

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>37813</p> <p>Based on observation, interview, and record review the facility failed to maintain a mechanical wheelchair in a clean sanitary manner for one resident (R16) of five residents reviewed for wheelchair cleanliness in a sample list of 35 residents.</p> <p>Findings Include:</p> <p>R16's Care Plan reviewed 5/21/24 documents (R16) is under the care of Hospice Services related to diagnosis of severe protein malnutrition. A further decline in Cognitive and Physical Abilities is expected, all care is directed towards maintaining comfort through end of life.</p> <p>On 8/12/24 at 10:15AM R16 was in her room seated in a mechanical wheelchair. R16 stated I got this special chair from hospice. It's pretty comfortable but look it's dirty. The chair was caked around the padded seat with a chunky brown and white substance.</p> <p>R16 stated she doesn't like sitting in a dirty chair.</p> <p>On 8/13/24 at 2:00PM V2, Director of Nursing verified the night shift staff are responsible for cleaning wheelchairs and all staff should wipe off any visible debris as soon as they see it.</p> <p>The facility did not provide a policy specific to the cleaning of wheelchairs or other equipment.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	

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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>32853</p> <p>Based on observation, interview, and record review the facility failed to secure catheter tubing to prevent tension and failed to position catheter tubing so that the flow was not interrupted for two of four residents (R40, R72) reviewed for catheters in the sample list of 35.</p> <p>Findings include:</p> <p>The facility's Catheter Care policy with a reviewed date of 2/27/20 documents, 11. Secure catheter as needed.</p> <p>1.) R40's Care Plan dated 8/9/24 documents diagnoses including Obstructive and Reflux Uropathy, Overactive Bladder and Urinary Tract Infection. This care plan documents R40 requires an indwelling urinary catheter related to diagnosis of Urinary Retention. The intervention dated 5/14/24 documents to manipulate the tubing as little as possible and to avoid obstructions in the drainage.</p> <p>On 8/14/24 at 9:56 AM, V21 and V22 Certified Nursing Assistants (CNA) prepared to complete urinary catheter care. V21 and V22 uncovered R40 and R40's urinary catheter drainage flow was being impeded by the pressure of R40's right thigh as the tubing was laying underneath the right thigh and over the side of the bed. There was no visible urine in the tubing. After completing care on R40's front side they rolled R40 onto her left side. There was a red imprint on the back of R40's right thigh where the catheter tubing had been compressed underneath R40's leg. V21 and V22 confirmed R40 did not have a securement device to anchor the tubing to her leg.</p> <p>On 8/14/24 at 10:44 AM, V23 Licensed Practical Nurse stated R40 had not had a securement device for a while for her catheter tubing. V23 stated that the tubing should not be placed under R40's leg either.</p> <p>On 8/14/24 at 12:04 PM, V2 Director of Nursing stated ideally the urinary catheter drainage tubing should not be placed underneath the resident's leg.</p> <p>37813</p> <p>2. R72's medical record includes a current physician's order for an indwelling urinary catheter and a diagnosis of Urinary Retention.</p> <p>On 8/14/24 at 9:30AM V20, Certified Nurse's Aide (CNA) and V19, Certified Nurse's Aide (CNA) rolled R72 in bed to complete catheter care. Upon rolling R72 the catheter tubing pulled causing visible tension at the insertion site. R72's Urinary meatus was red and slightly swollen. V19 stated R72 Should have the catheter anchored to his leg. R72 stated I broke my leg in a car accident and it's hard for me to turn and it pulls on the tubing when (the CNAs) turn me.</p> <p>On 8/14/24 at 1:00PM V2, Director of Nursing confirmed R72 should have an anchoring device to keep the catheter tubing from pulling.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>32853</p> <p>Based on observation, interview, and record review the facility failed to implement Dietician recommendations for significant weight loss for two of three residents (R39, R40) reviewed for weight loss in the sample list of 35.</p> <p>Findings include:</p> <p>The facility's Weight Management Protocol with a revised date of July/2020 documents, Monthly (or as ordered by MD {medical doctor}) weights for all residents will be obtained. A copy of accurate weights will be provided to dietary monthly. Any residents with a significant weight change will be referred to the consultant dietitian. The Dietitian and food management will assess the resident's condition and make recommendations as necessary. Physician will be made aware of recommendations and place orders as needed.</p> <p>1.) R39's Care Plan dated 7/14/24 documents diagnoses including Femur Fracture, Rheumatoid Arthritis, Gastroesophageal Reflux Disease, Hypothyroidism and Type 2 Diabetes Mellitus. This Care Plan documents R39 is at nutritional risk and to monitor weights monthly.