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	IL6003008	A. BUILDING: _____ B. WING _____	C 03/11/2020

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GROVE OF BERWYN, THE	3601 SOUTH HARLEM AVENUE BERWYN, IL 60402

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S 000	Initial Comments Complaint investigation: 2091694/IL00120714	S 000		
S9999	Final Observations LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210b)d)3)5) 300.3240a) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan	S9999	Attachment A Statement of Licensure Violations	

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of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator,

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employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met as evidenced by:

Based on observation, interview and record review the facility failed to implement its wound care prevention and management program policy by failure to provide ongoing clinical assessment, documentation, notification of physician for any skin changes to obtain appropriate treatment, wound pain assessment and care plan evaluation and revision. This failure resulting to necrosis/gangrene of bilateral feet and transfer to the hospital for further evaluation and treatment. This deficiency affects one (R1) of two residents reviewed for wound care management.

Findings include:

On 3/10/20 at 1:41pm, V3 (Family member) stated that she informed the nurse (she cannot remember the name but able to recognize her when she sees her) 2 weeks ago of R1's skin discoloration on right foot and nothing was done. Her both feet got worse and became necrotic/gangrene. No wound treatment/dressing was provided to R1.

On 3/10/20 at 10:34am, R1 is lying across the bed with both lower extremities hanging from the bed and both feet touching the floor. No socks on right foot exposing 100% necrotic/gangrene great toe, 2nd and 3rd toes with dried open wound and with long toe nails. Foul smelling odor coming the gangrene toes. Right foot swollen/edematous,

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reddened and dry skin. She is very sleepy unable to maintain conversation. V7 (Licensed Practical nurse) stated that she is not familiar with R1, she is floated to different units. She does not know if she has wound treatment. V7 assessed R1's necrotic/gangrene right foot. R1 complained of pain as she touches her right foot. V7 stated that she has 100% necrotic/gangrene tissues on Right great toe, 2nd and 3rd toes. Her entire right foot is cold to touch. Foul smelling coming from necrotic/gangrene toes. She removed the sock on her left foot and observed necrotic tissue on left great toe, 2nd and 3rd toe. No open wound noted. Left foot swollen. R1 complained of pain when she touches her left foot. She stated the left foot is cold to touch too. She stated that she will call V9 Wound care nurse. V7 LPN stated that she has not given her medication yet because she is lethargic.

On 3/10/20 at 10:38am, V8 (Certified Nurse Assistant) stated that she is regularly taking care of her and has not seen her with bilateral feet dressing. Her black skin discoloration on her both feet/toes are the same no changes. She cannot remember when she developed it, but it has been there.

On 3/10/20 at 10:51am, V7 (LPN) gave R1 her morning medications but was not given pain medication as needed.

On 3/10/20 at 11:11am, V9 (Wound care Coordinator) stated that R1 was admitted on 1/31/20 with skin intact. She stated that she documented on 3/5/20 the necrotic/eschar 100% on right foot 2nd and 3rd digit tips. No other skin issues noted during assessment. She stated that she notified V12 (Nurse Practitioner) and informed V3 (Family member). Reviewed R1's

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medical record with V9 indicated re-admission comprehensive assessment dated 3/4/20 indicated skin assessment intact, podiatric- no problem with feet. No comprehensive skin evaluation was done on 3/5/20. On 3/6/20 R1's physician order sheet for March 2020 indicated: Cleanse Left foot 2nd digit and 3rd digit with NSS (normal saline solution) or wound cleanser, pat dry apply betadine soaked gauze and cover with dry dressing once daily/PRN (as needed) if loose or soiled very day shift to promote wound healing and Cleanse Right foot great toe and 2nd digit with NSS or wound cleanser, pat dry apply betadine soaked gauze and cover with dry dressing once daily/PRN if loose or soiled every day shift to promote healing ordered by V13 (Primary care Physician). R1 was not seen by wound care physician.

