STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014369	A. BUILDING: ______ B. WING ______	C 05/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF WHEELING	730 WEST HINTZ ROAD WHEELING, IL 60090

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S9999	Final Observations	S9999		

Statement of Licensure Violation:

300.1010h)
300.1210b)
300.1210d)5)
300.3240a)

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 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

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S9999	Continued From page 1 and shall be practiced on a 24-hour, seven-day-a-week basis: 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, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to assess, identify, treat and update physician's orders for one of one residents (R1) reviewed for diabetic ulcers. These deficient practices resulted in R1 requiring hospitalization for excisional debridement of left toe diabetic foot ulcer and intravenous antibiotic therapy for Staph aureus (Staphylococcus aureus). Findings include: R1 (per review of Admission Diagnoses List) was	S9999		

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S9999	Continued From page 2 admitted to the facility with diagnoses that include uncontrolled diabetes mellitus, history of left third toe amputation and dementia. E6 (LPN-Licensed Practical Nurse, 5/6/15 at 2:00 p.m., 5/7/15 at 10:18 a.m.) said all assessments (including skin) are to be completed by the nurse upon the resident's admission to the facility and there is an admissions check list that is utilized. E6 said she is unaware of any admissions policy and procedure. E6 said she has worked at the facility for 4 years and she knows what needs to be done when a resident is admitted. E6 admitted that she did not complete a skin assessment for R1 because he refused. E6 said she believes she documented in the 24 hour shift report R1's refusals for skin assessment. E2 (Director of Nursing, 5/7/15 at 3:10 p.m.) said skin assessments are part of the admission process. The assessment is to be completed in the EMR (Electronic Medical Record) in addition to completing an admission check list. E3 (Assistant Director of Nursing, 5/6/15 at 12:15 p.m.) said skin assessments should be completed upon the resident's admission to the facility. E3 said reviewed R1's EMR and said the skin assessment had not been completed. Both E2 and E3 said R1's refusal should have been documented in the 24 hour shift report and endorsed to the next shift to complete. Review of R1's medical record (Progress Notes 4/25 and 4/30/15, Assessments) document an incomplete skin assessment. Review of the 24 hour reports (4/25/15 hand dated by E3) document that skin assessment was not completed upon admission and the need for next shift to follow up.	S9999		

Illinois Department of Public Health

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S9999	Continued From page 3	S9999		

Continued From page 3

E6 said she did not perform a skin check on R1 when he received a shower on 4/27/15 because she was in the middle of something; the CNA (Certified Nursing Assistant) completed the skin check. E6 said it is the nurse's responsibility to complete a skin check before the resident leaves the shower.

E2 (5/7/15 at 3:10 p.m.) said a nurse should complete a skin check during a resident's shower. She said E6 did not complete a skin check for R1.

E3 (5/6/15 at 12:15 p.m.) said a nurse must complete a skin check before the resident leaves the shower.

Review of R1's Skin Observation Worksheet (Shower Log, 4/27/15) documents R1 received a shower and skin check was completed with no changes.

Z1 (DPM-Doctor of Podiatric Medicine, 5/6/15 at 3:31 p.m.) said he did a debridement of the tip of the 4th toe of R1's left foot on 4/27/15 for a Grade I ulcer. Wound care was to include daily bathing and dressing change with application of Neosporin or Bacitracin ointment. Z1 said he was notified by the facility that R1 did not have any paperwork when he returned to the facility. Z1 said he faxed the information to the facility the following day (4/28/15). Z1 said R1, who has a history of diabetic foot ulcers and toe amputation, developed a very significant foot/toe ulcer while at the facility. He said if he had known that R1 had any symptoms of infection and that wound care was not being done, he would have sent R1 immediately to the hospital. When asked by the surveyor, what could happen if wound care was

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S9999	Continued From page 4	S9999		

not done, Z1 responded: "what could happen, did happen."

Per review of R1's Report of Consultation (4/27/15) a debridement of the tip or R1's left 4th toe was done for a Grade I ulcer measuring approximately 0.25 cm in diameter. R1's wound care status post debridement included daily bathing and dressing change; apply Neosporin or Bacitracin ointment after bathing.

Z3 (Physician, 5/7/15 at 2:56 p.m.) said he was not informed by the facility that R1 had been seen by a podiatrist and had a debridement of the left 4th toe for Grade I ulcer nor was not contacted regarding podiatrist's wound care instructions. He said if wound care is not done (as is the case of R1), a wound could potentially get worse. It could get larger, deeper, become infected and spread to surrounding tissue. Z1 said he agreed with Z2 regarding sending R1 to the hospital.

Review of R1's medical record (Progress Notes 4/25 and 4/30/15) doesn't document: that paperwork was or was not received from Z1; any further attempts to obtain paperwork from Z1; any assessment of R1's feet before or after his visit to Z1; doesn't document any notification of R1's physician regarding R1's visit to Z1/debridement of R1's left 4th toe/wound care instructions nor does it document any wound orders for resident's left 4th toe.

E3 (5/2/15 at 1:20 p.m.) said staff missed wound to R1's left foot and toe.

E7 (Nurse, 5/6/15 at 4:20 p.m.) said he was approached by R1's wife on 4/30/15 stating R1 has an infection somewhere because his blood sugar is high. E7 said he looked at R1's right

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S9999	Continued From page 5 great toe and it was red. E7 said he knew R1 saw the foot doctor on 4/27/15, but didn't see any new orders in his chart. Review of E7's Progress Note of 4/30/15 documents R1's wife told him resident's uncontrolled blood sugar was due to a possible infectious disease of the "right big toe", therefore she is taking him to the foot doctor. The note does not document any assessment of R1's feet. In a late entry created on 5/2/15, E7 documents on 4/30/15, before wife and resident left the facility, the wife called him to assess R1's feet. E7 assessed R1's feet and "found redness towards the big toe." Review of R1's hospital record (Daily Progress Note 5/2/15, Infectious Disease Progress Note 5/2/15) documents R1 was admitted to the hospital on 4/30/15 with diagnoses including diabetic foot ulcer. An excisional debridement of the left toe diabetic foot ulcer was performed. Culture of foot drainage was positive for Staph aureus. (B)	S9999		