STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145719	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Village Healthcare	2202 North Kickapoo Street Lincoln, IL 62656

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - 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** 33971 Based on observation, interview, and record review the facility failed to obtain physician orders for use and care of an indwelling urinary catheter (R1), failed to notify a physician of a resident's abnormal urine laboratory testing results (R1), failed to timely treat a urinary tract infection/UTI (R1), and failed to obtain a physician ordered urine laboratory test (R4) for two of three residents (R1 and R4) reviewed for indwelling urinary catheters and UTIs in the sample of six. These failures resulted in R1 experiencing lower abdominal pain; urine with increased sediment in R1's indwelling urinary catheter tubing and bag; abnormal urine laboratory test results with a delay of physician notification and treatment. R1 was subsequently transferred to two different local area hospitals and admitted to the intensive care unit with a diagnosis of UTI with septic shock. Findings include: The facility's Urinary Tract Infections/Bacteriuria revised April 2007 states, 1. As part of the initial assessment, the physician will help identify individuals who have a history of symptomatic urinary tract infections, and those who have risk factors (for example, an indwelling urinary catheter, urinary outflow obstruction, etc.) for UTIs. 2. The staff and practitioner will identify individuals with signs and symptoms suggesting a possible UTI. 1. The physician will order appropriate treatment for verified or suspected UTIs based on a pertinent assessment. (continued on next page)

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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F 0690 Level of Harm - Actual harm Residents Affected - Few	The facility's Lab, Diagnostic Test Results and Change in Resident's Condition-Clinical Protocol (undated) states, Policy: To establish guidelines for physician notifications concerning resident lab and diagnostic test results and change(s) in resident conditions. 1. A licensed nursing will review all diagnostic test results: b. if the staff member who first receives or reviews lab and diagnostic test results is unable to follow the remainder of this procedure (i.e., reporting and documenting the results and their implications), another nurse in the facility should follow and coordinate procedural compliance. 2. The person who is to communicate results to a physician will review and compile the information and be prepared to discuss the following: the individual's current condition and any recent changes in status, including vital signs and mental status; b. major diagnoses, allergies, pertinent current medications, other recent pertinent lab work, actions already taken to address the results and treat the resident, and pertinent aspects of advanced directives; c. Why the test results were obtained, d. How the test results might relate to the individual's current status, treatments, or medications; e. any concerns the physician will be expected to address upon receiving the results. 3. The attending physician is responsible for responding in a timely manner to nurses regarding prompt notification calls or emergencies. The attending physician is also responsible for communicating the results of assessments and medical plans to a licensed nurse when appropriate. 4. Nurses should promptly notify the physician of any significant abnormal laboratory results. In such situations, direct communication with the physician is required and may not be faxed. Prompt calls must be made after office hours or when physician offices are closed. The following symptoms, signs and laboratory values should prompt the nurse to notify the physician as soon as possible: c. any of the following abnormal reports: Positive urine culture > (greater than) 100,000 colonies/ml (per milliliter) of a pathogen only if 1. Resident has symptoms and is not on treatment; or 2. The pathogen is not sensitive to the antibiotic which has been prescribed. 5. If a response from an attending physician concerning abnormal lab results is not obtained, the designated alternate physician should be called. If a response is still not received, the Director of Nursing/Designee should be notified for further instructions. 