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F 309	Continued From page 40 policies and procedures: a) Review, discussion and verified understanding of job description b) Physician Notification Change in Resident Condition c) CNA orientation d) Agency CNA orientation 5. Admitting LPN designated as Do Not Return from agency nursing completed by E2 (Acting Director of Nursing) on 3/17/08. 6. Positive discipline completed on 3/19/08 at 9:45 am by E1 (Administrator) and E2 (Acting Director of Nursing) with all nurses involved in R1's care from admission on 2/20/08 through 2/25/08. Positive discipline to be rendered to all nursing staff aware of the worsening condition of R1, failure to follow physician orders as prescribed, failure to notify physician of changing status, failure to follow policies and procedure in place to obtain medications, failure to communicate in report on 24 hour sheet and complete and accurate nursing documentation of resident status.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)3) 300.1220b)2) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician	F9999		

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of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care or treatment of such accident, injury or change in condition at the time of notification.

300.1210 General Requirements for Nursing and Personal Care

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
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.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of

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the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge ptoential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

300.3240 Abuse and Neglect

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 requirements are not met as evidenced by:

Based on record reviews, interviews and observation, the facility failed to seek medical treatment for at least 40 hours for one of three sampled residents (R1) when he was first noted to have increased pain in his left lower extremity and his left lower extremity was first noted cold and discolored, failed to identify and obtain treatment when R1's condition worsened, failed to communicate in report on 24 hour sheet R1's worsening condition, and failed to document in the nursing notes the worsening of R1's condition.

The facility:

- failed to promptly notify the physician of a change in condition for one of three residents (R1). The facility neglected to follow facility policy titled "Physician Notification Change in Resident Condition" for at least 40 hours when R1 experienced increased pain in his left leg, his leg turned blue to purple with discoloration

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F9999	Continued From page 43 progressively moving up from toes to above the ankle, and became cold to touch. - Neglected to follow facility policy and procedure titled "Abuse Prohibition." - Neglected to follow facility "Job Description" for "Licensed Practical Nurse" and "Registered Nurse" when nurses failed to react to a resident's change and worsening of condition for at least 40 hours, and calling resident's physician during assigned shift(s). - Neglected to follow facility "Documentation Policy" by not consistently documenting the changes in R1's condition as they occurred for at least 40 hours. - Neglected to have a policy or procedure in place for the use of (untitled) document verbally called "24 hour nursing report sheet." - Neglected to follow facility "Admission Checklist" by not completing a full nursing system assessment. - Neglected to utilize facility "Pain Assessment" to assess for changes in resident level of pain from admission to when R1 began experiencing increased pain. - Neglected to utilize facility "Screening Test for Vascular Insufficiency." Staff failed to know the tool existed and therefore neglected to utilize the guidelines available to distinguish between venous and arterial blood flow problems. - Neglected to know facility "Agency Orientation" and "Agency Orientation Checklist" existed in the	F9999		

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current policy and procedures book. Facility neglected to use these tools to ensure agency personnel were consistently oriented to facility policies and procedures before working as staff at the nursing home.

R1 was admitted to the hospital with "left lower leg arterial occlusion" (no arterial blood flow). R1's left lower leg was amputated above the knee.

Findings include:

The facility face sheet shows R1 admitted on 2/20/08 at 3:30 pm with diagnoses including: Pneumonia, Rhabdomyolysis (destruction of skeletal muscle), Oxygen dependent, Lymphoma, Atrial Fibrillation, Congestive Heart Failure, Diabetes Type II with use of insulin and Chronic Obstructive Pulmonary Disease.

The facility "Resident Assessment-Data Collection Form" dated 2/20/08 at 3:30 pm documents R1 as alert, cooperative and oriented to person, place and time with clear speech. Documentation under "General Skin Condition" notes R1's skin to be pale, dry and warm with an "abrasion" noted on the left knee area. The nursing notes show no documentation of R1's pulses by the facility staff.

The initial nursing note dated 2/20/08 by Z1 (agency Licensed Practical Nurse/LPN) at 4:00 pm states, "...Skin warm and dry color fair. Has scab area on knee and the other leg. Some petachia (sic) on his arms and bruising...."

