

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/30/2024
NAME OF PROVIDER OR SUPPLIER  Lewis Memorial Christian Vlg		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 West Washington Springfield, IL 62702	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701</b></p> <p>Based on observation, interview and record review, the Facility failed to ensure Resident's Rights and dignity were honored regarding timely assistance in order to prevent incontinence as well as ensure residents were not left in soiled linens for 4 of 5 residents (R2, R6, R9, R10) reviewed for dignity, in the sample of 12.</p> <p>Findings include:</p> <p>1. R10's Minimum Data Set, dated dated [DATE] documents R1 is cognitively intact, requires substantial/Maximal assistance with toileting needs and is frequently incontinent of bowel and bladder.</p> <p>R10's Care Plan dated 7/26/2024 documents R10 is incontinent of bladder, but does not address bowel incontinence.</p> <p>On 5/21/2024 at 9:35 AM, R10 stated, I don't get my call light answered to go to the bathroom. I've been trying to go to the bathroom and I've been waiting 20 minutes, maybe longer. I put my call light on at 9 (AM) according to my watch. They wonder why I dirty my clothes. I've seen at least 10 people walk by. It's ridiculous. I feel like I've dirtied my clothes. I hope not. At this time two Certified Nursing Assistants (CNAs) entered R10's room but left again, telling R10 they had to get a gait belt. R10 then rolled her eyes and stated, Great, not it'll be another 20 minutes. Shortly after, less than a minute, the CNAs returned to the room and assisted R10 to the bathroom. R10 had an area of feces on the backside of her gown. V9 removed R10's adult brief that was soiled with feces. R10 stated, It's all over!</p> <p>At this time, R10's roommate, R6 stated, See, there's an example of not having enough staff. They are trying to get people back from the dining room but people in their rooms need them too.</p> <p>2. R2's Face Sheet dated 5/28/2024 documents R2 has a diagnosis of Multiple Sclerosis (MS).</p> <p>R2's MDS dated [DATE] documents R2 is cognitively intact.</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>On 5/21/2024 at 10:20 AM, R2 stated, The other day, I went down to the nurses station and told them I was starting to have a BM (bowel movement). By the time they helped me, it was all the way down to my knees and all over my shirt. They had to put me to bed and then change the whole bed. There is not enough staff to get to me. They need more employees.</p> <p>3. R6's MDS dated [DATE] documents R6 is cognitively intact.</p> <p>On 5/21/2024 R6 stated, There's not enough staff. I use the sit to stand to use the bathroom, but I have to wait a long time. The girls just can't get to me. Sometimes I dribble a little bit while I wait. Usually there is only one (staff member while using the sit to stand) but occasionally there are two.</p> <p>4. R9's MDS dated [DATE] documents R9 is always incontinent of urine and frequently incontinent of bowel.</p> <p>On 5/20/2024 at 10:15 AM, V4, R9's advocate, stated on 4/16/2024, 5/1/2024 and 5/7/2024 R9's pad/linens were soiled with either urine or feces and the bed was made. V4 showed this surveyor the pictures she took of a bed pad with a ring of area that appeared a different color as the rest of the pad and appeared wet. V4 also showed this surveyor a picture of a brown spot on R9's comforter.</p> <p>On 5/21/2024 at 1:52 PM, V3, Assistant Director of Nursing stated R9's caregiver approached her about R9's bed being made while it was soiled. V3 stated she inspected it and it looked more like a stain.</p> <p>On 5/28/2024 at 11:00 AM, V4 stated, If they told you it was a stain they are liars. I talked to (V3) about it. I could smell it. There was a wet pee ring and the pillow was even dirty. It was not a stain.</p> <p>On 5/28/2024 at 2:03 PM, V1 stated, They (staff) shouldn't use linens if they are stained. It's a dignity issue.</p> <p>The Facility's Grievance QA (Quality Assurance) Log dated 5/8/2024 documents a grievance was filed for R9 regarding soiled linens.</p> <p>On 5/29/2024 at 3:19 PM, V1 stated, My expectation is that the call lights are answered as soon as feasibly possible.</p> <p>The Facility's Call Light Policy dated 12/20/2011 documents, It is the policy of (Facility) to provide a means of communication to meet the needs of each resident. It continues to document, staff will respond promptly when the call light is activated.</p> <p>The Facility's Resident Rights Policy documents, The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely as well as, The resident has a right to be treated with respect and dignity.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40701</p> <p>Based on observation, interview and record review, the Facility failed to follow their mechanical lift policy to ensure the safety of residents for 2 of 4 residents (R2,R6) reviewed for Resident Injuries, in the sample of 12.