STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145883	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piatt County Nursing Home	1111 N State St Monticello, IL 61856

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain dignified quality of life for one of one resident (R68) reviewed for dignity on the sample list of 39. Findings Include: The facility's Quality of Life - Dignity policy revised in 2024 documents each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff should always treat resident with respect and dignity. Treating with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Demeaning practices and standards of care that compromise dignity are prohibited. Staff should promote dignity and assist residents as needed by promptly responding to a resident's request for toileting assistance (incontinence care). R68's Medical Diagnoses List dated June 2025 documents R68 is diagnosed with Diarrhea, Legal Blindness, Age-related physical debility, and Depression. R68's Minimum Data Set, dated [DATE] documents R68 has some cognitive impairment, uses a wheelchair, is always incontinent of bowel and bladder, and is dependent on staff for toileting hygiene and transfers. R68's Care Plan dated 9/25/24 documents R68 is at risk for skin breakdown, is legally blind, and staff are to place the call light within easy reach, place frequently used personal items within easy reach and respond to requests for assistance promptly. R68 is at risk for neglect and staff should ensure all needs are met while maintaining dignity and quality of life. On 6/16/25 at 11:05 AM R68's room has a strong foul odor. R68's call light is not within her reach. R68 is sitting in her wheelchair and the call light is behind her wheelchair and attached to the side of the bed under the covers. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/16/25 at 11:05 AM R68 stated she did not know where the call light was but had been looking for it because she has been needing to be changed for a long time and is very uncomfortable and in pain. R68 stated she is partially blind. R68 stated her bottom is burning from diarrhea and she has been sitting in it since shortly after breakfast. R68 stated she cannot control her bowels, but she always has to go after she eats. R68 stated she had diarrhea after breakfast and has been sitting in it ever since. R68 stated the diarrhea has moved up into her perineal area and on her stomach and up her back. R68 stated her bottom is very painful and feels like it is on fire. R68 stated she is very angry and upset with the situation and can't believe that staff left her in her room without her call light. R68 stated if she had her call light, she would've called staff when she knew she was having the bowel movement so they could change her quickly, so she did not have to sit in it. R68 stated she must be lifted with the full mechanical lift to get into bed and she cannot move her wheelchair on her own. R68 stated she hurts so bad and just wants to be cleaned up and not feel so gross. R68 stated the situation is horrible and she feels disgusting. On 6/16/25 at 11:10 AM V8 Certified Nurse's Assistant (CNA) was called into the room and confirmed R68's call light was not within her reach. V8 apologized and stated she would return with the mechanical lift and another staff member to assist in getting R68 cleaned up. V8 confirmed call lights should be secured within reach of the residents and resident needs are to be addressed promptly. On 6/16/25 at 11:13 AM both V8 CNA and V9 CNA entered R68's room with the mechanical lift and began to assist R68 in getting cleaned up. During cleaning, R68 jerked in pain and yelled out for V9 to be easy because her bottom is burning. R68's bottom was very dark red in appearance. On 6/16/25 at 11:30 AM V9 Certified Nurse's Assistant stated if R68 had been given her call light then she would have used it when she felt the need to have a bowel movement. V9 stated R68 is quick to use her call light because she doesn't like to sit in her soiled brief. V9 confirmed she could tell R68 was very upset and she shouldn't have been made to sit in a soiled incontinence brief for so long.