STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145183	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL MANOR	620 WARRINGTON AVENUE DANVILLE, IL 61832

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on interview and record review the facility failed to follow up on issues and resolve issues discussed in the resident council meetings. These failures affect 13 of 13 residents (R25, R68, R36, R49, R45, R11, R35, R44, R16, R33, R9, R15, and R2) reviewed for resident council concerns on the sample list of 43 residents. Findings include: The undated list documents R25, R68, R36, R49, R45, R11, R16, R35, R33, R44 and R9 attended the January Resident Council Meeting. The Resident Council Meeting Minutes dated January 2020 (January 28, 2020) document unresolved issues as food arriving cold especially the soups and Pork too tough to chew. The January 2020 Resident Council Meeting Minutes document new issues as leaving food carts in the hallways after dietary brings them, nurses aides discussing non care topics amongst themselves in resident rooms and call lights being turned off with staff stating they will be back and then they don't return. The undated list documents R25, R68, R36, R49, R45, R11, R35, R44, R9, R15 and R2 attended the February Resident Council Meeting. The February 2020 (February 20, 2020) Resident Council Meeting Minutes document the issues discussed in the January resident council meeting are still unresolved and the meeting minutes do not document follow up or a plan to resolve the resident's concerns discussed in the January Resident Council Meeting. On 3/3/20 at 11:00 am R68, R45 and R36 stated they attend the resident council meetings regularly. R68, R45 and R36 stated residents bring up concerns about the food, long wait times for assistance, and staff ignoring their requests for help during the resident council meetings but staff do not provide the council with solutions for their concerns or updates on resolving the issues. R45 stated nothing gets done. On 3/3/20 at 12:00 PM V10 Activity Director stated when the resident council has a concern V10 fills out a concern form and gives it the the appropriate department head for resolution of the issue. V10 stated the department heads should write the follow up and plan to resolve the issue on the form and return it to V10 so V10 can report back to the resident council. V10 confirmed some of the resident council concerns have been ongoing for several months. On 3/3/20 at 1:40 PM V10 provided concern forms dated 1/28/20 from the January Resident Council Meeting regarding call lights being turned off with staff not providing help, staff leaving dietary carts in the hall for long periods of time allowing the food to cool, and the pork being too tough. None of the forms document any follow up, plan or resolution for the issues. V10 stated the department heads do not always give the concern forms back to V10 so V10 does not know what is being done to resolve the issues. V10 stated V10 could not provide documentation V10 reported the status of the Resident Council's concerns from the January 2020 meeting to the Resident Council during the February 2020 meeting. On 3/3/20 at 1:55 PM V1 Administrator stated the department heads should return the completed concern forms to V10 within 10 days and V10 should report the status of concerns to the resident or the resident council at the next meeting. The Grievances policy dated 11/28/16 states The facility will make prompt efforts to resolve grievances that the residents may have.
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 observation, interview, and record review, the facility failed to obtain pressure ulcer measurements upon identification and upon readmission, failed to notify the physician and obtain treatment orders for a newly identified pressure ulcer, and failed to implement pressure relieving interventions for one of three residents (R52) reviewed for pressure ulcers in the sample list of 43. Findings include: R52's Face Sheet dated 3/3/20 documents R52 admitted to the facility on [DATE] and has [DIAGNOSES REDACTED]. R52's Admission MDS (Minimum Data Set) dated 12/31/20 documents R52 uses extensive assistance of two staff for transfers and bed mobility. This MDS documents R52 is at risk for developing pressure ulcers and R52 admitted