

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2113730/IL134404 2113783/IL134466	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1210b) 300.1210c) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to provide necessary care and services by not repositioning, toileting, or providing incontinence care for a resident dependent upon staff for all activities of daily living and who was severely cognitively impaired. This failure resulted in R1 receiving no personal care or well-being check for a period of approximately 8-12 hours prior to R1 being found deceased.</p> <p>Findings include:</p> <p>R1's face sheet showed he was admitted to the facility on 9/24/20 with diagnoses to include but not limited to Parkinson's disease, atherosclerotic heart disease, pain in right hip, complete rotator cuff tear or rupture of unspecified shoulder, bradycardia, difficulty walking, unsteadiness on feet, lack of coordination, repeated falls, amnesia,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>hallucinations, cognitive communication deficit, unspecified fracture of shaft of left ulna, and reduced mobility.</p> <p>R1's facility assessment dated 4/1/21 showed he required limited assistance of 1 staff member for bed mobility and extensive assistance of 1 staff member for toileting, dressing, and personal hygiene. The same facility assessment showed R1's cognitive skills for daily decision making were severely impaired.</p> <p>R1's care plan initiated on 10/4/2020 showed, "I have an ADL (Activities of Daily Living) self-care performance deficit related to Parkinson's disease ... I require extensive assist of 1 with turning and repositioning in bed ..." The same care plan showed another intervention with the same date of 10/4/2020, "Bed Mobility: I require extensive assist x 2 staff and as necessary ..."</p> <p>R1's care plan showed a care plan initiated on 1/24/21, "I had an actual fall with no injury related to Parkinson's Disease, dementia, impulsive behavior and a history of falls ... intervention: Maintain regular toileting at set intervals and PRN (as needed)." R1's care plan for impaired cognitive function related to dementia showed, "... ask yes/no questions in order to determine my needs ... Cue, reorient, and supervise as needed ..."</p> <p>R1's physician progress note dated 5/20/21 showed, "... needs close monitoring due to his frequent falls/poor ambulation ..."</p> <p>R1's 5/1/21 skilled charting nursing assessment showed he required assistance with bed mobility and is incontinent of urine.</p> <p>The facility's fall log printed on 6/2/21 showed R1</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENALIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>had 6 witnessed falls and 3 unwitnessed falls in the previous 6 months. R1's last fall occurred on 4/28/21 at 5:55AM when he was found sitting on the edge of his bed with blood on the right side of his neck. R1 was sent to the acute care hospital and received 2 staples to the back of his head. R1's 5/29/21 8:30AM nursing progress note entered by V3 (Registered Nurse/RN) showed, "This nurse was informed that resident was not breathing. Resident dressed without shoes, laying prone face down on a pillow. Small amount of sanguineous drainage assessed on pillow. Right arm cold. Administrator notified."</p> <p>On 6/3/21 at 9:09 AM, V11 (County Coroner) said he responded to the call from the police department and when he arrived at the facility he went straight to R1's room. He said when he went into the room R1 had been rolled over on the bed from what appeared to be his sleeping position (one arm down and one arm up). V11 said R1's skin on his anterior body was a deep purple color. V11 said there was obvious lividity which gives experts an idea of the length of time he had been deceased. V11 said from his experience in being a coroner, his experience from his previous position in law enforcement, and his current research it had likely been 8-12 hours since R1 had expired. V11 said through his collection of statements from staff at the facility he believes the resident was not looked in on from approximately 10-10:30 PM until the next morning when it was discovered that he was deceased.