STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145135	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51792 Based on observation, interview, and record review the facility failed to ensure residents were assisted with activities of daily living (ADL's) and call lights were answered in a timely manner promoting dignity for 3 of 5 (R3, R4, R5, R10 and R13) residents reviewed for dignity in the sample of 26. This failure resulted in R13 asking for assistance to toilet for at least 35 minutes while in the dining room and common area and subsequently having an episode of incontinence. R13 was visibly upset and crying out for help during this 35-minute time frame. This would cause any reasonable person to feel embarrassed and humiliated. Findings include: 1. R13's Resident Face Sheet with a print date of 5/6/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, moderate, with anxiety. R13's MDS (Minimum Data Set) dated 2/5/25 documents a BIMS (Brief Interview for Mental Status) score of 01, indicating R13 has a severe cognitive deficit. This same MDS documents R13 is frequently incontinent of urine and bowel and requires substantial/maximal assistance with toileting hygiene and partial/moderate assistance with toilet transfer. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Actual harm Residents Affected - Few	On 5/6/25 from 12:25 PM until 12:58 PM this surveyor conducted continuous observation of the common area/dining room. At 12:25 PM, when this surveyor entered this area, R13 was sitting in the dining room in her wheelchair talking with V25 (Patient Aid/PA). R13 asked V25 to take her to the bathroom. V25 responded to R13 that she couldn't but they (Certified Nursing Assistants/CNA's) would take her as soon as they could. V25 told R13, They can't stop feeding residents to take you. R13 continued to ask V25 who then told R13, They can't take you right now. They will take you as soon as they can. At 12:27 PM, R13 stopped an unknown staff member who entered the unit and asked them where she was supposed to go. R13 told this staff member she was about to pee my pants. This unknown staff member told R13 they would get to her as soon as they could. At 12:29 PM, R13 self-propelled her wheelchair out of the dining room and through the common area surrounding the nurse's station. R13 was crying out, I got to go to the bathroom. Why can't I go to the bathroom. Someone help me. R13 was visibly upset. V21 (Dietary Manager) entered the unit and R13 said Help me someone, help me. V21 told R13 she would get someone to help her. Throughout this observation, V22 and V23 (Certified Nursing Assistants/CNA's) were feeding residents in the dining room. At 12:31 PM, R13 yelled, Help, I am going to pee in the floor. R13 continued to yell for help. At 12:35 PM, R13 stated, It is an awful place when you can't get waited on in the nursing home. At 12:44 PM, R13 asked for help again with no response from staff. At 12:48 PM, R13 cried out, Help, help, help. At 12:49 PM, R13 told V21 (Dietary Manager) Help me, help me. I just peed myself. V21 moved R13's wheelchair next to a chair in the common area and sat down next to R13 and began to talk with her. R13 was visibly upset throughout this observation. On 5/6/25 at 12:59 PM, V22 (CNA) stated R13 yells out for help even if the staff have just taken her to the bathroom. V22 stated she had been told R13 was asking to toilet, and she would take her after she charted lunch. On 5/6/25 at 1:02 PM, V23 (CNA) stated they had three CNA's when they came to work this morning but one got sick and had to leave early. V23 stated they currently have two CNA's and one PA working. When asked if that was enough staff to meet the residents needs timely, V23 stated, No. V23 stated, We had people hollering to go to the bathroom while we were feeding, and we aren't allowed to stop feeding to take them to the bathroom. V23 stated they had taken R13 to toilet right before lunch (around 11:00 AM). V23 stated R13 hollers out a lot but she can tell when she urinates. On 5/6/25 at 1:13 PM, this surveyor reviewed the observation with V24 (LPN/Licensed Practical Nurse) and V24 stated R13 yelled out for help frequently and was previously on a bladder training program. V24 stated staff need to stop what they are doing and help. When asked if they were allowed to stop feeding residents to provide needed care to other residents, V24 stated she only worked on Tuesdays, so she wasn't sure if something had changed but they used to stop and help residents. On 5/6/25 at 1:31 PM, V25 (PA) stated she is not allowed to provide direct resident care, she is only there for extra eyes and support. V25 stated R13 constantly asks to go the bathroom, even after they have just taken her. On 5/6/25 at 1:37 PM, V26 (CNA) stated she clocked in for her shift at 1:00 PM and took R13 to the bathroom. V26 stated R13 had feces in her incontinence brief, and it was soaked with urine. V26 stated she also had to change R13's pants because they were wet. (continued on next page)

