STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145333	A. Building B. Wing	08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Suburban Nursing & Rehab Center	311 Edgewater Drive Bloomingdale, IL 60108

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** 15845 Based on observation, interview and record review, the facility failed to thoroughly assess, closely monitor and refer a resident for additional evaluation and treatment of a deteriorating foot ulcer. These failures resulted in a resident's (R1) right below knee amputation due to a gangrene that was undetected. The facility also failed to follow physician order regarding a dressing treatment for a recent surgical amputation. This applies to 1 of 3 residents (R1) reviewed for foot ulcer. The findings include: The Face Sheet documents that R1, a [AGE] year-old was admitted to the facility on [DATE]. R1's diagnoses included diabetes mellitus, ESRD (End Stage Renal Disease), non-pressure chronic ulcer of right ankle with unspecified severity, major depressive disorder, idiopathic peripheral autonomic neuropathy, vitamin deficiency, anxiety disorder, CVA (Cerebral Vascular Accident) with residual affect. The Face Sheet documents that R1 was sent out on 7/2/2021 and returned to the facility on [DATE] with new onset of the following diagnoses: gangrene of the right foot, cellulitis, osteomyelitis, encounter for orthopedic after care following surgical amputation and acquired absence of right leg below knee. On August 19, 2021 at 11:20 A.M., R1 was observed lying in his bed. R1 was semi-alert and responded yeah, yeah, yeah to questions asked such as how are you?, responded yeah; have you eaten breakfast?, responded yeah; are you comfortable?; responded yeah; do you have pain?, responded yeah. Together with V3 (LPN-Licensed Practice Nurse/Wound Care Coordinator), V4 (LPN/Wound Care Nurse) and V5 (Wound Care Technician), R1's right lower leg stump was exposed. V3 changed the dressing on R1's right lower leg stump. V3 stated R1's entire right foot, all the way to the lower leg was amputated on 7/8/2021 due to a gangrene. The incision site was macerated (looked wet and pale) with approximately with 12 sutures. The incision site was covered with a gauze dressing and wrapped with Kerlix gauze dressing. The dressing was moderately soaked with serosanguinous drainage. V3 removed the soiled dressing, applied gauze, and wrapped R1's leg with Kerlix gauze dressing. (continued on next page)

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.

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Social Service Notes dated 7/19/2021 showed (R1) scored an 8/15 (moderate cognitive impairment) on the BIMS (Brief Interview Mental Status) assessment. (R1) was able to repeat the three words at the beginning of the assessment but could not recall them at the end, even with the aid of a cue. (R1) was able to report the correct year and month but could not report the correct day of the week. (R1) disclosed feeling depressed, over-sleeping, having little energy, poor appetite, difficulty concentrating, and moving slower than usual. (R1) does not present with physical or verbal behaviors. (R1) does not refuse care/treatment. (R1) does not wander and appears to be at low risk for an elopement currently. (R1) presents with adequate vision, hearing, and unclear speech. The chronological timeline of R1's foot care were as follows as reviewed on the wound assessments and progress notes: -5/25/2021, R1 was admitted with diagnoses of diabetic right foot ulcer. The ulcer was assessed on 5/26/2021 by V3. The assessment showed: right heel diabetic ulcer; length measurement was 13 cm. x width was 7 cm. x depth was 0.2 cm., an exudate of moderate amount of serous drainage, no odor; the tissue type was identified as 30 % granulation; 0 slough; 40 % necrosis (dead tissue), skin was 30 %. There was fluid filled blisters around the wound. The treatment was to cleanse the wound with wound cleanser, chemical debridement, gauze dressing daily and if needed. -6/1/2021- was evaluated by wound care Nurse Practitioner (V8). The ulcer was described as follows: screw visible on top of the right second toe; had surgery at an unknown time ago; right foot pedal pulse --- (was left blank, not assessed) left foot pedal pulse --- (left blank, not assessed). The plan of care was to continue with dressing, prevent infection, and wound debridement as needed. V8 ordered Doppler study with ABI (Doppler, an ultrasound study that can be used to estimate the blood flow through blood vessel and determine poorly functioning valves in leg veins, and if there was a blocked artery that will impede circulation. ABI is ankle-brachial index, a test that compares the blood pressure in the upper and lower limbs. The normal ration is between 1.0 and 1.4. A ratio of 0.9 means patient has PAD (peripheral arterial disease). -6/2/2021, Doppler study and ABI was done on 6/2/2021 with results that showed: Segmented pressure measurements demonstrated ABI of 0.99 on the right foot, and 1.05 on the left foot. ABI is borderline on the right and normal on the left. No evidence of hemodynamically significant luminal stenosis (narrowing of blood vessel) on visualized vessels. Please correlate CLINICALLY to determine if further evaluation or follow up is indicated. - 6/1/2021, assessed by V3; right foot ulcer measures: length was 8 