

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Tuscola Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1203 Egyptian Trail Tuscola, IL 61953	

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 - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview and record review the facility failed to maintain a residents' dignity by not providing timely incontinence care for one (R1) of three residents reviewed for incontinence care in a sample of seven residents.</p> <p>Findings include:</p> <p>R1's Face Sheet documents R1 was admitted to facility on 6/21/24. R1's Cognitive assessment dated [DATE] documents R1 as cognitively intact. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as being dependent on staff for dressing, toileting and personal hygiene. This same MDS documents R1 requires the assistance of two staff members and a total body mechanical lift for transfers.</p> <p>a.) On 8/14/24 at 10:15 AM R1 stated I had to lay in my own urine all night long. I put on my call light four times that night (8/7/24). (V23) Certified Nurse Aide (CNA) answered my call light each time, turned it off and left my room. (V23) did not change my incontinence brief or pad underneath me. I had to lay in urine all night. On the fourth time I put on my call light (V23) and (V10) CNA's both came in and changed me. I shouldn't have to lay in pee for hours and hours. Four times I put on my call light. Each time I waited at least an hour in between because I thought (V23) CNA would come back but she never did. By the time they (V10, V23) changed me before their shift was over, I was soaking wet with urine. My brief was soaked, my incontinence pad underneath me was soaked and my bed sheets were wet. I told (V4) (R1's) family member the next morning (8/8/24) and (V4) told (V1) Administrator about it. (V1) Administrator came and talked to me later in the day (8/8) and said the staff should be changing me every two hours and whenever I ask them too. (V1) needs to tell the staff that!</p> <p>On 8/14/24 at 10:35 AM V10 Certified Nurse Aide (CNA) stated V23 CNA and V10 worked together on night shift starting 8/7/24 and ending on 8/8/24. V10 stated I had not been in (R1's) room until the early morning of 8/8/24. After (V23) and I got finished cleaning (R1) up, (R1) thanked me for helping her because (V23) kept turning off her call light and not changing her incontinence brief. I had seen (R1's) call light on a few times that night but that was (V23's) side of the hall so I thought (V23) was taking care of it. I was busy helping my own residents. (R1's) incontinence brief, the incontinence pad she was laying on, the flat and fitted sheets and part of her comforter were soaked with urine. You could tell (R1) had been laying there for a long time.</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 - Few</p>	<p>On 8/15/24 at 3:00 PM V23 Certified Nurse Aide (CNA) stated R1 is incontinent of urine. V23 stated I don't ever check on (R1) every two hours. I know (R1) is incontinent but she can use her call light so I don't need to check on her. I remember that night (8/7/24). (R1) was pretty upset with me. (V1) Administrator called me the next day (8/8/24) and told me I am supposed to check all incontinent residents every two hours no matter if they are oriented or not. I know when we (V10, V23) did go in and change (R1) she was pretty wet. I had to change her whole bed. I don't remember shutting her call light off but I could have if I were busy with something else. I probably did just shut it off thinking I would get back to her and forgot. I hate the way (R1) felt about it all. I feel bad for making (R1) feel upset.</p> <p>b.) On 8/14/24 at 1:15 PM V10 and V16 Certified Nurse Aides (CNA) completed perineal care for R1. V10 and V16 CNA's transferred R1 from her recliner chair using a total body mechanical lift to her bed. R1's incontinence brief was fully saturated with urine. The inside cotton of R1's incontinence brief had separated and clumped into pieces. R1's incontinence pad on her recliner chair had yellow spots on it in the center where R1 had been sitting.</p> <p>On 8/14/24 at 1:31 PM V16 Certified Nurse Aide (CNA) stated V16 had not assisted R1 with any cares since arriving for her shift at 8:00 AM. V16 CNA stated (V10, V11 and V16) CNA's are the only staff assigned to (R1's) hall. There wouldn't be anyone else that provided cares to (R1).