STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008759	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE HEALTH CARE CENTER	900 EAST NINTH STREET METROPOLIS, IL 62960

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)3) 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. These requirements were not met as evidenced by:	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Based on observation, interview, and record review, the facility failed to recognize the urgency of a worsening wound and seek immediate evaluation and treatment after noting a significant change in the condition of the wound for 1 (R38) of 7 residents reviewed for wound care in a sample of 77. This failure resulted in R38 developing gas gangrene with underlying osteomyelitis requiring emergent trans-metatarsal amputation and subsequent Chopart's (forefoot and midfoot) amputation and R38 has been placed on hospice care. Findings include: R38's Face Sheet documents admission to this facility on 10/07/19 with diagnoses to include type 2 diabetes without complications and blindness in right eye. Additional diagnoses incurred on 02/28/23 include type 2 diabetes with foot ulcer, type 2 diabetes with other specified complications, acute osteomyelitis, left ankle and foot, and partial traumatic amputation of left foot. R3's annual Minimum Data Set (MDS) dated 10/17/22 documents R38 to be totally dependent for activities of daily living requiring 2 plus staff for transfer via mechanical lift. R38 is severely cognitively impaired, incontinent of bowel, and has an indwelling foley catheter. R38's Quarterly MDS dated 01/17/23 and Significant Change MDS dated 02/26/23 indicate R38's cognition and required assistance needs had not changed from the previous MDS. R38's Braden Assessments include: On 04/20/22, R38 is assessed to be at very high risk with a score of 9 (at risk 15-18, moderate risk 13-14, high risk 10-12, very high risk 9 or below); On 02/09/23, R38 is assessed to be at moderate risk	S9999		

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S9999	Continued From page 2 with a score of 13. On 02/28/23, R38 is re-assessed to be at very high risk for skin breakdown, scoring a 9. R3's care plan dated 08/26/20 includes the following: Focus: (R38) has potential for altered skin integrity, decreased mobility r/t (related to) CVA (cerebrovascular accident), unable to make needs known, communication deficit, foley to DD (down drain), diabetes brittle. Goal: (R38) will maintain or develop clean and intact skin by the review date. Date Initiated: 10/08/2019, Revision on: 10/18/2021, Target Date: 03/07/2023. Intervention/Tasks: (R38) has a pressure reducing mattress on bed to protect and prevent skin breakdown while in bed. Keep skin clean and dry. Use lotion on dry skin. Monitor for side effects of the antibiotics and over-the-counter pain medications: gastric distress, rash, or allergic reactions which could exacerbate skin injury. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etcetera to MD (Medical Doctor). Obtain blood work such as CBC (complete blood count) with Diff (differential), Blood Cultures and C&S (culture and sensitivity) of any open wounds as ordered by Physician. (Pressure relief cushion) in chair at all times to protect and prevent skin break down while in chair. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Weekly treatment documentation to include measurement of each area of skin breakdown width, length, depth, type of tissue and exudate and any other notable changes or observations. Focus: The resident has infection of gangrene of the left foot; Ceftriaxone sodium injection solution reconstituted 2 GM (gram) use 2 gram intravenously one time a day for infection	S9999		

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S9999	Continued From page 3 left foot, gangrene for 32 days, date initiated 02/16/23; 3/24/23 Levaquin 500 mg (milligrams) daily x (times) 10 days. Date Initiated: 02/16/2023. Revision on: 03/28/2023. Goal: The resident will be free from complications related to infection through the review date. Date Initiated: 02/16/2023. Target Date: 03/07/2023. Intervention/Tasks: Administer antibiotic as per MD orders. Monitor temperature/pulse as per facility protocol. Monitor/document/report to MD s/sx of delirium: Changes in behavior, Altered mental status, Wide variation in cognitive function throughout the day, Communication decline, Disorientation, Periods of lethargy, Restlessness and agitation, Altered sleep cycle. Date Initiated: 02/16/2023, Revision on: 03/01/2023. Focus: (R38) is on IV (intravenous) Medications R/T infection to left foot, S/P (status post) Chopart's amputation, osteomyelitis left foot. Date Initiated: 03/01/2023. Revision on: 03/01/2023. Goal: (R38) will have not have any complications related to IV therapy through the review date. Date Initiated: 03/01/2023. Revision on: 03/01/2023. Target Date: 03/07/2023. Intervention/Tasks: IV Dressing: Nursing change PICC (Peripherally Inserted Central Catheter) dressing to left arm weekly and PRN (as needed) as indicated. Monitor site daily for S/S infection. Monitor/document/report PRN s/sx of infection at the site: Drainage, Inflammation, Swelling, Redness, Warmth. Monitor/document/report PRN s/sx of leaking at the IV site: Edema at the insertion site, Taut, shiny or stretched skin, whitening/blanching or coolness of the skin, slowing or stopping of the infusion, leaking of IV fluid out of the insertion site. Nursing administer IV meds via PICC as ordered by MD. Date Initiated: 03/01/2023; Focus: (R38) has an ADL (activities of daily living) self-care performance deficit r/t hx (history) Stroke and impaired vision.	S9999		

