STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146128	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Place	315 North LA Grange Road LA Grange Park, IL 60526

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33330 Based on interview and record review, the facility failed to protect the resident's right to be free from neglect when the facility failed to have R1's non-healing, chronic wounds assessed by a physician. This failure resulted in R1 being admitted to the hospital within 25 hours of discharge from the facility with a diagnosis of gangrene of the left first, second, and third toes, and requiring a left, above the knee leg amputation. This applies to 1 of 1 resident (R1) reviewed for wound care in the sample of 8. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 transferred to a different nursing facility on December 10, 2024. R1 had multiple diagnoses including, acute on chronic diastolic congestive heart failure, UTI (Urinary Tract Infection, COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure, Klebsiella pneumoniae, difficulty walking, cognitive communication deficit, lack of coordination, anemia, major depressive disorder, and generalized anxiety disorder. R1's MDS (Minimum Data Set) dated September 10, 2024 shows R1 was cognitively intact, required setup assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with toilet hygiene, showering, lower body dressing, personal hygiene, and bed mobility, and was dependent on facility staff for transfers between surfaces. R1 had an indwelling urinary catheter and was always incontinent of stool. R1's care plan for actual impairment to skin integrity, initiated on September 5, 2024 shows: Site: LT (Left) great toe scab. LT 2nd toe scab. R1 had multiple care plan interventions, initiated September 5, 2024, including, Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	R1's skin assessment, completed by V3 (WCN/LPN-Wound Care Nurse/Licensed Practical Nurse) on September 4, 2024 shows R1 had an open lesion on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. (centimeter) by 1 cm. V3's documentation does not show measurements for each of R1's wounds on his left great toe and R1's left second toe. V3's documentation does not show she notified R1's physician. On September 5, 2024 at 10:56 AM, V3 (WCN/LPN) documented R1 had intact scabbing to LT (Left) great and 2nd toe. On September 5, 2024 at 12:32 PM, V3 (WCN/LPN) documented a Skin Only Assessment. The assessment showed #005 New. Issue type: Open lesion (other than ulcers, rashes and cuts). Location: Left toe(s). Length (cm) 1, Width 1. R1's skin assessment, completed by V3 on September 10, 2024 shows R1 had an open lesion on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. by 1 cm. V3's documentation does not show she notified R1's physician. R1's skin assessment, completed by V3 on September 17, 2024 shows R1 had an open lesion on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes measurement as 1 cm. by 1 cm. V3's documentation does not show she notified R1's physician. R1's skin assessment, completed by V3 on September 28, 2024 shows R1 had an open lesion on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds, despite her ability to do so using the updated form available to her on September 28, 2024. V3 documented the left toes wound measurement as 1 cm. by 1 cm. The skin assessment form also shows: Skin issue notification: Dietitian, Family, Guardian, Manager, Other legally authorized representative, Provider, and Wound Nurse. V3 did not check the box to document any of the parties were notified of the wound, including R1's physician. R1's skin assessment, completed by V3 on October 1, 2024 shows R1 had a scab on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. by 1 cm. V3 did not document any parties were notified of R1's wounds, including R1's physician. R1's skin assessment, completed by V3 on October 8, 2024 shows R1 had a scab on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. by 1 cm. V3's documentation also shows: Stable, previously deteriorating wound characteristics plateaued. V3 did not document any parties were notified of R1's wounds, including R1's physician. V3 continued to document the same skin assessment for R1 on October 15, 22, 30, 2024 and November 11, 2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	R1's skin assessment, completed by V3 on November 13, 2024 shows R1 had a scab on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. by 1 cm. V3's documentation also shows: Stalled: previously improved wound characteristics plateaued. V3 continued to document the same assessment on November 20, 26, 2024 and December 4, 2024. V3 did not document any parties were notified R1's left toes wound healing had stalled, including R1's physician. On December 30, 2024 at 2:12 PM, V1 (Administrator) said, [V3] (WCN/LPN) should have documented separate wound measurements for each toe, as well as the appearance of each wound separately. There is no documentation to show [V3] spoke to [V8] (Attending Physician), or that [V8] was