</p> <p>On 8/14/24 at 1:34 PM V10 Certified Nurse Aide (CNA) stated V10 had not assisted R1 with any cares since arriving for her shift at 6:00 AM.</p> <p>On 8/14/24 at 1:40 PM V11 Certified Nurse Aide (CNA) stated V11 had not provided any cares for R1 since arriving on her shift at 5:00 AM. V11 stated I know (V10 and V16) CNA's changed (R1's) incontinence brief a few minutes ago but I don't think anyone has been in there since this morning when she got up. V11 CNA stated any resident who is incontinent should be checked on and have their incontinence brief changed if needed at least every two hours.</p> <p>On 8/14/24 at 1:35 PM R1 stated It feels good to be clean. No one has moved me since I got up at 6:00 AM. I haven't been moved and nobody has changed my incontinence brief since they (staff) got me up at 6:00 AM. I had bed sores before and now my butt is red again. I don't want to get bedsores again and I know sitting in urine isn't good for my skin.</p> <p>c.) On 8/15/24 at 8:00 AM R1 was laying in her bed in her room. R1's room smelled of urine. R1 stated at that time Today is my shower day so I don't get up until I get my shower.</p> <p>On 8/15/24 at 9:00 AM R1 was laying in her bed in her room. R1's room still smelled of urine.</p> <p>On 8/15/24 at 11:45 AM R1 stated I put my call light on at 9:15 AM. One of the girls (V15 Certified Nurse Aide) came in and told me that Hospice was coming today and that they (Hospice staff) would help me get changed and showered when they arrived. (V14) Hospice CNA came in at 10:00 AM. I had been laying in bed in my own urine since they (staff) changed me around 5:00 AM. This is just awful. I didn't do anything to deserve this. No one should have to lay in their own urine. I understand if they (staff) get busy and I am not the one person they have to take care of but hours on end is awful.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/14/24 at 11:55 AM V14 Hospice Certified Nurse Aide (CNA) stated I see (R1) four times a week. I gave (R1) a bath yesterday (8/13/24) and saw that her bottom was very red. (R1) told me that the staff leave her laying in urine for hours on end. Sometimes when I get (R1) up, her sheets are really soaked with urine. I let the staff know but I haven't seen any real change.</p> <p>On 8/15/24 at 11:55 AM V11 Certified Nurse Aide (CNA) stated V11 had not assisted R1 with any cares since arriving for her shift at 5:00 AM.</p> <p>On 8/15/24 at 11:57 AM V16 Certified Nurse Aide (CNA) stated V16 had not assisted R1 with any cares since arriving for her shift at 8:15 AM.</p> <p>On 8/15/24 at 12:00 PM V7 Certified Nurse Aide (CNA) stated V7 had not assisted R1 with any cares since arriving for her shift at 3:00 AM. V7 stated I think (R1) was changed right before the other girl (V23) CNA left but I know I didn't help (R1) at all. I was on the other side of the hall.</p> <p>On 8/16/24 at 2:05 PM V2 Director of Nurses (DON) stated all residents should be offered and/or provided incontinence care every two hours and as needed. V2 DON stated a resident's call light should be answered and cares provided at that time or the staff should leave the resident call light on so that other staff are aware that the resident still may need something. V2 DON stated Leaving any resident to lay in their own urine for hours is unacceptable. This could lead to infection such as a Urinary Tract Infection (UTI), Pressure Ulcers or even Depression. I will be doing education with the staff to make sure they understand how important it is to provide cares timely and to maintain resident dignity. V2 DON confirmed that V7, V11 and V16 CNA's would be the only staff caring for R1 on 8/14/24 and V10, V11 and V16 CNA's would be the only staff caring for R1 on 8/15/24.</p> <p>The Illinois Long Term Care Ombudsman Program Resident's Rights for People in Long Term care revised 11/18 documents the facility must treat residents with dignity and respect and must care for residents in a manner that promotes their quality of life.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview and record review the facility failed to ensure a residents' preferences for personal care (toileting) were honored. This failure affects one (R5) of three residents reviewed for dignity in a sample list of seven residents.</p> <p>Findings include:</p> <p>R5's undated Face Sheet documents R5 admitted to facility on 12/1/2023. R5's Physician Order Sheet (POS) dated August 2024 documents R5's medical diagnoses as Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease (GERD), Restless Leg Syndrome, Cerebral Palsy, Asthma and Sleep Apnea. R5's Cognitive assessment dated [DATE] documents R5 as cognitively intact.