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S9999	Continued From page 4 Goal: (R38) will maintain current level of function through the review date. Intervention/Tasks: ...Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 11/09/2022. R38's "Wound - Weekly Observation Tool worksheet" and "Treatment Nurse Weekly Note" assessments include: 12/20/22: A. Communication. 1a. Date MD/Alternate Notified/Last Updated: 12/20/22; 1b. Details (Who, how, what, and by whom?) V12 (Primary Care Physician/PCP/Medical Director)...; 2a. Date Family/NOK(next of kin)/POA Notified/Last updated: 12/20/22; ...3. Special Equipment/Preventative measures (i.e., gel mattress/pad, special bed/mattress, side rails, etc.) Bil (bilateral) heel lift boots, resident is on turning and repositioning routine; B. Observations/Data. 1. Location: Left 2nd toe. 2a. Indicate whether this site was acquired during the resident's stay or whether it was present on admission: Acquired. Date Acquired: 12/20/22. 3a. Diabetic/Ischemic... 5. Visible Tissue: 5a. First observation, no reference... 5e. Necrotic tissue present (brown, black, leather, scab-like)... 5g. Dry. 5h. 12/20/22 sent to ER (emergency room) with orders for Bactroban ointment twice daily. 5i. Describe the extent (% - percentage) of necrosis and/or slough in the wound bed. 12/20/22 whole length/circumference left 2nd toe; 6. Drainage: Type. 6a. None... 7. Odor: 7a. No... 8. Wound Measurements: 8a. Length (mm) 40. 8b. Width (mm) 30. 8c. Depth (mm) 0. 8d. Describe the extent of tunneling and/or undermining: 0... 10. Infection: 10a. Infection suspected? (bright red surface, swelling, induration, erythema, fever, increased size, undermining, probing to the bone,	S9999		

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S9999	Continued From page 5 increased drainage, foul odor, etc.) Blank. 12/26/22: R38's Weekly Wound Observation Tool assessment is unchanged from 12/20/22, other than the following - 5. Visible Tissue: 5a. Overall Impression is marked as c. Unchanged; 11. Inflammation: 11a. Inflammation/Induration present? No... 11c. Treatment: Describe any changes to treatment plan in the last week: 12/22/22 Bactroban ointment discontinued per V12 (PCP). 2. Current treatment plan: 12/22/22 skin prep to left 2nd toe every shift; and D. Evaluation: Wound Progress: 12/26/22 No change, 12/20/22 new-whole length/circumference of the left 2nd toe. 01/02/23: R38's Weekly Wound Observation Tool assessment remains unchanged, other than the following - D. Evaluation: Wound Progress. 01/02/23 no change - Remains dry/necrotic appearing. 01/03/23: R38's Treatment Nurse Weekly Note assessment includes - C. Preventative Treatments Used - 1. (Pressure relief cushion) ... 6. Pressure relieving mattress... (Foam boots to both feet for protection, float heels off bed on pillow)... E. Plan of Care. 1. Changes to treatment order?... 1.2. No ... 2. Skin condition improving? ... 2.3. Not applicable. 01/09/23: R38's Treatment Nurse Weekly Note assessment documents no change. Toe remains dry/necrotic appearing. 01/16/23: R38's Weekly Wound Observation Tool assessment documents no change. Whole toe remains dry/necrotic appearing. 01/17/23 - R38's Treatment Nurse Weekly Note	S9999		

