

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Hickory Point Christian Village		STREET ADDRESS, CITY, STATE, ZIP CODE 565 West Marion Avenue Forsyth, IL 62535	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>31642</p> <p>Based on observation, interview, and record review, the facility failed to prevent cross contamination during pressure ulcer/wound treatment for one of two residents (R6) reviewed for pressure ulcers/wounds on the sample 27.</p> <p>Findings included:</p> <p>R6's Physician Order Sheet (POS), dated 5/15/24, documents the following:</p> <p>Cleanse wound to sacrum with generic wound cleanser, pat dry, apply medihoney to wound, cover with sacral foam dressing daily and PRN (as needed) every evening shift. The same POS documents: Cleanse open area to left heel, pat dry, apply medihoney and cover with bordered gauze daily and PRN every day shift, for skin integrity. The same POS documents:</p> <p>Cleanse open area to right heel, pat dry, apply medihoney and cover with bordered gauze daily and PRN, every day shift.</p> <p>R6's Specialty Physician Wound Care Follow-up Assessments, dated 5/9/24, documents R6's wounds as follows: Sacrum Stage III pressure Ulcer, Left Heel Stage II pressure ulcer, and</p> <p>Right Heel Deep Tissue Injury.</p> <p>On 5/16/24 at 10:22 am, V8, Registered Nurse (RN), stated she was notified the wound dressings on R6 Stage III sacrum pressure ulcer, Stage II Right Heel ulcer, and Right Heel Unstageable Deep Tissue Injury, came off during morning care. V9, Licensed Practical Nurse (LPN) assisted R6 in maintaining his right side lying position. R6's Sacrum Stage III pressure ulcer was open, red, raw, with scant yellowish colored drainage. R6 had red, fresh blood quarter sized spot noted on R6's incontinence brief. After cleansing, V8, RN, measured R6's sacrum pressure ulcer as follows: Length 2.5 centimeters (cm) by Width 1.5 cm by Depth .1 cm. V8, RN, applied medi-honey wound and burn ointment without using an applicator swab or tongue depressor. V8 squeezed the ointment directly into R6's opened, red, raw, Sacrum Stage III pressure ulcer wound and touched the wound bed and edges of the pressure ulcer with the open nipple tip of the ointment tube. V8 mashed the ointment with repetitive movement to pack the ointment into R6's Pressure ulcer with the open nipple tip contaminating the open nipple tip of the ointment tube. During the same pressure ulcer treatment, V8, RN, repeated the same cleaning process, then measured and applied the now contaminated medihoney ointment into the cavity of R6's Left Heel Stage II pressure ulcer and Right Heel Unstageable Pressure ulcer.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/16/24 at 10:42 am V8, RN, stated, This was such a silly mistake. I realize I should have used a (name brand cotton tip applicator) to apply the medi-honey. I was being pretty careful. I wanted to make sure I got a good amount into the wound beds (mashed contaminated ointment). I did contaminate the medihoney tube and continued treatment the treatments to (R6's) heels.</p> <p>On 5/16/24 at 11:58 am, V4, Regional Clinical Consultant Nurse, stated V8 should have used a separate applicator for each wound when applying the medihoney, to prevent cross contamination.</p> <p>The facility policy Skills Assessment Checklist, Aseptic Treatments/Dressing Changes dated 07/01/19 documents the following: Standard: Using accepted standards of practice, the nurse ensures the wound is cleansed and protected with a dressing; ensuring prevention of contamination, trauma to wound or periwound areas and promoting resident comfort during the procedure.</p> <p>The sameSkills Assessment Checklist, Aseptic Treatments/Dressing Changes protocol documents: Competency Assessed number 16 as follows: Performs treatment per physician's order; applying any topicals with a tongue depressor; loosely filling wound as required and covering wound with appropriate primary, secondary or tertiary dressing as ordered.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 31642</p> <p>Based on observation, interview, and record review, the facility repeatedly failed to document fluid intake and output according to facility policy and residents plan of care, for one of one resident (R156) reviewed for indwelling urinary catheters on the sample list of 27.</p> <p>Finding include:</p> <p>R156's Face Sheet documents R156 admitted to the facility on [DATE].</p> <p>R156's Diagnoses Sheet, dated as revised 5/16/24, documents the following: Chronic Kidney Disease Stage 3, Encounter for Fitting and Adjustment of Urinary Device, Bladder Neck Obstruction, and Diabetes Mellitus With Diabetic Chronic Kidney Disease.</p> <p>On 05/14/24 at 10:17 am, R156 had an indwelling urinary catheter and bedside drainage bag containing approximately 200 cc of clear, straw colored urine. V12, R156's Family Member, stated R156 had a urinary tract infection and was in a local and distant hospital before admission to this facility on 5/6/24.</p> <p>R156 (Distant Hospital) Neurocritical Care Admission History and Physical Note, Impression and Plan, dated 5/3/24 documents the following: Presentation included: R156 reported bothersome obstructive urinary tract symptoms and hematuria that spontaneously resolved upon admission with noted 51-150 count red blood cells. Urology consulted for assessment and treated. Due to cloudy urine in the indwelling urinary drainage bag with urine cultures obtained.