STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on observation, interview and record review the facility failed to have orders, consents or assessments for R52 and R219, failed to complete an initial assessment for a soft waist restraint for R47 and failed to obtain a consent for a soft waist restraint for R55 for four of four residents (R47, R52, R55, R219) reviewed for restraints on a sample list of 42 residents. Findings include: The facility Restraint Program Policy and Procedure dated 11/10/15 documents that prior to the use of any restraint, each resident is assessed for potential alternative by using the restraint Pre-Restraining and Quarterly Evaluation. If a restraint is deemed appropriate, a consent will be obtained, a quarterly review of the restraint will be completed, the care plan will be updated and reduction attempts will be documented. 1.) R52's Minimum Data Set, dated dated dated [DATE] documents that R52 is severely cognitively impaired. R52's progress notes document that on 5/17/24, the body pillow was in use on R52's bed. R52's medical record does not document an order, a consent, or an assessment for a restraint or body pillow. On 6/3/24 at 12:18PM, R52 was laying in bed with a large body pillow tucked under the sheets from his waist to his toes, separating R52 from the edge of the bed with the body pillow. On 6/3/24 at 10:30AM, V10 Certified Nursing Assistant said that they use a body pillow to keep R52 from getting up and out of the bed. On 6/4/24 at 9:53AM, V3 Assistant Director of Nursing said that R52 didn't have an order for a body pillow, R52 shouldn't have a body pillow, that R52 can get up and out of the bed if he wants to and that the use of a body pillow could be considered a restraint. 40385 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) On 2/3/24 at 9:14 AM and 9:51 AM R219 was lying in bed and one side of the bed was against the wall. The opposite side of the bed had a large body pillow positioned between the mattress and bed frame, which caused the foot of the mattress to be raised. R19 was confused and not interviewable. On 6/04/24 at 8:35 AM R219 was lying crossways in the bed, with feet hanging over the edge of the bed. There was no body pillow underneath of the mattress. On 6/03/24 at 9:51 AM V12 Certified Nursing Assistant (CNA) stated the body pillow is used because R219 tries to wiggle out of bed a lot, and a lot of times we find R219's feet hanging out of bed onto the floor. V12 confirmed the pillow is used to keep R219 in bed. V12 stated R219 is not able to remove the pillow. On 6/04/24 at 10:00 AM V11 CNA stated other staff were using the body pillow because R219 has a tendency to shift around in bed. V11 confirmed R219 is able to independently place R219's legs over the side of the bed. R219's Care Plan revised 5/30/24 documents R219's diagnoses include malignant neoplasm of stomach and liver, anxiety disorder, and restless leg syndrome. There is no consent, assessment, or order for the use of the body pillow restraint in R219's medical record. On 6/04/24 at 10:22 AM V3 Assistant Director of Nursing confirmed the use of the body pillow for R219 could be considered a restraint and V3 stated staff should not be using it. V3 stated there should be a physician's order, consent, and an assessment for restraint use. 37813 3. R47's Minimum Data Set (MDS) dated [DATE] documents R47 as severely cognitively impaired and uses a restraint while up in chair daily which prevents R47 from rising. R47's consent for restraint dated 7/20/24 documents a breakaway lap cushion was initiated for R47 related to poor safety awareness. There is no documentation of an initial assessment for this restraint. On 6/3/24 at 11:30AM R47 was observed in the front hall with the breakaway lap cushion in place to her wheelchair. 6/03/24 12:10 PM V22, R47's family member, stated (R47) can't remove the lap cushion herself. V22 stated (R47) was getting up on her own and face planted several times and I think (R47) needs the (Lap cushion). On 6/4/24 at 2:00PM V2, Director of Nursing stated We don't have an initial assessment for (R47) when we started using the (breakaway lap cushion). I think we must have just missed that. 32853 4.) R55's diagnosis list documents diagnoses including Dementia, Muscle Weakness, Muscle Wasting, Obesity, Anxiety and Depression. R55's Care Plan dated 7/10/24 documents R55 is at risk for falls due to weakness with an intervention of a soft lap cushion while in the wheelchair to remind her not to stand on her own. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R55's Physician's Orders document an order for a soft lap cushion when in the wheelchair, remove during ADLs (Activities of Daily Living) and meals for diagnoses of Dementia, Lack of Safety Awareness and Frequent Falls. On 6/03/24 at 11:00 AM, R55 was in another resident's room sitting by their bed. R55 was in the wheelchair and had the soft lap cushion on her lap with both sides of the cushion threaded through the arms of the wheelchair (as designed). On 6/3/24 at 11:27 AM, R55 was in her wheelchair with the soft lap cushion across her lap with the sides of the cushion threaded through the arms of the wheelchair. On 6/3/24 at 12:09 PM, R55 was in her wheelchair in the dining room with the soft lap cushion on her lap with the sides of the cushion threaded through the arms of the wheelchair. On 6/4/24 at 8:38 AM, R55 was in her wheelchair sitting at the front desk with the soft lap cushion on her lap with the sides of the cushion threaded through the arms of the wheelchair. On 6/4/24 at 9:56 AM, R55 was in activities sleeping in her wheelchair with the soft lap cushion on her lap with the sides of the cushion threaded through the arms of the wheelchair. R55's medical record does not contain a consent for the soft lap cushion. On 6/04/24 at 12:26 PM, V2 Director of Nursing confirmed there was no consent for the soft lap cushion and V2 stated it was changed from a hook and loop closure belt to a soft lap cushion back in July 2023, because R55 kept taking off the hook and loop closure belt and kept trying to stand up from the wheelchair so they placed the soft lap cushion on her in the wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on interview and record review the facility failed to obtain a level II PASRR (Preadmission Screening and Review) for one resident (R57) with Post-traumatic Stress Disorder (PTSD) of one resident reviewed for PASRR in a sample list of 42 residents. Findings Include: R57's Minimum Data Set (MDS) dated [DATE] documents R57 has an active diagnoses of PTSD and is cognitively intact. R57's Diagnoses list includes a diagnosis dated 6/30/23 of PTSD. There is no evidence in the medical record the facility obtained a Level II PASSR screening when they became aware of R57's diagnosis of PTSD. On 6/5/24 at 1:00PM V1, Administrator stated I was not aware that if the Level I PASRR did not indicate a Level II we had to get a level II in the event we became aware of a diagnosis of a serious mental Illness. V1 also verified that while the facility's policy for Care Plan Procedure does state the PASRR recommendations will be included in the initial Care Plan the facility does not have a policy specific to when to obtain a level II PASRR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on observation, interview and record review the facility failed to shave two (R12 and R17) of two dependent residents reviewed for dependent activities of daily living on a sample list of 42 residents. Findings include: The facility provided A.M. (morning) Care procedure dated April 2009 documents that staff are to provide personal hygiene to residents in the morning. This includes providing assistance with shaving including a razor, shaving cream and a basin of warm water. 1.) R17's Functional assessment dated [DATE] documents that R17 is dependent for all activities of daily living. On 6/3/24 at 9:47AM, R17 had whiskers all over his face and neck, approximately 1/2 inch long. On 6/3/24 at 9:50AM, R17 said that he liked to be clean shaven and that he really misses that here. On 6/3/24 at 9:55AM, V17 Certified Nursing Assistant asked R17 if he would like to be shaved and he responded in the affirmative. On 6/5/24 at 9:35AM, R17 had beard growth of 1/4 inch. On 6/5/24 at 9:30AM, R17 said that he is unable to use his hands, and that he has to have assistance for anything that requires his hands to do. On 6/5/24 at 9:40AM, R17 said that he would like to be shaved, but that he hadn't been shaved for a couple of days. 2.) R12's Minimum Data Set, dated dated dated [DATE] documents R12 as cognitively intact. R12's care plan dated 12/2019 documents that R12 requires assistance with shaving. On 6/3/24 at 11:30AM, R12 was unshaven with hair approximately 1/4 inch long on his face and neck. On 6/5/24 at 9:38AM, R12 face remained unshaved and was approximately 1/2 inch long. On 6/5/24 at 9:39AM, R12 said that he likes to be shaved daily and that he doesn't get shaved daily. On 6/5/24 at 10:00AM, V4 Registered Nurse said that she would expect all residents to be shaved with morning cares.