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S9999	Continued From page 6 assessment at 2:29 AM documents no new skin issues at this time. 01/17/23: R38's Weekly Wound Observation Tool assessment at 11:24 AM documents "... A. Communication. 1a. Date MD/Alternate Notified/Last Updated: 01/17/23; 1b. Details (Who, how, what, and by whom?) V12...; 2a. Date Family/NOK(next of kin)/POA Notified/Last updated: 01/17/23; ...3. Special Equipment/Preventative measures (i.e. gel mattress/pad, special bed/mattress, side rails, etc.) Bil (bilateral) heel lift boots, resident is on turning and repositioning routine; B. Observations/Data. 1. Location: Between left great and left 2nd toe down to bottom of foot. 2a. Indicate whether this site was acquired during the resident's stay or whether it was present on admission: Acquired. Date Acquired: 01/17/23. 3a. Diabetic/Ischemic... 5. Visible Tissue: 5a. First observation, no reference... 5e. Necrotic tissue present (brown, black, leather, scab-like)... 5g. Dry. 5h. 01/17/23 new necrotic area between left great toe/left 2nd toe down bottom foot. 5i. 01/17/23 100% dry/necrotic area. 6. Drainage: Type. 6a. None... 7. Odor: 7a. No... 8. Wound Measurements: 8a. Length (mm - millimeter) 45. 8b. Width (mm) 12. 8c. Depth (mm) 0. (Included in this assessment is a separate measurement specifically to bottom of left foot as - Length (mm) 12. Width (mm). Depth (mm) 0.) 8d. Describe the extent of tunneling and/or undermining: 0... 10. Infection: 10a. Infection suspected? (bright red surface, swelling, induration, erythema, fever, increased size, undermining, probing to the bone, increased drainage, foul odor, etc.) Blank. 11. Inflammation. 11a. Inflammation/Induration present? No. C. Treatment... 2. Current treatment plan: 01/17/23 MD aware has not given specific treatment orders for area - does want resident	S9999		

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S9999	Continued From page 7 seen by wound care. D. Evaluation. Wound progress: 01/17/23 New. 01/23/23: R38's Weekly Wound Observation Tool assessment includes 8. Wound Measurements: 8a. Length (mm) 40. 8b. Width (mm) 30. 8c. Depth (mm) 0. (Included in this assessment is a separate measurement specifically to bottom of left foot as - Length (mm) 12. Width (mm) 12. Depth (mm) 0.) 8d. Describe the extent of tunneling and/or undermining: 0... 10. Infection: 10a. Infection suspected? (bright red surface, swelling, induration, erythema, fever, increased size, undermining, probing to the bone, increased drainage, foul odor, etc.) Blank. 11. Inflammation. 11a. Inflammation/Induration present? No. C. Treatment. 1. Describe any changes to treatment plan in the last week: 12/22/22 Bactroban ointment discontinued per MD. 2. Current treatment plan: 12/22/22 skin prep to left 2nd toe every shift. D. Evaluation. Wound progress: 02/07/23 resident remains in the hospital at this time. 01/30/23 resident in hospital at this time. 01/23/23 no change. 01/16/23 no change - whole toe remains dry/necrotic appearing. E. Comments: 01/23/23 resident has wound care appointment at Veteran's hospital wound clinic on 01/26/23. Prior to and during the period of time when R38's wound was first discovered on 12/20/22 and worsened on 01/17/23, R3's record under Vital Signs indicate he did experience intermittent fluctuations/elevation in temperature as follows: 11/8/2022 9:57 AM - 99.4; 12/17/2022 5:49 AM - 99.8 (tympanic); 1/1/2023 5:31 PM - 100.0 (tympanic); 1/4/2023 10:53 AM - 99.6; 1/13/2023 12:04 AM - 100.3 (tympanic); 1/16/2023 5:01 PM - 99.4; 1/18/2023 11:57 PM - 99.1 (tympanic); 1/20/2023 12:29 AM - 100.8 (tympanic);	S9999		

