STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146083	A. Building B. Wing	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Princeton	140 North Sixth Street Princeton, IL 61356

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33971 Based on interview and record review, the facility failed to follow their policy to ensure that an effective discharge plan was developed and implemented. The facility also failed to ensure that referrals were made to the appropriate community resources at the time of discharge for one of four residents (R1) reviewed for discharge planning in the sample of four. Findings include: The facility's Discharge Planning, Process, and Procedure revised 9/23 documents the objective is to assist the resident in attaining a safe transition back to the community. This same procedure states, 6. The resident's individualized discharge plan shall be discussed from a multidisciplinary perspective during the Medicare meeting. 7. The Admissions/Social Service Director shall then communicate post discharge needs to the nurse. 8. Medical considerations are to be made and teaching and training related to medical equipment, post discharge care, etc. shall be provided to the resident by qualified nursing staff prior to discharge from the facility. Such education and training shall be documented in the medical record. 9. The Admissions/Social Service Director shall discuss any post discharge supply needs or continued services with the resident and/or responsible parties, and then provide assistance in making referrals to appropriate agencies to attain needed services and equipment. Documentation of discussion and contact with outside agencies shall be placed in the medical record. 10. The Admissions/Social Service Director shall consult with nursing staff regarding specific discharge date and needs. Nursing staff shall then contact the physician to obtain orders for discharge and any post discharge service or supply needs. At the time of discharge, discharge instructions and medications shall be reviewed with the resident and/or responsible parties by a qualified nurse. This discussion shall be documented in the medical record. 13. A discharge summary shall be completed by the discharging nurse following the resident's discharge from the facility. The facility's Care Plan Policy dated 6/1/22 states, 5. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent. 7. The comprehensive care plan will describe at a minimum the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being. c. The resident's goals for admission, desired outcomes, and preferences for future discharge. d. Discharge plans, as applicable. 8. The comprehensive care plan will be prepared by an interdisciplinary team. (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Social Service/Admissions Director Job Description revised 9/19, states, Job Function: Completion of Admission and Discharge Planning Process, Delivery of all other Social Service Functions. Primary responsibilities: 4. Serve as a liaison between facility, residents, responsible parties, and outside agencies. 5. Facilitate the discharge planning process; development and implementation of discharge care plans. 6. Refer resident to outside agencies as appropriate. Specific Duties: 1. Complete admission paperwork and processes. 2. Complete on-going discharge planning documentation and discharge care plan for all short-term residents. Follow up with residents post-discharge. This same Job Description documents the Social Service/Admissions Director assists in the development of the resident's care plan and is responsible for discharge planning documentation. R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses to include but not limited to: Pressure Ulcer of Unspecified Site; History of Falling; Reduced Mobility; Lack of Coordination; Weakness; Non-pressure Ulcer of Left Ankle; Polyosteoarthritis. R1's Census Report documents R1 admitted to the facility on [DATE] and discharged home on 10/9/23. R1's Progress Note dated 9/24/23 at 4:08 PM signed by V5 (Licensed Practical Nurse/LPN) documents R1 admitted to the facility after a hospital stay. (R1) fell at home and laid on the floor for four days. This led to anemia, duodenal ulcer, and pressure areas to coccyx/buttocks. R1's Discharge Minimum Data Set/MDS assessment dated [DATE] documents the following: R1 admitted to the facility from the hospital. R1 to be discharged home and a return to the facility was not anticipated. R1 is cognitively intact. R1 required setup or clean-up assistance for toilet hygiene. Supervision or touching assistance-Helper provides verbal cues an/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. R1 required supervision or touching assistance for showering/bathing, lower body dressing, putting on/taking off footwear, the ability to stand up from a sitting position, the ability to transfer to/from a bed to a chair, the ability to get on/off a toilet, and the ability to get in/out of tub/shower. R1 is 80 