<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S000</td>
<td>Initial Comments</td>
<td>S000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complaint Investigation:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>#2047803/IL 127369</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>#2047342/IL 126859</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A Focused Infection Control Survey/COVID-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Focused Survey was conducted by Illinois Department of Public Health on October 23, 2020.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9999</td>
<td>Final Observations</td>
<td>S9999</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statement of Licensure Violations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300.610a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300.1210b)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300.1210(d)2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300.1220(b)2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300.3240(a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section 300.610 Resident Care Policies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>(X5) COMPLETE DATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9999</td>
<td>Continued From page 1</td>
<td>S9999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

1) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
### Continued From page 2

Section 300.3240 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 were not met evidenced based on:

Based on observation, interview, and record review, the facility failed to accurately evaluate and provide a pain management regimen to promote comfort and compliance for effective wound care for 1 (R4) of 3 residents reviewed for pain the sample of 17. This failure resulted in R4 experiencing pain, compromising the effectiveness and compliance level of wound care, and resulted in R4 acquiring a maggot infestation with otitis externa to his right ear requiring Emergency Room evaluation and treatment on 9/11/20 and 9/12/20. Also, the facility failed to assess, develop, and implement an effective plan of care for cancerous lesion, in order to prevent otitis externa and a maggot infestation within a wound for 1 (R4) of 5 residents reviewed for wound care in the total sample of 17. This failure resulted in R4 acquiring a maggot infestation with otitis externa to his right ear, requiring Emergency Room evaluation and treatment on both 9/11/20 and 9/12/20.

The Findings Include:

R4's admission record documents an admission date of 9/6/19 and includes the following diagnoses: protein-calorie malnutrition, dysphasia, diabetes, chronic kidney disease, repeated falls, unspecified knee pain, pain in right
S9999 Continued From page 3

shoulder, muscle weakness, unspecified abdominal pain, and malignant melanoma of the skin. R4's quarterly MDS (Minimum Data Set) dated 10/13/20, documents a BIMS (Brief Interview of Mental Status) of 10 indicating a moderate cognitive impairment. On this same MDS for ADL (Activities of Daily Living) care, R4 is coded as needing a one-person physical assist for: bed mobility, transfers between surfaces, walking in room, walking in corridor, dressing, toilet use, and personal hygiene. R4 is coded as needing a one-person physical assist for bathing. These were all coded the same on all MDS's dated on a quarterly on 9/29/20, and annual MDS on 8/27/20 and an annual MDS on 6/15/20.

A Minimum Data Set dated 10/13/20 documents R4's Brief Interview for Mental Status (BIMS) score as 10, indicating moderate cognitive impairment.

Review of R4's Plan of care documents a problem area with a revision date of 9/10/19 stating "chronic pain r/t (related to) Arthritis, Cancer (skin), gout" with interventions including but not limited to, "Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care .... Provide the resident and family with information about pain and options available for pain management. Discuss and record preferences."

Review of R4's current and active physician orders documents an order with a start date of 9/6/19 stating, "Pain- Record highest level of pain every shift." The same physician's orders also document an order with a start date of 9/6/19 and discontinue date of 10/16/20 stating "Acetaminophen Tablet 325 MG (milligram) Give
S9999 Continued From page 4

