או אינ PRINTED: 06/27/2023 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING IL6007389 05/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST PIATT COUNTY NURSING HOME MONTICELLO, IL 61856 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) **Initial Comments** S 000 Annual Licensure & Certification Survey S9999 Final Observations S9999 Statement of Licensure Violations: (Findings 1 of 2) 300.610a) 300.1210a) 300.1210b)3) 300.1210d)2 300.3240a) Section 300.610 Resident Care Policies 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

Section 300.1210 General Requirements for Nursing and Personal Care

and dated minutes of the meeting.

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

Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that

Attachment A Statement of Licensure Violations

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

TITLE

(X6) DATE

PRINTED: 06/27/2023 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6007389 05/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST PIATT COUNTY NURSING HOME MONTICELLO, IL 61856 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's quardian or representative, as applicable. (Section 3-202.2a of the Act) The facility shall provide the necessary b) 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. Restorative measures shall include, at a minimum, the following procedures: All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling

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d)

catheter is not catheterized unless the resident's

Pursuant to subsection (a), general

nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,

clinical condition demonstrates that catheterization was necessary.

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indwelling urinary drainage device or a

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6007389 05/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST **PIATT COUNTY NURSING HOME** MONTICELLO, IL 61856 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 comprehensive care plan after the development of the wound to R53's penis. R53's medical record documents on 2/8/23, (V10 Wound Physician) here on 2/6/23 to assess wounds. Resident has a urethral split to penis due to foley. Area measures 1x0.5cm with light serous drainage. 10% devitalized tissue, 90% subcutaneous noted. Will apply petroleum jelly to area daily, V10 recommends an urology consult. (V7 Physician) notified, states to continue to monitor. R53's Wound Evaluation and Management summary completed by V10 Wound Physician documents, on 2/6/23, "NON - PRESSURE WOUND PENIS FULL THICKNESS, Etiology -Trauma/Injury Duration less than 1 day, Wound Size (L x W x D): 1 x 0.5 x 0 cm, Surface Area: 0.50 cm². Exudate: Light Serous, Thick adherent devitalized necrotic tissue: 10 %, Other viable tissues: 90 % (SubQ) DRESSING TREATMENT PLAN: Primary Dressing(s): Petroleum jelly apply once daily for 30 days, PLAN OF CARE REVIEWED AND ADDRESSED, Recommendations: Urology consult. Chronic stable wound with insignificant amount of necrotic tissue and no signs of infection. Monitor closely for now." R53's Wound Evaluation and Management summary dated 2/13/23, completed by V10 documents Non-Pressure Wound Penis, Full Thickness, Etiology: Trauma/Injury, Wound Size: 1 x 0.5 x 0 cm. Periwound radius: turbid exudate, Exudate: Moderate Serous, Thick adherent devitalized necrotic tissue: 10 %, Other viable tissues: 90 % (SubQ) (subcutaneous), Wound

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progress: Deteriorated, DRESSING TREATMENT

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REVIEWED AND ADDRESSED.
Recommendations: Urology consult."

daily from 2/20/23 through 5/7/23.

R53's medical record did not document the initiation or completion of physician ordered recommendation of Petroleum jelly apply once

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R53's medical record documents on 5/8/23 at 9:47 PM, V12 Registered Nurse wrote to V7 Physician, "Resident's Foley catheter has been

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ECONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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PIATT CO	DUNTY NURSING HO	ME 1111 N ST MONTICE	ATE ST LLO, IL 618:	56			
(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	Continued From pa	ge 6	S9999				
	Current Foley size i	one week for non-patency. is 18Fr, may we increase to					
		y also benefit from a r as the shaft of the penis is is scrotum."	12		6 25		
8	Summary dated 5/8 documents, "NON FULL THICKNESS	uation and Management 3/23 completed by V10 - PRESSURE WOUND PENIS , Etiology (quality) ation > 83 days, Wound Size					
is.	cm², Exudate: Light 100 % (SubQ), Wo DRESSING TREAT Dressing(s): Petrole	s x 0.05 cm, Surface Area: 1.00 t Serous, Other viable tissues: und progress: Deteriorated. TMENT PLAN: Primary eum jelly apply once daily for CARE REVIEWED AND	V			N. T. S.	
91	ADDRESSED. Reconsult."	commendations: Urology	- si				
	stated, "I just return (R53) developed th off, (R53) had a urd wheelchair wouldn' cancelled. (V10 Wo	5 AM V3 Registered Nurse ned from (medical leave), e (penis wound) when I was blogy appointment but the twork in the van so it was bund Physician) wants (R53) to 53) needs a urethral splint. used the wound."	2 ' VA				
	out (R53) admitted from taking a look a catheter issues at t came from, we did identified the (penil V3 stated, "I think t was the first appoir (R53), I was not ab documentation that	PM V3 RN stated, "I found to us in January 2023 and at the record, (R53) had he other nursing facility he not document that we e wound) until February 2023. he April Urologist appointment atment that was available for le to find any further the appointment has been /10) was notified. I saw the					

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rail, not on the floor.

more drainage to the open area, so they discontinued it, I dont know if it was a

miscommunication or what, I did not see a follow up or documentation if (V10) had been notified."

