STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146026	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lewis Memorial Christian Vlg	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)
F 0550 Level of Harm - 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** 33112 Based on interview, observation, and record review, the facility failed to answer call lights in a timely manner for 3 of 10 residents (R17, R58, R102) reviewed for dignity in the sample of 51. This failure resulted in R58 feeling less than a person, R102 feeling humilated, and R17 fell ing terrible. Findings include: 1. On 09/23/24 at 11:27 AM, R58 stated, It can take up to 1 hour for them to come and get me to the bedpan. They have to (full mechanical lift) me into bed and then get the bed pan. With waiting that long, I have accidents. I have lost a lot with my disease and being put in a nursing home. I am continent still and I don't want to lose that. When I have accidents, I feel like less of a person. R58's Admission Record, Print date of 9/24/24, documents that R58 was admitted on [DATE] and has diagnoses of Multiple Sclerosis and functional Quadriplegia. R58's Minimum Data Set,(MDS), dated [DATE], documents R58 is cognitively intact, is totally dependent on staff for all care and mobility, is occasionally incontinent, and that bowel continence was not rated. 2. On 09/23/24 at 11:10 AM, R102 was questioned about how timely staff assist with answering the call light, R102 stated, This morning I was in the dining room, I asked to be taken back to my room because I had to go to the bathroom. The aide in the dining room said, Ok I will be back. If I ever write a book about this place that is going to be the title because that is all they ever tell you. They never took me to the bathroom. I had a number 2 in my pants because I couldn't hold it during breakfast and exercise class. When they finally brought me back to my room, I got cleaned up. It makes me humiliated when I have an accident because I have to wait so long. (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 - Actual harm Residents Affected - Few	R102's Nurses Note, dated 9/12/2024 10:15 documents, The staff member informed this writer that they were going to go on break and when they come back they are going to get up the resident. The staff member left on her break, the resident put on her light. This writer went to check on the call light and see what the resident needed. Resident stated that she needed the aid. This writer informed the resident that it was be just one moment and left the room to go get help. This writer walked down the hall to see if staff had returned, when resident put back on her light. Staff went back down to her room to check on the resident. Resident stated that she had soiled herself and she still need to go some more and wanted to get up to go to the restroom. This writer informed her it would be just one moment and went to go to get the aid. This writer left the floor to get the other staff member. However, did not see the staff member outside and returned to the floor. This writer could hear noise down the hall and resident call light was back on. This writer went back to the resident room with wipes and a depend. Resident was crying and very upset. She stated that it wasn't fair and that she always has to wait, and she is sick of it all. This writer and a different staff member assisted getting the resident up. She was placed on a sit-to-stand and transfer to the restroom. We were in the process of cleaning up the resident, when the aid returned to the floor and saw that the two of us were in the resident room. The different staff member and this writer finished cleaning up the resident while the aid went to get another resident up. R102's Admission Record, print date of 9/24/24, documents that R102 was admitted on [DATE] and has diagnoses of Polyarthritis and a history of falls. R102's MDS, dated [DATE], documents R102 is cognitively intact, has bilateral leg range of motion issues, dependent on staff for transfers and toileting hygiene, always continent of bowel, and frequently incontinent of urine. 