STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145400	A. BUILDING ______ B. WING ______	C 08/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE	2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701

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F 000	INITIAL COMMENTS Complaint Investigation #1262685/IL58886	F 000		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010 h) 300.1210 b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility Shall notify the resident's physician 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	F9999		

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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F9999	Continued From page 1 percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the 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 b) The facility must 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 assessment and plan of care. 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. 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	Continued From page 2 agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidenced by: Based on record review and interview, the facility failed to monitor and assess a newly developed wound as directed by their Policy and Procedure. The facility failed to notify the physician and family in a timely manner of the development of the foot wound and the onset of gangrene in that wound for one of three residents (R1) reviewed for stasis ulcers in the sample of three. These failures resulted in R1's wound progressing to a gangrenous state. Findings include: A Physician's Order Sheet, dated 5/01/12, documents R1 has the current diagnoses of Dementia and Peripheral Vascular Disease. A Minimum Data Set, dated 3/30/12, indicates R1 has severe cognitive impairment, can rarely make himself understood, and requires full staff assistance for Activities of Daily Living (dressing, bathing, and grooming). A fax report sent to Z3 (Physician) on 4/26/12, documents: "Noted redness, bleeding and drainage on the last three toes of the right foot. Do you want us to treat it with normal saline, Bacitracin and Kirlex or would you prefer another treatment?" A Treatment Record documents that the requested treatment was provided to the right foot toes starting on the third shift 4/27/12 through 5/03/12.	F9999		

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F9999	Continued From page 3 Nursing notes by E5 (Licensed Practical Nurse) on 5/02/12, at 10:00 p.m., document: "(right) foot, last 3 toes are totally black and draining serosanguinous drainage. Redness noted around foot and toes." On 5/03/12 at 3:00 a.m., Nursing Notes by Z2 (Licensed Practical Nurse) document: "Dressing changed on (right) foot, last 3 toes black with serosanguinous drainage." Nursing Notes indicate that tZ3 (Physician) and R1's family were not notified of the condition of R1's right foot and toes until approximately 12 hours later. Nursing Notes on 5/03/12, at 9:30 a.m., further document that the right foot toes continued to be black and noted drainage with a foul odor, which prompted E4 (Licensed Practical Nurse) to notify the Z3 (Physician) and R1's family. This was the only documentation in R1's medical record that the family was notified of the right foot wound, which developed on 4/26/12. On 8/06/12 at 2:00 p.m., E5 (Licensed Practical Nurse) stated when she came on shift 5/02/12 a C.N.A. (Certified Nursing Assistant) asked her to look at R1's foot. E5 stated she was unaware R1 had a wound on his right foot that was being treated, did not see any documentation on the wound and did not know the origin of the wound or its progression. E5 stated that on 5/02/12 the last three toes on R1's right foot were "totally black with drainage" and recalled redness around the wound. E5 stated she is aware that redness is a sign of possible infection, but "didn't think" about it. E5 stated she left a note for the Wound Nurse to look at R1's toes the next day. E5 stated she did not notify the family or physician of the condition of R1's toes and further stated she	F9999		

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F9999	Continued From page 4	F9999		

"should have contacted the Doctor." E5 stated she notified Z2 (Licensed Practical Nurse) at the change of shift that R1's toes "didn't look good" and asked him to assess the wound.

On 8/06/12 at 1:42 p.m., Z2 (Licensed Practical Nurse) stated he could not recall notifying R1's family of the development of the right foot wound on 4/26/12. Z2 stated he would have documented any family notification in the nursing notes. Z2 stated E5 (Licensed Practical Nurse) did ask him when he came on shift 5/02/12 to assess R1's right foot wound. Z2 confirmed the last three toes on R1's right foot were black and draining. Z2 stated R1's wounds had deteriorated since he last saw them on 4/28/12. Z2 stated he didn't "think to notify the Doctor" when he observed R1's wounds on 5/03/12 at 3:00 a.m. Z2 (Licensed Practical Nurse) stated he was not certain if the right foot wound was related to pressure or a diabetic ulcer, but likely a diabetic ulcer given his medical history. Z2 did not recall initiating the Daily Wound Assessment form, as directed in the Facility's "Instructions for Implementation of Wound Protocol." Z2 did not initiate a Wound Clinic referral as directed in the Facility Wound Protocol for Diabetic Ulcers.

