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S 000	Initial Comments Complaint Investigation: 2197327/IL138866	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 a) b) 300.1210 d)2)3) 300.1210 d)5) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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,	S9999		

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S9999	Continued From page 2 and prevent new pressure sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop a plan of care with interventions to prevent and/or reduce the risk of diabetic complications leading to foot injury, the facility also failed to follow physician orders for treating foot ulcer/wounds and failed to contact a podiatrist to assist with cutting overgrown toenails. These failures affect 4 of 4 residents (R3, R4, R5, R6) reviewed for quality of care. This failure resulted in R3 foot becoming decolored, R3 being sent to the local hospital, and treated for gangrene and diabetic foot infection. Findings include: R3 R3 is re-admitted on 6/23/21 with diagnosis listed to include Multiple fracture of ribs, left side, Fracture of Lumbosacral spine and pelvis, Fracture of shaft of humerus, Fall, Type 2 Diabetes Mellitus with diabetic neuropathy, Peripheral Vascular Disease, Adult Failure to thrive, Vascular Dementia, Restless leg syndrome, Need for assistance with personal care. R3's care plan indicates that she has potential for impairment to skin integrity related to weakness and urinary incontinence. R3 has an ADL self-care performance deficit related to weakness and deconditioning requiring staff extensive assistance. She has Diabetes Mellitus with neuropathy. No care plan intervention for diabetic foot care. On 10/19/21 at 11:16am, V11 (Licensed Practical Nurse/LPN) said that on 10/3/21, V6 (R3 family	S9999		

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S9999	Continued From page 3	S9999		

member) came to visit. R3 complaint to V6 of foot pain and when he removed her shoes observed 3rd middle toe pad on left foot discoloration of brownish black and reported it to her. R3 did not complaint of pain to her. V11 assessed R3's left foot 3rd toe brownish black discoloration measures 1.7 cm x 1.8 cm x depth undetermined. V11 notified V12 (Primary Care Physician/PCP) and gave orders for blood test, arterial doppler studies of LLE and wound consult. V11 said that R3 has tight ill-fitting shoes provided by family. V11 said that she was not aware of the discoloration of R3's foot when V6 informed her. V11 said that the CNA (Certified Nurse Assistant) is the one dressing R3, so she did not see her foot. The CNA did not inform her of any changes in R3's foot. V11 added that R3 does not take off her socks.

Review R3's progress notes with V11 that she documented indicates that on 10/4/21, Doppler report of Left lower extremity revealed no flow in proximal left superficial femoral artery. Stenosis in rest of visualized arteries: Severe in distal superficial femoral and the dorsalis pedis arteries. V12 came to see R3 at the facility and sent R3 to the hospital for evaluation after talking to R3's family. R3 was admitted with infection.

R3's Hospital emergency record dated 10/4/21 indicates that "R3 presents with complaint left 3rd toe color changes over the past week. R3 was sent to hospital over concern for dry gangrene to the left 3rd toe. R3 is notice redness and swelling over the dorsum of the left foot and left ankle, states she has not had any fever or chills. R3 states she otherwise feels generalized weakness and fatigue, endorses decreased po (oral) intake. Physical Exam: Skin: dry gangrene noted to left 3rd toe distal swelling noted circumferentially,

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S9999	Continued From page 4 redness/erythema and warmth spreading over dorsum of foot to left ankle and left shin, mild tenderness palpation over left 3rd toe. R3's admitting diagnosis of Diabetic foot infection and dry gangrene". R3's weekly skin assessment dated 9/2/21, 9/9/21, 9/15/21 and 9/30/21 were not marked/not done. No record of podiatrist consult. On 10/19/21 at 12:55pm V3 (Director of Nursing/DON) said that there is no wound coordinator person, the nurses on the floor do the wound care/treatment, make rounds with the wound care physician, and does the weekly skin/wound documentation as scheduled. On 10/21/21 at 10am, V1 (Executive Director/ED) said that R3 was not seen by podiatrist during R3 stay at the facility. On 10/21/21 at 12:38pm, V12 (PCP) said that R3's necrotic tissue on middle toe left foot spread fast due to infection. He said that the necrotic /gangrene of R3's toes is unavoidable due to no circulation and no sensation based on doppler studies due to significant peripheral arterial disease. She has history of amputation of R foot toe 3 years ago. She has compromise condition and poor prognosis. He said that staff told him that the family cause the problem because they brought the ill-fitting shoes that cause a problem. Informed V12 that Therapist (V24 Physical Therapist and V25 Occupational Therapist) said that they used the shoes during ambulation therapy period from 8/26 to 9/21/21. R3 did not complaint of pain on her feet when wearing her shoes. V12 said that R3 will not complaint of pain because she does not have sensation on her feet due to no circulation at all. Asked V12 (PCP) why	S9999		