</p> <p>R5's Care Plan intervention dated 2/22/24 documents R5 requires the assistance of two staff members and a total body mechanical lift for transfers. R5's Minimum Data Set (MDS) dated [DATE] documents R5 as cognitively intact. This same MDS documents R5 as dependent on staff for toileting and requires maximum assistance for lower body dressing and bathing.</p> <p>On 8/14/24 and 8/15/24 at various times during first and second shifts R5 did not have a commode in her room.</p> <p>On 8/15/24 at 1:00 PM R5 stated I asked to have a commode put in my room so that I could use the commode instead of the bedpan. They (staff) make me use the bedpan at night to have a bowel movement. I have to lay on that thing for an hour sometimes because I am on Iron (supplement) and it makes it hard to go to the bathroom. I am getting sore spots on my butt because I have to lay on the bedpan so long. I used a commode for years and now I can't because they won't let me. R5 stated (V21) Minimum Data Set (MDS)/Care Plan Coordinator came to my room and told me I couldn't have a commode. (V21) told me that I can't use a commode because I go too much. I am not a complainer. I just want to use the commode. I don't understand why they (facility) isn't allowing me to have one since I have used one here before.</p> <p>On 8/16/24 at 9:00 AM V1 Administrator stated V21 MDS/Careplan nurse has been counseled on resident rights, preferences and dignity. V1 administrator stated After (R5) complained to me about being told she couldn't use the commode, I should have had two people go talk with her.</p> <p>V1 further stated, (R5) will be assessed for the use of a commode and then the facility will provide one if (R5) is considered safe to use one. I really don't see a problem with it. We (facility) will most likely be able to honor (R5's) preference of using a commode instead of a bedpan. V1 stated the facility does not have a policy regarding resident preferences. V1 stated the staff are expected to honor any reasonable resident preference as a standard of care.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview and record review the facility failed to provide timely incontinence care for a resident dependent on staff assistance with toileting and a history of skin breakdown. This failure affects one (R1) of three residents reviewed for incontinence care in a sample of seven residents.</p> <p>Findings include:</p> <p>R1's Face Sheet documents R1 was admitted to facility on 6/21/24. R1's Cognitive assessment dated [DATE] documents R1 as cognitively intact. R1's Medical Record documents R1's medical diagnoses as Acute Systolic Heart Failure, Anxiety Disorder, Chronic Kidney Disease Stage 3, Stage II Left Buttock Pressure Ulcer, History of Falls, Human Metapneumovirus, Morbid Obesity, Paroxysmal Atrial Fibrillation, Stage 3 Right Buttock Pressure Ulcer and Unsteadiness on Feet. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as being dependent on staff for dressing, toileting and personal hygiene. This same MDS documents R1 requires the assistance of two staff members and a total body mechanical lift for transfers.</p> <p>a.) On 8/14/24 at 10:15 AM R1 stated I had to lay in my own urine all night long. I put on my call light four times that night (8/7/24). (V23) Certified Nurse Aide (CNA) answered my call light each time, turned it off and left my room. (V23) did not change my incontinence brief or pad underneath me. I had to lay in urine all night. On the fourth time I put on my call light (V23) and (V10) CNA's both came in and changed me. I shouldn't have to lay in pee for hours and hours. Four times I put on my call light. Each time I waited at least an hour in between because I thought (V23) CNA would come back but she never did. By the time they (V10, V23) changed me before their shift was over, I was soaking wet with urine. My brief was soaked, my incontinence pad underneath me was soaked and my bed sheets were wet. I told (V4) (R1's) family member the next morning (8/8/24) and (V4) told (V1) Administrator about it. (V1) Administrator came and talked to me later in the day (8/8) and said the staff should be changing me every two hours and whenever I ask them too. (V1) needs to tell the staff that!