh at this time, notified wound NP, obtained new orders, PCP also notified, [R1's son] called and updated on skin alteration and plan of care . R1's EMR (Electronic Medical Records) did not show that R1 had been seen by the Wound Care Provider between 9/20/24 and 10/1/24. On 10/2/24 at 10:09 AM, V33 (Wound Care Nurse Practitioner) said she had not seen R1 yet. V33 said she just received a consult for R1's wounds yesterday (10/1/24). V33 said the staff mentioned there was a coffee spill and initially R1 just had redness, but now the skin had opened and there was slough in the wound bed and the wound wasn't improving. V33 said a description of the wound on R1's left inner thigh was provided and it sounds like a second degree. V33 said she will see R1 10/3/24. V33 said the coffee was spilled on R1 if he had redness and pain in the area, that would be considered a 1st degree burn (left forearm). V33 said some residents are more sensitive to hot liquids and more cautions must be taken. V33 said measurements of a burn must be completed to determine the severity and track the progress of the wound and treatments being provided. The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations dated 3/2/21 showed, Policy: .2. Identify the presence of pressure injuries and/or other skin alterations. 3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized care plan. Procedure: .4. Non-pressure skin alterations ie: skin tears, abrasions, surgical wounds, MASD (moisture associated skin damage), lesions and rashes, will be documented weekly on a Skin Progress Note .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 39537 Based on observation, interview, and record review the facility failed to ensure hot liquids were safely served; failed to ensure a process was in place for service of hot liquids; and failed to identify safe hot liquid temperature. These failures resulted in R1 sustaining a first degree burn to his left forearm and a second degree burn to his left inner thigh. These failures have the potential to affect all residents residing in the facility. The Immediate Jeopardy started on 9/20/24 at 8:36 PM when R1 sustained burns to his left forearm and left inner thigh from spilled coffee. V1 (Administrator) was notified of the Immediate Jeopardy on 10/2/24 at 3:54 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 10/2/24, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-services and the process changes. The findings include: The facility Data Sheet dated 10/1/24 showed there were 148 residents residing in the facility. On 10/1/24 at 11:33 AM, R1 was sitting on the toilet. R1 was wearing a long-sleeved shirt, but was exposed from the waist down. V8 (Wound Care Nurse) and V17 (CNA) assisted him to a standing position. R1's left inner thigh had a dark red area, the size of an irregularly shaped baseball. The skin was peeling and there were open areas. V8 said R1 had a change to his wound today and she had ordered a Wound Care Consult. V8 said coffee was spilled on R1 and he had redness to his left forearm and left inner thigh. V8 said R1's forearm had healed, but his thigh wound was worsening. R1 said the server guy spilled coffee on the table and it went on me and burned me. R1 said it wasn't my fault, I can't move that fast any more and boy did it hurt. R1 said his arm doesn't hurt anymore, but his leg does. R1's dressing came off during the transfer and V8 (Wound Care Nurse) obtained more supplies. When V8 applied the Medi-honey treatment, R1 complained of pain. V8 administered Tylenol. R1's Face sheet showed he had diagnoses to include, but not limited to: right sided weakness following a stroke; congestive heart failure; pulmonary hypertension; chronic atrial fibrillation; other epilepsy; other epilepsy; and Brown-Sequard Syndrome (a rare spinal disorder from injury to one side of the spinal cord). R1's facility assessment dated [DATE] showed R1 needed partial to moderate assistance for eating. R1's BIMS (Brief Interview for Mental Status) assessment dated [DATE] showed he was cognitively intact. R1's Risk Management Report dated 9/20/24 at 8:36 PM showed, staff reported a cup of coffee spilled on the dining room table while being served to resident and the coffee went from the tabletop to the resident's lap. This document showed R1 had redness to his left forearm and left thigh. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R1's Progress Notes dated 9/20/24 at 8:48 PM showed, Staff reported he slipped the coffee cup and opened the lid of hot coffee on the table and (the coffee was) dripping down onto the resident. Resident stated, It wasn't my fault, I could not get up fast enough. Removed the resident from the table and assessed the area. (There was) redness noted to left forearm ad left inner thigh at that time . This note doesn't include the size or measurements of the wound. R1's Post Occurrence Documentation dated 9/21/24 at 3:50 AM showed R1 had redness and blisters. (This note contains no further details). R1's Order Note for MAR dated 9/21/24 at 6:53 PM showed, Redness and blister noted to left inner thigh, skin intact. No open wound. R1's Skin/Wound Progress Note dated 10/1/24 at 9:54 AM, showed R1 had an open area to the left inner thigh. R1's Physician Order Sheet dated 10/1/24 showed