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S9999	Continued From page 8 1/21/2023 1:49 AM - 99.5; 1/22/2023 4:27 AM - 101.7; and 1/26/2023 12:27 AM - 100.0 (rectally). On 04/10/23 at 10:34 AM, V2 (Director of Nursing/DON) stated, "R38 did have a urinary tract infection during this time and receiving antibiotic treatment, but we attributed the elevation in temperature to this. Other than the change in R38's wound on 01/17/23, there really was no other change, no odor, no drainage, and no inflammation." V2 continued that while R38 was out for his appointment with the veteran's hospital on 01/26/23 they sent him over to the emergency room due to the condition of his toe. The veteran's emergency room transferred R38 to another hospital, where R38 was a direct admit the same day. V2 stated V2 does not think there is anything more the facility could have done to prevent this from happening. R38's progress notes include: On 12/20/22 at 11:16 AM, V3 (Licensed Practical Nurse/LPN/Wound Care Nurse) writes, "Res (resident) left 2nd toe is noted to be black, dry and what appears to be necrotic from tip of the left 2nd toe to base of the left 2nd toe. (V12/Primary Care Physician/PCP) to be in facility this evening and to evaluate." "12/20/22 at 5:49 PM - MD here on rounds. Necrotic left digit noted new orders to send to er for eval and treat (evaluation and treatment). Spoke with V23 (Family Member/Representative) request (hospital). EMS (emergency medical services) called for transport at approx (approximately) 545p (5:45 PM). (Hospital) ER called with update spoke with (nurse)." R38's ER record dated 12/20/22 to 12/21/22 included: History of Present Illness: ...peripheral vascular disease with gangrene of the (right)	S9999		

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S9999	Continued From page 9 second toe, which is chronic... Physical Exam: ...distal pedal pulses are palpable...chronic appearing (right) second toe gangrene. With the tissue sloughing off, no evidence of cellulitis...On examination of the skin there is no is no evidence of any skin breakdown, there is no evidence of cellulitis...he is not in very good hygienic condition from the nursing home...patient's toe will auto amputate. It cannot be revascularized. We will place him on topical antibiotics and discharge him home and have him follow-up with his primary MD... Final Diagnoses: Gangrenous toe..." Of note, documentation through this ER record references the right toe. V2 (DON) and V3 confirmed it is R38's left toe and the ER record contains a misprint when documenting the right toe. R38's progress notes dated 12/21/22 and 12/22/22 document he returned to the facility on 12/21/22 with new orders to apply a topical antibiotic ointment three times a day for 7 days. On 12/22/22, V12 discontinued the topical antibiotic ointment this day and gave a new order to apply skin prep topically every shift, as noted on R38's progress note and POS (Physician's Order Sheet). R38's progress note dated 01/17/23 at 8:00 AM documents: "There is a new 4.5 cm (centimeter) x 1.2 cm x 0 necrotic appearing area noted now starting between the previous necrotic left 2nd toe and the left great toe and a 1.2 cm x 1.2 cm necrotic appearing area to bottom of left foot just below this area..." V12 (PCP) notified by V3 (LPN/Wound Nurse). On 01/17/23 at 8:15 AM, R38's progress notes continue to document, (V24/LPN) along with treatment nurse to evaluate resident's necrotic left 2nd toe. Upon evaluation,	S9999		

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S9999	Continued From page 10 this nurse contacted MD regarding the worsening of necrotic toe and possibility of diabetic ulcer forming on bottom of left foot. MD gave new order to refer to (out of state wound care clinic)...contacted Veteran's hospital...regarding this matter and proper paperwork will be sent to Veteran's hospital to attempt prior authorization for treatment at (out of state wound care clinic) waiting on authorization from the veteran's association to wound care. R38's progress note dated 01/25/23 indicates V12 was in the facility doing rounds. R38's progress note dated 01/26/23 at 12:15 PM contain, (R38) to veteran's association for wound care appointment...; 01/26/23 at 2:30 PM, Transport aide called and reported that while resident was at wound care, office decided he needed to go to the ER for eval of his toe. Resident is currently at ER at (hospital). R38 was a direct admit from the ER to the hospital on 01/26/23. R38's facility progress notes continue to document: 01/27/23 at 2:30 PM - Resident is currently at (name of hospital)...Resident is currently in the ICU (Intensive Care Unit) for DKA (diabetic ketoacidosis) and on an insulin drip. ICU nurse stated once he comes out of DKA he will be able to be admitted to a step-down unit...01/30/23 at 10:57 AM, resident continues to be inpatient at (hospital) Resident is on the third floor, came out of ICU on1/28/23. Update from his nurse today was, patient is eating very little, his left foot still has an infection, and gangrenous. His nurse today told me, there is no plans for discharge anytime soon...01/31/23 at 4:25 PM - update from (out of state hospital) Resident is in inpatient care after partial amputation of left foot. Nurse that called to give update stated, the infection was not clearing up and the next step was amputation of the entire left foot.	S9999		

