STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146127	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Nursing Home	546 East Grant Highway Marengo, IL 60152

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on observation, interview, and record review the facility failed to transfer a resident in a safe manner. This applies to one of two residents (R13) reviewed for safety in the sample of 23. The findings include: The face sheet for R13 shows she was admitted to the facility with diagnoses to include Alzheimer's, hypertension and muscle weakness. The facility assessment dated [DATE] shows her to have severe cognitive impairment and requires maximum staff assistance with transfers. On 5/6/2025 at 9:12 AM, R13 was observed being transferred from her wheelchair to her bed by V3 Certified Nursing Assistant (CNA). V3 who was wearing a gait belt around her waist, lifted R13 up from her wheelchair by placing her arms under R13's arms, pivoted her to the bed and lowered her onto her bed. On 5/7/2025 at 1:52 PM, V3 said a gait belt should have been used to transfer R13 from the chair to her bed. On 5/7/2025 at 1:48 PM, V2 Director of Nursing (DON) said a gait belt should always be used during a transfer for the safety of the resident and the staff. The undated facility gait belt policy shows to assure the safety of the residents and staff when assisting with a transfer or ambulation a gait belt will be used. 2. All residents who require assist with transfers and do not require an electric lift will utilize a gait belt with all transfers unless contraindicated.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to provide incontinence care in a manner to prevent cross-contamination for 2 of 3 residents (R1, R23) reviewed for infection control in the sample of 23. The findings include: 1. On 5/6/25 at 9:34 AM, V3 and V4 (Certified Nursing Assistants - CNAs) used a total mechanical lift to transfer R1 into bed. They turned R1 side to side to removed the sling. V4 (CNA) opened R1's incontinence brief to provide care. V4 said R1's brief was wet and used wipes to cleanse the urine from R1's perineal area. V4 used the same (contaminated) gloves to obtain a clean brief and remove R1's glasses. Then V4 used a wipe to clean R1's bottom, applied barrier cream, turned R1 and closed the clean brief. V4 covered R1 with a blanket. V4 was wearing the same contaminated gloves throughout the observation. R1's Facesheet dated 5/8/25 showed R1 had diagnoses to include, but not limited to: osteoarthritis, palmar facial fibromatosis, Alzheimer's Disease, hypertension, contracture of her left hand, diarrhea, and mixed obsessional thoughts and acts. R1's facility assessment dated [DATE] showed she had severe cognitive impairment; required substantial to maximal staff assistance for personal hygiene; was dependent on staff for toileting, transfers, and bed mobility; and was always incontinent of bowel and bladder. V1 said V4 should not have worn the same gloves throughout R1's incontinence care due to the risk of cross-contamination. V1 said V4 should have changed her gloves and performed hand hygiene when moving from dirty to clean tasks. V1 said there will be in-services for this. The facility's Incontinence Policy dated 2024 showed, Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services . The facility's Personal Protective Equipment - Using Gloves Policy dated 2010 showed, Purpose: To guide use of gloves. Objectives: 1. To prevent the spread of infection . Miscellaneous . 4. Use non-sterile gloves primarily to prevent the contamination of the employee's hands when providing treatment or services to the patient and when cleaning contaminated surfaces. 5. Wash hands after removing gloves . 2. On 5/6/25 at 10:12 AM, V4 (CNA) and V5 (Hospice Nurse) transferred R23 to bed using a mechanical lift. V4 and V5 rolled R23 side to side to remove the lift sling. V4 (CNA) opened R23's incontinence brief and said it was wet. V4 threw the soiled incontinence brief at the foot of R23's bed. The brief was opened and landed on R23's bed linens. V4 provided incontinence care and applied barrier cream to R23's bottom before changing her gloves. V4 applied a clean brief, covered R23, and removed the soiled brief from R23's bed linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's Facesheet dated 5/8/25 showed diagnoses to included, but not limited to: diabetes, stroke with right sided weakness, Chronic Obstructive Pulmonary Disease (COPD), hypothyroidism, mild protein-calorie malnutrition, and a history of C. diff (Clostridium difficile colitis - inflammation of the colon caused by a bacteria) and urinary tract infections. R23's facility assessment showed she had severe cognitive impairment; was dependent on staff for personal hygiene, toileting, transfers, and bed mobility; and was always incontinent of bowel and bladder. On 5/8/25 at 10:28 AM, V1 (Administrator) said she is the Infection Preventionist for the facility and she takes that role very seriously. V1 said V4 has been a CNA for a long time. The surveyor asked V1 if a soiled incontinence brief should be thrown at the foot of the resident's bed. V1 replied, Absolutely not, the soiled brief should be placed in a trash bag and not contact the resident's bedding. It's a cross-contamination risk.