3. On 09/23/24 at 11:40 AM, R17 stated, I am continent but it can take an hour before they come and answer the light. When it takes that long, I have accidents. I then feel terrible about it. R17's Admission Record, print date of 9/24/24, documents that R17 was admitted on [DATE] and has diagnoses of Type 2 Diabetes and Schizoaffective Disorder. R17's MDS, dated [DATE], documents that R17 is cognitively intact, dependent on staff for toileting, chair to bed transfer, uses a wheelchair, is occasionally incontinent of urine, and always continent of bowel. The Resident Council Minutes, dated 9/3/24, documents, New Business: Nursing: A lot of complaints about CNA's (Certified Nurses Aide) not coming to calls. The Resident Council Minutes, dated 7/2/24, documents, New Business: Nursing: call light/ won't give to resident. Long wait times. The Illinois Long Term Care Ombudsman Program Resident Rights', dated 11/18, Your rights to dignity and respect. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32874 Based on record review and interview the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice (SNF/ABN) form CMS 1055 to residents prior to discharge from Medicare Part A services for 2 of 3 residents (R106, and R315) reviewed for Medicare Part A services in the sample of 51. Findings include: 1. R106's facesheet dated 9/26/2024 documents R106 was admitted to the facility on [DATE]. R106s' face sheet documents a diagnosis in part of unspecified fracture of T9-T10 vertebra, chronic kidney disease, syncope, collapse and repeated falls. Review of record documents R106 Medicare Part A Services stated 6/24/2024 and terminated on 8/5/2024 with benefit days remaining. The SNF/ABN form CMS 1055 was not provided to R106 by the facility. 2. R315's face sheet dated 9/26/2024 document R315 was admitted to the facility on [DATE] with diagnosis of bilateral primary osteoarthtritis of hip, radiculopathy lumbar region, repeated falls and spinal stenosis. Review of R315's record documents R315 Medicare Part A Service started on 7/1/2024 and services terminated on 8/16/2024 with benefit days remaining. The SNF/ABN form CMS 1055 was not provided to R315 by the facility. On 9/25/2024 at 12:30 PM, V28, social services stated she does not complete the Advanced Beneficiary Notice (ABN). V28 stated they are not being done as she has not been trained to do them. V28 stated she started employment at the facility on 6/28/2024. On 9/25/24 at 01:02 PM, V2, Director of Nursing (DON) stated she would expect the facility to complete ABN's. The facility undated training notes non-covered and SNFABN docx. documents medicare requires that notices be sent to beneficiaries when Medicare services are ending

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50908 Based on interviews, observations, and record reviews the facility failed to provide assistance with personal hygiene and feeding for 5 out of 32 residents, (R43, R46, R60, R7, R8), reviewed for assistance with activities of daily living (ADL) in a sample of 51. Findings include: 1. R43's Minimum Data Set (MDS), dated [DATE], documents she is moderately cognitively impaired and requires supervision or touching assistance while eating. This MDS also documents she requires a mechanically altered diet involving the change in texture of food or liquids to pureed food or thickened liquids. R43's care plan, dated 8/20/2024, documents she has a behavior problem of throwing feces in room, throwing food, plates on floor, related to dementia. Interventions put in place for staff to follow involve monitoring/documenting/reporting targeted behaviors and to attempt interventions as well as analyze key times, places, circumstances, triggers, what de-escalates the behavior and to document. On 9/23/2024 at 12:02 PM, R43 was eating pureed food with her right thumb. R43 picked up her spoon and flung her food on the floor. R43's food was observed to be to the right of her on the ground, on her wheelchair handle, and on the table. The food was not cleaned up throughout the meal. R43 continued to eat her food with her thumb and spoon while occasionally touching other surfaces with her thumb such as her wheelchair. R43 did not receive staff assistance or redirection to eat with her utensils and no staff sat at her table throughout the meal. On 9/25/2024 at 3:15 PM, V2 (Director of Nursing/DON), stated she would expect staff to redirect R43 from using her thumb to eat and provide more assistance. 