STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145717	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INTEGRITY HC OF COLUMBIA	**253 BRADINGTON DRIVE COLUMBIA, IL 62236**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor, assess, and coordinate wound care with outside providers to treat wounds for 2 of 4 residents (R2 and R7) reviewed for wounds in the sample of 11. Findings include: 1.R2's Face Sheet, dated 10/28/2017, documents R2 has a [DIAGNOSES REDACTED]. R2's Minimum Data Set ((MDS) dated [DATE] documents R2 is cognitively intact. The MDS documents R2 requires extensive assistance with two or more staff with bed mobility, transfers, dressing, and personal hygiene and does not ambulate. The MDS documents R2 has no current pressure ulcers or other skin conditions. R2's Care Plan, undated, documents R2 has Diabetes and staff are to monitor, document and report to physician any signs and symptoms of infection such as redness, pain, heat swelling or pus to any opened areas. R2's Care Plan documents R2 had a wound to her right first toe and any skin issues should be conveyed to the charge nurse for further evaluation and or treatment. The Care Plan documented the Physician would be contacted if needed. The Care Plan also documented R2 was receiving antibiotic for her right great toe. R2's Wound Management Notes, dated 8/31/19 and 10/28/19, 11/25/19, documented V13, Wound Specialist Physician was treating wounds to R2's right toes. R2's Wound Management Note, dated 12/22/19, documented all wounds to R2's right foot had healed and V13 discontinued treatments. R2's medical record has no documenation regarding the facility monitoring of R2's feet for wound and/or infection from 12/22/19 to 1/28/2020. R2' Progress note dated 1/28/2020 at 9:53 AM documents, Resident's son, (V4) here to take resident to podiatry appointment. R2's Podiatrist Progress notes, written by V10, Podiatrist, dated 1/28/2020 documents, There is an ulceration present on the dorsal (back) aspect of the right hallux (big toe) where toenail would be. The ulcer has no signs of infection. The ulcer measures 1.5 cm (centimeter) x (by)1.0cm x 0.1 cm. The Progress Note documented Care Plan: Infection Protocol documents Patient instructed to observe foot for signs of infection, including but not limited to: increased redness and warmth to the area, increased drainage from the area. If patient experiences any of the above, they are to call the office immediately, if someone is not present in the office then proceed to the nearest ER (emergency room). Based on clinical findings, the patient has the following grade ulceration: 1 (superficial ulcer without subcutaneous (under skin) tissue involvement). R2's physician's orders [REDACTED]. Please soak right foot in warm water and Epson salt twice a day for 10-15 minutes. 2. After soak, dry and apply a thin layer of mupirocin (antibiotic) ointment to wound bed and cover with gauze and band-aid. 3. Treatment will be sent to patients' pharmacy and daughter will bring to patient. 4. If patient develops fever, chills, or increased redness on right foot please send to nearest ER or Urgent Care for infection care. 5. Follow-up with (V10) in 1.5 weeks for continued care. R2's Progress note dated 1/30/2020 documents, Administered treatment to right great toe. Soak foot in warm water with Epsom salt for 15 minutes. Pat dry. Apply mupirocin ointment and cover with gauze. Complain of some pain during treatment. Pain scale 3. R2's Facility Progress Notes, from 1/28/2020 to 2/7/2020 do not document staff monitoring any changes to R2's toe. R2's Progress Note, written by V7, Nurse Practitioner, dated 2/4/2020 documents, Routine follow-up on chronic medical conditions. History and Physical: Patient seen today while she was at activities listening to a band. Patient was glad to step away to sit down and speak with me today. States that she has been doing well. Per nursing staff patient has been doing well. It is noted that patient was seeing (V13) for wounds to the left foot previously, but these have been healed and now patient is going to podiatry for a wound to the right foot. Nursing and Patient deny any other concerns or complaints currently. Physical Exam: Extremities: No [MEDICAL CONDITION], Diagnosis: [REDACTED]. R2's Podiatrist Progress Note, dated 2/7/20, written by V10 documents, Chief Complaint: 2nd complaint Patient complains of an issue to the left toe(s), (L-1st toe). Duration of problem 1 week. Patients left great toe has started causing similar issues that patient is having on the right great toe. There is an ulceration present on the dorsal aspect of the right hallux where toenail would be. The ulcer has no signs of infection. The ulcer measures 1.5 x 1.0 x 0.1 cm. R2's PO dated 2/7/20 documents Please soak R (Right) foot in warm water (and) Epsom salts twice a day for 10-15minutes. Soak L (Left) foot as well but in separate container. 