STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A357	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Square	620 North Ottawa Avenue Dixon, IL 61021

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on interview and record review, the facility failed to obtain orders and implement treatments for wounds to a residents feet upon admission to the facility for 1 of 1 residents (R13) reviewed for pressure ulcers in the sample of 11. The findings include: R13's Nurse's Notes, dated 6/17/24, showed, (R13) was admitted to the facility on [DATE]. A skin assessment was done and charted. Will continue to monitor. R13's Admit Shower Sheet, dated 6/17/24, showed the left foot had a 1 cm (centimeter) open area to the inner foot; a 1 cm area to the right inner foot that did not say it was open; and a 2 cm x 1 cm area to the right heel. The shower sheet was signed by the nurse. R13's Admission Nursing Evaluation, dated 6/17/24, showed the following: 16) Left antecubital 3 cm x 3 cm bruise from IV (intravenous) site; 37) Right knee (front) 2 cm x 1 cm bruise; 38) Left knee (front) 24 cm long scar from knee surgery; 50) Left heel 2 cm x 1 cm necrotic area on heel; 51) Right toe(s) scab on outer area of big toe; and 52) Left toe(s) scab on outer area of big toe. R13's Physician Orders from 6/17/24 through 6/25/24 did not show any orders for treatments to R13's left inner and right inner foot or left heel. R13's Interim Care Plan, dated 6/17/24, showed he had an alteration in skin integrity - see body audit. Existing open areas will not worsen or show improvement in 14 days. Pressure reduction mattress, turn and reposition every 2 hours, treatments as ordered, reduce pressure of heels with pillows or heel protectors, body audits per protocol, monitor skin and notify skin nurse as needed. R13's Skin/Wound Note, dated 6/26/24 at 3:48 AM, showed, During care staff noticed redness and excoriation underneath his scrotum,on the right side, area cleaned and barrier cream applied. Resident was yelling that he was in pain. Also it was noted there is a necrotic area on his right [sic] heel (black scab) 3 cm long by 2 cm wide some new redness to surrounding skin, no drainage noted. R13's Nurse's Note, dated 6/26/24 at 4:37 PM, showed, Doctor notified of wound to left heel. Orders to offload and monitor and to have wound nurse follow progress. R13's Physician Orders, dated 6/26/24, showed air mattress for wound prevention. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Task Documentation in the computer showed on 6/26/24, V2, DON (Director of Nursing), created CNA (Certified Nursing Assistant) tasks to place bilateral heel boots on while in bed to relieve pressure. Pressure reducing device. R13's Physician Orders showed on 6/27/24 - wound orders for skin prep to right and left medial foot ulcers daily. No treatment other than offloading for the heel. R13's June 2024 Treatment Administration Record showed no interventions or treatments in place for R13's inner right foot, inner left foot, or left heel from 6/17/24 to 6/26/24. On 6/27/24 a treatment for R13's left heel was present and showed, wound care to stable unstageable ulcer to left heel. Off load bilateral heels with moon boots when in bed and reposition. This treatment was not marked as being completed on 6/27/24, 6/28/24, and 6/29/24. A treatment for R13's right medial foot showed skin prep daily, one time per day that was not signed off as being completed on 6/17/24, 6/28/24, and 6/29/24. R13's Nurse's Notes, dated 7/9/24, showed: At 3:01 PM, Blood noted on sock of left foot where heel wound is. Director of Nursing notified. Protective dressing applied, foot in protective boot and foot floating on pillow. At 5:26 PM - Notified provider of change in condition in wounds to left foot. Medical doctor gave orders for podiatry referral, supplements, and dressing orders. At 6:30 PM, Notified provider of drainage and odor of wound to left medial foot. Provider stated to start dressing treatments and podiatry will see for further treatment. R13's Physician Orders, dated 7/9/24, showed, Wound care to left medial foot stage 3 ulcer: 1. Cleanse wound with sterile saline; 2. Apply 2x2 soaked with betadine; 3. Cover with 4x4; 4. Wrap with roll gauze. Change twice a day, every day and night shift. Wound care to left heel pressure ulcer: 1. Cleanse wound with sterile saline; 2. Betadine to wound; 3. Cover with foam dressing. Change two times a day. R13's Wound/Skin Record showed: On 6/17/24 he had a left heel unstageable wound with eschar present that measured 2 cm x 1 cm. R13 had a diabetic ulcer to left medial foot that was scabbed and measured 1.5 cm x 0.5 cm. R13 had a diabetic ulcer to the right medial foot that was scabbed and measured 0.5 cm x 0.3 cm. On 7/9/24 left heel, unstageable ulcer with eschar present that measured 2.5 cm x 1.0 cm. Left medial foot, stage 3 pressure ulcer with slough present, surrounding skin dark in color, odor present, and measured 1.5 cm x 1.5 cm x 0.3 cm, The left medial foot was changed from being a diabetic wound on 6/17/24 to a pressure ulcer on 7/9/24. The right medial foot wound was resolved on 6/24/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 