to the facility with one stage one and three stage two pressure ulcers. R52's MDS dated [DATE] documents R52 has severe cognitive impairment and uses extensive assistance of two staff for bed mobility and transfers. This MDS documents R52 has two stage 3 pressure ulcers and two unstageable pressure ulcers. R52's Skin Risk assessment dated [DATE] documents R52 is at high risk for developing pressure ulcers. R52's Care Plan revised on 3/3/20 documents R52 has impaired skin integrity with MASD (Moisture Associated Skin Damage) to bilateral buttocks and left and right Diabetic heel ulcers. This Care Plan documents interventions to have an air mattress on bed, chair cushion, and heel lift boots on while in bed for pressure reduction. R52's Order Summary Report dated 3/3/20 documents a physician order [REDACTED]. R52's Admission Nursing Assessment and Care Plan dated 12/24/19 documents R52 admitted to the facility with shearing/open areas to R52's left and right buttocks. There is no documentation in R52's medical record that R52 admitted to the facility with bilateral heel wounds. R52's Ulcer/Wound Documentation report dated 12/29/19 documents R52 had a Stage two pressure ulcer to the left buttock that measured 3.5 cm (centimeters) long by 3 cm wide by 0.1 cm deep and a Stage two pressure ulcer to the right buttock that measured 4 cm long by 2.5 cm wide by 0.1 cm deep. This report documents R52 had a suspected deep tissue injury to bilateral heels described as redness initially identified on 12/29/19. R52's Ulcer/Wound Documentation report dated 12/31/19 documents R52 had a blister/stage two pressure ulcer to R52's right heel that measured 1.8 cm long by 2.4 cm wide, and a stage one pressure ulcer to the left heel that measured 2.8 cm long by 3.5 cm wide. There is no documentation in R52's medical record that R52's bilateral heel deep tissue injuries were measured until 12/31/19. R52's Nursing Note dated 12/31/19 at 3:21 PM by V12 Wound Nurse documents a blister was observed to R52's right heel and redness to R52's left heel. V12 notified V16 Nurse Practitioner and received orders to apply skin prep to R52's bilateral heels twice daily. There is no documentation in R52's medical record that V8 Nurse Practitioner or V11 Physician were notified of R52's heel wounds until 12/31/19 (two days after the heel wounds were identified.) R52's TAR (Treatment Administration Record) dated 12/1-12/31/19 does not document a treatment was administered to R52's bilateral heel wounds. R52's TAR dated 1/1-1/31/20 documents a treatment order to apply skin prep to R52's right and left heel wounds was initiated on 1/1/20. R52's Admission Nursing Assessment and Care Plan dated 2/22/20 documents R52 readmitted to the facility with a stage two pressure ulcer to the coccyx, a left heel ulcer, and right heel ulcer. This assessment does not document measurements of R52's wounds to the coccyx and bilateral heels. There are no documented measurements of R52's wounds in R52's medical record until 2/25/20 (3 days after R52 readmitted to the facility.) R52's Ulcer/Wound Documentation report dated 2/25/20 documents R52's left heel wound measured 5 cm long by 5 cm wide with undetermined depth, right heel wound measured 3.6 cm long by 5 cm wide by undetermined depth, left buttock wound measured 5 cm long by 3.2 cm wide by 0.1 cm deep and right buttock wound measured 9 cm long by 3 cm wide by 0.1 cm deep. This report documents R52's bilateral heel ulcers contained eschar (dead tissue.) R52's Ulcer/Wound Documentation report dated 3/3/20 documents R52's right heel wound measured 2.4 cm long by 4 cm wide by undetermined depth and R52's left heel wound measured 3.2 cm long by 4.2 cm wide by undetermined depth. This report documents R52's bilateral heel wounds contained eschar. R52's Nursing Note dated 3/3/20 at 1:49 PM by V12 Registered Nurse/Wound Nurse documents V12 assessed and changed R52's dressings today on weekly wound rounds. This note documents R52 had an open area on R52's left buttock that measured 0.5 cm by 0.2 cm. On

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