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32853 Based on observation, interview and record review the facility failed to complete a safe sit to stand mechanical lift transfer for one (R55) of four residents reviewed for falls in the sample list of 42. Findings include: R55's diagnosis list documents diagnoses including Dementia, Contracture of the Right Knee, Contracture of the Left Knee, Muscle Weakness, Muscle Wasting, Abnormal Posture and Obesity, Anxiety and Depression. R55's Physical Therapy Evaluation and Plan of Treatment signed on 12/18/23 documents R55's goals of therapy were to increase knee range of motion and strength to be able to continue to use the stand lift. On 6/3/24 at 12:10 PM, V5 Certified Nursing Assistant (CNA), V6 and V7 CNA students wheeled R55 into the central bathroom to assist R55 to the toilet. They removed the soft lap cushion and wheeled her close to the mechanical sit to stand lift. They placed her feet on the foot plate and placed the sling under her arms and around her back, and placed the loops of the sling in the hooks on the lift. They raised R55 with the mechanical sit to stand lift. They did not use the leg strap around her legs and R55's knees were not against the knee pad of the lift. R55's knees were at least six inches away from the knee pad. As they lifted R55, her elbows raised towards the ceiling and made a chicken wing look. R55's elbows were at more than a 45 degree angle up towards the ceiling and R55's legs were bent. R55 never came to a standing position in the lift. R55's knees were bent and she started sliding down in the sling as her elbows raised towards the ceiling. They moved her to the toilet and lowered her onto the toilet. V5 stated that R55 has been started on therapy again to assist with the mechanical sit to stand transfers. On 6/4/24 at 1:21 PM, V14 Certified Occupational Therapy Assistant/Therapy Program Manager stated that R55 was recently evaluated to restart Physical and Occupational Therapy. V14 stated that when using the mechanical sit to stand lift that staff should place the resident's feet on the foot platform, attach the sling around the resident, direct their hand placement on the handle bars and lift the resident. V14 stated that she assumed R55 could straighten her legs enough to be safe on the mechanical sit to stand lift since that is what they are using to transfer her. V14 stated that some residents have to use the leg strap and some do not. V14 stated that the resident's knees should be against the knee pad and their arms should not be chicken winging (elbows raising up) and that the elbows should be at the residents side, definitely not up like chicken wings. On 6/5/24 at 10:45 AM, V2 Director of Nursing stated that they do competency training with staff on all the mechanical lifts. V2 confirmed that the resident's knees are supposed to be against the knee pad, the resident's elbows should not be raised up and if there is a leg strap on the mechanical sit to stand lift they should use it on the resident's legs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The mechanical sit to stand lift instruction manual provided by V2 Director of Nursing on 6/5/24 documents when lifting the resident that the resident's knees should rest against the knee pad.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on observation, interview, and record review the facility failed to identify potential triggers and implement resident centered trauma based interventions for one resident (R57) with Post-traumatic Stress Disorder (PTSD) of one resident reviewed for PTSD in a sample list of 42 residents. Findings Include: The facility's policy Trauma Informed Care dated 1October 2022 states It is the policy of this facility to ensure that residents who are trauma survivors receive culturally competent, trauma informed care. Resident experiences and preferences will be taken into account in an effort to eliminate or mitigate triggers that could cause retraumatization. This policy also states The Interdisciplinary team will work with the resident as well as family if indicated