33112 2. On 9/23/24 during the noon meal which is roasted turkey, mixed vegetables, and mashed potatoes. R46 is feeding herself. No staff member offered or assisted R46 with cutting up her turkey, encouraged her to eat, or offered her something else to eat. R46 ate no turkey, 40% of her mashed potatoes and mixed vegetables. R46's Admission Record, print date of 9/25/24, documents that R46 was admitted on [DATE] and has diagnoses of Senile Degeneration of the Brain, anorexia, Dementia, skin cancer of the nose and right lower leg. R46's MDS, dated [DATE], documents that R46 is severely cognitively impaired and requires supervision or touching assist for eating. R46's Diet Order, dated 6/5/24, documents, Regular diet, Regular texture, Thin consistency. R46's Electronic Medical Record fails to document any other dietary orders (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 9/24/24 at 11:57 AM, R60 was served her lunch tray. At 12:00 PM, R60 is trying to cut her roasted turkey with a spoon. At 12:24 PM, V30, Chaplin, came and removed her from the dining room to take her back to her room. R60 was unsuccessful with cutting up turkey and only ate a few bites of mashed potatoes. R60 was never encouraged to eat, assisted with cutting up the turkey, or questioned if she wanted something else. R60's Admission Record, print date of 9/25/24, documents that R60 was admitted on [DATE] and has diagnoses of Mild Protein Calorie malnutrition and Glaucoma. R60's MDS, dated [DATE] documents that R60 is severely cognitively impaired and requires set up or clean up assistance with dining. R60's Diet Order, dated 3/27/23, documents, Regular diet, Regular texture, Thin consistency. 4. On 9/24/24 at 11:58 AM, R7 was served her lunch tray. During the meal R7 sat still and looked at her food. At 12:20 PM, the Chaplin came and removed her from the dining room to take her back to her room. During the meal, R7 was not offered help with cutting up her turkey, encouragement to eat, or offered something else to eat. R7's Admission Record, print date of 9/25/24, documents that R7 was admitted on [DATE] and has a diagnosis of Dementia. R7's MDS, dated [DATE], documents that R7 is severely cognitively impaired and requires set up or clean up assistance with dining. R7's Diet Order, dated 9/18/24, documents, Sodium precautions diet, Regular texture, Thin consistency. 5. On 9/24/24 during the noon meal, R8 was not offered assistance with cutting up her turkey, encouraged to eat, or offered anything else to eat. At the end of the meal, R8 ate 100% of cake and mashed potatoes and 25% of vegetables. R8's Admission Record, print date of 9/25/24, documents that R8 was admitted on [DATE] and has a diagnosis of Dementia. R8's MDS, dated [DATE], documents that R8 is cognitively intake and set up or clean up assistance with dining. R8's Diet Order, dated 4/18/24, documents, Regular diet, Regular texture, Thin consistency. On 9/24/24 at 4:05 PM, V1, Administrator, stated, We do not have a feeding assistance policy, but staff should be assisting those that need help.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40650 Based on observation, interview and record review, the facility failed to perform complete incontinent care, for 2 of 5 (R6, R45) residents, reviewed for incontinence, in a sample of 51. Findings include: 1. On 09/25/2024 at 10:15 AM, V23, Certified Nurse Assistant (CNA), cleansed R6's left buttock down to inner thigh, and cleansed front to back peri rectal and rectal area using wet cleansing wipes. V23 did not dry the cleansed areas. R6 was then rolled onto her back, and V23 cleansed her abdominal fold, bilateral groins and labia with the wet cleansing wipes. These areas were not dried nor was R6's left hip, buttock or back of left thigh cleansed. V23 then put a clean incontinent brief on R6 and then pulled her pants back up. R6's Physician's order sheet, dated 9/2024, documented a diagnoses of personal history of urinary tract infections, dementia and anxiety. R6's Minimum Data Set (MDS), dated [DATE], documented that she was always incontinent of her bowels and her bladder, that her cognition was severely impaired and that she was dependent upon staff for toileting and personal hygiene. R6's Care Plan, dated 7/22/2024, documented, Maintain clean/dry skin. Dry well under skin folds. Do not apply powders. Apply lotion on dry skin. Do not apply lotion to open areas. It continues, Incontinence care with each incontinence episode. 