aware of the wounds. R1's Discharge Summary, dated December 6, 2024 shows: Clinical Summary: 1. Skin Intact: No (If no, a wound assessment must be completed). The facility does not have documentation to show a wound assessment was completed as shown on the facility's Discharge Summary form. The facility does not have documentation to show V3 (WCN/LPN) or any other facility staff assessed R1's left toe wounds from December 5, 2024 to December 10, 2024, the date of R1's discharge from the facility. V8 (Primary Care Physician) documented the following regarding R1: September 5, 2024: Wound care follow for superficial wounds. V8's documentation does not show any skin assessment was completed or documentation regarding R1's left toe wounds. September 10, 2024: Wound care follow for superficial wounds. V8's documentation does not show any documentation regarding R1's left toe wounds. September 17, 19, 24, 26, 2024 and October 3, 8, 2024: Wound care as needed. V8's documentation does not show any documentation regarding R1's left toe wounds. October 10, 15, 17, 22, 24, and 29, 2024: V8's documentation does not show any documentation regarding R1's left toe wounds. The facility does not have documentation to show any provider (Physician/NP-Nurse Practitioner/Podiatrist) examined R1 from October 29, 2024 to December 10, 2024, the date of his discharge. On December 19, 2024 at 2:25 PM, V7 (LPN) said she was the nurse who discharged R1 from the facility on December 10, 2024. V7 said, I did not see [R1's] feet the day of his discharge from the facility. He wore shoes. He always wanted them on. On December 19, 2024 at 3:12 PM, V5 (CNA-Certified Nursing Assistant) said, I had [R1] the day he discharged from the facility. He was already dressed when I started work that day, so I did not remove his shoes. A couple of days before, his toe looked black on his big toe. The last couple of days it was dark. I reported it to the nurse, but she said it was already reported. He liked to keep his socks on because he said his feet were always cold, so we left his socks on. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On December 23, 2024 at 10:20 AM, V3 (WCN/LPN) said, I did not actually see [R1's] toes on the day of his discharge (December 10, 2024). I did not do wound care on him the day he left even though I signed that I did it. I documented that I did his wound treatments, but I actually did not do the wound care treatments that day. He was gone from the facility by the time I got to him. On December 30, 2024 at 1:01 PM, V9 (RN-Registered Nurse) said he signed the TAR (Treatment Administration Record) on December 7, 2024 to show he completed a skin assessment on R1. V9 said, He (R1) always had a toe that was discolored. The second toe on the left foot was discolored, from betadine, I thought. I am assuming that I looked at his toes that day (December 7, 2024). We don't take off his socks all the time. We are required to look at the skin, so I guess I looked at it. They (CNAs) give us the shower sheet paper, and we sign it. I know the wounds have been there. We all know they have been there. Wound care takes care of it. I do not remember if more than one toe was involved. He usually liked a bed bath. If the CNA reports it to me, then I look at him. I am assuming I saw it, but I cannot remember every single patient. The discoloration was the color of betadine. Later I was told his toe had gangrene. I couldn't tell you if the discoloration I saw was gangrene or from betadine. V9 said he did not notify the physician of R1's toe discoloration. Hospital documentation for R1 shows R1 was admitted to the local hospital on December 11, 2024 at 1:28 PM. On December 11, 2024 at 5:44 PM, V10 (Vascular Surgery NP-Nurse Practitioner) documented, Subjective: [AGE] year-old male with history of CHF (Congestive Heart Failure) and COPD (Chronic Obstructive Pulmonary Disease) presents with ischemic left toes. Patient recently transferred from [the facility] to a different facility where they did their evaluation and noticed his gangrene left toes (1st through 3rd, starting to spread to 4th/5th). Unsure of how long have been like that. Family noted foul smell for over a week. Has not taken off socks in a while. Patient's foot is warm and can feel outside of gangrene toes. Cannot move left toes but can move at ankle. Plan: ischemic toes unsure of timeline (likely over a week), can feel foot and move at ankle . On December 12, 2024 at 9:45 AM, V11 (Hospital Podiatrist) documented, Given the amount of tissue loss and necrosis, a midfoot or proximal foot amputation is unlikely to heal and to be functional. [R1] and family did not want to have multiple procedures. I cannot guarantee that [R1] would ultimately heal or heal despite revascularization. As such, patient and family agreed a proximal amputation and vascular surgery is the best course of action. Hospital documentation dated December 13, 2024 continues to show R1 underwent a left above the knee amputation of the left leg, became hypotensive postoperatively and was admitted to