STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Rehab & Health Care CT	136 South Dipper Lane Decatur, IL 62522

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35046 Based on interview and record review the facility failed to prevent the physical abuse of one resident (R25) by another resident (R7) for two (R25, R7) of three residents reviewed for abuse on the sample list of 21. Findings include: R7's nurse's note dated 7/7/22 at 7:00 AM, written by V3 Licensed Practical Nurse documents, (R7) was yelling at another (R25) and hit him on the arm. Writer separated them and brought (R7) to the desk. Notified (doctor) and Administrator (V1). On 7/25/22 at 8:39 AM, V3 stated on 7/7/22 at 7:00 AM that, I was passing meds and I don't know what was said but I heard a smack and (R25) said, Don't you smack me. I separated them (R7 and R25) and called the Administrator. The facility's final abuse investigation report form dated 7/11/22 written by V1 Administrator documents an allegation of physical abuse was reported on 7/7/22 at 7:00 AM. This form documents that R7 hit R25 on the arm. On 7/27/22 at 10:16 AM, V1 Administrator stated R7 is alert and oriented and knows what R1 is doing. V1 stated R7 did hit R25 on the arm on 7/7/22 at 7:00 AM.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 31642 Based on record review, observation and interview the facility failed to perform timely incontinence care to prevent shearing over R28's bilateral ischium (pressure ulcers), continued to implement nursing order while waiting for physician to be notified for a pressure ulcer treatment for two newly, facility acquired, Stage II pressure ulcers (shearing over bony prominence) 7/2/22-7/27/22 (25 days) and failed to measure the new, worsening pressure ulcers in accordance with facility policy for R28. These failures affected R28 and resulted in avoidable Stage II pressure ulcers with deterioration of the pressure ulcer as evidence by an increase in size. The facility also failed to ensure pressure relief device was in working order for R9. R9 and R28 are two of three residents reviewed for pressure ulcers on the sample list of 21. Findings include: 1. R28's Physician Order Sheet (POS) dated 7/1/22- 7/31/22 documents the following diagnoses: Dementia, CVA (Cerebrovascular Accident/ Stroke), Cellulitis, and HX (history) DVT (deep vein thrombosis/blood clot). The same POS does not have a treatment order documented until 7/27/22. (Pressure ulcer were identified 7/1/22 as documented below). R28's Minimum Data Set (MDS) dated [DATE] (same day pressure ulcers discovered) documents the following: R28's Brief Interview of Mental status score was 10 out of a possible 15 indicating moderate cognitive impairment. The same MDS documents R28 had a history of pressure ulcers with no pressure ulcers at the time of the MDS assessment. The same MDS documents R28 is always incontinent of bladder and frequently incontinent of bowel and has had no behaviors of rejecting care. The same MDS documents R28 is dependent on total physical assistant of two staff for hygiene needs and requires extensive assistance of one staff with toileting and transfers. R28s Care Plan dated 5/12/22 documents the following: P (Problem) High Risk for Pressure Ulcers per (Formal) Risk Assessment. (Formal) Risk score of 13 on 5/12/22. Risk factors Include bladder incontinence, history of pressure ulcers to left fourth toe, healed January 2015. Resident Specific Information: Requires assistance with toileting, bathing, dressing, needing reminders and physical assistance. G. (Goal) Will have no open areas caused by pressure or friction for the next review. A (action to be implemented) Apply house stock (Brand name) to peri-area with every (sic)after incontinent episode and as needed. Toilet/change brief when wet and upon rising, hs (bedtime) and after meals. The same Care Plan documents the following: P (Problem) Alteration in bladder elimination as related to incontinence. G (Goal) Skin will remain intact thru (through) next review. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A (action to be implemented) Toilet and/or change padding and give proper hygiene before/after meals, upon rising, upon request, before retiring for the evening, after napping, and prn (as needed) for incontinence. R28's (Formal) scale for predicting pressure ulcer risk date 7/1/22 (the same date as the MDS look back assessment) documents R28 is at high risk for level for developing pressure ulcers. 