</p> <p>The facility daily staffing schedule showed from 10:00 PM on 5/28/21 through 8:30 AM on 5/29/21 the following CNAs (Certified Nursing Assistants) were scheduled on R1's hall. V7 was scheduled from 2 PM - 1030 PM on 5/28/21. V8 was scheduled 10:30 PM - 1 AM to cover another hall</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>but was told she would need to keep an eye on the residents on R1's hall as well. V6 was scheduled from 2 AM - 6:30 AM. No one appeared on the daily nursing schedule for 5/29/21 as the 1:1 aide for R1. V6 and V7 both reported V10 was assigned to be 1:1 with R1 on 5/29/21. The nurse assigned to R1's hall on the night of 5/28/21 through the morning of 5/29/21 was V4 (Licensed Practical Nurse/LPN). The nurse assigned to R1's hall on 5/29/21 starting at 6:00 AM was V5 (LPN).</p> <p>On 6/3/21 at 12:24 PM, V7 (CNA) said on 5/28/21 she helped R1 to bed about 9:30 PM because they were trying to get him on a schedule since he sometimes gets up in the middle of the night. V7 said the last time she saw R1 was approximately 10:15 PM and R1 was sleeping. V7 said R1 was fine when she checked on him at 10:15 PM. V7 said her shift ended at 10:30 PM and there was no one specifically assigned to cover R1's hall at that time so she reported off to V16 (CNA Supervisor) when she left. V7 said there would usually be someone coming on that hall to report off to, but staffing is short quite a bit. V7 said when she came back in at 6:00 AM she was back on R1's hall. V7 said she did not check on R1 because R1 was supposed to be with a 1:1 aide. V7 said she was the only aide scheduled on that hall for the day shift.</p> <p>On 6/2/21 at 3:28 PM, V8 (CNA) said she was scheduled to work another hall on 5/28/21 and she arrived late to work that day because she overslept. V8 said when she got to work she was told she was going have to keep an eye on R1's hall as well. V8 said she went into R1's room between 10:30 PM and 10:50 PM and took an oxygen saturation reading and a temperature for their typical monitoring of residents and R1 did</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>not wake up. V8 said the last time she checked on R1 was approximately 1:00 AM and she did not enter his room. V8 said she peeked into R1's room from the door and he was still sleeping.</p> <p>On 6/2/21 at 1:30 PM, V6 (CNA) said she was the only aide who worked R1's hall from 2:00 AM until 6:00 AM on 5/29/21. V6 said they check on residents every hour to two hours whether they are sleeping or not. V6 said they check on incontinent residents every 2 hours throughout the night to make sure they are not wet. V6 said they are told usually not to wake up R1 if he is sleeping and just do a visual check, if he isn't stirring then just leave him. V6 said she sometimes does the visual checks from outside the room. V6 said R1 was incontinent at times. V6 said when she saw R1, he was lying flat on his stomach but his head appeared to be facing the wall. V6 said the lights were not on. V6 said she left at 6 AM and reported to V7 (CNA) that R1 was sleeping. V6 said V10 was also there at 6:00 AM and V10 was assigned to be 1:1 with R1 that day. V6 said R1 did not wake up at all between 2 AM and 6 AM. V6 said before she arrived at the facility at 2 AM there were only 2 CNAs in the entire building, and this does happen on some nights. V6 said she did not go in R1's room and check on him from 2 AM - 6 AM.</p> <p>On 6/2/21 at 2:36 PM, V4 (LPN) said she worked R1's hall from 6:30 PM on 5/28/21 until 7:00 AM on 5/29/21. V4 said R1 had a 1:1 CNA with him on 1st and 2nd shift but not on 3rd shift. V4 said R1 gets up in the night at times and he would have to have someone with him. V4 said she walked past his room during her shift but never went into the room. V4 said when she left at 7:00 AM, R1 was in his bed. V4 said R1 is scheduled to receive some medications at 6:00 AM but</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 6</p> <p>since he was still in bed she put the medications in the top drawer of the medication cart and reported to V4 (LPN) that R1 would need his medications when he gets up. V4 said the last time she gave medications to and interacted with R1 was between 9:00 PM and 9:30 PM on 5/28/21. V4 said she documented that she gave R1 his morning medications, but she should have struck out that administration record because she did not give him his medications. V5 said she did not go in the room after 9:30 PM on 5/28/21.