Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010342	A. BUILDING: ____ B. WING ____	C 05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAIRO	2001 CEDAR STREET CAIRO, IL 62914

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S 000	Initial Comments Complaint # 1952910 / IL111534 Complaint # 1952938 / IL111564 Complaint # 1953585 / IL112282 Facility Reported Incident of 5/6/19/IL112010	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) 1 of 3 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 06/12/19

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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:
6)All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b)The DON shall supervise and oversee the nursing services of the facility, including:
3)Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be

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reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

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

These requirements were not met evidenced by:

1.) Based on record review, and interview, the facility failed to provide supervision and develop individualized interventions to ensure that smoking materials were not obtained by a newly admitted resident, with a known suspicion/history of setting fires, for 1 of 1 resident (R15) reviewed for a history of starting fires in the sample of 26.

R15 was found near two separate fires (4-27-19, and 5-7-19), one in R15's room, and one in R14's room.

This has the potential to affect all 69 residents living in the facility.

Findings include:

R15 was admitted to this facility on 3-6-19 from the hospital, with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Unspecified Dementia without Behavioral Disturbance and Personal History of Nicotine

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Dependence, as noted on the Admission Minimum Data Set dated 3-13-19. This same document identifies R15 as 64years old with a cognitive assessment (Brief Interview for Mental Status- BIMS) of 9 out of 15 (moderate impairment).

R15's history prior to admission to this facility on 3-6-19 (Admission Minimum Data Set dated 3-13-19) is as follows:

A hospital admission History and Physical Note dated 2-14-19 documents a chief complaint of "Fire in nursing home room" and indicates that R15 had previously had a similar experience in the past when her cigarette smoking led to a fire in her home".

A hospital Consult Note dated 2-14-19 presents a history of R15 smoking cigarettes resulting in fires. This same note documents R15's family reported that there was a house fire associated with a lithium battery. This same note also documents that R15 and her husband, V52, had been living in hotels, and that R15 had caused 4 fires because of alcohol intoxication and smoking. This same document also included that a trial stay at an assisted living facility had fell through due to a fire there on the day of the hospital admission. Hospital documentation in part also included a "Shift Report Review" dated 2-20-19 that lists a chief complaint of Dyspnea after accidentally setting her apartment on fire.

On 5-1-19 at 1:30 pm, V1, Administrator, stated the following "We were aware of (R15) having a recent house fire, and of being accused of starting a fire at another facility. The paperwork we received during screening included this information. We agreed to accept her under the

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condition that she would not be smoking, and we verified she would be using a smoking patch to help her."

On 5-8-19 at 12:40 pm,V7, Social Service Designee (SSD), stated "there was paperwork that came with her (R15) and we were aware of a history of suspicion of having set a home fire, and some reports of setting fire in hotels and at another facility, we questioned accepting her, and decided to accept only under the condition that she was not going to smoke, and was going to be on a patch for stopping."

R15's Initial Care Plan to this facility includes a focus area, with an initiation date of 3/7/19, addressing R15 as a smoker with a history of setting fires to several places she had lived in the past, "including (my) home and several hotel fires and one facility fire". The only interventions added at that time, included instructing R15 about smoking risks and hazards, smoking cessation aides, and the facility policy on smoking, as well as interventions to observe clothing and skin for signs of cigarette burns, and smoking assessments to be done as needed. The Admission Care Plan also includes a focus area of resident behaviors of taking things that do not belong to R15 from other rooms with a date of 3-8-19. There were no individualized interventions/tracking in place to ensure this focus area was met.

A Social Service Note dated 3-7-19 8:35 AM documents admitting diagnoses of Smoke Toxicity, Carbon Monoxide Toxicity, Dementia and COPD and includes a notation of "...hazardous behavior with smoking products" and indicates no current use of smoking products. A 3-8-19 "Orders-Administration Note" documents R15

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having a Nicotine Patch applied at 2:25 PM.

The following are incidents involving R15 regarding threats to "burn the place down and actual fires that occurred:

Nurse Progress Notes entered by V8, Registered Nurse (RN)/former Director of Nurses (DON), at 7:27 PM on 3/25/19 that R15 had been going in and out of other resident rooms during the shift taking items that did not belong to her and that earlier in the day (no time documented) R15 had stated, "I have cigarettes and if you don't take me outside to smoke I'll just smoke in my room and burn this place down." V8 documented that she then provided education to R15 that she could not smoke due to wearing a patch and R15 stated "bxxxx I don't care what you say, I'll smoke in my room if I want and I don't care if I burn this f'in place down." V8 documented that R15 had been hard to redirect during the shift.

Social Service Progress Notes entered earlier that same day (3-25-19) at 9:57 AM, by V7, Social Service Director (SSD), note that (unidentified) nurse had reported during the morning meeting that R15 had made comments that R15 had cigarettes and wanted to go outside and smoke. V7 documented that after learning that R15 had stated that she had cigarettes, V7 and another staff had gone to R15's room and asked her about the comment and were told by R15 that she did not have any cigarettes but could get some. At that time, V7 asked R15's permission to search her room and no smoking materials were found. V7 documented counseling R15 about the danger of smoking while wearing a nicotine patch and R15's earlier agreement that she would not smoke.

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On 5-10-19 at 1:45 pm and 2:15 pm respectively, V7 and V1(Administrator) both stated that it was never reported to them that R15 had made statements the morning of 3/25/19 about threatening to cause a fire or burning the place down.

On 5/9/19 at 2:55 PM, V3, Minimum Data Set (MDS)/Care Plan Coordinator/Licensed Practical Nurse (LPN), was asked if R15's Care Plan was updated or if any new interventions were put into place following the 3/25/19 threat to burn the place down. V3 stated that he (V3) had been working the floor so much that Care Plans weren't being kept updated and he (V3) was not aware of anything new being put into place for R15 at that time.

Social Service note dated 3-27-19 at 11:35 AM notes that V7 had received a call from V52 (Husband) reporting that V52 was concerned because R15 had called him twice that morning stating that if he didn't come and get R15, he would be sorry. V52 stated that he wasn't sure what R15 meant but was concerned R15 "would take it out on someone or herself." The note further documents that V7 told V52 that R15 was being cared for 1:1, and that nursing would be made aware of his concern. In addition, the note documents that V31 (RN) was notified at this time and spoke to R15 about what she had told V52. R15 stated to V7 that she was trying to be good and apologized for causing trouble but said that she just could not help herself.

3-28-19 3:44 PM Social Service Note by V7 documents that R15 "is currently on 1:1's with staff because of R15's comments.

R15's Care Plan nor medical record made any

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further mention of 1:1 care being provided, including when 1:1 care was initiated or for how long it continued. This was verified with V3, MDS/Care Plan Coordinator on 5-9-19 at 2:55 PM.

