STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145736	A. BUILDING _____ B. WING _____	C 11/22/2016

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ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN CICERO, IL 60804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation Alden Town Manor Rehab & HCC 1696387/ IL 89709, no deficiency 1696421/ IL 89756, no deficiency 1686402/ IL 89727, no deficiency 1696200/ IL 89508, no deficiency 1696536/ IL 89877 - F157, F309 & F314 cited	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		

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

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F 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow its own policy governing physician notification by failing to notify one resident's (R3) physician of a change in condition regarding worsening of arterial wounds, for one out of three residents reviewed for change in condition, out of a sample of five residents. This failure resulted in R3's admission to the hospital on 11/6/16 for bilateral gangene to both feet and subsequent above the knee amputation of R3's right lower limb. Findings include: On 11/16/16 at 12:15pm, Z1 (complainant) stated that R3 developed a blister on the right foot while at the facility. Z1 stated that both of R3's feet were always wrapped when Z1 visited. Z1 stated that on 11/2/16, Z1 finally saw R3's feet and discovered that the skin on R3's right foot was black and told the facility to transfer R3 out. Z1 stated that since then, R3 has had the right foot amputated just above the knee due to lack of care R3 received at this facility. R3's emergency room documentation dated	F 157		

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F 157	Continued From page 2 11/6/16 reads "83 year old male seen in emergency department for bilateral foot gangrene. R3 is with family member who states that she has been noticing discoloration of R3's toes and heels for past couple of weeks. Skin - left dry exchar at posterior heel, right dry eschar at posterior heel and dry ischemic changes of digits 1 and 2, discoloration of remaining 3 digits, gangrenous appearing and foul smell from right foot, and dry eschar at lateral aspect of right foot. Ischemic changes of right digits. Impression - right foot gangrene and left heel decubitus ulcer." R3's emergency room notes read "Left heel 6 cm x 6cm necrotic decubitus. Right heel 4.5 cm x 5 cm and right lateral foot 3 cm x 4 cm - both necrotic base, positive gangrene to right great toe and second toe. Vascular surgery evaluation. R3's facility wound care evaluation notes dated 10/19/16 read "Right great and second toe eschar has become moist in the inferior parts. Debrided the moist areas, some purulent drainage noted, culture taken." R3's lab report dated 10/22/16 reads "Wound culture final report MRSA - growth many." R3's clinical notes dated 10/24/16 read that Z2 (Attending physician) was notified on 10/24/16. R3's notes dated 10/24/16 read "Relayed lab results to Z2. Z2 is going to see R3 in the facility." There is no further follow up to R3's MRSA lab result. On 11/17/16 at 3pm, E1 (Administrator) stated that she does not know what happened. R3's surgical consult report dated 11/6/16 reads "RLE (right lower extremity): mummification of hallux and 2nd digit, necrosis of dorsum of foot to midfoot and involving toes, also extending to	F 157		

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F 157	Continued From page 3	F 157		

plantar aspect of foot down to the mid metatarsal region. Dry eschar 5 cm x 2 cm on lateral aspect of 5th metatarsal and dry eschar over heel 3 cm x 3 cm. Foul odor." R3's notes dated 11/9/16 read that R3 had a above right knee amputation."

On 11/17/16 at 12:30pm, Z2 (Attending Physician) stated that he was not aware of how bad R3's right foot was until he was called by the nursing home on 11/6/16 with a report that R3's wounds were getting bigger. Z2 stated that he ordered R3 to be sent to the hospital. Z2 stated that he received R3's arterial doppler bilateral lower extremity report dated 10/24/16 which Z2 stated showed "mild peripheral vascular disease." Z2 stated that he was not notified by the wound doctor or any nurse at the nursing home regarding how bad R3's right foot had become until 11/6/16. Z1 (complainant) stated that she visited R3 on 11/2/16 and Z1 stated she told the facility to send R3 to the hospital. On 11/17/16 at 3:30pm, E2 (Director of Nursing) stated that as soon as she saw R3's right foot on 11/6/16, she sent R3 to the hospital. On 11/17/16 at 1:00pm, E8 (Wound Nurse) stated that he can't remember if he reported to Z2 that R3's right foot was black. E8 stated refer to WASA (Weekly Assessment of Skin Alteration) forms. E8 stated that he called Z2 on 11/6/16 because R3's wounds were getting bigger and Z2 stated to send R3 to the hospital. Z2's clinical notes dated 11/6/16 read "R3 admitted to the hospital with right foot gangrene."

