STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint 2120605/IL130542	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise a care plan to include interventions related to the use of a leg immobilizer for one of three residents (R1)	F 657	F 657 Care Plan Timing and Revision Corrective actions which will be accomplished for those residents found to	3/1/21

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

Electronically Signed | 02/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 657	Continued From page 1 reviewed for pressure ulcers in a sample of three. Findings include: The facility's 3-10-17 Care Planning policy documents the following: "The comprehensive care plan will describe, at a minimum, the following: . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being." R1's POS (Physician Order Sheet) documents R1 was admitted on 1-15-21 with diagnoses of paraplegia and a fracture of the lower end of his right femur. R1's emergency room orders dated 1-15-21 document R1 needed emergency admission to a skilled nursing facility with orders for therapy and to wear his immobilizing right leg brace at all times. There were no other orders related to R1's right broken leg and leg brace. R1's care plan initiated 1-16-21 documents R1 is at risk for pressure ulcers and to monitor for any changes in skin appearances. R1's care plan does not contain any mention of R1's right leg brace. There are no intervention related to monitoring of R1's leg/brace for tightness, circulation, or reddened areas or when and for how long to remove the brace. On 1-22-21, an order to "remove brace to right lower leg extremity and complete skin check every shift" was added to R1's POS. There was no revision to R1's care plan related to this new order.	F 657	have been affected by the deficient practice: R-1 no longer resides at the facility and was discharged from the community on 1/29/2021 prior to the survey. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing Services reviewed care plans and determined that residents with a brace or splint device has the potential to be affected by the alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur: Resident Assessment Coordinators will be in-serviced by Corporate Consulting Nurse on writing person centered, individualized care plans with consideration of the resident□s physical and mental status when choosing goals and appropriate interventions. This training will include a review of a brace and splint care plan template created in guiding appropriate interventions for monitoring, skin inspections and other measures to prevent skin breakdown or associated complications. The Resident Assessment Coordinators will update the Task List in the point of care electronic documentation of residents with braces or splints to include monitoring, skin inspections, and skin care tasks for the direct care staff responsible for the residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 657	Continued From page 2 On 2-3-21 at 1:30 pm, V2 Director of Nursing verified there were no interventions related to the care/positioning/monitoring of R1's leg brace on R1's care plan.	F 657	The nurses will be educated by the Director of Nursing or designee on ensuring care plan interventions, orders for and completion of monitoring, skin inspections, and skin prevention measures for residents with braces or splints are in place. C.N.A.□s will be re-educated regarding consistently implementing care plan interventions including monitoring, skin inspections, skin care and identification/notification of change in condition for residents with braces or splints in place. The Director of Nursing or designee will audit 3 residents per week x 4 weeks then random audits of 1 resident per week for 6 weeks to confirm brace/splint care plan interventions including monitoring, skin inspections, and pressure injury prevention are in place. Documentation of the task will be monitored in the electronic point of care charting. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: The DON will present a summary of the audits to the QAPI committee. The committee will determine if further auditing or other corrective measures are necessary to attain and maintain compliance. Continued auditing will be completed as recommended by the committee and a summary of those audits presented at subsequent QAPI meetings	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		3/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 686	Continued From page 3 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy for the prevention of pressure ulcers including daily skin checks, ensuring proper placement of a medical brace, and wound assessment upon initial observation for one of three residents (R1) reviewed for pressure ulcers in a sample of three. These failures resulted in R1 developing multiple Deep Tissue Injuries and an unstageable pressure ulcer subsequently requiring hospitalization for wound infections. Findings include: The facility's undated Pressure Ulcer Prevention policy documents the following: "A pressure ulcer is defined as any lesion caused by unrelieved pressure that results in damage to underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed." "An	F 686	Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: R-1 no longer resides at the facility and was discharged from the community on 1/29/2021 prior to the survey. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing Services reviewed care plans and physician orders then determined that all residents with prescribed brace or splint device has the potential to be affected by the alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 686	Continued From page 4 integral part of any skin care program is a systematic skin evaluation. It is through these inspections that early skin problems can be detected and interventions started." "These inspections start on admission. Evaluations must continue on a daily basis for all residents that are at risk for skin breakdown." "Pressure ulcers may develop from positioning as well as the use of medical devices. Pressure ulcers may develop from the use of nasal tubing, catheters, casts, braces, cervical collars or other medical devices. Monitor all devices for proper placement to avoid pressure on surrounding tissue." The facility's Wound Assessment policy revised 7-1-19 documents, "New wounds and/or other skin impairments/abnormalities will be assessed and documented using the Skin and Wound Program in the electronic medical record upon being observed." R1's nursing notes dated 1-29-21 document R1 was sent to a local hospital for "sepsis wounds right leg peripheral artery disease." R1's admission nursing assessment dated 1-15-21 documents R1 had no skin issues on admission but was at risk for skin injury. R1's Braden pressure ulcer risk assessment dated 1-15-21 documents R1 is at risk for pressure ulcers. R1's emergency room orders dated 1-15-21 document R1 needed emergency admission to a skilled nursing facility with orders for therapy and to wear his immobilizing right leg brace at all times. There were no other orders related to R1's right broken leg and leg brace.	F 686	reoccur: The nurses will be educated by the Director of Nursing or designee on ensuring care plan interventions, orders for and completion of monitoring, skin inspections, and skin prevention measures for residents with braces or splints are in place. C.N.A.'s will be re-educated regarding consistently implementing care plan interventions including monitoring, skin inspections, skin care and identification/notification of change in condition for residents with braces or splints in place. The Director of Nursing or designee will audit 3 residents per week x 4 weeks then random audits of 1 resident per week for 6 weeks to confirm brace/splint care plan interventions and appropriate device orders including monitoring, skin inspections, and pressure injury prevention are in place. Documentation of these items will also be monitored in the electronic point of care charting and treatment or medication administration records. A head to toe skin audit was completed on every resident to confirm that no resident has any skin condition that has not been appropriately identified and documented and has proper treatment orders as necessary. A new protocol will be implemented which will include the need for any therapist who notes a skin condition change to notify the nurse both verbally and in writing using a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 686	Continued From page 5 R1's Skin and Wound Evaluation form dated 1-22-21 note the following areas were found that day: Coccyx a DTI (Deep Tissue Injury) measuring 4.7cm (centimeters) x 2.7cm, a right shin Medical Device Related Pressure Injury, DTI measuring 5.3cm x 2.7cm, right lateral malleolus (ankle) Medical Device Related Pressure Injury, DTI measuring 7.5cm x 4.3cm, a right thigh Medical Device Related Pressure Injury, DTI measuring 5.2cm x 2.4cm, a right heel DTI measuring 2.1 x 1.2 DTI and a MASD (Moisture Associated Skin Damage) to the sacrum measuring 10.5cm x 8.3cm. R1's Skin and Wound Evaluation forms dated 1-24-21 document the following areas were found that day: Right trochanter Stage 1 measuring 5.5cm x 3.9cm, left trochanter Stage 1 measuring 3.9cm x 2.9cm, and left ischial tuberosity unstageable pressure ulcer measuring 7.2cm x 4.1cm. R1's POS (Physician Order Sheet) documents R1 was admitted on 1-15-21 with diagnoses of paraplegia and a fracture of the lower end of his right femur. There are no orders for the care and treatment of R1's right leg/immobilizing brace until 1-22-21, after R1 developed pressure ulcers to that area. An order obtained 1-22-21 states "remove brace to right lower leg extremity and complete skin check every shift." R1's care plan initiated 1-16-21 documents R1 is at risk for pressure ulcers and to monitor for any changes in skin appearances. R1's care plan does not contain any mention of R1's right leg brace. R1's current care plan does not include intervention related to monitoring R1's leg/brace for tightness, circulation, or reddened areas or	F 686	Skin Attention Form and to also notify the DON/Wound nurse and Unit Manager of the noted change in the resident's skin condition. A new weekly skin check assessment will be initiated in the electronic health record that requires any medical devices to be removed for thorough inspection and documentation of the skin status under the device. Any resident who has an order for a brace, splint or similar medical device that could potentially cause skin breakdown will have an order on the TAR to remove and check the skin status (minimally) once a day. The Director of Nursing or designee will monitor records to confirm that this order is entered on admission (if the resident is admitted with a brace/splint/medical device) or when the brace/splint/medical device has been initiated. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: The DON will present a summary of the audits to the QAPI committee. The committee will determine if further auditing or other corrective measures are necessary to attain and maintain compliance. Continued auditing will be completed as recommended by the committee and a summary of those audits presented at subsequent QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 686	Continued From page 6	F 686		

