

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Accolade Healthcare Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 801 North Logan Avenue Danville, IL 61832	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately code the minimum data sheet (MDS) for three (R24, R38, R76) of 17 residents reviewed for MDS accuracy in a sample size of 38.</p> <p>Findings include:</p> <p>1.) R76's MDS dated [DATE] documents R76 has limited range of motion (ROM) in bilateral lower extremities and no impairment in upper extremities ROM. R76's prior MDS dated [DATE] documents no impairment in upper and lower extremities.</p> <p>On 05/20/25 at 09:22 AM R76 used both hands and arms in the hallway. R76 had left hand contracture in a semi-fist position. R76 did not flex fingers on the left hand.</p> <p>2.) R38's MDS dated [DATE] documents one sided impaired ROM to upper and lower extremity. R38's 10/22/24 and 1/6/25 MDS does not document impaired ROM. R38's 7/1/24 MDS documents one sided impaired ROM to upper and lower extremity.</p> <p>On 05/20/25 at 09:31 AM V19 CNA, stated she does ROM with R38 every morning. V19 stated R38 has been totally dependent on staff for activities of daily living since time of admission and no changes have been seen. V19 stated R38 has upper and lower extremity impaired ROM.</p> <p>3.) R24's MDS dated [DATE] documents one sided impairment for ROM to upper and lower extremities. R24's previous MDS dated [DATE] documents no impairment to upper and lower extremities.</p> <p>On 05/19/25 at 11:19 AM V5 CNA stated V5 has always used a mechanical lift for R24 for transfer since he admitted to the facility. R24 can move his arms and legs just fine. R24 helps with feeding. R24 can hold his legs up to dress him when he's in bed.</p> <p>On 05/19/25 at 12:58 PM V22 CNA, and V5 CNA entered R24's room. R24 was leaning forward and left in the wheelchair, pillow positioned beside R24. V22 and V5 used a mechanical lift to transfer R24 into bed. R24 demonstrated ability to move legs and left arm. R24's right arm remained at his side. V22 and V5 stated R24 can move both arms.</p> <p>On 05/20/25 at 09:29 AM R24 was holding a coffee cup with his right hand and drinking unassisted.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/20/25 at 10:00 AM V16 on 5/20/25, V16 MDS Coordinator stated V16 misunderstood what impaired ROM meant when previously coding MDS's and V16 has since had education regarding what ROM assessments entailed. At 2:00 PM V1 Administrator stated V16 should have completed corrections to any MDS submitted that were inaccurate.</p> <p>The facility's policy titled Resident Assessment Instrument dated August 2017 documents the purpose is to provide guidelines for identifying resident care needs, strengths, and assisting the resident to attain their highest practical level of mental and physical function and well-being. It is the responsibility of all resident care providers under the supervision of the attending physician to ensure that the resident is accurately and thoroughly assessed per MDS 3.0 Manual guidelines.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assistance with fingernail care, eating, and shaving for four of four residents (R24, R26, R190, R38) reviewed for Activities of Daily Living in the sample list of 38.</p> <p>Findings include:</p> <p>1.) On 05/18/25 at 2:26 PM R24's fingernails were long, approximately 1/4 inch past fingertips, and jagged. On 5/19/25 at 11:01 AM R24's fingernails remained long and jagged.</p> <p>On 5/19/25 at 1:12 PM V11 Assistant Director of Nursing (ADON) confirmed R24's fingernails were long and jagged. V11 stated the Certified Nursing Assistants (CNAs) are supposed to trim and clean fingernails as needed and V11 will have the CNAs trim R24's fingernails.</p> <p>R24's Minimum Data Set (MDS) dated [DATE] documents R24 has moderate cognitive impairment and is dependent on staff assistance for personal hygiene. R24's active care plan does not document R24 refuses nail care.</p> <p>2.) On 5/18/25 at 8:41 AM R26 was lying in bed and R26's fingernails were long, approximately 1/4 inch past fingertips, and jagged. There was a dark substance underneath R26's fingernails.</p> <p>On 5/19/25 at 2:49 PM R26's fingernails were long, jagged, and had a dark substance underneath. V11 ADON checked R26's fingernails and confirmed they were long, jagged and dirty. V11 stated V11 will follow up with the CNAs to provide nail care.</p> <p>R26's MDS dated [DATE] documents R26 has severe cognitive impairment and is dependent on staff assistance for personal hygiene. R26's active care plan does not document R26 refuses nail care.