2. Apply mupirocin ointment to both great toes. Cover with dry gauze and band-aide. Change daily. 3 will hold on antibiotics for now; however, should staff doctor at nursing home notice increased redness worsening will leave to their discretion on adding oral antibiotics. 4 follow up with (V10) in 2 weeks. R2's Progress Notes, from 2/7/2020 to 2/21/2020 do not document facility staff were monitoring R2's feet. There are no descriptions of R2's wounds during this time period. R2's Podiatrist Progress Note dated 2/21/2020, written by V10 documents, Chief complaints: Patient in for follow-up wound check. (Right-1st digit), (Left-1st digit). Her right great is worse with redness and swelling. Redness is starting to cover foot and swelling is moving up through the ankle to her leg. Her right great toe is draining and did not have a band aid on it. Left great had a band aid on it from yesterday. Patient's son is having (facility) date her bandages. The ulcer measures 1.5cm x 1.5cm x 0.1cm. R2's POS dated 2/21/2020 documents, 1. Please continue soaks for right foot in warm water and Epsom salts daily for 10-15 minutes. Discontinue soaks for left foot. 2. Apply [MED] ointment to right great toe wounds, cover now with 2x2 gauze and roll gauze. Change daily. Do not apply abrasive tape to skin! 3. Rx (Medication) [MEDICATION NAME] (antibiotic) 250 mg (milligrams) take once a day for 7 days. 4. Please have house doctor (V9, R2's Primary Physician) see patient this weekend (2/21-2/23/20) to check on status of right foot. Need to watch [DIAGNOSES REDACTED] (redness) level. If worsens recommend sending to ER (emergency room). Also recommend diuretic for [MEDICAL CONDITION]. 5. Follow up with (V10) in 1 week. R2's Weekly Skin Record dated, 2/22/2020 documents, Treatment in progress to right foot. Left foot healed. No other sign/symptoms of skin breakdown noted, no other open/red areas noted. R2's Progress Note dated 2/22/2020 at 10:29 PM documents, Continues antibiotic for toe infection. No sign or symptoms of adverse reaction noted. No complaint of pain or discomfort noted. This Note contained no description of the toe redness or swelling. There was no documentation R2 was seen by V9 during the weekend of 2/21 through 2/23/20. The Facility provided a list of residents V9 was to see on 2/23/2020 when he was in the facility. R2 was not on this list. R2's Progress Note dated [DATE]20 at 10:25 AM documents, Continues on observation for right great toe infection. Continues to propel self around facility in wheelchair. Wears grip sock on right foot. Denies pain at present time. No distress noted. Will continue to monitor. This Note contained no description of R2's right toe or right leg. The Facility's Wound Log, dated [DATE]20 does not document a wound for R2. On 2/25/2020 at 10:55 AM V8 LPN stated, I called (V9, Primary Care Physician) and he said he did not see (R2) on his rounds this weekend on 2/23, and I should have the Nurse Practitioner (NP) see her today. On 2/25/2020 at 1:07 PM, V7, NP, entered R2's room to evaluate R2's right foot/great toe. R2 was up in her wheelchair with non-skid sock over bandage to right foot. V7 removed and discarded R2's old dressing. R2's right leg was swollen from the calf to the foot. R2 complained of pain when V7 examined/touched the swollen calf of her leg. R2's right great toe had black tissue covering the tip to the middle of the toe. Redness was covering the entire toes to the middle of her entire foot. V7 left R2's right foot open to air and went to get a nurse to put a new dressing on it. V7 stated to R2, Your leg is swollen. The podiatrists (V10's) plan

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) is not working. My plan is, I am going to call and consult with the podiatrist, and she may suggest sending her to the emergency room (ER). V7's Progress Note assessment dated [DATE] documents, (R2's) Right Foot. Patient seen today while in her room for concerns of right great toe. Patient seen by podiatry on 2/21/20 and was started on [MEDICATION NAME] for what I am assuming is a suspected [MEDICAL CONDITION] with a decrease in the Epsom salts foot soaks from twice daily to once daily and plans for [MEDICATION NAME] ointment with a 2x2 and Kling wrap daily after the Epsom salts soaks. Patient states the area is somewhat painful but otherwise denies any concerns of complaints at the time. When I spoke with nursing, they are unable to give a definitive answer if the [DIAGNOSES REDACTED] has worsened. Patient has an appointment with podiatry at 2:10 (PM) this