3-28-19 4:40 PM Nurses Note indicates R15 was to be sent out to the emergency room due to making threats of suicide and being very unhappy about being at the facility. A psychiatric Physician Progress Note dated 3-30-19 notes that R15 was oriented to time, place, and person, with no suicidal or homicidal ideations and no delusions or paranoid thoughts, but with limited insight and fair judgement.

4-2-19 psychiatric hospitalization Progress Note states "patient is alert and oriented x 3". R15's record documents that R15 returned to the facility on 4-2-19 at 6:15 PM with a diagnosis of Major Depression, and notes R15 to still be going into other rooms and removing things.

R15's Care Plan was updated on 3-29-19, the day after the transfer to the hospital, with a focus area of being at risk due to suicidal issues as evidenced by voicing suicidal thoughts and /or intentions. R15's Care Plan was not updated with any new interventions or any additional information when R15 returned to the facility on 4-2-19.

4-27-19 7:16 AM Behavior Note by V12, LPN documents the following: "Resident returned about 3:00 AM from outing with husband. About 4:30 AM aide reported to nurse that resident was smoking cigarettes in the bathroom of her room. Staff noticed that the floor, blanket, sheet, and mattress was burnt. Staff searched resident and found a lighter, and cigarettes. Body assessment

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done. Resident has no burns or other injuries. At that time the nurse explained to resident's husband that resident cannot have a lighter, and cigarettes on their person per policy. Director of Nursing (DON) notified. "

On 5-9-19 at 4:00 pm, V12 stated that on 4-27-19, around 4:00 AM to 4:30 AM, staff reported to me (V12) that they had smelled smoke and started checking and found R15 in the bathroom of her room smoking. One of the CNA's (certified Nurse Aides) took the cigarette from her, V12 stated that he (V12) came into the room, noted V52, husband, was asleep in a chair in R15's room and then noted that the floor by R15's bed, blanket, bed sheet, and a small spot on the bed mattress all had what appeared to be burn marks. V52 then stated that he had put out a small fire by stomping it out. V12 stated that he and staff immediately searched R15 and R15's room and found that R15 was sitting on a lighter in her wheel chair, and several cigarettes were found in her bedside drawer. V12 stated to V52 that R15 was not allowed to have a lighter or smoke in the building and noted that V52 did not reply. V12 stated that he called the DON and reported the incident shortly after. V12 stated that he (V12) thought the blanket and sheets from the room were saved. V12 said R15 had been out of facility on a visit with her husband and they came back to the facility at around 3 AM. This small fire happened about 4:30 AM. V12 stated that R15 was monitored the rest of the night with 1:1 observation in the dining room of blue wing and that when he returned to work on his next shift, R15 was on 15-minute checks.

On 5-9-19 at 2:25 pm, V35, CNA stated on 4-27-19 about 4:00 AM she and another aide were sitting at the nurse's station while V12 was

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at lunch when she smelled smoke, so she and the other aide went to investigate and looked in R15's room and found R15 sitting in her bathroom smoking. V35 stated that they took the cigarette from R15, and noted that V52, husband, was asleep on the bed when they walked in the room, V35 went and got V12 and when they returned to the room V12 noted what looked like a burn place in the floor and on the bed stuff and mattress. V52 told them there was a little fire but he had stomped it out. V12 went and called the Administrator to report the incident. V35 said that they put R15 in a recliner in the dining room on blue hall where she could be monitored 1 on 1, and V52 got mad at R15 and told R15 that he had told her not to bring his cigarettes and lighter into the building and told R15 that she had her stuff in the lock box with the nurses. When R15 was searched a lighter was found when R15 stood up from her wheel chair and there were 5-6 cigarettes in her drawer beside the bed.

5-1-19 Nurses Note includes documentation that R15 was on 15-minute checks. There is no further documentation of the 4-27-19 incident until V7 documented on 4-29-19 at 8:55 AM the following: "R15 was found smoking in her room with her husband present and asleep on her bed" and that several objects had been set fire in the room. V7 documented that she did a new smoking assessment since R15 was smoking, after having agreed when admitted that she would not smoke. V7 documented on 5-2-19 at 1:56 PM that V52, husband, told her there were two fires on 4-27-19, the one at the facility and that V52 had told her R15 had set a bag of popcorn on fire with a lighter while out of the facility at the hotel with him, so they had left in a hurry and came back to the facility during the night.

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On 5-8-19 at 2:00 pm, V1 stated that she had not done an incident report of the 4-27-19 fire involving R15 but thought that she did have a written statement from one of the staff who was there. V1 stated that since there was no injury to anyone, she didn't think she needed to report it, the fire was so small that no alarm sounded, and there was just a little burn spot on floor and a piece of a blanket on the bed.

On 5-9-19 at 2:55 PM, V3 was asked if after the 4/27/19 incident when R15 was found smoking in her room, were there any new interventions put into place and if the Care Plan was updated to address the potential for a serious incident with in the facility, V3 stated that he thought that R15 was on 15 minute checks but that he did not update the Care Plan, again due to having to work the floor as the nurse frequently.

A final Abuse Investigation Report dated 5-8-19 indicates that on May 6, 2019 at approximately 11:30 PM there was a fire located in a resident room.

5-7-19 1:33 AM Nurses Note documented in R15's record by V34, Licensed Practical Nurse, notes the following aide reported to nurse, resident (R15) was seen leaving out of R14's room shortly before small fire was detected. Resident (R15) was directed back to her room at the time. Upon discovery of the fire, resident (R15) stated she (R15) had not been in another room and hasn't had a lighter in weeks. At 3:34 AM, V34 documented that R15 was strictly 1 on 1 until further notice, as per V1.

On 5-9-19 at 10:45 AM, V34, LPN stated "R15 had gone out with her husband on 5-6-19 and

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didn't return until around 10:50 PM on that date." V34 further stated that "R15 went straight to bed." V34 stated she helped R15's husband, V52, carry in a bunch of stuff. V34 was unsure what time V52 had left the facility. V34 stated that "on 5-6-19 about 11:30 PM that staff present on the wing and two employees of the alarm company were present in the facility, saw smoke near the ceiling and found a fire on the empty bed in R14's room. R14 was removed from the room, staff started evacuating the wing, the fire was put out using a fire extinguisher and the police and fire department arrived within minutes. R14 was sent to the hospital by ambulance for evaluation and returned with no new orders a few hours later. V35, Certified Nurse Aide, reported to me (V34) that she (V35) had seen R15 coming out of R14's room about 5 minutes before the alarm sounded. We (V34, V35) searched R15 and her room after the fire and found no smoking stuff or lighters. R15 denied that she had been in the room.