an order for Silver Sulfadiazine cream 1%. Apply to inner left thigh topically every day and night for skin condition, burn area. This record also showed a new order for a Medihoney Wound/Burn Dressing Paste to be applied to R1's left inner thigh and cover with a dressing daily. R1's EMR (Electronic Medical Records) did not show that R1 had been seen by the facility's Wound Care NP (Nurse Practitioner) between 9/20/24 and 10/1/24. On 10/1/24 at 10:23 AM, V15 (RN) said she was familiar with R1. V15 said he is alert to person, place, and time, but will be forgetful from time to time. V15 said R1 is able to make his needs known and communicate effectively. V15 said R1 had a stroke and had weakness to one side of his body. The surveyor asked what the nurse could tell her about R1's wound. V15 replied, Are you talking about the burn? V15 said she was not present the day of the incident, but her understanding was that a cup of coffee was spilled and landed on R1. On 10/1/24 at 10:42 AM, V17 (CNA) said the CNAs ensure the residents are in the dining room for meals, but the dietary staff handles the meal service. V17 said if a resident asks for a cup of coffee and dietary is not available, then the nursing staff can obtain a cup of coffee from the automatic coffee machines in the kitchenettes. On 10/1/24 at 11:01 AM, V19 (Server) said he serves the residents coffee. V19 said he checks the temperature of the coffee from the machine before each meal service. V19 said the temperature is written on the log. V19 said he didn't know if there was a temperature that they were supposed to report. V19 said he did not know if there was too high of a temperature. V19 said he usually serves it in a styrofoam cup with a lid. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/1/24 at 11:12 AM, V6 (Dietary Supervisor) used the facility's digital thermometer to check the temperature of the coffee from the automatic machine, on the 2nd floor. The temperature was 158 degrees. The Coffee Temperature Log was posted on the corkboard. This document showed on 10/1/24 at Breakfast the temperature was 172 degrees (Fahrenheit) and the Lunch Temp was 167 degrees. V6 said the automatic coffee machine temperatures are checked before each meal service (three times a day). V6 said the coffee machine does not display the temperature. V6 said only the service technician can see the temperature. V6 said that's why we check the temperatures. V6 said the coffee/hot liquids are not served to the resident right away. V6 said he doesn't re-check the temperature of the hot liquids before serving them to the residents. V6 said the coffee shouldn't be served above 155 degrees. At 11:12 AM, V6 used the facility's digital thermometer to check the automatic coffee machine, on the 3rd floor. The temperature was 173 degrees. There were no trays of prepared coffee or hot liquids that were sitting to cool, before service. A hot liquid temperature was not checked before coffee was served to the residents. V25 (Server) obtained coffee directly from the coffee machine, into white coffee cups and delivered to the resident table. The hot liquid was not set aside to cool. On 10/1/24 at 11:21 AM, V21 (Dietary Aide) said he puts the food on the plates and the servers usually handle the tray delivery and beverage service. V21 said he wasn't sure if coffee temperatures were checked. V21 said the coffee is made to order, so it stays hot. V21 said he is unsure if there is temperature that is too high. On 10/1/24 at 2:32 PM, V6 (Dietary Supervisor) calibrated the digital thermometer in an ice bath. The coffee temperatures were obtained. The 2nd floor coffee temperature was 158 degrees. The 3rd floor coffee temperature was 172 degrees. V6 said he calibrates the thermometers every day in an ice bath. V6 said the thermometers used today were calibrated before checking the temperatures. V6 said he was not in the building the evening of 9/20/24, but he was notified coffee was spilled on R1 by V12 (Server). V6 said he was not sure if the temperatures were adjusted after R1 was burned. V6 said he did not call the service company for temperatures to be adjusted, maybe V7 (Building Manager) did. V6 said the hot liquid temperatures are taken to ensure they won't cause burns or scalding. On 10/2/24 at 7:47 AM, V6 was preparing room trays for R2, R5, R7, R8, and R9. R2's tray had a styrofoam cup of coffee with a plastic lid on top. The surveyor asked V6 to obtain a coffee temperature from the machine. The temperature was 158. V6 continued assembling R5, R7, R8 and R9's trays. V6 obtained hot liquid from the automatic dispenser, into a styrofoam cup, placed a lid on top, and placed the beverages on the trays. At 8:04 AM, V6 left the kitchenette to deliver the trays. There were no cooling or pre-prepared hot liquids in the kitchenette. At 8:02 AM, R10 was seated in a high back wheelchair. R10 was positioned in a slightly reclined position. R10 had a steaming cup of coffee on the upper right corner of her tray. There was no lid on the coffee. There was no staff present in the dining room. V27 (Server) left the kitchenette to deliver room trays. R10 rocked her body and reached toward the cup of coffee, but was unable to reach it. R10 repeated this rocking motion a couple times, but was unsuccessful in reaching her coffee. At 8:09 AM, R11 was seated at a table, drinking from a steaming cup of coffee from a Styrofoam cup. On 10/2/24 at 8:12 AM, V28 (Server) obtained a coffee temperature from the automatic machine. The temperature was 168. There were no pre-prepared or cooling hot beverages in the kitchenette. V25 (Server) was preparing room trays, obtaining hot liquids from the automatic machine and placing them on the trays. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/1/24 at 12:46 PM, V9 (LPN - Licensed Practical Nurse) said she was R1's nurse on 9/20/24. V9 said she was on break when the coffee was spilled on R1. V9 said V10 (LPN) was in the dining room and provided immediate care. V9 said R1 is able to make his needs known and so nice. V9 said she feels bad about what happened to R1. V9 said R1 told her the server guy' spilled coffee on the table and it dripped onto him. V9 said R1 said, It's not my fault. He said it really hurt. V9 said she did a skin assessment. V9 said R1's left arm was slightly reddened. V9 said R1's left inner thigh was angry red and raised a little bit. V9 said she did not measure R1's burns. V9 said she notified V4 (R1's PCP), V8 (Wound Care Nurse) and R1's POA. On 10/2/24 at 9:42 AM, V10 (LPN) said she was in the dining room the evening of 9/20/24, assisting another resident with eating. V10 said she heard R1 yell, OUCH! V10 said when she looked up V12 (Server) was standing next to R1. V10 said V12 told her coffee spilled on the table and dripped into R1's lap. V10 said she removed R1 from the dining room and immediately removed his clothing and assessed his skin. V10 said R1 had pain and redness to his left forearm and left inner thigh. On 10/2/24 at 10:45 15 AM, V12 (Server) said the resident food order is taken and they go get it. V12 said he doesn't take coffee temperatures. V12 said the machine has a preset temperature. V12 said he puts the coffee in the cup and takes it directly to the resident. V12 stated, It's pretty quick delivery. V12 said R1 was in the dining room on 9/20/24. V12 said he was delivering R1's dinner tray and coffee. V12 said as he was sitting the coffee down on the table, he must have squeezed the Styrofoam cup too hard and the lid popped off. V12 said the coffee dripped on his hand and then spilled on the table. V12 said the coffee ran off the table onto R1. V12 said the nurse was in the dining room and responded right away. On 10/1/24 at 12:08 PM, V8 (Wound Care Nurse) said she was on call 9/20/24 (when R1 was burned). V8 said V9 (LPN) notified her via telephone. The nurse told me that the dietary staff had spilled coffee and it had landed on R1. She said he had redness to his left forearm and left inner thigh. V8 said R1 told her that the Server spilled coffee on the table and it fell in R1's lap. V8 said R1's left forearm redness had already resolved, but he still had the wound to his left inner thigh. V8 said R1 had not seen the Wound Care Provider, but she had ordered a consult today because R1's wound was open and had slough. V8 said she's not sure what degree of burns R1's would be considered. V8 said the Wound Care Provider will see him the next time they round and they will make that determination. V8 said she did not measure R1's wounds because they weren't open. On 10/1/24 at 2:54 PM, V4 (R1's PCP) said R1 is a nice gentlemen. He is decisional, his mood fluctuates, and he is considered stable at this time. V4 said if a hot liquid spills on the skin and redness or pain occurs this would be considered a first degree burn. V4 said if the underlying flesh is exposed, the area blisters or opens then it would be considered a second degree burn. V4 said the facility notified her on 9/20/24 that coffee was spilled on R1. V4 said R1's burns to his left forearm and left inner thigh were caused by the coffee being spilled on him. V4 said she would expect the facility to serve hot liquids at a temperature that is safe for the residents. On at 10/1/24 1:42 PM, V23 (Coffee Machines Customer Service) said the facility had just called in a service ticket today 10/1/24. V23 said the facility requested the temperature be turned down to 135 degrees for two automatic coffee dispensing systems. V23 said the facility did not make a request for service between 9/20/24 (when R1 was burned) and today. V23 said she can see the service history and the last time the technician was at the facility for repairs was 3/21/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/1/24 at 3:31 PM, V26 (Dietician) said the corporation does not have a set maximum hot liquid temperature. V26 said she was reviewing the corporation policy's and does not see a maximum temperature for hot liquids. V26 said that she knows the food service temperature should be around 120 degrees and the hot liquids should be similar. V26 said she would expect the hot liquids to be served at a safe temperature to avoid burns. V26 said coffee temperatures of 160-170 definitely sounds too high. On 10/1/24 at 3:20 PM, V1 (Administrator) said the facility does not own the coffee machines. V1 said the coffee company loans them to us for using their coffee. V1 said the coffee company services the machines. V1 said she did not call the service company. V1 said she was aware V12 (Server) had spilled