STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN TERRACE	**2324 NORTH KICKAPOO STREET LINCOLN, IL 62656**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS INCIDENT INVESTIGATION Incident of 2/2/12IL58694	W 000		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210b) 350.1220e) 350.1230b) 350.1230e) 350.1410a) 350.1410d) 350.1410h) 350.1420a) 350.1430a)2) 350.1610f) 350.3220f) 350.3240a) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1220 Physician Services	W9999		

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

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W9999	Continued From page 1 e) All residents shall be seen by their physician as often as necessary to assure adequate health care. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.1410 Medication Policies and Procedures a) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. d) All medications administered shall be recorded as set forth in Section 350.1620. h) A facility may stock drugs that are regularly available without prescription. These shall be administered to a resident only upon written order of a licensed prescriber. Administration shall be from the original containers, and shall be recorded in the resident's clinical record.	W9999		

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W9999	Continued From page 2 Section 350.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. Section 350.1430 Administration of Medication a) 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 350.1620.) Section 350.1610 Resident Record Requirements f) A medication administration record shall be maintained which contains the date and time each medication is given, name of drug, dosage, and by whom administered. Section 350.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on interview and record review, the facility failed to follow their own policies to prevent	W9999		

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W9999	Continued From page 3 neglect, resulting in second and third degree burns to R1's foot, when the facility failed to: 1 - ensure accurate assessment of R1's independence in water temperature regulation relative to his diagnoses of Insulin Dependent Diabetes Mellitus; 2 - ensure an accurate reading of water temperature prior to providing a"tea soak" to R1's feet; 3 - ensure reproducible documentation for implementing R1's foot "tea soaks", foot wrap and application of Sensa Care Protect Barrier; 4 -ensure that the consulting nurse assessed R1's feet after staff expressed concern, prior to instructing direct care staff to administer "tea soaks" and a cream with wrap, without obtaining a physician's order; 5 - ensure that the consulting nurse was notified of R1's deteriorating foot condition after the initial 1/31/12, 4:30 p.m. notification; 6 - ensure timely physician services for R1's documented foot injury and pain; Findings include: In review of R1's 7/12/11 Individual Service Plan (ISP), R1 functions in the moderate range of mental retardation. His 6/24/11 Scales of Independent Behavior-Revised (SIB-R), documents an overall functioning level of 7 years and 10 months. This ISP further documents that R1 ambulates with the assistance of a cane, is able to communicate and make his wants and needs known. An undated facility guardianship list for individuals of the facility validates that R1 does not have a	W9999		

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legal guardian.

R1's 2/12 physician's orders document that R1 is 56 years of age, with medical diagnoses of Insulin Dependent Diabetes Mellitus (IDDM), Coronary Artery Disease (CAD), Peripheral Vascular Disease (PVD), Hypertension, Chronic Renal Insufficiency, Recurrent Foot Ulcers, Cellulitis of Right Foot and Anemia.

In review of a 2/3/12 facsimile from the facility to the Department, it states that on 2/2/12, R1 was admitted to the hospital for treatment of blisters due to a burn to his right foot.

The facility's 2/7/12 "Investigative Committee Summary" and signed, dated, handwritten staff interviews obtained through the facility's own investigation was reviewed and documents the following:

On 1/31/12 at approximately 4:00 p.m. E1 (cook), prepared a "tea soak" for R1. E3 and E4 (direct service persons - DSP) assisted. R1's feet were placed into two separate containers for approximately 15-20 minutes.

E3's 2/3/12 handwritten signed interview documents the following:

E3 observed that R1's feet looked swollen, with sores and were blackish in color. E3 called E7 (Registered Nurse -RN). E3 received permission from E7 (RN), to soak R1's feet in a tea bath, and further direct E3 to look for a cream to apply to his legs and feet, and to clean and bandage the ulcerated area.