2 tablet by mouth every 6 hours as needed for mild pain (1-3 on the pain scale) NTE (not to exceed) 3gms (Grams) of Acetaminophen in 24 hours. Review of R4's Clinical Record documents a new physician order with a start date of 10/17/20 that states, "Acetaminophen Tablet 325 MG, Give 2 tablet by mouth one time a day for 2 tablets = (equals) 650mg related to Malignant Melanoma of Skin, Unspecified, assess for pain if pain is > (greater than) 4 notify MD (Medical Doctor) AND Give 2 tablet by mouth every 8 hours as needed for pain 1-4. Notify MD if pain is greater than 5/10 related to Malignant Melanoma of Skin, Unspecified PRN (as needed) is not to be given within 8 hours of scheduled dose." R4's Physician Orders with a start date of 11/22/19 and discontinue date of 10/15/20 documents, R4 self-administers. Cleanse lesions to right ear, left nares/upper lip with n/s (normal saline), pat dry. Monitor for weeping/drainage/bleeding. Start date 10/18/19 and discontinue date of 10/15/20, "White Petrolatum Apply to left nose/upper lip topically every day shift for wound care unsupervised self-administration cleanse with normal saline." Additional Physician Orders are noted with a start date of 9/12/20 for Neomycin-Polymyxin-HC (Otic) Suspension 5-10000-1 MG (milligram)

"Emergency Department (ED) Provider Notes" from the local hospital document on 9/11/20, R4 was seen for evaluation and treatment related to R4's right ear being impacted with maggots. Upon arrival to the ED, R4 denied pain but stated his right ear did not feel as good as the left. The same document states R4's ear was irrigated with multiple maggots being flushed out. "Review of Systems" documents R4 was "positive for ear discharge." "History of Present Illnesses" documents R4 as having a history of facial
Continued From page 5

melanoma brought in by Emergency Medical Services (EMS)...Pt. (patient) is apparently not getting treatment for his melanoma." R4's "Visit Diagnosis" is documented as "Infestation by fly larvae."

"Emergency Department Provider Notes" from the local hospital document on 9/12/20, R4 was seen for evaluation and treatment related to "Infestation (maggots in right ear)." The report states R4 was present in the ED yesterday for the same complaint in which numerous maggots were irrigated, and no further evidence of maggots was noted. Upon recheck by facility staff today, maggots were noted to then again be present. "Review of Symptoms" documents R4 as "positive for ear pain." A Physical exam was conducted in which it was noted R4 had "Several chronic lesions within the helix. On initial inspection greater than 10 maggots were seen in the auditory canal. Movement of the pinna resulted in significant pain." "ED Course" documents shortly after R4's arrival viscous lidocaine was placed in R4's external auditory canal to reduce discomfort. Treatment included flushing R4's right ear in which 15 maggots were produced. After allowing R4 to rest, the ear was irrigated again producing an additional 6 maggots. The report documents irritation within the external auditory canal consistent with otitis externa and "suspect this as cause of patient's maggot food source." R4's "visit diagnosis" are documented as "Maggot Infestation and Otitis Externa." R4 is documented as being discharged back to the facility on Cortisporin drops, "with hope of reducing inflammation and aiding in clearance of any further debris or infestation."

R4's care plan, dated 9/14/20, has a focus area of: resident has noncompliance by refusing to
allow staff to do treatment to cancer lesions for face/ear, and refuses to keep dressings on. The goal is for the resident to verbalize understanding of consequences of non-compliance through review date. The interventions/tasks listed for this problem area include: 1) accept residents right to refuse, 2) discuss with resident his/her objections, reasons, fears, ideas, 3) give positive feedback and reinforcement for resident's compliance, 4) inform resident about risks of noncompliance, 5) offer as many alternatives as possible for resident to choose from. The care plan also has a focus area stating that the resident has impaired cognitive function/dementia or impaired thought processes with a revision date of 9/16/19. The goal for this focus area is that the resident will maintain current level of cognitive function through review date and that resident will be able to communicate basic needs, daily through review date. Interventions for this focus area include administer medications as ordered and monitor/document for side effects and effectiveness, communicate with resident/family/caregivers regarding resident's capabilities and needs, and to cue/reorient/supervise as needed. A focus area on the same care plan documents that R4 has the potential for impaired skin integrity due to cognitive deficits and resident picks at skin. The goal is for no new pressure areas to develop in the next 90 days. Interventions for this focus area include bath/shower per schedule and observe skin integrity during am/pm care.

