STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145008	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Duquoin Nursing & Rehab	514 East Jackson St Du Quoin, IL 62832

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 - 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** 40666 Based on interview and record review, the facility failed to provide wound treatments as ordered for 1 (R1) of 3 residents reviewed for wound treatment in a sample of 3. This past non-compliance occurred between 4/3/24 and 5/12/24. The findings include: R1's admission record documents that R1 was admitted to the facility on [DATE]. The same admission record also documents some of R1's diagnoses as Lymphedema, not elsewhere classified, Chronic Venous Hypertension (idiopathic) with ulcer of right lower extremity, excoriation (skin picking) disorder. R1's MDS (Minimum Data Set) dated 3/29/24 documents a BIMS (Brief Interview for Mental Status) of 15, indicating R1 is cognitively intact. R2's Care Plan documents a Care Plan Description to include Stasis Ulcer/[NAME] with a Category listed of Skin. Interventions listed included, provide pillows or other supportive devices to assist with positioning, provide pressure reducing surfaces on bed and chair, and perform wound care as ordered. R1's facility Wound Healing Progress Report documents under Type of Wound/Location, Other: Lymphedema Left Leg - Entire Leg and Venous Ulcer Right Calf with a date identified of 3/29/24. R1's Physician's Order Summary Report documents an order dated 4/2/24 noting bilateral lower extremities - paint areas to bilateral legs with betadine solution and cover with gauze followed by ABD's (absorbant pads), wrap with rolled gauze and secure with coban (self-adherent wrap) starting at base of toes up lower leg to no higher than 2 inches below the bend of the knee. Change two times daily and prn (as needed). R1's TAR (Treatment Administration Record) dated April 2024 documents N (No) on 4/3/24, 4/4/24, 4/7/24, 4/8/24, and 4/9/24. There was no documention found in R1's record stating the reason the treatments were not administered. (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 - Minimal harm or potential for actual harm Residents Affected - Few	R1's Physician's Order Summary Report documents an order dated 4/12/24 noting treatment changed to Right lower leg: Cleanse with normal saline, apply maxorb Ag (antimicrobial dressing) to open ulcer and cover with ABD pad. Paint remainder of open/weeping area with betadine solution. Cover with gauze followed by ABD. Wrap with tolled gauze and secure with coban starting at the base of the toes up lower leg to no higher than 2 inches. Left lower leg: Cleanse with normal saline, paint open/weeping areas with betadine solution. Cover with gauze followed by ABD's. Wrap with rolled gauze and secure with coban starting at the base of toes up lower leg to no higher than 2 inches below the bend of the knee. R1's TARs dated April 2024 documents for the right lower leg, 4/13/24, 4/14/24, 4/15/24, 4/17/24, 4/18/24, 4/24/24, 4/27/24 all have N (no) documented in the 8:00 AM treatment time. The left lower leg also has N documented on the 4/13/24, 4/14/24, 4/15/24, 4/17/24, 4/18/24, 4/24/24, 4/27/24 times. There was no documention found in R1's record stating the reason the treatments were not administered. R1's Physician's Order Summary Report documents an order dated 4/19/24 for the right lower leg: Cleanse with normal saline, apply calcium alginate to open ulcer and cover with ABD pad. Paint remander of open/weeping area with betadine solution. Cover with gauze followed by ABDs. Wrap with rolled gauze and secure with coban starting at the base of the toes up lower leg to no higher than 2 inches below the bend of the knee. Change two times daily and prn. R1's TAR dated April 2024 documents N on 4/24/24 and 4/27/24. There was no documention found in R1's record stating the reason the treatments were not administered. R1's Physician Order Report documents an order dated 5/1/24 for the left lower leg: Cleanse with normal saline, paint open/weeping areas with betadine solution. Cover with gauze followed by ABDs. Wrap with rolled gauze and secure with coban, starting at the base of the toes up lower leg to no higher to 2 inches below the bend of the knee. Change two times daily and prn. There was no treatment noted on R1's May 2024 TARs for the left lower leg. R1's Physician's Order Summary Report documents an order dated 5/1/24 for the right lower extremity: Cleanse with normal saline, apply calcium alginate to open ulcer and cover with ABD pad. Paint remainder of open/weeping area with betadine solution. Cover with gauze followed by ABDs. Wrap with rolled gauze and secure with coban starting at the base of the toes up lower leg to no higher than 2 inches below the bend of the knee. Change two times daily and prn. R1's May 2024 TAR has no documentation that the treatment was done on the following days: 5/1/24 at 1600 (4:00 pm), 5/2/24 at 1600, 5/3/24, 5/4/24, 5/6/24, 5/7/24, 5/8/24, 5/9/24 at 1600, 5/10/24, 5/11/24, and 5/12/24. On 5/16/24 at 1:30 PM, R1 stated staff do not change his dressing like they are supposed to. R1 said he does good to get it changed once a day and sometimes it doesn't get changed at all. R1 said he went 6 days last week and it did not get changed. On 5/16/24 at 2:00 PM, V2 (Director of Nurses/DON) stated that a N on the TARs means the treatment was not given and a progress note should be done to explain why it was not done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/17/24 at 11:30 AM, V2 said she was made aware of problems with dressing changes not being done on R1 and did an inservice to staff. V2 said she is working on fixing the problem. On 5/16/24 at 11:45 AM, V3 (Licensed Practical Nurse/LPN/Infection Preventionist) said there were a couple of days she did not do R1's dressing change. V3 said the lymphedema clinic called on the 15th of May and said the dressing changes were not being done. V3 said she did not know she could chart in the TARS (Treatment Administration Record) and has never signed a dressing change off on them. V3 also said that R1's wounds on both legs have improved alot since his admission. R1's Wound Healing Progress Report note on admitted [DATE] documents R1's left leg wound measured 20.00 x 61.20 and right calf measured 20.00 x 57.50 x 0.30. On 5/16/24 measurements of the left leg were noted to be 18.70 x 40.20 and the right calf measured 10.00 x 20.00 x 0.20. The Facility Wound Care Policy documents under the heading Documentation: The following should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. Under Reporting, the Wound Care policy documents: 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice. Prior to the survey date, the facility implemented the following actions to correct the deficient practice: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A Quality Assurance and Performance Improvement meeting was held on 5/13/24. Staff in attendance included the Medical Director, Administrator, Director of Nursing, Infection Preventionist, Regional Clinical Nurse and MDS Specialist. An action plan was developed to include goals of all medication/treatment administration records to be completed in their entirety in real time and all treatment changes will be completed according to the current physician order. The action documented included education of all nursing staff and monitoring to be completed x (times) 4 weeks. 2. Nursing In-Service/Education was provided to all nursing staff documenting the importance of ensuring all dressing changes are completed as ordered; if at any time for any reason an appointment for wound clinic is missed, nurses are required to perform treatments as ordered, the importance of completing the MAR/TAR documentation daily, and importance of completing weekly skin assessments. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur: DON or Designee to monitor dressing changes daily for 1 week then 3 times weekly for 2 weeks, then weekly for 2 weeks.