inches tall. R1 has one unhealed stage 3 pressure ulcer. R1 takes high-risk drug class medications: Diuretics, Opioids, and Hypoglycemics. R1's Admission Observation Report dated 9/24/23 documents the following: R1 lives alone. R1 does not have assistance with personal care. R1 has fallen in the last month. R1 experiences unsteady gait and weakness with activity. R1 uses a walker and wheelchair. R1's Discharge Planning Observation Report signed by V4 (Social Service/Admissions Director) and dated 9/26/23 documents Post Discharge Service/Referrals as outpatient therapy. Other possible measures to be taken at discharge, including home health care are blank and not marked. Post Discharge Supply Needs including dressings, bandages, gauze are blank and marked as none of the above. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Wound Evaluation and Management Summary dated 10/6/23 and signed by V3 (R1's Wound Physician) documents R1 has wounds to R1's coccyx, left lower medial leg, left posterior ankle, right lower buttock, and left lower buttock. This same note states, Stage 3 Pressure Wound Coccyx Full Thickness. Etiology: Pressure. Wound Size: 1 Centimeter (cm) x 0.5 cm x 0.2 cm. Exudate: Light sero-sanguineous. A primary dressing treatment plan is documented as Hydrocolloid Sheet (thin) apply three times per week for 30 days. R1's non-pressure wound of the left, posterior ankle documents an etiology of trauma/injury and measures 1.5 cm x 2 cm. The primary dressing treatment plan is documented as apply skin barrier protectant wipes once daily for 30 days. R1's non-pressure wound of the left lower medial leg documents an etiology of trauma/injury and measures 3.5 cm x 1 cm x 0.1 cm. The primary dressing treatment plan is documented as Xeroform gauze apply three times per week for 30 days. R1's left lower medial leg documents a secondary dressing of apply Abdominal Gauze Pad and cover with a gauze roll three times a week for 30 days. R1's non-pressure wound of the left lower buttock documents an etiology of trauma/injury and measures 0.4 cm x 0.4 cm x 0.1 cm with light sero-sanguineous exudate. The primary dressing treatment plan is documented as Hydrocolloid Sheet (thin) apply three times per week for 30 days. R1's non-pressure wound of the right lower buttock documents an etiology of trauma/injury and measures 0.6 cm x 0.3 cm x 0.1 cm with light sero-sanguineous exudate. The primary dressing treatment plan is documented as Hydrocolloid Sheet (thin) apply three times per week for 30 days. This same Wound Care Summary states, Follow-up: Evaluation by a wound care specialist within seven days with further intervention as indicated. R1's Physician Order Report dated 9/24/23-10/26/23 documents an order dated 10/2/23 that R1 may discharge home with PT/OT (Physician Therapy/Occupational Therapy). This same Physician Order Report documents an order dated 10/5/23 that R1 may discharge home with all current medication, treatments, and outpatient PT/OT. R1's Notice of Medicare Non-Coverage signed by R1 on 10/5/23 documents payment for R1's skilled nursing services will end on 10/8/23. R1's Social Service Note on 10/5/23 at 10:56 AM signed by V4 documents R1 was issued a NOMNC/Notice of Medicare Non-Coverage and documents R1 will discharge home on 10/9/23 with outpatient therapy. This same Social Service Note does not document R1 discharging with home health care or nursing services. R1's Social Service Note on 10/6/23 at 11:10 AM signed by V4 documents R1 was requesting to appeal R1's NOMNC due to (R1) does not feel that he is strong enough to return home at this time. R1's Progress Note on 10/8/23 at 9:30 AM signed by V6 (Special Care Unit Coordinator) states, Spoke to (R1) about his appeal being denied. (R1) stated that he still needs help in getting stronger. (R1) is going to call the QIO (Quality Improvement Organizations) right away and speak to them about reconsideration. (V6) spoke to (R1) that it would take 14 days to process and if denied (R1) would be responsible for his stay at (name of skilled nursing facility). R1's Social Service Note on 10/9/23 at 8:15 AM signed by V4 states, (R1's) appeal was denied. (R1) would like to discharge home today with therapy at (name of outpatient physical therapy center). (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Nursing Progress Note on 10/9/23 at 12:20 PM signed by V7 (LPN) documents R1 left the facility via personal vehicle. This same note states, (V7) went over discharge instructions with (R1) and gave him a copy upon discharge. Medications sent with as well. This same progress note does not contain documentation that wound care teaching was completed with R1 or any caregivers for R1. On 10/26/23 at 10:49 AM, V4 (Social Service/Admissions Director) V4 stated that V4 is responsible for all discharge planning for residents and ensuring all discharge orders/instructions are set up prior to discharge. V4 stated that R1 lived alone and did not have much family support. V4 denied that R1 denied