The pain assessment for R1 dated 2/20/08 at 4:00 pm (unsigned) under the question "Does

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resident complain of pain" the answer checked is "No."

Documentation by Z1 (agency LPN) in facility nurses notes dated 2/24/08 at 9:20 pm states, "Resident complains left leg pain left lower leg and toes are purplish blue color. Doesn't like to move it because of pain." There is no documentation the physician of R1 was notified of the change in pain level and discoloration of R1's left lower leg.

On 3/11/08 at 2:20 pm Z1 confirmed she did not notify R1's physician of the pain or change of color noted in R1's left lower leg, only informed the next nurse on the 24 hour report sheet and verbally.

On 3/11/08 at 2:20 pm Z1 stated, "He (R1) didn't stand at all. On 2/24/08 I covered his (R1's) feet up with blankets. The son (Z2) did not want me to send (R1) to the hospital unless it was really necessary. I am sure I went back to check on (R1) around 9:00 - 9:30 pm and they (feet) were getting pink again. The note I wrote at 9:20 pm (on 2/24/08) was for what happened at around 5:30 pm (when leg was purplish blue color). I didn't document the foot was getting better until the next night. I was able to feel pulses but they were weak. When (R1) was admitted his pulses were weak and the color (of left lower leg) was pale purplish (like a bruise). I didn't document the pulses (on admission date of 2/20/08 or 2/24/08)."

Hospital transfer papers included assessment of R1's pulses on 2/18/08 at 4:00 pm as: Left and right radial pulses (wrist area) - 2+ (normal); left and right pedal pulses (top of the foot) - 2+

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F9999	Continued From page 46 (normal). Facility nurses notes on 2/25/08 at 8:40 pm (after R1 was admitted to the hospital) by Z1 states ".....I also explained to doctor that resident only really complained of pain when his son was in the room. He (R1) shook his bedside rail and screamed and yelled. But when this nurse touch (sic) him and put some pillows between his leg and covered his leg up and when I came back and checked on his leg and it had some color to it and pedal pulse - not much but some. This nurse asked the doctor if this was cause (sic) from a blood clot...but doctor said they were going to amputee (sic) his (R1's) left leg on 2/26/08." On 3/11/08 at 2:20 pm Z1 was asked what "not much but some" meant in the nurses notes from 2/25/08 at 8:40 pm and stated, "I was able to feel pulses but they were weak. Pulses were like a 1+ but not documented......I wrote the note (2/25/08 at 8:40 pm). I thought he (R1) was putting on a show for his son when he shook the rail." A facility document untitled but verbally called the "24 hour nursing report sheet" by E2 (Acting Director of Nursing), E3 (Registered Nurse), Z1(agency LPN) and Z5 (agency LPN) shows no notations regarding R1's pain, discoloration or coldness of his left lower extremity until the 10:00 pm (2/24/08) to 6:00 am (2/25/08) shift when it is documented "left lower leg blue." The day shift on 2/25/08 notes "hospital 9:30 am - zero pedal pulses." On 2/25/08 second shift the report notes "Hospital ICU (Intensive Care Unit) surgery tomorrow amputate left lower leg." On 3/14/08 at 4:00 pm E2 (Acting Director of	F9999		

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Nursing/RN) stated, "(There is) no policy regarding the 24 hour nursing report sheet or what to include. E2 also stated nursing staff should put "condition changes and anything they chart so other nurses can follow up" on the 24 hour nursing report form. When asked if the increase in pain, coldness and discoloration of R1's leg should have been put on the 24 hour nursing report form E2 stated, "Absolutely."

On 3/13/08 at 10:38 am, Z2 (son of R1) stated, "I was there on Saturday and Sunday both (2/23/08 and 2/24/08). He (R1) was complaining of his leg being in pain for a couple of days. I know the nurse on Saturday (5:00 - 5:30 pm) knew because I told her. It may have been a CNA (certified nursing assistant) but I would think she would tell the nurse. I showed the staff Saturday his leg was blue colored and cold. Sunday (5:00 - 5:30 pm) the nurse came in to look at his leg. When she moved it he (R1) darn near jumped out of bed. He was in pain! I told the nurse to be sure and put it on the report that night. I would have thought it would have been put on the report the day before too. I made sure to tell the nurse to include the coldness and blueness that day. I didn't ask them about sending him or not sending him to the hospital. I figured they were the medical professionals and should know what to do. Any touching or moving his leg would hurt him. The staff on Saturday knew he was in pain because I told them and they knew his left foot was blue colored and cold because I showed them."

