STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145438	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** Based on interview and record review, the facility failed to notify the physician and family representative of a skin injury/wound for 1 of 5 residents (R3) reviewed for wound care in the sample of 5. Finding includes: R3's Nurse's Notes dated 6/8/2020 at 6:00 AM, documents, Resident obtained a skin tear to right lower extremity (RLE) upon giving care. Patient became combative and started kicking and scraped RLE on bedside table. R3's Nurse's Notes dated 6/8/2020 at 2:00 PM, documents, No signs and symptoms (s/sx) of infection on Rt (right) skin tear. There was no documentation including size and monitoring of R3's right leg skin tear on R3's Weekly Wound Log dated 6/15/2020. There was no documentation on R3's June 2020 Treatment Administration Record regarding R3's skin tear. There were no treatment orders for R3's right lower extremity skin tear. There was no documentation in R3's Nurse's Notes V9, R3's Wound Physician, was notified of the wound to R3's right lower extremity. R3's Nurse's Note written by V12, Former Assistant Director of Nursing (ADON) dated 6/17/2020 at 3:50 PM, documents, This nurse notified by floor nurse that she saw maggots under dressing on patient's right leg. After assessing wound this nurse notified (V11, Former Director of Nursing, DON) and (V21, Former Administrator). (V9, Wound Doctor) notified of wound and gave new order for Santyl, Calcium Alginate and dry dressing. On 6/30/2020 at 3:36 PM, V12 stated that on 6/17/2020 during the evening shift she was told to check on R3 because staff found maggots on a dressing covering a wound to R3's right lateral leg. The dressing to R3's wound was dated 6/10/20. V12 stated she had not been aware of any wounds on R3's right leg. V12 stated she went on wound rounds with V9 on 6/15/2020, two days prior, and they did not see any wounds on R3's right leg. V12 stated they were all trying to figure out who applied the dressing to R3's right leg wound, but they couldn't read the signature and it didn't seem to match with any name in the agency list they use. V12 stated the wound under R3's dressing was the size of a quarter and there were maggots on the wound. On 6/30/2020 at 2:10 PM, V11, Former Director of Nursing (DON), stated during a phone interview that on 6/17/2020, she saw very tiny maggots crawling out of R3's right lateral leg dressing. V11 stated she also noted maggots on the bed and on R3's heel wound. V11 stated it was V16, Licensed Practical Nurse (LPN), who reported to her, V12 and V21 (Former Administrator) about the maggots on R3's wound dressing. V11 stated it was unacceptable that there was a 7-day old dressing with maggots, and they could not find any documentation about it in R3's record. V11 stated they found a nurse's note dated 6/8/2020 about a skin tear on R3's right leg but they could not identify the signature of the nurse who documented it. V11 stated the nurse who initially noted it should have notified her, the physician and the family. On 6/30/2020 at 2:46 PM, V9, Wound Doctor, stated during a phone interview he was not aware R3 had an opened area on her right lateral leg. V9 stated he was notified of maggots found in R3's left heel wound and right lateral wound on 6/17/2020. On 7/1/2020 at 9:58 AM, V19, Nurse Practitioner, stated during a phone interview she was notified of maggots in R3's wounds on the right lateral leg on 6/17/2020 while she was en route to the facility to do swabbing and when she saw R3 her wounds were already cleaned and rewrapped. V19 stated she unwrapped the wound to the right leg and it was red but cool to touch. V19 stated she found a few tiny maggots on R3's right lateral leg outside the wound and maggots were present in the left heel wound and were trying to come out of the wound when she was pressing on the wound. V19 stated that was the first time she knew about the wound to the right leg. On 7/1/2020 at 4:20 PM, V7, R3's Power of Attorney for Healthcare/Son stated he was not aware that R3 had a wound on her right lateral leg and that maggots were found in it. On 7/2/2020 at 12:58 PM, V3, Care Plan Nurse, stated they can't identify who wrote the nurses note on the skin tear on 6/8/2020. V3 stated there should have been physician and family notification done when the skin injury to the right leg was first noted. The Facility's Notification for Change in Resident Condition or Status Policy dated 12/17/17 documents, The facility and/or facility staff shall promptly notify appropriate individuals (Administrator, Director of Nursing, Physician, Guardian, HCPOA, etc.) of changes in the resident's medical/mental condition and/or status. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there is an accident or incident involving the resident; a significant change in the resident's physical/emotional/mental condition; a need to alter the resident's medical treatment significantly; a need to transfer the resident to the hospital/treatment center.