11:58 AM, V2, DON (Director of Nursing/Wound Care Nurse), stated, Skin assessments are done by the admitting nurse upon admission. They should document any alterations in skin like skin tears, bruises, wounds etc. They should document the assessment of the wound. They are capable of that. They should describe the wound. Here they document the wounds on a shower sheet and on the initial assessment. If they identify a wound the provider should be notified for treatment orders. The wound nurse should be notified. The nurses will do measurements and then I will do it. I expect them to get treatments. Usually after they tell me, within a day I will look at them (wounds), determine what the wound is, the stage of the wound, what it looks like, and document the appearance and measurements. Contact the doctor and get treatment orders. Put the treatments on the TAR. The treatments are marked off on the TAR to show they were done. Wound assessments are done weekly. V2 stated she knew R13 did not have any wound orders in place when he came in on 6/17/24. V2 stated, It looks like we don't have orders in place. His initial treatment was just to offload the heel because it was just eschar. That would be the treatment for that. You could do betadine but the doctor just said to offload. One of the medial wounds resolved, the right one. The left medial wound treatment was skin prep. I should have put the orders in right away. I didn't have the medial wounds to his feet as a stage because there was a scab. I though they were diabetic wounds at first. Even though he doesn't have any vascular problems, he does have type 2 diabetes that isn't being treated because they (family) don't want his diabetes treated. I staged it recently as a stage 3 pressure ulcer because it is open now. They notified me yesterday that the medial wound was open and draining. When I saw it yesterday, the medial wound had slough present so there was something hiding under the scab. I thought this was a [NAME] wound or something. I am not a wound expert. We don't have a wound doctor that comes here. His wounds are beyond my expertise now; his left foot medial wound is draining and bleeding; I don't know if the heel is. On 7/10/24 at 8:10 AM, the nurse on duty was notified that the surveyor would like to see R13's wound and dressing changes. At 8:27 AM, V2, DON (Director of Nursing), stated R13 was leaving at 8:45 AM for a podiatry appointment and had to get ready to leave. At 1:29 PM, V2 stated R13's dressings were already changed at the podiatrist office. No observations of the wounds could be made. The facility's Wound Care Protocol (6/10/24) showed, 1. Assessment: Evaluate the wound's size, depth, location, and tissue type. 2. Cleaning: Debride (remove dead tissue) and clean the wound with saline solution or sterile water. 3. Dressing: Apply an appropriate dressing to protect the wound, manage drainage, and promote healing. 4. Infection Prevention: Use antimicrobial agents and techniques to prevent infection. 5. Monitoring: Regularly assess the wounds progress and adjust the treatment plan as needed. Wound care protocols include: pressure ulcer protocol The facility was asked for the pressure ulcer protocol and it was not received.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 39543 Based on interview and record review, the facility failed to implement weight loss interventions for a resident with weight loss. This applies to 1 of 2 residents (R12) reviewed for weight loss in the sample of 11. The finding include: R12's Admission Record (Face Sheet) showed diagnoses to include depression, anxiety, and dementia. R12 weight history documentation showed a weight of 127 pounds on 4/2/24 and 115.2 pounds on 5/4/24. (The electronic charting showed this was a weight loss of 9.4 percent.) R12's next documented weight was on 6/4/24 and was 123.7 pounds. R12's weight documentation did not show weekly weights were done from 4/2/24 to 5/4/24. On 7/10/24 at 11:04 AM, V5 (Dietary Manager) stated, I requested a re-weigh for her May to June weight loss but it fell through the crack. Her weight did go back up in June. I did talk to [V2, Direcor of Nursing] about that (the weight not being done), that it is an issue, that she was not re-weighed. V5 stated she spoke to the facility's Dietitian, and she agreed R12 needed to be re-weighed. V5 said, I requested the re-weigh because it was a huge weight loss. She did have more than a 5 percent weight loss month to month. I also looked at her intakes because her intakes did not decrease. If the weight was accurate, I would have done a nutritional assessment, contacted the Dietitian, and developed creative ways to increase calorie intake, but I knew that weight was not accurate (despite having a weight to contradict this belief) .The [weight loss] interventions are important to prevent a further decline in weight. It's important to catch the weight loss early and to get interventions started right away to prevent further weight loss. The facility's Weight Loss policy showed weights should be done at least monthly. The policy also showed, . All residents with unintended weight loss should be placed on weekly weights. Do not wait for the physician to do so . The policy showed the physician and dietitian should also be notified of the weight loss.