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S9999	Continued From page 5 he did not order a podiatrist consult for R3 during his stay at the facility if R3 has is risk for developing diabetic complications. V12 said he is not aware that R3 was not seen by podiatrist. R4 R4 is admitted on 3/31/21 with diagnosis listed to include Difficulty in walking, Muscle weakness, Need for assistance with personal care, Protein calorie malnutrition, Dementia. R4's care plan indicates that she has potential for impairment to skin integrity related to weakness. Intervention: Monitor/ document location, size and treatment of skin injury. Report abnormalities to physician. R4 has an ADLs self-care performance deficit related weakness requiring extensive assistance with ADLs function. On 10/19/21 at 11:46am, Observed R4 lying in bed with a multi-purpose elasticated tubular bandage to both bilateral extremities and socks. V11 (LPN) removed both socks. Observed long toenails and dry skin. Observed both heel with non-blanchable redness and bluish discoloration on left heel. R4 complaint on tenderness when V11 touches her bilateral heel. V11 cut the multi-purpose elasticated tubular bandage/sleeves on both lower legs because it was too tight. V11 said that she is not aware of R4's bilateral heel redness and bluish discoloration. V11 added that the night shift is the one who applied the lower leg sleeves. V11 said she will do change in skin condition assessment. V3 (DON) notified of observation made. Review R4's most recent weekly skin assessment with V11 (LPN) dated 10/17/21 indicates none noted. On 10/20/21 at 12:52pm, review R4's changes of	S9999		

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S9999	Continued From page 6 skin condition/assessment done by V11 (LPN) dated 10/19/21 stated called V3 (DON) and informed the observation reported to her yesterday of R4's bilateral heel non blanchable redness with tenderness and bluish discoloration on left heel was not documented in change of skin condition. V3 DON said that V11 should do a skin assessment/evaluation on any changes in skin condition and call the physician for treatment order and notify family member. Skin assessment includes measurement and description. V3 said that V11 should get an order for heel protector for bilateral heel/ off loading and wound consult due to tenderness and bluish discoloration yesterday. On 10/20/21 at 1:00pm, V3 (DON), V21 (LPN) and V15 (CNA) came to R4's room to assess her bilateral heel. Observed R4 lying in bed, with bilateral socks on. V15 removed both socks and elevate both heels. R4 complaint of pain when heels are being touch. Observed non blanchable redness with tenderness on bilateral heels and bluish discoloration on left heel. V3 DON instructed V21 to call the nurse practitioner in the building to see R4 and get order for bilateral heel protectors. On 10/20/21 at 1:24pm, telephone interview with V11 (LPN). V11 said that she forgot to include the observation yesterday with surveyor of R4's bilateral heel non blanchable redness on both heels with tenderness and bluish discoloration on left heel in her skin assessment documentation. She said did not notify the physician and family member. Review R4's progress notes dated 10/20/21 documented by V21 (LPN) indicates R4 notes with redness to left heel measuring 3cm x 3cm x0cm. R4 also noted with slight bluish	S9999		

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S9999	Continued From page 7 discoloration to center of reddened area measuring 1cm x .5cm x 0cm. Skin remains intact. Nurse practitioner of V12 PCP called with new orders for pressure relieving boots to both feet and consult with wound care physician. On 10/21/21 at 9:51am, the surveyor observed R4 up in wheelchair in the dining room with bilateral pressure relieving boots on that were touching the floor. R4 does not wear socks. The surveyor observed reddish purplish skin color of the lower extremities, still with long toenails. On 10/21/21 at 1:02pm, called V23 (Registered Nurse/RN) and showed R4's discoloration on both lower extremities and dependent edema. V23 said that R4 has insufficient circulation due to the reddish purplish discoloration of bilateral lower extremities. V23 said she will call the physician for venous and arterial doppler studies for bilateral lower extremities. R4's Physician order sheet dated 10/21/21 indicates BLE (bilateral) Venous Doppler and Arterial studies. Diagnosis: Discoloration. On 10/22/21 at 12:12pm, V1 (Executive Director) said that the venous and arterial doppler will done not until Monday. On 10/25/21 at 4:12pm, R4's bilateral duplex lower extremity arterial ultrasound done on 10/22/21 indicates no flow right posterior tibial artery. Stenosis in the rest of the bilateral intrapopliteal especially in the left posterior tibial artery. R5 R5 is admitted on 5/7/21 with diagnosis listed to include Hemiplegia and hemiparesis following	S9999		

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cerebral infarction affecting left dominant side, Type 2 Diabetes Mellitus with diabetic polyneuropathy, diabetic kidney disease, Pressure ulcer on sacral region stage 3, unstageable right heel, Congestive heart failure. R5's Care plan indicates that he has right heel wound observed with osteomyelitis and is being treated with oral antibiotics. Right heel wound stage 3, sacrum wound stage 3, left lateral ankle stage 4, and shearing right buttocks. R5 has an ADLs self-care performance deficit requiring staff extensive assistance.