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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 3/2/20 at 11:24 AM V13 (R52's spouse) stated R52's bilateral heel wounds developed at the facility and the wounds worsened when R52 was in the hospital. V13 stated R52 is suppose to have a pressure relieving cushion in R52's wheelchair and recliner, and an air mattress on R52's bed. V13 stated hospice ordered a cushion for R52's wheelchair and an air mattress a week ago, but the cushion and air mattress haven't arrived yet. Located on the seat of R52's spare wheelchair was an air mattress inside of a bag. There was no air mattress observed to be on R52's bed. R52 was sitting in R52's wheelchair and R52's wheelchair did not contain a cushion. On 3/3/20 at 9:21 AM R52 was sitting in a wheelchair in the dining room. R52's wheelchair did not contain a cushion. On 3/4/20 at 12:35 PM R52 was sitting in a wheelchair in the dining room with V13. R52's wheelchair did not contain a cushion. On 3/3/20 at 11:48 AM V12 Wound Nurse and V14 CNA (Certified Nursing Assistant) entered R52's room. R52 was lying in bed and there was no air mattress on R52's bed. R52's wheelchair did not contain a cushion. V12 removed the dressings to R52's bilateral heel wounds, cleansed, and measured the wounds. There was black eschar covering R52's left and right heel wounds. V12 applied an antimicrobial dressing, gauze, and a gauze wrap to R52's left heel. V12 applied Sodium Chloride soaked gauze and a gauze wrap to R52's right heel. V12 and V14 assisted R52 onto R52's right side and removed R52's incontinence brief. There was reddened area to R52's bilateral inner buttocks, and an open area to R52's left buttock. On 3/3/20 at 12:16 PM V12 stated R52's bilateral heel wounds developed at the facility and started out as stage two pressure ulcers/blisters. V12 stated R52 is suppose to have an air mattress on R52's bed and a cushion in R52's wheelchair. V12 stated the facility was using an air mattress on R52's bed prior to R52 being admitted to the hospital in February 2019. V12 stated R52 returned to the facility on hospice, and hospice was suppose to deliver an air mattress and a geriatric chair with a built in pressure relieving cushion. On 3/4/20 at 9:48 AM R52 was lying in bed. R52 was not wearing pressure relieving boots. R52's pressure relieving boots were sitting in R52's wheelchair. V15 CNA confirmed R52 was not wearing pressure relieving boots. V15 stated V15 thought R52 wore pressure relieving boots only when R52 was in the wheelchair. On 3/4/20 at 2:05 PM V2 Director of Nursing stated R52's wounds were not measured when R52 readmitted to the facility on [DATE] and were not measured until 2/25/20 (3 days after R52 readmitted to the facility.) V2 stated R52 should have pressure relieving boots on when R52 is in bed. V2 stated R52 had an air mattress and cushion in R52's wheelchair prior to admitting to hospice, but the facility thought hospice was providing an air mattress and wheelchair cushion. V2 stated V2 was not sure why the air mattress in R52's room was not applied to R52's bed. On 3/5/20 at 1:50 PM V1 Administrator confirmed there is no documentation that R52's bilateral heel wounds were measured upon identification on 12/29/19 and V8, Nurse Practitioner or V11 Physician were notified. V1 confirmed a treatment order for R52's bilateral heel wounds was not initiated until 1/1/20 (3 days after the wounds were identified.) V1 stated when a wound is identified the nurses are to assess the wound, obtain measurements, and notify the practitioner to obtain treatment orders. The facility's Wound and Ulcer Policy and Procedure revised on 10/1/2018 documents residents with existing pressure ulcers will be considered as high risk for impaired skin integrity. This policy documents that a specialty mattress with enhanced pressure reducing/relieving properties may be placed on the resident's bed and chair. This policy documents that when a resident is found to have a wound upon admission or during their stay the nurse will document an assessment of the wound, notify the physician and initiate treatment orders. This policy documents a suspected deep tissue injury is a discoloration of intact skin or a blood-filled blister due to damage caused by pressure and/or shearing and the wound can evolve and become covered by eschar. This policy documents when a suspected deep tissue injury is identified the facility should implement pressure relief to the affected area, and apply a skin protectant wipe covered by a dry dressing.