afternoon. The Note documented R2 has swelling to her right lower extremity redness going from all 5 toes to midfoot with warmth noted. The Note documented The nail area of the right great toe noted to be necrotic no drainage. The Assessment documented Plan. For the last 4-6 weeks we have been following recommendations of podiatry on treatment of [REDACTED]. On evaluation of her toe today right great toenail area noted to be necrotic. Currently she is several days into [MEDICATION NAME] dosing for what I am assuming she is being treated for [REDACTED]. The Note documented V7 made a call to V10 office to discuss R2's care. The Note documented I do feel would be appropriate that is she would be returning to our facility to obtain stat labs and arterial doppler of the right leg, as well as x-rays of the right foot with intentions to rule out osteo[DIAGNOSES REDACTED], elevated white blood cell count,[MEDICAL CONDITIONS]. Patient is at increased risk due to her diabetes and overall advancing age. I will wait for the podiatrist to return my phone call to further discuss management. V10's Podiatrist Progress Note dated 2/25/2020 documents, Patient's son does not think the house doctor saw her at all despite the order that was written. There is an ulceration present on the dorsal aspect of the right hallux where toenail would be and has now spread around the toe laterally and to the plantar surface from what appears to be from the band-aid pulling at her skin. The ulcer has surrounding [DIAGNOSES REDACTED]. The ulcer measures 3.5 cm x 1.5 cm x 0.1cm. The Note documented Patient is being sent to the ER-will re-evaluate when she has been discharged from the hospital. Based on clinical findings, the patient has the following grade ulceration: 2 (Penetration through subcutaneous tissue (may expose bone, tendon, ligament or joint capsule). On 2/26/2020 at 8:40 AM, V8, LPN, stated, (R2) did come back from podiatry appointment, and per her family she was sent to the hospital. On 2/26/2020 at 9:20 AM V10 Podiatrist stated, Yes (R2) was seen in my office yesterday for a follow-up for her right foot. (R2's) condition has worsened, she was lethargic which is unusual for her. I recommended sending her to the emergency room (ER) due to her lethargy, and the toe was more ischemic (black tissue), [DIAGNOSES REDACTED] (redness) was still present. Yes, I think if she were seen by the physician over the weekend it could have been caught sooner. R2's Hospital Emergency Department (ED) Records dated, 2/25/2020 at 4:44 PM, documents, [DIAGNOSES REDACTED]. R2's Hospital Vascular Consultation dated 2/26/20 at 4:09 PM documents, [AGE] year-old non-ambulatory nursing home patient with dry gangrene of the right great toe-as there is no evidence of infection, no amputation is required at present. The patient is not a candidate for any type of revascularization procedure given her multiple comorbidities and non-ambulatory status. Amputation would only be necessary in the future to control infection or pain. On 2/26/2020 at 9:30 AM V3 Regional Director of Nursing (DON) stated, I would have expected the nurse to place (R2) on the list to see (V9), or to call (V9) about the podiatrist order. On 2/28/2020 at 11:54 AM, V6, LPN, stated, I saw (R2's) foot on 2/25 with you before her podiatrist visit, and I think the last time I did it was Thursday (2/20). I think the toe looked like it had scab and slough. I think it was red with maybe some [MEDICAL CONDITION]. I don't think it looked much different from what it looked like on Tuesday when I saw it with you. On 2/28/2020 at 12:12 PM, V9 (R2's Primary Provider) stated, Yes, I am aware of (R2)'s right foot. I spoke with (V7). I would have expected a specialist to call me to discuss if there were significant concerns, not to leave it up to the nurses to decide whether she should go to the hospital or not. I do think the nurse who took the order should have put (R2) on the list to see me. Somehow the line of communication broke down. I make my rounds, and my priority is seeing any new admissions, readmissions, and any acute problems. The Nurse Practitioner generates the list, and I ask the staff while I am there if anyone else should be seen. Sometimes even families will ask me to see people while I'm there. I did not get any progress notes from the podiatrist (V10), because I did not make the referral. In my opinion, obviously the patient worsened and went to the ER. I haven't reviewed the notes yet but based on my consult with the Nurse Practitioner, the progression may be due to arterial insufficiency, so I don't feel the few days she was not seen would have made a difference in the outcome. 