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain call lights within reach for one of one resident (R68) reviewed for call lights on the sample list of 39. Findings Include: The facility's Call Light Policy dated October 2010 documents when residents are in bed or confined to a chair staff are to make sure the call light is within easy reach of the resident. R68's Medical Diagnoses List dated June 2025 documents R68 is diagnosed with Diarrhea, Legal Blindness, Age-related physical debility, and Depression. R68's Minimum Data Set, dated [DATE] documents R68 has some cognitive impairment, uses a wheelchair, is always incontinent of bowel and bladder, and is dependent on staff for toileting hygiene and transfers. R68's Care Plan dated 9/25/24 documents R68 is at risk for skin breakdown, is legally blind, and staff are to place the call light within easy reach, place frequently used personal items within easy reach and respond to requests for assistance promptly. R68 is at risk for neglect and staff should ensure all needs are met while maintaining dignity and quality of life. On 6/16/25 at 11:05 AM R68's room has a strong foul odor. R68's call light is not within her reach. R68 is sitting in her wheelchair and the call light is behind her wheelchair and attached to the side of the bed under the covers. On 6/16/25 at 11:05 AM R68 stated she did not know where the call light was but had been looking for it because she has been needing to be changed for a long time and is very uncomfortable and in pain. R68 stated her bottom is burning from diarrhea and she has been sitting in it since shortly after breakfast. On 6/16/25 at 11:10 AM V8 Certified Nurse's Assistant (CNA) was called into the room and confirmed R68's call light was not within her reach. V8 apologized and stated she would return with the mechanical lift and another staff member to assist in getting R68 cleaned up. V8 confirmed call lights should be secured within reach of the residents and resident needs are to be addressed promptly. On 6/16/25 at 11:30 AM V9 Certified Nurse's Assistant (CNA) stated if R68 had been given her call light then she would have used it when she felt the need to have a bowel movement. V9 stated R68 is quick to use her call light because she doesn't like to sit in her soiled brief. V9 confirmed she could tell R68 was very upset and she shouldn't have been made to sit in a soiled incontinence brief for so long.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a notice of bed hold to a resident being discharged to a local hospital. This failure affects one resident (R11) out of one reviewed for hospitalization on the sample list of 39. Findings include: R11's Census Detail dated 6/18/25 documents R11 was hospitalized starting on 8/20/24 through 8/26/24. R11's comprehensive Electronic Medical Record did not contain a notice of bed hold provided to R11. On 6/17/25 at 9:17 AM, R11 stated she had been to the hospital several times for various reasons. R11 further stated she did not remember anyone telling her anything about being able to come back to the facility nor that the facility would hold a bed for her. R11's Minimum Data Set, dated [DATE] documents R11 received a score of 15 out of a possible 15 during a Brief Interview for Mental Status indicating R11 is cognitively intact and without memory recall problems. On 6/17/25 at 3:50 PM, V3, Administrative Assistant, stated there was not a bed hold notice for R11 from the 8/20/25 hospitalization.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to transmit minimum data set resident assessments for significant change in status, and discharge, in the required time frame. These failures affect one resident (R5) out of one reviewed for minimum data set transmissions on the sample list of 39. Findings include: R5's Minimum Data Set for significant change in status dated as completed 5/16/25 did not document any transmitted or accepted date. R5's Minimum Data Set for discharge with return anticipated, likewise dated as completed 5/16/25, did not document any transmitted or accepted date. The Centers for Medicare and Medicaid Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2024 documents these minimum data sets for R5 are required to be transmitted within 14 days of the completion date. On 6/17/25 at 1:58 PM, V5, Minimum Data Set Assistant, stated he was not sure about the timing requirements for the Minimum Data Sets as he was new to his position. On 6/17/25 at 2:00 PM, V19, Dementia Unit Coordinator/ Dementia Unit Minimum Data Set Coordinator, stated in general a facility has 14 days to complete a resident's Minimum Data Set and another 7 days to transmit. V19 stated R5's Minimum Data Sets should have been transmitted before today (6/17/25). V19 further stated the computer system is supposed to select all of the Minimum Data Sets that have been completed since the previous transmission and transmit them all in one batch. V19 reviewed the batch reports for transmitted Minimum Data Sets from 5/11/25 through 5/20/25 and stated neither of R5's Minimum Data Sets were transmitted. On 6/17/25 at 2:10 PM, V4, Assistant Director of Nursing, stated the Minimum Data Sets are transmitted through a computer system (IQIES) operated from the Centers for Medicare and Medicaid Services. V4 continued to state that someone at the facility