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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 0550 Level of Harm - Actual harm Residents Affected - Few	On 5/6/24 at 2:58 PM, V2 (Director of Nurses/DON) stated V22 (CNA) should have taken R13 to the bathroom instead of charting lunch. V2 stated they don't stop feeding because the meal will get cold, but someone should have taken over with feeding residents so the CNA's could have provided care. The facility Quality of Life Dignity policy dated 2/2012 documents, Policy: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Procedure: .11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: .b. Promptly responding to the resident's request for toileting assistance . 2. On 5/6/25 at 9:37AM, R3, who was alert and oriented to person, place, and time, stated she has lived here a few years at least. R3 stated that the call light wait times are too long. R3 stated, Sometimes I even take myself to the bathroom because they don't answer it soon enough, and I don't want to have an accident. They (the staff) get mad at me, but I don't want to have an accident. 3. On 5/5/25 at 11:41AM, R10, who was alert and oriented to person, place and time, stated, Sometimes during lunch hour my call light can be on for an hour or longer. 4. On 5/6/25 at 9:20 AM, R5, who was alert and oriented to person, place, and time, stated that call light wait times have improved in the past two months but are still too long. She said there are residents who require two CNA's (Certified Nurse's Aides) to assist them, and that takes away from staff that can answer call lights. She says they only have two CNA's on her hall, and they need three. 5. On 5/6/25 at 9:26 AM, R4, who was alert and oriented to person, place, and time, stated that call light wait times are too long. R4 stated that on average it takes fifteen minutes to get them answered, sometimes longer. R4 stated that call light wait times are worse on evening shift when they have less staff. 6. Resident council meeting minutes dated 1/30/25 documents call light wait times as a concern for the residents. On 5/7/2025 at 11:52 AM, V1 (Administrator) stated that he would consider a reasonable amount of time to wait for a call light to be answered as ten to fifteen minutes at most. When asked if he thought that it was appropriate for a resident to take herself to the toilet without assistance, knowing that she needs assistance, but unable to wait for staff to answer her call light because of fear she may have an episode of incontinence, V1 stated no, that was not acceptable practice for assisting residents with toileting needs. Facility's call light policy dated July 2014 in step 8 under heading General guidelines documents, Answer the resident's call as soon as possible.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51792 Based on observation, interview, and record review the facility failed to maintain the Dining Room floor in a clean and sanitary condition for 14 of 14 residents (R3, R4, R5, R7, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25) reviewed for a clean homelike environment in a sample of 26. Findings include: On 5/5/25 at 11:17 AM, there were two white spots on the floor of the Dining Room used for the Center and East Halls that appear to be a dried liquid substance resembling dried milk. There were also other spots of what appeared to be dried drops of clear or semi clear liquid substances scattered throughout the Dining Room for the Center and East halls. The Dining room floor also had small pieces of debris of what appeared to be food particles, dirt and maple tree seeds strewn about on it. On 5/6/25 at 8:56 AM, the same two dried white spots of what appeared to be dried milk remained on the floor of Center and East Halls Dining Room. At that time there were also other scattered, dried drops of clear/semi clear unknown liquid scattered throughout dining room. V9 was sweeping another area of the dining room. The Dining room floor also had small pieces of debris of what appeared to be dirt, maple tree seeds and food particles strewn about on it. On 5/6/25 at 12:20 PM this surveyor took V1 (Administrator) to the East and Center halls Dining Room and showed him the dried spills of white substance, spots of what appear to be dried clear/semi clear liquid spots on the floor, and the debris of what appeared to be dirt, food particles and maple tree seeds scattered on the floor that had been on the floor the last two days. When this surveyor asked V1 if this was acceptable to his standard of cleanliness for the facility, V1 stated that was not up to his standards of cleanliness for the facility. On 5/6/25 at 10:20 AM, V9 (Housekeeper) stated that his shift is 8a-4:30pm. V9 stated that there are 3 housekeepers every day, seven days a week unless there is a call in. V9 stated that when he begins shift, he starts with Center/East halls Dining Room. V9 stated to clean the Dining Room on Center/East halls he begins by spraying tops of tables and cleans those, then he sweeps and mops the floor, and last gets the trash. V9 states that he believes three housekeepers are enough to keep the facility clean. On 5/6/25 at 9:13 AM, V4 (LPN/Licensed Practical Nurse) stated cleanliness of the facility could be better. She said that housekeepers are not good about sweeping and mopping routinely. She said that she often will sweep and mop around the nurse's station she is stationed at some time throughout the day because housekeeping staff aren't good about keeping the area clean. An undated document provided by V1 on 5/6/25 lists all of the residents who dine in Center/East Dining room and it included R3, R4, R5, R7, R16, R17, R18, R19, R20, R21, R22, R23, R24, and R25. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's undated cleaning policy documents, It is the policy of this facility that the workplace will be maintained in a clean and sanitary condition with a written schedule of cleaning and decontamination based on the area of the facility, type of surface to be cleaned, type of soil present and tasks being performed in the area. It is important that a clean, safe and sanitary environment is maintained for our residents. Surfaces such as tabletops, window ledges, bedside stands, counters, sinks, tubs, shower floors, toilet seats, floors, etc. will be cleaned daily using an EPA (Environmental Protection Agency) approved hospital grade disinfectant - detergent solution. These surfaces will also be cleaned as needed when spills or soiling occur.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure residents were assisted with activities of daily living (ADL's) in a timely manner for 2 of 5 (R2 and R13) residents reviewed for ADL's in the sample of 26. Findings Include: 1. R13's Resident Face Sheet with a print date of 5/6/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, moderate, with anxiety. R13's MDS (Minimum Data Set) dated 2/5/25 documents a BIMS (Brief Interview for Mental Status) score of 01, indicating R13 has a severe cognitive deficit. This same MDS documents R13 is frequently incontinent of urine and bowel and requires substantial/maximal assistance with toileting hygiene and partial/moderate assistance with toilet transfer. R13's current Care Plan documents a problem area with a start date of 11/21/2024 of, Resident exhibiting Behaviors as seen by: Wandering, yelling out Help me significant number of times throughout the day and night. Refusing meds (medications), Physical aggression towards staff. This same Problem area includes the following interventions with start dates of 11/21/2024, Encourage family support and/or involvement . encourage resident to keep involvement in activities of choice .Encourage resident to vent feelings, fears, frustrations prn (as needed) Notify MD (physician) as needed .Provide meds as ordered and monitor effectiveness .Psychiatric consult as needed .1:1 visits as needed for reassurance .Call light within reach while in room .Check for pain Observe for changes in appetite, signs of withdrawal, crying and tearfulness, decreases in social interactions, and changes in routine . This same Care Plan includes a Problem area with a start date of 08/13/2024 of, Resident needs set up/supervision to substantial assistance for Activities of Daily Living. This Problem area includes the following intervention with a start date of 8/13/2024 of, Assist as needed with toileting . (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 from 12:25 PM until 12:58 PM this surveyor conducted continuous observation of the common area/dining room. At 12:25 PM, when this surveyor entered this area, R13 was sitting in the dining room in her wheelchair talking with V25 (Patient Aid/PA). R13 asked V25 to take her to the bathroom. V25 responded to R13 that she couldn't but they (Certified Nursing Assistants/CNA's) would take her as soon as they could. V25 told R13, They can't stop feeding residents to take you. R13 continued to ask V25 who then told R13, They can't take you right now. They will take you as soon as they can. At 12:27 PM, R13 stopped an unknown staff member who entered the unit and asked them where she was supposed to go. R13 told this staff member she was about to pee my pants. This unknown staff member told R13 they would get to her as soon as they could. At 12:29 PM, R13 self-propelled her wheelchair out of the dining room and through the common area surrounding the nurse's station. R13 was crying out, I got to go to the bathroom. Why can't I go to the bathroom. Someone help me. R13 was visibly upset. V21 (Dietary Manager) entered the unit and R13 said Help me someone, help me. V21 told R13 she would get someone to help her. Throughout this observation, V22 and V23 (Certified Nursing Assistants/CNA's) were feeding residents in the dining room. At 12:31 PM, R13 yelled, Help, I am going to pee in the floor. R13 continued to yell for help. At 12:35 PM, R13 stated, It is an awful place when you can't get waited on in the nursing home. At 12:44 PM, R13 asked for help again with no response from staff. At 12:48 PM, R13 cried out, Help, help, help. At 12:49 PM, R13 told V21 (Dietary Manager) Help me, help me. I just peed myself. V21 moved R13's wheelchair next to a chair in the common area and sat down next to R13 and began to