</p> <p>3.) On 5/18/25 at 8:48 AM R190 was in bed and had facial hair stubble to upper lip, chin, and cheeks. R190 stated R190's family member was supposed to be bringing R190 a razor since the facility has not offered to shave R190 or provided a razor. R190 stated he would like to be shaved. On 5/19/25 at 10:57 AM R190 still had facial hair stubble. R190 stated R190 is supposed to have a shower today.</p> <p>On 5/19/25 at 2:49 PM V11 ADON stated residents should be shaved on shower days. At 3:04 PM V11 stated R190 had a shower today. V11 entered R190's room and asked R190 if R190 wanted to be shaved. R190 still had facial hair stubble. R190 told V11 that R190 had not been shaved since admitting to the facility and R190 prefers to be clean shaven.</p> <p>R190's Care Plan dated 5/15/25 documents R190 admitted to the facility on [DATE] and requires extensive assistance of one staff person for bathing/showering. R190's Shower Sheet dated 5/19/25 documents R190 received a shower and R190 was not shaved.</p> <p>4.) On 5/18/25 at 12:15 PM, 12:25 PM, 12:40 PM and 12:50 PM R38 was lying in bed and R38's meal tray was covered on an overbed table in R38's room near the foot of the bed. There was no staff present in R38's room.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/18/25 at 12:51 PM V5 CNA stated R38 is not able to feed himself and requires staff to feed R38. V5 stated V5 had not attempted to feed R38 lunch and V7 CNA is assigned to R38's hall. V6 CNA entered R38's room. V6 stated V6 is going to feed R38 lunch now. V6 confirmed V6 had not attempted to feed R38 lunch earlier. V6 uncovered R38's meal, which was untouched, and began feeding R38. At 1:52 PM V7 CNA stated V7 had not served R38's lunch meal tray and had not assisted R38 with lunch. V7 confirmed V7 was assigned to R38's hall and should have been notified when R38's meal was served.</p> <p>On 5/19/25 at 2:49 PM V11 ADON stated the CNAs should assist residents with eating at the time the meal tray is delivered to the resident's room.</p> <p>R38's MDS dated [DATE] documents R38 has severe cognitive impairment and is dependent on staff assistance for eating.</p> <p>The facility's Nail Care (Finger and Toes) policy dated April 2025 documents resident's nails will be kept clean and neat in order to provide cleanliness, prevent spread of infection and skin problems, and for comfort. This policy documents resident refusal of nail care will be documented in the resident's care plan.</p> <p>The facility's Shaving Resident policy dated August 2017 documents facial hair will be shaved by the CNAs on shower days and as needed or requested; and the charge nurse is responsible for ensuring residents who prefer to be shaved are free of facial hair.</p> <p>The facility's Feeding the Dependent Resident policy dated 8/2/17 documents to take the meal tray into the resident's room, place the tray directly in front of the resident, cut the food into small portions, give the resident your complete attention, sit at the same level as the resident while assisting with the meal, and remove the meal tray when the resident is finished eating.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement interventions to prevent and treat pressure ulcers and failed to complete initial wound assessments for three residents (R24, R84, R140) of five residents reviewed for pressure ulcers in a sample list of 38.</p> <p>Findings include:</p> <p>1. R140's current diagnoses list includes the following diagnoses: Type II Diabetes, Morbid Obesity, Congestive Heart Failure, Chronic Kidney Disease Stage III, History of Cerebral Infarction, Major Depression, Difficulty in Walking, Anemia, and Pilonidal Cyst with abscess.</p> <p>R140's Minimum Data Set (MDS) dated [DATE] documents R140 is mildly cognitively impaired and requires a wheelchair for mobility.</p> <p>R140's Care Plan reviewed 4/21/25 documents R140 requires a specialized air mattress and is to be turned and repositioned every two hours and as needed.</p> <p>On 5/18/25 at 10:00AM R140 was seated in his wheelchair beside his bed. R140's sweat pants were soaked down to his knees in the front. R140's bed was stripped and there was no air mattress in place to the bed. R140 stated he hadn't had an air mattress for a while. R140 stated I stay up in the wheelchair from breakfast until after lunch.</p> <p>On 5/19/25 at 12:00PM R140 was again seated beside his bed. R140's bed again did not have a specialized mattress in place. R140 was eating his lunch. V26, R140's family member was assisting and encouraging R140 to eat. V26 stated I visit (R140) at least two or three times a week. (R140) is always constantly up in the wheel chair from before breakfast until after lunch. (R140) has that sore spot on his butt and he hasn't had an air mattress since he got back from the hospital.