STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDENVIEW MANOR	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist one resident (R2) to get up in his electric wheel chair. R2 is one three residents reviewed for ADL (Activities of Daily Living) care in a sample list of three residents. Findings Include: R1's progress note by V8, Nurse Practitioner (NP), dated 2/23/20, documents readmit to facility s/p (after) hospitalization for distal femur fracture s/p (after) a fall from his wheelchair while at the (Clinic). R1's Care Plan, reviewed 8/12/20, includes the following Diagnoses: [REDACTED]. R1's care plan also documents, two person assist with transfers using the (sling type mechanical lift). R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact. On 9/30/20 at 12:10PM, R1 was lying in bed in his room. R1 stated, I want to get up and sit in my electric wheel chair. I have asked many times and the staff refuse to get me up. I feel like all I ever do is lay here in bed and look out the window or watch television. I eat all my meals in bed. They won't get me up. They say it is because they are afraid I will fall again. I think I might just die without ever getting out of this bed. On 10/1/20 at 1:41PM, V10, R1's family member, stated, They (facility staff) say (R1) refuses, but I have been listening on the cell phone when (R1) asks to get up and I have heard them (facility staff) tell (R1) he can't be up in his chair. On 9/30/20 at 12:30PM, V9, Licensed Practical Nurse (LPN), stated, No (R1) doesn't get out of bed any more. I think it is because they (management) are afraid he will fall again. (R1) fell out of the (sling type mechanical lift) a while ago and broke his hip. Then not too long after that he was at a doctor's appointment and slipped out of his chair and broke his femur. I guess everyone is just afraid he will get hurt again. On 10/3/20 V2, Director of Nursing (DON), stated, (R1) has fallen with major injuries twice. He is alert and oriented and can tell you what he wants. I can agree that he needs to be up to prevent his ADL's from declining. I don't see where there is any documentation that he refuses to get up except from August and I can't tell who documented this or when it was documented. R1's behavior symptom tracking tool, labeled August 2020, indicates an R on all days on the sheet. However, there is no indication of who documented this or what time of day it was documented. R1's Care Plan, reviewed 8/12/20, does not indicate R1 refuses to get up. There is no documentation in R1's progress notes to indicate R1 refuses to get up.
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** Based on interview and record review, the facility failed to complete and document nursing assessments of multiple pressure ulcers for one resident (R2) of three residents reviewed for wounds in a sample list of three residents. Finding include: R2's Care Plan, revised 8/31/20, includes the following Diagnoses: [REDACTED]. R2's Wound Progress Notes from 3/3/20 to 9/30/20 document R2 has had a total of 23 pressure related wounds ranging from Stage II to Stage IV. R2's wound progress notes from 9/30/20 documents R2 currently has two Stage IV and three Stage III pressure ulcers. The Wound Progress Notes are documented by V6, Wound Physician. There are no Wound Progress Notes documented from 3/10/20 until 3/24/20. R2 progress notes document R2 was hospitalized from [DATE] until he returned to the facility 3/18/20. There is no Skin/Wound assessment documented from 3/18/20 until V6 documented 3/24/20. R2 is documented as having eleven pressure areas as of 3/10/20. R2's Wound Progress Notes by V6 for 3/24/20 document that at that time R2 had thirteen pressure ulcers. There is no documentation to indicate when R2 developed the two additional pressure ulcers. In addition there were no wound assessments documented between 6/10/20 and 6/24/20. R2's Treatment Administration Sheet (TAR) for September 2020 documents R2's dressing to the five current pressure sores are scheduled to be completed every Monday, Wednesday, and Friday and PRN (as needed). Although the dressings are documented as completed by the licensed nursing staff per R2's TAR, there is no wound assessment documented in R2's medical record. On 10/2/20 at 1:00PM, V2, Director of Nursing (DON), stated, (R2) was in the hospital from 3/13/20 until 3/18/20. There was no admission wound assessment when (R2) returned. The first wound assessment after (R2) returned from the hospital was 3/24/20 when (V6) made rounds. V2 was unable to explain the absence of wound assessment documentation from 6/10/20 to 6/24/20. V2 verbalized V4, Licensed Practical Nurse (LPN), is the current wound nurse and is responsible for documenting weekly wound assessments. V2 stated (V4) has been responsible for wound documentation a short time. The previous nurses who were responsible went back to floor nursing after management discovered the lack of documentation.

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