the ICU. On December 23, 2024 at 11:32 AM, V8 (Attending Physician) said, It is unlikely that someone would go from a one centimeter wound to full gangrene in a day. It is unlikely that gangrene would come in one day, especially with an odor. I depend on wound nurses and facility staff to do their job. [R1] had chronic peripheral arterial disease, we know that. His leg was not a concern when I last saw him in October. If that changed, they should have notified me. The wound nurse and the wound care doctor work together at the facility. They should have automatically involved the wound care physician in [R1's] wound care. I was not aware [R1] was not being seen by the wound care doctor. These failures resulted in the poor outcome for [R1], requiring a leg amputation. That is not appropriate support or care for someone who comes to a facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's Abuse and Abuse Prevention Policy and Procedure reviewed, 1/16/24 shows: Each resident has the right to be free from abuse, neglect, exploitation, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, team members, other residents, consultants or volunteers, employees of other agencies serving the resident, family members or legal guardians, friends, or other individuals. This includes abuse and privacy violations that results from unauthorized and inappropriate use of social media. For purposes of our abuse policy, abuse includes verbal abuse, sexual abuse, sexual misconduct, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Definitions: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This includes but is not limited to failure to assist in personal hygiene or the provision of clothing for an elder, failure to provide medical care for the physical and medical health needs for an elder, and failure to protect an elder from health and safety hazards. It is the failure to monitor and/or supervise the delivery of resident care and a service to assure that care is provided as needed by the residents. In a community, neglect occurs when a community fails to provide necessary care for residents, such as situations in which residents are not being cleaned when necessary and appropriate.

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(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** 33330 Based on observation, interview, and record review, the facility failed to ensure a resident's non-healing, chronic wounds were assessed by a physician, failed to do a wound assessment prior to a resident's discharge from the facility, and failed to provide wound treatments as ordered by the physician. This failure resulted in R1 being admitted to the hospital within 25 hours of discharge from the facility with a diagnosis of gangrene of the left first, second, and third toes, and requiring a left, above the knee leg amputation. This applies to 8 of 8 residents (R1, R2, R3, R4, R5, R6, R7, and R8) reviewed for wound care in the sample of 8. The findings include: 1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 transferred to a different nursing facility on December 10, 2024. R1 had multiple diagnoses including, acute on chronic diastolic congestive heart failure, UTI (Urinary Tract Infection, COPD (Chronic Obstructive Pulmonary Disease), acute respiratory failure, Klebsiella pneumoniae, difficulty walking, cognitive communication deficit, lack of coordination, anemia, major depressive disorder, and generalized anxiety disorder. R1's MDS (Minimum Data Set) dated September 10, 2024 shows R1 was cognitively intact, required setup assistance with eating, partial/moderate assistance with oral hygiene, substantial/maximal assistance with toilet hygiene, showering, lower body dressing, personal hygiene, and bed mobility, and was dependent on facility staff for transfers between surfaces. R1 had an indwelling urinary catheter and was always incontinent of stool. R1's care plan for actual impairment to skin integrity, initiated on September 5, 2024 shows: Site: LT (Left) great toe scab. Lt 2nd toe scab. R1 had multiple care plan interventions, initiated September 5, 2024, including, Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD. R1's skin assessment, completed by V3 (WCN/LPN-Wound Care Nurse/Licensed Practical Nurse) on September 4, 2024 shows R1 had an open lesion on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. (centimeter) by 1 cm. V3's documentation does not show measurements for each of R1's wounds on his left great toe and R1's left second toe. V3's documentation does not show she notified R1's physician. On September 5, 2024 at 10:56 AM, V3 (WCN/LPN) documented R1 had intact scabbing to LT (Left) great and 2nd toe. (continued on next page)

