

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145968	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2024
NAME OF PROVIDER OR SUPPLIER Kewanee Care Home		STREET ADDRESS, CITY, STATE, ZIP CODE 144 Junior Avenue Kewanee, IL 61443	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187</p> <p>Based on interview, observation, and record review the facility failed to ensure physician ordered treatments, skin checks, and infection monitoring were completed for three of three residents (R1, R2, R3) reviewed for wounds in the sample of three.</p> <p>Findings include:</p> <p>The facility's Medication Administration policy dated 11/18/17 documents, Policy: Drugs and biologicals are administered only by physicians and licensed personnel. Definition: The complete act of administration entails removing and individual dose from a previously dispensed, properly labeled container (including a unity dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given. Procedure: 19. Document any medication not administered for any reason by circling initials and documenting on the back of the MAR (Medication Administration Record) the date, the time, the medication and dosage, reason for omission and initials.</p> <p>The facility's Preventative Skin Care policy (undated) documents, Policy: It is the facility's policy to provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin conditions to keep them clean, comfortable, well groomed, and free from pressure ulcers. Procedures: 2. Staff on every shift and as necessary will provide skin care.</p> <p>1. On 7/26/24 at 12:00 PM R1's door had a droplet/contact precaution sign on her door. At this time R1 was lying in bed and was observed to have two dressings covering her left amputated knee stump. R1 stated she has been in and out of the hospital for the last few months for her left stump wound infection, urinary tract infections, and other issues with being confused.</p> <p>R1's Face Sheet documents R1 was admitted to the facility on [DATE]. This same form documents R1 has the following but not limited to diagnoses: Acquired absence of right foot, Morbid Obesity, Type Two Diabetes Mellitus with Diabetic Polyneuropathy, Gastroenteritis, Colitis, Cardiac Septal Defect, Anxiety disorder, type two Diabetes Mellitus with Diabetic Peripheral Angiopathy without Gangrene, Peripheral Vascular Disease.</p> <p>R1's Hospital Record dated 5/29/24 documents R1 is a status post above the knee left amputation.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's TAR (Treatment Administration Record) dated June 2024, documents Physician ordered treatments Start date 5/14/24: Cleanse open are to LT (left) inner buttock with wound cleanser, pat dry, apply to area and over with dry dressing one time a day for wound care. Start date 5/14/24: Cleanse open area to RT (right) inner buttock with wound cleanser, pat dry, apply and cover with dry dressing one time a day for wound care. This same record documents from 06/01/24 to 06/30/24, seven treatments to the right and left inner buttock were not completed on 6/3/24, 6/4/24, 6/6/24, 6/7/24, 6/17/24, 6/21/24, and 6/24/24.</p> <p>R1's TAR dated June 2024, documents a Physician ordered treatment, Start Date 6/6/24: Cover stump with dressing daily and prn (as needed) d/t (due to) drainage in the evening for dressing to left stump. This same record documents from 6/6/24 to 6/24/24, five treatments were not completed to left stump on 6/7/24, 6/10/24, 6/19/24, 6/20/24, and 6/23/24.</p> <p>R1's TAR dated June 2024, documents a Physician ordered treatment, Start date 6/6/24: Monitor left stump for s/s of infection every shift for staples/sutures. This same record documents from 6/6/24 to 6/27/24, ten treatments to monitor for s/s of infection to the left stump were not completed on 6/7/24, 6/10/24, 6/11/24, 6/17/24, 6/19/20 (evening and nights), 6/20/24 (evening and nights), 6/23/24, and 6/24/24.</p> <p>R1's TAR dated June 2024, documents a Physician ordered treatment, Start date 6/10/24: Place an unfolded 4 x 4 under each retention suture. Cover with fluffs, kerlix wraps gauze, tape and ace wrap daily every evening shift for seven days. This same record documents from 6/10/24 to 6/16/24, one treatment to the left stump was not completed on 6/10/24.</p> <p>R1's TAR dated June 2024, documents a Physician ordered treatment, Start date 6/21/24: Left stump incisor cleaned with wound cleaner, apply wet to dry dressing using 4 x 4 wet with normal saline, and covered with abd (Abdominal) pads until wound vac arrives two times a day for Wound Treatment. This same record documents from 6/21/24 to 6/24/24, one treatment to the left stump was not completed on 6/23/24.