STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146116	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Salle County Nursing Home	1380 North 27th Road Ottawa, IL 61350

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 33973 Based on observation, interview, and record review the facility failed to ensure resident call devices were in reach for one (R8) of 15 reviewed for call devices in a sample of 27. Findings include: The undated facility's Call Light, Use Of policy documents Procedure: 11. Be sure call lights are placed within resident reach at all times, never on the floor or bedside stand. On 8/12/24, at 10:05am, R8 sat in a recliner in her room. R8 stated that she uses the call light for help to get to the bathroom. I am on a water pill, so I go a lot. At this time R8's call device is on the floor beside her and out of R8's reach. On 8/12/24, at 10:10am, V18 (Unit Attendant), stated the following: As a Unit Attendant I answer call lights and also when in a room I check to make sure the residents have their call light. On 8/12/24, at 10:16am, V18 confirmed R8's call device was on the floor and stated, It must have fallen when she got up in the chair earlier and I didn't see it. R8's current Care Plan includes a focus of The resident is at moderate risk for falls related to incontinence, hemiplegia, history of CVA (Cerebral Vascular Accident), on antidepressant, diuretics, anti-seizure, antihypertensive with an intervention of Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33973 Based on interview and record review the facility failed to perform a PASRR (Pre-Admission Screening & Resident Review) rescreen after a severe mental illness diagnosis was added for one (R22) one resident reviewed for PASRRs in a sample of 27. Findings include: The facility's undated PASRR policy documents a Project Introductions including but not limited to PASRR. Level I screen identifies known/suspected PASRR conditions: MI (Mental Illness)/ID (Intellectual Disability)/RC (related condition). Level II assessment - individualized to determine presence of MI/ID/RC and needed services and supports. Determination & Needs - (NFs) Nursing Facility's must incorporate PASRR findings in the person's plan of care. Refer for Level II - Has/suspected PASRR condition; Requires a Level II. R22's Face Sheet documents R22 admitted to the facility on [DATE] and includes a diagnosis of Unspecified Psychosis not due to a Substance or known Physiological Condition with a revised date of 4/20/23. R22's PASARR Level I, review date 3/28/23, documents PASRR Level I Determination: No Level II Required - Situational symptoms; Mental Health Diagnoses - Anxiety Disorder, current. R22's Minimum Data Set/MDS assessment, dated 6/20/23, documents 'Psychiatric/Mood Disorder: Diagnoses include: Psychotic disorder (other than schizophrenia) and Anxiety Disorder; Yes - Antipsychotics were received on a routine basis only. On 8/13/24, at 2:25pm, V22 (Admissions Coordinator) stated, On admission I request a Level I or whatever they required .V9 (Social Service Director/SSD) coordinates with V6 (Minimum Data Set/MDS and Care plan Coordinator) regarding changes like behaviors or medications. V9 would get a Level II if needed. If she is not here, then I would intervene and do it. On 8/14/24, at 11:55am, V6 (MDS/Care plan Coordinator) confirmed R22's Face Sheet includes a diagnosis of Unspecified Psychosis. V6 stated the following: (R22) came in with that diagnosis and was on Seroquel. I did not mark psychosis on (R22's) admission MDS because I did not have the psychotic diagnosis until 4/20/24 when we got verification from the doctor. V6 confirmed that R22 should have had another PASRR Level I Screening done when we saw that diagnosis. On 8/15/24, at 8:37am, V9 (SSD) stated the following: I did not realize that (R22) had the psychotic disorder diagnosis. If I had known, I would have put in for another Level 1 Screening then they would have determined if a Level II was needed. V9 confirmed that R22 should have been referred for another Level I Screening.