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	IL6003545	A. BUILDING: _____ B. WING _____	C 08/02/2019

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HIDDEN VALLEY	204 SOUTH PECAN JONESBORO, IL 62952

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S 000	Initial Comments Complaint Investigation 1955364/IL114192	S 000		
S9999	Final Observations Licensure Violations 330.710a) 330. 720b) 330.4220f) 330.4240a) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility Section 330.720 Admission and Discharge Policies b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care. Section 330.4220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 orders. (Section 2-104(b) of the Act) Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not Met as evidenced by the following. Based on interview, observation, and record review, the facility failed to ensure that the facility does not keep a resident requiring nursing services and failed to follow the physicians orders for 1 of 3 (R2) residents reviewed for nursing care needs and physicians orders in the sample of 4. Findings include: R2's admission face sheet lists 12-8-92 as the date of admission to this facility. R2's most recent diagnoses in part, as listed on V4's (Wound Physician) Encounters and Procedures note dated 8-1-19, are as follows: Wound right foot medial and dorsal, Diabetes Mellitus, Hypertensive Disorder, Borderline Mental Retardation and Personality Disorder. On 8-1-19 at 2:30 pm, V1 (Administrator) stated "I believe R2's wounds on his feet started sometime in May of this year. V6 (Physician) was here to see R2 and R2 took his sock off and showed V6. We didn't write it down anywhere. I thought it was on V6's note, but I don't see it." The physicians progress note for May is dated 5-30-19 and does not mention anything about foot wounds.	S9999		

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S9999	Continued From page 2 The first documentation found in R2's facility record regarding the wounds on R2's feet is on a Universal Progress noted dated 6-6-19 that states "R2 (resident's name) to V4 (physician's name). This Dr. sent R2 (resident's name) to E.R. to get x-rays done to see if it was broken anywhere since the incident on 6-2-19 with other res stomping on it. There was not broken bones the doctor rescheduled R2 (resident's name) for Thursday 6-13-19 at 10:30 V4 (physicians name)." R2's Encounter and Procedures Records from local surgery clinic by V4, Wound Care Physician dated 6-6-19 lists under Physical Exam, Skin:... Right foot dorsum 2x2 cm skin ecchymosis, surrounded by soft tissue edema and tenderness and bruises - Right foot medial ankle dry ulcer with eschar measure 1.7 x 1.7 cm no fluctuation no induration. Discussion Notes- The ankle ulcer seems to be stable and need to be treated with dressing changes a possible subsequent debridement. However, patient symptoms of severity from the trauma not allowing us to exam the foot well and do active wound care. Patient instructed to go to the emergency room to rule out fracture.... R2's Encounter and Procedures Records from local surgery clinic by V4, Wound Care Physician dated 6-13-19 lists under Physicat Exam, Skin...Right foot dorsum 1.7 x 2 cm skin eccymosis and eschar with mild fluctuate, surrounded by soft tissue edema and tenderness and bruises, adjacent blister 2 x 2 cm - Right foot medial ankle dry ulcer with eschar measure 1.2 x 1.7 x 0.1 cm no fluctuation no induration. Under Procedure Documentation an Incision and Drainage is listed:... excised the eschar...large amount of old clot hematoma and debris	S9999		