talk with her. R13 was visibly upset throughout this observation. On 5/6/25 at 12:59 PM, V22 (CNA) stated R13 yells out for help even if the staff have just taken her to the bathroom. V22 stated she had been told R13 was asking to toilet, and she would take her after she charted lunch. On 5/6/25 at 1:02 PM, V23 (CNA) stated they had three CNA's when they came to work this morning but one got sick and had to leave early. V23 stated they currently have two CNA's and one PA working. When asked if that was enough staff to meet the residents needs timely, V23 stated, No. V23 stated, We had people hollering to go to the bathroom while we were feeding, and we aren't allowed to stop feeding to take them to the bathroom. V23 stated they had taken R13 to toilet right before lunch (around 11:00 AM). V23 stated R13 hollers out a lot but she can tell when she urinates. On 5/6/25 at 1:13 PM, this surveyor reviewed the observation with V24 (LPN/Licensed Practical Nurse) and V24 stated R13 yelled out for help frequently and was previously on a bladder training program. V24 stated staff need to stop what they are doing and help. When asked if they were allowed to stop feeding residents to provide needed care to other residents, V24 stated she only worked on Tuesdays, so she wasn't sure if something had changed but they used to stop and help residents. On 5/6/25 at 1:31 PM, V25 (PA) stated she is not allowed to provide direct resident care, she is only there for extra eyes and support. V25 stated R13 constantly asks to go the bathroom, even after they have just taken her. On 5/6/25 at 1:37 PM, V26 (CNA) stated she clocked in for her shift at 1:00 PM and took R13 to the bathroom. V26 stated R13 had feces in her incontinence brief, and it was soaked with urine. V26 stated she also had to change R13's pants because they were wet. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 1:45 PM, V27 (LPN/Unit Manager) stated R13 cries out and asks to go to the bathroom all the time. This surveyor reviewed V26's interview with V27 and V27 stated, she wouldn't say R13 doesn't have to go to the bathroom when she says she does. On 5/6/24 at 2:58 PM, V2 (Director of Nurses/DON) stated V22 (CNA) should have taken R13 to the bathroom instead of charting lunch. V2 stated they don't stop feeding because the meal will get cold, but someone should have taken over with feeding residents so the CNA's could have provided care. 51792 2.) R2's Face Sheet documents R2 has an admitted [DATE]. R2's Face Sheet documents R2 has diagnosis that includes but is not limited to polyosteoarthritis, transient cerebral ischemic attack, chronic obstructive pulmonary disease, and difficulty in walking. R2's current Care Plan documents R2 needs partial assistance to total dependence for most activities of daily living related to cerebrovascular accident (stroke) with a problem start date of 10/29/2020. R2's Care Plan documents R2 requires two (person) assist with Hoyer (mechanical lift) transfers, assist as needed with ADL's (activities of daily living) and assist as needed with toileting. R2's MDS (Minimum Data Set) dated 2/17/2025 documents in section GG that R2 is dependent for shower/bathe self meaning helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Section GG of the MDS also records R2 is dependent for transfer to tub/shower meaning helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Section C of MDS documents R2 has a BIMS score of 11 documenting R2 has moderately impaired cognition. On 5/5/2025 at 11:23 AM, R2, who was alert and oriented to person, place and time, stated he hasn't received a shower in about two to three weeks now. R2 stated he does want one, and that he is supposed to get one twice a week. R2 stated he doesn't know why he hasn't gotten one in two to three weeks. R2 denies refusing a shower. R2's current Physician's Orders documents R2 is ordered to get a shower twice a week on Tuesday and Friday nights per resident's preference with a start date of 4/23/2024. R2's ADL Point of Care History in R2's EHR (Electronic Health Record) for 4/1/25-5/1/25 documents R2 did not receive a shower in between 4/4/25-4/11/25 and in between 4/15/25-4/22/25. This record documents R2 went two six-day periods of not receiving a shower. On 5/6/2025 at 2:34 PM, while reviewing R2's ADL documentation for showers, V13 (Certified Nurse's Aide/CNA) stated as far as she knew that R2 did not get a shower anytime between the dates 4/4/2025-4/11/2025 and 4/15/2025-4/22/2025. Upon reviewing the ADL documentation for showers with V13 she stated that on days 4/8/25 and 4/18/25 where it is documented by her in EHR activity did not occur in relation to shower, she entered those by mistake. V13 stated that R2 gets a bed bath every night at bedtime. There is no documentation in the EHR that documents R2 gets a bed bath every night at bedtime. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 11:42 AM, V5 (RN/Registered Nurse) stated they (the facility) has enough staff to do showers, but it is after everyone is put to bed which is around 10:30 PM. V5 stated residents may not want to get out of bed for a shower at that time, so they refuse them. On 5/7/25 at 11:52 AM, V1 stated that his expectations for showers were for them to be offered to the residents at twice per week. V1 stated they should also be able to get one more often if requested. When asked if it was an acceptable practice for someone to go six days without being assisted with showering/bathing, V1 stated no that is not an acceptable practice. V1 stated they should have been offered at least a bed bath during that time frame. Facility's bathing policy dated July 2014 states, It is the policy of (Name of Facility) that residents will receive a shower/bath will [sic]be scheduled regularly and prn (as needed). Step 10 in bathing policy states, Assist the resident in showering/bathing if necessary.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure sufficient staff to monitor and provide timely care for 4 of 7 (R8, R13, R14, and R15) residents, reviewed for staffing in the sample of 26. This failure has the potential to affect all 79 residents currently residing at the facility. Findings Include: The facility Daily Census Report dated 5/5/25 documents there are 79 residents currently residing at the facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. On 5/6/25 from 12:25 PM until 12:58 PM this surveyor conducted continuous observation of the common area/dining room on the Alzheimer's unit. At 12:25 PM, when this surveyor entered this area, R13 was sitting in the dining room in her wheelchair talking with V25 (Patient Aid/PA). R13 asked V25 to take her to the bathroom. V25 responded to R13 that she couldn't but they (Certified Nursing Assistants/CNA's) would take her as soon as they could. V25 told R13, They can't stop feeding residents to take you. R13 continued to ask V25 who then told R13, They can't take you right now. They will take you as soon as they can. During this conversation, V25 was scraping food scraps off plates and stacking them to return to the kitchen. R15 was standing next to V25 while she was scraping the food. V24 (LPN/Licensed Practical Nurse) was standing behind the nurse's station and told this surveyor she had to take a card of medications to the Director of Nurses/DON, and she would be right back. At 12:26 PM, the exit door in the dining room started to alarm and there were two unknown residents attempting to exit. V25 left the dirty dishes on the cart with R15 standing next to them and went to the door to redirect the other two residents. R15 started moving the dirty dishes around, stacking them in different places and wiping them off with her bare hands. R15 smeared food on her hands and began rubbing them together while continuing to move dirty dishes and wipe at the food scraps left on the plates. At 12:27 PM, R13 stopped an unknown staff member who entered the unit and asked them where she was supposed to go. R13 told this staff member she was about to pee my pants. This unknown staff member told R13 they would get to her as soon as they could. R15 continued to move the dirty dishes and wipe the scraps of food off with her fingers. At 12:28 PM, V25 (PA) went back to the dining room and washed R15's hands. At 12:29 PM, R13 self-propelled her wheelchair out of the dining room and through the common area surrounding the nurse's station. R13 was crying out, I got to go to the bathroom. Why can't I go to the bathroom. Someone help me. R13 was visibly upset. V21 (Dietary Manager) entered the unit and R13 said, Help me someone, help me. V21 told R13 she would get someone to help her. An unknown male resident opened a bathroom door and told R13 to come here. R13 told this resident she couldn't go in the bathroom without permission. Throughout this observation, V22 and V23 (Certified Nursing Assistants/CNA's) were feeding residents in the dining room. At 12:31 PM, R13 yelled, Help, I am going to pee in the floor. V25 (PA) got a book off the nurse's station and started documenting in it, while observing residents in the dining room/common area. R13 continued to yell for help. At 12:33 PM, an unknown resident attempted to pull the fire alarm located down the hallway and other unknown residents were wandering the hallways entering and exiting resident rooms. At 12:35 PM, R13 stated, It is an awful place when you can't get waited on in the nursing home. The same unknown male resident attempted to get R13 to enter the bathroom again. R13 told this resident she wasn't going in there without permission and yelled, Help. V22 and V23 continued to feed residents in the dining room, V24 (LPN) had not returned to the unit, V25 (PA) continued to document in the binder. An unknown male resident attempted to push R13's wheelchair. V25 told R13 she would have to wait to use the bathroom because other residents couldn't assist her to the toilet. R14 who had been pacing the hallways and entering and exiting resident rooms, walked into the dining room, and started eating mashed potatoes off a partially eaten plate of food that had been left on a table. V21 (Dietary Manager) stated R14 was on a mechanical soft diet and that wasn't her plate of food. V21 