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W9999	Continued From page 5 E1's 2/3/12 hand written signed interview documents the following: E1 proceeded to find a coffee pot of hot water and placed a container of brewed tea in it, took it to the kitchen and split the tea/water mixture between two containers. E1, "Run cold water from the tap and proceeded to place cold water in the hot tea water. Checked and stirred it with my hands and then checked the contents with my elbow." E1 had R1 get out of bed and place his feet into the two separate containers. E1 then went back to the kitchen and set the microwave alarm for 20 minutes, the "time recommended on soaking his feet." E7's (RN), 2/3/12 hand written signed interview documents the following: On 1/31/12 between 4:00-5:30 p.m., he was called by facility staff, regarding R1's feet. E7 instructed staff to apply moisturizing cream. Staff was not able to apply as did not have any cream. Staff asked if they could soak R1's feet in water with tea. "Informed that was okay to moisturing (moisturize) areas to prevent from areas getting worse." E6's (Qualified Mental Retardation Professional - QMRP), handwritten signed interview documents the following: E6 (QMRP) called (E7) after he was notified of the condition of R1's feet. At this time E7 (RN) told E6 (QMRP) that he would call the pharmacy and ""get some ointment on his feet tonight". E7 told E6 that he would call the facility back and inform them that he would order some ointment that they could put on R1's feet when it comes in.	W9999		

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E2's (DSP), 2/1/12 handwritten signed interview documents the following:
E2 came into work on 1/31/12 at 11:30 p.m. The ointment had just come in for R1's feet. When R1 removed his right sock, "water squirted out. When he got his sock off the top of his foot just below his toes was all peeled back. A big blister had bursted. He had a huge blister on the whole outside of his foot and a 2 1/2 x 1/2 inch wide on the inside of the heel. His big toe had a huge blister as well. His toes was discolored (black, blue, purple), with some sores on them. His foot was very swollen. I called (E6 - QMRP) and explained what we had just seen. (E4) was still here. He said to go ahead and dress it and he would be looked at the next day by the RN or Dr....(R1) told me that it burned when he soaked it...the next morning (2/1/12), I changed his dressing and the blisters had oozed quite a bit. He had a new dime size blister that had popped up during the night on the inside of foot by his big toe. I applied ointment (Sensi-Care protect Barrier) and bandaged it back up...A doctor's appointment was made for 1:00 p.m. ...".

E2's GP-15 "Progress Note", dated 2/1/12 at 9:30 a.m., regarding R1's 1/31/12 foot incident was reviewed. This document also validates that E6 (QMRP) was notified by E2 after she came in for her 11:30 p.m. shift. It further validates that nursing was not called after E2's 11:30 p.m. observation of R1's foot, "as the nurse had been notified earlier in the evening."

E8's (DSP) 2/3/12, handwritten signed interview documents the following:
"I was notified of (R1's) foot around 7:15 a.m. Wednesday Feb. 1, 2012...At 7:30 I talked to

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W9999	Continued From page 7 (E7-RN) about sick residents then informed him about (R1's) (r) foot being swollen, red & blistered." E7(RN) instructed to get R1 in to be checked. A 2/1/12 physician's consult documents blisters on R1's right foot, swelling and open sores. Diagnosis is right foot burn. Under 'recommendations' - "see daily for dressing change", and Keflex 500 mg. p.o., three times daily for 1 week. A 2/2/12 physician's consult documents that R1 has partial and full thickness burns to his right foot. Recommendations for admission to the burn clinic for wound care and possible surgical debridement. In review of 2/2/12 hospital admit records, R1 was admitted to the hospital on 2/2/12. "The patient has a history of peripheral neuropathy and does have frequent wounds on his right lower extremity...The patient states that the burns are painful...The foot has demarcated lines of burns on the medial and lateral aspects of the foot...The burns, however, do appear to be deep partial-thickness as well as some full-thickness area....There is some white eschar present...All the toes on the right foot have large blisters present. The foot has demarcated lines of burns on the medial and lateral aspects of the foot...superficial burns to the left foot, especially the left 2nd toe..." The assessment and plan area of the document states, "2nd and 3rd-degree burns to the right foot...Due to the depth of the burns and the	W9999		

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history of diabetes, the patient will require admission to the burn unit for further wound care as well as possible surgical debridement. We will apply (antibiotic) to the burns twice daily and place him in whirlpool tub daily...We will use p.r.n. (as needed), Morphine and Norco for his pain...".

Hospital discharge notes of 2/15/12 document that R1 was discharged to a nursing home on this date. Physician discharge orders are documented for the following: Silver Sulfadiazine Cream, apply topically twice daily, with wound care dressing change twice daily. R1 to return to the burn unit for followup in two weeks.

In an interview with E9 (Executive Director), on 7/20/12, at 10:52 a.m., E9 stated that R1 was discharged from the hospital to the nursing home for other pre-existing health problems, not specifically for the foot burn.

