

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Knox County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 800 North Market Street Knoxville, IL 61448	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50962</p> <p>Based on observation, interview, and record review the facility failed to serve all residents at a table at the same time for five (R9, R27, R32, R36 and R45) of 26 residents reviewed for residents' rights in a sample of 28.</p> <p>Findings include:</p> <p>Resident's Rights for People in Long-Term Care Facilities dated 3/2017 documents You have the right to safety and good care; your facility must provide services to keep your physical and mental health, and sense of satisfaction.</p> <p>Facility Routine Mealtimes Report, dated 04/01/2023, documents mealtimes of 7:30 am, 11:30 am and 4:30 pm.</p> <p>On 08/13/24 at 11:45 am to 12:40 pm, during the lunch hours in the Main Dining Room, meal trays and drinks were being passed.</p> <p>1. On 08/13/24 at 11:45 am, three residents were eating their meal tray at the same table that R36 was sitting at. R36 did not have a meal tray. At 12:25 pm, R36 was served R36's meal tray and the resident's sitting at R36's table had already consumed their lunch meal. R36 stated that R36 was upset to have to wait as R36 feels they forgot her and R36's table mate's meals, and said that this happens all of the time. They have one staff member passing trays in no particular order with several tables that have residents eating, and others at the table waiting for their food.</p> <p>34131</p> <p>2. On 8/13/24 at 12:45 pm, R27's table mate was served the lunch meal tray. R27 was seated at the same table with his table mate, but R27 did not receive a meal tray. R27 sat by R27's self, for about ten minutes, before R27 was served the lunch meal tray. R27's table mate had already left the table. R27 stated, They don't have enough staff in the dining room. They always serve us late and it happens a lot. It was two hours one time to get a meal because people walked out, and they never called anyone in to replace them. It bothers me that they don't serve our whole table together, and I sit and watch them eat when I don't have my food.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 8/13/24 at 12:47 pm, R9 was seated at a table with one table mate. R9's table mate received the lunch meal tray. Fifteen minutes later, R9 was served the lunch meal tray.</p> <p>4. On 8/13/24 at 12:50 pm, R45 was seated at a table with a table mate. R45's table mate received the lunch meal tray, consumed the food, and walked out of the dining room before R45 got served R45's lunch meal tray. R45 stated They need more help in the dining room, and they always seem to serve the meals separate and not one table at a time.</p> <p>5. On 8/14/24 at 9 am, R32 stated, We do not get served our meals at the same time if we are sitting at the same table.</p> <p>On 8/16/24 at 11:00 am, V1 (Administrator/ADM) stated that the residents don't have assigned seating, but some residents like to sit with the same people daily. Their dining room times are 7:30am, 11:30 am and 4:30 pm. At that same time, V1 stated We need to come up with something to get them served at the time they arrive, and especially if the table mate already has their food.</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>30722</p> <p>Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions were implemented and failed to ensure proper disposal of Personal Protective Equipment for four residents (R6, R11, R51, R150) of 28 residents reviewed for Infection Control in a sample of 28.</p> <p>Findings include:</p> <p>Enhanced Barrier Precautions Policy documents, Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBP's) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents. 2. EBP's employ targeted gown and glove use during high contact resident care activities when precautions do not otherwise apply. A. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). B. Personal protective equipment (PPE) is changed before caring for another resident. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for the EBP's include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing. 5. EBP's are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.</p> <p>Personal Protective Equipment Policy documents, Gowns, Aprons, Lab Coats Policy Interpretation, and Implementation, dated 2001, documents, 7. Soiled gowns, aprons, and lab coats must be removed prior to leaving the work area and discarded into the appropriate receptacle located in the work area.</p> <p>1. R11's Wound Consultation Note, dated 08/14/24, documents R11 has a Stage Four Pressure Wound of the Right Ear full thickness which measures 0.4 x 0.7 x not measurable (centimeters).</p> <p>R11's July 2024 Physician Order Sheet documents an order, dated 08/23/24, to administer J-Tube (Jejunostomy) enteral feedings six times a day for supplement and flush the J-Tube with 210 milliliters of water.</p> <p>On 08/13/24 2:16 pm, V5/Charge Nurse and V6/CNA/Certified Nursing Assistant were observed providing incontinence care to R11. V5 and V6 were not wearing gowns. V5 stated during an interview on 08/13/24 at 2:23 pm, We were in a hurry, we should have worn gowns.</p> <p>On 08/14/24 at 2:48 pm, V7/LPN entered R11's room and donned gloves, but no gown. Medication (Tylenol 325 milligram two tablets) were crushed prior to entering R11's room. V7 then gathered water and spoke with R11 before checking placement and residual of R11's J-Tube. V7 then flushed and administered the medication through R11's J-Tube. V7 did not wear a gown during the administration of R11's J-Tube medications.</p> <p>2. R150's August 2024 Physician Order Sheet documents a diagnosis of Non-Pressure Chronic Ulcer of unspecified part of Lower Leg.</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>R150's Wound Consultation Sheet, dated 8/14/24, documents R150 has a Non-Pressure Wound of the Right Lower Lateral Leg which is full thickness and measures 2.0 x 0.7 x 0.3 centimeters.</p> <p>On 08/13/24 at 12:13 pm, V8/LPN entered R150's room and performed glucose monitoring. V8 did not wear a gown. R150 was on a bedpan. V9/CNA and V10/CNA entered R150's room, removed R150's bedpan and used the mechanical lift to assist R150 to R150's electric wheelchair. V9 and V10 did not wear gowns while providing direct care and transferring R150. V8 returned on 8/13/24 at 12:21 pm and administered medication (insulin) to the left lower quadrant of R150's abdomen without wearing a gown.</p> <p>During interview on 08/13/24 at 12:25 pm, V8 does not know why R150 is on Enhanced Barrier Precautions but states that V8, V9 and V10 should have worn gowns.</p> <p>50962</p> <p>3. On 8/14/24 at 08:30 am, R6 stated that R6 has an area to the left heel that had originally started as a blister that opened and got infected. R6 is noted to have a bandage showing above the left sock and pressure boot to the left foot.</p> <p>On 08/15/24 at 10:40 am, V3 (Licensed Practical Nurse/LPN) provided wound care to R6 who is in Enhanced Barrier Precautions. V3 (LPN) removed V3's gloves and disposed of them in R6's room. V3 (LPN) then rolled up R6's soiled gown and carried it down the hallway to place it in a linen barrel in the shower room.</p> <p>4. On 08/15/24 at 10:15 am, V3 (Licensed Practical Nurse/LPN) provided wound care to R51 who is in Enhanced Barrier Precautions for a coccyx wound. V3 walked out of R51's room with V3's gown and gloves on, walked up the hallway to the shower room, and then back to R51's room. V3 then removed and disposed of V3's contaminated gloves, rolled up the contaminated gown, and walked back up the hallway carrying the gown to a barrel in the shower room.</p> <p>On 8/15/24 at 10:30 am, V3 (LPN) stated that V3 should have removed and disposed of V3's gown and gloves in R51's room before exiting.</p> <p>On 08/15/24 11:14 am, V4 (Registered Nurse/ Infection Preventionist) stated that, Staff should have a linen barrel inside of the room to place contaminated gowns in after caring for residents on Enhanced Barriers, and if not available they should place the gown in a plastic trash bag and walk it down to linen barrel.</p>		