On 10/14/20 at 11:30 AM, R4 was observed to be seen sitting on the side of his bed with a bandage hanging loose off his right ear. The bandage was saturated with a brownish-red substance. R4's undershirt and flannel shirt were observed to have the same brownish-red dried substance
Continued From page 7

down the front, as well as dried white liquid down the front of his shirt. R4's bed linens and pillowcase had the same dried brownish-red substance on them as well. On 10/14/20 at 1:25 PM, R4 was observed as being alert to person and place and describes his care at the facility as, "I'm passed by." R4 states he is unsure why staff don't tend to him but states, "Anything is better than what I've got."

R4's progress notes documented by V20 (Registered Nurse/RN) and dated 9/7/20, state that R4's right ear had serous drainage from area noted to be cancerous. The ear was assessed and tolerated by resident. Serous drainage was cleansed from neck and outer ear with normal saline and gauze. R4 would only allow light cleansing to concha close to ear canal. Gauze was lightly packed to concha and ear covered with medical tape to secure. On 9/9/20 a progress note was entered stating that R4 was seen by doctor on 9/8/20, and no changes to plan of care. A 9/9/20 Progress Note by V20 documents the following: that resident was having serous drainage from his R (right) ear. V20 went to assess resident's ear. Upon entering room R4 was noted to be picking at the concha of his Right ear. V20 asked resident why he was picking at the cancerous spot to his ear. R4 stated "I'm not." Serous drainage was observed to R4's nails. Per tolerated by resident, orea cleansed with NG (normal saline), gauze. No additional drainage noted from opening of right ear canal. R4 would not allow additional assessment of ear. Right ear concha was lightly packed with gauze and secured with medical tape. R4's nails were trimmed, and hands cleansed. On 9/10/20, V31 (LPN) documented the following in a Progress Note: V31 was alerted to resident's room by CNA. R4 was noted with moderate amount of dried and
Continued From page 8

bright red blood to right ear, lateral neck and anterior neck/throat regions. Active bleeding from right ear noted. R4 also noted with dried blood to nail plates and right hand. Resident known for picking at cancerous lesion areas. V31 asked R4 if he had been picking at his right ear. Blood noted to tissues on the over the bed table as well as in the trash can. Care and assistance offered to R4. R4 was resistant and refused initially. Encouragement and education provided to resident for proper wound care and hygiene. R4 then allowed this nurse to assist. R4 was carefully cleansed of blood from right ear then from neck and throat region. R4 would not allow nurse to assess ear or other cancerous lesions further once cleansed. Ear packed with gauze per resident's tolerance of pressure and secured in place with a gauze wrap around his head. Gauze was secured with tape.

A Progress Note dated 9/11/20 at 5:45AM shows that V45 (LPN) documented that R4 complained of pain to right ear. Upon assessment, right ear canal found to be impacted with maggots. Nurse on call notified. MD (Medical Doctor) notified and stated to send to Emergency Department for evaluation and treatment. Resident's Power of Attorney notified. At 6:18AM, R4 was transferred out via ambulance. At 1:00 PM on 9/11/20, R4 returned from emergency room, documenting that the right ear was flushed during emergency room visit. No new orders at this time.

On 10/20/20 at 2:00 PM, V45 stated that she was the nurse on duty when the maggots were found in R4's ear. She had just passed medications and R4 stated that his ear was hurting, and she asked if she could look at it, which he allowed. V45 stated the order at that time was that nursing is to supply the items for him to clean his own
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL6001663</td>
<td></td>
<td>10/23/2020</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

HIGHLAND HEALTH CARE CENTER

1450 26TH STREET

HIGHLAND, IL 62249

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9999</td>
<td>S9999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued From page 9

ear. V45 stated that when she looked into the ear, she found the maggots. V45 stated that there were a large amount of flies in his room that evening, more than usual. V45 stated that R4 scratches his ear often, likely because it itches. He doesn't complain of pain until you touch the ear to do the treatment, and then he will yell to stop. V45 stated R4 did not get any type of pain medication prior to cleaning the ear, and that poor hygiene and the large number of flies likely caused the maggot infestation. V45 stated that R4 went to the hospital twice before all the maggots were removed from his ear.