cm; width was 12 cm; depth was 0.2 cm. There was moderate amount of serous exudates. The granulation tissue was 20%; slough was 10%; and necrosis of 50%. The treatment was the same. -6/8/2021 assessed by V3; right foot ulcer measures; length was 5 cm; width was 12 cm; depth was 0.2. No slough; increased of necrotic tissue to 70% from 50% from a previous week assessment. -6/8/2021 assessed by V8; right and left pedal pulses were left blank--- (not assessed). V8 noted the 6/2/2021 Doppler Study and ABI result. V8 failed to provide order for close monitoring and thorough assessment to correlate clinically to determine if further follow was indicated for a proper treatment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-6/15/2021, assessed by V3; right foot ulcer measures; length was 5 cm. x width was 10 cm; and depth was 0.1 cm. There was moderate amount of serous exudates, necrosis was 50%. -6/22/2021, assessed by V3; right foot ulcer measures length was 5.5 cm. width was 9.8 cm. and depth were 0.2 cm. There was moderate amount of serous drainage that was FOUL in odor , necrosis was 60%. V3 assessed and documented that there was no S/S (sign and symptoms) of infection. This was a change of condition of the right foot ulcer because of the foul smell of the serous exudates. -6/29/2021, assessed by V3; right foot ulcer measures: length 5.5 cm. x 11 cm in width and 0.7 in depth. There was still a foul odor from the serous exudates coming from the foot ulcer. The necrosis had increased to 90%. The assessment also showed that the ulcer worsened. -6/29/2021, assessed by V8; No infection (Note: FOUL odor from the ulcer as documented by V3 on 6/22 and 6/29/2021 and a necrosis had increased to 90%.) Again, V8 left the capillary refill assessment of the feet to determine blood circulation flow was left blank and was not assessed. V8 also failed to order follow up referrals to a specialist such as a vascular surgeon since the necrosis was already had increased to 90% and this would help determine any circulatory blockage and further treatment. V8 failed to address and order diagnostic test that might determine osteomyelitis and sepsis, considering that there was a sign of infection due to foul smelling odor. The progress notes showed the following: -7/2/2021 at 7:41 A.M., R1 had a change in condition such as abnormal vital signs including fever, altered mental status change and functional decline. -7/2/2021 at 9:10 A.M., R1 was sent to the hospital for further evaluation. -7/2/2021 at 12:49 P.M., R1 was admitted with sepsis. The hospital records showed the following: -7/2/2021, (R1) from SNF (Skilled Nursing Facility), non-verbal, with fever of 102.7 and significant elevated WBC (White Blood Count) of 15.4. (R1's) right foot notably gangrenous on physical examination. X-ray were done showing soft tissue gas within the hind foot abutting the calcaneus with erosion of the posterior calcaneus with cannulated screw fixating the IP (intra phalanges) joint of the great toe, and lucency, with erosion also involving the 1st and 3rd metatarsal. Right heel with gangrene and malleolar surrounding by dry eschar. Admit to ICU (Intensive Care Unit), referred to ID (Infectious Disease Doctor); Podiatry, for surgical wound care, going for surgery. Guarded condition, and poor prognosis. The hospital podiatry notes dated 7/12/2021 documents Lower Extremity Focus Examination showed the following foot assessment: -DERMATOLOGY: skin cool and dry; right lower keg surgical incision is well coated with sutures, mild drainage, no signs of infection. - VASCULAR: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1. Dorsalis Pedis (dorsal artery of the foot, which is a blood vessel of the lower limb that carries oxygenated blood to the dorsal surface of the foot) was 0 for the right and 4 for the left. 2. Posterior tibial pulse: (delivers oxygenated blood to the posterior compartment of the lower leg) was 0 for the right /4 for the left. 3. CRTs to digits: (Capillary Refill Test; a rapid test used for assessing the blood flow through peripheral tissues, normal CRT time is 2 seconds or less) was 5 seconds to left foot. - NEUROLOGIC; Sensation to touch and pressure was absent to bilateral lower extremities The hospital final report dated 7/12/2021 showed: 1) Septic shock resolved. 2) Escherichia Coli and Proteus bacteremia, source was the right foot, on 7/2/2021, cleared 7/4/2021. 3) Gangrene and osteomyelitis of the right calcaneus. 4) PVD (Peripheral Vascular Disease) with 100 % right occlusion. The progress notes dated 7/12/2021 showed R1 had returned to the facility with right foot amputated, covered with elastic wrap with order of DO NOT OPEN OR CHANGE THE DRESSING. To be changed by podiatrist on Wednesday. The Physician Progress Notes dated 7/13/2021 showed R1 had a fever, gangrene of the right foot and osteomyelitis. R1 also has medical history of anemia, diabetes, depression, vitamin D deficiency, neuropathy, and undergone right foot amputation on 7/8/2021. The Skin Wound Notes dated 7/15/2021 showed a call was made to V10 (Foot surgeon/podiatry) to set up an appointment but R1 already had an appointment for next week (7/21/2021) and not to touch the dressing until seen by V10. R1 verbalized understanding wearing the heel protector. The Nursing Progress Note dated 7/17/2021 showed that R1's dressing to right amputated lower leg had fallen