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S9999	Continued From page 11 R38's Veteran's Hospital Consultation Results at wound clinic dated 01/26/23 authorized by V22 (Podiatrist) include: Physical Exam: To clinic per (tilt back) chair. Follows simple commands. Limited vocabulary. Entire second toe of the left foot with dry necrosis and strong, foul odor. Copious drainage on old dressing. 2nd metatarsal head also necrotic. 2 cm of peri-wound erythema that is tender to touch. DP (dorsalis pedis) pulse cannot be palpated nor auscultated. R38's hospital record dated 01/26/23 by V15 (Podiatry) included: Reason for Consultation: Gas gangrene left 2nd toe...Chief Complaint/History of Present Illness: R38 is a 70-year old male with past medical history of diabetic retinopathy, epilepsy, bilateral cataracts, traction detachment of retinal left eye, hyperlipidemia, deep vein thrombosis bilateral lower extremities...pressure ulcerations to heel and buttock, diabetes mellitus I, ileus, hemiplegia from cerebral vascular accident, neurogenic bowel, megacolon who presented to local veteran's hospital from outlying nursing home to evaluate the left 2nd toe. Patient was direct admitted to (hospital) for further evaluation... Exam: ...Skin: left 2nd toe ulceration with malodorous drainage extending up the foot... Extremities: left 2nd toe ulceration with malodorous drainage noted... Vascular: Dorsalis pedis and posterior tibial pulses diminished bilaterally... Assessment/Plan: Patient presents to (hospital) from the local veteran's hospital with ulceration to the left 2nd toe. Patient is unable to give medical history due to vascular dementia. Upon exam, the patient has diminished pedal pulses, bilaterally. Ulceration to the left 2nd toe with malodorous drainage. Gas gangrene noted. Therefore, we will proceed with left trans metatarsal amputation... Diagnosis: Necrotic toes	S9999		

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	IL6008759	A. BUILDING: _____ B. WING _____	04/14/2023

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S9999	Continued From page 12 left foot. "Chopart's Amputation for Osteomyelitis of the Midfoot - Staged Surgical Approach - Midfoot amputation secondary to acute infection is often performed in a staged manner. The first stage is an incision and drainage procedure or partial foot amputation which is left open for initial management of the infection. Care is taken to completely excise the ulceration while draining any abscess collection, as well as copious irrigation of the wound. A bone biopsy is procured if osteomyelitis is suspected. The second stage is typically performed 3-5 days later allowing the remaining tissues to demarcate and vascular intervention if needed. During the stage 2 operation, Chopart's amputation is performed and closed as outlined below." Source: https://musculoskeletalkey.com/choparts-amputation-for-osteomyelitis-of-the-midfoot/. "What Is Gas Gangrene? Gangrene is the death of body tissue. Clostridial myonecrosis, a type of gas gangrene, is a fast-spreading and potentially life-threatening form of gangrene caused by abacterial infection from Clostridium bacteria. The infection causes toxins to form in the tissues, cells, and blood vessels of the body. These bacteria will release toxins that cause tissue death and release a gas. Most gangrene infections occur in situations where open wounds from an injury or surgery are exposed to bacteria. Non-traumatic gas gangrene, a more rare form of gas gangrene, can develop when blood flow to body tissues is compromised and bacteria gets inside. There is a greater risk in people who have a peripheral vascular disease, atherosclerosis, or diabetes mellitus. Gas gangrene can occur anywhere on the body, but it most commonly affects the arms or legs. Common symptoms	S9999		

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S9999	Continued From page 13 include increased heart rate, fever, and air under the skin. Skin in the affected area also becomes pale and then later changes to dark red or purple. These symptoms usually develop six to 48 hours after the initial infection and progress very quickly. Treatment may include antibiotics and surgery to remove the dead tissue. Occasionally a hyperbaric oxygen chamber may be used. Surgery consists of debridement (removal of dead tissue) and sometimes amputation. Gas gangrene is a rare condition. However, it can quickly become a life-threatening infection when it goes untreated. You should call 911 or go to the nearest emergency room right away if you are experiencing symptoms of gas gangrene." Source: https://www.healthline.com/health/gas-gangrene#symptoms. Overview - Osteomyelitis is an infection in a bone. Infections can reach a bone by traveling through the bloodstream or spreading from nearby tissue. Infections can also begin in the bone itself if an injury exposes the bone to germs. Smokers and people with chronic health conditions, such as diabetes or kidney failure, are more at risk of developing osteomyelitis. People who have diabetes may develop osteomyelitis in their feet if they have foot ulcers. Although once considered incurable, osteomyelitis can now be successfully treated. Most people need surgery to remove areas of the bone that have died. After surgery, strong intravenous antibiotics are typically needed. Source: Osteomyelitis - Symptoms and causes - Mayo Clinic. On 04/06/23 at 9:30 AM, R38's wound care was observed with V3 (LPN/Wound Nurse) and V21 (LPN) providing care. R38's left foot appeared consistent with recently having undergone	S9999		