The facility Wound Log did not contain any documentation regarding the areas that were being treated on R1's right foot. The nursing notes do not contain any documentation as to the condition of R1's right foot wound or any further assessment until 5/02/12.

On 8/06/12 at 12:57 p.m., E2 (Director of Nursing) stated the physician and family are to be notified as soon as possible if a resident develops

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F9999	Continued From page 5 a wound or if a wound deteriorates. E2 stated she would have expected staff to notify the physician immediately after discovering R1's toes had become black and were draining. E2 stated E5 is essentially responsible for wound monitoring and had Z2 completed the Wound Assessment Form on 4/26/12, E5 would have assessed the wound the following day. E2 stated staff should be charting daily on the appearance of wound, upon onset and with the daily dressing change. E3 confirmed that the only documentation regarding the condition of R1's foot wound after it was discovered on 4/26/12, was on 5/02/12 at 10:00 p.m. and the subsequent notes. The Facility Policy, titled "Instructions for Implementation of Wound Protocol," documents, "(6.) When a wound protocol requires the nurse to call the physician, the primary care physician (or the on call physician) must be called in a timely manner." The "Instructions for Implementation of Wound Protocol" further indicates, "(9.) Educate the family. Make sure the family is notified of the change in their loved one's status." The Facility Policy and Procedure, titled "Instructions for Implementation of Wound Protocol," documents, "(4.) Initiate a Daily Wound Assessment Form for all pressure ulcers. Place the form in the treatment book......This form will become a legal part of the chart and must be filled out each day to stay in compliance with state regulations.......(5.) Using the Status Report Form, notify the following departments: A. Director of Nursing, B. Assistant Director of Nursing (this takes care of the wound team), C.	F9999		

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Dietary (this takes care of the dietary referral), D. Physical Therapy. Include the following information on the Status Report: A. Date wound/skin problem discovered B. What the wound/skin problem is C. Where the wound/skin problem is D. What wound protocol has been initiated."

The Facility Wound Protocol for Diabetic Ulcers, indicates staff are to "call physician for treatment orders and referral to (Wound Clinic)," "educate family," and "notify the Wound Team."

The Facility Wound Protocol for Stage II Pressure with s/s (signs and symptoms) of infection documents, "If wound bed shows signs of infection, purulent drainage, or foul odor, cleanse affected area with Hibiclens one time only, removing any loose debris or drainage. Rinse with normal saline. Call Physician for treatment orders. Consider oral antibiotic.......Notify Wound Team."

The Facility Policy and Procedure, titled "Wound Rounds," documents "1. Wound rounds will be done weekly by wound contact nurse.....2. Team will document on tracking form: Stage, measurement, wound appearance, pain and if acquired/admitted with wound. 3. Contact nurse will then document when doctor was notified, treatment ordered, interventions put in place, and verify that interventions are on the care plan. 4. Doctor will be notified of any new wound, or any change in the wound (if it becomes worse or improves)...."

Hospital Admission Records indicate R1 was admitted on 5/03/12 with Peripheral Vascular

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F9999	Continued From page 7 Disease, Ischemic Right Lower Extremity, and Wet Gangrene. The 5/03/12 History and Physical, by Z3, documents, "Right lower extremity black, ischemic, oozing wet on right lateral three digits in the distal foot. Also, medial mid foot ischemic changes. Positive warmth and diffuse erythema (redness) in distal half of right foot." A Vascular Surgery Consult, dated 5/03/12, documents, "if the patient/family does wish to proceed with further treatment, then we will proceed with lower extremity angiogram and amputation of the right root in a few days after some antibiotic treatment." The Hospital Discharge Summary dated 5/04/12, documents, "Due to the severity of the wet gangrene, it was deemed that the patient definitely would require a prolonged course of IV (intravenous) antibiotics and then at some point a probable partial foot amputation. Due to the patient's dementia and overall quality of life.....the family decided to just proceed with comfort care." (A)	F9999		