nursing care services at home at the time of R1's discharge from the facility. V4 stated V4 was not aware that R1 had wounds that required treatments while R1 was a resident at the facility. V4 stated V4 would absolutely have arranged nursing care for R1 at home to help with R1's wound treatments. V4 stated V4 was arranged for outpatient physical therapy and no other services at the time of R1's discharge. On 10/26/23 at 1:43 PM, V9 (Wound Nurse/Infection Preventionist/Registered Nurse) stated that if a resident has wounds and they are going home without much support at home, home health is generally ordered. V9 stated that R1's wound dressings were to be changed three times a week which would have sufficed for home health. V9 stated, R1's wounds were ok to be managed at home but under the direction of a nurse. You worry about infection concerns especially with wounds around the coccyx. Wounds in the coccyx area need well covered and cleaned. You risk contamination from urine or feces, increasing your risk of infection. V8 stated that due to the anatomical location of R1's wounds, R1 would not have been capable of cleaning R1's wounds or changing the dressings himself. V8 stated R1 was very tall and even reaching the wounds on R1's legs would have been difficult for R1. V8 stated, (R1's) wounds needed to be cared for under the direction of a skilled provider. V8 stated if it had been a situation where home health nursing care was being refused, V8 or another nurse would have had to ensure that education with return demonstration was completed with the caregiver who would have been responsible for caring for R1's wounds. V8 stated V3 (R1's Wound Physician) saw R1 in the facility on 10/6/23. V8 stated, That would have been a great opportunity for the nurse to speak out and explain each step of the wound care being completed with R1's caregiver. I wasn't aware on Friday (10/6/23) that (R1) would be discharging home so soon. At this time, V8 denied that V8 provided wound education of any kind to R1 or any of R1's family/friends for caring for R1's wounds at home. V8 stated that two to three days of wound care supplies are also sent home with residents to make sure they are well-equipped with supplies to treat the wound site or area before home health comes or more supplies are ordered. V8 stated a detailed progress note would be completed after wound teaching was completed. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/27/23 at 9:57 AM, V8 (R1's Family Member) stated that R1 lives alone and does not have family other than R1's ex-wife and V8. V8 stated that V8 picked R1 up from the facility on 10/9/23 to drive R1 home. V8 stated, I was there to take (R1) home, and no one talked to me or told me anything. We sat in (R1's) room for a while waiting for the nurse to go over his instructions, his medications, his wounds, anything. No one came in. Staff kept popping their head in and out to see if we were still in the room, but no one ever came and talked with us. (R1) has wounds. How are we supposed to care for them? What did they need? I don't know. I work out of town, and for at least 10 hours a day, (R1) is by himself. Those wounds are on (R1's) butt and his lower legs. There's no way he can reach them on his own. He's 6 foot 8 (inches) and 240 pounds. He's a big guy. He can't even reach the ones on his legs. The dressings weren't changed for about 10 days until his ex-wife came to visit. He had to call places to get help himself. It's not right. At this time, V8 verified that no wound supplies of any kind were sent home with R1 and that no staff from the facility educated R1 or V8 about caring for R1's wounds and did not have V8 demonstrate how to perform R1's wound treatments. On 10/27/23 at 10:15 AM, R1 stated that prior to leaving the skilled nursing facility, R1 was not set up with home health care or nursing services. R1 denied ever telling anyone that R1 didn't want help at home after discharging from the facility. R1 stated R1 was asked about Physical Therapy and that's it. R1 stated, I wasn't anywhere ready to be on my own. I need the help. I took it on my own to call around to get a nurse or an aide in here to help me. I have wounds on my backside that I can't get to. I tried taking care of them on my own; it's too hard by myself. R1 stated that when R1 left the skilled nursing facility, R1 nor any caregivers for R1 were provided wound care instructions, no wound teaching was completed, and R1 was not given any wound care supplies. As of 10/27/23 R1's medical record did not contain documentation that R1 was offered home health or nursing services after discharge. That R1 had ever declined home health or nursing services and that R1 was arranged for home health or nursing services after discharge. There was not documentation that R1 or any caregivers for R1 were provided wound care teaching with return demonstration; or that wound care supplies/treatments were provided to R1 at the time of R1's discharge from the facility.