STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imboden Creek Senior Living	180 West Imboden Decatur, IL 62521

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. 34058 Based on record review and interview, the facility failed to provide physician ordered wound care for a surgical incision. This failure affects one resident (R1) on a sample of three reviewed for wound care in the sample list of 37. This failure resulted in R1 experiencing a wound infection which required being sent to the hospital for a surgical debridement and multiple intravenous antibiotics. This past non-compliance occurred from 8/14/24 when the facility failure to monitor and treat R1's surgical incision through 8/22/24 when R1 was discharged from the facility. Findings include: R1's Face Sheet Admission Record documents R1 was admitted to the facility 8/8/24. This same record documents R1 was being admitted to the facility for medical diagnoses including Surgical Aftercare Following Surgery on the Nervous System (lumbar laminectomy, procedure to remove portions of vertebrae to relieve nerve pain), Post-Laminectomy Syndrome (pain following surgery), and Dislocation of Internal Left Hip Prosthesis. R1's Physician Order Sheet, dated 8/8/24 through 8/22/24, documents a physician order initiated 8/13/24 for facility nursing staff to complete wound care daily as lower lumbar surgical incision, cleanse with normal saline, pat dry, apply dry dressing, every day shift and as needed. This same Physician Order Sheet documents facility nursing staff were to monitor lower lumbar surgical incision for s/s (signs and symptoms) of infection or dehiscence every shift, notify MD (Medical Doctor) if complications. R1's Treatment Administration Record dated for August 2024 documents facility nursing staff did not provide R1's incision cleaning and dressing on 8/14/24, 8/17/24, and 8/20/24. This same record documents facility nursing staff did not complete monitoring of R1's surgical incision on these same dates during the day shift. R1's Nursing Progress Note, dated 8/22/24, documents, Resident had follow-up appointment this AM for back, doctor (V16, Surgeon) called and is sending resident straight to (local hospital emergency room) for direct admit related to infection to back incision. (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	On 8/27/24 at 10:03 AM, V12, Daughter of R1, stated, (R1) had to have a second surgery to remove E. coli (Eshericia coli, bacteria present in fecal material) from the incision. The nurses at the facility did not do the cleanings of her incisions like they were supposed to, the dressings they had would never stick in place, they left her on the bedpan for over an hour, she was left laying on her back almost all the time, now she has rashes under her breast and in her groin, and bed sores on her backside. V12 concluded by stating, (R1) is still in the hospital and has to stay here until the antibiotics are done. R1's partial Hospital Record, dated from 8/22/24 through 8/27/24, documents the hospital had obtained cultures from R1's dehisced (surgical incision split open) and draining back incision fluid and surrounding tissues, both of which resulted in heavy growth of E. coli. This same record documents R1 received preliminary doses of intravenous antibiotics including Vancomycin 1 gram every 12 hours requiring strict blood level monitoring and dosing by the hospital pharmacy, and Zosyn 3.375 grams every 8 hours, as a broad spectrum treatment until the susceptibility reports from R1's cultures could be processed to determine a more targeted antibiotic regimen. This record documents R1's laminectomy had been conducted on 8/3/24, with a subsequent discharge to (the facility name) on 8/8/24. This record documents V16's (R1's Neurosurgeon) comments during her evaluation of R1 in the hospital as, Multiple samples are growing E. coli as a result of fecal contamination and not from surgery, consistent with (R1's) statements of poor quality care at (the facility name) and V16 is in consultation with the Infectious Disease Department of the hospital. This record documents V16's further evaluation of R1 as, Rashes under both breasts and groin, and bed sores on the buttocks not present at discharge from the hospital on 8/8/24. This record documents V16 conducted a surgical debridement of R1's lumbar incision, removing staples, noting a large amount of brown purulent material and liquid, surgically trimming the edges of the incision, and noted the muscle layer was also separated which required a deep debridement through the muscle layers, sanitized the deep debridement with 2 rounds each of Betadine Iodine and Hydrogen Peroxide, placing 1 gram of Vancomycin below the muscle layer, and 1 gram of Vancomycin above the muscle layer before being able to re-close the incision. This record documents R1's intravenous antibiotic was changed on 8/26/24 to Ceftriaxone 2 grams daily. On 8/28/24 at 4:45 PM, V18, [NAME] President of Administrative Operations, and V19, [NAME] President of Clinical Operations, stated they had become aware of the issues with R1's wound care treatments on 8/22/24, when R1's daughter (V12) had called the facility. V18 and V19 stated they had implemented a plan of correction to address the issues with the nursing staff to ensure treatments were being completed according to physician orders, and being documented correctly. Prior to the survey date of 8/27/24 and 8/28/24, the facility had taken the following actions to the non-compliance: 1. Held a Quality Assurance and Performance Improvement meeting including V23, Medical Director, V1 Administrator, V2, Director of Nursing, V19, Regional Clinical Nurse (Vice President of Clinical Operations), and V17 Registered Nurse, to determine a plan of correction. 2. Formulated a plan of correction including: 3. Residents with identified wounds have been provided wound treatments according to physician orders; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	4. Conducted a 100 percent audit of all residents residing in the facility to identify residents with wounds; 5. Provided inservice education to the licensed nursing staff regarding wound care, wound care policies, and documentation of treatments. 6. Implemented a wound monitoring tool to audit residents with wounds to ensure residents with wounds have an appropriate physician order for treatment, treatments completed timely and according to the physician order, wound monitoring documented timely, any changes in the wounds reported to the physician. These audits were completed for 6 residents on 8/22/24, 8/23/24, and 8/26/24, and for 4 residents on 8/25/24. These audits are scheduled in the plan of correction to be conducted for 5 residents weekly for 4 weeks.