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S9999	Continued From page 3 evacuated.....wound packed with iodoform gauze and dressed with sterile 4x4 gauze and Medipore tape. Patient Instructions- for the ankle ulcer. Clean with normal saline. Apply iodoform packing and cover with cover with sterile gauze daily for 3 days. after 3 days, no need for packing, clean with normal saline and apply wet to dry dressing with sterile gauze with normal saline. Change daily... Per review of R2's facility Universal Progress Notes and verified through a local Home Health Agency Note, R2's next daily dressing change wasn't done until 6-15-19 the start of care for the Home Health Agency. The Home Health Agency note dated 6-15-19 adds to R2's diagnoses, Methicillen susceptible Staph infection.This same note lists under Integumentary: 1-unhealed pressure ulcer/injury at stage 2 or higher, 1-unhealed pressure ulcer/injury at stage 3, 1-unhealed pressure ulcer/injury unstageable and 1- unhealed pressure ulcer/injury at unstageable: Deep Tissue Injury. This same note under Care Coordination indicates lack of caregiver available for teaching on start of care...According to the Home Health Agency Notes they only provided 4 additional visits on 6-17-19, 6-19-19, 6-25-19 and 7-2-19. R2 was admitted to the hospital on 6-27-19 and discharged back to this facility on 7-1-19 with a diagnoses of Right Foot Cellulitis, according to the Patient Discharge Summary Report. This same report documents orders for a daily dressing change to the right foot: clean with normal saline, aquacell ag, wet to dry dressing and wrap with kerlex. R2's Encounter and Procedures Records from local surgery clinic by V4, Wound Care Physician	S9999		

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S9999	Continued From page 4 on 7/18/19 document, "Chief Complaint- wound care, right dorsal foot wound.... Problems.. Wound- right foot medial and dorsal." This same document further documents, "Skin: inspection and palpation: no rash and decreased turgor; Right foot dorsum 1.7 x 1.7 x 0.4 cm open wound- moderate drainage, adjacent skin eschar 2.5 x 2.5 cm. No fluctuation. Mild drainage. Right foot medial ankle dry ulcer with eschar measure 0.7 x 0.7 x 0.1 cm no fluctuation no induration, low drainage." This same encounter note also documented, "Patient Instructions: On the open wound on right foot dorsum: Daily dressing changes after cleaning the wound with normal saline (and) apply Aquacel and guaze or Mepilex border. On the eschar on the foot dorsum and ankle, apply hydrocolloid dressing and change every two days." This note further documents that patient has completed vancomycin in the hospital 2 weeks ago. Was in hospital 4 days... The note also indicates under discussion notes that the patient did not have the right dressing on the wound....Due to the chronic nature of the ulcer I will order vascular surgery evaluation... R2's Encounter and Procedures Records from local surgery clinic by V4, Wound Care Physician dated 07/25/19 documented, Patient has missed multiple appointments for venous doppler and ABI(Ankle-Brachial Index). No duoderm on the ankle found (this was ordered). Right foot dorsum 1.2 x 1 x 0.4 cm open wound- moderate drainage, epithelial edges adjacent skin eschar 2.5 x 2 cm mild fluctuation, mild drainage. Right foot medial ankle dry ulcer with tan eschar measure 0.7 x 0.5 x 0.1.... couple of open wounds on the dorsum measures 0.5x1 cm.Discussion notes: The eschar is ready to be debrided, which was completed and increased the measurements to 2.6 x 2.1 x 0.7 cm. Patient	S9999		

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S9999	Continued From page 5 Instructions On the open wounds (2) right dorsum: daily dressing changes to clean with normal saline, apply aquacel ag, cover with gauze or mepilex border. On the ankle: apply hydrocollid (Duoderm) dressing and change every 2 days... R2's most recent Encounter and Procedures Records from local surgery clinic by V4, Wound Care Physician dated 8-1-19 indicates skin: right foot dorsum 1.2 x 10.6 x 0.6 x 0.3 cm open wound- moderate drainage, epithelial edges - adjacent skin eschar 2.1 x 2.4 cm. Some nonviable biofilm present. mild erythema surrounding. Moderate yellow drainage. - right foot medial ankle ulcer measure 0.4 x 0.5 x 0.1 cm no fluctuation, no drainage. - couple of open wounds on the dorsum it measures 0.5 x 0.6 x 0.1 cm. The physicians orders for dressing changes remain the same as last visit. Under infection of the skin: Local infection of the skin and subcutaneous tissue, unspecified. Ceftriaxone 2 gram solution for injection- Take 2 g every day by injection route as directed for 3 days. On 07/25/19 at 9am, V1, Administrator, stated that R2 was scheduled for a follow up appointment with V4, Wound Care Physician, on 07/11/19. V1 stated he was the only person on duty in the facility and he could not leave to take R2 to the appointment. V1 stated he called some PRN(as needed) staff to see if they could work but nobody was available. V1 stated R2's appointment therefore had to be rescheduled to 07/18/19 . V1 stated V4 has been treating R2 for diabetic venous wounds on his right foot which were further injured on 06/02/19 when a peer intentionally stomped on the foot. V1 stated the facility obtained home health nursing services to dress R2's wounds, and this continued until	S9999		