</p> <p>On 8/14/24 at 10:35 AM V10 Certified Nurse Aide (CNA) stated V23 CNA and V10 worked together on night shift starting 8/7/24 and ending on 8/8/24. V10 stated I had not been in (R1's) room until the early morning of 8/8/24. After (V23) and I got finished cleaning (R1) up, (R1) thanked me for helping her because (V23) kept turning off her call light and not changing her incontinence brief. I had seen (R1's) call light on a few times that night but that was (V23's) side of the hall so I though (V23) was taking care of it. I was busy helping my own residents. (R1's) incontinence brief, the incontinence pad she was laying on, the flat and fitted sheets and part of her comforter were soaked with urine. You could tell (R1) had been laying there for a long time.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/15/24 at 3:00 PM V23 Certified Nurse Aide (CNA) stated R1 is incontinent of urine. V23 stated I don't ever check on (R1) every two hours. I know (R1) is incontinent but she can use her call light so I don't need to check on her. I remember that night (8/7/24). (R1) was pretty upset with me. (V1) Administrator called me the next day (8/8/24) and told me I am supposed to check all incontinent residents every two hours no matter if they are oriented or not. I know when we (V10, V23) did go in and change (R1) she was pretty wet. I had to change her whole bed. I don't remember shutting her call light off but I could have if I were busy with something else. I probably did just shut it off thinking I would get back to her and forgot. I hate the way (R1) felt about it all. I feel bad for making (R1) feel upset.</p> <p>b.) On 8/14/24 at 1:15 PM V10 and V16 Certified Nurse Aides (CNA) completed perineal care for R1. V10 and V16 CNA's transferred R1 from her recliner chair using a total body mechanical lift to her bed. R1's incontinence brief was fully saturated with urine. The inside cotton of R1's incontinence brief had separated and clumped into pieces. R1's incontinence pad on her recliner chair had yellow spots on it in the center where R1 had been sitting.</p> <p>On 8/14/24 at 1:31 PM V16 Certified Nurse Aide (CNA) stated V16 had not assisted R1 with any cares since arriving for her shift at 8:00 AM. V16 CNA stated (V10, V11 and V16) CNA's are the only staff assigned to (R1's) hall. There wouldn't be anyone else that provided cares to (R1). On 8/14/24 at 1:34 PM V10 Certified Nurse Aide (CNA) stated V10 had not assisted R1 with any cares since arriving for her shift at 6:00 AM. On 8/14/24 at 1:40 PM V11 Certified Nurse Aide (CNA) stated V11 had not provided any cares for R1 since arriving on her shift at 5:00 AM. V11 stated I know (V10 and V16) CNA's changed (R1's) incontinence brief a few minutes ago but I don't think anyone has been in there since this morning when she got up. V11 CNA stated any resident who is incontinent should be checked on and have their incontinence brief changed if needed at least every two hours.</p> <p>On 8/14/24 at 1:35 PM R1 stated It feels good to be clean. [NAME] has moved me since I got up at 6:00 AM. I haven't been moved and nobody has changed my incontinence brief since they (staff) got me up at 6:00 AM. I had bed sores before and now my butt is red again. I don't want to get bedsores again and I know sitting in urine isn't good for my skin.</p> <p>c.) On 8/15/24 at 8:00 AM R1 was laying in her bed in her room. R1's room smelled of urine. R1 stated at that time Today is my shower day so I don't get up until I get my shower. On 8/15/24 at 9:00 AM R1 was laying in her bed in her room. R1's room still smelled of urine. On 8/15/24 at 11:45 AM R1 stated I put my call light on at 9:15 AM. One of the girls (V15 Certified Nurse Aide) came in and told me that Hospice was coming today and that they (Hospice staff) would help me get changed and showered when they arrived. (V14) Hospice CNA came in at 10:00 AM. I had been laying in bed in my own urine since they (staff) changed me around 5:00 AM. This is just awful. I didn't do anything to deserve this. [NAME] should have to lay in their own urine. I understand if they (staff) get busy and I am not the one person they have to take care of but hours on end is awful.</p> <p>On 8/14/24 at 11:55 AM V14 Hospice Certified Nurse Aide (CNA) stated I see (R1) four times a week. I gave (R1) a bath yesterday (8/13/24) and saw that her bottom was very red. (R1) told me that the staff leave her lay in urine for hours on end. Sometimes when I get (R1) up, her sheets are really soaked with urine. I let the staff know but I haven't seen any real change.