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 30678 Based on observation, interview, and record review the facility failed to identify a severe weight loss and put interventions in place for one (R33) of one resident reviewed for nutrition in the sample of 27. This failure resulted in R33 having a continued severe weight loss of 10.2% in one month and 12.9% loss in six months. Findings include: The facility's Resident Weight policy, dated 7/1/18, documents Any significant weight discrepancy from the previous weight is to be investigated at that time to rule out errors in weighing the resident (scale errors, incorrect procedure.) The nurse will report significant weight gains or losses to the physician and to the dietary department. (Significant weight gains or losses are defined as 5% in one month, 7.5% in 3 months, or 10% in 6 months. The Monthly Weight Summary for R33, documents the following weights: 8/15/24 at 128.0 pounds; 8/6/24 at 132.0 pounds; 7/3/24 at 147.0 pounds; 6/4/24 at 144.4 pounds; 5/2/24 at 148.0 pounds; 4/8/24 at 146.0 pounds; 3/12/24 at 145.0 pounds; and 2/12/24 at 147.0 pounds. This weight record documents a significant weight loss of 10.2% in one month (7/3/24 to 8/6/24) and 12.9% loss in six months. The Electronic Health Record for R33, does not document that V4 (Dietary Manager) or V17 (R33's Physician) was notified of R33's significant weight loss. The current Physician Order Sheet for R33, documents R33 is on a regular diet with no other dietary orders and to ensure R33 was offered snack three times a day. On 8/12/24 through 8/14/25, between 8:30 am through 3:00 pm, R33 paced the facility, circling one hallway to the next, and refused to rest frequently. On 8/13/24, 8/14/24, and 8/15/24, R33 was not seen in the dining room during mealtimes and was walking the hallways during those times. Meal trays were delivered to R33's room and R33 did not eat the meal provided. On 8/14/24 at 9:11 am, V2 (Director of Nursing) stated, We all encourage (R33) to rest and take breaks and she will at times. Sometimes (R33) with say no and keep on walking. We have to encourage her frequently. On 8/14/23 at 10:00 am, V10 (Certified Nursing Assistant/CNA), V11 (CNA), and V12 (CNA) stated R33 walks around the facility all day long. R33 used to be given finger foods and she would eat while walking but R33 won't eat now. R33 won't eat in the dining room most of the time and will say she is not hungry. On 8/15/24 at 9:45 am, V15 (Restorative CNA) stated she does all the monthly weights for the facility. V15 stated the last weight she got for R33 was 120 something (pounds), so she reweighed R33 and that is when she got the weight of 132 (pounds) and put the weight in R33's medical record. I did notice (R33) had a weight loss. V15 stated R33 walks even more now, it is harder to get her to stay focused, and her attention span is shorter than it used to be. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 8/15/24 at 12:58 pm, V2 stated she does all the monthly weight meetings and is unaware of R33 having any recent weight loss. V2 stated, No one has reported anything to me.

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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 respiratory assessment was completed pre and post nebulizer treatment for one (R5) of one resident reviewed for nebulizer treatments in a sample of 27. Findings include: The facility's undated Nebulizer policy documents Purpose: 1. To administer bronchial medications and humidifying agents into the lungs. 2. To assist in loosening lung secretions .Procedure: 6. Note pre-treatment data such as pulse and breath sounds .14. Note post treatment data (pulse, breath sounds and any side effects) and record in the medical record. (If pulse is increased more than 20 beats per minute over baseline, notify Physician.). R5's current Physician Order Sheet/POS documents R5 has an order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg (milligrams)/3ml (millimeters) (Ipratropium-Albuterol) 1 vial inhale orally via nebulizer four times a day related to Chronic Obstructive Pulmonary Disease, Unspecified. On 8/14/24, from 9:45am - 10:00am, R5 sat in her room. V8 (Licensed Practical Nurse/LPN) administered an Ipratropium Bromide & Albuterol nebulizer treatment to R5. V8 did not auscultate R5's lungs or take any vital signs before or after the treatment. On 8/14/24 at 1:43pm, V8 (LPN) confirmed that V8 did not auscultate R5's lungs or take R5's vital signs before or after giving R5 a nebulizer treatment. V8 stated, I don't auscultate lungs or take vitals unless the doctor ordered it specifically or it is a prn (as needed) dose for someone having breathing issues. (R5) gets nebulizer treatments regularly. I don't do that for scheduled maintenance nebulizer treatments but would for prn. On 8/14/24, at 2:30pm, V2 (Director of Nursing) confirmed that their policy states they are to auscultate lungs and take vital signs before and after a nebulizer treatment. V2 stated We will have to change our policy since that is not what we are doing for residents with scheduled nebulizer treatments.