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(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	On September 5, 2024 at 12:32 PM, V3 (WCN/LPN) documented a Skin Only Assessment. The assessment showed #005 New. Issue type: Open lesion (other than ulcers, rashes and cuts). Location: Left toe(s). Length (cm) 1, Width 1. R1's skin assessment, completed by V3 on September 10, 2024 shows R1 had an open lesion on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. by 1 cm. V3's documentation does not show she notified R1's physician. R1's skin assessment, completed by V3 on September 17, 2024 shows R1 had an open lesion on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes measurement as 1 cm. by 1 cm. V3's documentation does not show she notified R1's physician. R1's skin assessment, completed by V3 on September 28, 2024 shows R1 had an open lesion on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds, despite her ability to do so using the updated form available to her on September 28, 2024. V3 documented the left toes wound measurement as 1 cm. by 1 cm. The skin assessment form also shows: Skin issue notification: Dietitian, Family, Guardian, Manager, Other legally authorized representative, Provider, and Wound Nurse. V3 did not check the box to document any of the parties were notified of the wound, including R1's physician. R1's skin assessment, completed by V3 on October 1, 2024 shows R1 had a scab on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. by 1 cm. V3 did not document any parties were notified of R1's wounds, including R1's physician. R1's skin assessment, completed by V3 on October 8, 2024 shows R1 had a scab on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. by 1 cm. V3's documentation also shows: Stable, previously deteriorating wound characteristics plateaued. V3 did not document any parties were notified of R1's wounds, including R1's physician. V3 continued to document the same skin assessment for R1 on October 15, 22, 30, 2024 and November 11, 2024. R1's skin assessment, completed by V3 on November 13, 2024 shows R1 had a scab on his left toes. V3's skin assessment does not differentiate which left toes were affected by the wounds. V3 documented the left toes wound measurement as 1 cm. by 1 cm. V3's documentation also shows: Stalled: previously improved wound characteristics plateaued. V3 continued to document the same assessment on November 20, 26, 2024 and December 4, 2024. V3 did not document any parties were notified R1's left toes wound healing had stalled, including R1's physician. On December 30, 2024 at 2:12 PM, V1 (Administrator) said, [V3] (WCN/LPN) should have documented separate wound measurements for each toe, as well as the appearance of each wound separately. There is no documentation to show [V3] spoke to [V8] (Attending Physician), or that [V8] was aware of the wounds. (continued on next page)

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(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	R1's Discharge Summary, dated December 6, 2024 shows: Clinical Summary: 1. Skin Intact: No (If no, a wound assessment must be completed). The facility does not have documentation to show a wound assessment was completed as shown on the facility's Discharge Summary form. The facility does not have documentation to show V3 (WCN/LPN) or any other facility staff assessed R1's left toe wounds from December 5, 2024 to December 10, 2024, the date of R1's discharge from the facility. V8 (Primary Care Physician) documented the following regarding R1: September 5, 2024: Wound care follow for superficial wounds. V8's documentation does not show any skin assessment was completed or documentation regarding R1's left toe wounds. September 10, 2024: Wound care follow for superficial wounds. V8's documentation does not show any documentation regarding R1's left toe wounds. September 17, 19, 24, 26, 2024 and October 3, 8, 2024: Wound care as needed. V8's documentation does not show any documentation regarding R1's left toe wounds. October 10, 15, 17, 22, 24, and 29, 2024: V8's documentation does not show any documentation regarding R1's left toe wounds. The facility does not have documentation to show any provider (Physician/NP-Nurse Practitioner) examined R1 from October 29, 2024 to December 10, 2024, the date of his discharge. On December 19, 2024 at 2:25 PM, V7 (LPN) said she was the nurse who discharged R1 from the facility on December 10, 2024. V7 said, I do not do head-to-toe skin assessments on residents. We have a wound care nurse for that. I did not see [R1's] feet the day of his discharge from the facility. He wore shoes. He always wanted them on. On December 19, 2024 at 3:12 PM, V5 (CNA-Certified Nursing Assistant) said, I had [R1] the day he discharged from the facility. He was already dressed when I started work that day, so I did not remove his shoes. A couple of days before, his toe looked black on his big toe. The last couple of days it was dark. I reported it to the nurse, but she said it was already reported. He liked to keep his socks on because he said his feet were always cold, so we left his socks on. The EMR shows the following order for R1 dated September 6, 2024: LT great toe, cleanse with NSS (Normal Saline Solution), pat dry and paint with betadine every day shift for wound care. The EMR shows the following order for R1 dated September 9, 2024: LT 2nd toe, cleanse with NSS, pat dry, and paint with betadine every day shift for wound care. The EMR continues to show V3 (WCN/LPN) documented R1 was provided with his wound treatments on his left toes on December 10, 2024. On December 23, 2024 at 10:20 AM, V3 (WCN/LPN) said, I did not actually see [R1's] toes on the day of his discharge (December 10, 2024). I did not do wound care on him the day he left even though I signed that I did it. I documented that I did his wound treatments, but I actually did not do the wound care treatments that day. He was gone from the facility by the time I got to him. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On December 23, 2024 at 10:33 AM, V1 (Administrator) said, The nurse should never document she did the dressing change if she did not do it. On December 30, 2024 at 1:01 PM, V9 (RN-Registered Nurse) said he signed the TAR (Treatment Administration Record) on December 7, 2024 to show he completed a skin assessment on R1. V9 said, He (R1) always had a toe that was discolored. The second toe on the left foot was discolored, from betadine, I thought. I am assuming that I looked at his toes that day (December 7, 2024). We don't take off his socks all the time. We are required to look at the skin, so I guess I looked at it. They (CNAs) give us the shower sheet paper, and we sign it. I know the wounds have been there. We all know they have been there. Wound care takes care of it. I do not remember if more than one toe was involved. He usually liked a bed bath. If the CNA reports it to me, then I look at him. I am assuming I saw it, but I cannot remember every single patient. The discoloration was the color of betadine. Later I was told his toe had gangrene. I couldn't tell you if the discoloration I saw was gangrene or from betadine. V9 said he did not notify the physician regarding R1's toe discoloration. Hospital documentation for R1 shows R1 was admitted to the local hospital on December 11, 2024 at 1:28 PM. On December 11, 2024 at 5:44 PM, V10 (Vascular Surgery NP-Nurse Practitioner) documented, Subjective: [AGE] year-old male with history of CHF (Congestive Heart Failure) and COPD (Chronic Obstructive Pulmonary Disease) presents with ischemic left toes. Patient recently transferred from [the facility] to a different facility where they did their evaluation and noticed his gangrene left toes (1st through 3rd, starting to spread to 4th/5th). Unsure of how long have been like that. Family noted foul smell for over a week. Has not taken off socks in a while. Patient's foot is warm and can feel outside of gangrene toes. Cannot move left toes but can move at ankle. Plan: ischemic toes unsure of timeline (likely over a week), can feel foot and move at ankle . On December 12, 2024 at 9:45 AM, V11 (Hospital Podiatrist) documented, Given the amount of tissue loss and necrosis, a midfoot or proximal foot amputation is unlikely to heal and to be functional. [R1] and family did not want to have multiple procedures. I cannot guarantee that [R1] would ultimately heal or heal despite revascularization. As such, patient and family agreed a proximal amputation and vascular surgery is the best course of action. Hospital documentation dated December 13, 2024 continues to show R1 underwent a left above the knee amputation of the left leg, became hypotensive postoperatively and was admitted to the ICU. On December 23, 2024 at 11:32 AM, V8 (Attending Physician) said, It is unlikely that someone would go from a one centimeter wound to full gangrene in a day. It is unlikely that gangrene would come in one day, especially with an odor. I depend on wound nurses and facility staff to do their job. [R1] had chronic peripheral arterial disease, we know that. His leg was not a concern when I last saw him in October. If that changed, they should have notified me. The wound nurse and the wound care doctor work together at the facility. They should have automatically involved the wound care physician in [R1's] wound care. I was not aware [R1] was not being seen by the wound care doctor. These failures resulted in the poor outcome for [R1], requiring a leg amputation. That is not appropriate support or care for someone who comes to a facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146128	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Place	315 North LA Grange Road LA Grange Park, IL 60526