A 4/2/12 "Voluntary Discharge Staffing" for R1 states that after week 1 at the nursing home, R1 is not able to walk on his foot; week 2 - "(R1)" has been laid up in his room, because of not being able to walk on his foot...will go out to the front of (nursing home) with his wheel chair to watch the people go and in and out..."; week 3 - "...doing a lot better with his foot, he has been walking around on his feet...still using a wheelchair..."; week 4 - "walking around on his foot."

Per the facility's 2/7/12 "Investigative Committee Summary", under "Summary of Findings", it states
"Neglect: Failure to provide good and services

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W9999	Continued From page 9 necessary to avoid physical harm, mental anguish, or mental illness." "The committee finds that the burn that affected resident (R1) was the result of staff failing to avoid physical harm while administering a "tea soak". As the "tea soak" was administered by staff, all individuals involved neglected to get an accurate reading of the water temperature. An accurate reading can only be done by using a calibrated thermometer. Findings indicate that this was not done. Also, applications of any type should be approved in writing by a physician and indicated as such on the residents POS (Physician's order sheet) and MAR (Medication Administration Sheet). Records indicate that resident (R1) had no such order." 1- ensure accurate assessment of R1's independence in water temperature regulation, relative to his diagnosis of Insulin Dependent Diabetes Mellitus; R1's 1/12 physician's orders document his admit to the facility on 7/21/09. His 7/20/09 "Pre-Admission Individual Service Plan" documents medical diagnoses of : Cellulitis of the Right Foot, Foot Ulcers, Chronic Renal Insufficiency, Hypertension, PVD, CAD, IDDM and Osteomyelitis to the right foot. In review of R1's "Regulating Water Temperature Assessment" of 6/22/11, R1 was assessed as capable of regulating water temperature.	W9999		

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W9999	Continued From page 10 His 7/12/11, IPP states that R1 can adjust water faucets for proper temperature for bathing. In review of the 7/12/11 IPP and the 6/22/11 "Regulating Water Temperature Assessment", there is no reproducible evidence that addresses the possible need to consider R1's Diabetes and associated medical diagnoses with regards to the water temperature regulation assessment. The facility's 2/7/12 "Investigative Committee Summary" recommends that R1 be re-evaluated regarding hot water regulation as his Diabetic condition may prohibit the sense of heat. 2- ensure an accurate reading of water temperature prior to providing a"tea soak" to R1's feet; E1's 2/3/12 hand written signed interview documents the following: E1 proceeded to find a coffee pot of hot water and placed a container of brewed tea in it, took it to the kitchen and split the tea/water mixture between two containers. E1, "Run cold water from the tap and proceeded to place cold water in the hot tea water. Checked and stirred it with my hands and then checked the contents with my elbow." E1 had R1 get out of bed and place his feet into the two separate containers. E1 then went back to the kitchen and set the microwave alarm for 20 minutes, the "time recommended on soaking his feet." The facility's 2/7/12 "Investigative Committee Summary" states, "As the "tea soak" was administered by staff, all individuals involved neglected to get an accurate reading of the water	W9999		

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temperature. An accurate reading can only be done by using a calibrated thermometer. Findings indicate that this was not done."

3 - ensure reproducible documentation for implementing R1's foot "tea soaks", foot wrap and application of Sensa Care Protect Barrier;

In review of R1's MAR for 1/31/12 and 2/1/12, there is no reproducible documentation regarding R1's 1/31/12 "tea soak", application of Sensa Care Protect Barrier or foot dressing.

In an interview with E2 on 7/31/12, at 12:42 p.m., E2 confirmed that she had not documented any of the above treatments for R1.

4 - ensure that the consulting nurse assessed R1's feet after staff expressed concern, and, prior to instructing direct care staff to administer "tea soaks" and a cream with wrap, without obtaining a physician's order;

Per the facility's investigation interview of 2/3/12 with E3 (DSP), E3 documents that at approximately 3:45 p.m., she became concerned that R1's feet appeared swollen, with sores and were blackish in color. E3 called E7 (RN).