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06/25/19 when R2's home health benefits were maxed out and facility staff took over with the dressings. V1 stated that staff change R2's dressing, "Every day or every other day." V1 stated they know how the dressing is to be changed as home health staff demonstrated it to them.

On 07/25/19 at 10am, V3, Registered Nurse employed by V4, stated R2 has venous wounds to his right foot which were exacerbated by a peer stomping on his foot several weeks ago. V3 stated when V4 has seen R2 there have been occasions when R2's dressing had not been applied according to physicians orders. V3 stated the facility failed to keep R2's appointments for an ABI (Ankle-Brachial Indexwere) on 06/20/19, 06/24/19, and 06/26/19. V3 stated R2 finally got the ABI performed during a recent hospital stay, during which R2 received infusion of Vancomycin intravenously due to cellulitis in the right foot.

On 07/25/19 at 9:30am,V1, Administrator, was observed changing R2's dressing to the right foot, assisted by V5, Aid. Without first performing hand hygiene, V5 donned clean nonsterile gloves and removed the old dressing. Without first performing hand hygiene, V1 donned clean nonsterile gloves. V1's phone rang, he answered it and wrote down a message while still wearing the gloves. V1 then took a pair of standard scissors from his top desk drawer and, without sanitizing them, placed them on the treatment cart. Still wearing the contaminated gloves, V1 took gauze sponges and wet them with normal saline and cleansed the two dorsal foot and the one ankle wound with the same sponge in a back and forth motion, going from clean to dirty and back to clean. V1 then wet a sponge with normal

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S9999	Continued From page 7	S9999		

saline and placed it over the two dorsal foot wounds. V1 then used the contaminated scissors to cut a piece of Aquacel which he placed over the ankle wound. V1 then wrapped the foot and ankle with gauze, leaving the wet sponge and Aquacel in place. V1 then applied tape which was not dated nor initialed. V1 then removed the gloves and did not perform hand hygiene. V5 also removed her gloves and did not perform hand hygiene.

On 07/25/19 at 11:55am, V4 stated R2 was seen for follow up that morning at 10:30am. V4 stated he observed that R2's foot wound was not dressed according to his orders. V4 stated this has also been an issue when R2 has previously seen and V4 stated he has reviewed the orders several times with facility staff. V4 confirmed the report of V3 about the failed doppler appointments. V4 stated the wounds are healing without complications and will not require surgical intervention. When the surveyor explained the wound care observation as described above, V4 stated V1 did not change the dressing according to V4's orders. V4 stated it is his expectation that facility staff follow his specific orders and to use proper aseptic technique in caring for the wound. On 8-1-19 at 2:50 pm V4 was asked, if by his professional evaluation does R2 require nursing care for dressing changes and monitoring, and V4's response was "They don't have nurses at this home? And yes R2 would be better served in a level of care that has nursing care until the areas are healed. I also ordered today for R2, an IM antibiotic to de administered daily times 3. I first saw R2 for the foot wounds on 6-6-19."

On 8-2-19 at 10:00 V6 (Primary Physician) stated "The regulation is the regulation and if R2 is better served at a nursing home, then he needs

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S9999	Continued From page 8 to get there." Review of R2's medical record showed no documentation of wound care since the last home health nurse visit on 06/25/19. An undated Handwashing Policy documents, "Meticulous handwashing plays a vital role in controlling infection. Make sure everyone washes his hands thoroughly, particularly after caring for residents with respiratory, enteric, wound, or skin infections." (B)	S9999		