STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145719	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GENERATIONS AT LINCOLN	2202 NORTH KICKAPOO STREET LINCOLN, IL 62656

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** Based on observation, interview, and record review, the facility failed to ensure resident call lights were responded to in a timely manner for seven residents (R6, R7, R8, R17, R18, R19 and R20) of 12 residents reviewed for call lights in a sample of 20. Findings include: The facility's Call Light policy, dated 5/2017, documents Objective: To respond to residents' requests and needs and Procedure: 1. Answer call light in a prompt calm courteous manner. The following Resident Council Minutes document dates and documentation as follows: 3/18/20 documents Residents expressed their frustration with call lights not being answered in a timely manner. 4/15/20 documents Residents expressed their frustration with call lights not be answered at night. 5/20/20 documents Call lights aren't being taken care of in a timely manner in the evenings. 6/24/20 documents Residents expressed their frustration with call lights being ignored at night. 7/15/20 documents Residents expressed their frustration with call lights going unanswered. On 8-20-2020 at 11:00am, V1 Administrator stated The expectation is that call lights are answered and can be by anyone. No need for an education or certification for that. It is not okay for staff to walk past a call light that is on. On 8-21-2020, at 12:30pm, V2 Director of Nursing/DON produced two Resident Concern/Compliment forms regarding call light issues. R19's form, dated 8-5-2020, documents R19's concern regarding increase wait on call lights and request to transfer to a different hall. R20's form, dated 7-27-2020, documents R20's concern regarding long call light times. 1. On 8-19-2020, at 8:55am, R17's call light was illuminating. At this time V17 Licensed Practical Nurse/LPN was standing across the hall at the medication cart. At 9:05am, V16 Certified Nursing Assistant/CNA was across the hall from R17's room watching over a resident in a reclining chair. V16 CNA stated at this time that the other CNA (V20) was giving a shower. At 9:08am, V17 LPN walked past R17's room with R17's call light still illuminating. R17 heard sighing Oh my as V17 walked past. At 9:10am, V16 and V20 CNAs entered R17's room. On 8-19-2020, at 9:17am, R17 stated that R17 needed his bedside tray moved out of the way because he felt like he had to vomit and couldn't reach the waste basket. R17 said he also needed the security leg strap to his indwelling urinary catheter adjusted because it slipped down and was uncomfortable since it was pulling down on the tubing. R17 also stated at this time that it doesn't make him feel very good to have to wait awhile for the call light to be answered and get help. R17's current care plan documents R17 is At risk for an ADL (Activities of Daily Living) self-care performance deficit which includes Approach: Encourage (R17) to use call bell for assistance; and is noted to be for all disciplines of staff members. 2. R8's current care plan documents R8 is At risk for an ADL (Activities of Daily Living) self-care performance deficit which includes Approach: Encourage (R8) to use call bell to call for assistance; and is noted to be for all disciplines of staff members. On 8/18/20 at 11:48 am, R8 stated They take forever to get me and my roommate sometimes. Have had to wait over an hour one time. 3. R7's current care plan documents R7 is At risk for an ADL (Activities of Daily Living) self-care performance deficit which includes Approach: Encourage (R7) to use call bell to call for assistance; and is noted to be for all disciplines of staff members. On 8/18/20 at 11:35 am, R7 stated It can take 10 to 15 minutes and sometimes longer than that for them to answer my call light. 4. R6's current care plan documents R6 is At risk for an ADL (Activities of Daily Living) self-care performance deficit which includes Approach: Encourage (R6) to use call bell for to call for assistance; and is noted to be for all disciplines of staff members. On 8/19/20 at 9:40 am, R6 stated It takes a long time for them to answer the call lights, worse at night. 5. R18's current care plan documents R18 is At risk for an ADL (Activities of Daily Living) self-care performance deficit which includes Approach: Encourage (R18) to use touch pad to call for assistance; and is noted to be for all disciplines of staff members. On 8/18/20 at 12:10 pm, R18 stated I have to have help. They know it. I turn on my light and it almost always takes a long time. I had to wait an hour and five minutes the other night. I've had to wait longer than that before. Night time is always the worst. I wait an average of 30 minutes most times. On 8/21/20 at 10:45 am, V26 AD stated the residents have been complaining that call lights take a long time to be answered to get help or for someone to get to their room. This information is then forwarded to V2 DON. V26 also stated it is not just during Resident Council meetings that residents complain; They complain about call lights a lot, to everyone. On 8/21/20 at 10:35 am, V2 DON stated Promptly means in a timely manner or as soon as able. Everyone is responsible for answering call lights. I've had no call light complaints since COVID started. V26 AD Activity Director, brings Resident Council Minutes to the morning meeting monthly and we go over them and address any concerns.