</p> <p>R140's treatment order dated 4/24/25 documents a current physician's treatment order for Sacrum: Cleanse area with wound cleanser, pat dry, apply Medihoney to wound bed, and cover with dry clean dressing daily and PRN (as needed).</p> <p>R140's Wound Assessment Detail Report dated 5/13/25 at 2:12PM by V11, Assistant Director of Nursing (ADON) documents R140 has a facility acquired infectious full thickness wound on his sacrum measuring 0.50 x 0.30 x 0.10 (Length x Width x Depth) Centimeters. On 5/20/25 at 10:30AM R140's wound was observed during the daily dressing change and noted to appear unchanged from the 5/13/25 assessment.</p> <p>On 5/19/25 at 1:00PM V11 verified (R140) should have a special mattress and hasn't had one for some time and (R140) should be repositioned at least every two hours and kept clean and dry to prevent skin breakdown.</p> <p>2.) On 5/18/25 at 9:11 AM R24 was lying in bed. R24 stated R24 has a sore on his bottom that isn't getting better. At 10:50 AM, 12:15 PM, 12:25 PM, 12:50 PM, and 2:26 PM R24 was sitting in his wheelchair. On 5/19/25 at 11:01 AM R24 was sitting in his wheelchair near the third floor elevator. At 12:06 PM R24 was in his wheelchair in the first floor dining room.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/19/25 at 1:00 PM R24 was sitting in his wheelchair in his room, R24 was leaning forward and to the left. V22 and V5 Certified Nursing Assistants (CNAs) transferred R24 into bed using a full mechanical lift. On 5/19/25 at 1:30 PM V5 CNA stated R24 was assisted into the wheelchair at 9:30 AM and had not been laid down or offered to lay down prior to 1:00 PM. V5 confirmed R24 is supposed to be repositioned every two hours to offload pressure from R24's bottom. V5 stated usually R24 stays in bed, but R24 was in activities this morning and R24's family likes for R24 to get out of bed.</p> <p>On 5/19/25 at 1:12 PM V11 Assistant Director of Nursing (ADON) and V15 Registered Nurse (RN) entered R24's room and administered R24's pressure ulcer treatment. R24 had a linear, backwards L shaped wound, that contained pink and white/yellow tissue. V11 stated R24's wound is a stage three pressure ulcer that had recently healed in April and then reopened as a stage three.</p> <p>R24's Minimum Data Set (MDS) dated [DATE] documents R24 has moderate cognitive impairment, is dependent on staff assistance for toileting, bed mobility, and transfers; and R24 is always incontinent of bowel and bladder. R24's active Care Plan documents R24 has a stage three coccyx pressure ulcer and includes an intervention dated 2/5/25 for turning and repositioning every two hours and as needed. This care plan does not document that R24 refuses repositioning.</p> <p>R24's May 2025 Treatment Administration Record documents the following: On 5/10/25 a treatment was initiated to cleanse and dry coccyx wound and apply dry dressing daily and as needed (entered by V15 RN). On 5/12/25 R24's coccyx wound treatment was changed to cleanse and dry wound, apply medicated honey, and cover with a dry dressing daily and as needed.</p> <p>R24's Wound Assessment Detail Report dated 4/4/25 documents R24's stage four facility acquired coccyx pressure ulcer was healed. R24's Wound Assessment Detail Report dated 5/12/25 documents R24's facility acquired stage three coccyx pressure ulcer measured 6 centimeters (cm) long by 2.5 cm wide by 0.1 cm deep, and 30% of the wound bed was white, fibrinous slough (dead tissue). There is no documentation in R24's medical record that this wound was measured/assessed on 5/10/25, when first identified, prior to 5/12/25. R24's Wound Assessment and Plan dated 5/14/25, recorded by V24 Wound Physician, documents R24's stage three coccyx pressure ulcer measured 5 cm by 4 cm by 0.1 cm. This plan includes recommendations to offload per facility policy. R24's Wound Assessment and Detail Report dated 5/19/25 documents R24's pressure ulcer measured 6 cm by 2 cm by 0.1 cm, and 40% of the wound bed contained white slough.</p> <p>On 5/20/25 at 10:31 AM V15 RN stated R24's coccyx wound reopened the day V15 entered the order for the dry dressing. V15 stated V15 did not document an assessment of the wound as it was towards the end of his shift. V15 described the wound as being smaller but deeper than it is now.