On 5-9-19 at 2:25 PM, V35 CNA, stated that she had come on at 11:00 PM and when she (V35) saw R15 come out of R14's room, asked R15 what she was doing. R15 told her (V35) she (R15) was just checking on R14. V35 said it was about two minutes later when the alarm went off, and another CNA was coming from up front who said the fire panel said blue wing and it was discovered there was a fire in R14's room. R14 was removed from the room in his bed. R14 didn't appear in distress, he wasn't coughing, and the nurse was checking him out. The fire department and police showed up almost immediately and R14 was sent to the hospital by ambulance for evaluation.

On 5-9-19 at 1:25 pm, V38 (employee of fire system company) stated that on 5-6-19 he (V38)

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had just come out of the kitchen and the alarm went off. V38 said staff were looking in rooms and they all saw smoke about the same time, coming from a ceiling area above doors that had closed on the hall. V38 said he opened the door on the right and saw the fire and yelled for his coworker to get the extinguisher. V38 said staff were closing doors to rooms nearby. His co-worker put out the fire and then immediately started helping him "to get the guy'" (R14) out of the room, while staff were starting to evacuate other residents about same time. V38 stated that is when the fire department and police arrived.

5/7/2019 1:12 AM Nurses Note in R14's record states the following: "Small fire detected in residents' room on other bed. R14 was found conscious in bed. Immediately removed resident from room to common area, continuous O2 admin 2L/minute for possible smoke inhalation. Head-to-toe assessment performed lung sounds clear throughout all fields upon auscultation. No s/s of pain, distress, or discomfort at the time. Vitals obtained, BP-162/74, T-96.4, R-24, P-76, O2-94. MD on file notified ....5/7/19 01:38 AM Resident sent out to (local hospital) for further evaluation. 5/7/19 06:51 AM Resident arrived back to facility via transport @ 0630. O2 at 2L/m (liters per minute) per N/C (nasal cannula). No new orders. Will continue to monitor".

R14's Diagnoses in part, based on the Audit Report: Acute Respiratory Failure with Hypoxia (7/19/18); Gastrostomy Status (7/19/18); Dependence on Supplemental Oxygen (7/19/18); Contracture, Right and Left Elbow (7/19/18); Contracture, Right and Left Knee (7/19/18); Anoxic Brain Damage, Not elsewhere classified (6/29/18); R14's Quarterly MDS dated 3/25/19 notes a BIMS score of 1/15, indicating that R14 is

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severely cognitively impaired. This same MDS scores R14 as needing extensive to total care assistance from staff, for all activities of daily living. The hospital Emergency Department Provider Note dated 5-7-19 documents chief complaint as "possible smoke inhalation with EMS (Emergency Medical Services) advising that the patient was in a room that a fire had started in, that patient had not been burned and had no soot on him.

On 5-9-19 at 1:30 pm, V1 stated that because the staff had reported seeing R15 come out of R14's room shortly before the fire on 5-7-19, R15 was immediately put on 1 on 1 observations up until R15 was transferred out of the facility on 5-7-19 to a psychiatric care unit because she (V1) felt that R15 needed to have a psychiatric evaluation. As of 5-10-19 at 4:00 PM, R15 had not returned to the facility.

The Clinical Resident List with a date of 4-24-19 listed a census of 69.

Violation (A)

(2 of 3)

300.610a)
300.1210b)
300.1210d)6
300.3240a)

Section 300.610 Resident Care Policies

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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

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:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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Section 300.3240 Abuse and Neglect

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

These requirements were not met evidenced by:

Based on interview and record review the facility failed to implement immediate interventions to protect 2 of 4 residents reviewed for abuse (R3, R4) in a sample of 26. This failure resulted in a paraplegic resident (R4) being thrown from his wheelchair, and R3 being hospitalized, receiving a traumatic subarachnoid hemorrhage, lip laceration, and nasal fractures.

The findings include:

The Echart Face sheet lists R3 as being 57 years old. A Discharge MDS (minimum Data Sets) assessment for R3 dated 5/12/18, lists R3 as being admitted into the facility on 8/17/15. The diagnosis listed in the Echart for R3 includes the following: Chronic Obstructive Pulmonary Disease; Other Chronic Pain; Arthropathy; Generalized Anxiety Disorder; Bipolar Disorder; Unspecified Psychosis not due to a substance or known Physiological Condition; Nicotine Dependence; and Inhalant Abuse, Uncomplicated.

A quarterly MDS (Minimum Data Sets) assessment dated 2/20/19 lists R3's Brief Interview for Mental Status (BIMS) Score of 15 indicating R3's cognitive status as being intact.

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This same MDS lists R3's behaviors as verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred 1 to 3 days in the 7 day look back period; This behavior significantly intrudes on the privacy, and significantly disrupts the living environment of others, and her behavior is scored as being the same as the previous MDS. The MDS activity of daily living scores for the quarterly MDS on 2/20/18 lists R3 as needing supervision from staff with no physical help for transfers, eating, dressing, or ambulation and R3 has no impairment with range of motion.

R3's Care Plan with an initiated date of 8/6/18 lists a focus area of "I have poor impulse control and anger easily and have become physically aggressive toward my peers as evidenced by recent altercation with a peer which became physical and me hitting her." An intervention listed for this focus area states, "When (R3) becomes agitated: Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later."

The Echart Face sheet lists R4 as being 42 years old with a date of birth being 06/16/76. The annual MDS dated 3/13/19 lists R4 as being admitted into the facility on 5/24/18. The diagnosis listed in the Echart for R4 includes: Paraplegia, complete both lower extremities; and Pressure Ulcers.

The annual MDS dated March 13, 2019 lists R4's BIMS score as 15, indicating he is cognitively intact. This same MDS lists R4 has having no behaviors, and needs supervision with set up help only with the activity of daily living areas of transfers, eating and dressing. R4 has no

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impairment in the upper extremities, and impairment on both sides of the lower extremities.

According to a preliminary 24 hours abuse investigation report received by the department from the facility on 4/16/19, completed by V1, Administrator, R3 had a verbal and physical altercation with R4 that ended with R3 being sent to a local hospital and R4 being pulled out of his wheelchair in the facilities parking lot. The five day report sent to the department dated April 22, 2019 completed by V1 says, R4 went to R3's room upon request of R3. Once R4 was in R3's room, R3 put her head down in R4's lap. V1's report stated R4 "blew her (R3) off which made her mad and she slapped him. (R3) started cursing at (R4) and trying to punch him. (R4) ducked several of her swings until she finally landed two and then he put his hand on her head and pushed her to the floor so he could attempt to open the door and back his wheelchair out the door. (R4) went back to his room to call a friend to come get him. He went out the front of the building to wait for his friends to come pick him up and he saw (R3) coming up the street and he tried to stay out of her path and went into the parking lot to avoid her. R3 approached him (R4) and started throwing punches. He (R4) was able to duck several punches until she (R3) pulled him out of his wheelchair and then he had to start fighting back."