Another Progress Note on 9/12/20 at 2:37AM, documents that R4 was again transferred on a gurney via ambulance to acute care hospital. Right ear impacted with maggots. Medical Doctor notified of transfer. R4 was back in building on 9/12/20 at 5:49AM. Emergency Room stated they flushed his ear twice and removed 21 maggots. At this time, a new order was received for antibiotic ear drops 4 times a day for 10 days. Emergency department notes dated 9/12/20 at 3:13 AM, document that R4 was seen in the emergency department "yesterday" with complaints of a maggot infestation in right ear. R4 is reporting an 8/10 pain in the right ear. R4 has cancer lesion to the right ear. Long Term Care facility reports R4 digs in right ear with finger. Visible redness and inflammation on outer part of ear. Physician medical discharge note was that viscous lidocaine was placed in right external auditory canal to decrease discomfort. Normal saline was used to irrigate ear aggressively. 15 maggots were removed, and after 30 minutes of rest, 6 more were removed with further irrigation. There does appear to be
Continued From page 10

some irritation within external auditory canal consistent with otitis external. Suspect this as cause of R4 maggot food source. Cortisporin drops were prescribed with hope of decreasing inflammation and aiding in clearance of any other debris or infestation.

A Progress note from 9/14/20 documents that R4 refuses personal hygiene. On 9/15/20, a new order was received to keep ear clean and dry by V26 (Physician). On 9/21/20, a note is made by V20: right ear inspected. R4 would only allow external examination. Drainage to concha/ear canal opening noted. Nothing new to report. On 9/23/20, a progress note made by V20 documents: right ear inspected. R4 would only allow external examination. Drainage to concha/ear canal opening noted. Nothing new to report. No further progress notes were documented after 9/23/20 through 10/16/20 regarding the condition of R4's right ear.

On 10/14/20 at 12:10 PM, V8 (Licensed Practical Nurse/LPN) was passing medications, and R4 was observed to be scratching and digging in his right ear, then stated he needed assistance with his ear. V8 stated she would send someone in to help him. Beginning at 12:10 PM, after a continuous observation and speaking with R4, the call light was pushed at 12:39 PM, and V20 arrived at 12:44 PM. At this time, V20 (Registered Nurse, RN) states that she works as a wound nurse at the facility. V20 states R4's wounds to his face and right ear are cancer lesions which he has refused to have surgery on. V20 states R4 is care planned to provide his own wound care and staff just assist as needed or as he requests. V20 was observed as placing normal saline into a medicine cup, gauze, and cotton tipped applicator-tips on a barrier on R4's
Continued From page 11

bed side table. V20 removed the already partially removed, visibly soiled with a red substance from R4's right ear. V20 asked if that was enough supplies, she had laid out for R4 to do his wound care, in which he didn't respond, but just stared at the supplies. Despite R4 observed as having a large amount of red/brown dried substance appearing to be blood to his shirt, pants, pillowcase, floor, wheelchair, hands, face, neck, arms, and blankets on his bed, no assistance with hygiene was noted to be offered or encouraged prior to providing him supplies to self-administer his own wound care. After a short moment of time passing with no response or action taken by R4, V20 stated she would help R4 in which she moistened gauze with normal saline and began wiping the outer edges of R4's right ear. V20 asked if she could clean inside of R4's right ear in which he stated, "No, it would hurt." V20 ensured she would be gentle and stop if it hurt too bad, which R4 then agreed to the care. V20 moistened a cotton tipped applicator-tip with normal saline and began wiping inside R4's right ear.