8. The following documentation should be entered into the resident's clinical record: a. Any calls to and from the physician indicating information conveyed or received, b. All orders taken from the physician or his designee (i.e., physician extender); c. Ongoing conversations with the physician regarding response to notification(s) of changes in condition and/or laboratory/diagnostic test results. The facility's Urinary Catheter Care Policy revised September 2005 states, The purpose of this procedure is to prevent infection of the resident's urinary tract. General Guidelines are documented as: Should the resident indicate that his or her bladder is full or that he or she needs to void (urinate), report it immediately to your supervisor; Observe the resident for signs and symptoms of urinary tract infection and urinary retention. Report findings to the supervisor immediately; Report to the supervisor any complaints the resident may have of burning, tenderness, or pain in the urethral area. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor. 5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. 6. Any problems or complaints made by the resident related to the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	1. R1's Resident Census documents R1 admitted to the facility on [DATE] and was placed on hospital leave on 4/10/24. R1's Admission Minimum Data Set assessment dated [DATE] documents the following: R1 is cognitively intact; R1 has impairment to both upper and lower extremities; R1 is dependent on staff assistance for all activities of daily living (ADLs); and R1 has an indwelling urinary catheter. R1's Admission Bladder Observation dated 3/22/24 documents R1 admitted to the facility with an indwelling urinary catheter. R1's Care Plan documents the following with a start date of 3/25/24: R1 requires an indwelling urinary catheter; R1 will have catheter care managed appropriately as evidenced by: not exhibiting signs of urinary tract infection or urethral trauma; Change catheter per MD (Medical Doctor) order; Provide Catheter Care during peri-care and as needed; and Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine). R1's Physician's Order documents a written order dated 4/3/24 and signed by V14 (Advanced Practice Nurse for UA C&S/Urinalysis with Culture and Sensitivity. R1's Order History documents an order with a start date of 4/4/24 to collect a Urinalysis with Culture and Sensitivity with special instructions as Chronic (Indwelling Urinary Catheter). As of 4/25/24, this same Order History did not document an order for: R1's Indwelling Urinary Catheter, including what size catheter and balloon to be used; Indwelling Urinary Catheter bag changes; or treatment orders for the care of R1's Indwelling Urinary Catheter. On 4/25/24 at 11:37 AM, V18 (Licensed Practical Nurse) verified R1 did not have orders for R1's Indwelling Urinary Catheter or Catheter Care and should have. V18 stated catheter care is completed minimally on each shift daily and would be on the resident's administration record to be completed each shift and as needed. As of 4/25/24, R1's medical record did not contain documentation that R1's indwelling catheter care was completed daily. R1's Resident Progress Notes dated 4/5/24 at 2:55 PM and signed by V7 (Licensed Practical Nurse/LPN) states, UA obtained and sent to (name of local area hospital). R1's Resident Progress Notes dated 4/8/24 at 2:38 PM and signed by V7 is recorded as a late entry on 4/12/24 at 11:45 AM. This note states, Writer (V7) called (name of local area hospital) lab to obtain UA C&S results that were sent to lab on 4/5/24. (Name of local area hospital) lab faxed preliminary results to writer (V7) and writer (V7) then calls back to (name of local area hospital) lab to get the final result faxed to facility. Writer (V7) then faxed C&S final results to PCP/Primary Care Physician. Awaiting response. R1's Resident Progress Notes dated 3/22/24-3/30/24 documents R1 with the presence of an indwelling urinary catheter draining yellow urine. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	R1's Resident Progress Notes dated 3/30/24 at 10:52 PM documents R1 complained during the shift of R1's indwelling urinary catheter not feeling right. V19 (LPN) attempted to irrigate R1's indwelling urinary catheter without success. V19 replaced R1's indwelling urinary catheter with an immediate return of yellow urine. R1's Resident Progress Notes dated 4/3/24 and signed by V15 (R1's Physician) states, Assessment: (indwelling urinary catheter) with yellow urine with sediment. This same note states, Plan: UA C+S (Urinalysis Culture and Sensitivity). R1's Resident Progress Notes dated 4/9/24 at 5:45 AM and signed by V10 (LPN) states, (R1) requesting catheter to be flushed; states he has been feeling some discomfort and pressure in his lower abdomen. Noted to have about 50 cc (cubic centimeters) of urine in the drainage bag. Abdomen distended and hard. Attempt to flush met with resistance. Catheter changed using size 14 fr (french) with 30 cc NS (normal saline). Upon insertion of new catheter, urine return of 1200 cc noted in the drainage bag right away. R1's Resident Progress Notes dated 4/10/24 at 1:21 PM and signed by V9 (LPN) states, (R1) complained of lower abdomen pain and states he can't pee. Moderate amount of sediment present in the (indwelling