An untitled incident report provided by the facility dated 4/16/19 at 11:03 PM, completed by V13, Licensed Practical Nurse (LPN) regarding R3 and R4's physical altercation, states under incident description as "At 7:45 PM, Resident (R3) was yelling 'let me go' and was sitting in floor of room. R4 was in his wheelchair, in front of resident. At 8PM resident (R3) was on ground outside with R4

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restraining resident by holding her arms and covering her legs with his." The immediate action taken according to the same report states "Resident's separated, DON (Director of Nursing), Administrator, and police called, statements taken. Resident (R3) taken to hospital" and behavior symptoms was checked on the form as predisposing situation factors.

A Nursing Home to Hospital Transfer Form completed as R3 was being transferred dated 4/16/19 by V13, LPN at 10:13 PM has harm to self or others checked as risk alerts.

A document entitled "Investigation of Abuse" between (R3) and (R4) in the investigation report file, regarding an incident on 4/16/19 between R3 and R4 provided by V1, Administrator says an interview was conducted with V13, and at around 7:30 - 7:45 PM she (V13) heard screaming from R3's room stating "let me go" when V13 went into R3's room, R4 had R3 down in the floor in front of his wheelchair with one hand and once V13 arrived R4 left the room. V13 went to R4's room and asked him what had occurred. Approximately 30 minutes later a staff member was returning and saw there was a fight outside in front of the facility between R3 and R4.

On 5/2/19 at 3:30 PM V13 said on 4/16/19 R4 had left R3's room and went back to his room after the incident between him and R3. R3 went out the front door of the facility to smoke. V13 added "a few of the resident's know the door code to get out of the building and both R3 and R4 know the door codes." V13 stated when she finished talking with R4 about what had happened in R3's room V13 left the blue hall and went to the green hall. She told R4 not to go out front to smoke. V13 stated "We did not try to keep either

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of them in the building since they are their own person and can come and go as they please." V13 then said the only thing we did to keep them apart that night was separating them after the incident in R3's room, and (R4) was told not to go out of the front door to smoke. He (R4) went out the front door anyway.

On 5/9/19 at 3:09 PM V13 said after she talked with R3 about the incident in her room around 7:30 PM or so R3 left the building and said she was going out front to smoke. V13 then stated "I don't think a staff member went with her. No one was assigned to monitor her or go with her. I went to talk to him (R4) and when I left his room, he was still in there and I told him not to go out front." When asked if she (V13) had a plan to keep the resident's separated from each other V13 said "no, except to tell him (R4) not to go out front to smoke.

On 5/9/19 at 3:30 PM, V33, Certified Nurse's Aide (CNA) said the altercation on April 16, 2019 between R3 and R4 began in R3's room. V33 stated, "I heard her (R3) screaming and went into her room and she was on the floor. R4 was rolling out of her room in his wheelchair." As R4 left R3's room he said 'I did not hit her.' V33 said V13 was also in R3's room asked her what happened. After R3 finished talking, V13 left R3's room to go call V1 or V2, Director of Nursing (DON). R3 said she was going to smoke and no one went with her, the last smoke break of the night had already occurred and no one was assigned to observe her. She (R3) keeps her own cigarettes and lighter on her person and she knows the door codes, so she leaves the facility without the staff's knowledge all the time. V33 stated "(V14 CNA), was working the back hall were R3's room was located and was on break when this occurred, so

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I was watching her hall while she was on break." V33 then said "R4 comes and goes as he pleases, has the front door codes to leave undetected, and his own cigarettes and lighter to go smoke when he wants also, so I do not believe anyone was assigned to observe him either."

The investigation report document entitled "Investigation of Abuse between (R3) and (R4)" completed by V1 regarding the incident on 4/16/19 says an interview was conducted with V33 that said around 7:45 PM she heard screaming coming from R3's room stating "help me, let me go." When V33 arrived to the room R4 was exiting and already headed up the hallway back towards his room. V33 took her break around 30 minutes or so later and when she was leaving she saw a fight outside. V33 also reported that earlier in the evening R3 had been arguing with other residents.

A social service note dated 3/20/19 in R3's Echart states "Two residents had complaints this morning of (R3) verbally abusing and cursing at them and threatening to hurt them, pull them out of their wheelchairs and 'f*** them up.' Residents were tearful when they reported the incidents and said they were fearful of her." This same note continues and says the local police department was called and they came out and took statements from 'all' involved and will give them to the state's attorney to see if he wants to pursue it. R3 denied doing anything wrong and refused a psychological evaluation, and to complete the police department statement of what happened. No updates were made to R3's care plan regarding her behaviors.

R3's Nurses Notes dated 3/6/19 at 4:14 AM say R3 "knows pass codes to front door in and out,

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and proceedsto let self in and out without notifying staff."

A social service note for R3 dated 2/19/19 at 2:20 PM says the care plan team met with R3 regarding her behaviors. V7, Social Service Director told R3 that rude and cursing other residents and staff was not acceptable and R3 threw a chair across the room, and stated "yes, sometimes I lose my temper, especially when I'm cycling and I'm cycling now." No updates were made to R3's care plan regarding her behaviors.

A behavior note for R3 dated 4/16/19 at 9:28 PM says R4 had physical altercation with (R3), housekeeping reported to V12, LPN that someone was on the ground outside and needed help. When V12 came outside R3 and R4 were both on the ground in front of the front entrance of the facility, R13 and R14, were both present and while R3 was on the ground she was continuously trying to get to R4. R4 was helped back into his wheelchair, and went down the street to have a cigarette after reporting no injuries. R3 had blood on her face, mouth and clothes and was escorted back into the building. The police arrived at that time.

A Police Department Detail Incident Report states, the case on April 16, 2019 at 8:07 PM, was referred to the states attorney for battery. This report lists R3 as the suspect, R4 as the victim, and is signed by V15, Police Officer.

A report entitled "Final Abuse Investigation Report" between R3 and R4 on 4/16/19 sent to the department dated 4/22/19 said, R3 approached R4 in the parking lot and started cussing and screaming at him. R3 bent down and was in R4's face and started throwing punches.

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R4 was able to duck several punches until R3 pulled him out of his wheelchair and then he had to start fighting back.

The Police Report dated 4/16/19 completed by V15, Police Officer, states "(R3) had abrasions and lacerations to her face. She also had a few contusions. All of her injuries were to the facial area."