when and for how long to remove the brace.

R1's admission MDS (Minimum Data Set) dated 1-22-21 documents R1 was alert and orientated, needed extensive assistance of two for bed mobility and transfers and had no pressure ulcers upon admission, but was at risk for developing pressure ulcers.

R1's MAR/TAR (Medication Administration Record, Treatment Administration Record) contains no documentation of daily skin assessments or monitoring of R1's right leg brace from admission on 1-15-21 until 1-22-21.

R1's nursing notes dated 1-17-21 is the first time R1's leg brace is mentioned since admission on 1-15-21. This note states, "(R1) able to place leg brace on himself, no swelling or pain noted pedal and radial pulses in intact." R1's nursing notes from 1-15-21 to 1-22-21 do not contain consistent assessment/monitoring of R1's right leg with R1's brace other than R1's 1-15-21 Nursing note nor do they contain general daily skin monitoring. These notes do not contain any documentation of R1's brace being removed and a skin assessment completed.

R1's OT/Occupational Therapy evaluation dated 1-17-21 documents R1 had a recent fall with a right distal femur fracture with right lower extremity brace in extension, right shoulder pain with plans to improve strength, range of motion and activity tolerance. R1's OT note dated 1-18-21 documents R1's knee immobilizer was causing pain and redness. Immobilizer adjusted and washcloths placed to help reduce risk of skin breakdown. There is no mention of R1's immobilizer being adjusted/washcloths placed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 686	Continued From page 7	F 686		

after this note until 1-24-21 nor is there any documentation that the redness was monitored. R1's OT note on 1-20-21 documents R1 complained of spasm in left leg. This note documents, "Leg inspected to check skin integrity. Pressure sore developing on left hip. Nursing notified." There is no further documentation and treatment of R1's left leg area in R1's medical record until documented on the Skin and Wound evaluation form on 1-24-21.

On 2-3-21 at 12:20 pm, V9 COTA/Certified Occupational Therapy Assistant, stated on 1-20-21, V9 noted a nickel sized reddened area with a tan center on R1's left hip area. V9 stated she reported the area to nursing but could not remember what nurse. V9 stated at times she would check R1's brace for tightness by putting her fingers under the brace but did not take off the brace and inspect R1's skin. V9 assisted R1 with bathing, wrapping the brace so it would not get wet but not taking the brace off.

R1's PT/Physical Therapy evaluation, dated 1-16-21 documents R1 had a recent fall with a right distal femur fracture with right lower extremity brace in extension, right shoulder pain present to therapy with deficits in transfers and bed mobility. R1's PTA/Physical Therapy Assistant note dated 1-21-21 at 11:38 am documents "This writer and nursing put another mattress on bed for pressure relief with nursing and (R1) reporting (R1) has pressure areas on gluteal area." There is no other documentation of an assessment or treatment of this area until 1-22-21 at 11:30 am when the Skin and Wound Evaluation form was filled out and orders for treatment were obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 686	Continued From page 8	F 686		

On 2-3-21 at 10:30 am, V6 PTA stated she would at times check R1's brace for tightness and adjust it but did not remove it and inspect his skin. V6 stated that on 1-18-21, she did notice some pink area on R1's right upper leg where the brace ended so she readjusted it and told nursing about the reddened area. The next day, V6 and V9 noted a reddened area to R1's left hip which V9 reported to nursing. V6 does not remember any other pressure/red areas.

On 2-3-21 at 11:30 am, V7 Licensed Practical Nurse stated that he occasionally worked with R1. V7 stated that he does not remember having orders to check R1's brace. V7 stated on shower days, he might adjust it and cover it for the shower but does not remember taking it off and evaluating R7's leg under the brace.

On 2-3-21 at 11:10 am, V5, Registered Nurse Unit Manager, stated that she spoke with R1 on 1-18-21. V5 stated that R1 had a routine at home and liked to do things a certain way. V5 stated that R1 needed staff assistance for bed mobility and transfers. V5 stated R1 did not always want to be repositioned. V5 stated R1 had his brace on at all times but could remove it for bathing and skin checks. V5 expected staff to check for the positioning of the brace, check for fit/tightness and assess the skin beneath the brace at a minimum of daily. There is no documentation of these brace checks being completed. V5 stated that on 1-22-21, when pressure ulcers were found, R1's brace was on too tight. V5 stated that sheepskin and monitoring of brace three times a day was implemented on 1-22-21.

On 2-3-21 at 12:10 pm, V8 CNA/Certified Nursing Assistant stated that when R1 was admitted, R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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) COMPLETION DATE
F 686	Continued From page 9	F 686		

stated he could turn and reposition himself but they found out that he could not. V8 stated that she did observe some red areas on R1's right leg but could not remember when. V8 stated that when R1 was first admitted, she does not remember any sheepskin/padding being placed between R1 and his leg brace.

On 2-3-21 at 1:30 pm, V2 Director of Nursing, verified there were no orders or care plan interventions upon admission for R1's leg immobilizing brace. V2 stated she was not aware of some of the reddened areas found on R1. V2 stated they should have been reported, assessed and a obtained a treatment order when the areas were first observed. V2 stated there were skin assessments checked off as being completed on R1's TAR on 1-15, 1-19 and 1-22-21 but could not tell if R1's brace was removed for those checks. V2 stated skin checks were not documented as being completed daily as per their policy. V2 stated they are now implementing a new skin check sheet that shows more detail.