</p> <p>R39's Nutritional Assessment completed by V26 Registered Dietician dated 6/11/24 documents R39 received a regular diet with regular texture and documents her weight was 117 pounds. R39's weight log documents her weight on 5/29/24 was 117.2 pounds and her weight on 8/8/24 was 106 pounds which was a 9.56 % (percent) weight loss in three months.</p> <p>V26's Weight Review note dated 7/16/24 documents R39 had an 11.1% weight decrease in one month and recommended adding a house shake with lunch to encourage weight maintenance.</p> <p>R39's Physician's Order Sheet dated 8/1/24 through 8/31/24 does not document an order for a house shake at lunch.</p> <p>On 8/13/24 at 12:00 PM, R39 was feeding herself lunch and there was no house shake served to R39. R39's menu card does not document an order for a house shake at lunch.</p> <p>R39's Dietary Recommendations for Physician Approval is dated 7/16/24 and documents Dietary Recommendations of adding a house shake with lunch due to a significant weight decrease in one month. This recommendation is signed by V26. There is no Physician's signature on this recommendation.</p> <p>On 8/14/24 at 1:14 PM, V2 Director of Nursing stated that the Dietician emails her recommendations to them monthly and they give the recommendations to the Physician or Nurse Practitioner to approve. V2 stated after they have approved the recommendations, they enter the order into the computer. V2 stated typically it can take 24 to 48 hours for this to happen. V2 confirmed that this dietary recommendation was missed. V2 stated that V26 adds the weight loss onto the Care Plans herself. R39's Care Plan does not document the significant weight loss.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	
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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) R40's Care Plan dated 8/9/24 documents diagnoses including Acute Respiratory Failure with Hypoxia, Stage 4 Pressure Ulcer to the Coccyx and Vitamin D Deficiency. This Care Plan documents R40 is at nutritional risk and to monitor weight daily.</p> <p>R40's Nutritional Assessment completed by V26 dated 5/19/24 documents R40 received a regular diet with regular texture and documents her weight was 164.6 pounds. V26's note dated 7/16/24 documents R40's current weight as 149.2 pounds and is an 11.4% decrease in 6 months. V26 recommended added a house shake at lunch to encourage weight maintenance.</p> <p>R40's Physician's Order Sheet dated 8/1/24 through 8/31/24 does not document an order for a house shake at lunch.</p> <p>On 8/14/24 at 12:41 PM, R40 was in her room eating her lunch. She was feeding herself. R40 did not have a house shake served to her with her lunch and the house shake was not on her menu card.</p> <p>R40's Dietary Recommendations for Physician Approval is dated 7/16/24 and documents Dietary Recommendations of adding a house shake with lunch due to a significant weigh decrease. This recommendation is signed by V26 but is not signed by a physician.</p> <p>On 8/14/24 at 1:14 PM, V2 confirmed R40's dietary recommendation of the house shake was missed. V2 confirmed that the significant weight loss should have been added by the Dietician to R40's Care Plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>37813</p> <p>Based on interview and record review the facility failed to identify/track resident specific behaviors to justify the use of an antipsychotic and failed to implement nonpharmacological interventions for one resident (R65) of five residents reviewed for unnecessary medication in a sample list of 35 residents.</p> <p>Findings Include:</p> <p>R65's medical record documents current physician's orders for the following psychotropic medications: 1. Fluoxetine (antidepressant) 10 mg (milligram) on Sundays Fluoxetine 20 mg on Monday, Tuesday, Wednesday, Thursday, Friday, Saturday. 2. Lorazepam (antianxiety) 2mg/ml (milliliter) 0.25ml every 2 hours PRN (as needed). 3. Quetiapine (antipsychotic) 37.5 mg at bedtime.</p> <p>R65's Treatment Administration Record (TAR) for August 2024 documents Acknowledgement of Behaviors: Episodes of self-isolating and refusal of care. There is no documentation of nonpharmacological interventions attempted. There is no specific behavior identified or tracked to justify the use of an antipsychotic medication.</p> <p>On 8/14/24 at 11:00AM V17, Registered Nurse (RN) Unit Manager stated The only behavior we have documented for (R72) is Self-Isolating and refusing care. V17 verified self-isolation and refusing care is not justification for an antipsychotic.</p> <p>The facility's Psychotropic Medication Policy reviewed February 2022 states An unnecessary medication is any medication used: 1. In an excessive dose, including duplicative therapy 2. For an excessive duration. 3. Without adequate monitoring. 4. without adequate indications of its use. 5. In the presence of adverse consequences that indicate the drug should be reduced or discontinued.