On 5/10/23 at 12:00 PM V2 DON stated, catheter bags should be placed on the bottom of the bed

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outward. The following items should be

documented in the residents medical record: 1-The date and time that catheter care was given."

2.) On 5/08/23 at 9:39 AM R52 was lying in bed. R52's urinary catheter collection bag was touching the floor, and not secured to the bed. R52 stated R52 has had the catheter for several

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	- 5	IL6007389	B. WING		05/11/2023		
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S9999	Continued From pa	ge 9	S9999	77			
	catheter cleaning/c	inserted after admission. R52's are is performed by the ssistants (CNAs) 3-4 times per					
	2023 Order Summa perform routine cat urinary catheter ord	ated 5/1/23 and R52's May ary do not document to heter care/cleaning. R52's der dated 1/17/23 documents ordered/inserted due to					
	do not consistently	e report dated 1/8/23 - 5/9/23 document catheter care as ach shift three times daily.	:=:				
2	performed R52's ca cleansed R52's inn	AM V32 and V17 CNAs atheter care/cleaning. V17 er and outer labia with a wash cross the top of the catheter	8				
83	approximately 1/2 i V17 did not wrap th and clean the lengt downward motion. clean R52's cathete	nch, near the insertion site. ne cloth around the catheter th of the catheter in a R52 asked if V17 was going er. V32 then provided catheter ay as V17. V32 did not clean	8	=			
	approximately 5 me training on catheter length of the catheter	AM V17 stated V17 was hired onths ago and received recare. V17 stated cleaning the ter was not part of the training. Y did not clean the catheter ter care.	i.ĉ	: ³			
Eq	stated catheter car once per shift/three on the catheter car	0 AM V2 Director of Nursing e is done by the CNAs at least times daily and documented to task report. V2 expects the ned during catheter care. V2	÷ ,2,	n 8			

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the facility and shall be reviewed at least annually by this committee, documented by written, signed

Comprehensive Resident Care Plan. A

Section 300.1210 General Requirements for

and dated minutes of the meeting.

Nursing and Personal Care

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6007389 05/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST PIATT COUNTY NURSING HOME MONTICELLO, IL 61856 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 11 S9999 facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's quardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: All nursing personnel shall assist and encourage residents so that a resident's abilities

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in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe. dress, and groom; transfer and ambulate; toilet;

eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain

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sample list of 39. These failures resulted in R13 experiencing an additional significant weight loss

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 05/11/2023 IL6007389 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1111 N STATE ST PIATT COUNTY NURSING HOME MONTICELLO, IL 61856 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 13 of 6.65 % in one month. Findings include: The facility's Impaired Nutrition/Unplanned Weight Loss Clinical Protocol revised October 2020 documents the nursing department are responsible for monitoring resident weights. Significant weight loss is identified as a loss of at least 5% in one month, 7.5 % in 3 months, and 10 % in 6 months. The physician will review possible causes of weight loss. Interventions will be implemented to address weight loss. The Dietitian and Physician will determine the resident's diet including if nutritional supplements need to be added. Monitoring weight loss/nutrition includes evaluating the care planned interventions, evaluating the resident's response to the interventions, determine weight monitoring intervals, identifying additional risk factors such as pressure ulcers, fever, or acute illness, and observing/reporting significant weight loss. The facility's Nutritional Assessment policy revised September 2011 documents nutritional assessments will be conducted upon admission and with changes in condition that include a risk for impaired nutrition. These assessments will be used to develop interventions to address the resident's risk for impaired nutrition. The Dietitian's component of this assessment will include the estimated calorie, protein, nutrient and fluid needs, and if the resident's intake is adequate to meet nutritional needs. R13's Minimum Data Set dated 3/22/23 documents R13 has short and long term memory impairment, had a significant weight loss within

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the last month, and is not on a prescribed weight