2. On 09/24/2024 at 01:10 PM, V18, CNA, cleansed R45's left groin, with cleansing wipe and there was smeared bowel movement was noted, she flipped over wipe, cleansed down right groin and then along R45's penis. R45 was not dried after. V18 then rolled R45 on to his left side, cleansed front to back R45 rectal area and right hip, areas were not dried, antifungal powder was applied to his buttocks and rectal area. R45 was turned onto his back and his penis appeared still wet from the cleansing wipe. Then R17, CNA and R18, CNA, attached new adult incontinent brief and pulled R45's pants up. R45's Physician's order sheet, dated 09/2024, documented diagnoses of Alzheimer's, Dementia and Parkinson's disease. R45 MDS, dated [DATE], documented that he was always incontinent of bowel and bladder and that he was dependent for toileting hygiene. It also documented that his cognition was severely impaired and that he was dependent upon staff for personal hygiene. R45's Care Plan, dated 06/14/2024, documented, Provide pericare after each incontinent episode. It continues, Maintain clean and dry skin. On 09/25/2024 on 01:25 PM, V29, CNA, stated that when incontinent care is being done, all areas should be cleansed and if using the cleansing wipes, for incontinent care, all areas need to dried. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/2024 at 01:29 PM, V21, CNA, stated that when performing incontinent care, if they are using cleansing wipes when doing incontinent care, all areas should be dried after using these and that all areas are cleansed during incontinent care. On 09/25/2024 at 01:35 PM, V27, CNA, stated that all areas are cleansed during incontinent care. V27 stated that all the areas that were cleansed during incontinent care need to be dried. On 09/25/2024 at 3:00 PM, V2, Director of Nurses, stated that staff should be cleansing all of the residents areas, during incontinent care and dry the resident skin when using the cleansing wipes. The facility's policy, Incontinence Care (Peri-Care), dated 06/05/2017, documented, 7. Assure all areas that may be contaminated by incontinence of urine or feces have been cleansed. It continues, Cleanse the buttocks/rectal area last.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review the facility failed to implement interventions to prevent weightloss, monitor weightloss, encourage resident eating for 2 of 7 residents (R7, R46) reviewed for weight loss in the sample of 51. This failure resulted in R7 and R46 both experiencing significant weight loss. Findings include: 1. On 9/24/24 at 11:58 AM, R7 was served her lunch tray. During the meal, R7 sat still and looked at her food. At 12:20 PM, the Chaplin came and removed her from the dining room to take her back to her room. During the meal, R7 was not offered help with cutting up her turkey, encouragement to eat, or offered something else to eat. R7's Admission Record, print date of 9/25/24, documents that R7 was admitted on [DATE] and has a diagnosis of Dementia. R7's Minimum Data Set (MDS), dated [DATE], documents that R7 is severely cognitively impaired and requires set up or clean up assistance with dining. R7's Diet Order, dated 9/18/24, documents, Sodium precautions diet, Regular texture, Thin consistency. R7's Dietary Note, dated 8/15/2024 08:58, documents, WEIGHT WARNING: Value: 134.2 Vital Date: 2024-08-06 11:27:00.0 MDS: -5.0% change over 30 day(s) [9.5% , 14.0] -7.5% change [8.2% , 12.0] RD (Registered Dietician) evaluation for unplanned wt (weight) loss. Wt (8/6) 134.2# BMI (body mass index) 28 (overweight). Sodium precautions. PO (oral) intakes had been varied/poor over the past month, but more meals >76% consumed recently per documentation. Continue to encourage intakes and fluids. Offer alternatives and snacks as desired. No pressure wounds reported as present. Continue to monitor PO (oral) intakes and wt trends. RD to f/u prn (follow up). R7's Weight Summary documents on 6/10/24 R7 weighed 147.2 pounds, on 8/6/24 134.2 pounds resulting in a 8.83% weight loss in one month, and on 9/10/24 133.2 pounds resulting in a 9.5% weight loss in 3 months. R7's Meal Intake Percentages Summary documents that from 9/1/24 - 9/24/25, 14 days were documented on and 20 entries made documented that R7 ate 0 - 25%. 