</p> <p>Findings include:</p> <p>1. R2's Face Sheet dated 5/28/2024 documents R2 has a diagnosis of Multiple Sclerosis (MS).</p> <p>R2's MDS dated [DATE] documents R2 is cognitively intact.</p> <p>R2' Care Plan dated 2/27/2024 documents R2 uses a mechanical lift (sit to stand) and requires an assist of 2 for all transfers.</p> <p>R2's Care Plan dated 9/3/21 documents R2 has a history of legs giving out during transfers.</p> <p>On 5/21/2024 at 10:20 AM, R2 stated, My left side is paralyzed. I use the sit to stand. The nurse says there is supposed to be two but they don't have the staff for two. There's never two, only one. I fell on e time, a couple weeks ago while using it (sit to stand lift). I got a bruise on my arm.</p> <p>The Facility's Incident/Accident Log documents R2 had a fall on 5/1/2024.</p> <p>R2's Fall Detail Report documents R2 was lowered to floor/ground by staff. The intervention was to ensure proper positioning of knees in sit to stand prior to transfer.</p> <p>On 5/30/2024 at 12:45 PM, V14, Certified Nursing Assistant (CNA) and V20 transferred R2 from R2's electric wheelchair to the toilet via the mechanical sit to stand lift. V14 put the foot rest/support of the electric wheelchair up so that R2's feet would be directly on the lift. At this time both V14 and R2 stated the foot rest on R2's electric wheelchair was not put up when R2 fell on [DATE] and that was the root cause of the incident.</p> <p>2. R6's MDS dated [DATE] documents R6 is cognitively intact.</p> <p>On 5/21/2024 R6 stated, There's not enough staff. I use the sit to stand to use the bathroom, but I have to wait a long time. The girls just can't get to me. Sometimes I dribble a little bit while I wait. Usually there is only one (staff member while using the sit to stand) but occasionally there are two.</p> <p>The Facility's Mechanical Lift Transfers Policy dated 12/13/2019 documents, Two nursing or therapy associated are requires when using a mechanical lift. It further documents, Before initiating a transfer with a mechanical lift (total or sit to stand) obtain assistance from another associate for transfer. This policy further documents, If using a wheelchair, verify the leg supports are out of the way.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40701</p> <p>Based on observation, interview and record review, the Facility failed to ensure there were enough staff available to meet the needs of residents safety for transfers and call light response time for 5 of 5 residents (R2, R6, R8, R10, R11) reviewed for Lack of Staff, in the sample of 12.</p> <p>Findings include:</p> <p>1. R10's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact, requires substantial/Maximal assistance with toileting needs and is frequently incontinent of bowel and bladder.</p> <p>R10's Care Plan dated 7/26/2024 documents R10 is incontinent of bladder, but does not address bowel incontinence.</p> <p>On 5/21/2024 at 9:35 AM, R10 stated, I don't get my call light answered to go to the bathroom. I've been trying to go to the bathroom and I've been waiting 20 minutes, maybe longer. I put my call light on at 9 (AM) according to my watch. They wonder why I dirty my clothes. I've seen at least 10 people walk by. It's ridiculous. I feel like I've dirtied my clothes. I hope not. At this time two Certified Nursing Assistants (CNAs) entered R10's room but left again, telling R10 they had to get a gait belt. R10 then rolled her eyes and stated, Great, not it'll be another 20 minutes. Shortly after, less than a minute, the CNAs returned to the room and assisted R10 to the bathroom. R10 had an area of feces on the backside of her gown. V9 removed R10's adult brief that was soiled with feces. R10 stated, It's all over!At this time, R10's roommate, R6 stated, See, there's an example of not having enough staff. They are trying to get people back from the dining room but people in their rooms need them too.</p> <p>2. R2's Face Sheet dated 5/28/2024 documents R2 has a diagnosis of Multiple Sclerosis (MS).</p> <p>R2's MDS dated [DATE] documents R2 is cognitively intact.</p> <p>R2' Care Plan dated 2/27/2024 documents R2 uses a mechanical lift (sit to stand) and requires an assist of 2 for all transfers.</p> <p>R2's Care Plan dated 9/3/21 documents R2 has a history of legs giving out during transfers.</p> <p>On 5/21/2024 at 10:20 AM, R2 stated, Staffing is definitely an issue. I was going to tell them I was coming outside, but I couldn't find anyone on my hall. I have waited four hours for tylenol before. They are supposed to check us every two hours but they never do. My left side is paralyzed. I use the sit to stand. The nurse says there is supposed to be two but they don't have the staff for two. There's never two, only one. I fell on e time, a couple weeks ago while using it (sit to stand lift). I got a bruise on my arm. The other day, I went down to the nurses station and told them I was starting to have a BM (bowel movement). By the time they helped me, it was all the way down to my knees and all over my shirt. They had to put me to bed and then change the whole bed. There is not enough staff to get to me. They need more employees.