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S9999	Continued From page 14 surgical amputation as documented in his hospital records above. During observation, V3 commented R38 did have a soft spot at the suture line where the staples previously were removed. V3 also stated that during R38's hospital follow-up appointment with V13 (Infectious Disease Physician) earlier this month, V3 relayed that the documentation indicated this wound would most likely not heal. R38's post-surgical left foot amputation documentation from V13 (Infectious Disease Physician) dated 03/16/23 includes: History of Present Illness: ..."I saw him in (hospital) in January for left diabetic foot infection, presented with gas gangrene and osteomyelitis...Wound culture grew MSSA (methicillin-susceptible staph). Patient was discharged to nursing home on Ceftriaxone and oral Flagyl. He received almost 6 weeks of intravenous antibiotics... He still has wound at the amputation site, with some purulent drainage...Patient has severe peripheral artery disease and prognosis is poor. Unlikely the wound will heal. He needs below-knee amputation, but the family continue to refuse..." MSSA infections are usually treatable with antibiotics...MSSA Bacteremia occurs when the MSSA bacteria enter your bloodstream. This is a serious infection that has a high risk of complications and death. Once it's in the bloodstream, the infection often spreads to other organs and tissues within the body such as the heart, lungs, or brain. Source: https://www.webmd.com/skin-problems-and-treatments/what-is-mssa-bacteremia. On 04/06/23 at 9:40 AM, V5 (Certified Nursing Assistant/CNA) and V6 (CNA) stated they did not recall anything significant regarding R38's left	S9999		

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S9999	Continued From page 15 foot. Both stated they were aware that he had surgery on his left foot earlier this year and have been involved in (his) care since that time. V5 and V6 stated R38 can be combative and resistant to care but do not recall anything emergent. On 04/07/23 at 1:00 PM, V3 (LPN/Wound Care Nurse) confirmed she became involved with and has performed R38's wound care to the left 2nd toe since 12/20/22. V3 stated that to her knowledge, R38's left toe/foot had never had any odor, drainage, or bleeding as she documented in her wound care assessments. On 04/07/23 at 2:22 PM, V13 (Infectious Disease Physician) stated he consulted with R38 during his hospital stay on 02/08/23 after undergoing a partial left foot amputation on 02/03/23. When told R38's weekly skin inspection report documents no skin issues on 12/19/22, then on 12/20/22 indicated that his left 2nd toe was observed by the facility wound nurse to be necrotic from tip to base, he stated a digit can become necrotic in a fairly short amount of time, sometimes even hours, but it is a case-by-case situation. When asked what the timeframe would be for R38 to have developed osteomyelitis of the left 2nd toe and left ankle, he stated osteomyelitis typically develops over a period of several weeks but recommended speaking to the actual surgeon regarding further comments on gas gangrene and osteomyelitis. On 04/07/23 at 3:15 PM, V23 (Family Member/Representative) stated she feels like the facility had "just let him go...(R38's) feet were already dark when he admitted to the nursing home but not like that. I don't feel like there was enough movement to keep the blood flow going	S9999		

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and it just got worse. When he was in the hospital, they explained to me that nothing could be done for his foot except to amputate below the knee. I suggested to just take his foot above the ankle but was told they could not do that. They wanted to go further up. I told them if the infection was not that far up his leg don't amputate. I was basically told that this would not get any better and they would just have to keep cutting, and I didn't see the sense in that. He (R38) went on hospice on 04/03/23..."

