STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146083	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Princeton	140 North Sixth Street Princeton, IL 61356

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33973 Based on interview and record review, the facility failed to ensure Advanced Directives were documented correctly in the resident's clinical record for one (R17) of two residents reviewed for Advanced Directives in a sample of 40. Findings include: The facility's Practitioner Orders for Life-Sustaining Treatment (POLST), revised ,d+[DATE], documents Policy: The facility will establish and follow a set cardiopulmonary resuscitation procedure. Purpose: To establish the decision-making process that will institute or stop cardiopulmonary resuscitation. Procedure: 7. Notations regarding this decision will be made in the resident's medical chart by Nursing. R17's Face sheet documents Advanced Directive: Full Code. R17's current Physician Order Sheet/POS documents Full Code status. The facility's Shift Notes (report sheet for nurses) for R17's hall documents all residents' code statuses; R17's is listed as Full Code. R17's POLST documents DNR (Do Not Resuscitate) and was signed on [DATE] by R17. On [DATE], at 2:15pm V4 Registered Nurse/RN confirmed R17's Face sheet, POS, and Shift Report sheet document Full Code status. V4 stated the following: When there is a code, I look at the report sheet first since it lists their code status. I would also look at their Face sheet and check their POLST (Practitioner Order for Life-Sustaining Treatment). R17 confirmed at this time that R17's POLST documents R17 is a Do Not Resuscitate. V4 explained that if R17 had coded V4 would have had the staff start CPR (Cardiopulmonary Resuscitation) on (R17) then V4 would have looked up (R17's) code status on (R17's) Face sheet and POLST. I would have had to yell for them to stop CPR after seeing the DNR on (R17's) POLST.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33973 Based on observation, interview and record review, the facility failed to include indwelling urinary catheter with cares on a Baseline Care Plan for one (R257) of 21 residents reviewed for Care Plans in a sample of 40. Findings include: The facility's Care Plan Policy, revised 11/28/19, documents Policy: It is the policy of this facility to develop and implement a Base Line Care Plan, a Comprehensive Person-Centered Care Plan and conduct Care Plan Meetings as appropriate for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Explanation and Compliance Guidelines: Base Line Care Plan: Base Line Care Plan: 1. The baseline care plan will: a. Within 48 hours of a resident's admission, the admitting nurse, or supervising nurse on duty, shall develop the Baseline Care Plan by gather information from the admission body assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative. b. Include the minimum healthcare information necessary to properly care for a resident representative. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: a) Initial goals based on admission orders. b) Physician orders. c) Dietary orders. d) Therapy services. e) Social Services. f) PASARR recommendation, if applicable. 2. A written summary of the baseline care plan shall be provided to the resident and resident representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. On 5/28/24, at 10:30am, R257 was lying in bed with an indwelling catheter draining clear amber urine. R257's clinical record documents R257 admitted to the facility on [DATE], transferred out to the hospital on 5/22/24 then returned on 5/23/24 with an indwelling urinary catheter. R257's current Physician Order Sheet/POS includes an order for a 16F (French) 30cc (cubic centimeters) (named indwelling) Catheter continuous with diagnosis of Retention of Urine, unspecified. R257's Baseline Care Plan does not include indwelling catheter/cares. On 5/30/24, at 10:49am, V14 Care Plan Coordinator/RN, stated the following: Catheters are not on the template that the nurses can pull up, but it should be on the Baseline Care plan. I would pull up the Care Plan Summary to see what's on it to know what then goes on the care plan. V14 printed R257's Care Plan Summary at this time and this summary documents (R257) has the following Physician and Nursing Orders in place: 16F (French) 30cc (cubic centimeters) (brand name) Catheter continuous.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38805 Based on observation, record review and interview, the facility failed to revise a Comprehensive Care Plan for one resident (R7) of 21 residents reviewed for Care Plan revision in a sample of 40. Findings includes: The facility's Care Plan Policy dated 6/1/22 documents: It is the policy of this facility to develop and implement a Base Line Care Plan, a Comprehensive Person-Centered Care Plan and conduct Care Plan Meetings as appropriate for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those change shall be incorporated into an updated summary provided to the resident and his or her representative, if applicable. 10. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the comprehensive assessment. R7's Progress Note dated 4/26/24 documents: (V16 Wound Physician) here to see resident for wound care. Area to coccyx has reopened due to incontinence,New order for collagen and dry dressing daily. Wound is 0. 6x0.4x0.3 with moderate Serosanguinous drainage. 100% granulation tissue. Area is pink with irregular edges. R7's Physician Order dated 4/26/24 documents: Cleanse coccyx with normal saline/N.S. Pat dry apply collagen and island dressing daily. R7's Wound Evaluation and Management Summary dated 5/24/24 documents: Stage four pressure wound coccyx full thickness. Wound size .4 x .4 x .3 centimeters/cm. On 5/29/24 at 1:15pm, observation of R7's coccyx area showed a small opening at mid coccyx area; no redness. At this time, V17 Licensed Practical Nurse/LPN provided R7's coccyx wound care treatment. V17 LPN stated: R7's wound is chronic, heals and then comes back; (R7) is seen by (V16 Wound Physician) once weekly for wound care. R7's current Care Plan does not document R7 has a wound on her coccyx. On 5/29/24 at 2:35pm, V14 Registered Nurse/RN/Minimum Data Set/MDS/Care Plan Coordinator stated that R7's Stage 4 coccyx wound issue should have been included in (R7's) care plan. At this same time, V14 RN stated, (R7's) wound had been in her care plan; it healed and then it came back; got the order for it on 4/26/24 and I was not aware of this; just found out today the wound had come back. I added this to the care plan just now.