07/24/22 at 10:05 am R28 stated I (R28) have sores on my (R28's) bottom from not getting changed often enough. R28 also stated The night staff got me (R28) up (out of bed) and dressed between 5:00 am - 6:00 am. I (R28) have not been changed (provided incontinence care) since. R28 also stated R28 incontinence brief is very wet at this time and has soaked through R28's pants. On 7/24/22 at 10:12 am V11, Certified Nursing Assistant (CNA) stated R28 was already up and dressed when V11, CNA came in to work at 6:00 am. V11, CNA stated (R28) usually gets up around 4:00 am, but I (V11, CNA) am not sure what time night shift (staff) changed (provided incontinence care) (R28). (R28) has not been changed since I (V11, CNA) came in at 6:00 am. I have been very busy. On 7/24/22 at 10:25 pm R28 had wheeled R28's wheelchair to the hall bathroom door. V11, CNA assisted R28 assisted to a standing position. R28's sweat pants were visibly saturated across the full seat of R28's pants. R28's incontinence brief was totally saturated, hanging down between her legs to mid-thigh, and dripped with urine onto R28's bilateral legs and the floor. V11, CNA removed R28's saturated incontinence brief. R28 stated Oh my sores hurt so bad. R28 did not have a treatment dressing on either of two Stage II pressure ulcers at the back of her thigh/buttock fold. R28 had two nickel sized open areas of shearing over the bony prominence, (Stage II pressure ulcers), one on each upper inner thigh crease, ischial region. Both areas were red and raw in appearance. R28's buttocks and thigh skin were deeply indented and red. V11, CNA stated Usually (in general) those open areas have a wound dressing on them. R28 asked V11, CNA if V11, CNA would put some cream on the areas because they 'hurt so bad.' V11, CNA could not find a barrier cream to apply to R28's open wounds. V11, CNA stated to R28 All I can do is get you washed up. You don't have any cream (barrier). I will make sure you are clean and dry and that will fill better (relieve pressure ulcer pain). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R28's A.I.M for Wellness nursing note dated 7/1/22 documented by V7, Licensed Practical Nurse (LPN) documents the following: Assess; This change in condition, symptoms, or signs observed and evaluated are MASD (Moisture-Associated Skin Damage) to bilat (bilateral) back thighs. This started on 7/1/22. This condition, symptom, or sign has occurred before (blank checked) Yes. Other relevant information: Is at risk for skin breakdown per (formal skin evaluation). The same AIM for Wellness nursing note documents the following: ' (Number) 7. Skin Evaluation, Contusion (bruise) check marked, Other MASD to back bilat (bilateral) thighs. (Number) 8. Pain Evaluation; Does the resident have pain? (checked) Yes. Is the pain new (checked) Yes. Description /location of pain; While performing peri-care (incontinence care). Intensity of pain (rate on scale of 1-10, with 10 being the worst): 5 (moderate). The same AIM for Wellness nursing note documents the following: Manage; Physician recommendations and /or nursing interventions, Assist c (with) toileting q (every) 2 (two) hours and prn (as needed) and toileting hygiene. Assist c (with) T and P (turning and repositioning) while in bed and wheelchair q two hours and prn. Implement physician ordered treatment. V7, LPN also provided a hand written pressure ulcer plan of care for additional interventions dated 7/1/22. The hand written plan documents: P (problem).) Resident (R19) has 2 (two), Stage 2 (two) pressure injuries on posterior thighs. G (goal). Residents wounds will heal and no new skin issues by next review. (first bullet) Start 7/1/22 nsg (nursing) A (action to be implemented).) Apply ordered TX (treatment)- see POS (Physician Order Sheet) for current TX (treatment) orders. (bullet number 10) Start 7/1/22 nsg A. Daily skin (check mark) c (with) documentation and prn with any new skin issues. On 7/26/22 at 9:30 am V7, Licensed Practical Nurse (LPN) reviewed a quality assurance document and stated she can give me the information from the document but is not allowed by the corporation to give a copy to the surveyors. V7, LPN stated I can tell you what happened, I was the nurse that found (R28's) shear wounds from (R28's) excessive incontinence on 7/1/22. (R28's) skin breakdown was obvious (obviously) from being so wet. I was helping (not sure which it was) CNA's with resident care. I cleansed (R28) peri-area. (R28) had two areas, very irritated and open. (R28's) Left, back inner thigh open area (identified below on plan of care as Stage II) measured 1.2 centimeter (cm) long by 0.2 cm wide, and superficial so depth could not be measured. (R28's) second