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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. 33973 Based on interview and record review, the facility failed to ensure a rationale was documented by the physician for a pharmacy recommendation for one (R53) of five residents reviewed for Medication Regimen Review in a sample of 27. Findings include: The facility's Psychotropic Medication Use policy, revised 10/24/22, documents Definition - Psychotropic drugs include but are not limited to antipsychotics, anti-anxiety, antidepressants, or sedative-hypnotics that affect brain activities associated with mental processes and behavior .14.1 Physician/Prescriber should document the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. R53's Physician Order Sheet/POS includes orders for Trazadone HCl (Hydrochloride) 100mg (milligrams) by mouth at bedtime for insomnia related to Primary Insomnia and Melatonin 5 mg by mouth at bedtime for insomnia related to Primary Insomnia. R53's Consultation Report, dated on 7/24/24 and signed by V23 (R53's Nurse Practitioner), documents Comment: (R53) has orders for duplicate therapy. Trazodone 100mg (milligrams) q hs (every bedtime) and Melatonin 5mg q hs. Recommendation: Please discontinue one agent. If dual therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences. Physician's Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. The Rationale is blank. On 8/14/24, at 4:05pm, V2 (Director of Nursing) confirmed that V23 (R53's Nurse Practitioner) signed the Consultation Report but did not give a rationale and should have.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 33985 Based on record review and interview the facility failed to document the rational for the continued use of an antibiotic for two of three residents (R16 and R51) reviewed for unnecessary medications in a sample of 27. Findings Include: The facility's Antibiotic Stewardship-Infection Control policy, undated, documents the following: Procedure of Core Elements, D.) Action-Implementing at least one policy or practice to improve antibiotic use this facility will implement a stricter policy (s) on antibiotic order specifics including, but not limited to identifying clinical situations in which inappropriate antibiotics are used such as asymptomatic urinary tract infections, treating a colonized asymptomatic resident, prophylaxis, and guidelines for treating infections. The key element involved is control over antibiotic use which will reduce the threat of antibiotic resistance. The goal is to add one or two activities to start the program and over time as the program evolves implement more strategies to improve antibiotic use. Procedure 3.) The nurse shall document any signs and symptoms of infection following the criteria for clinical infecting on the infection Report form as well as in the nurses' notes. 4.) Floor nurse shall update the physician with a change in condition. if infection criteria met, inform physician of antibiotic algorithm as well as any culture and sensitivity results, and the strict standards our antibiotic stewardship program follows. 5.) If orders are received for antibiotics, double check the algorithm and or sensitivity report before administrating. If a conflict is noted, update physician and request replacement. R16's Physician Order Sheet, dated 8/14/2024, documents the following: Macrobid Oral Capsule 100 MG (milligram) (Nitrofurantoin Monohydric Macro Anti-bacterial) give one capsule by mouth one time a day every other day for UTI (urinary tract infection) prophylactic related to personal history of urinary tract infection. Order date 6/13/2024- (admitted). Start date 6/14/2024. R16's Progress Notes, dated 7/24/2024, documents the following: (R16) remains on prophylactic antibiotics. No signs of adverse effect or complaints. R16's Care Plan, dated 6/26/2024, documents the following: R16's urinary tract infection is related to chronic history of UTI. Intervention: Obtain and monitor lab/diagnostic work as ordered. Report results to V17 (R16's Physician) and follow-up as indicated. On 8/14/2024 at 11:10 AM V2 (Director of Nurses) stated, R16 was admitted to us with this antibiotic in place. R16 is hospice, so we just left her on the Macrobid (antibiotic). No labs or urinalysis have been done for (R16) to indicate that (R16) has a UTI. 30678 2. On 8/12/24 at 10:54 am, R51 stated she is on an antibiotic for a UTI (urinary tract infection) and has not had any problems with it. R51 stated Today is the last day. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The urine laboratory results for R51, dated 7/29/24, documents a urine culture was obtained for R51. This laboratory result does not document R51 with a current urinary tract infection. This form has a handwritten physician order to administer the Antibiotic Macrobid, even though the colony count for R51 was not indicating infection due to symptomatic. The current Physician Orders for R51, document a Physician Order dated 8/5/24 for R51 to start Macrobid 100 mg (milligrams) bid (twice daily) for seven days for symptomatic urinary with no infection noted. The Progress Notes for R51 documents the following: 8/5/24 Received new order for Macrobid despite no infection noted for symptomatic urinary issues and 8/6/24 Remains on Macrobid for urinary issues but has no active infection at this time, temperature 97.9 degrees. On 8/15/24 at 8:40 am, V3 (Infection Control Preventionist) stated she believes that R51 had a urinary tract infection. V3 confirmed R51's urine culture did not indicate R51 with a urinary tract infection due to the colony count not being high enough but R51's Physician decided to treat her anyway.