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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. 33973 Based on observation, interview, and record review the facility failed to change gloves and sanitize between glove changes during Indwelling Urinary Catheter cares for one (R257) of three residents reviewed for Catheters in a sample of 40. Findings include: The facility's Infection Control policy, revised 11/28/19, documents Standard Precautions: Standard Precautions are based upon the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions should be applied to the care of all residents regardless of the suspected or confirmed presence of an infectious agent. Standard Precautions include but are not limited to: 1. Hand hygiene .3. Proper use of PPE (Personal Protective Equipment) (gloves, gowns, mask, etc.) .Gloves, disposable in nature, will be worn unless sterile gloves are necessary. Gloves will be changed after direct contact with resident's secretions or excretions, even if care of resident has not been completed. R257's current Physician Order Sheet/POS includes an order for a 16F (French) 30cc (cubic centimeters) (named indwelling) Catheter continuous with diagnosis of Retention of Urine, unspecified. On 5/28/24, at 1:20pm, R257 was lying in bed with an indwelling urinary catheter draining clear amber urine. With gowns and gloves on V7 and V8 Certified Nursing Assistants/CNAs lowered R257's shorts and soiled incontinence brief to perform catheter care for R257. Neither V7 nor V8 performed hand hygiene or changed gloves at this time. V8 cleansed R257's meatus and catheter tubing. Without performing hand hygiene V8 changed V8's gloves then dried R257's meatus and catheter tubing. Without performing hand hygiene and donning new gloves, both V7 and V8 touched R257's bare skin to assist him to turn. V8 removed R257's soiled incontinence brief then both CNAs placed a new one on and assisted R257 to roll back onto his back. On 5/28/24, at 1:46pm, V8 confirmed she did not change her gloves after drying R257 off and stated, I probably should have so stuff doesn't get contaminated. O5/28/24, at 1:47pm V7 confirmed he did not perform hand hygiene in between glove changes and should have. On 5/30/24, between 1:47pm and 3:00pm, V2 Director of Nursing DON stated she expects the staff to use hand sanitizer or wash hands in between glove changes during cares and to change gloves when going from dirty to clean. V2 stated they do not have a glove policy that supports her expectations.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 33971 Based on interview and record review, the facility failed to obtain weekly weights as ordered by the physician for one of two residents (R92) reviewed for nutrition in the sample of 40. Findings include: The facility's Weight Monitoring Policy revised 6/21 states, Objective: To consistently assess residents for significant weight loss or gain. This same policy documents weekly and monthly weights are recorded by dietary in the resident's electronic medical record. R92's Face Sheet documents R92 admitted to the facility with diagnoses to include but not limited to: Cerebral Infarction; Dysphagia; and Gastrostomy Status. R92's current Physician Orders documents orders for the following: Osmolite 1.5 Cal (Calorie) Nutritional Supplement via Gastric Tube; Free Water Flushes via Gastric Tube; Daily Supplement Shakes; and Weekly Weights. R92's Vitals Weight Summary documents a weight of 215.8 pounds on 5/8/24. As of 5/30/24, no further weights are documented in R92's medical record. On 5/30/24 at 10:43 AM, V3 (Dietary Manager) stated V3 was not aware of R92 having weekly weights ordered. At this time, V3 verified R92's weekly weight physician order and stated that V3 would be responsible for entering R92's weights into R92's medical record. V3 verified V3 could not provide any documentation showing V3 had been weighed again since 5/8/24. On 5/30/24 at 11:05 AM, V5 (Registered Nurse) stated R92 has been on weekly weights since R92 admitted to the facility due to R92 being on tube feedings. At this time, V5 verified R92 has not been weighed since 5/8/24 and