On 04/11/23 at 4:31 PM, V15 (Podiatrist/Surgeon) stated he does remember R38 presenting to the hospital on 01/26/23, recalling he performed surgery late that same night. V15 stated the doctor called him from the veteran's hospital and said he was transferring a patient that needs "emergent surgery." V15 accepted the transfer. R38's x-ray showed "gas" on the x-ray positive for gas gangrene. V15 stated, "R38 is really frail and we had a lot of trouble getting labs on him. R38 was not able to give history, and it was very difficult to get labs because he was very sick. We did emergent surgery." V15 stated, "I met him at 8:00 PM and was done with surgery at 9:30 PM. We drained 75 ml (milliliters) of pus from the foot." V15 continued, "Basically when I met him (R38), he was in pretty rough shape. When you're not a good historian and have a lot of comorbidities, these things can happen really quick,, but this would not have developed overnight. From my standpoint, he was indeed needing surgical intervention to get rid of the infection. For that much pus, it would definitely have been beneficial to have been seen when the changed occurred on 01/17/23. For something like this it would have been best to be referred at the first sign of change. He had a fluid collection abscess of pus. Had he been verbal, he might

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have said it hurt or been able to communicate. Since he is not, you would need a high index of inspection to catch that. I generally do not perform surgery. Hindsight is 20/20, however there is a possibility we might have been able to save his foot had he been seen right away."

On 04/12/23 at 1:01 PM, V12 (PCP/Medical Director) stated R38's necrosis to the left 2nd toe was initially observed on 12/20/22. V12 was notified and gave orders to refer to the emergency room for evaluation and treatment. V12 stated R38 was diagnosed with necrosis and chronic gangrene and sent back to the facility with a prescription for topical antibiotic. V12 stated he changed that order to skin prep on 12/22/22. When asked about R38 experiencing an elevation in temperature intermittently between 12/20/22 and 01/26/23, V12 stated (R38) had a couple of urinary tract infections and was on antibiotics, which could account for the elevation in temperature. V12 also stated that one particular antibiotic R38 was prescribed has also been historically used to treat osteomyelitis. V12 stated he was again notified on 01/17/23 of the change in R38's wound and condition, at which time he referred R38 to be seen by wound care. V12 stated he was in the facility making rounds on 01/25/23 and was notified of R38's worsening wound. When asked if V12 would have expected R38 to be seen by wound care sooner than 01/26/23, 9 days after the initial change, V12 stated he believed R38 was seen in a timely manner. V12 continued that R38 had multiple medical problems including uncontrolled diabetes, and a combination of vascular and diabetic issues. V12 stated R38 would have benefited from being on hospice a long time ago. V12 confirmed there would have been no way to know the depth or underlying presentation of the

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wound until it was "opened up." When asked if he thought it might have been beneficial for R38 to be evaluated at the emergency room prior to his appointment made at the veteran's hospital on 01/26/23 in light of his wound worsening, V12 stated he does not believe it would have done any good since he was already evaluated at the emergency room on 12/20/22 and nothing was done. V12 stated he believed the emergency room would not have done anything and just sent R38 back to the facility like they did in December.

On 04/12/23 at 2:00 PM, V2 (DON) stated, "R38's referral to a wound specialist began on 01/17/23 in an attempt to get him to a nearby wound care facility, who we normally send our residents to. Normally, the VA (veteran's affairs hospital) will approve right away, but this time we were having trouble getting prior authorization approval. If it would have been deemed necessary, he could have gone back out to the ER, but we did not receive an order to do that. We would still have to notify the VA, but we don't need prior approval to send to the ER. They prefer we not send residents to the ER unless it is an emergent situation, and then we would send R38 to the local ER. V12 was updated and involved in R38's condition up until the time he went to the Podiatry appointment at the VA on 01/26/23." When asked if there was a wound doctor at the veteran's hospital R38 would have seen, V2 stated, "No, he only saw the Podiatrist there."

On 04/12/23 at 2:35 PM, this surveyor contacted the veteran's hospital to speak with the Podiatrist who saw R38 on 01/26/23. The receptionist stated R38 was actually seen at the wound clinic, who sent him to their emergency room, then transferred to another hospital for treatment. This surveyor requested any documentation for that

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date of service. The receptionist commented that they always do a write-up and would speak with the nurse to fax that to this surveyor via the facility at the end of clinic today. This surveyor spoke with V2 (DON) again at this time, who stated she thought R38 saw the Podiatrist but learned that he was seen in wound clinic instead.