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** Based on observation, interview, and record review, the facility failed to implement post fall interventions and investigate a fall to determine the root cause for one of four residents (R12) reviewed for falls in the sample list of 43 Findings include: R12's Face Sheet dated 3/4/20 documents R12's [DIAGNOSES REDACTED]. R12's Minimum (MDS) data set [DATE] documents R12 has severe cognitive impairment and uses extensive assistance of two staff for transfers. R12's Care Plan revised on 2/11/20 documents R12 is at risk for falls r/t (related to) left side weakness, limited mobility, [MEDICAL CONDITIONS] med (medication), and hx (history of) fall. This Care Plan documents interventions dated 2/13/20 to continue with current interventions, beveled mattress. Low bed, fall mat, bed alarm on bed and upper side rails x 1 to enable bed mobility. Left side rail tied down for safety. R12's Fall Risk assessment dated [DATE] documents R12 is at high risk for falling. The facility's Occurrence Report dated 2/2/20 documents at 7:30 PM R12 was found lying on R12's left side on the floor mat next to R12's bed. This report documents Alarm-None under the category of preventative measures at the time of R12's fall. This report documents the root cause of R12's fall as (R12) reports (R12) was sleeping and rolled out of bed and a recommendation to continue with low bed, beveled mattress and fall mats. The facility's Occurrence Report dated 2/7/20 documents at 7:10 PM R12 was found lying on R12's left side on the floor mat next to R12's bed. This report documents Alarm-None under the category of preventative measures at the time of R12's fall. This report documents a recommendation for the left side rail to be tied down to prevent injury. The facility's Occurrence Report dated 2/14/20 documents at 4:05 AM R12 was found lying on R12's right side on the floor mat next to R12's bed. This report documents Alarm-None under the category of preventative measures at the time of R12's fall. This report documents (R12) has been very behavioral lately, yelling out frequently for long periods. Root cause: (R12) used bed rail to pull self out of bed onto floor for attention as (R12) has beveled mattress. This report documents a recommendation that the left side rail was tied down and R12 already has a low bed and beveled mattress. The facility's Occurrence Report dated 2/29/20 documents at 12:17 AM R12 was found lying on the floor mat next to R12's bed. This report documents Alarm-None under the category of preventative measures at the time of R12's fall. This report does not document the root cause of R12's fall or any post fall interventions implemented. On 3/02/20 at 9:28 AM R12 was lying in R12's bed low to the floor with a mat positioned next to the bed. There was no alarm on R12's bed. On 3/02/20 at 1:10 PM V18 (R12's Family Member) stated R12 has had four falls and V18 is worried that R12 is going to get injured from falling. V18 stated R12 is suppose to have R12's bed in low position at all times. On 3/03/20 at 10:40 AM V15 Certified Nursing Assistant (CNA) entered R12's room to provide incontinence care. R12 was lying in bed with R12's bed low to the floor and there was no alarm on R12's bed. V15 stated there is no alarm on R12's bed, R12 used to have one but it wasn't working and V15 was not sure if someone had removed it. On 3/04/20 at 1:26 PM R12 was sitting up in bed eating lunch. R12's bed was elevated and not low to the floor. There was an overbed table positioned over R12's bed and there was no mat beside the bed. There was no staff or family present in R12's room. On 3/4/20 at 1:30 PM V14 CNA stated the staff keep R12's bed elevated while R12 is eating. V14 stated the staff lower the bed and place the fall mat on the floor when R12 is finished eating. On 3/03/20 at 4:10 PM V2 Director of Nursing stated no new interventions were implemented following R12's falls on 2/2/20 and 2/14/20. V2 stated R12 was already using a beveled mattress, low bed, and fall mats prior to R12's fall on 2/2/20. V2 stated the left side rail on R12's bed was tied down following R12's fall on 2/7/20. V2 stated R12 no longer uses a bed alarm and that intervention should have been removed from R12's care plan. On 3/4/20 at 2:10 PM V2 stated the fall investigation for R12's fall on 2/29/20 was incomplete and does not identify a root cause or post fall interventions. The facility's Fall Assessment and Management Policy revised on April 2019 documents the facility will assess each resident's fall risk and help facilitate an interdisciplinary approach for care planning to monitor, assess, and reduce risk for injury. The care plan will include factors related to the resident's fall risk and will be person centered to reflect the needs of the resident. This policy documents interventions will be based on fall risk assessments and the circumstances surrounding the risk for and actual injuries and falls. This policy documents a nurse will consult with the resident's care givers and interdisciplinary team to identify interventions and risk factors, and include the resident and family in the care planning process.