On 3/10/20 at 12:01pm, Observed V9 (Wound care coordinator) performed wound treatment to R1. She assisted R1 from sitting on bed to lying position. R1 complained of pain as she touches and position her both feet. She cleanses left foot with wound cleanser. She applied Vit A and D to dry skin of entire foot. R1 complained of pain and moans x 5, stating "ouch". She wrapped the 100% necrotic/gangrene great toe, 2nd and 3rd toe with betadine-soaked gauze and wrapped it with dry gauze bandage. R1 complained of pain as she wrapped the left toes. She cleanses the right foot with wound cleanser. R1 complained of pain as she cleans the right toes. She applied Vit A and D ointment to dry skin of entire right foot. R1 complained of pain. She wrapped the 100% necrotic/gangrene right great toe, 2nd and 3rd with betadine-soaked gauze and wrapped it with dry gauze bandage. R1 complained of pain and moans x 6 as she applied the gauze, stated "ouch". She positions R1 on sitting position and

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applied both socks. R1 complained of pain as she applied her socks.

On 3/11/20 at 9:30am, V9 (Wound care coordinator) stated that she did not document wound assessment done with R1's yesterday and did not call V12 (Nurse Practitioner) or V13 (Primary care Physician) for new order of increased progress of 100% necrotic/gangrene tissues of Right foot to great toe, 2nd and 3rd; and Left foot great toe, 2nd and 3rd toe. No comprehensive skin evaluation was done. V7 (LPN) did not document assessment done with R1 bilateral necrotic feet and did not call V12 or V13.

On 3/11/20 at 9:58am, V12 (Nurse Practitioner) stated that she sees R1 for V13 Primary Care physician. She has seen R1 several times since admission. She comes to the facility on daily basis and will ask floor nurses if she needed to see assigned residents for any clinical conditions that needed to be addressed. She is not aware of R1's necrotic/gangrene toes on both feet. Reviewed R1's progress notes documented by V12 indicated that all her 12 visits from admission, she documented: Ext- no redness or swelling to feet, no BLE edema and skin intact. She admitted she did not perform physical examination of R1's BLE. She was notified of her leg pain upon standing and addresses the concern when she visited her on 2/26/20. She did not assess/examin R1's BLE but ordered doppler ultrasound for BLU. Reviewed R1's Arterial ultrasound of bilateral extremities dated 2/26/20 with V12 indicated: History: Swelling if limb. Impression: mild to moderate peripheral vascular disease without occlusion, bilateral lower extremities. Surveyor requested V12 and V9 (Wound care coordinator) to examine R1's

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bilateral necrotic/gangrene feet.

On 3/11/20 at 10:17am, R1 lying on bed, undressed gown and loosen disposable brief but covered with blanket. She is sleepy but responsive. She complained of pain as V9 (Wound care coordinator) repositioned her on bed. V9 removed right sock, R1 complained, moans and flexed her right leg when she touched her. V9 removed right foot dressing. Observed necrotic/gangrene of right great toe, 2nd and 3rd toes 100% with dried open wound and with long toe nails. R1 moans and complained of pain as V12 (Nurse practitioner) assessed her right foot. V12 stated "I was informed that she is in this condition". She stated that R1 has necrotic/gangrene on right great toe, 2nd and 3rd toes with dried open wounds and foul-smelling odor coming from the gangrene toes. Entire foot/ankle swollen, reddened and cold to touch. V9 removed left sock and wound dressing. Again, R1 moans and complained of pain as she touches her. V12 assessed R1's left foot and stated her great toe, 2nd and 3rd toes 100% necrotic/gangrene, no open areas and with long toe nails. Foot and ankle swollen, reddened and cold to touch. V12 stated that she will call V13 (Primary Care Physician) to update with R1's clinical condition.

On 3/11/20 at 10:56am, R1 sleepy but responsive and stated that she has pain rate of 10/10 on her bilateral feet. She stated that she has not received yet her morning and pain medication.

On 3/11/20 at 12:50pm, V12 Nurse Practitioner stated that she spoke with V12 Primary care physician and discussed R1's increased progression of necrotic/gangrene on both feet and order to send her to hospital for further

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evaluation and management.