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/15/24 at 11:55 AM V11 Certified Nurse Aide (CNA) stated V11 had not assisted R1 with any cares since arriving for her shift at 5:00 AM. On 8/15/24 at 11:57 AM V16 Certified Nurse Aide (CNA) stated V16 had not assisted R1 with any cares since arriving for her shift at 8:15 AM. On 8/15/24 at 12:00 PM V7 Certified Nurse Aide (CNA) stated V7 had not assisted R1 with any cares since arriving for her shift at 3:00 AM. V7 stated I think (R1) was changed right before the other girl (V23) CNA left but I know I didn't help (R1) at all. I was on the other side of the hall.</p> <p>On 8/16/24 at 2:05 PM V2 Director of Nurses (DON) stated all residents should be offered and/or provided incontinence care every two hours, and as needed. V2 DON stated a resident's call light should be answered and cares provided at that time or the staff should leave the resident call light on so that other staff are aware that the resident still may need something. V2 DON stated Leaving any resident to lay in their own urine for hours is unacceptable. This could lead to infection such as a Urinary Tract Infection (UTI), Pressure Ulcers or even Depression. I will be doing to education with the staff to make sure they understand how important it is to provide cares timely and to maintain resident dignity. V2 DON confirmed that V7, V11 and V16 CNA's would be the only staff caring for R1 on 8/14/24 and V10, V11 and V16 CNA's would be the only staff caring for R1 on 8/15/24.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview and record review the facility failed to prevent cross contamination during incontinence care for one (R1) resident out of three residents reviewed for incontinence care in a sample list of seven residents.</p> <p>Findings include:</p> <p>R1's Face Sheet documents R1 was admitted to facility on 6/21/24. R1's Cognitive assessment dated [DATE] documents R1 as cognitively intact.</p> <p>R1's Medical Record documents R1's medical diagnoses as Acute Systolic Heart Failure, Anxiety Disorder, Chronic Kidney Disease Stage 3, Stage II Left Buttock Pressure Ulcer, History of Falls, Human Metapneumovirus, Morbid Obesity, Paroxysmal Atrial Fibrillation, Stage 3 Right Buttock Pressure Ulcer and Unsteadiness on Feet. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as being dependent on staff for dressing, toileting and personal hygiene. This same MDS documents R1 requires the assistance of two staff members and a total body mechanical lift for transfers.</p> <p>On 8/14/24 at 1:15 PM V10 and V16 Certified Nurse Aides (CNA) completed perineal care for R1. V16 CNA did not wash hands prior to providing incontinence care. V16 CNA wore the same pair of disposable gloves for the entire procedure. V16 CNA did not change gloves, wash hands nor use alcohol based hand rub prior to or during incontinence care for R1's front perineal area and buttocks areas. V16 CNA did not apply barrier cream to R1's buttocks after providing incontinence care.</p> <p>On 8/14/24 at 1:30 PM V16 Certified Nurse Aide (CNA) stated she should have washed her hands prior to beginning perineal care for R1. V16 CNA stated V16 should have changed gloves and applied barrier cream after providing incontinence care.</p> <p>On 8/15/24 at 1:50 PM V2 Director of Nurses stated staff should follow infection control guidelines when providing incontinence care. V2 stated hand washing is an integral part of trying to prevent the spread of organisms and maintaining basic hygiene. V2 DON stated I will reeducate the staff on proper technique when providing incontinence cares to all residents.</p> <p>The facility policy titled Perineal Cleansing revised 9/21/2010 documents the basic infection control concept for perineal care is to wash from the cleanest to the dirtiest are and remember to change or remove gloves and wash hands when going from working with contaminated items to clean items.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Tuscola Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1203 Egyptian Trail Tuscola, IL 61953	