DM7U11

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ B. WING IL6007389 05/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST PIATT COUNTY NURSING HOME MONTICELLO, IL 61856 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 14 loss regimen. R13's Care Plan revised 4/25/23 documents R13 had significant weight loss noted 1/9/23 and 4/5/23. Interventions dated 1/7/22 include to notify the family and physician of significant weight loss, review diet, intakes, disease process, and behaviors to determine cause, and the dietitian should assess the resident annually and as needed to ensure needs are met. R13's Care Plan dated 7/2/19 documents R13 is at risk for nutritional deficit and includes an intervention revised on 5/4/23 that documents the dietitian evaluated R13 on 2/10/23 with no recommendations, on 3/14/23 with no recommendations, and on 4/28/23 with recommendations. R13's dated 5/10/23 documents R13 weighed 169.2 pounds (lbs.) on 12/1/22, 163.6 on 1/9/23, 153.8 on 1/31/23 (5.64 % loss since 1/9/23), 160 on 2/7/23, 159 on 3/2/23, 156.2 on 3/8/23, 153 on 3/16/23, and 150.4 on 4/3/23 (5.41% loss since 3/2/23). There are no recorded weights again until 5/4/23 when R13 weighed 140.4 lbs (an additional 6.65 % loss since 4/3/23, and a 17% loss since 12/1/22). There are no documented nutritional assessments after 12/15/22 in R13's medical record. There is no documentation that R13 was assessed by V25 Registered Dietitian between 1/1/23 and 2/9/23, or that R13's physician was notified of R13's significant weight loss noted on 1/31/23. R13's Dietary Notes document on 2/10/23, R13 has an unstageable pressure ulcer of the right heel. R13's weight was stable

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between 160-170 lbs with decrease to 153 on 1/31/23 and returned to 160 on 2/7/23. R13 was

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6007389 05/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST PIATT COUNTY NURSING HOME **MONTICELLO, IL 61856** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 15 S9999 started on a frozen nutritional supplement two days prior on 2/8 (of the prior year). On 3/14/23 R13 receives a frozen nutritional supplement twice daily. R13's wound healed and weight has been stable for 60 days. No nutritional changes were recommended. On 4/28/23 V25 recommended the addition of a nutritional shake twice daily. There is no documentation that V25 assessed R13 after 3/14/23 until 4/28/23 (25 days after R13's significant weight loss noted on 4/3/23). R13's Nursing Notes document on 4/12/23 R13's significant weight loss was reported to the practitioner with no new orders given. On 5/4/23 the practitioner was notified and gave orders for 60 cc (Cubic Centimeters) of (nutritional supplement) twice daily and obtain weekly weights for one month. R13's May 2023 Order Summary includes physician orders to administer a frozen nutritional supplement twice daily for weight loss initiated on 2/23/23 and to administer 60 cc of (nutritional supplement) twice daily initiated on 5/4/23. R13's January 2023 through May 2023 Medication Administration Records (MARs) document R13 received a frozen nutritional supplement once daily, that was ordered from 2/8/22 until 2/23/23. The MAR does not document the amount consumed of the 60 cc nutritional supplement initiated on 5/4/23. There is no documentation that any new nutritional supplements/interventions were implemented to address R13's January weight loss prior to 2/23/23 when the frozen nutritional supplement was increased to twice daily, and then no additional nutritional supplements were

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implemented to address R13's April 2023 weight

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	IL6007389			<u> </u>	05/1	05/11/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE			
PIATT C	OUNTY NURSING HO	ME 1111 N ST. MONTICE	ATE ST LLO, IL 618	56			
(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	loss until 5/4/23 wh 60 cc was ordered. On 5/08/23 at 11:54 room eating. R13's frozen nutritional sunoon meal. R13's n sandwich, peas, po and did not contain supplement, and R reuben sandwich. Omeal tray did not co supplement, and R R13's food, besides at 12:08 PM V17 C (CNA) delivered R1 The meal tray contachips, and 2 % milk nutritional supplement a frozen nutritional	en the nutritional supplement AM R13 was sitting in R13's meal ticket documented a upplement as part of R13's neal tray included reuben tato salad, and cheesecake,	S9999				
	On 5/9/23 at 12:35 nutritional supplem department with the R13 was not given supplement as part stated if the frozen on the meal ticket, On 5/09/23 at 12:3 Nurse stated (nutrit the nurses and the on the MAR. The fr served by dietary, a documenting the air On 5/10/23 at 1:00	7 PM. PM V17 stated the frozen ents are served by the dietary e meal trays. V17 confirmed a frozen nutritional of the noon meal. V20 CNA nutritional supplement is listed then R13 should be getting it. 7 PM V19 Licensed Practical tional supplement) is given by amount consumed is recorded ozen nutritional supplement is and the nurse is responsible for		¥ (7)		U	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	COMPLETED				
	80	22			24			
		IL6007389	B. WING		05/11/2023			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	0.			
PIATT CO	PIATT COUNTY NURSING HOME 1111 N STATE ST MONTICELLO, IL 61856							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	I ID	PROVIDER'S PLAN OF CORRECT	ON (X5)			
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE			
S9999	Continued From pa	ge 17	S9999		5			
u u	resident names for submitted to V25 do weight lost. V25 do recommendations u V25 was not sure w facility to do to addr interim until V25 ev	until V25 rounds at the facility. what V25 would expect the ress resident weight loss in the aluates the resident. V25						
	documented under the electronic media are completed upon with any significant frozen nutritional suweight loss. V25 sta 2/10/23 and V25 disinterventions since supplement was im the physician. V25 displacement was implement was implement was implement was implement was implement v25 displacement.	res nutritional assessments the assessments section of cal record. The assessments in admission, annually, and changes. V25 confirmed the applement is ordered for R13's ated V25 evaluated R13 on indicated the property of the frozen nutritional plemented two days prior by evaluated R13 in March and tabilized. V25 did not evaluate						
	addition of a nutritic stated V25 did not recommendational supplementals weight loss a frozen nutritional surgical recommendation weekly, but V25 recommendation weekly, but V25 wasn's should be doing. On 5/09/23 at 3:36 stated weights are constant of the stated weights are constant of the stated weights are constant.	and recommended the small shake twice daily. V25 receive notification in April of eight loss until 4/28/23. The ents may have prevented and confirmed not receiving the applement may have affected stated if residents are trending all expect the facility to following policy. In the past V25 has attions to monitor weights ently stopped doing that the transfer it was something V25.						
5	otherwise ordered. significant weight lo	If the resident triggers for a use then we notify the jian. V25 rounded on 4/26 and						

