STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005235	A. BUILDING: _____ B. WING _____	C 04/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD NRSG & REHAB CENTER	14716 S EASTERN AVENUE PLAINFIELD, IL 60544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Complaint 1972286/IL110848	S 000		
S9999	Final Observations Licensure Violations 300.610a) 300.1210b) 300.1210d)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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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:

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.

These regulations were not met as evidenced by:

Based on interview, and record review the facility failed to provide treatment to prevent a pressure sore for a diabetic resident and failed to provide podiatry or wound physician consultation for a worsening pressure sore.

This failure resulted in the resident sustaining osteomyelitis requiring hospitalization, intravenous antibiotics, and a below the knee amputation.

This applies to 1 of 3 residents (R3) reviewed for

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S9999	Continued From page 2	S9999		

pressure sores.

The findings include:

According to the Electronic Health Record (EHR) R3 had diagnoses including anemia, heart failure, hypertension, orthostatic hypotension, peripheral vascular disease, renal failure, pneumonia, diabetes with neuropathy, cerebrovascular accident, cerebral infarction, legal blindness, atherosclerotic heart disease, chronic kidney disease stage 3, and bilateral lower extremity edema.

The Admission Minimum Data Set (MDS) dated 12/19/18 showed R3 was cognitively intact with a Brief Interview for Mental Status (BIMS) 15 out of 15 possible points. R3 needed extensive assistance of one person for bed mobility, transfers, locomotion, dressing, hygiene. Needs limited assistance of one person for eating and supervision of one person for toilet use. The MDS did not show any unhealed pressure sores, diabetic ulcers, or venous or arterial ulcers. The MDS showed R3's height was 6 feet 3 inches (75 inches) tall and weighed 180 pounds.

The Physician Order Sheet (POS) showed orders dated 02/22/19 to cleanse: the distal lateral left foot with normal saline or wound cleanser, pat dry and cover with ABD (Army Battle Dressing) and secure with gauze wrap daily; the medial lateral left foot with normal saline or wound cleanser, pat dry, apply nickel thick application of Medi-honey to wound bed, cover with ABD and secure with gauze wrap daily; and the proximal lateral left foot/posterior heel with normal saline or wound cleanser, pat dry, apply nickel thick application of Medi-honey to wound bed, cover with ABD and secure with gauze wrap daily. The POS showed

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S9999	Continued From page 3	S9999		

only one change in treatment dated 03/11/19 to the distal lateral left foot to cleanse with normal saline or wound cleanser, pat dry, paint wound with betadine, cover with ABD and secure with gauze wrap daily. The treatment to the posterior left heel remained the same.

A Care Plan dated 02/22/19 showed R3 had altered peripheral perfusion due to peripheral vascular disease, arterial ulcers of the left foot and was readmitted with a reopened pressure ulcer with interventions including to offload heels at all times and elevate the lower extremities when possible if edematous. The Care Plan does not show R3 was non-compliant with care or treatment.

No Care Plan interventions or Physician orders were documented for pressure relieving boots.

A Nursing Progress Wound Nurse Note dated 02/22/19 showed R3 was assessed with three new wounds, a distal lateral, a medial lateral and posterior heel, on the left foot. R3 reported no sensation on his bilateral feet (below the medial/lateral malleolus) when writer tapped them with a cotton tipped applicator, weak pedal pulses, and left foot edema. The note showed the following wounds:
Wound 1: Distal lateral left foot wound measuring 4.0 centimeters (cm) by 3.6 cm by undetermined depth, wound bed noted with thick adherent eschar and a 0.5 cm depression, wound edges regular, no exudate observed, surrounding tissue dry/flaky;
Wound 2: Medial lateral left foot wound measuring 3.8 cm by 2.2 cm by undetermined depth, wound bed noted with thick adherent eschar and a 0.4 cm depression, wound edges regular with what appears to the writer as a flap

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S9999	Continued From page 4	S9999		

of peeled skin on the proximal margin from a de-roofed blister, no exudate observed, surrounding tissue dry/flaky; and
Wound 3: Proximal lateral left foot/posterior left heel blister measuring 12.0 cm by 10.5 cm by undetermined depth, blister cap intact (ruptured/opened on the superior aspect), wound bed observed through intact tissue with dark purple discoloration on the superior aspect of the effected area, wound edges irregular and macerated, moderate amount of sero-sanguineous exudate observed, surrounding tissue dry/flaky.