</p> <p>R156's Care Plan, dated intervention 5/8/24, documents the following:</p> <p>The resident (R156) has 16Fr (French) /10cc (cubic centimeters) Indwelling Catheter (urinary): Bladder neck obstruction.</p> <p>The resident will remain free from complications through review date.</p> <p>Monitor and document intake and output.</p> <p>R156 Medication Administration Record 5/1/24- 5/31/24 and Treatment Administration Record, dated 5/1/24- 5/31/24, does not document fluid intake or output for R156's indwelling urinary catheter.</p> <p>R156's Nurse Progress Notes since Admission fail to document fluid intake and output each shift.</p> <p>R156's Certified Nursing Assistants Task Sheet documents fluid output measurement were only documented 6 of 36 shifts since R156's admission 5/6/24. There was no documentation of R156's fluid intake.</p> <p>On 5/16/24 at 10:50 am, V6, Licensed Practical Nurse, confirmed R156 electronic medical record does not document fluid intake or output each shift.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/17/24 at 11:40 am, V2, Director of Nursing, stated fluid intake and output for residents with indwelling urinary catheters is expected to be recorded each shift.</p> <p>The facility policy Intake and Output Measurement, dated 10/3/2011, documents the following:</p> <p>Policy: It is the policy of Christian Horizons to obtain accurate measurements of the resident's intake and/or output to assess fluid balance using the following guidelines.</p> <p>Procedure:</p> <p>Resident Requiring I/O (Input and Output)</p> <p>The following residents require measurement and general documentation guidelines of intake and/or output every eight hours, including a 24-hour total and weekly evaluation.</p> <ol style="list-style-type: none"> 1. All residents with indwelling catheters for a minimum of the first 14 days or as clinically indicated. (Output required) 2. All residents receiving enteral nutritional therapy. (Intake required) 3. All residents receiving hypodermoclysis or intravenous therapy. (Intake required) 4. All residents with specific physician's orders for measurement of intake and/or output. 5. All resident with an order for specific fluid management. (Intake required) <p>Intake Measurement</p> <ol style="list-style-type: none"> 1. Measure and record all liquids ingested. 2. Estimate and record all ice and food(s) that become liquid at room temperature. 3. When enteral nutritional therapy, or intravenous fluid is administered, record amount on individual record. 4. Intake is totaled every twenty-four hours. <p>Output Measurement</p> <ol style="list-style-type: none"> 1. Instruct resident to urinate in bedpan, urinal, or specimen container in toilet, and notify nurse. Measure urine and record amount on individual record. 2. If any bleeding, emesis, diarrhea or drainage occurs, measure and record as output. 3. Output is totaled every twenty-four hours.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34058</p> <p>Based on interview and record review, the facility failed to review their Infection Control policies annually. This failure has the potential to affect all 60 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's policy 'Infection Surveillance' was dated as approved 11/1/17. There were no further review or revision dates. The 'Guidelines for Infection Surveillance Procedures for Infection Preventionist' are dated (copied) 2020 (month unspecified).</p> <p>The facility's policy 'Antibiotic Stewardship' was dated as approved 11/1/17. There were no further review or revision dates.</p> <p>The facility's policy 'Antibiotic Stewardship and MDRO's' (Multi-drug Resistant Organisms) was dated as updated January 2023. The facility email provided by V1, Administrator, documents a Home Office review dated 3/31/23.</p> <p>The facility's policy 'Pneumococcal Vaccines' was dated 3/2022. There were no further review or revision dates. The facility's policy 'Covid Vaccination' was dated as approved 11/29/21. The email provided by V1, Administrator, documents a Home Office review for resident immunizations dated 2/15/23.</p> <p>On 05/16/24 at 11:20 am, V10, Infection Preventionist, stated, I asked (V1) Administrator and (V3) Regional Clinical Director regarding the infection control policy reviews but (V3) sent me the same policies that I already gave you, so no I do not have any documented proof that the policies are reviewed annually at the QA meetings.</p> <p>On 05/17/24 at 09:49 am, V1, Administrator, stated, Yes, (V10, Infection Preventionist) did make us aware of the concern about the Infection Control policy reviews and the only one we had located was the one influenza policy review, but the others we cannot locate a more recent review date. We are scheduling a QA (Quality Assurance) meeting for next week to do the reviews, but unfortunately I cannot make it happen any sooner.</p> <p>The facility's CMS (Centers for Medicare and Medicaid Services) Form 671, Long Term Care Facility Application for Medicare and Medicaid, dated 5/14/24, documents 60 residents reside in the facility.</p>		