needed to manually designate on their computer that R5's Minimum Data Sets were ready to be transmitted so their computer would transmit the Minimum Data Sets, and no one had designated R5's Minimum Data Sets as ready to be transmitted. On 6/17/25 at 2:16 PM, V2, Director of Nursing/ Minimum Data Set Coordinator, examined her computer screen and stated R5's Minimum Data Sets should have been transmitted by now (6/17/25). V2 further stated she would need to do a correction on R5's Minimum Data Sets and get them transmitted. V2 stated it was facility staff who made an error by not designating R5's Minimum Data Sets as ready to be transmitted. V2 concluded by stating that generally there is a pattern for transmitting the Minimum Data Sets where a facility has 7 days from the assessment reference date to do the physical assessment of the resident, another 7 days to encode the Minimum Data Set, and another 7 days to transmit the Minimum Data Set.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Failures at this level required more than one deficient practice statement. A. Based on observation, interview, and record review the facility failed to label insulin, eye drops, and nose spray containers with the date opened for three of eighteen residents (R24, R33, R46) reviewed for medication administration on a sample list of 39. B. Based on observation, interview, and record review the facility failed to discard expired insulin for two of eighteen residents (R3, R68) reviewed for medication administration on a sample list of 39. Findings include: a. The facility's Storage of Medications Policy dated 2023 documents that all injectable medications, eye drops, nose spray, ear drops, liquid medications shall be labeled with date upon opening containers. R24's Medication Administration Record (MAR) dated [DATE] documents R24 is receiving Fluticasone Propionate nose spray. R33's MAR dated [DATE] documents R33 is receiving Dorzolamide HCl-Timolol eye drops. R46's MAR dated [DATE] documents R46 is receiving Lantus insulin. On [DATE] between 3:18 PM and 3:50 PM, the Team One and Team Three medication carts were observed. R24's bottle of nose spray (Fluticasone) was open and did not have an open date on the bottle. R33's bottle of eye drops (Dorzolamide HCL/Timolol) were open and did not have an open date on the bottle. R46's insulin vial (Lantus) was open and did not have an open date on the vial. On [DATE] at 3:28 PM, V2 Director of Nursing (DON) stated insulin, eye drops, and nasal spray should have the opened date on the container. On [DATE] at 3:42 PM, V6 Licensed Practical Nurse (LPN) stated insulin, eye drops, and nose sprays should be labeled with the date when opened. b. The facility's Storage of Medications Policy dated 2023 documents the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. R3's Medication Administration Record (MAR) dated [DATE] documents R3 is receiving Admelog insulin. R68's MAR dated [DATE] documents R68 is receiving Lantus insulin. On [DATE] between 3:18 PM and 3:50 PM, Team One and Team Three medication carts were observed. R3's insulin (Admelog) vial had an open date of [DATE] and an expiration date of [DATE]. R68's insulin (Lantus) vial had an open date of [DATE] and instructions to discard after 28 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:11 AM, V2 Director of Nursing stated the expired insulins should have been destroyed by the nursing staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to use required personal protective equipment during the transfer of a resident on contact isolation and failed to prevented cross contamination during incontinence care and urinary catheter care for three of four residents (R26, R68, R76) reviewed for infection control on the sample list of 39. Findings Include: 1. R26's Physician Order dated June 2025 documents R26 is to be on contact isolation related to Methicillin-Resistant Staphylococcus Aureus (MRSA) of the foot. On 6/17/25 at 8:45 AM V8 Certified Nurse's Assistant (CNA) and V18 CNA transferred R26 using a full mechanical lift. R26 was on contact isolation for Methicillin-Resistant Staphylococcus Aureus (MRSA) of the right foot. Neither V8 nor V18 wore gowns during the transfer. On 6/17/25 at 9:00 AM V2 Director of Nurses confirmed R26 is on contact isolation related to MRSA of his foot and both V8 and V18 should have been wearing both gloves and gowns during the transfer. The undated Contact Precautions sign posted on R26's door documents staff must put on gloves and a gown before entering the R26's room. 2. The facility's Diarrhea and Fecal Incontinence policy dated September 2010 documents residents must be cleaned after each episode of incontinence. Disposable items soiled with feces must be handled to prevent