open area (identified below on plan of care as Stage II) to her right, inner back thigh open wound measured 1.3 cm long by 0.4 cm long and the depth was superficial and could not be measured. I (V7, LPN) cleaned them with Theraworx (wound cleaner), applied skin prep around the outside of the wounds and put hydrocolloid dressings on them to prevent further destruction of the tissue. I did this as a nursing judgment and faxed (facsimile) the doctor for actual orders (physician). I notified the family and (V1, Administrator in Training), we don't have a DON (Director of Nursing who is required to be notified of new pressure ulcers). I faxed the orders to (V23, Physician) and reported off to the next shift nurse. I can't remember which one (nurse). I thought they (nurses) would follow-up and get an order (physician, pressure ulcer treatment order). I didn't put (document) the treatment (V7, LPN implemented as a nursing judgement) on (R28's) POS (Physician Order Sheet) because the next nurse had to confirm that is what the doctor wanted. (R28) has a history of skin breakdown, MASD (Moisture-Associated Skin Damage) the cause. I (V7, LPN) educated the CNA's (unidentified) on turning and repositioning resident (R28), and proper timely incontinence care. R28's Treatment Administration Record (TAR) dated 7/1/22-7/31/22 documents R28 was not provided weekly skin assessments 7/11/22, and 7/25/22. R28's same TAR documents on 7/4/22, R28's had redness to buttocks and groin, on 7/8/22, R28 had irritation at an unidentified location, and on 7/18/22, R28 had redness and/or irritation in the groin area. On the same TAR there are no measurements documented of R28's bilateral, posterior thigh pressure ulcers (identified 7/1/22) until 7/27/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The same TAR does not document the following treatment was completed until 7/27/22. The treatment order documents: R28's Bilateral thigh had shearing related to Moisture-associated Skin Damage, clean area with (name brand wound cleaner) and apply hydrocolloid dressing, every three days and as needed. The back of the same TAR documents measurements were obtained on 7/27/22 as follows: Left, posterior med (medial) thigh, shearing (Stage II, shearing over bony prominence) related to MASD, measured 1.4 cm long, by 0.2 cm wide, by 0 cm, (increased from 7/1/22 Stage II measurement of left, posterior thigh 1.2 cm long by 0.2 cm wide by 0 cm depth). Right, posterior med (medial) thigh, shearing (Stage II, shearing over bony prominence) related to MASD, measured 3.0 cm long, by 0.4 cm wide, by 0 cm, (increased from 7/1/22 Stage II measurement of right, posterior thigh 1.3 cm long by 0.4 cm long by 0 cm depth). In comparison to the only measurements obtained prior to 7/27/22, from the quality assurance document 7/1/22 mentioned above, and reviewed by V7, LPN, R28's left thigh pressure ulcer increased by .2 cm in length, and R28's right thigh pressure ulcer increased by 1.7 cm in length. On 7/26/22 at 1:55 pm V17, Medical Director/Physician (MD) stated V17, MD expects all incontinent resident to receive timely incontinence care. MASD (Moisture-associated skin damage) causes skin breakdown. V17 also stated V17, MD was not informed (R28) had open areas caused by MASD. V17, MD stated V17, MD should have been informed. A treatment order would have been given. V17, MD also stated the Hydrocolloid dressing applied by the V7, LPN that found the open areas was appropriate and should have been continued to prevent further breakdown. V17, MD also stated R2's incontinence saturation observed, and no dressings on the open wounds after R28 complained of being wet for hours, Absolutely, caused the added pain, pressure ulcers and possibly further skin impairment. 35046 2. On 7/25/22 at 12:10 PM, multiple scarred areas were present on R9's buttocks. R9 stated she used to have sores on her bottom. R9 stated that her bed deflates frequently and she has told the staff about it and that they taped the hose. R9 stated that the bed was semi-deflated now. The mattress was about halfway deflated when touched. Duct tape was taped around the middle of the air mattress hose and at the connection to the air mattress pump. On 7/25/22 at 11:26 AM, V14 Hospice Nurse stated that R9 has the air mattress to prevent pressure ulcers. V14 stated the air mattress hose should not be taped. V14 stated the facility should have called and notified her that the air mattress was not working so that it could be replaced. R9's Baseline care plan dated 5/16/22 documents R9 is at high risk for pressure ulcers.