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 provide wound treatments as ordered to 3 of 4 residents (R2, R3, R4) reviewed for wound care in the sample of 5. Findings include: 1. R3's June physician's orders [REDACTED]. R3's April 2020 Treatment Administration Record (TAR) documents new treatments dated 4/20/20 as follows: [MEDICATION NAME] to right calf once daily; [MEDICATION NAME] to left calf once daily; apply [MEDICATION NAME], crush [MEDICATION NAME] 500 mg (milligrams) apply to L (left) lateral toe, calcium alginate, wrap with kerlix. These treatments were initialed as only given on 4/20, 4/22, 4/26, 4/27 and 4/28/2020, 5 of 11 days. R3's May 2020 TAR documents R3's physician order [REDACTED]. R3's TAR documented she received this treatment only on 5/13, 5/14, 5/16, 5/19, 5/27 and 5/28. R3's Nurse's Notes dated 6/8/2020 at 6:00 AM, documents, Resident obtained a skin tear to right lower extremity (RLE) upon giving care patient became combative and started kicking and scraped RLE on bedside table. R3's Nurse's Notes dated 6/8/2020 at 2:00 PM, documents, No signs and symptoms (s/sx) of infect on Rt (Right) skin tear. R3's Weekly Wound Management Consultant Note dated 6/15/2020 documents 8 wound sites to R3's left lower extremity including description of wounds and all treatments to be done daily. There was no documentation R3 had a wound to her right lower extremity. There was no documentation including size and monitoring of R3's right leg skin tear on R3's Weekly Wound Log dated 6/15/2020. There was no documentation on R3's June 2020 Treatment Administration Record regarding R3's skin tear. There were no treatment orders for R3's right lower extremity skin tear. R3's Nurse's Note written by V12, Previous Assistant Director of Nursing (ADON) dated 6/18/2020 at 3:50 PM, documents, This nurse notified by floor nurse (V16, Licensed Practical Nurse/LPN) that she saw maggots under dressing on patient's right leg. After assessing wound this nurse notified (V11, Previous Director of Nursing, DON), and (V21, Previous Administrator). (V9, Wound Doctor) notified of wound and gave new order for Santyl, Calcium Alginate and dry dressing. R3's Nurse's Notes by V11 dated 6/18/2020 at 4:15 PM documents, This nurse was notified by (V12) that (V16, LPN) reported to her that she observed maggots in patient's wound. Upon assessment it was noted that the patient had maggots in her right leg wound. Got a call from (V19, Nurse Practitioner, NP) that patient's white blood cell count was elevated. Informed her at that time of my findings. (V19) came to evaluate patient and new order received to send patient out to ER for further evaluation. On 6/30/2020 at 8:22 AM, V15, Certified Nursing Aide

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) (CNA), stated she worked evenings and was assigned to R3's hall. V15 stated the last few times she worked she was assigned to R3 and on 6/15/2020 she noticed the dressing on R3's left foot was wet and smelly, and she reported it to the nurse. V15 stated she did not see any maggots in R3's bed or dressing or body and she was not sure if the nurse changed R3's wet dressing. On 6/30/2020 at 1:52 PM, V13, CNA, stated that she was assigned to R3's hall on 6/16/2020 during the evening (2 PM - 10 PM) and night (10 PM - 6 AM) shifts. V13 stated she noted R3's left foot dressing was wet, and she reported it to the nurse on the hall and she can't remember who it was then. V13 stated she was not sure if the dressing was changed that night. On 6/30/2020 at 1:58 PM, V14, CNA, stated that she took care of R3 on 6/17/2020, the day R3 was transferred to the hospital. V14 stated she went to check R3 at the start of the shift. V14 stated R3 was in bed and she noted R3's dressing on the left foot was dated 6/15/2020. V14 stated she heard a couple of hours later that the nurses found maggots on R3's wounds but she did not see them herself. On 6/30/2020 at 3:36 PM, V12, Former Assistant Director of Nursing, (ADON), stated that on 6/17/2020 evening shift she was told to check on R3 because maggots were found on her wound on the right lateral leg covered by a dressing dated 6/10/2020. V12 stated she was not aware of any wounds on R3's right leg. V12 stated she went on wound rounds with V9 (Wound MD) on 6/15/2020 and they did not look at any wounds on R3's right leg. V12 stated they were all trying to figure out who applied the old dressing. V12 stated the wound was the size of a quarter and there