STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000970	A. BUILDING: _____ B. WING _____	01/17/2025

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CASEY REHAB AND NURSING	100 N.E. 15TH CASEY, IL 62420

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S 000	Initial Comments Annual Licensure Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)2)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1210 General Requirements for	S9999		

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 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. These requirements were not met as evidenced by:	S9999		

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Based on observation, interview and record review the facility failed to prevent cross contamination during wound care for one (R24) resident's left plantar heel open diabetic ulcer, failed to monitor R24's left heel diabetic ulcer and failed to follow physician orders for R24's left heel wound treatments for one of two residents (R24) reviewed for skin conditions in a sample list of 27 residents. R24 experienced the worsening of her left heel open wound due to dressing changes not being completed per physician order and not being provided timely incontinence care which led to R24's dressing to be fully saturated with wound drainage and urine which required antibiotics due to a Staphylococcus (Staph) infection.

Findings include:

R24's medical diagnosis list documents medical diagnoses of Acute Osteomyelitis of the Left Ankle, Diabetes Mellitus Type II with foot ulcer, Morbid Obesity and Polyneuropathy.

R24's Minimum Data Set (MDS) dated 12/19/24 documents R24 as cognitively intact. This same MDS documents R24 requires maximum assistance for toileting and moderate assistance for personal hygiene.

R24's Physician Order Sheet (POS) dated January 2025 documents a physician order starting 12/24/24 of left plantar heel: Cleanse with Normal Saline, apply nickel thick Santyl (chemical debriding agent) to wound bed. Cover with absorbent pad and secure with gauze roll daily and as needed if loose or soiled. R24's POS documents a physician order starting 1/3/25 and ending 1/13/25 for Amoxicillin 875 milligrams (mg) Give 875 mg by mouth two times a day related to non-pressure chronic ulcer of Left Heel

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and midfoot.

R24's Skin Integrity care plan initiated 8/24/24 documents (apply) dressing to (R24's) Left Foot. Observe dressing every shift. Change dressing and record observations of site daily. R24's care plan intervention dated 4/3/24 instructs staff to provide incontinence care as needed. This same care plan documents an intervention dated 4/3/24 to monitor, document and report and signs and/or symptoms of infection.

R24's Weekly Wound Log dated 12/24/24 documents R24's Left Plantar Heel Diabetic wound with Calcaneus bone exposed as initiating in facility on 7/24/24 as having slough and necrotic tissue with yellow, increased purulent drainage, foul odor and measuring 11.6 centimeters (cm) long by 5.0 cm wide by 0.8 cm deep.

R24's Weekly Wound Log dated 12/31/24 documents R24's Left Plantar Heel Diabetic wound with Calcaneus bone exposed as initiating in facility on 7/24/24 as having slough and necrotic tissue with yellow, increased purulent drainage, foul odor and measuring 11.8 centimeters (cm) long by 6.0 cm wide by 0.8 cm deep.

R24's Weekly Wound Log dated 1/7/25 documents R24's Left Plantar Heel Diabetic wound with Calcaneus bone exposed as initiating in facility on 7/24/24 as having slough and necrotic tissue with yellow, increased purulent drainage, foul odor and measuring 12.0 centimeters (cm) long by 6.9 cm wide by 1.0 cm deep. This same log documents an antibiotic was started for Methicillin Resistant Staphylococcus Aureus (MRSA) of R24's Left

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Plantar Heel wound.

R24's Treatment Administration Record (TAR) does not document R24's Left Plantar Heel wound dressing change was completed on 1/3, 1/5, 1/6, 1/10, 1/12 and 1/17/25.

R24's Nurse Progress Noted dated 1/9/25 at 9:39 AM documents Interdisciplinary Team (IDT) met to discuss R24's behaviors with no refusals of care noted.

On 1/14/25 at 10:45 AM R24 was sitting in her wheelchair with her Left foot on a stationary foot pedal. R4's Left foot and ankle were wrapped in gauze that was completely saturated with yellow drainage. R4's gauze dressing was saturated from the upper ankle area to the toes.