</p> <p>On 6/2/21 at 3:15 PM, V3 (Registered Nurse Manager) said she was on call on Saturday, 5/29/21. V3 said she arrived at the facility at 7:30 AM. V3 said, "At roughly 8:30AM, V7 (CNA) came into my office and said R1 was gone." V3 said V10 (1:1 aide for R1) went to get V5 (LPN). V3 said R1 was a 1 person assist for all cares. V3 said she went to the room and R1 was lying face down in his pillow with his face directly on the pillow. V3 said she could tell his right cheek was purplish blue and there was blood visible on the pillow. V3 said R1's face was not off to the side. V3 said it was just before the EMS arrived that R1 was rolled over to get him "presentable." V3 said R1's face was a dark purple color except for his chin was white. V3 said R1 had blood around mouth, on his teeth, and in his mustache area. V3 said R1's arm was up and at a 90-degree angle because rigor mortis had set in. V3 said she notified the administrator right away at 8:34 AM. V3 said, "It was a scene like no other, nothing I had ever seen." V3 said V4 (LPN) told her she had not gone into R1's room and there was a discussion about just leaving him sleep. V3 said V5 (LPN) reported to her that she had not yet gone into R1's room. V3 said she spoke with V10 (1:1 CNA) and V10 told her she looked in the room from outside the door but had not gone into</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>R1's room since her shift started at 6:00 AM. V3 said through her investigation she found that the last time anyone was in R1's room was on 5/28/21 before 11:00 PM. V3 said there was no staff in R1's room between 11:00 PM and 8:15 AM.</p> <p>On 6/2/21 at 9:15 AM, V15 (Police Chief) said he was dispatched to the facility on 5/29/21. V15 said R1 had been moved prior to him arriving at the facility. V15 said rigor mortis had set in and he was concerned when V10 (CNA) said she had checked on R1 every 15 minutes since she arrived for her shift at 6:00 AM. V15 said there was blood on the resident's face around his nose and blood on a pillow that had been moved to the floor. V15 said lividity (bluish-purple discoloration of skin after death which is a sign of livor mortis and occurs when blood pools at the lowest point of the body due to gravity and loss of blood circulation) had clearly set in which he feels would be the cause of the blood on the pillow. V15 said based on his investigation as of 6/2/21 he is concerned that no staff entered R1's room between approximately 10:20 PM on 5/28/21 and 8:30 AM on 5/29/21.</p> <p>On 6/2/21 at 9:32 AM, V14 (Paramedic) said they responded to a call to the facility for a DOA (Dead on Arrival). V14 said when they entered R1's room there was many staff members in the room and R1 was laying on his back. V14 said because R1 was found lying face down in his pillow he had full lividity from his face to his toes and appeared to have been dead greater than 12 hours. V14 said he works for the ambulance service and also for a funeral home. V14 said he determined how long R1 had been deceased based on the full lividity to R1's body. V14 said when a person dies, their body starts to deteriorate. V14 said at</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>about 6-10 hours gravity starts pushing blood down out of the vascular spaces and causes the part of the person's body at the lowest point to become a deep purple. V14 said if you apply pressure to an area of recent lividity the area will turn white and that is an indicator of the time frame of death. V14 said if you apply pressure to an area of lividity and there is no change it means the tissue has now been stained by the components of the blood and indicates a longer time frame of death. V14 said based on the pattern of lividity he observed, R1 was laying directly face down. V14 said facility staff told him they do 20-minute bed checks and he is concerned why staff would not have repositioned him if they had done the bed checks.</p> <p>On 6/3/21 at 10:43 AM, V2 (Assistant Director of Nursing) said R1 was pretty much 1:1 since he got to the facility due to his poor safety awareness. V2 said she is unsure of what the CNAs do during rounding or how often they do rounds. V2 said she knows they don't go in some of the resident's rooms and they don't shake them or anything, but they do open the door and look in. V2 said if a resident is incontinent they are checked on throughout the night and the staff physically put their hands on the resident. V2 said R1 was both continent and incontinent; there were a lot of times he would say he had to go to the bathroom. V2 said if someone is continent and incontinent she would think they would be checked on throughout the night just like those who are always incontinent. V2 said residents that require assistance with bed mobility would be repositioned every 2 hours.</p> <p>On 6/2/21 at 12:43 PM, V9 (CNA) said residents are checked on every 1-2 hours sometimes more frequently. V9 said if residents are sleeping they</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LENALIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 9</p> <p>are still checked on every 2 hours. V9 said she would gently wake them up.