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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. 33973 Based on observation, interview, and record review, the facility failed to ensure proper diagnoses and targeted behaviors were in place for psychotropic medications for two residents (R53 and R49) of three residents reviewed for psychotropic medications in a sample of 27. Findings include: The facility's Psychotropic Medication Use policy, revised 10/24/22, documents Definition - Psychotropic drugs include but are not limited to antipsychotics, anti-anxiety, antidepressants, or sedative-hypnotics that affect brain activities associated with mental processes and behavior. Procedure - 1. Psychotropic medication is prescribed for a diagnosed condition and not being used for convenience or discipline .2.1 The facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors .2.1.3 Staff should become familiar with the cultural, medical, and psychological information about the resident to identify potential environmental and other triggers to prevent or reduce behavioral symptoms and/or distress, types and the consequences of behaviors exhibited by the resident and interventions that may be indicated for a specific behavior type .5. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms .13. When Physician/Prescriber orders a psychotropic medication for a resident, facility should ensure that Physician/Prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacologic medication is necessary. 14. If Physician/Prescriber orders a psychotropic medication in the absence of a diagnosis Facility should ensure that the ordering Physician/Prescriber reviews the medication plan and considers a gradual dose reduction (GDR) of psychotropic medications for the purpose of finding the lowest effective dose unless a GDR is clinically contraindicated. 14.1 Physician/Prescriber should document the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. 1. On 8/12/24, at 12:32pm, R53 sat quietly in the Dining Room eating with assistance. On 8/13/24, at 1:25pm, R53 sat quietly in the lounge area eating a cookie. On 8/15/24, at 10:20am, R53 sat quietly in the Activity room smiling while watching the game being played. R53's current Physician Order Sheet/POS documents diagnoses including but not limited to Unspecified Dementia without Behavior Disturbance, Restlessness and Agitation, and Insomnia; there are no diagnoses for Anxiety or Depression. R53's Medication Administration Records/MARs for July and August 2024 includes orders for Lorazepam Oral Tablet 0.5 mg (milligrams) (Lorazepam) *Controlled Drug* Give 1 tablet by mouth every 8 hours as needed for anxiety for 14 Days and Trazadone HCl (Hydrochloride) Oral Tablet 100mg Give 100 mg by mouth at bedtime for insomnia related to Primary Insomnia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R53's July MAR documents R53 received Trazadone every evening and Lorazepam on 7/1, 7/3, and 7/31/24. There is no documentation of any behavior on this MAR or in R53's Nursing Progress Notes. R53's August MAR documents R53 received Trazadone every evening and Lorazepam on 8/5, 8/10, and 8/11/24. There is no documentation of any behavior on this MAR or in R53's Nursing Progress Notes. R53's Behavior Summary Reports for 7/1/24 - 8/15/24, do not include specific targeted behaviors. On 8/14/24, at 12:05pm, V6 (Minimum Data Set/Care Plan Coordinator) stated that R53's indication for use of Ativan is anxiety and the indication for use of Trazadone is insomnia. V6 stated that the diagnosis for R53's Ativan is restlessness and agitation. V6 confirmed that restlessness and agitation are symptoms and was unable to locate a diagnosis of Anxiety from R53's clinical record. V6 stated that Trazadone is an Anti-depressant, but the diagnosis for Trazadone is insomnia. V6 was unable to locate a diagnosis of Depression from R53's clinical record. On 8/15/24, at 10:15am V2 (Director of Nursing) stated there are no individualized targeted behaviors documented for (R53) or (R49). V2 confirmed that they go by the generic behaviors that the CNAs (Certified Nursing Assistants) track. V2 also confirmed that R53's list of diagnoses do not include Anxiety or Depression and should. On 8/15/24, at 1:47pm, V19-V21 (CNAs) stated that R53 gets antsy at times, but does not have any aggressive or harmful behaviors. 