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F 0689 Level of Harm - 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** 31642 Based on observation, interview and record review the facility failed to lower R19's bed after providing cares and left R19 unattended in an elevated bed by resulting in a fall with serious injury and failed to complete neurological assessments for R19's fall. This failure resulted in R19 sustaining a fracture of the left wrist. R19 is one of three residents reviewed for falls on the sample list of 21. Findings include: R19's Face Sheet dated 6/30/17 documents the following diagnoses: Guillain-Barre syndrome, Paraneoplastic Neuromyopathy and Neuropathy, Muscle Weakness Generalized, and Unsteadiness on Feet. R19's Physician Order Sheet (POS) dated July 1-31, 2022 documents the following: Continue to wear splint, make appointment with (Private Hospital) 7/9/22. R19's Minimum Data Set (MDS) dated [DATE] documents the following: Brief Interview of Mental Status score of 15 out of a possible 15, (no cognitive impairment). The same MDS documents R19 has limited range of motion in one upper extremity, and bilateral lower extremities. The same MDS documents R19 is totally dependent on two staff for transfers and bed mobility. R19's Care Plan dated 6/26/22 documents the following: (R19) will use bed rail for repositioning at every opportunity thru (through) next review. Bed in lowest position. The same Care Plan documents: (R19) rolled out of bed, alleged fall. Fall mat placed, ed (education) given to (R19) and staff (unidentified) on bed in the lowest position. On 07/24/22 at 10:48 am, R19 was seated in R19's wheel chair next to R19's bed. R19 had a splint on the left wrist. R19 stated the following: All is good here except, I fell out of my bed about a month ago (6/26/22) and fractured my (left) wrist. I had to wait several days before the facility would get an X-ray (second X-ray). I don't think I would have broke my wrist if the bed was in a lower position. It was high like it is now. (R19 points to the elevated bed. R19's bed was three and a half feet above the floor). I (R19) fell far and hard. They were worried about my head. I am hard headed. It (R19's head) didn't hurt but I kept telling them my left wrist hurt and I wanted an X-ray (completed 6/27/22 and 7/8/22). I should have put on my call light and waited for staff to turn me. I thought I could adjust my position in bed on my own. Obviously, I won't do that again. R19's A.I.M. (Assess, Intercommunicate, Manage) for Wellness (nurses note) dated 6/26/22 (Sunday), signed by V6, Regional Director of Clinical Operations, documents the following: Alleged fall. The same AIMS for Wellness note documents the following; Manage, Physician recommendations and/or nursing interventions. X-Ray to L (left) wrist, may wait till Monday d/t (due to) patient (R19) request of not wanting to leave the facility and wait till Monday (6/27/22). Fall mat placed, and resident and staff educated on bed in lowest position. There was no documentation of neurological assessments noted on the AIM note or in the Nurse Notes after R19's unwitnessed fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R19's X-ray report dated 7/8/22 was ordered by V17, Medical Director documents the following: Reason: Swelling, pain with movement post fall (6/26/22). The same report documents Left wrist, two views. Findings; see impressions. Impression: Acute distal ulnar fracture. R19's Illinois Department of Public Health (IDPH), Final report (initial report 7/8/22 after second X-ray) dated 7/14/22 documents the following: (R19) Rolled out of bed and landed on her arm. It was not fractured at the time of the incident but was later determined that her wrist was fractured. The same IDPH report documents: Staff Interview: (V20, Certified Nursing Assistant) CNA, I had laid resident (R19) down to use the bathroom, when I went back a few minutes later she (R19) was on the floor. I put a pillow under her head and the other CNA (V22) went to get the nurse (unidentified). On 7/26/22 at 9:55 am V7, Licensed Practical Nurse (LPN)/ Minimum Data Set Coordinator stated