and other healthcare providers to develop and implement resident specific investigations in an effort to avoid re-traumatization. The team will also identify ways to mitigate or decrease the effect of the trigger in the resident. Trauma specific interventions shall recognize any relationship between the trauma and symptoms of trauma such as: substance abuse, eating disorders, depression, and anxiety. The need to access support groups shall also be considered. R57's Minimum Data Set (MDS) dated [DATE] documents R57 has an active diagnoses of PTSD and is cognitively intact. R57's Diagnoses list includes a diagnosis dated 6/30/23 of PTSD. R57's Care Plan revised 4/19/24 does not document the events which lead to R57's PTSD or potential triggers for R57's PTSD. The Care Plan does not include any resident centered interventions for R57's PTSD. On 6/3/24 at 10:30AM R57 was observed lying in the bed in her room with the blinds closed and the room nearly dark. R57's eyes were open and she was awake. When asked if (R57) preferred the room dark R57 answered Yes I like it that way. I get really nervous and the dark helps me stay calm. On 6/4/24 at 11:00AM V3, Assistant Director of Nursing stated I'm not sure what the cause of (R57's) PTSD is or what triggers it. (R57) is stable and doesn't talk about it so I don't bring it up. We Haven't had a Social Service Director since January. We all just kind of share the duties and we have a consultant. I don't think (R57's) PTSD has been addressed with the consultant. I do see the PTSD is not addressed on (R57's) Care Plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 40385 Based on observation, interview, and record review the facility failed to administer medications as ordered and in accordance with manufacturer's instructions for three (R7, R270, R59) of 11 residents reviewed for medication administration in the sample list of 42. This failure resulted in four medication errors out of 25 opportunities, a medication error rate of 16%. Findings include: 1.) R7's June 2024 Medication Administration Record (MAR) documents Metamucil Powder 28.3 % (Psyllium) Give 12 gram by mouth in the evening for constipation Drink at least 8 oz (ounces) of cool liquid per dose scheduled daily at 4:00 PM. On 6/03/24 at 4:38 PM V13 Registered Nurse (RN) administered R7's medications including 1/2 teaspoon of Metamucil dissolved in water. The Metamucil label documented one tablespoon equals 12 grams. V13 confirmed 1/2 teaspoon of Metamucil was administered. On 6/04/24 at 11:48 AM V16 RN stated R7 receives Metamucil and the dose is 12 grams. V16 read the Metamucil label and confirmed one tablespoon is 12 grams. 2.) R270's June 2024 MAR documents to administer Humalog (insulin) Kwikpen 200 units per milliliter (u/ml) give 5 u subcutaneously before meals at 5:30 AM, 11:00 AM, and 4:00 PM, and three times daily per sliding scale 0-149=0, 15-200=2 u, 201-250=4u, 251-300=6u, 301-350=8u, and 351-600= 10 u. On 6/4/24 at 10:55 AM V15 RN stated R270's blood glucose was 317 and R270 will get 5 units of scheduled insulin and 8 units per sliding scale. At 11:01 AM V15 administered Humalog 13 units into R270's left upper arm and did not prime the pen prior to administration. There was no food at R270's bedside. R270 was served the noon meal in the dining room at 11:38 AM (over 30 minutes after receiving insulin.) On 6/04/24 at 12:12 PM V15 RN confirmed V15 did not prime R270's insulin pen prior to administration. V15 stated V15 was not aware that insulin pens should be primed. 3.) R59's June 2024 MAR documents Admelog (insulin) 100 u/ml give before meals at 6:00 AM, 11:30 AM, and 4:30 PM per sliding scale 151 - 200 = 2u, 201 - 250 = 4u, 251 - 300 = 6u, 301 - 350 = 8u, and 351 - 400 =10 u. On 6/04/24 at 11:09 AM V16 RN stated R59's blood sugar was 241. At 11:13 AM V16 administered Admelog 4 u into R59's abdomen. There was no food at R59's bedside. At 11:53 AM R59's noon meal was served (over 40 minutes after receiving insulin). On 6/04/24 at 1:37 PM V2 Director of Nursing stated short acting insulin should be given within 30 minutes before a meal. The facility's Medication Administration policy dated 1/11/2010 documents to follow physician's orders when administering medications and to compare the medication label with the MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Humalog Highlights of Prescribing Information dated August 2023 