were maggots on the wound. On 6/30/2020 at 2:10 PM, V11, Former Director of Nursing (DON), stated during a phone interview that on 6/17/2020, she saw very tiny maggots crawling out of R3's right lateral leg dressing. V11 stated she also noted maggots on the bed and on R3's heel wound. V11 stated it was V16 who reported to her, V12 and V21 (Former Administrator) about the maggots on R3's wound dressing. V11 stated it was unacceptable that there was a 7-day old dressing with maggots and they could not find any documentation about it in R3's record. V11 stated they found a nurse's note dated 6/8/2020 about a skin tear on R3's right leg but they could not identify the signature of the nurse who documented it. On 6/30/2020 at 4:26 PM, V16, LPN, stated she was the nurse who first noted maggots on R3. V16 stated she was trying to insert a urinary straight catheter on R3 for urinalysis and saw a lot of maggots coming out of the wound on R3's right lateral leg. V16 stated she can't remember the date on the dressing, it was intact, but it was days old. V16 stated she called V11, V12 and V21 into the room before she changed the dressing and cleaned R3. V16 stated she cleansed the wound, applied Dakin's solution and covered it with dry dressing while waiting for orders. V16 stated she also changed the dressing on the left heel and foot and did not see any maggots there. On 6/30/2020 at 2:46 PM, V9, Wound Doctor, stated he was not aware R3 had an open area on her right lateral leg. V9 stated R3 had very poor chronic serious arterial circulation problem of the left lower extremity and with an amputated left first toe done months ago, the blood supply to the other toes were compromised and further aggravated the preexisting circulation problem. V9 stated he was notified of maggots found in R3's left heel wound and right lateral wound on 6/17/2020. V9 stated the presence of the maggots in the wounds did not cause any harm or caused infection to the wounds but obviously indicate untimely wound dressing change. V9 stated timely wound care is very important and expected from the nurses. On 7/1/2020 at 9:58 AM, V19, Nurse Practitioner, stated the facility notified her of maggots in R3's wounds on 6/17/2020 while she was en route to the facility to do swabbing and when she saw R3 her wounds were already cleaned and rewrapped. V19 stated she unwrapped the wound to the right leg and it was red but cool to touch. V19 stated she found a few tiny maggots on R3's right lateral leg outside the wound and maggots were present in the left heel wound and were trying to come out of the wound when she was pressing on the wound. V19 stated that was the first time she knew about the wound to the right leg. V19 stated she ordered for R3 to be transferred to the ER for evaluation of the redness of the right leg and elevated white blood count. On 7/1/2020 at 1:18 PM, V8, R3's Vascular Surgeon, stated he performed R3's left great toe amputation early on 1/2020. V8 stated the maggots possibly migrated from any of the wounds in the foot, flies are attracted by dead tissue found on R3's wounds, they lay eggs that become maggots in 24 hours. V8 stated that when a fly laid eggs on R3's dressing, if timely and adequate wound dressing change was done there would have been no maggots found in R3's wounds at all. 2. R4's TAR dated an order which was started on 6/22/2020 which documented, Apply [MEDICATION NAME] to right stump 4 times a day (QID). The TAR documents the [MEDICATION NAME] treatments were done only once a day on 6/22, 6/25, 6/26, 6/27, 6/28 and 6/29/20. R4's Physician order [REDACTED]. There is no order for [MEDICATION NAME] to be applied to the stump 4 times a day. The Weekly Wound Management Consultant Notes dated 6/22/2020 documents, [MEDICATION NAME] to rt leg stump 4 times a day but it was not transcribed in the POS. On 6/25/2020 at 2:21 PM, V6, Licensed Practical Nurse (LPN), provided wound care to R4's buttock and right leg stump. The stump was dry with an open area measuring 1 centimeter (cm) x 0.5 cm x 0.5 cm. V6 took gauze wet with [MEDICATION NAME] and applied it to the stump. On 6/25/2020 at 2:30 PM, R4 stated he used to have dressing on his stump, but it was never done daily and now he gets the dark liquid applied to it and they hardly ever do it daily. R4 can answer questions appropriately. The Facility Policy on Wound Dressing Change dated 07/2007, documents, 17. Cleanse wound per physician's orders [REDACTED]. 