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to dispose of discontinued medication for one of one residents (R47) reviewed for medication storage on the sample list of 43 residents. Findings include: The physician's

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) orders [REDACTED]. On 3/4/20 at 2:59 PM the East Hall medication room was observed with V5 Licensed Practical Nurse. At that time an unopened bottle of 30 ml of [MEDICATION NAME] 2 mg/ml was present in the refrigerator labeled with R47's name. V5 stated R47 does not have a current order for the [MEDICATION NAME]. V5 stated the [MEDICATION NAME] needed to be wasted. On 3/5/20 at 9:00 am V2 Director of Nurses confirmed the order for R47 to have [MEDICATION NAME] was discontinued in August (2019). V2 stated the medication should have been disposed of by the nursing staff when it was discontinued. The undated Storage of Medication policy states All discontinued/expired medications are to be removed from the active storage/medication use area and All discontinued/expired controlled substances are to be destroyed in the facility.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to administer medications according to physician orders [REDACTED]. The facility had two medication errors out of twenty five opportunities for error, resulting in an 8 percent medication error rate. Findings include: 1. R38's Order Summary Report dated 3/4/20 documents an order for [REDACTED]. is less than 60 BPM (Beats Per Minute.) R38's Medication Administration Records (MAR) dated 2/1-2/29/20 and 3/1-3/31/20 documents R38 received [MEDICATION NAME] 3.125 mg twice daily, but does not document R38's pulse was checked prior to administering [MEDICATION NAME]. There is no documentation in R38's medical record that R38's pulse was being obtained prior to administering [MEDICATION NAME]. On 3/3/20 at 9:30 AM V6 Registered Nurse administered [MEDICATION NAME] 3.125 mg to R38. V6 did not check R38's pulse prior to administering [MEDICATION NAME]. On 3/3/20 at 9:35 AM V6 confirmed V6 had not checked R38's pulse prior to administering [MEDICATION NAME]. V6 stated we (the nurses) don't check (R38's) pulse before giving [MEDICATION NAME]. There is no order to check (R38's) pulse. On 3/04/20 at 3:30 PM V2 Director of Nursing confirmed R38's physician order [REDACTED]. 2. R28's Order Summary Report dated 3/4/20 documents an order for [REDACTED]. On 3/4/20 at 11:58 AM V7 Licensed Practical Nurse administered 2 units of [MED] [MEDICATION NAME] Solution 100 units/ml into R28's left deltoid (shoulder muscle). V7 did not pinch R28's skin prior to administering the [MED]. On 3/4/20 at 12:02 PM V7 confirmed V7 administered R28's [MED] into the deltoid and not the posterior fatty part of the arm. On 3/04/20 at 3:30 PM V2 Director of Nursing stated when giving a subcutaneous injection in the arm, the injection is to be given in the posterior fatty part of the arm. V2 stated the deltoid is considered an IM (Intramuscular) injection site. The facility's Injections-Subcutaneous policy revised on 11/5/09 documents the objective is To inject medication into the subcutaneous tissue as ordered by a physician. 3. Select site for administration. Check site rotation documentation prior to injection. (Favorite sites are the exterior surfaces of the upper arms, the back and the lateral aspects of the thigh, or abdomen. When injecting into the abdomen you should be at least one inch from from the umbilicus in all directions.) 6. Inject needle by pinching skin between thumb and forefinger and then firmly and quickly inserting the needle through all layers of skin. The facility's Intramuscular (IM) Injections policy revised on February 2016 documents Acceptable injection sites include the deltoid muscle, the ventrogluteal muscle, and the vastus lateralis muscle. The facility's Physician order [REDACTED].