R3's WASA form dated 8/1/16 reads right heel 2 cm x 2 cm. R3's WASA form dated 10/21/16 reads right heel 4 cm x 6 cm, 90% eschar, on 10/27/16 right heel measured 4 cm x 6cm x 0.3 cm, 90% eschar, on 11/2/16 right heel measured 5 cm x 7 cm x 0.3 cm, 90% eschar. R3's WASA

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F 157	Continued From page 4 forms dated 10/21/16, 10/27/16 and 11/2/16 read that Z2 was notified on 9/28/16. R3's WASA form dated 10/14/16 reads "Right great toe 0.5 cm x 1 cm. R3's WASA form dated 10/14/16 0.5 cm x 1 cm, no eschar. MD notified on 8/1/16. R3's WASA form dated 10/21/16 reads "Right toes (great toe) 2 cm x 3 cm x 0.2 cm, 100% eschar. MD notified on 8/1/16. There was no documentation in R3's WASA forms that that Z2 was notified that R3's right great toe worsened in size and had eschar. R3's WASA form dated 10/21/16 reads "Right lateral foot 1 cm x 1cm." R3's wound care evaluation form dated 10/26/16 reads "Right lateral foot post debridement size 4 cm x 3.5 cm, color black, 80% eschar." R3's WASA forms dated 11/2/16 read "Right lateral foot 4 cm x 3.5 cm, 75% eschar, MD notified 9/7/16. There was no documentation that Z2 was notified in a timely manner regarding R3's right lateral foot increasing size and 75/80% eschar, black in color. The facility's change in condition policy dated 2/14 reads "Purpose is to ensure that the resident's physician/physician on call/NP and responsible party is kept informed regarding the resident's change in condition. Policy: The attending physician or physician on call/NP and responsible party will be notified of changes in a resident's condition. Procedure - Attending physicians or physician on call/NP and responsible party will be notified of all changes in condition."	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 5 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to treat a MRSA (Methicillin- Resistant Staphylococcus Aureus) infection in one out of three resident's (R3), reviewed for wounds in a sample of five, who was identified with a wound to the right great toe. This failure resulted in R3's lack of treatment for MRSA and subsequent admission to the hospital. Findings include: R3 was admitted to the nursing home on 7/29/16. R3's face sheet lists the following diagnoses: Muscle weakness, hypertension, atrial fibrillation, hypertensive heart disease and chronic kidney disease with heart failure, hemiplegia and hemiparesis following cerebral infarction affecting left- nondominant side, seizures, hypothyroidism, gout, hyperlipidemia, cerebrovascular disease, dementia, benign neoplasm of prostate and peripheral vascular disease. R3's WASA (Weekly Assessment of Skin Alteration) form dated 10/14/16 reads "Right great toe 0.5 cm x 1 cm. R3's WASA form dated 10/14/16 0.5 cm x 1 cm, no eschar. MD notified on 8/1/16. R3's WASA form dated 10/21/16	F 309		

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F 309	Continued From page 6	F 309		

reads "Right toes (great toe) 2 cm x 3 cm x 0.2 cm, 100% eschar. MD notified on 8/1/16.

R3's facility wound care evaluation notes dated 10/19/16 read "Right great and second toe eschar has become moist in the inferior parts. Debrided the moist areas, some purulent drainage noted, culture taken."

R3's lab report dated 10/22/16 reads "Wound culture final report MRSA - growth many." R3's clinical notes dated 10/24/16 read that Z2 (Attending physician) was notified on 10/24/16. R3's notes dated 10/24/16 read "Relayed lab results to Z2. Z2 is going to see R3 in the facility." There is no further follow up to R3's MRSA lab result. On 11/17/16 at 3pm, E1 (Administrator) stated that she does not know what happened.

On 11/17/16 at 12:30pm, Z2 (Attending Physician) stated that he was not aware of how bad R3's right foot was until he was called by the nursing home on 11/6/16 with a report that R3's wounds were getting bigger. Z2 stated that he ordered R3 to be sent to the hospital. Z2 stated that he received R3's arterial doppler bilateral lower extremity report dated 10/24/16 which Z2 stated showed "mild peripheral vascular disease." Z2 stated that he was not notified by the wound doctor or any nurse at the nursing home regarding how bad R3's right foot had become until 11/6/16. Z1 (complainant) stated that she visited R3 on 11/2/16 and Z1 stated she told the facility to send R3 to the hospital. On 11/17/16 at 3:30pm, E2 (Director of Nursing) stated that as soon as she saw R3's right foot on 11/6/16, she sent R3 to the hospital. On 11/17/16 at 1:00pm, E8 (Wound Nurse) stated that he can't remember

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F 309	Continued From page 7	F 309		

if he reported to Z2 that R3's right foot was black. E8 stated refer to WASA forms. E8 stated that he called Z2 on 11/6/16 because R3's wounds were getting bigger and Z2 stated to send R3 to the hospital. Z2's clinical notes dated 11/6/16 read "R3 admitted to the hospital with right foot gangrene."