R5's Physician order sheet indicates Bactroban ointment 2% apply to right heel topically every night shift and as needed after cleansing with 0.9% NS cover with Calcium Alginate and support with abdominal pads and secure with kerlix. Betadine solution 10% apply to left heel topically every shift for pressure ulcer, leave open to air. Collagenase ointment apply to sacrum topically every night shift and as needed for pressure ulcer after cleansing with 0.9% NS cover with border foam.

On 10/19/21 at 1:34pm, the surveyor observed R5 lying in bed with bilateral heel protectors/boots. R5 is not on low air loss mattress. V11 LPN open the Velcro of R3's left heel protector/boots. V11 said they placed disposable diaper underneath the left foot to protect the heel protector from betadine stain. Observed left heel 100 % necrotic is soaked with betadine gauze. V11 said that she just did the betadine paint and applied gauze and placed the disposable diaper underneath then apply the heel protector/boots the secure with Velcro. Observed right heel wrapped with kerlix. V11 said that the night shift does the right heel dressing. She does not know the wound condition. V11 used scissors

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S9999	Continued From page 9 from her pocket to cut the kerlix then put it back to her pocket without disinfecting. The surveyor observed right heel with stain of betadine cover with non-adhesive gauze and abdominal pad with moderate amount of brownish greenish drainage. V11 removed the right heel dressing. The surveyor observed necrotic right heel with greenish slough formation. V11 left the room to review wound treatment orders and get R5's wound dressing. On 10/19/21 at 1:55pm, V11 (LPN) irrigate with normal saline solution right heel and applied Bactroban ointment using the same gloves. V11 applied calcium alginate and wrapped with kerlix. Review R5's wound treatment orders with V11 (LPN). V11 did not follow treatment orders of R5 for both right and left heel. Left heel was not left open to air after betadine paint. V11 acknowledged that the night nurse who does the dressing used Betadine paint to right heel based by night betadine stain marking. Non-adhesive dressing was used instead of calcium alginate. V11 did not used abdominal pad to cover before applying kerlix bandage. V11 did not clean the right heel with normal saline solution instead just irrigate it. V11 did not perform hand hygiene after wound irrigation before applying Bactroban ointment. V11 did not sanitize scissors after using it and put it back to her pocket. R5 has also sacral wound that was not observed. On 10/19/21 at 2:17pm, V11 (LPN) performed wound care on sacral area. Observed 100 % greenish slough formation. R5's weekly wound documentation dated 10/14/21 done by V2 (Clinical Executive Director) indicates R5 usage of low air loss mattress as	S9999		

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S9999	Continued From page 10 preventive measures. R5's weekly skin check dated 10/2/21 and 10/6/21 were not marked/not done. R5 is not on low air loss mattress. Informed V1 (Executive Director), V2 (Clinical Executive Director) and V3 (DON) of above observation. V3 said that V11 should disinfect her scissors after using to cut the kerlix dressing. Hand hygiene is performed after cleaning wound and don new pair of gloves when applying treatment/medication to right heel. R6 R6 is re-admitted on 5/19/21 with diagnosis listed to include Type 2 Diabetes Mellitus, Traumatic subdural hemorrhage, Long term use of oral hypoglycemic drugs, Acute kidney failure, Generalized idiopathic epilepsy and epileptic syndromes. R6's Care plan indicates R6 has diagnosis of Diabetes Mellitus, is on oral diabetic medication and has diabetic shoe. R6 has potential for impairment of skin integrity related to urinary incontinence. R6 has an ADLs self-care performance deficit requiring staff extensive assistance. Care plan intervention does not include foot care. R6's Physician order sheet indicates Bacitracin ointment apply to left big toe topically daily related to diabetes. Triple antibiotic ointment apply to left 1st toe medial grove topically every night shift for open area daily until healed. R5's Oct 2021 Treatment record administration does not include the Bacitracin and Triple antibiotic ointments treatment to left big toe and left 1st toe. On 10/20/21 at 9:59 am the surveyor observed R6 transferred from wheelchair to bed by V19 (CNA). V20 (RN) placed all treatment medications and dressing on bedside tray table.	S9999		