On 04/13/23 at 10:52 AM, V25 (Surgical Services Nurse Practitioner) stated she has known R38 for many years. V25 stated, "Outside of his left toe, he has remained relatively the same. He experienced a stroke as a young man, he is aging, but his toe was bad. It was smelly and bad. That's why I got V22 (Podiatrist), and she sent him out. The toe probably should have been looked at a week prior. He presented to me from the facility with a dressing. When I say copious it was probably soaked because when something is that necrotic with a black streak going down the bottom of his foot and wet gangrene...that was bad. Two doctors saw him in our ER, and they said they couldn't take care of him, and they sent him out. The only fault I can see with the nursing facility is that they probably should have sent him to the ER on the 17th (01/17/23) when they noticed the change in condition."

On 04/13/23 at 10:30 AM, during further review of R38's activities of daily living task sheets it should be noted the last documented shower R38 received was dated 01/10/23. When asked about this, V2 (DON) stated R38 is combative and often refuses care, and if that was not documented, it should have been.

On 04/13/23 at 11:12 AM, V27 (CNA) confirmed other than her first observation of the significant change in the left foot on 01/17/23 which was reported to the nurse, R38's foot did not change.

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S9999	Continued From page 20 V27 stated the facility did contact the doctor when they thought it was getting worse, but he opted not to send (R38) to the emergency room. They were doing everything they could and V27 confirmed she had not seen or been told by any other staff that there was an odor or drainage coming from the toe or any part of R38's left foot prior to being sent out on 01/26/23. V27 confirmed she is assigned to R38's care on a daily basis and was involved in his care between 1/17/23 and 01/26/23. V27 stated, "I can confirm the description of R38's left foot in the note from the veteran's appointment on 01/26/23 was not what staff here observed." On 04/13/23 at 11:26 AM, V28 (CNA/Transportation/Activities) confirmed she transferred R38 to the Veteran's Hospital appointment on 01/26/23, stating, "When I placed him in the transportation van, he was wearing his street clothes, with heel lift boots on each foot." When asked if R38 was wearing socks or had a dressing on his left foot, V28 stated, "He (R38) was covered from head to toe with a blanket, but the blanket looked like he was wearing his heel lift boots because it was puffed up, so I just assumed." When read the veterans clinic notes, V28 stated she doesn't believe that was accurate because if there was a dressing on R38's foot it would have been fresh. When asked if she observed R38's feet at any time while she was accompanying him to his appointment, V28 was not able to confirm that she had seen his foot or if his left foot had a dressing of any kind. V28 stated to her knowledge he had no drainage, odor, or open area to the left foot. When asked how she might come to this conclusion if she did not see the foot and he was covered with a blanket, V28 stated, "Oh yeah, I've smelled those before."	S9999		

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S9999	Continued From page 21 On 04/13/23 at 2:00 PM, V2 (DON) presented a cell phone (identified as V24's/LPN) containing a picture V2 verbally identified to be R38's left foot, taken in his tilt back chair while sitting in the "day area" where residents sit and eat or watch TV. This particular area is located in front of the nursing station down the hall where R38 resides, and currently includes a round table with chairs and TV that has been observed during this survey to be utilized on a daily basis by residents, including R38. V2 stated this picture was taken on 01/17/23 by V24 when she observed the significant change to R38's existing left 2nd toe wound. Visualized in this picture was a left 2nd completely necrotic toe with necrosis between the 2nd and great toe. The skin to the bottom of the foot had areas of necrosis, with red, peeling skin. The bottom of the foot was swollen with an ulceration at approximately the mid foot level. On 04/14/23 at 9:33 AM, V30 (LPN) confirmed as of 04/13/23 she assessed all resident wounds as indicated in the abatement plan. V30 confirmed she participated in the inservice education regarding wounds, read the revised policy, and signed off that she had received this training. V30 provided a list of residents whom she assessed, the area observed, and treatment provided (R20, R26, R27, R31, R33, R34, R38, R39, R56, R66, R69, R73, R128). R279 was out to an appointment. The facility's revised wound care policies and procedures were provided and read. On 04/14/23, the following interviews were also conducted: 11:23 AM, V26 (Registered Nurse): "I got inserviced this morning on wound care and the changes to the policy." 11:25 AM, V31 (CNA): "I'm agency; I work here about two days a week. I was inserviced on wound care when I clocked in	S9999		

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S9999	Continued From page 22 this morning. 11:31, V32 (CNA): "I was inserviced on wound care and reporting when I was hired. I'm new to this facility. I was inserviced this morning. There was a change in the wound care policy." (A)	S9999		