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 20042 Based on observation, interview, and record review, the facility failed to ensure a resident was provided his prescribed mechanically altered diet and thickened liquids for 1 of 1 residents (R4) reviewed for mechanically altered diets in the sample of 11. The findings include: On 7/9/24 at 11:40 AM, R4 was sitting in his wheelchair at the dining room table for lunch. R4 had minced chicken strips with liquid in the bowl, thin sliced raw carrots with onions and a dressing in a small bowl, a whole brownie, soup in a cup, juice (in 12 ounce cup) and thickened water (in 12 ounce cup). At 11:47 AM, V9 (CNA/Certified Nursing Assistant) was at R4's table assisting him with his meal. V9 gave R4 a bite of chicken on a spoon and asked him if he swallowed it. R4 lifted the next bite of chicken from his bowl himself. V9 stated, (R4) is on a mechanical soft diet, but needs liquids mixed with his food. V9 stated R4 had chicken that is chopped and mixed with gravy, a brownie that is regular that she would put in a bowl with some milk. V9 stated the carrots in the small bowl were shredded and in some type of liquid. V9 stated stated the carrots were hard and crunchy. V9 stated the liquid in a coffee cup was a florentine soup. The resident had thickened water. The tall glass of juice at the table was a thinner consistency. V9 stated she had put one packet of nectar thick liquid thickener in the (12 ounce) glass of juice, but it wasn't as thick as the water. V9 stated she did not know what the consistency of R4's drinks were supposed to be. At 11:57 AM, R4 was coughing and trying to clear his throat. V9 was patting R4 on the back telling him to just try and breathe. V10 (RN/Registered Nurse) came into the dining room to check on R4, and V9 stated R4 was coughing on water. On 7/9/24 at 12:13 PM, V5 (Dietary Supervisor) stated R4 was on a moist minced diet for his meat and mechanical soft for the rest of his food. V5 stated R4 was on nectar thick liquids. V5 stated she has juice, milk, and water that they purchase that is already nectar thick. V5 stated she had packets of thickener available to mix in coffee if a resident wanted coffee. V5 stated R4 was at risk for aspiration and chokes on everything. V5 stated R4's carrots should have been diced; they were hard. V5 stated she would have never served those (carrots - copper penny salad) to him. V5 stated there was a diet card on his tray that states what kind of diet he is on. The CNA's know that and can look to see what their diet is in the computer. On 7/9/24 at 12:55 PM, V5 brought a packet of instant thickener - mildly thick nectar thick and stated R4's juice was in a 12 ounce cup, so it should have had three of the packets of the thickener mixed in. in it. V5 stated R4's juice was not thickened correctly and should have been nectar thick; it is what the doctor ordered. V5 stated the purpose of following the nectar thick liquid for a resident was so the resident could adequately consume liquids in a safe manner. V5 stated she had pre-thickened juices, milk, and water available. The thickener packet should really only be used if a resident wanted a cup of coffee. V5 presented R4's diet card and it stated his diet was minced moist; no beef; grind meat and drown in juice or gravy. Use ketchup for hot dogs. V5 stated R4's diet card should show that he is on a mechanical soft diet and nectar thickened liquids. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Orders for R4 showed on 6/20/24 an order for a regular diet, mechanical soft texture, thick consistency, nectar thick liquids; minced; moist. R4's Nutrition/Dietary Assessment completed by the Registered Dietician on 6/22/24 showed Feeding aids needed: consistency modified. Diet order/progression: general mechanical soft and nectar thick consistency. R4's Care Plan, dated 6/24/24, showed, R4 is on a regular diet, minced and moist texture, nectar thick liquids; R4 will receive his diet as ordered. R4 will be free from aspiration through review date. R4's Face Sheet, dated 7/10/24, showed diagnoses including aphasia following cerebral infarction, dementia, type 2 diabetes mellitus, urinary tract infection, hypertension, hyperlipidemia, gastro-esophageal reflux disease, hypothyroidism, and other sequelae of cerebral infarction. The facility's Therapeutic Diet Policy (5/27/24) showed, Objective: Enhance resident health through appropriate nutrition. Scope: All residents requiring therapeutic diets as prescribed by healthcare professionals. Training and Education - staff training: provide regular training for dietary and nursing staff on therapeutic diet requirements, food safety, and handling resident dietary preferences. Monitoring and Evaluation: Regular Assessment: Monitor residents' nutritional status and adherence to prescribed diet. The Diet and Nutrition Care Manual (2019) that V5 stated on 7/9/24 at 2:31 PM that she uses as a working policy/guide showed, Dysphagia Advanced (Level 3) or Mechanical Soft Diet: This diet is used for individuals with mild oral and/or pharyngeal phase dysphagia. Foods that are difficult to she are chopped, ground, shredded, cooked, or altered to make them easier to chew and swallow. Food should be prepared according to individual tolerance to the food. Any foods that are very hard, sticky, chewy, or crunchy should be avoided. Fluids (especially water) at ordered thickness. Foods Allowed: Vegetables - should be soft, well cooked and chopped if needed. May substitute cooked vegetables or juices for difficult to chew items. Foods to Avoid: raw vegetables (except shredded lettuce). Cooked rubbery or non-tender cooked vegetables. The Dysphagia Mechanically Altered (Level 2) or Mechanical Soft Diet: This diet is for people with mild to moderate oral and/or pharyngeal dysphagia. Some chewing ability is required. Difficult to chew foods are chopped, ground, shredded, cooked, or altered to make them easier to chew and swallow. Fluids (especially water) at ordered thickness. Vegetables should be soft, well cooked and easily mashed with a fork. Foods to avoid: Raw vegetables (including lettuce) The sample daily meal plan for a well balanced dysphagia mechanically altered (Level 2) or mechanical soft diet (similar to minced and moist) showed pureed or soft cooked vegetables, pureed or baked soft fruits, and chopped meat with gravy or other sauce like tartar sauce for fish.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39543 Based on observation, interview, and record review, the facility failed to handle mechanically altered food in a manner to prevent cross-contamination. This applies to 2 of 2 residents (R4 and R12) reviewed for dietary services in the sample of 11 and 4 residents (R7, R9, R11, and R16) outside the sample. The findings include: The plating of the 7/9/24 lunch service was observed from its initiation through its completion (11:17 AM until 11:30 AM) On 7/9/24 at 11:17 AM, V7 (Cook) was plating all meals including mechanical soft diets. During the plating, V7 touched numerous surfaces including oven handles, door handles, and the handle for the tray cart. V7 did not change her gloves when going from these high touch surfaces and then back to serving lunch. During the lunch service, V7 would use her gloved right hand, the same gloved hand that contacted door handles, to touch the residents' mechanical soft chicken tenders. V7 scooped the chicken with her gloved hand and placed it in the ladle. On 7/10/24 at 9:24 AM, V5 (Dietary Supervisor) stated, Staff should not be handling food after touching high touch surfaces like door handles, due to cross contamination. Gloved hands often give the staff a false sense of security that they are protecting the residents when they handle their food. On 7/10/24 at 9:30 AM, a policy for the safe handling of food was requested and not provided.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 35175 Based on observation, interview, and record review, the facility failed to accurately submit payroll-based journal hours. This has the potential to affect all 16 residents. The findings include: The facility's 7/9/24 application for Medicare and Medicaid showed 16 residents in the health center. The Centers for Medicare and Medicaid Services (CMS) payroll-based journal (PBJ) report for January 1-March 31, 2024, showed the facility failed to have licensed nursing coverage 24 hours per day. This report specifically showed 1/13, 1/20, 1/28, 2/3, 2/11, 3/2, 3/7, 3/10, 3/17, and 3/24/24 as the dates not having coverage. The facility's first floor has sheltered care beds. The second floor has certified beds. The second-floor health center had a notice posted on the bulletin board dated 7/1/24, that showed this facility does not currently meet the minimum staffing ratios required by law. Posted at the direction of the Illinois Department of Public Health. On 07/09/24 at 10:24 AM, V2 (Director of Nursing/DON) said there is always a nurse on duty. On 7/9/24, V1 (Administrator) said there is always licensed nurse coverage 24 hours per day. The PBJ report reflects data entry errors. At 2:10 PM, V12 nurse and V10 (Registerred Nurse/RN) said there was always a nurse on duty. At 2:20 PM, V4 (Bookkeeper) said she submits the PBJ data, but the previous bookkeeper submitted the data in question. V4 said she uses the timesheet data to input the information. We always have a nurse working upstairs (health center). On 07/10/24 at 8:00 AM, V1 provided a signed contract with a third-party vendor to be responsible to submit PBJ data going forward. V1 said the PBJ report showed data submission errors not staffing deficiencies. At 8:30 AM, V4 said, It's important to submit accurate PBJ staffing data to ensure adequate staffing levels are achieved on all shifts for resident required care. The information was not submitted correctly in the report to CMS. The facility staff schedules, and licensed nurse time reports were reviewed for the above dates. The facility was able to show there was licensed nurse coverage 24 hours a day. The facility's 5/31/24 Staffing Policy showed they will meet or exceed the minimum requirements set forth by the Illinois state regulations.