30678 2. The current Physician Orders for R49 document R49 is currently receiving the following psychotropic medications: Duloxetine 60 mg/milligrams daily, Mirtazapine 7.5 mg in the evening and Ativan 0.5 mg three times daily. On 8/12/24 at 9:45 am, 8/13/24 at 9:38 am, 12:03 pm, and on 8/14/24 at 8:40 am and 12:00 pm, R49 was alert and oriented, up in a wheelchair in his room, in the dining room, or lying in bed with eyes closed and without behaviors. On 8/14/24 at 9:20 am, V2 (Director of Nursing) stated R49 came to the facility as a Hospice patient, is alert and oriented with periods of confusion and is currently receiving psychotropic medications for Anxiety and Depression. V2 stated R49 has not had any behaviors related to his Depression or Anxiety but generally does well. V2 stated, We have not had any behaviors from him. On 8/14/24 at 10:00 am, 10:07 am, and 10:12 am, V10, V11, and V12 CNAs stated R49 is alert and oriented with periods of confusion, able to make needs known and has not had any behaviors, other than refusing cares at times and will reproach at later time with no problems. On 8/15/24 at 10:15 am, V2 stated the staff just chart any behaviors that R49 might have in the progress notes and on the Behavior Tracking sheets. V2 confirmed there are no specific targeted behaviors for R49.

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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. 34048 Based on observation, interview, and record review the facility failed to date opened food items, use items within the opened date timeframe, and failed to implement the cleaning schedule of equipment. This has the potential to affect all 59 residents residing in the facility. Findings include: The facility's Food Storage: Cold Foods, revised 04/2018, documents that all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The facility's Equipment policy, revised 09/2017, documents that all food service equipment will be clean, sanitary, and in proper working order. This form also documents that all food contact equipment will be cleaned and sanitized after every use. This form documents that all non-foods contact equipment will be clean and free of debris. On 8/12/24 at 9:00am there were four plastic containers of open, undated cereal on the counter. V4 (Dietary Manager) stated that the cereal is supposed to be dated when it is opened and put into the containers. V4 stated that it is only good for seven days after opened. V4 opened the drink refrigerator and there were two containers of thickened water, one apple and one cranberry thickened liquid containers open and undated. V4 stated that the containers of thickened liquids are to be dated when opened and kept for only seven days. A container of whole liquid eggs was dated as opened on 7/1/24. V4 verified that the eggs are only kept for seven days after opened. The two basket deep fryer baskets were covered in a dark brown greasy substance. The oil in the deep fryer was dark brown with burnt foods and crumbs on the bottom and on the shelf of the fryer. V4 stated that the deep fryer oil is to be changed weekly. V4 also stated that the debris is to be filtered out of the oil every night. V4 stated that is does not appear that it was done last night. The convection oven had a spilled brownish liquid on the floor. V4 stated that the chicken leaked over this morning the oven will be cleaned today. On 8/13/24 at 1:30pm, the convection oven had a dark brown dry crusty area on the floor. V4 verified that the oven was not cleaned yesterday (8/12/24). On 8/15/24 at 9:30am, V5 (District Dietary Manager) verified that all opened foods are to be covered and dated when opened. V5 stated that opened items are only kept for seven days. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 8/12/24, documents 59 residents residing in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146116	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Salle County Nursing Home	1380 North 27th Road Ottawa, IL 61350