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853</p> <p>Based on observation, interview, and record review the facility failed to administer medications in accordance with Physician's Orders and manufacturer's recommendations for two of five residents (R4, R25) reviewed for medication administration in the sample list of 35. The facility had 2 medication errors out of 30 opportunities resulting in a 6.67% (percent) medication error rate.</p> <p>Findings include:</p> <p>The facility's Medication Administration Policy with a reviewed date of February/2024 documents, Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice.</p> <p>The (insulin aspart) manufacturer's instructions dated [DATE] documents, Throw away all opened insulin aspart vials after 28 days even if they still have insulin left in them.</p> <p>1.) R4's Medication Administration Record (MAR) dated [DATE] through [DATE] documents an order dated [DATE] for insulin aspart U-100 insulin solution 100 units/ml (milliliters) per sliding scale before meals for diagnosis of Diabetes Mellitus.</p> <p>On [DATE] at 11:40 AM, V4 Licensed Practical Nurse (LPN) checked R4's blood glucose level and R4's blood glucose level was 406 which indicated R4 needed 12 units of insulin aspart. V4 removed the vial from the medication cart, cleaned the plunger and withdrew 12 units of insulin aspart from the vial. The vial had an open dated of [DATE] written on the side. V4 continued to administer the insulin to R4 in R4's stomach. After administering the insulin aspart, V4 confirmed the open date on the vial of insulin aspart said [DATE] therefore is expired and should not have been used. V4 stated she misread the date.</p> <p>2.) R25's Medication Administration Record dated [DATE] through [DATE] documents an order dated [DATE] for Vitamin C 500 mg (milligrams) two tablets for a diagnosis of Vitamin Deficiency.</p> <p>On [DATE] at 8:50 AM, V3 LPN prepared R25's medications at the medication cart outside of R25's room. V3 removed one 500 mg tablet of Vitamin C from the bottle and confirmed that she only removed one tablet. R25 took her medications whole with water.</p> <p>On [DATE] at 12:04 PM, V2 Director of Nursing confirmed R25 should have received two 500 mg tablets of Vitamin C.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>37813</p> <p>Based on observation, record review, and interview the facility failed to label medication with date opened for two residents (R150, R151) of 25 residents reviewed for medication in a sample list of 35 residents</p> <p>Findings Include:</p> <p>1.) R150's Medication Administration Record (MAR) includes a current physician's order for Refresh tears 0.5% (percent) two drops in each eye as needed every six hours.</p> <p>On 08/14/24 at 11:37 AM an opened bottle of Refresh eye drops with R150's name was observed on the 400 Hall medication cart not labeled with date opened.</p> <p>2.) R151's Medication Administration Record (MAR) includes a current physician's order for Maxitrol (neomycin-polymyxin b-dexameth) 3.5mg(milligram)/g(gram)-10,000 unit/g-0.1 % ointment apply to right eye, ophthalmic (eye), At Bedtime.</p> <p>The insert for the Maxitrol eye ointment indicates it should be discarded 30 days after opening.</p> <p>On 08/14/24 at 11:36 AM an opened bottle of Maxitrol Eye drops with R151's name was observed on the 400 Hall medication cart not labeled with date opened.</p> <p>On 08/14/24 at 11:36 AM V25, Licensed Practical nurse stated we are supposed to label multidose medication containers with the time and date they are opened. I see the Maxitrol and the Refresh are not dated. I did not open either of them.</p> <p>The policy for medication administration provided by the facility does not address this issue.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER McLean County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Main Normal, IL 61761	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37813</p> <p>Based on observation, interview, and record review the facility failed to maintain the juice dispenser in a clean sanitary manner and failed to date perishable refrigerated foods when opened. This failure has the potential to affect all 100 residents who reside at the facility.</p> <p>Findings Include:</p> <p>The facility's Long Term Care Application for Medicare and Medicaid dated 8/12/24 documents the facility census as 100 residents.</p> <p>On 8/12/24 during the walk through of the main kitchen the juice dispenser was noted to have dried juice on the surface of the nozzles and the surrounding flat surface. Some of these dried juices were covered by green fuzzy material. V8 cook verified the dispenser is used to pour drinks for all residents who reside in the facility. Opened containers of almond milk, juices, thickening agent, and ice cream toppings were in the refrigerator on the front wall of the kitchen. The containers were not dated as to when they were opened. V8 verified the containers should be labeled with the date when opened.</p> <p>On 8/13/24 at 10:00 AM the juice machine in the kitchen had not been cleaned. V9, Dietary Manager verified the juice machine should be cleaned daily.</p> <p>The facility's policy Cleaning Instructions states Coffee Makers, Urns, Juice machines, frozen yogurt and/or ice machines will be cleaned thoroughly.</p>		