and Admelog Highlights of Prescribing Information dated August 2023 document these medications are fast acting and should be administered within 15 minutes before a meal or immediately after a meal, and hypoglycemia (low blood sugar) is a possible side effect. The Humalog Kwikpen Instructions for Use dated July 2023 documents to prime (remove air) the insulin pen with 2 units prior to administration and repeat as needed until insulin is seen at the tip of the needle. These instructions document if the pen is not primed, too little or too much insulin may be administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 40385 Based on observation, interview, and record review the facility failed to ensure medications were labeled with the resident's full name and opened dates, ensure medications were not used past the beyond use date, and discard medications for eight (R1, R6, R269, R62, R53, R59, R44, R9) of 18 residents reviewed for medication storage on the sample list of 42. Findings include: On 6/04/24 at 12:12 PM the C side medication cart was viewed with V15 Registered Nurse (RN). R1's Lispro insulin pen was labeled with an opened date 4/12/24 (past the beyond use date). R6's Basaglar insulin pen was not labeled with an opened date. There was a Novolog (Aspart) insulin pen that did not contain a resident's name, only R269's nickname, or an opened date. V15 verified the labeling of these medications. V15 stated the pen belonged to R269, and confirmed it was not labeled with R269's full name. V15 stated V15 thinks insulin is good for 30 days once opened. On 6/04/24 at 12:38 PM the A Wing medication cart was viewed with V16 RN. R62's Latanoprost (Xalatan) eye drop bottle was labeled with an opened date 4/16/24 (past the beyond use date.) The pharmacy label documented to discard six weeks after opening. V16 stated eye drops should be labeled with opened dates and discarded as labeled. The cart contained R53's Azelastine 0.05% eye drops. V16 stated R53 no longer resides in the facility. R59's Lispro (Humalog) insulin pen with opened date of 5/3/24 (past the beyond use date) was only labeled with R59's first name and last initial. R44's Aspart insulin pen was only labeled with R44's first name. V16 stated these insulin pens belonged to R59 and R44. R9's Basaglar insulin pen with dispensed date 5/16/24 was not labeled with an opened date. V16 stated R9 does not use insulin anymore, and discontinued medications should be returned to the pharmacy. V16 verified the labeling of these medications. On 6/04/24 at 1:02 PM V2 Director of Nursing (DON) confirmed medications should be labeled with resident's first and last names, and insulin and eye drops should be labeled with opened dates. V2 stated the facility follows the pharmacy's chart for when eye drops and insulin should be discarded once opened. At 1:20 PM V2 stated medications should be destroyed or returned to the pharmacy when a resident expires and R53's eye drops should have been destroyed since R53 expired. On 6/04/24 at 1:05 PM V3 Assistant DON viewed R6's and R269's insulin pen pharmacy labels, and stated R6's Basaglar pen was dispensed from pharmacy on 5/17/24 and R269's Novolog pen was dispensed on 6/6/23. R1's June 2024 Medication Administration Record (MAR) documents R1 receives Lispro per sliding scale three times daily. R6's June 2024 MAR documents R6 receives Basaglar 23 units every morning and 28 units every evening. R269's June 2024 MAR documents R269 receives Novolog per sliding scale three times daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R62's June 2024 MAR documents R62 receives Latanoprost daily. R59's June 2024 MAR documents R59 receives Lispro per sliding scale three times daily. R44's June 2024 MAR documents R44 receives Aspart per sliding scale three times daily. R9's June 2024 MAR does not document an active order for Basaglar. R53's Census documents R53 expired on 5/29/24. The facility's pharmacy guide titled Medication with Beyond Use Dates dated September 2023 documents Once these products are opened or prepared, they must be used within a specific timeframe to avoid reduced stability, sterility, and reduced efficacy. All of these medications should be labeled in such a way that the Beyond Use Date is securely attached to part of the package and will not be discarded. Beyond use dating can be found in the products' package inserts, typically under the How