urinary catheter tube). Attempted to flush indwelling urinary catheter and was not effective. Changed indwelling urinary catheter #14 30 cc with scant amount of yellow sediment urine. Spoke with V14 (R1's Advanced Nurse Practitioner) and to send to ER (emergency room) for evaluation. Call placed to 911 for transport to (name of local area hospital). R1's Urinalysis Laboratory Result dated 4/5/24 documents the following results: Color: Amber; Appearance: Cloudy (with a normal result being clear); pH (potential of Hydrogen): 9 (with a normal result being 5-7); Leukocyte esterase: 2+ (with a normal result being negative); Nitrite: Positive (with a normal result being negative); Protein: 1+ (with a normal result being negative-trace); [NAME] Blood Cells 6-10 (with normal range being 0-5); Bacteria: 3+. This same lab result contains a handwritten note on the bottom corner that it was sent to V14 and V16 (R1's Physician). R1's Urine Culture Laboratory Result documents it was collected on 4/5/24 and resulted on 4/8/24. The Final Report states, > (greater than) 100,000 col/ml (colonies per milliliter) Proteus mirabilis. The Sensitivity report of susceptible antibiotics is listed at the bottom of the page. R1's History and Physical (H&P) from the local area hospital dated 4/10/24 documents R1 presented to a local area hospital from the skilled nursing facility for evaluation of a UTI (Urinary Tract Infection), but R1 was not started on any antibiotics and R1 had complaints of lower abdominal pain. (R1) reports that he has had some abdominal pain the past few days. His blood pressure was on the lower side on arrival with a bp (blood pressure) in the upper 70s. (R1's) labs demonstrated mild leukocytosis and urinalysis consistent with UTI. A CT (Computed Tomography) of (R1's) abdomen and pelvis was performed (on 4/10/24) and demonstrated abnormal appearance of urinary bladder with mucosal hyperenhancement bladder wall thickening, findings of cystitis. This same H&P states, Impression/Plan: Severe Sepsis secondary to complicated UTI (Urinary Tract Infection), Leukocytosis, Sepsis protocol. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	R1's Discharge Summary from the local area hospital dated 4/19/24 documents R1 was initially evaluated at a local area hospital closer to the facility and transferred to a second hospital where R1 remained until R1's discharge. R1 was admitted to the Intensive Care Unit/ICU on 4/10/24. R1 was discharged from the hospital on 4/19/24 after a nine-day hospital stay. R1 required blood pressure support medication while in the ICU. R1's significant problems are again stated as: Severe Sepsis (with) shock secondary to complicated UTI and Leukocytosis-Source appears to be r/t (related to) UTI in the context chronic (indwelling urinary) catheter. On 4/23/24 at 10:06 AM, V20 (R1's Spouse/Power of Attorney) stated that R1 had been complaining about lower abdominal pain and not feeling well for almost a week. V20 stated, I kept pointing out that (R1) had what looked like thick strands of mucous in his (indwelling urinary catheter) tubing and bag and the staff just kept brushing me off. (R1) is immunocompromised and he gets UTIs easily. I knew he was getting an infection, and no one was listening. They were telling me the way his catheter looked was 'expected.' V20 stated V20 was aware a urine sample was taken and V20 reported never being made aware what R1's urine test results were. V20 stated R1 was in the hospital for nine days and discharged to another skilled nursing facility. On 4/24/24 at 11:59 PM, during a third shift telephone interview with V10 (LPN), V10 stated when V10 came onto shift on 4/8/24, V10 received a report from V7 (LPN) that R1 was complaining of bladder burning and that the V7 had sent R1's UA C&S results to V14 (APN) and V16 (R1's Physician) earlier in the shift with no response. V10 stated that V7 had not received an answer back from V14 or V16 on V7's shift. V10 denied following up with V14 (APN), V15 (R1's Physician) or V16 (R1's Physician) regarding R1's UA C&S results. V10 denied being aware of R1's urine lab test results. V10 stated, I was just told (V7) faxed them. V10 stated during V10's shift, R1 had complained of abdominal pain and that R1 had expressed R1 felt as if R1's indwelling urinary catheter wasn't draining. V10 stated V10 attempted to flush R1's catheter and was not able to, so V10 replaced R1's urinary catheter with a new one. V10 denied speaking to any of R1's physicians or nurse practitioner (V14-V16) regarding R1's complaints of pain, issues with R1's indwelling urinary catheter, or R1's abnormal urine test results during V10's shift. On 4/24/24 at 2:22 PM, V7 (LPN) stated that V7 was the admitting nurse when R1 arrived at the facility. V7 stated that R1 had an indwelling urinary catheter in place at the time of R1's admission to the facility. V7 stated that V7 recalls