2. R46's Admission Record, print date of 9/25/24, documents that R46 was admitted on [DATE] and has diagnoses of Senile Degeneration of the Brain, anorexia, Dementia, skin cancer of the nose and right lower leg. R46's MDS, dated [DATE], documents that R46 is severely cognitively impaired and requires supervision or touching assist for eating. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R46's Diet Order, dated 6/5/24, documents, Regular diet, Regular texture, Thin consistency. R46's Electronic Medical Record fails to document any other dietary orders. R46's Dietary Note, dated 9/16/2024 11:07, documents, WEIGHT WARNING: Value: 121.6 Vital Date: 2024-09-10 15:15: 00.0-3.0% change over 30 day(s) [4.3% , 5.4] -7.5% change [12.1% , 16.7] RD (Registered Dietician) evaluation for wt (weight loss) loss x 3 mo (months). Insignificant 4/3% wt loss x 1 mo. Anticipated wt loss r/t (related to) hospice. Wt (9/10)121.6# BMI 19.6 (low based on age). Regular diet. Most meals 51-100% per documentation. Continue to encourage intakes and fluids as desired. See Skin & Wound Evals (evaluations) for cancer lesions details. Chart reviewed. Declines including poor intakes and wt loss r/t hospice. RD to plan to f/u (follow up) monthly/prn (as needed). R46's Weight Summary documents that R46's weight on 6/6/24 was 138.3 pounds, 7/10/24 was 138.1 pounds, 8/6/24 127 pounds (8.03% loss in one month), and on 9/10/24 it was 121.6 pounds (4.25% weight loss in one month). R46 had a 11.94% loss from July to September. R46's Care Plan,dated 9/9/2024, (R46) is at nutritional risk related to Admit to hospice for senile degeneration of brain and anorexia 6/5/24 History of weight loss Impaired skin integrity r/t CA (cancer) lesions to nose/R (right) thigh. Interventions: Nutrition Interventions to encourage adequate intakes r/t underweight per BMI (body mass index) and altered skin integrity 9/9/24 - Fortified Juice BID (twice a day) (B/D meals)(breakfast and dinner). Serve diet as ordered, weight as ordered, record meal intake, encourage appropriate intake of food and fluids, offer substitutes for dislikes. 6/5/24 Regular diet. On 9/24/24 at 4:05 PM, V1, Administrator, stated, We do not have a feeding assistance policy, but staff should be assisting those that need help. On 9/25/24 at 2:20 PM, V2, Director of Nurses, stated that even though she (R46) is on hospice some intervention should be put into place to at least try to keep the weight loss at a minimum. V2 further stated that residents should be encourage to eat, receive assistance from staff if they need it, and offered something else to eat if they are not eating.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to address Pharmacy Recommendations in a timely manner for 1 of 5 residents (R87) reviewed for medication review in the sample of 5. Findings include: R87's Admission Record, print date of 9/24/24, documents that R87 was admitted on [DATE] and has diagnoses of Parkinson's Disease, Depression, Dementia, and Anxiety. R87's Pharmacy Recommendation, dated 6/27/24, documents, (R87) has been receiving clonazepam 0.25 mg once daily for anxiety since 1/20/24. Dose reduction attempts should be made for anxiolytic medications at least twice in the first year and then yearly to ensure drug effectiveness with minimal side effects. This Pharmacy Recommendation was reviewed and signed by V31, Medical Director on 9/25/24. R87's Pharmacy Recommendation, dated 7/12/24, documents, (R87) has been receiving Quetiapine 12.5 mg in the afternoon and 50 mg at bedtime for Major Depression since dose was increased 1/2024. Dose reduction attempts should be made for antipsychotics medications at least twice in the first year and then yearly to ensure drug effectiveness with minimal side effects. This Pharmacy Recommendation was reviewed and signed by V31, Medical Director on 9/25/24. On 9/25/24 at 2:15 PM, V2, Director of Nurses, stated that the previous Director of Nurses had not been keeping up with the Pharmacy Recommendations so once she came onboard she had to send them all back out to V31 and he has not answered the recommendations letters after requesting them many times. V2 stated that she expects the Doctor to reply to the Pharmacy Recommendations is 2 weeks. The Pharmacy Consultant Policy, undated, does not address Physician replies to Pharmacy Recommendations.