</p> <p>R1's TAR dated July 2024 document a Physician ordered treatment, Start date 7/13/24: Cleanse left stump with wound cleanser, pat dry. Apply 4 x 4 (gauze) with (wound neutralizing solution) and cover BID (Twice a Day). Every day shift and evening shift for wound care. This same record documents from 7/13/24 to 7/23/24, one treatment to left stump was not completed on 7/18/24.</p> <p>On 7/26/24 at 1:57 PM V2 (Director of Nursing) verified the treatments not completed on the June 2024 and July 2023 TARs. V2 stated, If a treatment is refused or the resident is out of the building, etcetera, the nurses should be documenting that on the TAR. The TARs should have no blanks in them. We (the facility) have had a lot of Agency Nurses, so I think that is why some of the treatments are getting missed.</p> <p>38396</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. R2's current care plan, dated 7/23/24, documents (R2) has Peripheral Vascular Disease (PVD) related to Diabetes and Heart Disease. Interventions: Monitor the extremities for signs and symptoms of injury, infection and ulcers. This same care plan documents (R2) has potential for skin tear and/or discoloration related to geriatric skin deconditioning and use of anticoagulants and PVD. Interventions: Monitor/document location, size, and treatment of skin tear. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, pain, etcetera to Medical Doctor.</p> <p>On 7/26/24 at 12:50 PM, R2 was sitting in her motorized wheelchair in her room. R2's right outer ankle contained a bandage dressing. R2 stated she has a wound to the outside of her right ankle from hitting it by accident and she must have the dressing changed by nurses every day.</p> <p>R2's Treatment Administration Record (TAR) dated, 6/1/24-6/30/24, documents R2 had Physician ordered treatments for Daily Skin Check, document using CROPS (Clear, Rash, Other, Pressure, Skin Tear) every night shift for preventative document weekly on Saturday. This TAR documents two scheduled daily skin checks were not completed in June on 6/11/24 and 6/21/24.</p> <p>This same TAR documents a treatment order Cleanse RT (right) outer ankle with wound cleanser, pat dry, apply mupirocin (topical antibiotic) ointment and cover with dry dressing every morning and at bedtime for wound care. This record documents the evening treatments were not administered on 6/5/24, 6/10/24, 6/12/24 and 6/24/24 for a total of four missed wound treatments.</p> <p>This same TAR documents the following Physician ordered treatments: Monitor RT outer ankle every shift for signs and symptoms infection/integrity every shift for scab area/ skin integrity. Skin prep to bilateral heels every shift for preventative. Site: Buttocks: Apply barrier cream as preventative every shift. This TAR documents for the month of June R2's right ankle monitoring, skin prep to bilateral heels and protective barrier cream to the buttocks were not administered/completed on three scheduled occasions on 6/10/24, 6/11/24, and 6/21/24.</p> <p>3. R3's current care plan dated, 5/6/24, documents R3 has diagnoses of Moderate Protein-Calorie Malnutrition, Type two Diabetes Mellitus, and Thrombocytopenia. This care plan also documents (R3) has the potential for pressure ulcer development related to decreased mobility, weakness, history of stage three (pressure ulcer) to sacral region, incontinence. (R3) also has diagnosis of Elastosis perforans serpiginosa. Interventions: Monitor/ document/ report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length by width by depth), stage.</p> <p>On 7/26/24 at 1:00 PM, R3 was in her room lying in bed. R3 confirmed she has had wounds and has needed dressings and treatments off and on.</p> <p>R3's Treatment Administration Record (TAR) dated, 7/1/24-7/31/24, documents R3 has a treatment order for Daily Skin Check every day shift Document: C=Clear; R=Rash, O=Other, P=Pressure, S= Skin Tear. This TAR documents that R3 did not have scheduled skin checks on 7/15/24 and 7/19/24.</p> <p>On 7/26/24 at 1:45 PM, V2 (Director of Nursing) confirmed R2 and R3 have missing treatments in their medical records for the months of June and July 2024. V2 stated If they are not signed off as being done, we have no way to prove they were done and there shouldn't have been holes in administration of those treatments.</p>		