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** Based on record review and interview, the facility failed to ensure that a qualified full-time nutrition professional was designated to be the director of food and nutrition service and meets the State requirements for food service managers and dietary managers. This failure has the potential to affect all 69 residents that reside at the facility. The findings include: The State of Illinois' definition for Director of Food Services is a full-time person, qualified by training and experience, responsible for the total food and nutrition services of the facility. This person is on duty a minimum of 40 hours each week and is either a dietitian or a dietetic service supervisor. Dietetic Service Supervisor is defined as a person who is a dietitian; or is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or is a graduate, prior to July 1, 1990, of a Department approved course that provided 90 or more hours of classroom instruction in food service supervision and has had experience as a supervisor in a health care institution which included consultation from a dietitian; or has successfully completed a Dietary Manager's Association approved dietary managers course; or is certified as a dietary manager by the Dietary Manager's Association; or has training and experience in food service supervision and management in a military service equivalent in content to the programs listed above. During the initial tour of the Dietary Department on 3-2-20 at 9:49 A.M., V4, Dietary Manager stated that the facility does not have a qualified Dietary Manager and V4 is currently in a training program to become a qualified Dietary Manager. V4 stated that V4 has completed one third of a qualifying correspondence course. V1, Administrator provided V4's personnel file. According to file information, V4 began as the Dietary Manager on 12-2-19. V1, stated that V4 began on 12-2-19 and is not currently enrolled in qualifying Dietary Manager program. According to the facility's Resident Census and Conditions of Residents dated 3-2-20, 69 residents reside at the facility,
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, record review, and interview, the facility failed to follow the planned menu and spreadsheet for 14 of 14 residents (R4, R25, R33, R9, R43, R50, R52, R55, R62, R120, R121, R122, R124, and R220) receiving a Low Concentrated Sweet (LCS) diet. Finding includes: The noon meal on 3-3-20 was observed for serving food according to the diet orders and serving sizes. According to the speadsheet for Tuesday of week 3 of the 2019-20 Autumn/Winter Menu, the dessert was bread pudding. The regular diet was to receive one square and the LCS diet was to receive a half of a square, half of the regular diet. The 3-3-20 meal service was observed. The bread pudding was on the trays for residents that eat in their rooms and served pieces of bread pudding on small serving plates. There was no size difference between one square and half of square. The size of the pieces of bread pudding was not the same for each resident. Some of the pieces varied greatly. Some were 2.5 by 2.5 by 2 inches and other were 3 by 2.75 by 2 inches. The recipe for the bread pudding did not have a measured serving size, like 2 by 2 inches. The recipe listed the portion size as one square. Did not observe any pieces of bread pudding that would be half a portion served. On 3-3-20 at 1:25 P.M. following the meal service, V4, Dietary Manager stated that the desserts are served the residents in the dining room. V4 was asked if she had a list of LCS residents to be followed by staff. V4 said no. V4 verified from the 2-27-20 Diet Type Report 14 residents (R4, R25, R33, R9, R43, R50, R52, R55, R62, R120, R121, R122, R124, and R220) are to receive a Low Concentrated Sweet (LCS) diet.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, record review, and interview, the facility failed to ensure food held and served to residents was attractive and palatable. R36, R45, R48, and R170 were affected and are four of four residents reviewed for food concerns on the sample list of 43. Findings include: The 3-3-20 the (12:00 p.m.) noon meal service was observed. The vegetable, broccoli was on the steam table in a pan with a lot of water. At the completion of the serving, a test tray was requested. The test tray included broccoli. The broccoli was pale, mushy, water logged and tasteless (bland). On 3/02/20 at 11:01 AM R170 stated the food at the facility does not taste good and is served cold. On 3/2/20 at 1:20 PM R48 was served chicken, mashed potatoes and mixed vegetables. On 3/2/20 at 1:25 PM R48 stated R48's lunch did not taste good and was barely luke warm. On 3/3/20 at 11:00 am during the resident council meeting R45 stated the food is the biggest concern. R45 stated the soup is luke warm, the meat is tough, the toast is not toasted and the french toast is burnt. R45 stated the cooks can't cook. On 3/3/20 at 11:00 am during the resident council meeting R36 stated the hot cereal is cold even though the plate is hot. R36 stated the food has been a problem for several months. On 3/4/20 at 8:20 am R48 was in R48's room eating breakfast. R48 stated R48 is not fond of the food at the facility. R48 stated They could do a lot better with the food. R48 stated the sausage this morning has no flavor.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides food prepared in a form designed**

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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 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **to meet individual needs.** Based on observation, record review, and interview, the facility failed to prepare ham (protein source) to smooth puree consistency to prevent the potential of choking for eight of eight residents (R8, R18, R26, R30, R52, R59, R62 and R69) receiving pureed protein. Finding includes: On 3-3-20 at 9:00 A.M., the surveyor was told to return to the Dietary Department at 11:40 A.M. to observe the puree food preparation. At 11:30 A.M., the pureed food had been already prepared. The noon meal was observed and sample test tray including pureed food items was obtained. The pureed ham was chunky and not smooth. V1, Administrator was asked to taste the food. V1 confirmed that the pureed ham was chunky and not smooth. On 3-4-20 at 2:30 P.M. V4, Dietary Manager verified from the 2-27-20 Diet Type Report that R8, R18, R26, R30, R52, R59, R62, and R69 receives pureed protein.