The nursing facility schedule showed E16 (Certified Nursing Assistant/CNA) as being on duty second shift on 2/20/08, 2/23/08 and 2/24/08. E16 confirmed during interview she

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worked those shifts. On 3/14/08 at 11:35 am E16 stated, "(R1) complained of pain from his left knee on down - it got progressively worse from the day I helped admit him to when I saw him a couple days later. I told (Z5/agency LPN) on Saturday (2/23/08) and (Z1/agency nurse/LPN) on Sunday (2/24/08). I did look at his foot. It was pale white color - noticeably different from his right leg and much colder than his right leg too. It was from the knee down. When I came back (2/23/08) and Z5 (LPN) was working I had her come in to look at the leg. She agreed with me. The leg was colder - more pale - and it was starting to mottle on his toes. Z5 came back and told me (R1) had a stroke before and this is what happened to stroke people. I didn't know if she was right or wrong. When we (Z5 and E16) lifted the leg he (R1) grimaced and yelled. He was obviously in pain - he didn't do that before. When (Z1) and I checked his leg on the 24th, he grimaced, tensed up, was more mottled (on his foot), and did the arching of his back and yelled it hurt. It was very obvious he was in pain then too. I didn't see Z1 or Z5 check for a pulse when I was in there. I tried but I wasn't sure where to look. He didn't get out of bed for me."

Documentation by Z5 (agency LPN) on 2/23/08 at 6:00 pm states, "Encouraged X 3 (three times) to get up for supper. Remained in bed, refused to get up.....0 (Zero) complaints of pain voiced."

On 3/14/08 at approximately 2:00 pm Z5 (agency LPN) stated, "I vaguely remember the name. I can't remember anything. I believe - I can't recall anything." Z5 then stated, "He was a frail old gentleman on oxygen. I took care of him two nights I think. I do believe I gave him pain medications for generalized all over pain. I

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looked at his legs - Saturday I think - the CNA pointed out discoloration (dark) not purple - someone told me that was how he came in. I didn't check for a pulse....I would have signed his pain meds on the MAR (medication administration record) or the narcotic book. I didn't call the doctor because they (other facility staff) said that was how he came in. I didn't document it for the same reason."

The initial nursing note by E3 (Registered Nurse/RN) dated 2/25/08 at 6:00 am stated, "Complains of pain when touching left lower leg - left lower leg cool to touch and toes discolored."

A "late entry" by E3 for 2/25/08 at 6:45 am states, "Assessed resident's left leg with nurse taking over - left leg cold - toes discolored - stated left leg hurt since fall prior to hospitalization and nobody would do anything. This writer was checking for Homans sign and when touched leg resident yelled and said that hurts - Homans sign negative....AM nurse stated she would call (Z4/physician) as soon as office opened at 9:00 am."

The facility schedule shows E3 as the third shift nurse on 2/24/08. On 3/13/08 at 5:05 am E3 stated, "(Z1) said she noticed some discoloration. I checked him on rounds using my flashlight. He always sleeps with his socks on so I looked at his legs. He didn't complain of pain. I read the note from (Z1) which was more detailed. He (R1) said his leg had been hurting since the fall. ....I didn't think from report it was as bad as when I read the note. When I went to take the sock off (morning of 2/25/08) then it hurt. At that time just his toes were discolored. He did have a faint pulse. I have no problem calling doctors in the middle of

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the night. (Z4/physician) has a triage. If I would have called the triage they wouldn't have called (Z4) because the Homans (sign) was negative. He would say 'Its been hurting since I fell and no one has done anything.' The day shift nurse said it was from the hospitalization. He had never complained of pain before even when I touched it."

E3 confirmed during this same interview she did not notify R1's physician regarding R1's increased pain, pulses, change in the color of R1's foot (bluish) or change in the temperature (cold) of R1's left foot.