A History and Physical report from a local hospital record dated 4/16/19 for R3, states "was brought in by EMS (emergency medical services) after being assaulted by a companion who also resides at the NH (nursing home) ....patient suffered laceration of the lower lip that was sutured in ED (emergency department). On CT (computerized tomography) scan she is found to have mandible acute subarachnoid hemorrhage in the left frontal lobe and questionable non-displaced nasal bone fractures. Neurosurgery was consulted by ED physician, Admission to ICU (intensive care unit) under hospitalist care was recommended.

A local hospital record dated 4/16/19 for R3 listed as a "Neurosurgery Consultation" page 3 of 6 Assessment/Plan specifies the following: 1. Traumatic subarachnoid hemorrhage; Small left frontal lobe subarachnoid hemorrhage most likely associated to the sustained head and facial trauma; 2. Lip laceration; 3. Nasal fracture; and 4. Alcohol intoxication.

The Abuse Prevention and Reporting policy provided by the facility dated 11/28/16 and revised 1/22/19 states on page 1, under guidelines, "The resident has the right to be free from abuse ..." and on page 6 under protection of residents, "The facility will take steps to prevent potential abuse while the investigation is

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underway, Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation."

Violation (A)

(3 of 3)

300.1210b)
300.1210d)2)5)
300.3240a)

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:
2) All treatments and procedures shall be administered as ordered by the physician.
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

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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. (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on observation, interview, and record review the facility failed to identify, asses, monitor and treat wounds according to physician orders for 2 of 3 residents (R2 and R5) residents reviewed for wounds in a sample of 26. This failure resulted in R2's injury worsening and requiring surgical amputation of R2's left second, third, and fourth digits with a potential for R2 to require amputation of his left hand.

Findings Include:

1)R2's MDS (Minimum Data Set) dated 3/15/19 documents a BIMS (Brief Interview for Mental Status) score of 13, which indicates R2 is cognitively intact.

R2's facility physician progress note dated 11/28/18 documents, "Currently has complaints of wounds to left hand sustained on his wheelchair spokes about 2 weeks ago. Some pain in hand

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...abrasions to left hand ...monitor wounds on left hand, wear glove when operating wheelchair."

R2's record documents a 72-hour admission/readmission note dated 12/20/18 that documents "wounds/skin concerns present with no changes in skin integrity. Dressing change not required. Applications of ointments/medications other than to feet."

R2's progress notes document R2's skin is "intact with no concerns" and within normal limits from 11/20/18 until 1/20/19.

R2's record does not have a 11/2018 treatment administration record. R2's December 2018 treatment administration record does not document a treatment for wounds on R2's left hand.

On 5/8/19 at 12:01 PM V31 (Interim Director of Nurses/DON) stated she did not remember R2 having gloves to wear while self-propelling his wheelchair. V31 stated if there was monitoring of the wound to R2's left hand it would be documented in R2's progress notes.

On 4/26/19 at 3:10 PM V2 (DON) stated according to her records, not documented in R2's record, show R2 injured his left hand on his wheelchair spoke sometime toward the end of November 2018. V2 stated R2's left hand was evaluated on 1/31/19 but the records are not available due to the previous Director of Nurses having them.

R2's progress notes document on 1/20/19, "Left hand has three areas that doesn't seem to be healing well, scabbed over measuring 1 cm; thumb, index and middle finger. Notified V30

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(Physician) about my concerns. Replied back with: continue Tx (treatment) and monitor closely ..."

R2's January 2019 treatment administration record does not document treatments for wounds on R2's left hand.

On 5/7/19 at 3:05 PM V3 (Licensed Practical Nurse/LPN) stated he did not see a treatment order for wounds to R2's hands on R2's 1/2019 treatment administration record.

On 5/8/19 at 12:01 PM V31 (Interim DON) stated the facility was wrapping R2's fingers with gauze in 1/2019 but she could not remember what medication was being used for the treatment. When asked where the order for the treatment was documented V31 stated, "I don't know. I don't see it."

On 5/8/19 V31 (Interim DON) stated she first noted small round circles on R2's fingers and asked him how he got them. V31 stated R2 told her he got them from spinning the wheels on his wheelchair. V31 was unable to tell me when she first noticed the wounds on R2's hands. V31 stated she believed it was after R2 was in the hospital for about a month because she noticed it was worse when he returned from the hospital stay. When asked where monitoring and assessment of R2's wounds would be in his record V31 stated it should be documented in R2's progress notes.

R2's progress notes do not document assessment, treatment or monitoring of wounds to R2's hands between 11/28/19 and 1/20/19.

On 5/8/19 at 3:30 PM R2 when asked if the

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wound on his hand was the same one that he got a few months back R2 stated they were the same ones. R2 stated, "They turned black and I had to get them cut off." When asked what care the facility provided to R2's wounds when he first got them R2 stated, "Nothing, they (the facility) just let it be. (The facility) Didn't talk about it or nothing."

R2's medical record documents R2 was hospitalized from 12/9/18 until 12/20/18.

R2's weekly skin observations document skin intact no concerns noted on 12/25/18, 1/8/19, and 1/15/19.

R2's progress notes document;

1/22/19, "left hand (back)- multiple ulcers present, wound clinic appointment made."
1/24/19 "Resident hand is red and swollen. Notified V30 (primary physician), updated him of s/s (signs/symptoms). Received orders to send to (name of regional hospital) for eval (evaluation)."

R2's emergency documentation from regional hospital dated 1/24/19 documents R2 arrived at the emergency department for treatment of complaints of left-hand pain and multiple wounds on the left hand. Under history of present illness R2's emergency room report documents, "47-year-old chronically ill patient with history including end-stage renal disease on hemodialysis presents to the emergency department for evaluation of left-hand pain and wounds. He reports that he has wounds to the left 3rd and 4th fingers, which have been there approximately 3 months. He came in today because the pain worsened .... He is S/P (status post) left BKA (below the knee amputation) which

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he reports was secondary to infection." Under medical decision making R2's emergency room report documents, "Chronic appearing wounds of the left hand. No signs of acute infection- no cellulitis, abscess, or wet gangrene. Plus, no systemic signs of infection ... Tissue is dry, brown-black in color, and unhealthy appearing, suspect formation of dry gangrene ..."

R2's emergency room documentation dated 1/24/19 documents recommendation for doppler and to keep appointment with wound clinic on 1/30/19.

R2's progress notes document;

1/25/19 "Patient had a doppler ultrasound to left hand. Results showed good circulation. Referred to wound care, appt (appointment) scheduled for 1/30/19."

1/30/19 "Miscommunication between wound care and (name of local transportation company). Resident did not go to wound care today. Rescheduled for Monday or Wednesday next week ..."