Wound care nursing notes document the declining of the left heel wound (Wound 3):
on 03/11/19 the wound measured 3.5 cm by 6.2 cm, depth could not be measured, full thickness through dermis and down to subcutaneous tissue and muscle, necrotic tissue-granulation 10 percent, slough 30 percent, eschar 60 percent;
on 03/21/19 the wound measured 11 cm by 6 cm, depth could not be measured, full thickness through dermis and down to subcutaneous tissue and muscle, necrotic tissue-granulation 20 percent, eschar 40 percent, non-granulation tissue 40 percent, declining; and
on 03/26/19 the wound measured 11 cm by 7.6 cm, depth could not be measured, full thickness through dermis and down to subcutaneous tissue and muscle, necrotic tissue-granulation 20 percent, eschar 40 percent, non-granulation tissue 40 percent, declining.

Wound care Nurse notes also document the declining of the left top of foot wound (Wound 1 and Wound 2, merged as one):
on 03/11/19 the wound measured 5.2 cm by 2.8 cm, depth could not be measured, full thickness through dermis and down to subcutaneous tissue

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	IL6005235	A. BUILDING: _____ B. WING _____	C 04/08/2019

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S9999	Continued From page 5	S9999		

and muscle, necrotic tissue, 100 percent eschar, declining;
on 03/21/19 the wound measured 10.2 cm by 4.3 cm, depth could not be measured, full thickness through dermis and down to subcutaneous tissue and muscle, necrotic tissue, 100 percent eschar, declining; and
on 03/26/19 the wound measured 10.6 cm by 5 cm, depth could not be measured, full thickness through dermis and down to subcutaneous tissue and muscle, necrotic tissue, 100 percent eschar, declining.

On 04/02/19 at 3:17 PM V6, Registered Nurse (RN) Wound Nurse, said R3 had edema of the lower extremities, very poor pedal pulses and was non-compliant with his care needing reeducation for offloading and elevating his feet. V6 said R3 was a little bit taller and would often lie in bed with his feet against or on the footboard. V6 said when R3's heel wound was discovered it was necrotic and V6 was unsure how it was not noticed until it became necrotic. V6 said there were no notable concerns prior to that. V6 said the foot wounds had progressively worsened after they were discovered. V6 said the nurse practitioner examined R3 but a physician did not see him. V6 said when R3 returned from the hospital the two lateral foot ulcers had become one ulcer. V6 said the facility does not automatically refer a resident to the wound doctor for all wounds. According to V6, the facility would refer a resident to the wound doctor if there wasn't any improvement after treatment. V6 said he would have spoken with the wound doctor during the week of 04/01/19 due to the wound worsening, however, R3 had been discharged to the hospital over the weekend before the wound doctor came to the facility. V6 said there should be a wound progress note once a week. V6 did not know why there was 10 days

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S9999	Continued From page 6	S9999		

between wound care notes of 03/11/19 and 03/21/19.

R3's wounds were initially discovered on 02/22/19. Between 03/09/19 and 03/29/19 (20 days), R3's multiple left foot pressure ulcers had progressively worsened without being referred to a wound doctor or podiatrist for consultation.

A Podiatry Consultation from V9, Podiatrist, dated 03/31/19 showed R3 was admitted to the hospital intensive care unit with sepsis, leukocytosis secondary to pneumonia and a left foot infection. The note includes R3 stated the ulceration began approximately four weeks prior to hospitalization which started as a blood blister. The note shows R3 also stated at the facility he was sleeping in a bed which was too short as his feet continued to rub and pressured against the foot board which (V9 wrote) may have developed other ulcerations. The consultation notes showed R3 had a severe equino-varus deformity to his left foot, mild to moderate edema of the left leg, with minimal erythema localized to the left foot. The note showed R3 had necrotic tissue to the lateral aspect of the fifth metatarsal and posterior heel which was unstageable and a plantar midfoot ulceration with 100 percent fibrotic tissue and dry blister formation consistent with the history of a blister with mild sero-sangounous drainage, malodor and erythema.