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STATEMENT OF DEFICIENCIES (X1) PR

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURV	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
			<u> </u>			
	<u> </u>	IL6007389	B. WING		05/11/20	23
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PIATT C	DUNTY NURSING HO	ME 1111 N ST	TATE ST SLLO, IL 618	356		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	lo ID	PROVIDER'S PLAN OF CORRE	CTION	(VE)
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S9999	Continued From pa	ge 18	\$9999			
	4/28/23 during Apri evaluated R13 on 2 recommendations, recommendations, recommendation to daily. V2 reviewed stated V2 did not so was evaluated by a 5/1/23 we increase supplement and sto not liking the shake for documenting the supplement. On 5/we ran a weight report flag for weight I weight report was retriggered a signification weight reports are and that is how R13	I. Per R13's care plan, V25 2/10/23 with no new 3/14/23 with no new and on 4/28/23 with the add nutritional shakes twice monthly dietitian reports and ee documentation that R13 dietitian in January 2023. On d the frozen nutritional apped the shakes due to R13 as. The nurses are responsible amount consumed of each 10/23 at 10:25 AM V2 stated fort on 1/24/23 and R13 did loss at that time. The next not done until 2/16/23 and R13 ant weight loss. V2 stated only done on a monthly basis 3's significant weight loss on d. There is no documentation				
	that R13's January reported to the physiconfirmed there we interventions imple R13 had a significa V25 did not evaluat 4/28/23. There were interventions imple 4/28/23. On 5/10/23 nutritional assessman quarterly, annually, changes including a confirmed R13's me	significant weight loss was sician and dietitian, and are no new nutritional mented until February 2023. In the weight loss on 4/5/23 and the R13's weight loss until the no new nutritional mented in March or April until 3 at 1:28 PM V2 stated tents should be completed and with any significant significant weight loss. V2 edical record does not nal assessment completed				
		order summary documents, ar Free with meals for skin 11/15/2022.				

77/200 PRINTED: 06/27/2023 Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6007389 05/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N STATE ST **PIATT COUNTY NURSING HOME** MONTICELLO, IL 61856 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) S9999 Continued From page 19 S9999 R16's wound evaluation and management summary dated 5/8/23 documents Moisture Associated Skin Damage to Sacrum, 2 centimeters by 2 centimeters by 0.3 cm. R16's Dietary Meal ticket documents, "Supplement: Might Shakes- No sugar." On 5/8/23 at 12:17 PM R16's lunch meal tray was on R16's over the bed table in front of R16. The tray contained a Reuben Sandwich, Peas, Salad in a cup, cheesecake, milk and tea. There was no might shake on R16's tray. On 5/9/23 at 11:53 AM R16's lunch meal tray was on R16's over the bed table in front of R16. The tray contained chicken, rice, turtle cake, milk and tea, There was no mighty shake on R16's tray. On 5/9/23 at 11:54 AM V11 Dietary Aide stated, "we give the mighty shakes if someone has an order, we sent the might shakes out on the hall trays if they eat in their room." On 5/10/23 at 12:00 PM V2 DON stated, "dietary serves mighty shakes and nurses should follow up if (the resident) received them and how much they drank." R16's care plan documents R16 has potential for

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(B)

Nutritional Deficit related to history of Colitis. Diverticulitis, Gastro Esophageal Reflux Disorder. weakness. Interventions: Serve Nutritional

supplements as ordered.