contamination of the environment with feces. R68's Medical Diagnoses List dated June 2025 documents R68 is diagnosed with Diarrhea, Legal Blindness, Age-related physical debility, and Depression. R68's Minimum Data Set, dated [DATE] documents R68 has some cognitive impairment, uses a wheelchair, is always incontinent of bowel and bladder, and is dependent on staff for toileting hygiene and transfers. R68's Care Plan dated 9/25/24 documents R68 is at risk for skin breakdown related to physical debility and urinary incontinence. On 6/16/25 at 11:05 AM R68's room has a strong foul odor. On 6/16/25 at 11:05 AM R68 stated she did not know where the call light was but had been looking for it because she has been needing to be changed for a long time and is very uncomfortable and in pain. R68 stated her bottom is burning from diarrhea and she has been sitting in it since shortly after breakfast. R68 stated she cannot control her bowels, but she always must go after she eats. R68 stated she had diarrhea after breakfast and has been sitting in it ever since. R68 stated the diarrhea has moved up into her perineal area and on her stomach and up her back. R68 stated her bottom is very painful and feels like it is on fire. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/25 at 11:13 AM both V8 CNA and V9 CNA entered R68's room with the mechanical lift and began to assist R68 in getting cleaned up. V9 donned gloves and used disposable perineal wipes to clean the bowel movement from R68's perineal area. After cleaning the perineal area, V9 used the same soiled gloves to assist R68 in turning on her side, V9 touched R68's thigh and gown. V9 then preceded to use disposable wipes to clean the bowel movement on R68's bottom. Once cleaned, V9 continue to use the same soiled gloves and touched R68's leg, arm, and clean incontinence brief. At that point, V9 CNA removed her soiled gloves and put on clean gloves however did not clean hands at all in between. On 6/16/25 at 11:30 AM V9 Certified Nurse's Assistant confirmed she should have changed her gloves after cleaning R68's perineal area and washed her hands or used sanitizer between glove changes. V9 confirmed she should not have touched R68's arm, leg, clothes, and clean incontinence brief with soiled gloves. 3. The Electronic Medical Record under the section Medical Diagnoses dated 6/17/25 documents the primary diagnoses for R76 are Chronic Lymphocytic Leukemia of B-CELL type not having achieved remission and secondary diagnosis for R76 is Infection and Inflammatory Reaction due to indwelling urethral catheter, subsequent encounter and Urinary Tract Infection. V18, CNA (Certified Nurse Assistant) performed incontinence care for R76 on 6/17/25 at 2:03 PM. V18 washed her hands and placed gloves on. V18 had positioned R76 to do care and R76 had a bowel movement. V18 with the same pair of gloves on touched R76 and positioned him on his side facing the wall so V18 could clean his buttocks area, V18 also pulled the privacy curtain, touch R76's personal items to find disposable wipes, picked up the disposable wipes and placed on end of the bed and V18 also placed a plastic bag on the end of the bed for trash. With the same pair of gloves V18 cleaned R76's buttock's area in order for R76 to be free of bowel movement. V18 then went and picked up a disposable pad and a clean depends with the same gloves on and placed the pad under R76 and positioned the depends next to V18's buttock's area. V 18 then reposition R76 on his back to position him for catheter care. V18 then removed the gloves and put a new pair of gloves on to perform catheter care without washing or sanitizing her hands. V18 started catheter care for R76, when V18 completed cleaning the shaft of the penis V18 cleaned under the scrotum sack with the same washcloth and not changing the area of the cloth. V18 took a clean washcloth to clean the catheter tubing and went over the catheter tubing twice with the same area of the washcloth and only cleaned about 4 inches of the catheter tubing. V18 stated upon completion of the catheter care on 6/17/25 at 2:25 PM, I should of changed gloves before I even started to clean R76 up, did not realize I had touched so many things. I did not realize I went over the catheter tubing twice with the same area of the cloth, I thought I flipped the cloth. The facility's policy titled Catheter Care, Urinary with the revision date of 06/2023 documents under #16 and #17: 16. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For a male resident: Use a washcloth with warm water to cleanse the meatus. Cleanse the glans using circular stokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. 17. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to end of catheter tubing.