</p> <p>The facility's undated policy Routine Resident Checks showed, "Staff shall make routine resident checks to help maintain resident safety and wellbeing ... 1. To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least once per each 8 hour shift. 2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. 3. The person conducting the routine check shall report promptly to the Nurse Supervisor/Charge nurse any changes in the resident's condition and medical needs ..."</p> <p>The facility's undated policy and procedure "Position - Side Lying" showed, " ... Nursing staff will reposition residents every 2 hours or more often as needed ..."</p> <p>The facility's undated policy and procedure "Perineal Care" showed, " ... Nursing staff will provide perineal care to residents twice a day, after each incontinence episode, or more often as needed ..."</p> <p style="text-align: center;">(A)</p> <p>(Violation 2 of 2)</p> <p>300.610a)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021	
NAME OF PROVIDER OR SUPPLIER LENALIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 10</p> <p>300.1210b) 300.1210d)1) 300.1210d)2) 300.1210d)5) 300.1220b)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 11</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 12</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to provide the necessary care and services for a newly admitted resident by not providing care for a resident's peritoneal drainage system for a resident with a diagnosis of pleural effusion and respiratory failure, failed to ensure an admission skin assessment was done timely, failed to ensure wound care treatments were in place, and failed to ensure oxygen orders were in place for 1 of 3 residents (R3) reviewed for nursing services. These failures resulted in R3's death with cause of death as bilateral pleural effusion and hypoxia resulting from pulmonary congestion.</p> <p>Findings include:</p> <p>R3's nursing progress note dated 1/3/21 at 4:22 PM showed, "went into resident's room for noon medications. Resident reported continued nausea. Resident requested to go to the bathroom. Writer assisted into wheelchair, reported nausea and requested to sit for a moment before moving further. Writer gave resident the emesis basin and stepped out of the room for a short time. Upon returning writer asked if he was ready to try to use the bathroom. Resident stated yes, d/t (due to) weakness writer asked CNA to assist also, two CNA's entered to assist to bathroom when resident became limp and began agonal breathing. CNA's called writer</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 13</p> <p>into room. Writer called residents name, resident looked at writer for split second and then became unresponsive ..."</p> <p>R3's nursing progress note dated 1/3/21 at 7:57 PM showed, "Fax sent to [physician] office to notify of resident's passing."</p> <p>R3's death certificate showed under cause of death, "a. bilateral pleural effusion, b. hypoxia resulting from pulmonary congestion ..."</p> <p>R3's face sheet showed he was admitted to the facility on 12/22/21 with diagnoses to include but not limited respiratory failure with hypoxia or hypercapnia, pleural effusion, shortness of breath, heart failure, hypertension, congestive heart failure, chronic embolism and thrombosis of unspecified deep veins of the left lower extremity, pneumonia, and chronic obstructive pulmonary disease.</p> <p>R3's 12/22/20 admission summary showed R3 arrived to the facility at 6:00 PM and was alert and oriented x 3.</p> <p>R3's 12/23/20 Nursing Progress Note showed, "Resident admission completed by off going nurse. Resident reported arrival was at 6 PM ... Resident was observed on portable oxygen ... Resident noted to be alert and able to verbally make needs known to staff. Endorsing nurse was completing orders as resident requested to have {Brand name} Pneumothorax drainage system drained. Resident noted to have output of 400ml after three hours plus draining duration ..."</p> <p>R3's 12/24/20 Nursing Progress Note showed, "Pneumo tube disconnected from the wound vac for the night ..."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LENALIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 14</p> <p>R3's 12/25/20 Nursing Progress Note showed, "Pneumo tubing dressing removed. Stated it wasn't put on right. States needs a sterile field, washed hands and put on alcohol around skin where tube is coming out, clamp was on and dressing applied. Was not happy with nurse. Told resident I can't tape with gloves on. Stated he would wait until morning to see someone that knows how he wants the procedure done."