During wound care multiple flies were observed landing on the wound care supplies, R4, V20, and multiple surfaces in the room. When asked if R4 has a problem with flies in his room, V20 pointed to a purple glowing light mounted directly above R4's bed, nodding yes. V20 states the light is supposed to help with the flies, but acknowledges they are still present. When asked why she thought there was such a problem with flies in R4's room, V20 states, "the blood maybe?"

A progress note made on 10/14/20 by V20 documents the following: physician notified of serous drainage to resident's right ear. Resident's call light on for assistance and answered by this nurse. R4 asked for additional assistance to ear.
Drainage to ear cleansed with normal saline, gauze, cotton tipped applicator per R4’s tolerance. R4 would only let this nurse cleanse outer ear and concha to ear. Minimal discomfort expressed by resident. No complaints of continued discomfort after ear bandaged. Additional supplies offered to R4 for cleansing purposes and refused. Assistance offered for cleansing of nose/upper lip. R4 declined assistance. Outer ear canal assessed at time of cleansing. No noted additional changes to ear. New order given per physician for as needed assistance per resident request and tolerance.

R4’s September and October medication administration reports (MAR) show an order that was initiated on 11/22/19 as: Resident self-administers. Cleanse lesion to right ear with normal saline and pat dry. Monitor for weeping/drainage/bleeding every shift. This was marked with a checkmark twice a day indicating it was completed until 10/15/20 when order was discontinued. The order as of 10/16/20 on the October MAR no longer states, “Resident self-administers” and documents the following: cleanse lesions to right ear with normal saline and pat dry. Apply a thin layer of petroleum jelly and cover lightly with gauze and tape. Monitor for weeping/drainage/bleeding.

On 10/14/20 at 12:44 PM, V20 (Registered Nurse, RN) states that she works as a wound nurse at the facility. V20 states R4’s wounds to his face and right ear are cancer lesions which he has refused to have surgery on. V20 states R4 is care planned to provide his own wound care and staff just assist as needed or he requests. V20 states many times R4 refuses assistance with wound treatment and care. V20 was observed as
placing normal saline into a medicine cup, gauze, and cotton tipped applicators on a barrier on R4's bed side table. V20 removed the already partially removed, visibly soiled with a red substance dressing from R4's right ear. V20 asked if that was enough supplies she had laid out for R4 to do his wound care, in which he didn't respond, but just stared at the supplies. After a short moment of time passing with no response or action taken by R4, V20 stated she would help R4 in which she moistened gauze with normal saline and began wiping the outer edges of R4's right ear, which he allowed without resistance. V20 asked if she could clean inside of R4's right ear in which he stated, "No, it would hurt." V20 ensured R4 she would be gentle and stop if it hurt too bad, with R4 then agreeing to the care. V20 moistened a cotton tipped applicator with normal saline and began wiping inside R4's right ear when he stated, "That hurts! That's too much!" V20 ceased wound cleansing at that time and placed a dry dressing over R4's right ear. V20 states R4 did not receive pain medication or pain alleviating treatments prior to receiving wound care. V20 acknowledges R4 was experiencing pain during care, which may have factored into his resistance with wound care. V20 was not observed as asking R4 to rate or describe any pain he was experiencing.

On 10/14/20 at 1:25 PM, R4 was observed as being alert to person and place. R4 describes his care at the facility as, "I'm passed by." R4 states he is unsure why staff don't tend to him but states, "Anything is better than what I've got." R4 denies ever being offered pain medication prior to having wound care. R4 describes his face and right ear wound area as "itchy mainly and hurts a little." When asked if he would like to receive pain
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9999</td>
<td>Continued From page 14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

medication prior to wound care to see if that would make care more comfortable for him, R4 states "yes." When asked to rate his pain on a scale of 0-10 with 10 being the worst and 0 being no pain at all, R4 describes pain to his wounds as a 0-1 now "when they aren't being bothered," and "close to a 10 when they are messing with it."