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.** Based on observation, record review, and interview, the facility failed to ensure that food was protected from potential contamination by food processing equipment and overhead fixtures, subjecting food to physical contaminants, making it potentially unsafe for consumption. This failure has the potential to affect all 69 residents residing in the facility. Findings include: 1. On 3-2-20 at 9:49 A.M., the table mounted manual can opener had dried and moist food residue and metal filing in the gears, on the blade, behind the blade and on the can opener body. The finish of the blade was nicked and worn off exposing bare metal. Food splatters and residue was on the can opener table brace. V4, Dietary Manager stated on 3-2-20 at 10:00 A.M., the can opener was cleaned every two days or so. The can opener is a food contact surface and is to be washed, rinsed, and sanitized after each use. 2. On 3-2-20 at 9:49 A.M., the light shields and fire extinguisher piping inside the exhaust ventilation hood above the range, grill, and oven combination was not clean. Grease residue and food splatters were on the shields and piping exposing food to contaminants during cooking process. According to the facility's Resident Census and Conditions of Residents dated 3-2-20, 69 residents reside at the facility,
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement their Antibiotic Stewardship program to ensure appropriate use of antibiotics to treat infections for four of four residents (R11, R59, R220, R4) reviewed for infection control in the sample list of 43. Findings include: The facility's undated Antibiotic Stewardship Protocol documents, This policy is aligned with the CDC (Centers for Disease Control) Core Elements of Antibiotic Stewardship for Nursing Homes (2015). POLICY: It is the policy of the facility to implement an Antibiotic Stewardship Program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of [REDACTED]. PROCEDURE: 2. Accountability a. The antibiotic stewardship review is a part of the Infection Prevention and Control Program in this facility and is overseen by the Infection Prevention and Control Committee. As a team they will: v. Review quality improvement antibiotic utilization form for number of residents on antibiotics that did not meet criteria for active infection. Action a. Facility utilizes McGeer Criteria to improve the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection. g. [MEDICAL CONDITION] waiting is utilized by facilities. Tracking b. The Infection Preventionist will collect and review data such as: i. McGeer Criteria for positive signs of infection ii. Antibiotic used and route of administration iii. Whether appropriate tests such as cultures were obtained before ordering antibiotic iv. Whether the antibiotic was correct based on sensitivity report v. Whether the antibiotic was changed during the course of treatment vi. Total days of antibiotic therapy. 1.) The facility's Antimicrobial Utilization Tool dated 11/30/19 documents R11 did not meet the McGeer criteria checklist for an infection. This report documents an antibiotic was ordered for R11 and was started on 11/27/19 ordered by V8 Nurse Practitioner. R11's McGeer Criteria for Suspected Urinary Tract Infection report dated 11/30/19 documents the resident has to meet one issue from criteria one and one issue from criteria two. This report documents R11 had two issues in criteria one, new onset suprapubic pain and purulent (thick and milky) discharge from around catheter but R11 did not meet the issue in criteria two which was a urinary catheter specimen culture with at least 100,000 cfu(colony forming units)/ml (milliliter) of any organism(s). This report documents the Outcome as No but also documents the treatment as [MEDICATION NAME] (antibiotic) 1 gram IM (intramuscular) x (times) 5 days initiated on 11/27/19. R11's Laboratory Final Report dated [DATE] documents the organism as Pseudomonas Aeruginosa of 80,000 cfu/ml. R11's Nurse Note dated 11/27/19 at 10:21 PM documents an order for [REDACTED]. R11's Laboratory Report documents the urine was collected on 11/29/19. 