</p> <p>On 5/19/25 at 11:43 AM V11 stated the facility has had prior discussions with R24's family regarding hospice care or a feeding tube. V11 stated R24's family wanted to see what R24's weight is this week before deciding on whether to move forward with hospice. R24's family is leaning more towards hospice since R24 does not want a feeding tube. On 5/20/25 at 12:16 PM V11 stated the floor nurses notify nurse management/wound nurse of newly identified pressure ulcers and the floor nurse should document an initial assessment of the wound in the nursing notes if the wound nurse is not available. V11 stated V11 thought the facility has 72 hours to document a wound assessment for a newly identified wound. At 12:55 PM V11 confirmed there was no documented assessment of R24's reopened coccyx wound prior to 5/12/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.) On 5/18/25 at 2:22 PM V10 CNA Coordinator removed R84's socks. R84 had a small dark scabbed area on the left heel. On 5/19/25 at 1:32 PM R84 was lying in bed and was not wearing pressure relieving boots. R84's heels were directly on the mattress. R84's heel boots were in the wheelchair beside R84's bed.</p> <p>On 5/19/25 at 3:00 PM V25 CNA stated today was the first time V25 was assigned to R84 and V25 was unsure if R84 has a pressure ulcer. V25 stated R84's pressure relieving interventions are turning and repositioning in bed every two hours and using pillows behind R84's back to position R84 on her side. V25 was unsure of any pressure relieving interventions for R84's feet and was unsure if R84 uses pressure relieving boots. V25 stated V25 has access to resident care plans and would look there to determine what pressure interventions should be used. V25 entered R84's room and confirmed R84's heels were directly on the mattress and R84's pressure relieving boots were in R84's wheelchair. R84 allowed V25 to apply R84's boots.</p> <p>R84's MDS dated [DATE] documents R84 is dependent on staff assistance for lower body dressing and uses substantial/maximal assistance for turning in bed. R84's active Care Plan documents R84 has a deep tissue injury of the right heel, and interventions include the use of pressure relieving boots and to monitor and document wound assessments. This care plan does not document R84 refuses pressure relieving boots.</p> <p>R84's Nursing Notes document the following: On 2/7/2025 R84 admitted to the facility following a fall with right femur fracture. R84 discharged home on 4/30/25 and readmitted to the facility on [DATE].</p> <p>R84's Wound Assessment and Plan dated 3/27/25, recorded by V24 Wound Physician, documents R84's right heel pressure ulcer measured 2 cm by 2 cm and was 100% eschar, dead tissue. This plan includes recommendations for offloading per facility policy and offloading boot was in place. R84's Wound Assessment and Plan dated 4/3/25 documents this pressure ulcer measured 2 cm by 1.5 cm. R84's Wound Assessment and Plan dated 4/24/25 documents this pressure ulcer measured 1 cm by 1 cm and was 100% covered in eschar. This plan documents the facility is contacting R84's family regarding possible hospice as R84 is overall declining.</p> <p>R84's Wound Assessment Detail Report dated 5/5/25 documents R84's right heel pressure ulcer was present on readmission on [DATE]. The wound measured 1 cm by 2 cm by 0.1 cm and the wound photograph shows a dark scabbed area. R84's Wound Assessment Detail Report dated 5/12/25 documents R84's right heel pressure ulcer measured 1 cm by 1 cm by 0.1 cm. R84's Wound Assessment and Plan dated 5/14/25, recorded by V24, documents R84's right heel unstageable pressure ulcer was 1 cm by 1 cm and 100% covered in eschar.</p> <p>R84's Nutrition/Dietary Notes dated 3/30/25, 4/2/25 and 4/16/25 document R84 had significant weight loss with supplements and medications in place to address this weight loss. These notes document R84 had no skin breakdown.</p> <p>R84's March, April and May 2025 Medication and Treatment Administration Records document the following: Pressure relieving boots were initiated 3/12-4/30/25 and 5/5/25. Daily skin protectant to right heel initiated 4/4-4/30/25 and 5/6/25. Multivitamin daily, Zinc 50 milligrams (mg) daily, Prostat 30 milliliters twice daily, and Vitamin C 500 mg twice daily for wound healing scheduled to begin on 4/24/25, but not implemented, and initiated on 5/2/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/20/25 at 12:16 PM V11 ADON confirmed R84 is supposed to have heel boots on when in bed. V11 stated R84 has had an overall decline related to failure to thrive and there is an upcoming care plan scheduled with R84's family to discuss hospice. V11 stated the facility discussed hospice with R84's family previously, but R84's family decided to take R84 home. V11 stated Vitamin C, Zinc, Multivitamin and Prostat should have been implemented as it is the facility's standard protocol for wound care. At 12:55 PM V11 confirmed there was no documented assessment of R84's right heel pressure ulcer on 5/2/25 when R84 readmitted to the facility, prior to 5/5/25. V11 confirmed R84's right heel wound was initially facility acquired, had not healed, and was present on readmission on [DATE].