On 10/14/20 at 1:39 PM, V1 (Director of Nursing) states R4 continuously picks at his facial wounds. V1 states the wounds are cancer lesions and acknowledges he has had maggots in the wound in the past while residing at the facility. V1 states R4 doesn't let the staff clean the wounds good. V1 states they have not tried administering pain medication prior to providing wound care and states R4 likes to do his own wound care. V1 acknowledges R4's poor hygiene as his hands are visibly soiled with a dark red/brown substance appearing to be dry blood, long fingernails, dark red/brown substance caked under his fingernails. V1 acknowledges the concerns of if effective wound care could be completed by the resident himself, not only due to his visibly poor hygiene status, but the fact that the wounds are on his face and inside his right ear, making it not visible to himself. V1 acknowledges the presence of flies in R4's room.

V1 was notified of observations of staff including but not limited to, V20 (Registered Nurse) and V8 (Licensed Practical Nurse) entering R4's room and despite R4 observed as having a large amount of red/brown dried substance appearing to be blood to his shirt, pants, pillow case, floor, wheelchair, hands, face, neck, arms, and blankets on his bed, no assistance with hygiene was noted to be offered or encouraged. V1 states she will talk to the doctor regarding R4's care.

On 10/16/20 at 11:30 AM, V43 (Family Member)
Continued From page 15

states the facility has not contacted her regarding options for pain management with wound care/conditions or been involved in a care plan meeting at all for R4.

On 10/16/20 at 11:40 AM, V1 (Director of Nursing) states that R4's physician is medical director and he comes every Tuesday to the facility. He assessed that R4 was able to provide self-care. V1 says however, this assessment was not a formal assessment, so there is no documentation to provide. V1 went on to state that since admission, R4 has declined somewhat in his cognition level. V1 states that no one monitors R4's self-care to his ear, they just ensure that he has all the necessary items in his room to take care of himself. V1 says that since it was not a physician order, the wound self-care is not documented on the treatment record as being completed/refused. V1 goes on to state that nurses would just pop in and check on R4 to see if he needed any assistance at various times of the day. V1 decided yesterday (10/15/20) that the nursing staff will begin to attempt to assist R4 daily, and document refusals because they need to attempt to 'at least give it a try to help clean it.' V1 believes that the smell, poor hygiene and improper cleansing of the right ear, along with all that drainage in the right ear attracted the flies and resulted in the maggot infestation. V1 states that in hindsight, she believes R4 only cleaned it superficially and that is why the maggot infestation happened. V1 is now having the staff check on him every 2 hours and change his clothes, wipe his hands and change sheets if soiled.

On 10/16/20 at 11:50 AM, V31 (LPN) states that she feels R4's cognition fluctuates, but he is normally "with it." V31 states R4 is resistant to
**NAME OF PROVIDER OR SUPPLIER**

HIGHLAND HEALTH CARE CENTER

1450 26TH STREET

HIGHLAND, IL 62249

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL6001663</td>
<td>A. BUILDING:</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
</tr>
</tbody>
</table>

| 10/23/2020 |

**STREET ADDRESS, CITY, STATE, ZIP CODE**

S9999

Continued From page 16

most treatments, and poor hygiene has likely caused the maggot issue in his ear, adding that sometimes a nurse can start the treatment, but it is not typically completed. V31 further states that it is up to R4 to do his own care, but the wound/treatment nurse would sometimes peek in at him. V31 says that when R4 would be checked in on, if the right ear looked like it wouldn't have been cleaned, she would ask why, and he would say he didn't have the supplies. V31 would get the supplies for him, which consisted of petroleum jelly and cotton tipped applicator for a moist barrier. V31 states if R4 would decline treatment, nursing staff try to re-approach him, otherwise they let the doctor know on Tuesday when he comes in. V31 says no change in treatment for R4's right ear has occurred until today, and now wound nurses are to clean the right ear and document if it is not completed/refused.