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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. 33112 Based on interview, observation, and record review, the facility failed to serve food, dispose of outdated food, label and date food items to prevent food borne illness. This has the potential to affect all 116 residents residing in the facility. Findings include: On 9/23/24 at 9:30 AM, V5, Dietary Manager stated food is only good for 3 or 4 days after preparing it, all food should be labeled and dated, properly sealed and employees should not have drinks in the refrigerators. On 9/23/24 at 9:30 AM, the kitchen was entered. In the stand-up refrigerators, a large pan of spaghetti and meat sauce, a small bowl of spaghetti and meat sauce, 1/2 cheese sandwich, large pan of cooked chicken breast, multiple small bags of carrots and purple cabbage that is shredded, 2 pies, large stainless container of shredded lettuce, large stainless container of shredded cheese, and stainless-steel container of red sauce. All of which are not dated or labeled. A large container of cooked hamburger patties dated 9/15/24, small container of tuna salad dated 9/16/24, large container of chicken breast dated 9/12/24. There is also a personal 16oz Mountain Dew and Pepsi both are half empty. On 9/23/24 at 11:46 AM, V12,Dietary Aide is serving the noon meal from the steam table. V12 is using her bare hands to grab a roll and place it on the plate. On 9/23/24 at 12:16 PM, V11, Certified Nurses Aide (CNA) is feeding R58 an orange. V11 with bare hands peeled the orange and then fed the orange to R58. In between bites, V11 is attempting to feed R71 and wiping R71's mouth with the clothing protector. V11 did not perform hand hygiene in between. On 9/24/24 at 12:01 PM, V19, CNA brought R59 her noon meal. V19 picked up the roll with her bare hands and buttered the roll for R59. The Policy Food Storage (Dry, Refrigerated, and Frozen), dated 2016, documents, 1. General storage guidelines to be followed: a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. It continues, c. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigerator. The Handwashing and glove use for food service policy, undated, documents, No Bare Hand Contact: Any ready to eat food item. bread toast, rolls and baked goods. The Long Term Care Facility Application For Medicare and Medicaid, dated 9/23/23, documents that 116 residents reside in the facility.

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	146026	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lewis Memorial Christian Vlg	3400 West Washington Springfield, IL 62702

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(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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to wear appropriate Personal Protective Equipment, perform hand hygiene between glove changes, and perform hand hygiene between resident contact to prevent cross contamination for 8 of 32 residents (R13, R25, R43, R45, R67, R86, R100, R106) reviewed for infection control in the sample of 51. Findings include: 1. On 9/24/24 at 12:15 PM, V20 Certified Nurse Aide (CNA) is assisting R100 with transfer and changing his clothes. V20 is wearing gloves only. V20 stated that she was going to switch R100's large urinary bag to his leg bag. V20 retrieved the leg bag and emptied a small amount of urine that was left in the bag previously. V20 then placed the leg bag into another bag. The urinary bags were never switched. V20 then removed her gloves and donned new gloves with no hand hygiene. V20 then removed R100's shirt and put a new shirt on him. R100's room door has signage indicating that he is on Enhanced Barrier Precautions and all Personal Protective Equipment (PPE) is hanging on the door. On 9/26/24 at 2:20 PM, V2, Director of Nurses, stated that R100 is on Enhanced Barrier Precautions because he has a dialysis shunt in his upper arm. V2 further stated that a gown, gloves should be worn when providing care for any resident on Enhanced Barrier Precautions and hand hygiene should be done before putting on gloves and after removing gloves. 