V7, LPN was the nurse that cared for R19 the day of R19's fall on 6/26/22. V7, LPN stated the fall was not witnessed. V7, LPN also stated I should have initiated neurological assessment according to the policy, but I did not. V7, LPN stated (V20, Certified Nursing Assistant/CNA) was the CNA that worked that day. I re-educated (V20, CNA) to lower the resident beds after providing resident care so, this kind of thing doesn't happen to anybody else. I had noticed (R19's) bed was too high, immediately when I did her assessment (6/26/22). V7, LPN also stated When (R19) fell , (R19) complained of serious left arm pain. I can't remember if I gave her Tylenol, but I think I gave it (Tylenol). V7, LPN also stated (V17, MD) gave and order that day for x-ray that showed no fracture. It was about six days later that (R19) continued to complain of wrist pain and another X-ray was done. The second (X-ray) did show a fracture (left wrist). (R19) only had a skin tear the day of the fall from her bed. There was no swelling. I wanted to send (R19) to the hospital but (R19) refused. (R19) said she was ok and did not hit her head. I am pretty sure I gave Tylenol for the pain. On 7/26/22 at 2:10 pm V17, Medical Director stated the height of R19's bed should have been in the lowest position. The elevated height of the bed would increase the impact during the fall and was the likely the cause of R19's wrist fracture. V17, Medical Director also stated R19's fall was unwitnessed, therefore neurological assessments should have been ongoing as our policy documents. The facility policy Fall Prevention dated December 2009 documents the following: Policy: To provide for resident safety and minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: All staff. Procedure: (Number 5). Immediately after any resident fall the unit nurse will assess the resident and provide any care and treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. Number 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new interventions deemed appropriate at the time. The unit nurse will also place any new interventions on the CNA assignment worksheet. The same Fall Prevention policy documents the following: Fall Prevention Interventions: (Number 10.) Bed in lowest position-wheels locked. The facility policy Head Injury: dated reviewed 12/22/17 documents the following: It is the policy of (Private Corporation) to evaluate head injuries for a minimum period of 72 hours, to determine any negative effects, and to allow for immediate treatment to minimize permanent damage.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to provide timely incontinence care, failed to perform incontinence care in a manner to prevent cross contamination and potential infection for R28, and failed to maintain R25's urinary indwelling catheter tubing off the floor to prevent cross contamination. R25 and R28 are two of four residents reviewed for bowel and bladder/catheter care on the sample list of 21. Findings include: 1. R28's Physician Order Sheet (POS) dated 7/1/22- 7/31/22 documents the following diagnoses: Dementia, and CVA (Cerebrovascular Accident/ Stroke). R28's Minimum Data Set (MDS) dated [DATE] documents the following: R28's Brief Interview of Mental status score was 10 out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R28 is always incontinent of bladder and frequently incontinent of bowel and has had no behaviors of rejecting care. The same MDS documents R28 is dependent on total physical assistant of two staff for hygiene needs and requires extensive assistance of one staff with toileting. R28's Care Plan dated 5/12/22 documents the following: P. (Problem) Alteration in bladder elimination as related to incontinence. G. (Goal) Skin will remain intact thru (through) next review. A. (action to be implemented) Toilet and/or change padding and give proper hygiene before/after meals, upon rising, upon request, before retiring for the evening, after napping, and prn (as needed) for incontinence. On 07/24/22 at 10:05 am, R28 stated I (R28) have sores on my (R28's) bottom from not getting changed often enough. R28 also stated The night staff got me (R28) up (out of bed) and dressed between 5:00 am - 6:00 am. I (R28) have not been changed (incontinence brief) since. R28 also stated R28 incontinence brief is very wet at this time and has soaked through R28's pants. On 7/24/22 at 10:12 am V11, Certified Nursing Assistant (CNA) stated R28 was already up and dressed when V11, CNA came in to work at 6:00 am. V11, CNA stated (R28) usually gets up around 4:00 am, but I (V11, CNA) am not sure what time night shift (staff) changed (provided incontinence care) (R28). (R28) has not been changed since I (V11, CNA) came in at 6:00 am. I have been very busy. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/22 at 10:25 pm R28 had wheeled R28's wheelchair to the hall bathroom door. V11, CNA brought clean towel, wash cloth and clean sweat pants. V11, CNA did not wash V11, CNA hands, use the facility preferred hand cleaner or hand sanitizer. V11, CNA donned gloves and pushed R28's wheelchair over to the toilet. V11, CNA assisted R28 to a standing position. R28's sweat pants were visibly saturated across the full seat of R28's pants. R28's incontinence brief was totally saturated, hanging down between her legs to mid-thigh, and dripped with urine onto R28's bilateral legs and the floor. V11, CNA removed R28's saturated incontinence brief. R28 stated Oh my sores hurt so bad. R28 had an open area on bilateral inner posterior thighs. R28's buttocks and thighs were deeply indented and red. Both open wounds were red and raw in appearance. R28 asked V11, CNA if V11, CNA would put some cream on the open areas because they 'hurt so bad.' V11, CNA asked resident to sit still on the toilet and V11, CNA would go to R28's room and see if V11, CNA can find some barrier cream. Wearing the same contaminated gloves V11, CNA removed R28's saturated incontinence brief and wet clothes, V11, CNA left the hall bathroom and went down the hall to R28's room. V11, CNA opened several R28's dresser drawers. Continuing with the same contaminated gloves, V11, CNA went back to the bathroom and reported to R28, V11, CNA could not find a barrier cream to apply to R28's sore buttocks. V11, CNA stated to R28 All I can do is get you washed up. You don't have any cream. I will make sure you are clean and dry and that will fill better (relieve pressure ulcer pain). V11, CNA continued with the original gloves, now contaminated and completed R28's incontinence care, applied a clean incontinence brief and clothing change. V11, CNA, with the same soiled gloves, straighten R28's clothes and pushed R28's wheel chair to the bathroom door way. V11, CNA stated I know I messed up. I should have washed my hands and changed my gloves several times. I just get nervous being watch by state (Illinois Department of Public Health Surveyor). The facility policy Perineal Cleaning dated December 2017 documents to wash hand and don clean gloves repeatedly. The same policy documents the following: Policy: To eliminate odor; to prevent irritation or infection and to enhance resident's self-esteem. Responsibility: All nursing personnel Equipment: 1. Washcloth and towel 2. Soap, other cleansing agent or Theraworx 3. Gloves 4. Wash basin 5. Plastic Bag Procedure: Female-without catheter (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Rehab & Health Care CT	136 South Dipper Lane Decatur, IL 62522

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Position resident on back with knees bent and slightly apart. 2. Keep resident's gown at mid-abdomen with bed linens pulled to the knees. 3. Place half of the towel lengthwise under the buttocks with the remaining half to be used for covering and drying the perineum. 4. Wet washcloth with cleansing agent chosen. 5. Wash pubic area including upper inner aspect of both thighs and frontal portion of perineum. a. Use long strokes from the most anterior down to the base of the labia b. After each stroke refold the cloth to allow use of another area. 6. Follow same sequence for rinsing area, if applicable. 7. Place soiled items in plastic bag. 8. Dry thoroughly. 9. Instruct or assist resident to turn on side with top leg slightly bent. 10. Rinse cloth and apply cleansing agent chose, if applicable. 