V20 stating that R1 goes septic quickly with UTIs. V7 stated that V20 was requesting a urine sample be ordered for R1 as V20 was concerned about R1's urine. V7 stated on 4/5/24, V14 gave a verbal order to obtain a UA C&S and V7 sent the sample out on that same day. V7 stated when V7 returned to work on 4/8/24, V7 followed up with the lab regarding R1's urine C&S results. V7 stated V7 faxed the urine test results to V14 and V16 on 4/8/24. V7 stated V14 and V15 were taking over as primary care of R1, but V16 was still overseeing in the transitional period, so V7 sent the results to both. V7 denied getting a physician response regarding R1's abnormal urine test results and V7 denied speaking with V14, V15, or V16 directly regarding R1's abnormal urine test results. V7 stated V7 faxed the results and nothing further. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 4/24/24 at 10:30 AM, V9 (LPN) stated that V9 was off work for a couple of days before returning to work on 4/9/24. V9 denied speaking with any physician or getting new orders on 4/9/24 regarding R1's abnormal urine test results. V9 stated V9 was aware R1's test results were faxed to a provider on 4/8/24, but V9 was not aware R1's test results were abnormal requiring a physician response. V9 stated if V9 had been aware of R1's urine test results were positive for a UTI, V9 would have attempted to speak with a physician directly. V9 stated, I would have sent the fax and immediately followed up with a phone call. V9 stated on 4/10/24, V9 was handed R1's UA C&S results and there was a sticky note on the results stating to call R1's daughter. V9 stated the UA was positive for a UTI. V9 stated, I went to (V2/Director of Nursing) and I asked who is taking care of this? V9 stated V14, V15, and V16, but V14 and V15 did not end up coming to the facility on [DATE] to see the residents. V9 stated on 4/10/24, R1 was complaining of severe abdominal pain with a lot of sediment in R1's indwelling urinary catheter tubing and bag. V9 stated V9 tried to irrigate R1's catheter and was unable to. V9 stated that V9 then replaced R1's urinary catheter and V9 still did not get much urine return, stating it was mostly sediment. V9 stated V9 asked about bladder scanning R1, but the equipment was broken and not able to be used. V9 stated, I thought ok, it's time to go. V9 stated V14 gave orders for R1 to be transferred to the local area emergency room for evaluation. On 4/23/24 at 12:57 PM, V2 (Director of Nursing) stated that the facility was in transition between two different lab companies and that in the interim, all lab samples had to be transported to the local hospital to be tested . V2 stated that since the hospital was running the lab tests, the results did not automatically show up in the system at the facility. V2 stated the hospital was not faxing over results once they were available; the facility was having to call to get them causing delays. V2 also stated that V14 and V15 were new providers to the facility and were going to be taking over as primary care for the respiratory care residents, including R1. V2 stated that V16 remained primary in the two-week transitional period while V14 and V15 got to know the residents and meet families. V2 stated V14 ordered the UA C&S on R1 during rounds and that the results were given to V14 and V16 on 4/8/24. V2 stated the nursing staff should have called V14, V15, or V16 to immediately notify of R1's UA C&S results. V2 stated V14 and V15 did not come to the facility on [DATE] as originally planned, so R1's urine lab tests were not reviewed then either. V2 stated R1's UA results were positive for a UTI and as soon as the C&S results were available, the nurses should have called to get treatment orders that day. V2 stated R1's UA resulted on 4/5/24 and that on 4/8/24, new orders should have been received based off the culture and sensitivity. V2 verified treatment orders were not obtained at the facility for R1's abnormal urine test results and should have been. V2 verified residents with indwelling urinary catheter should have orders for the catheter indicating the size catheter and balloon to be used and orders for catheter care to be completed. V2 stated the residents' electronic administration record would document the catheter care was completed. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 4/24/24 at 11:30 AM, V14 (Advanced Practice Nurse) stated that during rounds on R1 on 4/3/24, it was noted that R1's urine in R1's indwelling urinary catheter bag was yellow and cloudy so V14 ordered a UA C&S to be obtained. V14 stated R1's initial UA result was sent to the wrong doctor as the nurses were not sure where to send results in the facility's transition period of primary care doctors changing. V14 stated, I was not able to be apprised what to do because I did not know. V14 stated V14 never saw the results from R1's 4/8/24 urine culture and sensitivity. V14 stated V14 would have expected to be made aware of R1's abnormal UA C&S result as soon as it was resulted. V14 stated V14 did not round in the facility on 4/10/24. V14 stated R1's UTI would have been easy to treat if V14 had been made aware of R1's lab findings. V14 stated if V14 had been made aware of R1's C&S result on 4/8/24, R1 would have had a full day or two of good relief and that it is possible R1 may not have needed to be sent out to the hospital. V14 stated, With UTI infections, the inflammation in R1's urinary tract is worsened, and antibiotics would have helped decrease that swelling. V14 stated R1's urinary sediment increases problems with obstruction, further leading to the importance of reducing the swelling and getting antibiotics started quickly. 2. On 4/24/24 at 2:56 PM, R4 was lying in bed with R4's eyes closed. R4's indwelling urinary catheter bag was hanging from the left side of R4's bed and was draining clear yellow urine. R4's current Physician Orders documents an order for an Indwelling Urinary Catheter for a diagnosis of urine retention. R4's Resident Progress Note dated 4/17/24 at 4:34 PM and signed by V3 (Assistant Director of Nursing) states, V14 (Advanced Nurse Practitioner) was here for weekly rounds and ordered UA C&S (Urinalysis and Culture and Sensitivity). Awaiting Progress Notes from NP (Nurse Practitioner). Order placed in computer. The facility's Lab Due Report documents a one-time order dated 4/19/24 for R1 for a Urinalysis; Urine Culture to rule out a urinary tract infection. As of 4/24/24, R4's medical record did not contain a result for R1's 4/19/24 physician ordered UA and C&S. On 4/24/24 at 2:36 PM, V2 (Director of Nursing) stated, I am not going to lie to you. V3 (Assistant Director of Nursing) placed the order for the UA and C&S to be completed, but it was never done. Whether the lab never picked it up or the staff never collected it, I don't know, but either way, it wasn't done. At this time, V2 verified R4's UA and C&S should have been collected on 4/19/24 and it was not.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 33971 Based on interview and record review, the facility failed to designate an Infection Preventionist onsite, who is responsible for assessing, developing, implementing, monitoring, and managing the Infection Prevention and Control Program (IPCP) to prevent and control infections in the facility. This has the potential to affect all 72 residents living in the facility. Findings include: The Infection Preventionist Job Summary dated 2/13/20 states, The Infection Preventionist (IP) is responsible for overseeing the infection control program. The IP systematically collects and assesses data in collaboration with the team to provide therapeutic, evidenced based care. The IP works collaboratively with the team to develop plans of care and documents progress toward achieving defined outcomes. This position requires the knowledge of epidemiology and application of public health practices in the facility, with the goal of implementing effective and efficient procedures and policies to combat disease transmission among residents and staff. Responsibilities: 1. Keeping Infection section of EMR (Electronic Medical Record) current on residents with infections, updating weekly and as needed. 2. Tracks and Trends employee related infections. 3. Ensuring assessments are done per program requirements. 4. Assessing and documenting on all infections within Infection Watch. 5. Audits infection control practices on the floor. 6. Monitors immunization process throughout the year on all residents and employees. 7. In-servicing staff on infection control program. 8. Updating all care plans relevant to infections and isolation. 9. Completing MDS (Minimum Data Set Assessment) section pertinent to infections. 10. Communicates with IDT (Interdisciplinary Team) regarding residents with wounds. 11. Evaluated all new admissions/readmissions within 24 hours of admission for any active infections or usage of antibiotics. 12. Completes analysis of information collected regarding infections and presents at QA (Quality Assurance) Meeting. The Key Personnel List provided by V1 on 4/23/24 is blank in the section titled Infection Preventionist with no staff member named. On 4/25/24 at 12:17 PM, V1 (Administrator) stated that the previous IP Nurse (V17) no longer works at the facility as of 4/2/24 and that V18 (Licensed Practical Nurse/Wound Nurse) has been V17's back up. On 4/25/24 at 11:37 AM, V18 stated V17 was the previous IP nurse and V17 no longer works at the facility. V18 stated that while V18 does have a current IP Certificate, V18 has not worked in the IP role in any capacity since V17 left. V18 stated V18 has not been made aware that V18 is acting as the IP nurse in the facility. The Daily Census Report dated 4/23/24 documents 72 residents currently reside in the facility.