50908 2. R67 was admitted to the facility on [DATE] with diagnosis of, in part, urinary tract infection (UTI), chronic kidney disease, stage 3, bladder-neck obstruction, diabetes mellitus type 2, benign prostatic hyperplasia with lower urinary tract symptoms and presence of urogenital implants. On 9/25/2024 at 10:30 AM, V24 CNA and V26 CNA provided indwelling catheter care to R67, both failing to place gowns on. R67's order dated 9/24/2024 documents, Enhanced Barrier Precautions related to catheter: Enhanced Barrier Precautions (EBP) sign outside resident's room. Gown and glove for high contact resident care activities. Face shield should be used for any tasks that have a high potential of splash or spray. On 9/25/2024 at 3:15 PM, V2 stated she would expect staff to wear the proper PPE when providing catheter care to a resident under enhanced barrier precautions; they should have put gowns on. 3. R43 was admitted to the facility on [DATE] with diagnosis of, in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia, and dysphagia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/23/2024 at 12:02 PM, R43 was eating her mashed potatoes with her right thumb. R43 picked up her spoon and flung her pureed food on the floor. R43's food was observed to be to the right of her on the ground, on her wheelchair handle, and on the table. The food was not cleaned up throughout the meal. R43 continued to eat her food with her thumb and occasionally would touch her right thumb on her wheelchair handle then back to her food or spoon. On 09/24/24 at 12:05 PM, R43 used her right thumb to eat her pureed food. After eating off her thumb, R43 then picked up her spoon and flung her food on the floor. R43 touched her wheelchair with her right hand and thumb to turn herself away from the table after eating. V23, Certified Nursing Assistant, CNA, was assisting another resident to eat, looked at R43 as she ate with her thumb. R43 was turned back around to face the table. R43 continued to use her thumb to eat after being turned back around to face the table. V23 moved her chair from the table she was at assisting another resident to the table R43 was sitting at. V23 did not complete hand hygiene and touched R43's hair then preceded to feed her food. On 9/25/2024 at 3:15 PM, V2stated she would expect staff to use proper hand hygiene between assisting residents with feeding and redirect R43 from using her thumb to eat. 40650 4. On 09/25/24 at 8:50 AM, V22, CNA, was passing breakfast trays to residents, she passed a breakfast tray to R25, came out of her room, without performing hand hygiene, took R106 her tray, exited her room without benefit of hand hygiene, took R86 her meal tray and set her up. V22 then exited R86's room without benefit of hand hygiene and took R13 her meal and set up her meal tray. On 09/25/2024 at 01:25 PM, V29, CNA, stated that when she is passing meal trays, she performs hand hygiene in between residents. On 09/25/2024 at 01:29 PM, V21, CNA, stated that she performs hand hygiene in between passing meal trays to residents. 09/25/2024 at 01:34 PM, V27, CNA, stated that he performs hand hygiene in between passing meal trays to residents. 5. 09/24/24 01:10 PM V17 and V18, both CNA's donned gloves without benefit of hand hygiene, used a sit to stand to transfer R45 into bed. Then with the same gloves, V18 pulled R45 pants down, and unfastened incontinent brief, which was smeared with fecal matter and laid R45 down in bed. She then performed incontinent care. V18, removed gloves and donned a new pair of gloves without benefit of hand hygiene. V18 took 3 cleansing cloths and laid them on R45's bed, and without glove change, rolled R45 on to his left side, cleansed R45's rectal area. R45's Physician's order sheet, dated 09/2024, documented diagnoses of Alzheimer's, Dementia and Parkinson's disease. On 09/25/2024 at 01:25 PM, V29, CNA stated that when she changes gloves, she uses alcohol based hand rub or wash her hands with soap and water in between glove changes. On 09/25/2024 at 01:29 PM, V21, CNA stated that when she changes gloves, she washes her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/25/2024 at 01:34 PM, V27, CNA stated that when he changes gloves he performs hand hygiene. The facility's policy, Handwashing/Hand Hygiene, dated 08/12/2024, documented, Handwashing .G. Before and after eating or handling food. H. Before and after assisting a resident with meals. The facility's policy, Infection Control, IIIC: Personal Protective Equipment- Using Gloves, dated 08/12/2024, documented, 5. Wash hands after removing gloves. (Note: Gloves do not replace handwashing.). It continues, Special considerations. 