18. Apply topical medication or irrigate per physician's orders [REDACTED]. 19. Apply dressing without touching wound or side of dressing. 20. Secure dressing according to type of dressing or physician's orders [REDACTED]. The Policy documents Procedure: 3. Any skin abnormality/lesion/wound will have a specific treatment order until area is resolved. PRN orders should not be obtained. 4. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. 3. R2's Physician order [REDACTED]. physician's orders [REDACTED]. R2's June 2020 Treatment Administration Record (TAR) has no documentation that R2's [MEDICATION NAME] cream, collagen, calcium alginate, island dressing treatment was completed on 6/19, 6/22, 6/23, 6/24, and 6/25. The TAR also has no documentation that R2's [MEDICATION NAME] to right foot three times a day treatment was completed on the 6AM-2PM shift on 6/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/22, 6/23, 6/24, 6/25, the 2PM-10 PM shift on 6/15, 6/16, 6/17 and the 10PM-6AM shift on 6/15, 6/16, 6/23, 6/24. The TAR also has no documentation that R2's treatment of [REDACTED]. There was no documentation on the back of the TAR or in the progress notes as to why R2 did not receive the treatment. On 6/25/2020 at 1:50PM R2 stated, No I don't get my treatment. They don't do nothing. There is a whole in my chest. Yesterday it was draining. Its only one nurse that does my treatment. She is not here every day. It (chest wound) hurts. It's already been infected. I guess they're waiting for it to get infected again. I'm tired of it. I have already been sick. I don't want to die. They (staff) told me to start complaining about it. So, I am. The midnight nurse changed my dressing on the 23rd on the night shift. It was never done yesterday, and it hasn't been done today either. On 6/25/2020 at 2:05 PM when asked if R2 treatments were done V4, MDS Coordinator, stated, I can't tell you if it was done. If you didn't document it, you didn't do it. On 6/25/2020 at 2:15 PM V6, LPN, stated, (R2) has complained about nurses not doing the dressings. I can't say for sure that the treatment was done. I can tell you that I do my treatments and if he tells me that he needs it (treatment) done I will do it. I document when I complete. If it's not documented, it's not done.
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, interview and record review, the facility failed to provide physician prescribed treatment for [REDACTED]. Findings include: R1's Care Plan, dated 4/30/2020, documents high risk for pressure ulcer. Risk factors include immobility, compromised nutritional status, and incontinence. R1's Minimum Data Set (MDS), dated [DATE], documents R1 is frequently incontinent of bowel and bladder and require staff's physical assistance for bed mobility and toilet use. R1's Physician order [REDACTED]. The POS did not document how often the treatment is to be done. R1's Medication Administration Record (MAR), dated 6/1-6/30/2020, has no documentation that R1 received the treatment to her left posterior thigh of [MEDICATION NAME] cream, collagen, and calcium alginate on 6-2 shift on 6/17, 6/19, 6/23, 6/24, and 6/26. The MAR also does not document the reason why R1 did not receive the treatment or any previous treatment orders. R1's Wound Evaluation and Management Summary, dated 6/8/2020, documents a treatment to R1's left posterior thigh of alginate calcium apply once a day for 30 days, collagen sheet apply once daily for 30 days, dry protective dressing daily for 30 days, and silver [MEDICATION NAME] apply once daily for 30 days. On 6/25/2020 at 1:10 PM V12, Certified Nursing Assistant (CNA), assisted R1 onto her side. The dressing to R1's pressure ulcer on her left posterior thigh was crumbled with the pressure ulcer uncovered. The wound bed of the pressure ulcer was dark red in color with dried dark brown drainage around the wound bed. A moderate amount of dark red and brown, foul smelling drainage on the bed pad and sheet beneath. On 6/25/2020 at 1:05 PM V4, MDS Coordinator, stated, The treatment sheet should be in the treatment book. (R1) was recently moved to this room and it (treatment sheet) may still be in that book. If it's not there, I don't know where the treatment sheet is. On 6/25/2020 at 1:15 PM R1 stated, I got it (pressure ulcer) from one of the girls pulling the pad from under me too hard. They (nurses) don't do the dressing every day. They said it's getting better and doesn't have to be done every day. Once or twice a week.