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 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview and record review the facility failed to ensure five (R1, R2, R5, R6, R7) residents received timely Physician visits out of five residents reviewed for Physician visits in a sample list of seven residents.</p> <p>Findings include:</p> <p>1.) R1's Face Sheet documents R1 was admitted to facility on 6/21/24.</p> <p>R1's Cognitive assessment dated [DATE] documents R1 as cognitively intact.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents R1 as being dependent on staff for dressing, toileting and personal hygiene. This same MDS documents R1 requires the assistance of two staff members and a total body mechanical lift for transfers.</p> <p>R1's Medical Record does not document a Physician visit since admission.</p> <p>On 8/14/24 at 9:30 AM R1 stated I have not been seen by any Physician since I have been here (facility).</p> <p>2.) R2's undated Face Sheet documents R2 admitted to facility on 7/3/24.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 as moderately cognitively impaired.</p> <p>R2's Cognitive assessment dated [DATE] documents R2 as moderately cognitively impaired.</p> <p>R2's Medical Record does not document a physician visit since admission to facility.</p> <p>3.) R5's undated Face Sheet documents R5 admitted to facility on 12/1/2023.</p> <p>R5's Physician Order Sheet (POS) dated August 2024 documents R5's medical diagnoses as Hypertension, Hypothyroidism, Gastroesophageal Reflux Disease (GERD), Restless Leg Syndrome, Cerebral Palsy, Asthma and Sleep Apnea.</p> <p>R5's Cognitive assessment dated [DATE] documents R5 as cognitively intact.</p> <p>R5's Medical Record does not document a Physician visit since admission.</p> <p>On 8/15/24 at 12:20 PM R5 stated R5 has not been seen by a Physician since her admission to facility on 12/1/2023. R5 stated R5 I have seen by (V20) Nurse Practitioner several times but never an actual doctor here at this facility. I have went to the hospital and seen doctors there, but never here at this facility.</p> <p>4.) R6's undated Face Sheet documents R6 admitted to facility on 6/14/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Tuscola Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1203 Egyptian Trail Tuscola, IL 61953	
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 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6's Medical Record documents medical diagnoses as Femur Fracture, Diabetes Mellitus Type II, Supraventricular Tachycardia, Obstructive Sleep Apnea and Hyperlipidemia.</p> <p>R6's Medical Record does not document a Physician visit.</p> <p>5.) R7's undated Face Sheet documents R7 admitted to facility on 6/10/24.</p> <p>R7's Medical Record documents medical diagnoses as Dementia, Hyperlipidemia, Chronic Pain, Congestive Heart Failure, Anxiety Disorder and Psoriatic Arthritis.</p> <p>R7's Medical Record does not document a Physician visit.</p> <p>On 8/14/24-8/16/24 during various hours and shifts at facility there were no observations of V24 Medical Director and/or V20 Nurse Practitioner.</p> <p>On 8/15/24 at 12:10 PM V20 Nurse Practitioner stated I am considered to have full practice authority. I do not need a Physician to review my progress notes. I do not require Physician collaboration. As far as I am aware, the facility does not know this. I have not told them that. Whenever a new resident admits to the facility I am the person who completes their admission assessment, signs off on the medications and/or treatments and orders general living orders.</p> <p>On 8/15/24 at 1:45 PM V2 Director of Nurses (DON) stated (V24) Medical Director does not routinely see residents. (V24) comes to our facility quarterly for mandatory meetings and is available if we (facility) need his guidance for any specific resident's care. (V20) Nurse Practitioner sees all of our new admission residents. (V20) completes the initial visits and follows up with residents regularly. (V20) has full practice authority so she does not need a Physician to see the residents. There is no other Physician that has any residents here. (V24) Medical Director is the Physician for 100% of our residents. I guess we (facility) will have to get (V24) to start seeing residents.</p> <p>On 8/16/24 at 9:10 AM V1 Administrator stated the facility does not have any policy that documents a Physician must see any resident nor the timeliness of Physician visits for new admissions or established residents. V1 stated Since (V24) Medical Director is our only Physician, he should be seeing all of our new residents. I was not aware of the fact that newly admitted residents had to be seen by a Physician. I thought them seeing a Nurse Practitioner was ok. We (facility) will adjust who sees our residents and when.</p>		