2.) The facility's Antimicrobial Utilization Tool dated 12/31/19 documents R59 did not meet the McGeer criteria checklist for an infection. This report documents an antibiotic was ordered for R59 and was started on 12/13/19 ordered by V9 Nurse Practitioner. R59's McGeer Criteria for Suspected Urinary Tract Infection report dated 12/16/19 documents the resident has to meet one issue from criteria one and one issue from criteria two. R59 did not meet any of the criteria in one or two. This report documents R59 was [MEDICATION NAME](antibiotic) 250 mg (milligrams) twice a day for five days initiated on 12/13/19. R59's Laboratory Final Report dated 12/14/19 documents R59's urine was collected on 12/12/19 and documents the organism as Alpha [DIAGNOSES REDACTED] Streptococcus SP (species) of 20,000 cfu/ml. R59's Laboratory Urinalysis dated 12/13/19 documents a hand written order from V9 Nurse Practitioner dated 12/13/19, Urine C/S (culture and sensitivity) pending.[MEDICATION NAME] mg po (by mouth) BID (twice a day) x (times) 5 days. [MEDICATION NAME] 1 cap (capsule) BID po x 14 days. signed by V9. R59's MAR indicated [REDACTED]. 3.) The facility's Antimicrobial Utilization Tool dated 12/31/19 documents R220 did not meet the McGeer criteria checklist for an infection. This report documents an antibiotic was ordered for R220 and was started on 12/26/19 ordered by V9 Nurse Practitioner. R220's McGeer Criteria for Suspected Urinary Tract Infection report dated 12/26/19 documents the resident has to meet one issue from criteria one and one issue from criteria two. R220 did not meet any of the criteria in one or two. This report documents R220 was prescribed [MEDICATION NAME] 1 gram one time only initiated on 12/26/19. R220's medical record does not have documentation of a culture and sensitivity being completed for the urinalysis dated 12/26/19. This urinalysis documents a few bacteria present but does not document the type of bacteria or a specific amount. R220's MAR indicated [REDACTED]. 4.) The facility's Antimicrobial Utilization Tool dated 2/3/20 documents R4 did not meet the McGeer criteria checklist for an infection. This report documents an antibiotic was ordered for R4 and was started on 1/21/20 ordered by V9 Nurse Practitioner. R4's McGeer Criteria for Suspected Urinary Tract Infection report dated 1/22/20 documents the resident has to meet one issue from criteria one and one issue from criteria two. R4 did not meet criteria two. This report documents R4 was prescribed [MED] (antibiotic) 500 mg four times a day for five days initiated on 1/21/20. R4's Laboratory Final Report dated 1/19/20 documents R4's urine was collected on 1/17/20 and documents the organism as Escherichia Coli of 80,000 cfu/ml. R4's Nurses Notes dated 1/20/20 at 2:55 PM documents new orders were received for [MED] 500 mg by mouth four times a day for five days and Culterelle one capsule every day for 14 days. R4's MAR indicated [REDACTED]. On 3/3/20 at 2:08 PM, V3 Assistant Director of Nursing confirmed that the providers are treating infections before they receive the culture and sensitivity report. V3 stated that it happens often that the residents don't meet the McGeer criteria but the Nurse Practitioners and Physicians still treat the residents with antibiotic anyway. On 3/5/20 at 8:28 AM, when asked what '[MEDICAL CONDITION] waiting' meant, V3 stated they watch for disposition changes in the residents. V3 stated they watch the residents and wait until there are symptoms to be certain antibiotic use is appropriate. V3 stated the usual process is if a resident reports symptoms or staff report symptoms to the nurse, the nurse should grab a McGeer criteria and check off symptoms present and then present that to the providers. V3 stated then the provider decides if they want to order a UA (urinalysis). V3 stated some providers prescribe antibiotics before the UA is back. V3 stated that it has been better since they had a meeting with the providers in February but they still have issues with them starting antibiotics before the C & S (culture and sensitivity) is back. On 3/5/20 at 8:40 AM, V2 Director of Nursing stated that V1 Administrator is going to talk to the V11 Medical Director regarding the antibiotic use. V2 stated that V2 talked to V8 and V9 about prescribing antibiotics unnecessarily.