On 3/11/20 at 2:41pm, V9 Wound care coordinator stated that she does wound treatment for R1 daily and pre-medicated her for pain an hour before she will provide wound treatment. She stated that she asked both V7 (LPN) and V16 (RN), who worked on 3/10/20 and 3/11/20 to give R1 her pain medication 1-hour prior her wound dressing. When asked what time she asked V7 and V16 to give her medication, she stated she cannot remember for V7 but for V16 she asked around 8:15am. Reviewed R1's MAR (Medication administration record) for March 2020 indicated that R1 was not given PRN (as needed) pain medication . R1's physician order sheet for March 2020 indicated order of Acetaminophen 325mg, give 2 tablets by mouth every 6 hours as needed for pain. She stated that she will write a standing order for pain medication of R1, 1 hour prior to wound treatment.

On 3/11/20 at 2:53pm, V13 Primary care physician stated that he expected that the nursing staff will call him for any changes in resident condition and follow the facility's protocol in wound management. He stated that R1's possible embolism of BLE causing occlusion. Her anti-coagulant aspirin and Plavix were on hold due to recent subdural hematoma. He would like to see her in the hospital to evaluate the bilateral necrosis/gangrene of her feet. He will follow up with neurosurgery and vascular surgeon.

On 3/12/20 at 10:52am, V17 (LPN) that on 2/20/20 she worked on 3-11 shift. V3 (Family member) at bedside and concern of R1's skin discoloration on 2nd digit/toe of right foot. R1's denied pain, no edema and no open areas. She documented it but did not notify V13 (Primary

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Care Physician) or V12 (Nurse Practitioner). She wrote it to be follow up in 24-hour report. She notified V9 (Wound care Coordinator) the following day (2/21/20). She did not able to follow it up because she was floated to another unit.

Reviewed of R1's progress notes dated 3/11/20 documented by V12 (Nurse Practitioner) indicated: R1 was examined for BLE (Bilateral lower extremities) necrotic toe. Ext: mild BLE edema. SKIN: redness to bilateral feet with necrosis to left foot digits 1-3 and right foot digits 1-3.

Review of R1's progress notes dated 3/8/20 indicated: No open area, redness or swelling noted. R1 has old scabs to both lower extremities. The documentation was deleted/strike out by V7 (LPN) on 3/10/20 at 12:52pm (after surveyor observed her assessment of R1's bilateral necrotic/gangrene feet/toes on 3/10/20 at 10:34am) and she did late entry notes for 3/8 indicated: Open areas noted on left foot between great toe and 2nd toe. Toes noted to be dark in color, cool to touch.

Facility's Wound Care Program Care guidelines revised date 7/3/19 indicated: Procedures: 1. Timely identification of residents assessed to be risk for skin breakdown. a) The Braden scale must be completed by a licensed nurse on admission/readmission and weekly for the first week of admission/re-admission in the facility. 2. Proper identification of risk factors that can impact in the development of unavoidable ulcer or may impede with healing process if resident does not have an ulcer. 3. Prevention of skin breakdown includes but not limited to: c) Inspection of skin every shift with care signs of breakdown. 5. Skin protection. 7. Pain a) Observe

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and assess for indication of pain and or discomfort. b) Manage pain by controlling source of pain. d) offer/administer analgesia, if ordered prior to dressing changes. 9. Documentation. c) The care plan shall be evaluated and revised based on resident's response to treatment; treatment goals and outcomes. d). The resident's skin alteration/breakdown (pressure ulcer, arterial, diabetic, venous ulcers and etc..) shall be documented in the resident's clinical records in accordance to the facility's policy and in compliance to current regulatory standards. 11. Wound assessment for pressure, diabetic, venous and arterial wounds: documentation shall include but not limited to: type of wound and or ulcer, location, date, stage (if applicable), length, width and depth; wound bed description, wound edge description and if present, exudates, undermining, tunneling and wound related pain.

Facility's Skin care treatment regimen revised date 8/2/19 indicated: it is the policy of this facility to ensure prompt identification, documentation, and to obtain appropriate treatment for residents with skin breakdown.

(B)