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S9999	Continued From page 11 R6 is on low air loss mattress with fitted sheet, cloth pad and wears disposable adult brief. The surveyor observed band aid to both right great toe and left great toe. The surveyor asked V20 what happened to his great toes, she said "the podiatrist cutting too close". V20 removed the band aid on right great toe, cleanse with normal saline solution, applied bacitracin ointment and covered with band aid using the same gloves. Right great toe is swollen and reddened particularly on the side of the toenail. V20 removed left great toe band aid, no redness /swelling, open wound noted. She said she will leave it open and will call the physician. V19 turned R6 to his right side and removed the disposable brief and observed redness on sacral area. V20 cleansed sacral area with normal saline solution and applied moisture barrier ointment to sacral area. V20 took the medications - bacitracin ointment and moisture barrier ointment tubes and placed it back inside the treatment cart without disinfecting. V20 said that she should disinfect it before putting it back inside the cart. Informed V19 that she did not remove gloves and performed hand hygiene after cleansing the right toe. She uses same gloves for performing wound care on right great toe. V20 did not response. V20 did wound dressing on right great toe without order. Both treatment orders are for left toe. V20 said that Bacitracin should be on right great toe. On 10/21/21 at 9:54am, V23 (RN) said that they do weekly skin assessment which includes head to toe assessment - including foot assessment especially for diabetic resident. CNAs does daily skin checks during personal care and hygiene. CNAs report to the nurse observation outside the normal skin condition. The nurse then will assess resident, call physician for treatment order and	S9999		

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S9999	Continued From page 12 notify the family. On 10/21/21 at 10:26am V18 (MDS/Care Plan Coordinator) said that the foot care in care plan for diabetic resident is included in skin prevention/impairment care plan because when nurse does the skin weekly assessment, the foot assessment is included. V18 said he depends on the nursing report for him to update the care plan. If he was not notified, he cannot update the care plan. Review R6's weekly skin documentation and weekly wound assessment with V18 and no documentation was done. The surveyor informed observations to V1 (Executive Director) and V3 (DON) of above concerns. On 10/21/21 at 2:30pm V1 presented new forms called skin alert that they will use for skin/wound monitoring to improve their documentation and communication in wound care including foot. Facility's policy on Nursing care of the resident with Diabetic Mellitus: Purpose: 4. Recognize, manage and document the treatment of complications commonly associated with diabetes Skin and foot care: 6. Encourage the use of non-constricting, well-ill-fitting shoes slippers and hose. 8. Toenails should be trimmed by qualified personnel Documentation: 3. Assessment of the skin including the following: a. Color, moisture and temperature and b. any redness, ulcers, irritation, abrasions and/or pruritis (itching) 12. Assessment of the feet should include the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016489	A. BUILDING: _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 following: c. Color; d. Circulation; g. Condition of the toes and toenails Facility's policy on Prevention of Pressure ulcer/injury indicated: The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and intervention for specific risk factors. Risk assessment: 4. Inspect the skin on daily basis when performing or assisting with personal care and ADLs. Monitoring: 1. Evaluate, report and document changes in the skin. Facility's policy on Pressure ulcer/injury risk assessment: The purpose of this procedure guidelines for the structured assessment and identification of residents at risk for developing pressure ulcer/injuries Steps in procedure: 4c. If new skin alteration is noted, initiate a (pressure/non pressure) form related to the type of alteration in skin 5. Develop the resident centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition and the resident's stated wishes and goals. Documentation: 12. Documentation in medical record addressing physician notification if new skin alteration noted with change of plan of care 13. Notifying attending physician if new skin alteration noted. Facility's policy on Change in a resident's condition or status: Our facility shall promptly notify the resident, his or her attending physician and representative of changes in the resident's	S9999		

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S9999	Continued From page 14 medical/ mental condition and or status. Facility's policy on Medication and Treatment orders: Orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medication shall be administered only upon written order of a person duly licensed and authorized to prescribe such medication in this state. Facility's policy on handwashing/hand hygiene indicates: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy and implementation: 6. Use an alcohol-based hand rub containing at least 62% alcohol or alternatively soap and water for the following situations: g. Before handling clean or soiled dressing, gauze pads k. After handling used dressing, contaminated equipment Facility's policy on Cleaning and disinfection of resident care items and equipment: Resident equipment includes reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne pathogens standard. "B"	S9999		