coffee over, it ran off the table, and came into contact with R1. V1 said she would expect V6 (Dietary Supervisor) to report any high temperature concerns to her, but he had not. V1 said the hot water temperatures should be kept below 165. V1 said the facility's hot liquid policy says it is the resident's preference. There is no exact temperature identified as safe. On 10/2/24 at 9:13 AM, V32, Coffee Machine's Regional Field Service Manager, said there is a contract with the facility. V32 said the facility is responsible for checking hot liquid temperatures and calling for service if there is an issue. V32 said the machines do not have a visible temperature reading. They would have to check the temperature of the hot liquid. V32 said the facility protocols determine the safe hot water temperatures and if they have a concern or need adjustments made, then they should call in a service request. V32 said the facility is responsible for ensuring the hot beverages is safely served to the residents. V32 said there is a low temperature kit, available for the coffee machines to keep the temperature below 145 degrees. V32 said this kit is used primarily by the healthcare industry for resident safety concerns. V32 said the low temperature kits are an available option for purchase. V32 said there are no routine services provided by his company, but they treat service as on demand. V32 stated, When they call us, we come. On 10/2/24 at 10:45 AM, V7 (Building Manager) said he had worked at the facility three months and had not called the service company for the coffee machines. The facility's Coffee Temperature Logs for September and October 2024 showed results of 152 to 172 degrees. This form does not show a safe hot temperature parameter or how the staff should respond. The facility's At Risk Hot Food & Beverage Temperature Policy dated 3/24 showed, Policy: Food and Beverages will be served at a temperature that is safe and palatable. Purpose: To reduce the risk of injury . 4. Coffee held at lower temperature will be placed in a carafe with a label reading, low temp coffee/liquid. Coffee temperatures are all based on resident preference and can change from day to day and resident need . The Coffee Machine service reports were requested, but not received. The Immediate Jeopardy that began on 9/20/24 was removed on 10/2/24 when the facility took the following actions to remove the immediacy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/2/24 education listed below was reinforced by the Administrator and Assistant Administrator, with all staff that were working and those that were scheduled to work upcoming shifts thereafter. Education will continue to be conducted prior to the start of the next shift for each nursing and dietary staff member and on an ongoing basis until all employees scheduled to work have been educated and demonstrate an understanding of the education through pop quizzes and/or return demonstration of competency. Education will focus primarily on dietary staff with the potential to be impacted by the non-compliance and not limited to staff involved in the actual incident. 1. All residents were reviewed for conditions that may make them more at risk for the unsafe handling and distribution of hot beverages. Completed 10/2/24. Care Plans and assessments updated as needed. Completed 10/2/24. 2. All dietary and nursing staff were educated on safe handling of hot beverages, safe vessels to hold hot beverages, temperature checking of coffee prior to serving, and notification to appropriate vendors of equipment malfunction. Completed 10/2/24 and ongoing for all oncoming staff not on duty today. 3. The coffee vendor was called on 10/1/24 to verify that all coffee makers are functioning properly and are producing coffee at the lowest safe temperature that the machine can brew. Completed 10/2/24. On 10/2/24, the facility Administrator and IDT reviewed policies and procedures on serving hot beverages and food to residents. The review included but is not limited to resident BIMS scores, beverage service, environment, addressing risk factors. The following policies were reviewed: At Risk Food Temperature Policy; Hot Water Temperature Policy; Incidents & Accidents; Coffee Machines Owner's Manual; A Cool Liquid Program was developed. All were completed 10/2/24. The Administrator and Assistant Administrator completed a QA audit tool for the Dietary Department to ensure that taking temperatures of hot beverages is occurring prior to the serving of coffee each meal. Coffee shall be served for the general population between 120-140 degrees and below 120 degrees for the at risk population. The results of the QA Audits shall be reviewed monthly by the Facility QAPI team to determine any necessary changes. Completed 10/2/24 and ongoing for QA monitoring. An Emergency QA meeting was held by the Administrator with the IDT and Medical Director on 10/2/24 to review the removal plan. The QA Committee shall meet monthly thereafter and review the results of the QA audits. Changes to the policy and procedure shall be made as indicated by the QA results. The Medical Director and IDT approved this Removal Plan. This will be monitored by the Administrator and Assistant Administrator. Completed 10/2/24 and ongoing for QA monitoring.