should have been weighed weekly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 33973 Based on observation, interview, and record review, the facility failed to ensure a resident's oxygen humidifier bottle was not empty while in use for one (R254) of one resident reviewed for Oxygen in a sample of 40. Findings include: The facility's Oxygen Therapy policy, revised 05/12, documents Objective: 1. To provide a source of oxygen to persons experiencing an insufficient supply of same .Procedure: 2. Assemble equipment at bedside: a. Humidifier bottle attached to tank flow meter and filled to appropriate level with sterile distilled water. This policy also states, Safety Factors: 1. Must have Oxygen in Use sign posted in space that is visible prior to actually entering room. On 5/28/24, at 9:26am, R254 sat in a wheelchair in her room wearing oxygen per nasal cannula via a portable oxygen tank. The oxygen concentrator next to R254's bed contained an empty, undated, humidifier bottle. R254 stated I use that one (concentrator) mostly at night. R254's room does not have an Oxygen in Use sign at the door. R254's current Physician Order Sheet/POS includes an order dated 5/22/24 for oxygen at 4L (liters) nasal cannula continuous for SOB (Shortness of Breath). R254's current POS includes but is not limited to diagnoses of Shortness of Breath, Other Pulmonary Embolism without Acute Cor Pulmonale, Panlobular Emphysema, Shortness of Breath, Other Pulmonary Embolism with and without Acute Cor Pulmonale, and Acute Respiratory Failure with Hypoxia. On 5/29/24, at 9:35am, R254 sat in her room with oxygen on per nasal cannula via oxygen concentrator. The humidity bottle was full and dated 5/28. R254 stated that after lunch she was hooked up to oxygen with the concentrator and it was hard to breathe, like it was dry air. I told V7 Certified Nursing Assistant/CNA and V7 said it was dry and told the nurse (V4 Registered Nurse/RN). (V4) came in a put a new one on. There is no Oxygen in Use sign on R254's entrance to room. On 5/29/24, at 9:43am, V4 RN confirmed that R254's oxygen humidifier container was empty yesterday while in use by R254. I changed it yesterday after being alerted to it by (V7 CNA). On 5/30/24, at 8:40am, R254 is in bed with oxygen in use. No Oxygen in Use sign on the door. On 5/30/24, at 8:44am V5 RN confirmed there is no Oxygen in Use sign on R254's door and stated, There should be a sign.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 30899 Based on observation, interview, and record review the facility failed to provide an appropriate indication for use for an antipsychotic medication, failed to identify target behaviors, and failed to identify non-pharmacological interventions for one (R2) of five residents reviewed for unnecessary medications in the sample of 40. Findings include: Facility Policy/Psychopharmacologic Drug Usage procedure, dated 10/18/17, documents: Documentation of behaviors and conditions requiring the use of these medications must be done on a routine basis, as well as medication response and adverse consequences. Psychopharmacological medication usage must also be addressed in the Care Plan, including appropriate goals, likely medication effects, and potential for adverse consequences. R2's Current Physician's Orders, with an order date of 4/3/24, documents R2 receives Risperidone (antipsychotic) 0.5mg (milligrams) at bedtime for Vascular Dementia with Other Behavioral Disturbance. R2's Behavior monitoring/tracking documentation record dated 4/3/24 - 5/30/24 does not identify specific behaviors to be monitored. R2's care plan did not include administration of an antipsychotic medication, goals, side effects, or interventions. On 5/28/24 and 5/29/24 R2 was seen in her room and in the dining room. R2 did not display any inappropriate, disruptive, or psychotic behaviors. On 5/31/24 at 1:45pm, V2 DON (Director of Nursing) stated there should have been a care plan initiated for R2's Risperidone. V2 stated they did not know why R2 was on Risperidone when she was admitted (on 4/2/24) or what behaviors she was displaying. V2 also stated R2 has had no behaviors since admission.