</p> <p>R3's 12/25/20 Skilled Evaluation showed, " ... Lungs, Left and Right crackles throughout ... diminished, absent ... Resident request to have {Brand name} Pneumothorax drainage system drained. Resident noted to have output of 425 ml after three hours plus draining duration ..."</p> <p>R3's electronic medical record showed no evidence of R3's Pneumothorax drainage system being drained on 12/24/20, 12/26/20, 12/27/20, 12/28/20, or 12/30/20. R3 was in the facility for 12 days and his drainage system was not drained 5 times. R3's Physician Order Sheet did not show an order concerning the Pneumothorax drainage system was entered in R3's medical record until 12/29/20 (7 days after admission). The 12/29/20 physician order showed, "Drain peritoneal catheter and change dressing daily."</p> <p>On 6/7/21 at 1:05PM, V17 (R3's Pulmonologist) said R3 had a recurrent history of pulmonary effusion and ascites (collection of fluid) in his abdomen. V17 said the placement of the {Brand name} catheter was a joint decision between himself and R3's gastrointestinal specialist because R3 was collecting so much fluid he was requiring thoracentesis and paracentesis approximately every 5 weeks. V17 said the gastrointestinal physician was draining up to 6</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/09/2021
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 15</p> <p>liters of fluid out of R3's abdomen and he [the pulmonologist] was draining up to 2 liters of fluid out of R3's lungs. V17 said the {Brand name} catheter was placed to give R3 a way to drain fluid without having to come in to the office and have repeated invasive procedures like the paracentesis and thoracentesis and gives the patient or family member a way to drain some of the fluid off so the patient does not have to be in distress. V17 said he would assume if a patient was admitted to a facility with orders for this type of catheter they would contact someone to get more information. V17 said he would assume the nurses at the facility would ask some questions if they weren't familiar with a patient's catheter.</p> <p>R3's 12/28/20 Skin/Wound note showed, "Admission skin assessment (6 days after admission) - Pneumo drainage to right lower quadrant - tube intact with clamp and cap in place. One stitch intact above site. Area covered with gauze and duoderm. Coccyx has a 0.2 cm OA (open area), area cleansed and duoderm placed ..."</p> <p>R3's nursing progress note dated 1/1/21 showed, "...OA (open area) to buttock ..." R3's physician order sheet showed no orders for wound care. R3's medical record included no wound measurements or treatments for a wound to the coccyx or buttocks.</p> <p>R3's POS (Physician Order Sheet) showed from 12/22/20 through 12/30/20 there were no orders regarding R3's oxygen. On 12/30/20 an order was entered to "change the oxygen tubing every Wednesday." R3's POS did not include an order for oxygen to include the rate of flow or method of administration.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005292	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2021
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 SOUTH LOGAN STREET LENA, IL 61048		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 16</p> <p>On 6/2/21 at 2:36 PM, V4 (Licensed Practical Nurse/LPN) said admission assessments are done as soon as possible but within 24 hours of admission to the facility for sure.</p> <p>On 6/3/21 at 10:43 AM, V3 (Assistant Director of Nursing) reviewed R3's chart with the surveyor and said she is not sure why there were no orders for oxygen, wound care, or the peritoneal drain. V3 said the nurse on the floor does the admission and the night nurse checks it for accuracy. V3 said she is not sure why an order that came through on 12/23/20 to hold R3's anticoagulant was not processed until 12/27/20. V3 said orders should be processed on the same day they are received.</p> <p>The facility's undated policy titled Admission Process showed, " ... 4. The charge nurse will complete the following: A. A complete head to toe assessment will be performed and documented in the nurse's notes. B. Complete the nurse's admission assessment. C. Verify all transfer orders with the MD (physician). D. Transcribe all orders to the POS (Physician Order Sheet), MAR (Medication Administration Record), and TAR (Treatment Administration Record). E. Complete the admission checklist and turn into the DON. 5. The DON will audit the admission chart within 24 hours to ensure completeness ..."</p> <p>(A)</p>	S9999		