On 04/03/19 at 4:31 PM when asked about a note from the March 9th hospitalization regarding an open blister on the foot, V9 (Podiatrist) said he believed that note was in reference to a separate blood blister which was on the bottom (arch area) of R3's foot. V9 said the blood blister was a diabetic ulcer. V9 said the unstageable necrotic tissue behind the heel and outside of the lateral

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S9999	Continued From page 7	S9999		

forefoot, were from resting against a surface, which was definitely caused by a pressure ulcer. V9 said R3 definitely had comorbidities and had a deformity where his ankle turns in almost like a club foot, but V9 felt R3's wound may have been prevented if the right treatments and the right preventative measures were put in place. V9 said R3 was a very tall man and probably needed a bed mattress extender. V9 also wondered if (R3) had an offloading boot as "the unstageable necrotic tissue and bone infection doesn't happen overnight." V9 guessed it probably happened within the last month and said the facility should have sent R3 for consult with this type of wound. V9 said R3 was sent to the hospital for pneumonia with an elevated White Blood Count (WBC) and they were not notified of the foot wound. V9 was consulted when R3 was admitted to the hospital 03/29/2019 for fever and pneumonia unrelated to the foot ulcers and the hospital discovered R3's foot ulcers. V9 said a Wound Doctor should have been consulted when a wound like this was discovered, especially when it was worsening. V9 said once the wound was necrotic it was already too late "When it's necrotic, we don't know how deep it is or what is under there."

An Orthopedic Surgeon Consultation Note (V10, Orthopedic Surgeon) dated 04/01/19 showed (R3) had a left foot ulcer appropriate for amputation. (R3) also had pneumonia, septicemia, and multiple medical comorbidities. "Non-amputation options could be tried however given the severity of his general condition, wound healing potential, diabetes, limited sensation and current appearance of the foot I believe this would be a long and difficult process which would likely ultimately result in amputation regardless.

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S9999	Continued From page 8	S9999		

On 04/03/19 at 4:50 PM V10, Orthopedic Surgeon, said R3 should have been followed by a podiatrist for the wound and his diagnoses, as they would have a better idea of his potential for wound healing. V10 said R3 had osteomyelitis.

On 04/04/19 at 9:33 AM V11, Nurse Practitioner (NP) said he had not physically seen R3's foot wound. V11 said he relied on the nurse's report if there are any changes or declines to a resident's wounds that they would tell me. V11 said he did not write any orders for the treatment of R3's wound and was unsure if the doctor had seen the wound. According to V11, if he was aware R3's wound was getting worse he would try to make changes to the treatment or refer R3 to a podiatrist. After showing V11 the Wound Care Notes of 03/11/19, V11 said he would have ordered a wound physician consult because wounds were not his area of expertise.

On 04/04/19 at 10:34 AM V12, Registered Nurse (RN) and V5 (RN) said R3 had an extended bed prior to going to the hospital 03/05/2019 but when R3 returned from the hospital on 03/09/2019 he only had a regular bed. V12 said she had asked maintenance last week about getting him the bed extender but then he was sent out to the hospital over the weekend. Both V5 and V12 said R3 probably had pressure relieving boots but he refused to wear them. R5 looked in room wardrobe and drawers where R3's belongings were still present and could not locate the heel protector boots. At 2:31 PM V5, said R3 did not have a low air loss or alternating pressure mattress in place because R3 didn't have any pressure sores on his back or buttocks.

On 04/04/19 at 3:55 PM V2, Director of Nursing (DON), said R3's wounds were diabetic ulcers,

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	IL6005235	A. BUILDING: _____ B. WING _____	C 04/08/2019

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S9999	Continued From page 9	S9999		

not pressure ulcers and weren't really worsening. They may have been getting larger in size, but the appearance of the wound wasn't really worsening. When asked how it could be determined the wound wasn't worsening underneath the eschar and necrotic tissue, V2 said "Well you can't determine what is under the eschar, but the outer appearance had remained the same." V2 said she thought R3 had a physician wound consultation during the early March hospitalization was unable to provide a report of the consultation or any treatment orders upon R3's return from the hospital on 03/09/19.

The facility's Pressure/Skin Breakdown Clinical Protocol dated January 2017 included "The physician will help the staff define the type of an ulceration. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatment, etc. The physician will help characterize the likelihood of wound healing, based on a review of pertinent factors."

(B)