11. Wash peri-anal area thoroughly with each stroke beginning at the base of the labia and extending up over the buttocks. a. Refold cloth, as before, to provide clean area. b. Washing should alternate side to side, ending with the center anal area. 12. Place soiled items in plastic bag. 13. Rinse cloth and entire area in the same sequence as above, if applicable. 14. Dry area thoroughly. 15. Remove gloves and wash hands with soap & water, cleansing gel or Theraworx. 16. Apply new incontinent product, clothes or reposition comfortably. 17. Wash hands with soap & water, cleansing gel or Theraworx. Note: The basic infection control concept for peri-care is to wash from the cleanest to the dirtiest area and remember to change or remove gloves and wash hands when going from working with contaminated items to clean items. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	35046 2. On 7/26/22 at 8:50 AM, R25 was sitting in dining room. R25's catheter tubing was hanging out of the bag and dragging on the floor. R25's Care Plan dated 7/26/22 documents R25 has a indwelling catheter and has a goal for R25 to be free from Urinary Tract Infections by the next review date. On 7/27/22 at 11:00 AM, V1 Administrator stated R25's catheter tubing should be kept from dragging on the floor to prevent Urinary Tract Infections.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35046 Based on observation, interview, and record review the facility failed to employ the services of a full time Director of Nursing. This failure has the potential to affect all 29 residents residing in the facility. Findings include: On 7/24/22 from 8:00 AM to 4:00 PM and on 7/25/22, 7/26/22, and 7/27/22 from 7:30 AM to 4:30 PM there was not a Director of Nursing working in the facility. On 7/26/22 at 12:00 PM, V1 Administrator stated that the facility has not had a Director of Nursing since the end of May 2022. The facility's Census and Condition report dated 7/24/22 documents that there are 29 residents residing in the facility.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 35046 Based on interview and record review the facility failed to redirect a resident (R7) from the dining room when an escalation of behaviors occurred for one (R7) of one resident reviewed for behaviors on the sample list of 21. This failure resulted in an escalation from verbal to physical behaviors in the dining room in which R7 slapped R25 on the arm. Findings include: R7's nurse's note dated 7/7/22 at 6:00 AM, written by V3 Licensed Practical Nurse documents, (R7) up in dining room wheelchair out in the dining room. Yelling out inappropriate comments at times. Cussing other residents and calling them names. 1:1 with (R7) ineffective. R7's nurse's note dated 7/7/22 at 6:30 AM, written by V3 Licensed Practical Nurse documents, Writer gave (R7) his medicine. (R7) states, I like that. Then threw the water and the medicine. Continues to yell out. R7's nurse's note dated 7/7/22 at 7:00 AM, written by V3 Licensed Practical Nurse documents, (R7) was yelling at another (R25) and hit him on the arm. Writer separated them and brought (R7) to the desk. Notified (doctor) and Administrator (V1). R7's Behavior tracking record dated for 7/1/22 through 7/31/22 documents R7 will make inappropriate comments to staff and other residents. This sheet documents interventions of to allow venting of feelings/concerns, orient to reality of situation, and to redirect to other areas. On 7/25/22 at 8:39 AM, V3 stated on 7/7/22 at 7:00 AM that, (R7) was having behaviors. I was passing meds and I don't know what was said but I heard a smack and (R25) said, Don't you smack me. I separated them (R7 and R25) and called the Administrator. V3 stated, Prior to that he (R7) was yelling and making statements against the staff. Since he (R7) was just yelling and having verbal behaviors I didn't take him out of the dining room until he hit (R25). On 7/27/22 at 11:15 AM, V1 Administrator and V6 Regional Director of Clinical Operations stated that V3 should have removed R7 from the dining room when R7 was yelling out at other staff or residents and throwing his medication and water.