1. Always perform hand hygiene before putting on gloves to avoid contamination the gloves with microorganisms from your hands.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews, observations, and record reviews the facility failed to review a urine culture and obtain a wound culture for 1 out of 6 residents, (R67), reviewed for antibiotic stewardship in a sample of 51. Findings include: R67 was admitted to the facility on [DATE] with diagnosis of, in part, urinary tract infection (UTI), chronic kidney disease, stage 3, bladder-neck obstruction, diabetes mellitus type 2, benign prostatic hyperplasia with lower urinary tract symptoms and presence of urogenital implants. R67's Minimum Data Set (MDS), dated [DATE], documents he is severely cognitively impaired and completely dependent on staff to provide assistance with toileting and personal hygiene. R67's care plan, dated 7/15/2024, documents he has a diagnosis of BPH and for staff to monitor for signs and symptoms of urinary retention: no urination for 8 hours - if he can barely urinate or feels like bladder if full for an hour or more, having urgency when he feels like emptying, frequent urination, a stream of urine that is slow or weak. R67 has an indwelling catheter related to bladder obstruction, BPH and has urethral stents in place and for staff to monitor/record/report signs/symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, foul-smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. R67 has an abscess to left upper quad of abdomen with intervention for staff to complete labs/diagnostics as ordered. R67's Wound Evaluation and Management Summary, dated 7/15/2024, documents a deep wound culture was recommended to be done that day. R67's orders, dated 7/16/2024, document him being placed on an antibiotic, Tetracycline HCl, oral tablet 500 milligrams (MG). Give 1 tablet by mouth two times a day for wound until 07/29/2024. Would cultures were not completed prior to or during the administration of R67's antibiotic. R76's urine culture results, reported 7/31/2024, document the superficial bacteria are not indicative of a urinary tract infection. If clinically indicated, recollect clean-catch, mid-stream urine and transfer immediately to urine culture transport tube. No Repeat culture was completed. R67's orders, dated 8/3/2024, document him being place on Cephalexin oral capsule 500 MG. Give 500 mg by mouth every 12 hours for UTI related to urinary tract infection for 7 Days Cephalexin 500mg every (q)12 hours(h) for 7 days. On 09/25/24 at 12:50 PM, regarding urinary tract infections, V3, (Assistant Director of Nursing/ADON) stated when the residents go out to the hospital and come back on antibiotics, we don't always get the results of their culture and sensitivity, we just go off of the orders given for antibiotics by the hospital providers. We do not ask for the results to be sent to us if they were not provided when the residents return. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/2024 at 8:55 AM, V34, Infection Preventionist, stated I do not know why R67 continued to stay on antibiotics after the culture results came back as not indicative of a urinary tract infection. I would have called the doctor with these results to ask to do a repeat urine analysis with culture and sensitivity and to see if we should stop the antibiotic. Upon return from hospital stays, I receive the results of cultures for the residents, and I am not sure why some of the results were not available on R67's chart. On 9/26/2024 at 11:15 AM, V34 stated the wound care nurse should have completed the wound cultures that were recommended. V34 stated she is not sure why R67 was placed on an antibiotics for his wound. The facility's Infection Prevention and Control Manual Antibiotic Stewardship and Multi-Drug Resistant Organisms (MDROs), dated January 2023 documents, Antibiotic stewardship refers to systemic efforts to optimize the use of antibiotics- not just reduce the total volume used- to maximize their benefits to patients, while minimizing both the rise of antibiotic resistance as well as adverse effects to patients from unnecessary antibiotic therapy.