The facility schedule shows E4 (LPN) on duty on 2/25/08 during day shift. The initial nursing note by E3 on 2/25/08 at 8:30 am notes, "Upon assessment lower left leg cool to touch 0 (zero) pedal pulses 0 (zero) sensation resident unable to move toes complains of pain Upper leg left leg above the knee warm to touch responds to touch. 2/25/08 at 9:00 am, "(Z4/attending physician) office (called). Z4 ordered to send to ER (emergency room) for evaluation and treatment resident alert and oriented X 3...0 (zero) distress...."

On 3/12/08 at 9:30 am E4 confirmed she worked on 2/25/08 during the day shift and stated, "(On 2/21/08) I did see the leg (left leg) because I saw the sore but the leg was normal color at that time. I looked at the assessment to be sure it was on there. On 2/25/08, in report I was told that the toes were a little discolored, still pedal pulses and we should call the doctor. He had very faint pulses. He could move his toes. He complained of pain in that leg (left lower extremity).......Just the toes were discolored at that time. About 7:45

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am I went back to check. He had very faint pulses and his foot was blue but his vital signs were stable. I told him I was going to call the physician. I got pulled away because a body alarm was going off and I had to help a CNA transfer a resident. I rechecked and it (left lower extremity) was discolored ankle to toes now with faint to no pulse. When we sent him to the hospital it (discoloration) was up his leg a little more......When I assessed him he complained of pain only when I touched it. In general, I found him to be an unpleasant person with negative things to say. First, I thought it was a vascular problem because he was a diabetic. He could still move his leg (when assessed with (E3/RN) on 2/25/08 at 6:45 am) so I thought he may be leading up to an occlusion.....I was thinking a DVT (deep vein thrombosis/blood clot) but (R1) only had pain with movement or touching the calf area."

Z4 (attending physician) stated in interview on 3/14/08 at approximately 3:30 pm, "If a resident's foot becomes cool to touch - a change for them or it turns color, I would expect them (facility) to call right away. I remember them calling me about the resident (R1) when the office opened."

Z3 (cardiologist) stated in interview on 3/11/08 at 3:00 pm, "It would be extremely important to identify a possible arterial occlusion immediately and seek treatment immediately. Every minute counts and may be the difference between us saving or losing a limb."

R1 was in bed in the Intensive Care Unit on 3/12/08 and 3/17/08. R1 had a dressing on his left upper leg above the knee covering the distal portion of his leg remaining after amputation of

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his leg. R1 was unable to answer questions at this time due to pain medications he was receiving. R1 did remember being sent the nursing home facility but stated, "I can't remember much right now. I am tired."

Hospital records reviewed on 3/12/08 include: "Exam: Bilateral lower extremity arterial duplex exam with service date noted as 2/25/08 at 12:24 pm," "History and Physical ICU (Intensive Care Unit)" dictated 2/25/08 at 10:22 pm, and "Report of operation" dictated 2/25/08 at 5:39 pm.

The "Bilateral lower extremity arterial duplex exam" states under "IMPRESSION: 1) Complete occlusion of the proximal left superficial femoral artery. No flow seen in the left ankle or foot indicating severe limb threatening ischemia."

The "History and Physical" completed by Z6 (Intensive Care Unit Physician) states, "...Today he (R1) comes in with complaints of pain in his left lower extremity with pallor and coldness. Patient states that he has had bilateral lower extremity pain for weeks but he has not had it evaluated. After this recent ICU stay on 2/6/08 this leg has bothered him but not to the degree which they have hurt him over the last three days. During that admission (2/6/08) he was getting up to chairs and not complaining of too much discomfort.....He was doing very well until the last two to three days when he began to have left lower leg pain......On arrival to the ER (emergency room) the foot was without any palpable pulses, cold and very pale. A Doppler study found the patient to have an arterial occlusion in actually both the left and right lower extremities....The left shows unattainable...pulses. (Z7/surgeon) was notified

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	145239	A. BUILDING ______ B. WING ______	C 03/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT CLARE HOME	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999		F9999		

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and at this point he (Z7) is planning on amputating the left lower extremity."

The section of this same report titled "Extremities" notes, "Left lower extremity shows livedo reticularis (purplish network-patterned discoloration of the skin caused); He is insensate (without feeling) to mid calf; Leg is cool to touch. There are no palpable pulses in this extremity. First toe noted to have dry blood around (this is apparently from a fall earlier this month)."