On 1/14/25 at 11:20 AM V4 Registered Nurse (RN) completed R24's dressing change to her Left Plantar Heel Diabetic Ulcer. V4 RN did not use hand hygiene, nor change gloves after removing R24's saturated, contaminated dressing prior to cleansing R24's entire Left Plantar Heel open wound. R24's prior dressing of a four inch long by four inch wide blue absorbent pad, a white six inch long by four inch wide absorbent pad and an entire roll of gauze were all saturated with yellow drainage. R24 did not have any intact skin on the entire bottom of her Left foot from the pads below the toes to the heel and expanding the entire width of R24's foot. R24's Heel bone was exposed.

On 1/15/25 at 9:45 AM R24 was sitting in her wheelchair with her Left foot on a stationary foot pedal. R4's Left foot and ankle were wrapped in gauze that was completely saturated with yellow/pink drainage. R4's gauze dressing was

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saturated from the upper ankle area to the toes.

On 1/14/25 at 10:50 AM R24 stated the staff don't always change her Left Plantar Heel dressing like it is supposed to be done by the Physician order. R24 stated the dressing changes are 'hit and miss'. R24 stated, "Look at my (Left) foot. It is soaked. I just got done with an antibiotic for that wound. You would think they (staff) would at least keep it clean. I would do it myself, but I can't reach my foot."

On 1/14/25 at 11:40 AM V4 Registered Nurse (RN) stated she should have changed her gloves in between removing R24's old dressing and cleansing R24's Left Plantar Heel open wound. V4 RN stated cross contaminating R24's wound could cause her wound to become re-infected. V4 RN stated R24's dressing was saturated with not only wound drainage but also with urine. V4 stated R24 was incontinent of urine which contaminated her Left Heel wound. V24 RN stated R24's prior dressing had a strong urine odor. V4 RN stated staff should have provided incontinence care for R24 so that the urine did not contaminate R24's dressing and/or open wound.

On 1/16/25 at 11:00 AM V2 Director of Nurses (DON) stated licensed nurses are expected to follow the physician orders for R24's dressing changes to her Left Heel. V2 DON stated R24 admitted to the facility in March 2024 with this same wound, it resolved and after two months it reappeared in July 2024. V2 DON stated R24's Left Plantar Heel open wound is categorized as a Diabetic Ulcer and started in July as a small 4.0 cm area on her Left Heel and has worsened to cover her entire bottom of R24's foot. V2 DON stated R24 has been on antibiotics via a

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S9999	Continued From page 6 Peripherally Inserted Central Catheter (PICC) line for this same wound in the recent past and was just on Amoxicillin 875 mg from 1/3/25-1/13/25 for the same Heel wound. V2 DON stated the staff should be very careful with all resident wounds, but especially with R24's Left Heel open wound to no contaminate it due to this could cause another infection. On 1/17/25 at 2:00 PM V1 Administrator stated the staff failed to monitor R24's Left Heel wound by not providing incontinence care timely to not allow R24's urine to contaminate R24's Left Heel open wound. V1 Administrator stated R24 can be non-compliant, but it is the responsibility of the staff to make sure R24's dressing is kept clean and dry. V1 Administrator stated the facility does not have any documentation that shows the staff were monitoring R24's wound, documenting treatments were completed as per the Physician order or implementing care plan interventions to reduce the risk of R24's wound worsening. The facility policy titled Wound Care revised 11/9/2018 documents staff are to apply gloves, remove dressing to be changed and discard, then remove gloves and discard. Perform hand hygiene, apply new gloves and clean wound bed per order. The facility policy titled Skin Prevention, Assessment and Treatment revised 5/2/2022 documents staff are to provide incontinence care after each incontinent episode, keep skin clean and dry. The goal of wound care of to protect the ulcer from contamination. (B)	S9999		