</p> <p>On 5/20/25 at 12:42 PM V23 Registered Dietitian stated if V23 was aware of R84's right heel pressure ulcer it would be documented in V23's notes. V23 stated V23 would have ordered Vitamin C, Zinc, Multivitamin with minerals and liquid Prostat to aid in wound healing if V23 was aware of R84's pressure ulcer.</p> <p>The facility's Skin Care Prevention policy dated April 2025 documents residents identified as being at increased risk for skin breakdown shall be repositioned as needed and based on the resident's assessment, and pillows or positioning devices may be used between skin surfaces or to elevate bony prominences and pressure areas off of surfaces. This policy documents pressure redistribution mattresses may be used on beds and in chairs for residents identified to be at risk for skin breakdown.</p> <p>The facility's Pressure Ulcer, Lower Extremity Ulcer Treatment and Documentation policy dated April 2023 documents to notify the wound nurse upon identified skin impairment, and if the wound nurse is not available the floor nurse will document the open area and notify the provider for orders. The wound nurse is responsible for assessing, measuring, and photographing the wound; reviewing the orders; and updating notes and care plans as appropriate.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility failed to maintain or improve range of motion and contractures following recommended restorative program for one (R76) of four residents reviewed in a sample size of 38.</p> <p>Findings include:</p> <p>The facility's policy titled Functional Maintenance Program dated April 2025 documents therapy will provide recommendations for maintenance programming based on therapy outcomes or screenings. Individual tasks will be documented in the Point of Care (POC) in the electronic health record (EHR). Measurable objectives, goals and interventions will be documented in the care plan.</p> <p>On 05/18/25 09:09 AM R76 was in bed and R76's right hand appeared contracted. On 5/20/25 at 9:22 AM R76 used hands and arms in the hallway. R76's left hand appeared contracted in a semi-fist position. R76 did not flex fingers on left hand.</p> <p>R76's face sheet dated 5/20/25 documents an admission date of 3/29/24 with a history of down syndrome, and adult failure to thrive.</p> <p>R76's MDS dated [DATE] documents R76 has limited range of motion (ROM) in bilateral lower extremities and no impairment in upper extremities ROM. R76's care plan dated 4/24/25 documents R76 has a deficit in activities of daily living related to down syndrome and cognitive impairments. Care plan does not document range of motion, contractures, or restorative program.</p> <p>R76's physical therapy discharge date d 1/16/25 documents Restorative Programs Established/Trained for range of motion, transfer program, and bed mobility all educated.</p> <p>On 5/19/25 at 9:42 AM V21 Director of Rehab/Certified Occupational Therapy Assistant stated R76 was discharged from physical therapy on 1/16/25. R76's transfer status was max assist with 75% cues, 2-person transfer. R76 was only able to walk with very maximum assistance and would not be safe for certified nurse aides (CNAs) to walk with her. R76 complained of knee pain which is partly why we stopped doing the walking. R76 stated restoratives were recommended for range of motion (ROM), transfers, and bed mobility, which can all be completed during activities of daily living (ADLs).</p> <p>On 5/20/25 at 11:45am V11 Assistant Director of Nursing stated the facility does not have a restorative program, they have a functional maintenance program. On 5/20/25 at 12:16pm V11 stated V11 did not have any documentation for functional maintenance program for R76 since it is provided by the CNAs as part of ADLs.</p>		

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NAME OF PROVIDER OR SUPPLIER Accolade Healthcare Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 801 North Logan Avenue Danville, IL 61832	