Supplied/Storage and Handling section. This guide documents the stability for Admelog, Humalog, Novolog, and Basaglar pens as 28 days; and to discard Xalatan eye drops 6 weeks after opening. The undated (facility's pharmacy) Pharmaceutical Services Policy and Procedure Manual documents all resident medication labels should include the resident's name and discontinued/expired medications (that are not controlled substances) should be removed from active medication storage area and returned to the pharmacy. This manual documents when a resident expires, immediately return the resident's medications to the pharmacy for destruction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42702 Based on observation, interview and record review the facility failed to label a refrigerated, plastic container of chopped onions and a refrigerated, plastic container of chopped tomatoes with any dates and failed to monitor temperature cooking times to ensure that food is being served safely. These failures have the potential to affect all 72 residents who reside in the facility. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 6/3/24 documents 72 residents reside in the facility. The facility provided Food Storage Chart dated 2/2022 documents that after a food item is opened, it will be covered, labeled, use by date will be put on, initialed and stored. On 6/3/24 at 9:10AM during the initial tour, chopped onions and tomatoes were stored in the refrigerator without any time or date label. On 6/3/24 at 9:11AM, V9 Dietary Manager said that the onions and tomatoes should have been dated when they were chopped and put into the refrigerator and now needed to be thrown away. Additionally, V9 Dietary Manager said that the onions and tomatoes would have been served today had the lack of dating not been brought to her attention. V9 stated All food has to be date labeled so that it isn't kept so long that bacteria grows and makes people sick. The facility provided Food Temperature Log for Meal Service sheet dated the week of 5/5/24 documents no temperatures taken for the week. The Food Temperature Log for Meal Service sheet dated the week of 5/19/24 documents no temperatures were taken for the supper meal service on 5/19/24 and 5/20/24. The Food Temperature Log for Meal Service dated the week of 5/26/24 documents no temperatures were taken for breakfast or lunch on 5/26/24 and no dinner temperatures were taken for the week. The Food Temperature Log for Meal Service Sheet dated 6/2/24 documents no temperatures were taken for supper on 6/2/24, no temperatures were taken for lunch or supper on 6/3/24 and no temperatures were taken for breakfast or lunch on 6/4/24. On 6/4/24 at 10:45AM, food was observed on the steam table. When asked for the cook temperatures from the oven, V21 [NAME] said that she didn't have them. V21 said We should, but we don't. They are supposed to be documented for every meal. On 6/4/24 at 2:00PM, V8 Dietary Manager said that cook times are to be monitored to ensure that food is cooked thoroughly, so that no one gets sick.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40385 Based on observation, interview, and record review the facility failed to perform hand hygiene before and after eye drop and insulin administration for two (R59, R62) of 11 residents reviewed for medication administration in the sample list of 42. Findings include: The facility's Medication Administration policy dated 1/11/2010 documents Wash hands according to facility protocol. Wash prior to med (medication) pass, after administering eye preparations, after removing gloves and when hands become soiled. On 06/03/24 at 4:43 PM V13 Registered Nurse applied gloves and injected Admelog insulin 2 units into R59's abdomen. V13 removed and discarded the gloves. At 4:47 PM V13 applied gloves and administered Timolol Maleate 0.5 % one drop to R62's left eye. V13 removed and discarded the gloves, and left R62's room. V13 did not perform hand hygiene prior to or after administering R59's insulin and R62's eye drops. On 6/03/24 at 4:52 PM V13 stated hand hygiene during medication pass should be done when leaving the resident's room. V13 confirmed V13 did not perform hand hygiene before or after R59's and R62's medication administration. On 6/04/24 at 1:37 PM V2 Director of Nursing stated nurses should perform hand hygiene/use hand sanitizer between each resident during medication pass.