Per the facility's investigation interview of 2/3/12 with E7 (RN), E7 documents that on 1/31/12, between 4:00-5:30 p.m., he instructed staff to apply moisturizing cream to areas on R1's right foot. Staff was not able to apply, did not have any cream." Staff asked if they could soak R1's feet in water with tea. "I informed that was okay...to

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prevent from areas getting worse." This interview further documents that E7 (RN) was contacted by staff the next morning, and was informed that the areas were weeping. E7 instructed staff to have R1 seen by a physician. (E8's -DSP 2/2/12 handwritten interview states that she talked to E7 (RN) about 7:30 on 2/1/12 and informed E7 that R1's right foot was swollen, red and blistered.)

E6's (QMRP), facility investigation interview of 2/3/12, documents that on 1/31/12, E7 (RN), told E6 (QMRP), that he would call the pharmacy and get some ointment for R1's feet on this same date. E6 instructed E2 (DSP) at 11:30 p.m. to apply the ointment that had come in and "wrap" R1's foot as E7 (RN) had instructed.

In review of R1's 1/1/12 physician's orders, there is no reproducible evidence of a physician's order for "tea soaks" or any creams or wraps for R1's feet.

E2's (DSP), facility's investigation interview of 2/1/12, documents that she came to work on 1/31/12 at 11:30 p.m. E2 stated in this interview that she applied the ointment and dressed the foot when she first arrived at 11:30 p.m. and again the next morning.

The facility's 2/7/12 "Investigative Committee Summary", under "Summary of Findings", states "...applications of any type should be approved in writing by a physician and indicated as such on the residents POS sheet and MAR record. Records indicate that resident (R1) had no such order."

This was further confirmed in an 8/6/12, 11:30

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W9999	Continued From page 13	W9999		

a.m., interview with E10 (Administrator). E10 stated that the Sense Care Protect Barrier was an over the counter medication obtained by the consulting nurse (R7) on 1/31/12. E10 further stated that this medication had been ordered by R1's physician previously, but was a one time past order and had been discontinued, thinking it was back in November of 2011.

Additionally, there is no reproducible evidence in R1's chart that nursing assessed R1's feet prior to instructing direct care staff on 1/31/12 to administer the "tea soaks", apply moisturizing cream and wrap the foot; and no reproducible evidence of nursing assessment on 2/1/12, when E7 was notified at 7:30 a.m. by (E8 - per her 2/3/12 handwritten interview), that R1's foot was swollen, red and blistered.).

In a 7/31/12, 11:50 a.m., interview with E10 (Administrator), E10 stated that E7 (RN) had been discharged, and that he could not locate any further nursing documentation.

5 - ensure that the consulting nurse was notified of R1's deteriorating foot condition after the initial 1/31/12 4:30 p.m. notification;

E2's 2/1/12 handwritten signed interview documents the following:

E2 came into work on 1/31/12 at 11:30 p.m. The ointment had just come in for R1's feet. When R1 removed his right sock, "water squirted out. When he got his sock off the top of his foot just below his toes was all peeled back. A big blister

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	14G208	A. BUILDING _____ B. WING _____	C 08/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN TERRACE	2324 NORTH KICKAPOO STREET LINCOLN, IL 62656

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W9999	Continued From page 14	W9999		

had bursted. He had a huge blister on the whole outside of his foot and a 2 1/2 x 1/2 inch wide on the inside of the heel. His big toe had a huge blister as well. His toes was discolored (black, blue, purple), with some sores on them. His foot was very swollen. I called (E6 - QMRP) and explained what we had just seen. (E4) was still here. He said to go ahead and dress it and he would be looked at the next day by the RN or Dr...".

E2's handwritten signed GP-15 further states that she called E6 (QMRP), but did not notify the nurse.

E6's handwritten signed 2/3/12 interview states that he was initially notified between 4:00-4:45 p.m., regarding the blisters on the top of R1's foot, at which time E7 (RN) was notified. At 11:30 p.m., the interview documents that E6 received a phone call from E2, stating that there are blisters and "it was red all around his heels." E6 instructed E2 to go ahead and apply the ointment and wrap the foot as per E7's instruction.

E7's (RN), 2/3/12, handwritten signed interview states that he was initially called on 1/31/12, between 4:00-5:30 p.m. regarding R1's foot and leg that was dry and cracked. E7 was then contacted the next morning (2/1/12) and informed that the areas were weeping.

In an 8/6/12, 3:30 p.m., phone interview with E6 (QMRP), when asked, E6 stated that the had not notified E7(RN), after E2's 11:30 p.m. call regarding R1's foot condition.