R2's wound clinic notes dated 2/4/19 documents R2 reports the areas to his left hand began from trauma due to getting caught in wheelchair. The arterial wounds on R2's left hand measure 0.7-centimeter (cm) x 0.9 cm x 0.1 cm (finger 1), 1.4 cm x 1.6 cm x 0.1 cm (finger 3), and 1.2 cm x 1. 7 cm x 0.1 cm (finger 4). The wound clinic notes document orders to obtain a 3-view x-ray of R2's left hand, facility to send R2 for evaluation to remove ring from left ring finger, referral for vascular evaluation, and physical therapy to evaluate for wheelchair seating and positioning due to current wheelchair too small for patient.

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New wound treatment orders were documented as follows for finger 1, 3, and 4; "Apply mupirocin 2% ointment to wound bed, cover with plain cotton gauze and roll gauze, secure with paper tape xspan. This dressing is to be performed TID (three times daily)."

R2's record did not document a 3-view x-ray, evaluation to have a ring removed from the left ring finger, an appointment for a vascular evaluation, or a therapy assessment for wheelchair seating and positioning.

On 5/7/19 at 3:05 PM V3 (Licensed Practical Nurse/LPN) stated he was unable to locate the results of the x-ray or that it was done as ordered by the wound doctor. V3 stated nursing does not complete the wheelchair assessments that therapy would be responsible for completing the assessment.

R2's medical record does not document a wheelchair assessment.

On 5/2/19 at 9:20 AM V17 (Occupational Therapy COTA) stated the facility therapy department routinely screen new residents for wheelchair fit and size. V17 stated she was not aware of recommendations made by V16 (R2's wound clinic physician) for physical therapy to evaluate R2's seating and positioning due to R2's wheelchair being too small and not providing proper support. V17 stated R2 was not seen until 3/2019 when V46 (family) brought in a motorized scooter for R2 to use.

R2's Treatment Administration Record dated 2/1/19- 2/28/19 document orders for mupirocin 2% to be administered three times daily to R2's wounds on finger 1, 3, and 4. R2's treatment

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record does not document treatments were completed on 2/8/19 (Friday), 2/10/19, 2/11/19 (Monday), 2/12/19, 2/15/19 (Friday), 2/16/19, 2/17/19, 2/20/19 (Wednesday), 2/21/19, 2/25/19 (Monday), and 2/26/19 at 8:00 AM, and 12:00 PM.

On 5/7/19 at 3:05 PM V3 (LPN) stated R2 would not receive his treatment in the facility on Monday, Wednesday, and Friday's because R2 would be at dialysis. V3 stated all other treatments should be documented as being done. V3 stated, "I don't know why they aren't documented."

On 5/8/19 at 1:40 PM V44 (Registered Nurse-Dialysis) stated the dialysis center does not provide wound treatment services and if a patient had an order for a dressing change during the dialysis treatment time the facility would be responsible for ensuring it was done.

R2's 2/2019 treatment record documents R2 missed 12 treatments to the wounds on finger 1,3, and 4 of the left hand.

The facility wound documentation shows measurements for R2's left 2nd, 3rd, 4th digit and thumb on 2/4/19. The facility wound documentation shows R2 was in the hospital on 2/11/19, 2/18/19, and 2/25/19 so no measurements were completed.

R2's progress notes document on 2/5/19 a weekly skin observation was completed and shows three small scabbed over areas on R2's thumb, middle and index finger. On 2/26/19 R2's weekly skin observation documents pressure ulcer noted to first digits of left hand.

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R2's 2/27/19 Physician Progress Note documents, "R2 was seen today for routine visit. Recent hospitalization for DKA (diabetic ketoacidosis) and fluid overload. Hx(history) of type 1 DM (diabetes mellitus) and ESRD (End stage renal disease). Also has necrotic areas on tips of fingers. Was evaluated by wound care. Returned to nursing home yesterday ...Plan: Send to vascular surgeon, continue as per wound care, monitor fluid restriction and Na."

R2's progress notes dated 3/4/19 documents, "residents wife brought a power wheelchair for resident ...Resident does not know how to work power wheelchair. Will pass it on in report to see about therapy working with resident to use it."

R2's wound clinic notes dated 3/11/19 documents R2 is to be evaluated by V32 (Orthopedic Surgeon) on 3/12/19 and physical therapy for wheelchair seating and positioning, due to current chair being too small and not providing proper support.

R2's 3/11/19 wound clinic notes document orders for Bactrim DS 800/160 1 tablet every 12 hours for 10 days. Cleanse R2's fingers on left hand with liquid non-fragrant antibacterial soap, rinse with saline, sterile or distilled water. Rinse well, pat dry, and apply betadine to the wound bed, cover with plain gauze and roll gauze, secure with paper tape daily.

R2's 3/1/19 to 3/31/19 Treatment Administration Record does not document an order to apply betadine to the wounds on R2's fingers on his left hand. R2's treatment record documents R2 was receiving the previously ordered treatment of mupirocin ointment.

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On 5/7/19 at 3:05 PM V3 (Licensed Practical Nurse/LPN) confirmed R2's treatment was not changed from mupirocin ointment to betadine on 3/11/19 as ordered by V16 (wound clinic physician). When asked why the orders had not been changed V3 stated he was unable to answer why since he did not see the new orders when they came in to the facility.

V32 (orthopedic surgeon) office note dated 3/12/19 documents, "Skin: Dry gangrene of left long finger with full-thickness eschars in a; patchy distribution around the digit ...Full thickness necrosis of the ring finger tip with dry eschar. The index finger shows patchy areas of ischemia with purplish discoloration and he is quite sensitive at this level ... Thumb is benign but for a 2 mm (millimeter) diameter eschar on the radial aspect ... Assessment/Plan: This is a 47-year-old male with critical small -vessel ischemia of the left arm ... He is not healing candidate for any of his fingers outside of a possibility of healing at the hand ...My recommendation would be for left index, long, and ring finger ray amputations.

R2's progress note dated 3/15/19 documents the facility received a wound care memo stating R2 had MRSA (Methicillin Resistant Staphylococcus aureus) and VRE (Vancomycin Resistant Enterococci) in the wound on R2's fingers of his left hand. R2's progress note documents orders were received and V32 (orthopedic surgeon) was notified of the culture results. "Amputation of 2nd, 3rd, and 4th digit of left hand will be postponed until wound culture returns clear. Resident is on contact isolation."

R2's progress note dated 3/19/19 documents "R2 to V32 (orthopedic surgeon) office today for exam and admitted to (name of regional hospital) this

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afternoon approximately @ 3:30 PM with plans for surgical intervention of amputation to left hand fingers with chronic wound & vascular insufficiency."