R3's emergency room documentation dated 11/6/16 reads "83 year old male seen in emergency department for bilateral foot gangrene. R3 is with family member who states that she has been noticing discoloration of R3's toes and heels for past couple of weeks. Skin - left dry eschar at posterior heel, right dry eschar at posterior heel and dry ischemic changes of digits 1 and 2, discoloration of remaining 3 digits, gangrenous appearing and foul smell from right foot, and dry eschar at lateral aspect of right foot. Ischemic changes of right digits. Impression - right foot gangrene and left heel decubitus ulcer." R3's emergency room notes read "Left heel 6 cm x 6cm necrotic decubitus. Right heel 4.5 cm x 5 cm and right lateral foot 3 cm x 4 cm - both necrotic base, positive gangrene to right great toe and second toe. Vascular surgery evaluation.

R3's surgical consult report dated 11/6/16 reads "RLE (right lower extremity): mummification of hallux and 2nd digit, necrosis of dorsum of foot to midfoot and involving toes, also extending to plantar aspect of foot down to the mid metatarsal region. Dry eschar 5 cm x 2 cm on lateral aspect of 5th metatarsal and dry eschar over heel 3 cm x 3 cm. Foul odor." R3's notes dated 11/9/16 read that R3 had a above right knee amputation."

The facility's infection control policy p.9 reads "Contact precautions may be considered for

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F 309	Continued From page 8 residents who have MRSA (Methicillin- Resistant Staphylococcus Aureus). Contact precautions are intended to prevent transmission of infectious agents including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment. There was no follow up from the facility to determine if R3 needed contact precautions or any other treatment for R3's MRSA lab report.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately identify risk for pressure ulcer development and failed to demonstrate what preventative measures were in place prior to and after the development of a stage 2, facility acquired pressure ulcer, for one out of 3 residents (R3), reviewed for pressure ulcers in a sample of five, who was identified as low risk for pressure ulcer development. Findings include:	F 314		

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F 314	Continued From page 9	F 314		

R3 was admitted to the nursing home on 7/29/16. R3's face sheet lists the following diagnoses: Muscle weakness, hypertension, atrial fibrillation, hypertensive heart disease and chronic kidney disease with heart failure, hemiplegia and hemiparesis following cerebral infarction affecting left- nondominant side, seizures, hypothyroidism, gout, hyperlipidemia, cerebrovascular disease, dementia, benign neoplasm of prostate and peripheral vascular disease.

R3's Braden scale score dated 8/20/16 reads "Score 18 - mild risk." The facility's Braden scale for predicting pressure sore risk policy and procedure reads "Mild risk: total score of 15-18, moderate risk: total score of 13-14, high risk: total score 10-12 and severe risk: total score of 9 or less. R3's Braden assessment dated 8/20/16 reads under mobility "No limitation, makes major and frequent changes in position." R3's MDS (Minimum Data Set) dated August 5, 2016 under section G reads "Bed mobility - how a resident moves to and from lying position, turns side to side, and positions body while in bed or alternated sleep furniture - 2 person assist." The facility failed to identify R3 as a higher risk for pressure ulcer development based on his admission assessment.

R3's nursing notes dated 10/10/16 at 13:56 read "MASD (moisture associated skin damage) on buttock 3.8 cm x 3.5 cm. R3's wound care evaluation dated 10/12/16 reads "Stage appropriate mattress and avoid bony prominences under direct pressure recommended." R3's wound care evaluation report dated 10/19/16 reads "Sacrum stage 2 pressure ulcer measuring 3 cm x 5.5 cm with 25% slough. Stage appropriate mattress and

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F 314	Continued From page 10 avoid bony prominences under direct pressure recommended." R3's clinical notes dated 10/23/16 read low air loss mattress. On 11/16/16 at 1pm, E8 (Wound Nurse) stated that R3 was noncompliant with getting out of bed. The facility's prevention and treatment of skin breakdown policy dated 6/13 reads "The facility will properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers. The facility will implement preventative measures and provide appropriate treatment modalities for skin impairment according to industry standards of care."	F 314		