On 10/19/20 at 8:41 PM, V39 (RN) states R4 is non-compliant with wound care. V39 states R4 does experience some pain with his face and ear cancer wounds and states the ear seems more painful for him, rather than his face. V39 states she is unsure if R4 receives any medication or treatment for pain.

On 10/19/20 at 8:57 PM, V40 (LPN) describes R4 as being alert to person and place only. V40 states R4 has never made direct complaints of pain to her, but will express phrases which indicate pain, such as him stating "not so hard" despite the wound area being touched gently. V40 states R4 is resistive to wound care and refuses much of the time. V40 states R4 has an as needed Acetaminophen order, but states "he will not ask for it, you have to ask him."
S9999 Continued From page 17

On 10/20/20 at 12:21 PM, V42 (Physician) states he cared for R4 in the past regarding his skin cancer lesions to his face and ear. V42 states if R4 was expressing or demonstrating that he is experiencing pain or resistive to care possibly due to pain, he would expect a pain treatment regimen to be implemented and re-evaluated as needed. V42 states he has not been notified of any pain R4 is experiencing. V42 states with an effective pain treatment regimen it is possible R4 would be more receptive and tolerable to cleaning the wounds which could help prevent a maggots infestation.

On 10/20/20 at 2:00 PM, V45 (Licensed Practical Nurse, LPN) stated she was the nurse on duty when the maggots were observed in R4's ear. V45 states R4 complained that his ear was hurting, and she asked if she could look at it. V45 states R4 allowed her to, and that's when she observed the maggots. V45 states R4 doesn't complain of pain until you touch the ear to do the treatment, and then he will yell to stop. V45 states R4 did not get any type of pain medication prior to cleaning the ear.

On 10/20/20 at 3:20 PM, V26 (Physician) stated that R4 was placed on the antibiotics at the emergency room on 9/11/20. R4 has had cancer for years and has refused surgical treatment to remove it. V26 feels that R4 is oriented most of the time but has intermittent confusion. V26 stated R4 refuses most treatment from nurses and doctors, so it was determined self-care would be the best for R4 to maybe get it cleaned up as best as it could be. When the dressing was applied to R4's ear to try to stop the drainage it occluded the ear and caused the perfect environment for the maggots to hatch. Poor hygiene likely was part of the cause of the
Continued From page 18

maggot infestation. The flies are attracted to both the blood and decaying skin. V26 feels that the staff update him adequately on R4's condition.

In a policy titled Management of Pain with a revision date of 9/16/20, the document states, "Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement." "We will achieve these goals through: Promptly and accurately assessing and diagnosing pain...Aggressively assessing pain in non-verbal and cognitively impaired residents ..." The policy goes on to state, "For the purposes of this policy, pain is defined as whatever the experiencing person says it is, existing whenever the experiencing person says it does." "Nursing observation is an important part of the pain assessment, especially in the non-verbal resident. Using the chart provided with the pain assessment, nursing will observe behaviors that may indicate pain in the non-verbal or cognitively impaired resident. Pain may also be indicated when there are changes in the following: facial expressions, vocal behaviors, body movements, routines, mental status."

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9999</td>
<td>Continued From page 19 pain from acute otitis externa will bring patients to your ED rather quickly. The onset can be fast and the pain excruciating. It is not usually life-threatening, but emergency physicians should still be aware of the issues surrounding acute otitis externa and how to approach it in the ED. This syndrome has multiple causes but is usually caused by a common bacterial infection.‖</td>
<td>S9999</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

 Despite staff interviews acknowledging R4 experiences wound pain and refusal/resistance to wound treatment, observation of R4 experiencing pain/resistance with wound treatment, and R4's own expression of pain, review of R4's Medication Administration Records for 07/2020 - 10/13/20 documents "0" as R4's pain ratings with no administration of as needed pain medication documented.

" B "