off. The nurse updated V11 (R1's Attending Physician) who had not examined R1. -7/17/2021: Skin Wound Notes: R1's dressing to the amputated right lower leg had fallen off. There were 12 stitches to amputated foot with 6 tapes around it. V10 was paged, awaiting call back. There was no follow up noted when V10 did not call back. R1 was seen by V10 at his clinic on 7/21/2021. There was a new order from V10 to change the dressing daily on the amputated lower leg. V10 noted a seroma and to leave sutures intact for follow up visit on 8/4/2021. The Skin Notes dated 8/4/2021 showed that R1 went to V10's clinic. V10 ordered to keep dressing clean and do not change dressing. Call if concerns arise. R1 was reminded not to put pressure when transferring self without calling. R1 has tendency to transfer self without calling for assistance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Nursing Progress Notes showed R1 saw V10 on 8/11/2021. The Skin/Wound Note dated 8/11/2021 showed R1 came back from follow up appointment with V10 with new order to change the dressing every other day with 4 x 4 gauze, thick pad and elastic bandage. Also, to call V10 if there is an issue. R1 scheduled for next appointment in 1 week. On 8/23/2021 at 2:00 P.M., V10 stated R1 should have been referred sooner for further diagnostic test and evaluation even if the Doppler study suggested borderline results. V10 stated close monitoring with comprehensive assessment that included capillary refill test for circulation, sensation and movement should have been done because of R1's right foot condition. V10 added if these were done sooner, R1's losing his right lower leg could have been avoided. V10 further stated that perhaps partial amputation of portions of the foot and some part of foot digits could not have been avoided. However, V10 stated the below right knee amputation could have been avoided. V10 explained that on 7/12/2021 he had ordered not to touch the dressing (dressing fell off 7/17/2021, R1 seen by V10 7/21/2021, V10 said he was not made aware). On 8/4/2021, V10 ordered again not to touch the dressing until seen on 8/11/2021. V10 said when he saw R1 on 8/11/2021, he was very upset that R1's right foot incision was improperly taken care regarding wound dressing treatment. V10 said that there were multiple tapes applied on the incision site that had compromised the stitches, had pulled the screw and cement and that it had appeared that it was ripped out of R1's bone. V10 said that he had sent his notes each time R1 had his appointment with him. V10 said that the facility had changed the wound dressing between 8/4/2021 and 8/11/2021 because it was not the dressing he had applied when R1 came to his clinic on 8/4/2021. V10 said he was not made aware why the dressing was changed. V10 said the way facility changed the dressing was inappropriate and that had compromised the bone screw and cement. V10 added, It had looked like it (dressing) was ripped off since the screw was attached to the bone 10 cm. How would it be possible for the bone to be exposed at the surgical site? V10 said there were approximately 2 fingers width that the surgical wound was dehiscence (splitting/ bursting) and sutures were missing. V10 provided pictures and notation of R1's amputated right lower leg during the appointment. The pictures/notation validated V10's statement. R1 had a dehiscence wound on 8/11/2021 appointment. The record review of R1's facility EMR (Electronic Medical Record) did not show documentation of R1's visit to V10 on 8/11/21. During the survey, V2 (Director of Nursing) was asked for documentation of R1's visits to V10. On 8/25/2021 at 9:30 A.M., the facility provided a Physician Clinic Communication note from V10 to the facility regarding R1's 8/11/2021 appointment to V10. There were no further progress notes or communication provided by the facility for other clinical visits of R1 to V10. The Physician Clinic Communication Notes dated 8/11/2021 from V10 for R1 showed Every other day dry dressing changes .CALL ME if there is an issue. I am PISSED I was not informed that bone and screw came out from his wound! Either somebody went digging into the wound OR magically it found its own way out. He (R1) also had tape directly on the incision 2 weeks ago, clearly somebody does not know wound care! (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/19/2021 2:01 P.M., V8 (Wound Care Nurse Practitioner) stated she saw R1 on 6/1/2021. V8 said she saw a screw sticking out of R1's foot from a previous unknown surgery. V8 stated the screw that was sticking out of R1's foot was not significant since it did not bother R1. V8 stated she was aware of R1's Doppler Study result and did not make a referral to a vascular surgeon because she does not think there was an urgency. The care plan dated 5/28/2021 showed R1's skin to be checked daily and any skin changes reported to nurse and physician for treatment. The care plan did not address any interventions to ensure dressing of the amputated leg stay intact. On 8/19/2021 at 11:30 A.M., V3 (LPN-Licensed Practice Nurse/Wound Care Coordinator) and V4 (Wound Treatment nurse) stated there was no report received for any skin changes except from V3's assessment. V3 and V4 said there was weekly wound assessment for R1, but it did not include monitoring of the CMS (Circulatory/capillary refill; movement and sensation).