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to obtain physician orders [REDACTED]. Findings include: The facility's Admission of a Resident policy, dated 5/2017, documents Objective: To facilitate the transition from prior living arrangement to long-term care in a caring, professionally comprehensive manner. This policy also documents Procedure: 3. Review resident's personal data with resident and family, to be sure all information on the Admission Notice is correct and current; and 6. Assess resident's condition specific to the admitting [DIAGNOSES REDACTED]. R5's clinical record documents R5 admitted originally on 2-12-19 from another skilled facility. R5's face sheet, documents R5 admitted with [DIAGNOSES REDACTED]. R5's progress note, dated 2-13-19, documents that R5 was seen by V25 (R5's PCP/Primary Care Physician in the facility; no new orders obtained. R5's Nursing Home visit physician note, dictated and signed by V25 on 2-18-19, documents that R5's past surgical history includes a [MEDICATION NAME] pump. This note was electronically attached to R5's clinical record on 2-26-19. R5's clinical record documents R5 transferred out to the hospital on 2-16-19 and returned on 4-12-19. R5's previous skilled facility progress note, dated 1-23-19, documents that R5 returned from a doctor's visit on 1-22-19; [MEDICATION NAME] administered in office; and follow-up appointment 3-19-19. This note was electronically attached to R5's clinical record on 2-15-19. R5's hospital discharge physician summary, dated 2-16-19, was provided on 8-21-2020 by V2 Director of Nursing/DON. This note documents R5 admitted to the hospital on 2-16-19 with an expected discharge date of [DATE]. This note also documents under the hospital course of stay (R5's) [MEDICATION NAME] pump was also refilled during (R5's) hospitalization . On 8-20-2020, at 4:10pm, V2 DON stated that they didn't know anything about R5's [MEDICATION NAME] pump the entire time R5 was a resident in their facility. V2 was unable to produce any orders for R5's [MEDICATION NAME] pump, guidance for filling the pump, or monitoring of R5's pump.
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, interview, and record review, the facility failed to ensure resident meals were delivered at an appetizing temperature for four of four residents (R6, R7, R8, R18) reviewed for meal service in the sample of 20. Findings

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 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) include: The facility's dietary Holding and Service policy, revised 5/20/14, documents Food is held and served using safe food handling methods which protect the food from contamination, prevent food-borne illness and preserve the nutritive value of the food. Resident Council Minutes on the following dates document the following: 3/18/20 documents Residents expressed their drinks are warm; 4/15/20 documents Residents expressed their frustration with food being cold when delivered; 5/20/20 documents Residents expressed their frustration with the food carts coming down and sitting so long in the hallways and Residents expressed their frustration with not having any ice in their drinks with their meals; 6/24/20 documents Residents expressed their frustration with food being cold at night. 1. On 8/18/20 at 12:00 pm, a plate was delivered to R8 covered with foil. When R8 removed the foil there was no steam, the foil was not warm, the grilled cheese sandwhich did not exhibit any heat, and the cheese was dried out on the edges. R8 stated the alternates are usually cold. 2. On 8/18/20 at 12:10 pm, R18 was delivered a plate covered with foil. When R18 removed the foil there was no steam, the grilled cheese sandwich did not exhibit any heat, and the cheese was hard and dried out on the edges. R18 picked up the grilled cheese sandwich and tapped it on her plate which made a knocking noise. R18 stated her food always comes cold. R18 stated Look at this grilled chesse. The cheese is hard and its cold. They wrapped my whole plate with foil and it's still cold. It doesn't help complaining it still comes cold. 3. On 8/19/20 at 9:40 am, R6 stated the meals and alternates are still coming to her cold and she could ask to have it reheated but it would be cold by the time it got back to her so she doesn't bother asking anymore. 4. On 8/18/20 at 11:35 am, R7 stated his food still comes to him cold sometimes. R7 stated it is more with the alternates than anything else and the facility staff are aware of it. On 8/21/20 at 1:52 pm, V4 stated regular meals are placed on warming plates, covered with insulated dome lids and then the warming cart is taken down to the hallways and passed out. The alternates are made to order and are to be placed on a warming plate and covered with an insulated dome and taken immediately to the resident's room. V4 stated she does not know why R8 and R18's grilled cheese sandwiches were covered with foil and stated At no time should any food or alternates leave my kitchen covered in foil.