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. The EMR shows R4 was admitted to the facility on [DATE]. R4 has multiple diagnoses including, displaced fracture of left femur, aftercare following joint replacement, heart failure, hypoxia, dementia, history of falling, insomnia, and heart failure. R4's MDS dated [DATE] shows R4 has moderate cognitive impairment, requires setup assistance with eating, supervision with oral and personal hygiene, partial/moderate assistance with transfers between surfaces, and substantial/maximal assistance with toilet hygiene, showering, lower body dressing, and bed mobility. R4 is frequently incontinent of urine and always incontinent of stool. The EMR shows the following order for R4 dated December 16, 2024: Left hip, cleanse with NSS (Normal Saline Solution), pat dry, and cover with dry dressing every Monday, Wednesday, Friday. The EMR shows wound treatment documentation by facility staff, including V3 (WCN/LPN) was completed as ordered on December 16, 18, and 20, 2024. On December 23, 2024 at 9:42 AM, R4 was lying in bed. V3 (WCN/LPN) was providing wound care treatments to R4. V3 turned R4 to his right side. A dressing was covering R4's left hip. The dressing was dated 12/16. V3 said, I was gone on December 18 and 20. No one did his wound treatment since I did it on December 16. V3 removed the dressing. Dark, red drainage was noted on the dressing. R4's left hip incision was approximately six inches long and had multiple staples in place. The skin at the top of the incision was bright red and appeared inflamed for approximately one inch in length, from the top of the incision towards the middle of the incision. The skin at the bottom of the incision was bright red and appeared inflamed for approximately one inch from the bottom of the incision towards the middle of the incision. V3 said there was drainage coming from the incision when she pressed on the incision. The dressing change was completed without incident. Following R4's dressing change, R4's December 2024 TAR was reviewed with V3. R4's TAR showed V3 documented she completed R4's dressing change on December 18, 2024, and V12 (LPN) completed the dressing change on December 20, 2024. V3 said, I documented that I did the dressing change, but I never did it because I did not come to work that day. My husband was in a car accident. 3. Wound care administration documentation was reviewed for R2, R3, R4, R5, R6, R7, and R8 with V3 (WCN/LPN) and V1 (Administrator) on December 23, 2024 at approximately 10:15 AM. The EMR shows the following order for R2's right heel arterial wound dated December 5, 2024: Right heel cleanse with NSS, pat dry, apply betadine saturated gauze, cover with [surgical pad], wrap with [stretch gauze] and secure with tape every Monday, Tuesday, Wednesday, Thursday, and Friday. The EMR shows the following order for R3's left medial foot arterial wound dated December 4, 2024: Left medial foot cleanse with NSS, pad dry, apply calcium alginate and cover with foam dressing every Monday, Wednesday, Friday for wound care. The EMR shows the following order for R5's right medial heel diabetic ulcer dated November 6, 2024: Right heel cleanse with NSS, pat dry, paint with betadine and cover with dry dressing every day shift every Monday, Wednesday, Friday for wound care. The EMR shows the following order for R6's Right hip surgical site dated December 11, 2024: Right hip cleanse with NSS, pat dry, and cover with foam dressing every day shift every Monday, Wednesday, Friday for wound care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146128	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Place	315 North LA Grange Road LA Grange Park, IL 60526

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The EMR shows the following order for R7's head laceration dated December 23, 2024: Top of head, cleanse with NSS, pat dry then cover with foam dressing every day shift every Monday, Wednesday, Friday. The EMR shows the following order for R8's right hip surgical wound dated December 9, 2024: Right hip cleanse with NSS, pat dry, apply xeroform and over with foam dressing every day shift every Monday, Wednesday, Friday for wound care. The TARs for R2, R3, R4, R5, R6, R7, and R8 all showed V3 (WCN/LPN) documented she administered wound care treatments to R2-R8 on December 18, 2024, despite V3 not working at the facility that day. With V1 (Administrator) present, V3 said she came to work for 30 minutes on December 18, 2024. V3 said she received a telephone call that her husband was in a car accident, and she had to leave the building. V3 continued to say she documented she completed the wound care treatments for R2, R3, R4, R5, R6, R7, and R8 on December 18, 2024. V3 said she documented she completed the wound care treatments but did not actually perform the wound care treatments as ordered. V3 also said she did not instruct any nursing staff to complete the wound care treatments in her absence, nor did she report this information to V1 (Administrator) or V2 (DON-Director of Nursing). V1 (Administrator) responded by saying, [V3] was not supposed to document she did the dressing changes when she did not do the dressing changes. The facility's time card printout for V3 (WCN/LPN), printed on December 23, 2024 shows V3 worked 0.5 hours on December 18, 2024, and was on vacation on December 20, 2024. The facility's policy entitled Wound Care, reviewed on 01/26/2024 shows: Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Procedures: Preparation: 1. Verify that there is a physician's order for this procedure . Documentation: The following information 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 name and title of the individual performing the wound care. 4. If resident refused dressing change document reason why.