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observation, interview, and record review the facility failed to check gastric residual volume during gastrostomy tube (g-tube) medication administration for one of two residents (R26) reviewed for g-tubes in the sample list of 38.</p> <p>Findings include:</p> <p>The facility's Tube Feeding (Administration of Medication) policy dated April 2025 documents to stop the feeding, disconnect the tubing, and check the tubing for placement before administering medications.</p> <p>R26's Care Plan dated 2/10/25 documents R26 has a g-tube and to monitor gastric residual volume prior to administering nutrition and medications.</p> <p>On 5/19/25 at 3:06 PM V17 Registered Nurse stopped R26's feeding, disconnected the tubing, and checked g-tube placement using air rush technique with syringe. V17 did not check gastric residual volume prior to administering water flushes, Tylenol, and Vitamin D3 into R26's g-tube. V17 confirmed V17 did not check gastric residual at this time. V17 stated V17 checked R26's gastric residual earlier, at the beginning of his shift.</p> <p>On 5/20/25 at 12:16 PM V11 Assistant Director of Nursing confirmed gastric residual volume should be checked at the time of g-tube medication administration.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review the facility failed to administer medications as ordered for three of nine residents (R24, R50, R78) reviewed for medication administration in the sample list of 38. This failure resulted in three medication errors out of 25 opportunities, a 12% medication error rate.</p> <p>Findings include:</p> <p>1.) R24's May 2025 Medication Administration Record (MAR) documents to administer Novolin Regular Insulin per blood glucose (milligrams per deciliter) based sliding scale, with meals, scheduled at 8:00 AM, 12:00 PM, and 5:00 PM.</p> <p>On 5/19/25 at 12:06 PM R24 was in the main dining room eating lunch. On 5/19/25 at 12:30 PM R24 was in R24's room. V15 Registered Nurse (RN) administered 6 units of Novolin Regular Insulin into R24's abdomen. V15 stated V15 checked R24's blood sugar just a few minutes prior, which was 280. V15 confirmed R24 already ate lunch prior to R24's blood glucose check and insulin administration.</p> <p>On 5/20/25 at 1:50 PM V1 Administrator stated blood glucose should be checked prior to meals. V1 confirmed sliding scale insulin should be administered based on blood glucose results obtained prior to meals, unless ordered differently.</p> <p>2.) R78's May 2025 MAR documents to administer Metoprolol Tartrate 25 milligrams (mg) one half tablet by mouth twice daily, hold for systolic blood pressure less than 130 and heart rate less than 90 beats per minute.</p> <p>On 05/19/25 at 3:45 PM V17 RN checked R78's blood pressure and heart rate which was 136/80 and 72. V17 administered R78's medications, including Metoprolol Tartrate 25 milligrams one half tablet by mouth. The medication card indicated to check blood pressure and heart, hold for systolic blood pressure less than 130 or if heart rate less than 90. At 3:52 PM V17 verified R78's Metoprolol card and physician ordered parameters. V17 confirmed V17 should not have administered this medication since R78's heart rate was less than 90.</p> <p>3.) R50's May 2025 MAR documents to administer Carvedilol 3.125 mg one tablet by mouth twice daily. Hold for systolic blood pressure less than 110 or heart rate less than 60.</p> <p>On 5/19/25 at 4:02 PM V3 RN administered R50's medications, including Carvedilol 3.125 mg one tablet by mouth. V3 did not check R50's blood pressure or pulse prior to administering this medication. At 4:09 PM V3 stated R50's blood pressure is checked daily. V3 confirmed R50's physician's ordered parameters for Carvedilol. V3 confirmed V3 did not check R50's heart rate and blood pressure prior to administering Carvedilol.</p> <p>The facility's pharmacy policy titled Administration Procedures for All Medications, dated 10/25/14, documents to check the MAR for the order and not any contraindications the resident may have prior to administering the medication. This policy documents to check the label against the order on the MAR and obtain/record any vital signs or other ordered monitoring parameters prior to medication administration.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to appropriately label and store medications and account for controlled medications for five of 16 residents (R40, R61, R71, R192, R63) reviewed for medication storage in the sample list of 38.</p> <p>Findings include:</p> <p>The facility's pharmacy policy titled Administration Procedures for all Medications, dated 10/25/14, documents to check the expiration date on package and container prior to medication administration and to label an opened date on multi-dose containers.