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) On 6/25/2020 at 1:30 PM V6, LPN, I don't usually work down here. I work on the other hall. They told me to do the treatment, so I am. There isn't a treatment sheet so I grabbed this sheet (Wound Evaluation and Management Summary, dated 6/8/2020) and will do the treatment from it. The residents have complained about the Agency nurses not doing the treatments. The DON (Director of Nursing) was made aware. On 7/1/2020 at 10:05 AM V3, Care Plan Coordinator, stated, She (R1) has been in this room for at least a week. The nurses are to look at the MAR and TAR every day. If it's (MAR/TAR) not there it is a possibility that the treatment would not be completed. The Facility Policy on Wound Dressing Change dated 07/2007, documents, in part, 17. Cleanse wound per physician's orders [REDACTED]. 18. Apply topical medication or irrigate per physician's orders [REDACTED]. 19. Apply dressing without touching wound or side of dressing. 20. Secure dressing according to type of dressing or physician's orders [REDACTED]. 2. R4's Weekly Wound Management Consultant Notes dated 6/22/2020 documents, Shear Wound of the Right Buttock. 0.5 cm (centimeter) x (by) 1.0 cm x not measurable depth, moderate serous exudate. Dressing: Alginate calcium, collagen powder, [MEDICATION NAME], and cover with dry protective dressing daily. On 6/25/2020 at 2:10 PM, V5 and V10, CNAs, provided incontinent care and catheter care to R4 in bed. R4 had an open area to his buttock with no dressing. V5 stated she informed V4, MDS Coordinator, about it. On 6/25/2020 at 2:21 PM, V6, Licensed Practical Nurse (LPN) provided wound care to R4's right buttock. A pressure ulcer measuring 1.0 cm x 1.0 cm x undetermined depth with reddened peri wound was noted with no dressing. V6 cleansed the area with wound cleanser. V6 opened an island dressing and layered collagen sheet, calcium alginate and a quarter size amount of [MEDICATION NAME] cream on top and applied the new dressing to the wound. On 6/25/2020 at 2:45 PM, V6 stated the staff are expected to let the nurse know immediately when they notice wound dressings are soiled or missing or loose or whenever there is a new open area. 3. R5's Weekly Wound Management Consultant Notes dated 6/22/2020 documents, Shear Wound of the Right Buttock.0.75 cm x 1.5 cm x not measurable depth, moderate serous exudate. 100% granulation tissue. Dressing: Alginate calcium, collagen powder, [MEDICATION NAME], and cover with dry protective dressing daily. On 6/25/2020 at 1:05 PM, V5 and V10, both CNAs, provided perineal care to R5. R5 had 2 open areas on her right buttock and there was no dressing on both. V5 stated R5 had a shower at 9 AM and the dressing must have fallen off. V5 stated she was to notify the nurse right away if a dressing is missing or soiled. On 6/25//2020 at 2:01 PM, V6, LPN, provided pressure ulcer dressing change to R5. V6 unfastened R5's brief and cleansed R5's right buttock with wound cleanser. Two open areas without dressing approximately 3 cm apart were noted on the right buttock, a smaller one measuring 1.0 cm x 1.5 cm and a larger one measuring 2 cm x 1.5 cm x undetermined reddened skin around the wound. V6 unwrapped an island dressing and layered a piece of collagen sheet, calcium alginate and a squirt of [MEDICATION NAME] cream on top. and applied the dressing to the 2 wounds. R5's June 2020 TAR failed to document there were 2 separate pressure areas on R5's right buttock.