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W9999	Continued From page 15 6 - ensure timely physician services for R1's documented foot injury; Per the facility's 2/7/12 "Investigative Committee Summary", on 1/31/12, facility staff prepared and facilitated a "tea soak" for R1's feet, at approximately 4:00-4:30 p.m. E2's 2/1/12 handwritten signed interview documents the following: E2 came into work on 1/31/12 at 11:30 p.m. The ointment had just come in for R1's feet. When R1 removed his right sock, "water squirted out. When he got his sock off the top of his foot just below his toes was all peeled back. A big blister had bursted. He had a huge blister on the whole outside of his foot and a 2 1/2 x 1/2 inch wide on the inside of the heel. His big toe had a huge blister as well. His toes was discolored (black, blue, purple), with some sores on them. His foot was very swollen. I called (E6 - QMRP) and explained what we had just seen. (E4) was still here. He said to go ahead and dress it and he would be looked at the next day by the RN or Dr...the next morning (2/1/12), I changed his dressing and the blisters had oozed quite a bit. He had a new dime size blister that had popped up during the night on the inside of foot by his big toe. I applied ointment (Sensi-Care protect Barrier) and bandaged it back up...A doctor's appointment was made for 1:00 p.m. ...". The facility's 2/7/12, "Investigative Committee Summary", documents that R1 complained to E2 (DSP), that his foot was hurting at approximately 11:30 p.m. E2's (DSP), 2/1/12 handwritten interview	W9999		

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W9999	Continued From page 16 documents that R1 did not receive medical attention until 2/1/12 at 1:00 p.m., R1 was subsequently diagnosed with 2nd and 3rd degree burns to his right foot, requiring hospitalization from 2/2/12-2/15/12 (hospital discharge notes). The 4/2/12 "Voluntary Discharge Staffing" for R1 states that after week 1 at the nursing home, R1 is not able to walk on his foot; week 2 - "(R1) has been laid up in his room, because of not being able to walk on his foot...will go out to the front of (nursing home) with his wheelchair to watch people go out..."; week 3 - "...doing a lot better with his foot, he has been walking around on his feet...still using a wheelchair...". week 4 - "walking around on his foot." Facility policies were reviewed. Per the 5/12 Investigative Committee policy, it defines Neglect as follows: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Per the 06/10, Nursing Services policy, it states, "The facility shall provide nursing services necessary to meet individual's needs and to comply with licensing standards. All individuals shall receive proper treatment of minor accidents and/or illnesses through the R.N. Consultant." The purpose of Nursing Services is "To maintain an optimal level of health to all individuals via R.N. Consultant intervention...To serve as a primary resource of health care...The R.N. Consultant ...shall provide care for minor illnesses, injuries and emergencies...shall	W9999		

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W9999	Continued From page 17 complete ...PRN (as needed) visits to facilities." Per the 11/08, Medical Services policy, it states that the purpose is to provide appropriate procurement...of medical services for individuals of the facility...The facility shall maintain effective arrangements through which medical and remedial services outside the facility that are required by individuals can be obtained promptly when needed...All medication taken by individuals must be ordered by the attending physician directly from a pharmacy...". Per the 11/08, Medication Administration Record policy, it states that the facility shall provide a medication administration record that is part of the individual's permanent record. It is an important record that describes the medications used by the individual, the doses, the routes, and the times medications were taken...The MAR shall provide the names of the medications, dosage form, dosage, and route of administration, as ordered by the physician, and the time or frequency of administration. Regarding documentation on the MAR, the initials of the authorized direct care staff must appear below the correct date and opposite the time the medication was administered. Staff are to record on the MAR immediately after administering the medication. Protocols for PRN (as needed) medications are also described in this policy. The physician order sheet shall include the name of the individual, name, route and dosage form of the medication, dosage or quantity to be taken, frequency or time of administration, conditions for which the medication may be given, a maximum or stop	W9999		

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W9999	Continued From page 18 dosage, and necessary special directions/precautions. Per the 11/08, Ordering Medications policy, it states that all medications/treatments shall be specifically prescribed for the individual in writing and signed by the prescribing physician. Per the 11/08, DSP Monitoring of Hot Water Temperatures policy, it states that the facility endeavors to maintain hot water, accessible to residents, at a safe temperature range (between 100-110 degrees Fahrenheit), with the purpose of ensuring the safety of all individuals. (B)	W9999		