</p> <p>The facility's Narcotic Count policy dated 9/5/22 documents a physical count of narcotics will be done by the oncoming and off-going nurses at each change of shift to identify discrepancies and to ensure controlled medications are handled, stored, disposed of and accounted for properly. This policy documents the controlled medication record will accompany the controlled medication.</p> <p>The facility's Storage of Medications policy dated April 2025 documents all resident medications should be stored in a locked cabinet, locked medication room, or locked medication cart.</p> <p>The facility's Self Administration of Medication policy dated April 2025 documents the care plan will reflect self-administration of medications and there will be a physician's order. This policy documents medications kept in a resident's room must be done in a way that prevents access by other residents, and only medications approved for self-administration may be left at the bedside.</p> <p>1.) On 5/18/25 at 2:41 PM the short hall medication cart on the second floor was reviewed with V4 Licensed Practical Nurse. R40's Glargine insulin pen was opened, dated with dispensed date of 3/2/25, and was not labeled with an opened date. R61's Lispro insulin vial was labeled with an opened date of 4/13/25 and discard date of 5/11/25. R71's Lispro insulin vial was labeled with opened date of 4/13/25 and discard date of 5/11/25. V4 confirmed the labeling of these medications. There was a bottle of Clonazepam (controlled medication) 1 milligram tablets labeled with R192's name. The controlled medication binder on the cart did not contain a controlled count sheet for this bottle of Clonazepam. V4 stated R192's bottle of Clonazepam was brought in from home yesterday or the day prior, but there was no count sheet for this medication. V4 stated the nurses are suppose to count the controlled medications and complete a count sheet.</p> <p>On 5/20/25 at 12:16 PM V11 Assistant Director of Nursing (ADON) stated controlled medications brought from home or an outside pharmacy should be counted and documented on a controlled medication form.</p> <p>R40's May 2025 Medication Administration Record (MAR) documents to administer Insulin Glargine 100 units/milliliter (u/ml) give 10 units subcutaneously daily at 6:00 AM as of 3/31/25.</p> <p>R61's May 2025 MAR documents to administer Insulin Lispro 100 u/ml subcutaneously per blood glucose based sliding scale four times daily as of 4/16/25.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R71's May 2025 MAR documents to administer Insulin Lispro 100 u/ml 8 units subcutaneously three times daily as of 1/17/25.</p> <p>R192's Census documents R192 admitted to the facility on [DATE]. R192's May 2025 MAR documents to administer Clonazepam 1 mg one tablet by mouth three times daily as of 5/15/25.</p> <p>The Insulin Glargine Highlights of Prescribing Information dated November 2018 documents vials/pens are good for 28 days once opened.</p> <p>The Insulin Lispro Highlights of Prescribing Information dated September 2023 documents vials are good for 28 days once opened.</p> <p>2.) On 5/18/25 at 8:12 AM and 8:23 AM R63 was in bed asleep with a medication cup in R63's hand that contained several pills. At 8:23 AM V14 Licensed Practical Nurse entered R63's room. V14 stated V14 gave those medications to R63 earlier this morning and usually R63 takes the medications, but R63 must have fallen asleep. V14 woke R63 and instructed R63 to take the medications. R63 stated the nurses leave her medications for her to take because they know R63 will take them.</p> <p>R63's active physician orders and care plan do not document self administration and bedside storage of medications.</p> <p>On 5/20/25 at 12:16 PM V11 ADON confirmed nurses should observe residents consume medications during medication administration and nurses should not leave the medications at the bedside. V11 stated there are currently no residents who are approved to self administer medications.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to initiate contact droplet precautions for two residents (R36, R69) and failed to sanitize a blood glucose meter following use to prevent cross contamination for one resident (R24) of 17 residents reviewed for infection control in a sample list of 38.</p> <p>Findings Include:</p> <p>The facility's Glucose Meter Cleaning policy dated July 2019 documents clean and disinfect the blood glucose meter after each use with an Environmental Protection Agency approved cleaner.