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Facility's Incident/Accident Log documents R2 had a fall on 5/1/2024.</p> <p>R2's Fall Detail Report documents R2 was lowered to floor/ground by staff. The intervention was to ensure proper positioning of knees in sit to stand prior to transfer.</p> <p>3. R8's Face Sheet dated 5/28/2024 documents R8 has Chronic Obstructive Pulmonary Disease (COPD/Breathing condition).</p> <p>R8's MDS dated [DATE] documents R8 is cognitively intact.</p> <p>On 5/21/2024 at 10:00 AM, R8 stated, I've waited from 6 AM until 9 AM for a breathing treatment. I have been wheezing. It's not their fault, they just don't have enough staff. They're over loaded. I told (V8, Licensed Practical Nurse, LPN) and V1 (Administrator, ADM). This hall (100) is the busiest. It's chaos.</p> <p>4. R6's MDS dated [DATE] documents R6 is cognitively intact.</p> <p>On 5/21/2024 R6 stated, There's not enough staff. I use the sit to stand to use the bathroom, but I have to wait a long time. The girls just can't get to me. Sometimes I dribble a little bit while I wait. Usually there is only one (staff member while using the sit to stand) but occasionally there are two.</p> <p>5. On 5/20/2024 at 2:21 PM, V8, LPN, stated, There's no staff (CNAs) on the hall if you're looking for someone. It's pretty common around here. Between 2 (PM) and 3 (PM) we only have on person on the hall. That's how we operate around here. At this time, R11 stated, Look, nobody that way, no body that way while pointing in two directions down the hallway. R11 continued to state, There's not enough staff and someone always needs something. At this time, there were 2 call lights activated, which V8 left the nurses station to answer.</p> <p>The Facility's Mechanical Lift Transfers Policy dated 12/13/2019 documents, Two nursing or therapy associates are requires when using a mechanical lift. It further documents, Before initiating a transfer with a mechanical lift (total or sit to stand) obtain assistance from another associate for transfer.</p> <p>On 5/29/2024 at 2:33 PM, V1 stated the census of the facility was 117 on both 5/20/2024 and 5/21/2024.</p> <p>The Facility's Staffing and Staffing Notification Policy dated 9/1/2009 documents, It is the policy of (Facility) that communities provide adequate staffing to meet needed care and services for our resident population. At the beginning of the shift, on a daily basis, actually staffing scheduled for the day is to be posted in a prominent place and be easily accessible to residents and visitors in a clear, easy-to read format. If further documents, Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlines on the resident's comprehensive care plan. It continues to document the posting should include the current date and census.</p> <p>On 5/29/2024 at 3:19 PM, V1 stated, My expectation is that the call lights are answered as soon as feasibly possible.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Facility's Call Light Policy dated 12/20/2011 documents, It is the policy of (Facility) to provide a means of communication to meet the needs of each resident. It continues to document, staff will respond promptly when the call light is activated.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>40701</p> <p>Based on observation, interview and record review, the Facility failed to ensure the current staffing record was posted. This failure has the potential to affect all 117 residents residing in the Facility.</p> <p>Findings include:</p> <p>On 5/20/2024 at 9:25 AM, there was a posting titled, Report of Nursing Staff directly responsible for resident care dated 4/26/2024 as well as a disclaimer dated 3/29/2024 documenting the Facility does not meet the federal staffing guidelines.</p> <p>On 5/21/2024 at 9:30 AM, the Report of Nursing Staff directly responsible for resident care was not posted.</p> <p>On 5/21/2024 at 12:44 PM, V1, Administrator stated she was aware the Report of Nursing Staff directly responsible for resident care was not posted and she sent an email to make sure it is kept current, because that is the regulation. V1 also stated, Hopefully it is posted today.</p> <p>On 5/29/2024 at 2:33 PM, V1 stated the census of the facility was 117 on both 5/20/2024 and 5/21/2024.</p> <p>The Facility's Staffing and Staffing Notification Policy dated 9/1/2009 documents, It is the policy of (Facility) that communities provide adequate staffing to meet needed care and services for our resident population. At the beginning of the shift, on a daily basis, actually staffing scheduled for the day is to be posted in a prominent place and be easily accessible to residents and visitors in a clear, easy-to read format. If further documents, Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlines on the resident's comprehensive care plan. It continues to document the posting should include the current date and census.</p>		