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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. 30899 Based on observation, interview, and record review the facility failed to provide a clean and sanitized floor in the facility kitchen. This failure has the potential to affect all 99 residents who receive food from the kitchen. Findings include: On 5/30/24 at 10:00am, V3 Dietary Manager stated that all (99) residents in the facility receive food from the kitchen. On 5/28/24 at 9:33am, a tour of the facility kitchen found built-up brown/black discolored grease, grime, and debris on the floor in front of both sides of the food preparation table, stove, and throughout other areas in the kitchen. At that time, V3 Dietary Manager stated that the floor guy had already done the floors that morning and that's the way it still looks. V3 stated the kitchen staff are also supposed to mop the floor every evening. An undated posted kitchen sign in the kitchen documents: Nightly Checklist before leaving: Floors swept and mopped. On 5/29/24 at 9:10am, the kitchen floor was free of the built-up grime and debris, however stains of where the grime and built-up grease had been remained. At that time, V3 stated Yes (stains), since they got it off now and I guess it should've been done that way before. On 5/30/24 at 2:05pm, V18 Custodian/Floors stated When we go in the morning to clean the floor with the machine we try to get in/out as quickly as possible to get out of the way. It took more time this morning, we had to go over and over the built-up grease and grime to get it off. We also had to use a different pad which was more abrasive. The other pad just went over those areas without removing the build-up.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 33973 Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precaution/EBP signage was posted and PPE (Personal Protective Equipment) was available for two (R257 and R25) of nine residents reviewed for Infection Control in a sample of 40. Findings include: The facility's Enhanced Barrier Precautions/EBP policy, undated, documents Policy: It is the policy of the facility to use proper PPE (Personal Protective Equipment) during high-contact resident care activities that provide opportunities for transfer of MDROs (Multi-drug resistant organisms) to staff hands and clothing. Purpose: The purpose of the program is to prevent the indirect transfer of MDROs from resident-to resident during high-contact care activities using EBP (Enhanced Barrier Precautions). Key Points: 1. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. 2. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. 3. EBP are indicated for residents with any of the following .b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . ii. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies .Procedure: 1. Post clear signage on the door or wall outside of the resident room indicating Enhanced Barrier Precautions are required. This will include type of PPE and potential high-contact resident care activities. 1. R257's current Physician Order Sheet/POS includes an order for a 16F (French) 30cc (cubic centimeters) continuous (named indwelling) Catheter with a diagnosis of Retention of the Urine, unspecified. On 5/28/24 at 10:30am, R257 was in bed with an indwelling urinary catheter draining clear amber urine. There is no signage posted for EBP, or an infectious linen trash bin located in R257's room. On 5/30/24 at 10:35am, V6 Infection Control Nurse confirmed that R257's room did not have EBP signage up the morning of 5/28/24. V6 stated that (R257) should have been in Enhanced Barrier Precautions with the sign up once he came back from the hospital on 5/23/24 for his midline (intravenous catheter), and his urinary catheter. 30899 2. R25's Hospital Note, dated 4/3/24, indicates Exam: Ileostomy right, midline in abdominal crease; appearance of fistulas approximately 1cm (centimeter) lateral and 10cm lateral with evidence of leakage of stool. Assessment/Plan: Course has been complicated by multiple fistulas near ileostomy site and difficulty with pouching/leakage of ostomy. R25's Current Physician's Orders document Change ostomy bag to ileostomy and fistula every three days, and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's current care plan indicates R25 was admit to the facility was related to the fistula of the intestine. On 5/29/24 at 1:30pm, R25 had ileostomy/fistula sites with an ostomy drainage collection bag in place over entire lower abdomen. R25 stated the drainage from the fistula is pus-like mixed with stool. R25 stated her physicians told her the fistula will only get worse over time and will likely need to go on antibiotics at some time. On 5/28/24 and 5/29/24, R25 did not have an EBP sign posted anywhere outside of her room, and did not have quick access to gowns before entering her room. On 5/30/24 at 12:45pm, V5 RN (Registered Nurse) stated that she recently changed R25's ostomy bag, and R25 has an ileostomy stoma and a small fistula opening that looks like hyper granulation tissue that does intermittently leak. V5 stated that there is also a small drain site from a previous drain device. V5 stated that she is unsure whether the drain site is actively draining, however the instructions are to keep all three sites covered with the ostomy appliance/bag to collect potential drainage. V5 confirmed the fistula is chronic and was told will only get worse with time as R25 is not a surgical candidate. On 5/30/24 at 2pm, V6 Infection Preventionist stated R25 was not placed on EBP as she did not consider the fistula and drain sites when R25 was evaluated, and acknowledged as draining wounds, R25 will be placed in Enhanced Precautions.