</p> <p>The facility's policy Transmission Based Precautions revised April of 2025 documents In order to prevent the spread of communicable diseases isolation will be initiated according to CDC (Center for Disease Control) transmission based guidelines. Transmission based guidelines will be used in all cases in which standard precautions does not provide adequate barrier protection. Transmission based guidelines will be used to determine whether airborne, droplet, or contact isolation precautions will be implemented.</p> <p>The CDC's Transmission Based Precautions guidance dated 4/3/24 documents to use contact precautions for patients with known or suspected infections that represent an increased risk for contact transmission, including use of gown and gloves for cares, limiting patient transport, placing the patient in a private room, using dedicated or disposable medical equipment or disinfecting shared medical equipment, and frequent cleaning/disinfection of rooms. This guidance documents to use droplet precautions for patients with known or suspected respiratory pathogens that can be spread through respiratory droplets by coughing, sneezing or talking. These precautions include having the patient wear a mask and follow respiratory hygiene/cough etiquette, preferably placing the patient in a single room, wearing a mask when entering the patient's room, and limiting transportation/movement of the patient.</p> <p>1. R69's care plan updated 5/16/25 includes the following diagnoses: Mild Persistent Asthma, Type II Diabetes, and Morbid Obesity.</p> <p>R69's Minimum Data Set (MDS) dated [DATE] documents R69 is cognitively intact.</p> <p>R69's Care Plan dated 5/16/25 documents (R69), has Pneumonia, an infection of the respiratory system and receiving Antibiotic therapy thru 05/20/25.</p> <p>On 5/18/25 at 10:15AM R69 was lying in her bed. R69 was coughing frequently with a moist sounding cough. R69 stated, I have pneumonia and I have a bad cough. I cough so hard it hurts and I am worn out. R69's family member was at the bedside and confirmed R69 has pneumonia. R69 was observed to fail to cover her cough.</p> <p>There was no transmission based precaution sign on R69's door and no Personal Protective Equipment was placed outside near R69's room.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R69's Advanced Practice Nurse's note dated 5/20/25 at 9:35AM documents, (R69) was sent to the Emergency Department (ED) yesterday due to coughing up blood. Reviewed (R69's) ED paperwork; (R69) received a CT (computed tomography) without contrast, CBC/CMP (Complete Blood Count/Complete Metabolic Panel), D-Dimer, PT/INR (Prottime and International Normalized Ratio) and was diagnosed with pneumonia and prescribed azithromycin which she was already diagnosed with and taking. Patient was referred to a local nurse practitioner for follow up. Will refer provider to a local pulmonologist for follow up.</p> <p>2. R36 is documented on the facility census of 5/18/25 as R69's roommate.</p> <p>R36's's Minimum Data Set (MDS) dated [DATE] documents R36 is severely cognitively impaired.</p> <p>R36's Nurse's Note dated 05/15/2025 at 2:19AM documents (R36) has a non-productive cough and is running a fever 101.6 F (degrees Fahrenheit). Tylenol 650 mg suppository was administered. (R36) refused cough syrup. Given sips of water. Will have Nurse Practitioner assess (R36) in the AM.</p> <p>On 5/18/25 at 10:15AM R36 was lying in her bed. R36 was coughing frequently with a moist sounding cough. R36 was unable to practice any kind of respiratory hygiene and was seen wiping her nose with her right hand and then touching bed linens.</p> <p>There was no transmission based precaution sign on R36's door and no Personal Protective Equipment was placed outside near R36's room.</p> <p>On 5/19/25 at 12:00PM and on 5/20/25 at 12:15PM R36 was seated in a wheelchair at a large table with other residents in the main dining room. R36 was noted to continue to cough.</p> <p>On 5/20/25 V11, Assistant Director of Nursing (ADON) verified that both (R36, R69) are roommates, and both are currently exhibiting respiratory signs and symptoms. V11 stated V11 would place both on contact droplet precautions.</p> <p>4.) On 5/19/25 at 4:13 PM V3 Registered Nurse used a blood glucose meter, labeled with R24's name, to obtain R24's blood glucose level. V3 did not disinfect R24's blood glucose machine after use. V3 placed R24's blood glucose machine on top of the medication cart, contaminating the top of the cart. On 5/19/25 at 4:26 PM R24's blood glucose meter remained on top of the medication cart. V3 stated V3 was unsure how often blood glucose meters are disinfected. V3 confirmed V3 did not disinfect R24's blood glucose meter after use.</p> <p>On 5/20/25 at 12:16 PM V11 Assistant Director of Nursing stated a bleach wipe should be used to disinfect blood glucose meters after each use.</p>		