R2's hospital record with a discharge date of 3/25/19 documents under surgical operative procedure note; "47 year old male with multiple medical problems including end-stage renal disease on dialysis, longstanding type 1 diabetes with poor glycemic control, and continued tobacco abuse with peripheral vascular disease and transcutaneal O2 (oxygen) measurements that are concerning for inability to heal wounds at the level of the fingers and marginal healing capacity over the dorsal hand who presents to my office with dry gangrene of the left long and ring fingers and eschar over the PIP (Proximal IP Joint) of the ring finger that is similarly consistent with progressive vascular disease ...The patient would like all of his involved fingers removed with amputation as he in intractable pain with his critical ischemia. The thumb has an eschar as well distal to the interphalangeal joint but is otherwise well maintained. I think it is reasonable to amputate the index, long, and ring fingers as he presents today but would delay any further intervention on the thumb as this would essentially negate the value of maintaining a hand awl. Possibility of the trans forearm amputation has been broached with the patient if this does not heal."

R2's 3/26/19 wound clinic notes document the following, "Wound clinic received a call from V32 (orthopedic surgeon) office on 3/25/19 that patient (R2) had discharged from (name of regional hospital) for amputation of left index, middle and ring finger ...Patient had finger amputation with V32 which is already failing, The

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facility did not provide medication list and we do not have a discharge summary from his surgery available at time of evaluation .... Call placed to (name of facility) and spoke with V8 (previous Director of Nurses) and discussed information below and verbalized understanding ...continue contact precautions ...referral appointment to V49 (infectious disease specialist) ..." The wound clinic notes document orders to start a treatment of a thin line of gentamycin cream to incision line and area of discoloration to peri-wound daily.

R2's 3/1/19-3/31/19 treatment administration record does not document an order for gentamycin cream to be applied to R2's incision line on his left hand.

R2's 4/1/19 to 4/30/19 treatment administration record does not document an order for gentamycin cream to be applied to R2's incision line on his left hand.

R2's wound clinic notes dated 4/2/19 documents the following under Dx (diagnosis/order association plan, " ...wound infection with MRSA and VRE, ID (infectious disease) appt (appointment) pending, continue contact precautions, current medication list not available from facility at time of evaluation."

R2's wound clinic notes dated 4/9/19 includes documentation that R2 was not using dressings as prescribed by the physician.

On 5/10/19 at 2:30 PM V3 (Licensed Practical Nurse) confirmed R2's 3/2019 and 4/2019 treatment administration records do not document the order for gentamycin to R2's incision on his left hand. V3 stated he had not seen the order for gentamycin to R2's incision line

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until this surveyor showed it to him.

R2's progress notes dated 4/3/19 document "Since the change in condition, the symptoms have become (sic) worse. Wound is reddened, warm and tender to touch. Called V32 (orthopedic surgeon) for advisement, who ordered resident be sent to ER (emergency room) for evaluation ..."

R2's medical record does not document R2 was evaluated at the emergency room until 4/5/19. When it is documented R2 returned from the emergency department with orders for an antibiotic (Clindamycin).

On 5/7/19 at 12:51 PM V19 (Licensed Practical Nurse/LPN) stated she remembered calling V32's (orthopedic surgeon) office on 4/3/19 but could not remember if R2 was sent to the emergency room as ordered or not. When asked why he would not have gone if he didn't V19 stated, "Maybe we didn't have transportation, or he may have refused."

On 5/2/19 at 9:50 AM V16 (Wound Clinic Physician) stated R2 was scheduled by the wound clinic to see V49 (Infectious Disease Specialist) on 4/15/19 and the facility did not take him to the appointment. When asked if there was anything the facility had done that would cause R2's wounds to not heal V16 stated she was frustrated with the facility for not keeping the appointment with V49. V16 stated appointments with V49 are hard to get and if someone misses an appointment without canceling it they sometimes will not reschedule. V16 stated she was not sure if R2 had seen V49 yet but if he had not he needed to.

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R2's medical record does not document an appointment with V49 (Infectious Disease Specialist).

On 5/2/19 at 3:20 PM when asked if R2 had missed any appointments with an infectious disease specialist V18 (transportation aid) stated she was not aware R2 had an appointment with V49 (Infectious Disease Specialist). V18 stated she had taken R2 to see V32 (Orthopedic Surgeon), an unnamed pulmonologist, and an unnamed cardiologist but could not find an appointment with V49.

On 5/3/19 at 9:05 AM V18 (transportation aid) stated she called R2's wound clinic on 5/2/19 regarding R2's appointment with V49. V18 stated the wound clinic told her they faxed an appointment to the facility for R2 to see V49 at the end of March. V18 stated she called V49's office and scheduled an appointment for R2 to see V49.

On 5/7/19 at 12:40 PM V41 (office manager wound clinic) stated the wound clinic had faxed orders to the facility on 3/26/19 with the referral and appointment for R2 to see the Infectious Disease Specialist.

R2's wound clinic notes dated 4/23/19 document " ...wound infection with MRSA (Methicillin Resistant Staphylococcus Aureus) and VRE (Vancomycin Resistant Enterococcus), continue contact precautions ...ID (infectious disease) clinic-missed Appt. (appointment) with V49 (Infectious Disease Specialist) on 4/15/19. Encouraged V18 (transportation aid), representative with (name of facility), to reschedule his (R2) appointment due to multi-resistant bacteria in wound ...keep all

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scheduled follow up with V32 (orthopedic surgeon)." R2's treatment orders documented on the wound clinic note are "apply a thin layer of gentamycin cream and nystatin cream 50/50 mix to incision line and area of discoloration to peri wound ...twice a day."

R2's 4/2019 treatment administration record does not document R2's gentamycin/nystatin order.

R2's 5/2019 treatment administration record documents R2 is receiving gentamycin/nystatin treatment to the incision line on his left hand daily.

On 5/7/19 at 3:05 PM V3 (LPN) stated he did not know why R2's gentamycin/nystatin order was not changed on R2's 4/2019 treatment administration record. V3 confirmed R2 should have been getting gentamycin/nystatin treatments twice daily from 4/23/19 until 5/7/19 and had only been receiving the treatment daily.

On 5/7/19 at 10:10 AM V3 (LPN) confirmed R2 did not have a treatment administration record for 5/2019. When asked how the nurses who took care of R2 knew what treatment to do V3 stated, "That was my question also." When asked if there was documentation R2's treatments had been done in 5/2019 V45 (Regional Nurse) stated I did it on 5/1/19 and it is documented under assessments. V3 stated R2 had a physician appointment on 5/6/19 so it would have been changed there. When asked for a copy of the appointment R2 had on 5/6/19 V3 stated he was not able to find it.

R2's medical record does not document skin assessments from 4/17/19 until 5/1/19.

On 5/7/19 at 3:05 PM when asked if there should

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be weekly skin assessments completed for R2 V3 (LPN) stated, "Yes there should be and no there is not."