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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. 20042 Based on observation, interview, and record review, the facility failed to doff (remove) personal protective equipment (PPE) for enhanced barrier precautions inside of the residents room for 1 of 2 residents (R4) reviewed for infection control in the sample of 11. The findings include: R4's Physician Orders showed orders, dated 6/18/24, for feeding tube care, flushes, and feedings. May use use enhanced barrier precautions per policy as needed for indwelling medical devices R4's Care Plan, dated 6/24/24, showed he is on EBP related to his feeding tube. R4 will have no negative effects from enhanced barrier precaution isolation protocol. R4's Face Sheet, dated 7/10/24, showed diagnoses including aphasia following cerebral infarction, dementia, type 2 diabetes mellitus, urinary tract infection, hypertension, hyperlipidemia, gastro-esophageal reflux disease, hypothyroidism, and other sequelae of cerebral infarction. On 7/9/24 at 9:19 AM, the sign on the door to R4's room showed he had EBP (enhanced barrier precautions) in place. The sign showed providers and staff must wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, changing linens, providing hygiene, changing briefs, assisting with toileting, and device care or use (central line, urinary catheter, feeding tube, tracheostomy, and wound care). V9 (CNA/Certified Nursing Assistant) and V8 (CNA) were wearing personal protective equipment (gowns and gloves) in R4's room and used a stand lift to transfer R4 to the toilet. V10 (RN/Registered Nurse) came to R4's room with a gown and gloves on to give R4 his medications when R4 was on the toilet. V10 stated she would wait to give his medications since R4 was on the toilet. V10 removed her gown and stated she was going to hang it up in the room. V10 looked for a hook on the back of the door to R4's room. V9 said they are supposed to use a new gown each time. V10 asked V8 and V9 if their was a container for the soiled cloth isolation gowns in the room. V8 and V9 stated, No. V10 stated there was supposed to be one in the room. V9 provided pericare after the resident was finished on the toilet, and V8 operated the stand lift. R4 was transferred to bed by V8 and V9. At 9:30 AM, V8 removed her gown inside R4's room and placed it in a clear plastic bag. V9 walked out of the room with her gloves and gown on, opened the isolation container drawer outside of the room, grabbed a yellow bag, removed her gown and gloves, and put them in the bag. V9 stated there is supposed to be something in the room for her to discard the gown because they should be close to the sink to wash their hands. V9 stated they should dispose of the gown in the room so they don't bring anything out into the hall; so there is no contamination. On 7/9/24 at 9:51 AM, V10 (RN) stated R4 was on EBP because he has a feeding tube and his roommate has a pressure ulcer to his foot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 11:43 AM, V2 (DON/Director of Nursing) stated, EBP are put in place for a resident that is at risk of contracting a disease because they have a feeding tube, wounds, etc Staff should put gloves and gown on for direct patient care such as dressing, bathing, toileting, and wound care. After the care is provided, staff are to discard the gown in a bin in the resident's room. The dirty PPE is discarded in the room for infection control so staff are not taking the infection out into the hall. The facilities Enhanced Barrier Precautions policy (2024) showed, Implementation of Enhanced Barrier Precautions: c. Position trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.