STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005185	A. BUILDING: _____ B. WING _____	C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND REHAB & HEALTHCARE CENTER	800 WEST TEMPLE STREET EFFINGHAM, IL 62401

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S 000	Initial Comments Complaint Investigation: 2454273/IL173804.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2)3)4)A) 300.3220f) 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 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	S9999		

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resident to meet the total nursing and personal care needs of the resident.

d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis

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

3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A)Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

Section 300.3220 Medical Care

f)All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

Section 300.3240 Abuse and Neglect

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S9999	Continued From page 2 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 regulations were not met as evidenced by : Based on interview and record review, the facility failed to remove surgical staples and to obtain an x-ray as ordered for 1 of 11 residents (R1) reviewed for quality of care in the sample of eleven. This failure resulted in R1's surgical hip incision becoming infected and requiring antibiotic therapy. Findings include: R1's Face Sheet documented an Admission Date of 12/27/23 and listed diagnoses including Congestive Heart Failure, Anxiety Disorder, and Chronic Kidney Disease. R1's 1/5/24 Minimum Data Set (MDS) documented that R1 had severe deficits in cognitive function. R1's Nursing Progress Notes documented the following: On 1/29/24 at 8:10am: "Continues to complain of severe pain right hip/right leg. Had hydrocodone and ativan around 3:20am, then Tylenol at 7:12am. No relief. Moaning. Will not sit up in wheelchair straight. Total assist with toileting and transfer this morning, unable to stand on right leg. No internal/external rotation of extremities noted. Complains of pain when right leg or hip touched or when right leg is moved. Called (V14, Physician) office and notified of severe pain and no relief from pain medications. Asked for Xrays. New order received to send patient to ER (Emergency Room) for evaluation for severe right hip pain."	S9999		

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On 1/29/23 at 11:37am: "Called (local hospital) ER to check on patient, daughter at ER. Patient has Right hip fracture and will be admitted."
On 2/5/24 at 4:38pm: "(R1) was (re)admitted to our community."

A 2/5/24 Hospital After Visit Summary documented, "Reason for admission: Hip fracture due to Osteoporosis. Discharge instructions: Schedule an appointment with (V15, Orthopedic Surgeon) as soon as possible for a visit. Remove (surgical) staples (to right hip incision) on 2/8/24. X-ray hip 2/8/24. Does not have to come to the office unless there are problems, as needed. Keep dressing in place for seven days."

R1's February 2024 Treatment Administration Record (TAR) documented, "2/5/24: Keep (right hip) dressing in place for seven days, (check) every shift." The TAR documented that this was done on all three shifts from 2/5/24 through 2/16/24. The same TAR documented, "2/5/24: On 2/8/24: Remove staples to right hip." There were no initials documented on the TAR on 2/8/24, indicating the staples had not been removed as ordered.

R1's Nursing Progress Notes further documented the following:
On 2/9/24 at 2:02pm: "(Portable Xray Provider) Technician called stated he is so sick and cannot come to do her follow up x-ray, will come tomorrow."
On 2/10/24 at 5:00pm: "Called (x-ray provider) (to) follow up x-ray ordered was not done yet. Reminded them (facility) called to set this up early in week. (Provider) reports no technicians to send out right now, they will send one out when they get someone."
On 2/11/24 at 9:15pm: "(Portable x-ray provider)

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was here to do follow-up x-ray of residents fractured right hip."

There was no documentation in these notes to indicate V15 (Orthopedic Surgeon) had been notified that the x-ray was not able to be obtained per V15's order.

R1's Progress Notes further document the following:
On 2/12/24 at 9:33am: "X-ray (right) hip done yesterday. Results came in last night. Sent report to (V15) for review. X-ray noted a total right hip replacement intact. Surrounding soft tissues normal."
On 2/16/24 at 2:15pm: "Right hip: Possible infection: Incision is red, warm to touch, has purulent drainage and a little swollen. Noted 24 staples. Called (V15's) office and spoke to his nurse (V6, Registered Nurse). (V6) said that she will call (V15) because he is on vacation and will get back to us."
On 2/16/2024 at 2:38pm: "(V6) called and she said that (V15) would like us to remove the staples and if we can take pictures to send. (V6) was advised that we are not allowed to take pictures. (V6) then stated if she can come over to take the pictures herself, she was advised that she can."
On 2/16/2024 at 2:40pm: "24 staples were removed, resident tolerated it well. Incision is approximated and no dehisce (dehiscence) noted."
On 2/16/2024 at 2:44pm: "(V6) is here to assess and take pictures to the right hip incision to send to (V15)."
On 2/16/2024 at 3:05pm: "(V6) gave an order (from V15) to start the following orders: Cefadroxil Oral Capsule 500 mg (milligrams) one tablet twice daily, (and) to the right hip incision:

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Cleanse wound with wound cleanser, apply (skin barrier) to peri (perimeter of) wound, apply triple antibiotic ointment, cover with abdominal pad and secure with gauze and tape."

R1's February 2024 Medication Administration Record (MAR) documented an order with a start date of 2/17/24 at 8:00am for Cefadroxil Oral Capsule Give 500 mg by mouth every morning and at bedtime for infection to right hip for 7 Days.

A Physician's Note from V15 dated 2/19/24 documented, "Patient (R1) has superficial irritation and/or infection at staple sites. Wound appears better today than it did on 2/16, now that staples are out. Contact (V14, Medical Doctor) regarding bilateral leg edema. Continue (Cefadroxil) 500mg BID (twice daily) until one week course completed. Return to office in one week if wound looks suspicious."

On 6/6/24 at 1:35pm, V3, Licensed Practical Nurse/Wound Care Nurse, stated on 2/16/24 she had assessed the hip incision, which appeared red, warm, and swollen with purulent drainage, and the staples were still intact. V3 stated prior to 2/16/24 she had not evaluated or treated the wound. V3 stated one of the floor nurses, she is not sure which one, had asked her to assess the wound when it was realized it was probably infected. V3 stated V6 gave them orders from V15 to remove the staples, apply a dressing, and begin an antibiotic. V3 stated she removed the staples and applied the dressing. V3 stated she left on maternity leave on 2/17/24 and does not know anything about R1's care after that point.

On 6/6/24 at 2:45pm, V2, Director of Nurses, stated she was not very familiar with R1's care,

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and does not recall ever having gone into her room. V2 stated she did not know why the staples were not removed on 2/8/24 as ordered. V2 stated to her knowledge, the issue was not identified until V3 evaluated the wound on 2/16/24. V2 stated the issue was discussed in the facility's Quality Assurance Meeting but the root cause of the failure was not determined. V2 stated when she reviewed the discharge summary, the orders were confusing as they were to take the staples out on 2/8/24 but leave the dressing in place for 7 days, which would have been 2/12/24. V2 stated an x-ray was ordered for 2/8/24 but was not done due to scheduling problems with the x-ray provider. V2 stated the x-ray was finally done on 2/11/24. V2 confirmed staff had not contacted V15 to clarify the discharge orders nor report that a portable x-ray could not be done, but they should have.

On 6/11/24 at 8:00am, V6 stated that V15 was currently on vacation and would be unable to speak to the Surveyor. V6 confirmed the office was called on 2/16/24 and she inspected the incision as stated in the Nursing Progress Notes. V6 stated when she saw the wound, the staples had been removed, and the incision was reddened and obviously irritated at the sites where the staples had been. V6 stated she took photos of the wound and V15 reviewed the photos and V15 stated to V6 that the staples being left in too long had caused it to get irritated and infected, and he ordered an antibiotic. V6 stated the facility staff had also told her the x-ray had not been done on 2/8/24 as ordered. V6 stated V15's standard orders on hip replacement surgery are to leave the dressing in place for 7 days after the surgery, then at that time get the x-ray and remove the staples. V6 confirmed the staples were to have been removed and an x-ray

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S9999	Continued From page 7 obtained on 2/8/24. V6 stated upon discharge, the resident did not need to make an appointment with V15 unless there were problems, but since the incision had become infected V15 had seen R1 on 2/19/24. V6 stated staff should have called to say the x-ray could not be done on the date it was ordered, but they did not. V6 further stated the facility could have called them to clarify the orders if needed but they did not. On 6/11/24 at 10:00am, V1, Administrator, stated the facility does not have policies for surgical wound care, following physician's orders, or readmitting residents following hospitalization. (A)	S9999		