2. R7's Minimum Data Set ((MDS) dated [DATE] documents R7 is cognitively intact. R7's undated Care Plan does not document a care plan for alteration in skin integrity or a Care plan concerning R7's left great toe. V7's, Nurse Practitioner, Note dated 0[DATE] documents Right (sic Left) great toenail noted to lift with mild [DIAGNOSES REDACTED] to the lateral nail without drainage. Less than the 3 second capillary refill to the great right toe. 2 plus pedal pulses. Start [MED] (an antibiotic) as prescribed for Onychosis (disease or deformity of the nail). Keep bandage over the nail until seen by podiatry as to not damage the nail. Nursing also states concerns for bleeding to the right great toe. (R7) denies any injury but noted that the nail does seem to lift some with concerns for redness to the toe. R7's PO dated 0[DATE] documents referral to podiatry for R7's left great toe, and [MED] 500 milligrams (mg) one tablet three times daily for 10 days. The PO documented Keep (R7's) left great toe covered. R7's Treatment Administration Record, TAR, dated February 2020 documents cover left great toe with a dry dressing daily. R7's Nurses Note dated 0[DATE] documents R7's left great toe was infected and to start [MED] 500 mg one tablet by mouth three times per day for 10 days. The Note documented to keep R7's left great toe covered. Also, referral to see the Podiatrist. R7's Nurses Note dated 02/19/2020 By mouth antibiotic related to her right (sic) great toe. (R7's) Band-Aid was change with a scant amount of serosanguinous drainage. R7's Nursing Progress note dated 02/20/2020 documents Skin warm and dry, skin color within normal limits. R7's left great toe was not mentioned in the note for this day. R7's Nursing Progress note dated 02/21/2020 documents skin warm and dry skin color within normal limits. R7's left great toe was not mentioned in this daily note. R7's Nursing Progress Note dated 02/22/2020 documents skin warm dry and skin color within normal limits. R7's great left toe was not mentioned in this daily note. The facility untitled Wound Form dated from 09/23/19 to [DATE]20 documents R7 had a skin tear to her left calf, but the form did not document her wound to her left great toe. R7's Nursing Progress Noted dated 02/25 through 02/28/2020 does not document an assessment of R7's left great toe. On 02/28/2020 at 9:35 AM R7 was yelling out My foot hurts, My toe hurts! On 02/28/2020 at 9:35 AM V23 Certified Nurse's Aide, removed both of R7's shoes and the sock on her left foot. R7's left great toe had a Band-Aid on it. The top portion of the Band-Aid was covered with a dried brown drainage. The Band-Aid was not dated. On 02/28/2020 at 10:35 AM V15, LPN entered R7's room and told her she was going to look at her toe. V15 removed the Band-Aid from R7's left great toe. V15 cleansed the toe with wound cleaner, and stated, It has an odor. I will call the doctor and let him know about the toe having a smell. R7's foot was dark in the corner of the nail. The nail was split at the top, and red around the area that was split. V15 placed a dry dressing on R7's left great toe. On 02/28/2020 at 1:26 PM V24 Social Service Designee stated, I don't see an appointment for her (for Podiatry). I make any kind of appointments I'm asked to make. If the doctor writes an order. I am handed a piece of paper, but I don't always see the orders.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to provide pressure relief to prevent the worsening of pressure ulcers for one of three residents (R5) reviewed for pressure ulcers in the sample of 11. Finding Include: R5's Minimum Data Set ((MDS) dated [DATE] documents R5 is severely cognitive impaired. R5's MDS documents she requires extensive assist of two staff persons for bed mobility. R5's Alteration in Skin Integrity/Pressure Ulcers Care Plan dated 07/30/19 documents R5 is at risk for alteration in skin integrity/pressure ulcers related to impaired cognition, incontinence of bowel and bladder, impaired mobility, impaired nutritional status and diabetes. R5's Care Plan goal is R5 will not develop any skin integrity issues through the next review period. R5's Care Plan interventions are 1. Staff will make sure the residents has shoes on, and her feet are not resting out in front of the chair. 2. staff will ensure R5's wheelchair is tilted back in the dining room until the food arrives. R5's Alteration in Skin Integrity/Pressure Ulcer Care Plan does not document the current pressure ulcer she has to her left heel. R5's Braden scale dated 2/3/2020 documents R5 score is a 11, which represents a high risk for pressure ulcers. R5's Physician order [REDACTED]. The POS also documents [REDACTED]. R5's Wound Physician Initial Wound Evaluation and Management Summary dated 01/13/2020 documents R5's Unstageable Deep Tissue Injury (DTI) to the left lateral heel which measures 1 centimeters (cm) by 1 cm. The Summary documents staff are to apply skin prep twice daily for 30 days to R5's DTI. The summary documents a pillow should be used

