STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145646	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKESIDE REHAB & HEALTHCARE	900 CENTENNIAL DRIVE EAST PEORIA, IL 61611

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 -** 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 interview and record review, the facility failed to ensure that treatments and assessments were completed for necrotic wounds for one resident (R2) of five residents reviewed for wounds in a sample of 12. This failure resulted in R2 being hospitalized for [REDACTED]. Findings include: The facility's Wound Care policy, revised 11-1-2018, documents Standard: It will be the standard of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of [REDACTED]. Skin will be assessed/evaluated for the presence of developing pressure injuries or other changes in skin condition on a weekly basis at least once each week or as needed by a licensed nurse. 3. Nurses are to be notified to inspect skin if newly developed skin changes are identified. 6. Wound care procedures and treatments should be performed according to physician orders. 10. Document in the clinical record when treatments are performed. 11 Document the progression of the wound being treated. Such observations should include items size, staging (if applicable), odors, exudate, tunneling, etiology, etc 12. Contact the physician for additional order changes as is appropriate or to notify of skin condition changes or refusals of care. R2's clinical record documents R2 was originally admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's unsigned assessment dated [DATE], documents that R2's body has sores noted to right hand, three fingers, scab noted to left hand ring finger, and questionable marking of left thumb with no explanation written as to type. R2's Skilled Nursing Admission History & Physical, dated 2-24-2020 and signed by V19 (R2's Medical Doctor/MD/nursing home physician), documents (R2) is hoping to salvage some of (R2's) fingers that has necrosis present. (R2) is questioning the treatment. The Physical Exam documents Left hand: left 4th digit with necrosis, digit 2, 3 partially amputated. The Assessment/Plan documents to admit to the facility and includes 3) wound care physician to see him for further management and care of his fingers and 11) weekly f/u (follow up) while SNF (Skilled Nursing Facility) status. R2's Physician order [REDACTED]. R2's Treatment Administration Record/TAR, dated 2-20-2020, documents R2's [MEDICATION NAME] treatment was not completed in February 2020 on the 20th, 21st, 22nd, 27th, 28th, or 29th. There is no documentation in R2's clinical record that indicates [MEDICATION NAME] was being applied to R2's necrotic fingers in March or April 2020. R2's February, March and April 2020 Physician order [REDACTED]. On 8-28-2020, at 11:36am, V4 Wound Nurse states that V3 received a referral on 1-30-2020 to see R2 by a facility facsimile. V4 also stated that V3's Wound Specialist visits should have continued without needing another referral post hospital re-admission if the issue was still present. On 8-26-2020, at 11:15am, V2 Director of Nursing/DON stated I would expect for any treatment orders for a necrotic wound to be carried out as ordered, but I wasn't here then. Typically for non-pressure wounds we would do weekly skin assessments with documentation. R2's shower sheets/skin audits are as follows: 2-26-2020 R2 refused shower and no body inspection done; 3-1-2020 R2 refused shower and no body inspection done; 3-4-2020 documents pressure to R2's bottom; 3-18-2020 documents R2's bottom is reddened with pressure; 3-22-2020 bruises noted to feet; and 4-1-2020 documents gangrene to fingers of bilateral hands and no new issues. R2's progress note dated 3/01/2020 documents that R2's family member stated that since the facility can't coordinate V32 (facility APN/Advanced Nurse Practitioner) or V19 (R2's MD/nursing home physician) to see R2 at the facility, R2's family member would like the facility to make an appointment with V20 (R2's PCP/Primary Care Physician). R2's physician office visit notes, dated 3-2-2020 and signed by V20 documents R2 was seen by V20 in V20's office for shortness of breath. V20 documented that R2 and R2's family member were unsure of R2's medications since R2 resided in the nursing home and seen by another physician. V20 also documented There are no discontinued medications, and Unclear how much his doctor at nursing home is managing vs (versus) me. On 8-27-2020, at 2:49pm, V20 stated that R2's fingers or treatment for [REDACTED]. V20 stated I wasn't managing that and didn't give any orders for it. V20 also stated There was question about who was managing his care. That was part of the issue too. R2's SNF (Skilled Nursing Facility) Transition of Care order form, dated 3-3-2020 and signed by V32 (facility APN/Advanced Nurse Practitioner), documents R2 has been discharged from V19's (R2's nursing home physician) practice due to being managed by V20 (R2's PCP) and to call PCP office for further orders. R2's nursing Progress note, dated 4-3-2020 at 3:00pm, documents that R2 complained of increased pain to his necrotic fingers on both hands, has increased redness, and that V19 (R2's MD/nursing home physician) was in the facility seeing R2. R2's nursing Progress note, dated 4-3-2020 at 4:00pm and signed by V6 (RN/Registered Nurse), documents orders were received by V19 (R2's MD/nursing home physician) to send R2 to the Emergency Department/ED due to increased pain and redness in both hands and fingers. On 8-27-2020, at 2:35pm, V6 RN stated that R2's fingers were necrotic and had been for months. V6 stated that on 4-3-2020 R2 complained of pain to R2's fingers which was the first time V6 saw that R2's fingers were red. V19 happened to be at the facility seeing R2 and V19 sent R2 out to the hospital. R2's Physician order [REDACTED]. R2's ED notes, dated 4-3-2020 at 4:49pm and signed by V12 Registered Nurse/RN, documents Patient to ED per EMS (emergency medical system) for necrotic finger. Patient states that for the past 4-6 weeks his fingers have been getting worse. Upon arrival fingers are black. Patient states he does not feel safe or that he is being cared for at (named facility). R2's ED Provider notes, dated 4-3-2020 at 4:51pm and signed by V10 Medical Doctor/MD, documents the chief complaint as (R2) has noticed over the past 4-5 weeks that multiple fingers on both right and left hand have become black and the changes were initially accompanied by when (R2) determined to be infection. According to the patient, no medical professional has evaluated his hands over this time. V10's notes continue with a review of R2's systems and documents for skin: Black discoloration of multiple fingers of the right hand as well as the left. Some surrounding redness and warmth with multiple fingers on the left hand. Left hand showed more active signs of infection. In particular the 1st, 3rd, and 4th digits were involved with gangrenous changes but also evidence of [MEDICAL CONDITION]. V10's notes include V10's clinical impression: The patient had signs of infection on the left side with dry gangrene on the right side. It continues to document It concerns me significantly that the patient has had this ongoing for 4-5 weeks and that it has not been addressed by a medical professional. R2's hospital Discharge Summary, dated 4-18-2020 and signed by V12 MD, documents that R2 was admitted to the hospital on 4-3-2020 with wet gangrene of the left hand. Orthopedic surgery was consulted on admission, took patient to OR/Operation Room for amputation of right index, long and ring finger, amputation of left thumb and excisional debridement of right thumb and left ring finger. Wound culture was significant for [MEDICATION NAME] ([MEDICAL CONDITION] Resistant Staph Aureus). This summary continues to document that R2 passed away on 4-17-2020. R2's hospital History and Physical note, dated 4-12-2020 and signed by V13 Medical Doctor, includes that R2's Septic shock is likely secondary to infected fingers with concerns for osteo[DIAGNOSES REDACTED]. Patient's altered mental status is also likely secondary to acute metabolic [MEDICAL CONDITION] in the setting of septic shock. R2's death certificate, date of death [DATE], documents R2's cause of death as: a.) Metabolic [MEDICAL CONDITION]; consequence of b.)[MEDICAL CONDITION]/septic shock; consequence of c.) Progressive bilateral upper extremity [MEDICAL CONDITION] status [REDACTED].

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

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