The section titled "Assessment and Plan" in this same report notes,"This is a 75 year old male with left arterial leg occlusion. 1) Arterial occlusion: Patient started on heparin for surgery. Patient to go to O.R. (operating room) in the morning for a left above the knee amputation."

The hospital document titled "Report Name: Operative Report" under the section "Preoperative diagnosis: Ischemic gangrene of the left leg." with "Postoperative Diagnosis: Ischemic gangrene of the left leg" and "Operation: Left above-knee amputation."

The facility did not implement facility policies and procedures in the care of R1 and staff were not aware of the current facility policies and procedures as follows:

The undated facility "Policy and Procedure regarding Abuse & Neglect" states, "10. Neglect means a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition."

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The facility document dated March 2007 "Physician Notification Change in Resident Condition" states under "Objective: To define resident care situation requiring physician notification." Under "Procedure: 1) Staff observe, document and communicate to physician changes in resident condition promptly. 2) Change in condition may include, but is not limited to the following: New or Increased Complaints of Pain. 3) Nurse Aides are responsible for reporting any changes they observe to nurse. It is the responsibility of each nurse to notify physician of a significant change in condition before end of shift."

The facility "Job Description" for "Licensed Practical Nurse" and "Registered Nurse" under "Duties and Responsibilities states,"Recognize changes in conditions during his/her shift. Consult with supervisor and director of nursing when necessary. Transcribe physician's orders. Personally receive or place calls to physician. Admit, discharge, and transfer patients from their assigned unit."

The facility policy dated March 2007 titled "Documentation Policy" states under "Purpose: To ensure residents, families and physicians are being notified of changes in condition,.....in a timely manner and to ensure charting is complete." Under "Procedure: 1) Any time a resident has a change in condition....or anything that is different for resident; the family and physician must be notified ASAP (as soon as possible). 2. Pull chart and chart changes. 3. Notify physician and chart. 4. Notify family and chart. 5. Put chart in designated area until everyone is notified and vitals and charting are complete."

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The facility procedure "Admission Checklist" dated December 2006 under the section "Admission Item" states "Nursing Admission Note (Including Full Systems Assessment)." No documentation in the facility nursing notes was located by facility staff. The facility procedure "Resident Assessment-Data Collection Form" dated 11/1991 and completed by Z1 (agency LPN) on 2/20/08 at 3:30 pm does not include a full system assessment. The initial facility nursing note completed by Z1 on 2/20/08 at 4:00 pm and subsequent nursing notes do not include a full systems assessment. On 3/14/08 at 4:00 pm E2 confirmed surveyor had all documentation regarding R1's stay from 2/20/08 through 2/25/08.

The nursing policy and procedures located at the nurses station on 3/13/08 at 6:00 am contains a facility policy/procedure titled "Screening Test Vascular Insufficiency" dated April 2007. This policy gives guidance to the nursing staff in determining "Arterial" versus "Venous" ulcers. The "description" in the arterial section notes "Pain, with walking or at rest; Foot cold or cool; peripheral pulses weak or absent; history of diabetes/hypertension/smoking" with the "description" in the venous section noting: Pain - none or only in dependent position or ankle; Foot warm; Lower extremity edema; Legs look brown, thick and 'woody'; History of DVT (deep vein thrombosis/blood clot)."

On 3/13/08 at 9:10 am E2 (Acting Director of Nursing) stated, "I didn't know those policies were in the nursing manual."

The nursing policy and procedures located at the

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F9999	Continued From page 56 nurses station on 3/13/08 at 6:00 am contains a facility policy/procedure titled "Agency Orientation" dated December 2006 and "Agency Orientation Checklist" dated April 2007. On 3/13/08 at 9:10 am surveyor asked E2 to see the completed checklists for the agency LPN's (Licensed Practical Nurses) and CNA's (certified nursing assistants) utilized by the facility. At this time E2 stated, "I did not know those policies and procedures were in our book. I have never seen them before. The nurses (facility) do show agency nurse around but as far as I know we haven't done this policy/procedure." (A)	F9999		