R2's wound clinic notes dated 5/7/19 document orders to discontinue the treatment order for gentamycin/nystatin and documents orders to start the following treatment; "cleanse with carra kleenz no rinse, leave on for 5 minutes ...apply zinc oxide to peri wound ...apply hydrofera blue classic (barely moistened with saline ...) loosely wick on continuous strip into wound bed ...cover with plain cotton gauze, wrap with kerlix and secure with paper tape ..."

On 5/9/19 at 4:14 PM V51 (Licensed Practical Nurse) stated they had just received new orders for R2 to be put on isolation precautions because he had VRE (Vancomycin Resistant Enterococcus) in the surgical wound on his left hand.

R2's wound clinic notes dated 5/9/19 documents R2's left hand wound culture results showed VRE (Vancomycin Resistant Enterococcus). The facility is to place R2 on contact precautions and notify dialysis.

On 5/9/19 at 5:03 PM R2's wound was observed with V50 (Licensed Practical Nurse/LPN) present. R2's incision line was open with the surrounding tissue being purple and red. The wound edges are yellow with red tissue noted at the center. Wound appears inflamed. Drainage noted on the dressing that was removed. R2's room did not have biohazard trash or linen carts, signage, or personal protective equipment located in or near room during this observation of the wound.

On 5/10/19 at 10:10 AM R2's room was observed

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with no biohazard trash or linen carts and no signage related to R2 having an order to be on contact isolation. V19 (Licensed Practical Nurse/LPN) stated she was not aware R2 was on isolation precautions. V19 located a note from V16 (wound clinic physician) in R2's record documenting R2 should be on contact precautions. V19 stated she was not aware R2 had been placed on contact precautions on 5/9/19. V19 stated it was not passed on in report and it should have been.

On 5/7/19 at 3:10 PM V3 (Licensed Practical Nurse) stated the facility did not have V32 (Orthopedic surgeon) office notes or discharge orders from the regional hospital after R2's amputation. When asked how the facility knew what care to provide R2 post amputation and after his office visits to the orthopedic surgeon V3 stated, "Very good question. I am sure they are here somewhere and just haven't been scanned into the system. I will call and request them."

On 5/9/19 at 2:15 PM V32 (Regional Nurse) stated the facility was unable to produce V32's (Orthopedic Surgeon) office visit notes from 3/12/19. V32 stated, R2 may have been admitted to the hospital after he saw V16 (wound doctor) on 3/11/19 and R2 may have seen V32 at the hospital. V32 stated R2 was seen by V16 (wound doctor) on 3/11/19 so he was being seen by a doctor.

R2's office notes with V32 (Orthopedic Surgeon) dated 4/16/19 document, "R2 is a 47-y.o. (year old) male. He presents today status post the above-mentioned procedure (left hand index, long, and ring finger ray amputations) who has been lost to follow up until today ...(R2) is adamant he does not wish to have amputation of

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forearm level which would be our next. If he does not have adequate healing capacity in the hand.

On 5/9/19 at 9:44 AM V32 (Orthopedic Surgeon) stated he should still be following R2, but he had been irregular in terms of following up. "He missed his last follow up with me." He canceled on 4/5/19 and was a no show on 4/10/19 and 4/23/19. V32 stated there was no note in the record why R2 missed the scheduled appointments. V32 stated it is not good when you have a patient that is disinterested in their care and a facility that is difficult to communicate with and unable to get R2 to appointments. V32 stated the facility will call the office with information that R2 is having symptoms, the office will tell the facility to bring R2 in to be seen and the facility says they can't get R2 to the office. V32 stated even with optimum care R2 may have had the amputation. The challenge has been that it is very difficult to get a straight story from the facility and maintain follow up appointments. "Even with optimum care R2 had a chance to do badly but you add to that the difficulties with the facility and his dialysis and tobacco use and you get an amputation." When asked if it would have made difference in the outcome for R2 if the facility were not doing treatments as prescribed V32 stated, "Sure it would."

On 5/8/19 at 4:15 PM when asked if the facility not following treatment orders could have a negative impact on the outcome of R2's wounds, V16 (Wound Clinic Physician) stated, "Absolutely it can have a negative impact on any patient that comes in here. I am evaluating and making changes every time I see them, and it could be detrimental. If they (treatment orders) aren't being followed."

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R2's care plan dated 4/22/19 documents R2 is at risk for pressure ulcers with the following interventions: educate related to transfer positioning requirements, follow the facility policy and procedures, inform the family/caregivers of any new skin breakdown, monitor nutritional status, obtain and monitor lab/diagnostic work, teach importance of changing positions. R2's care plan has not had new interventions implemented since 4/22/19 and does not include a focus area related to the injury/surgical wound on R2's left hand.

On 5/7/19 at 3:05 PM V3 (LPN/Care Plan Coordinator) stated he had worked the floor every day and had not had the opportunity to update R2's care plan.

2) R5's MDS (Minimum Data Set) dated 4/17/19 documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R5 is cognitively intact.

R5's medication review report documents a treatment order dated 3/30/19 to "irrigate perirectal wound with NS (normal saline). Pack with ½ in iodoform gauze strips. Cover with gauze or ABD pad. Secure with cloth tape daily and PRN (as needed) x (times) 1 week."

R5's treatment order dated 3/1/19 to 3/31/19 does not document an order for treatment to R5's perirectal area.

R5's treatment order dated 4/1/19 to 4/30/19 documents a treatment to irrigate R5's perirectal wound with normal saline and pack with ½ in iodoform gauze strips for one week starting on 4/20/19.

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On 5/9/19 at 2:20 PM V31 (Interim Director of Nurses) stated R5's treatment of iodoform to the perirectal wound did not show up on the 3/2019 treatment sheet or the 2/2019 treatment sheet until 4/20/19 because it was not entered into the computer correctly on 3/30/19 when R5 was admitted. V31 stated R5 received the treatment from 3/30/19 until 4/20/19 when the nursing staff updated the treatment sheet to reflect the order. V31 stated the treatment continued until the wound was healed. When asked if the physician had been notified and ordered the treatment to be repeated since it was originally ordered for one week only, V31 stated she did not know.

On 5/9/19 at 3:05 PM V19 (LPN) stated she did not know why R5's treatment orders from 3/30/19 were not on the 3/2019 treatment sheet or the 4/2019 treatment sheet until 4/20/19. V19 stated she knew R5 got the treatment everyday he was at the facility until there was not a crater left to put the iodoform in. V19 stated she did not know if the physician wrote a new order to continue the iodoform treatment beyond one week. V19 stated, "I just know he needed it, so we did it. We treated it until it was healed."

Violation (A)