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) for pressure relief. R5's Wound Physician Wound Evaluation Management Summary dated 01/19/2020 documents R5's Unstageable DTI of the left lateral heel measures 1cm by 1cm. R5's Wound Physician Wound Evaluation and Management Summary dated 01/27/2020 documents R5's Unstageable DTI measures 1 cm by 1cm. R5's treatment remains the same. R5's Wound Physician Wound Evaluation and Management Summary dated 02/03/2020 documents R5's Unstageable DTI measures 1 cm by 3 cm. The Summary documented the treatment of [REDACTED]. R5's Wound Physician Wound Evaluation and Management Summary dated 02/10/2020 documents R5's Unstageable DTI measures 2 cm by 3 cm. The Summary documents staff are to apply [MEDICATION NAME] twice daily to R5's heels and to continue to float heels in bed and elevate legs. R5's Wound Physician Evaluation and Management Summary dated 2/16/2020 documents R5's unstageable DTI measures 2 cm by 3 cm. R5's treatment remain the same as listed above. R5's Wound Management Wound Evaluation and Management Summary dated 0[DATE]20 documents R5's unstageable DTI measures 1.5 cm by 3 cm. R5's treatment remains the same. On 02/28/2020 from 9:00 AM to 10:30 AM based on 15-minute observation intervals, R5 was sitting in her geriatric chair leaning to left side of her chair. R5's legs were not elevated, and they were hanging down. R5 was wearing pressure relieving boots, but her feet and heels were sitting directly on the floor. On 02/28/2020 at 10:35 AM R5 was placed in bed, and incontinent care was performed. R5 was covered over with her blanket, and her heels were not floated on a pillow and her legs were not elevated. On 02/28/2020 at 1:45 PM R5 was sitting up in her high back wheelchair without foot pedals, and her feet were hanging down. R5 had pressure relieving boots on both feet. V15 Licensed Practical Nurse (LPN) donned gloves and removed the left heel boot and sock. R5 performed R5's treatment. There is a black area to the heel approximately the size of a quarter with dried edges intact. [MEDICATION NAME] was applied to her left heel. R5's right pressure relieving boot and sock was removed and there were no open areas on her foot, but redness was noted. V15 stated I've been here for three months, and (R5) has had this since I've been here, and it looks the same. On 03/03/2020 at 11:00 AM when asked how staff are providing pressure relief to R5 while in bed, V3, Regional Clinical Director stated, She is wearing pressure relieving boots. The Facility Policy Decubitus Care/Pressure Area dated January 2014 documents To ensure proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer identified. The pressure area will be assessed and documented. Reevaluate the treatment for [REDACTED].
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide complete incontinent care for two of three residents (R5, R6) reviewed for incontinent care in the sample of 11. Findings Include: 1. R6's Minimum Data Set ((MDS) dated [DATE] documents R6 is moderately cognitively impaired. R6's MDS also documents R6 is frequently incontinent of bowel and bladder. On 02/28/2020 at 9:05 AM V16 and V23, Certified Nursing Assistants (CNAs) entered the room and told R6 they were going to put her into her bed to get her cleaned up. V16 and V23 transferred R6 into bed. R6 had been incontinent of urine. V16 went into the bathroom and wet several washcloths and put no rinse peri wash on them. V16 then placed the wet washcloths on the bed. V23 took a washcloth and wiped the middle of R6's vaginal area, and each side. V23 did not wipe R6's buttocks or inner thighs. 2. R5's MDS dated [DATE] documents R5 is severely cognitively impaired. R5's MDS also documents R5 is always incontinent of bowel and bladder. On 02/28/2020 at 10:48 AM V11 and V23, CNAs, entered R5's room and informed her they were going to put her to bed. V11 and V23 assisted R5 to bed. R5 was wearing two incontinent briefs. V23 removed the soiled incontinent briefs from R5. R5's inner incontinent brief was wet with urine with a brown streak. V23 wet several washcloths with no rinse peri wash. V23 only wiped the middle and one side of her vagina. V23 didn't wipe her inner thighs or buttocks or the other side of her vagina. 02/28/2020 at 10:48 AM, V23 stated I'm the only on the hall, and I'm trying to get my hourly checks done, I was rushing. The facility policy Perineal Care dated 04/2015 documents The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritations, and to observe the residents skin condition.