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 33973 Based on interview and record review, the facility failed to ensure all required staff attended the facility's Quality Assurance Meetings. This has the potential to affect all 59 residents residing in the facility. Findings include: The facility's policy Quality Assurance and Performance Improvement (QAPI) last modified 6-20-18, documents Procedures: 1) The facility will maintain, at all times including staff transitions, a Quality Assurance and Performance Improvement (QAPI) committee which will meet at least quarterly and more frequently according to the facility's needs. The committee will consist of at least the following: 1. The QAPI officer. 2. The Medical Director of this facility. 3. The Administrator of this facility. 4. The Director of Nursing. 5. The Restorative RN (Registered Nurse). 6. The Admissions Coordinator. 7. The Dietary Service Coordinator. 8. The Director of Social Services. 9. The Pharmaceutical Representative. 10. The Infection Control/Preventionist Coordinator. 11. Activities Coordinator. 12. MDS (Minimum Data Set) Coordinator. 13. Administrative Assistant/HR (Human Resources) Coordinator. The facility's Quality Assessment and Assurance Committee Meeting, dated 4/18/24, documents Absent for this meeting: (V16 Previous Administrator). The facility's Quarterly Quality Assurance Meeting Attendance Record, dated 4/18/24, does not include a signature by V16. On 8/15/24, at 9:29am, V2 (Director of Nursing) confirmed that (V16) the previous Administrator was not at the April 18, 2024, meeting. The facility's Long-Term Care Facility Application for Medicare and Medicaid, dated 8/12/24, documents a census of 59 residents residing in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146116	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Salle County Nursing Home	1380 North 27th Road Ottawa, IL 61350

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 33985 Based on interview and record review, the facility failed to ensure that the Antibiotic Stewardship Program was complete, accurate and done monthly for residents who are receiving antibiotics or have any type of infection. This failure has the potential to affect all 59 residents residing in the facility. Findings Include: The facility policy, named Antibiotic Stewardship-Infection Control Program, no date, documents the following: It is the policy of the facility is to monitor and maintain an Antibiotic Stewardship Program that monitors the use of antibiotics and their order specifics to decrease the amount antibiotic resistant organisms following the procedure: A.) Utilize the antibiotic tracking form to monitor reason for antibiotics and; B.) Identify the use of antibiotics and the appropriateness of the situation. C.) Analyze if antibiotic meets the appropriate criteria for infection using the algorithm for treatment of specific infections if available. D.) Track whether the patient is colonized and/or if they are clinically infected. Only treat if warranted. E.) Monitor for appropriateness of prophylaxis. F.) Physician compliance tracking and education. Procedure 4.) Infection Prevention Program Coordinator has the key expertise and data to inform strategies to improve antibiotic use. The Infection Preventionist tracks antibiotics, monitors adherence to evidence-based published criteria, reviews antibiotic resistance patterns in the facility. In coordinating using education and training, dedicated time, and resources to collect and analyze surveillance data, this will be used to support the antibiotic stewardship program. The facility's Monthly Infection Control Log dated May 1st through May 31st 2024, documents only the following information: Residents name, body site, and antibiotic with start date. The Infection Control Log for May is blank for the following pertinent information: Date of onset of infection, a culture when applicable, organism, antibiotic resistant, and classification of the infection, type of antibiotic, how long the antibiotic is for and symptoms to support the use of the antibiotic. The facility's Monthly Infection Control Log dated June 1st through June 31st 2024, documents only the following information: Residents name, body site, the antibiotic with start date and what the resident is being treated for. June's Infection Control Log does not document the following pertinent information: Date of the onset of the infection, a culture when applicable, antibiotic resistant, the classification of the infection, the organism that is being treated, any symptoms to support the use of the antibiotic, and stop date for the antibiotic. On 8/14/2024 at 11:32 AM V3 (Infection Preventionist), stated, I have not started the Infection Control Log for July or August yet. Typically, it should be started at the beginning of each month to accurately track, monitor infections or any trends, and to ensure that the resident is being treated appropriately for the infection. The logs are not complete. The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 8/12/2024, documents 59 residents currently reside within the facility.