redirected R14 from the plate and removed the plate from the table. At 12:41 PM, V22 and V23 continued to feed residents in the dining room, V25 continued to document in the binder, multiple residents were wandering the hallways entering and exiting resident rooms. At 12:44 PM, R13 asked for help again with no response from staff. R14 walked to another table in the dining room and took a bite of another unknown residents' food. V27 (LPN-Licensed Practical Nurse/Unit Manager) stopped R14 after the first bite. V27 removed the plate and turned away, R14 went to another table and started eating another resident's food. At 12:46 PM, V27 stopped R14, took the spoon away from R14 and told R14, No, no. R14 began to pace the hallways again with other residents. At 12:48 PM, R13 cried out, Help, help, help. At 12:49 PM, R13 told V21 (Dietary Manager) Help me, help me. I just peed myself. V21 moved R13's wheelchair next to a chair in the common area and sat down next to R13 and began to talk with her. At 12:55 PM, an exit door alarm sounded, unknown residents were attempting to exit. At 12:58 PM, V22 (CNA) walked behind the nurse's station and logged onto computer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/6/25 at 12:59 PM, V22 (CNA) stated R13 yells out for help even if the staff have just taken her to the bathroom. V22 stated she had been told R13 was asking to toilet, and she would take her after she charted lunch. On 5/6/25 at 1:02 PM, V23 (CNA) stated they had three CNA's when they came to work this morning but one got sick and had to leave early. V23 stated they currently have two CNA's and one PA working. When asked if that was enough staff to meet the residents needs timely, V23 stated, No. V23 stated We had people hollering to go to the bathroom while we were feeding, and we aren't allowed to stop feeding to take them to the bathroom. This surveyor reviewed with V23 the observation that occurred, beginning at 12:25 PM, and asked her if that was a typical day. V23 stated it was and if they have a third CNA it is better, but it would be even better if they had four. V23 stated they couldn't keep up with all the residents. V23 stated they had taken R13 to toilet right before lunch (around 11:00 AM). V23 stated R13 hollers out a lot but she can tell when she urinates. V23 stated residents wander into other rooms because they don't have enough staff to monitor them. V23 stated she gets to work at 5:30 AM, and there are two CNA's on night shift, and they tell her they can't keep up. V23 stated on night shift the nurse is shared between the Alzheimer's unit and the Behavioral Unit. V23 stated that isn't enough staff to meet the needs of the residents on those units. On 5/6/25 at 1:13 PM, V24 (LPN) stated they started the shift with three CNA's and one PA but one of the CNA's had to leave between 10 and 11 AM. When asked if that was enough staff to meet the needs of the residents timely, V24 stated, I would think they would need another CNA in the afternoons. This surveyor reviewed the observation, beginning at 12:25 PM, with V24 and asked her if this was a typical day. V24 stated R13 yelled out for help frequently and was previously on a bladder training program. V24 stated R14 got extra trays at mealtimes because she was always hungry. V24 stated it wasn't right for her to get into other people's food and it was dangerous. V24 stated staff need to stop what they are doing and help. When asked if they were allowed to stop feeding residents to provide needed care to other residents, V24 stated she only worked on Tuesdays, so she wasn't sure if something had changed but they used to stop and help residents. V24 stated they don't have enough staff to meet the needs of the residents timely, everyday. V24 stated if they had more staff during meals and in the evening it would help. On 5/6/25 at 1:23 PM, this surveyor reviewed the observation with V22 (CNA) and asked if that was a typical day and if so, why. V22 stated, Well, I am feeding and can't stop feeding and they (administration) aren't out here helping us anymore. When asked if they had enough staff to meet the needs of the residents timely, V22 stated, No. V22 stated if they have three CNA's and a PA it is better. V22 stated the PA is off every Thursday, Friday, and Saturday. V22 stated they have two CNA's on evening shift and sometimes have three. When asked if they could meet the needs of the residents, V22 stated they also have to fill out the elopement book every 30 minutes, which means they have to check on half the residents every thirty minutes and document the checks. V22 stated she can keep the book up, but resident care doesn't get done as it should. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/6/25 at 1:31 PM, V25 (PA) stated she is not allowed to provide direct resident care, she is only there for extra eyes and support. V25 stated R13 constantly asks to go the bathroom, even after they have just taken her. V25 stated she went to the door to redirect the residents attempting to exit, and when she returned R15 was scraping food off the plates with her fingers. V25 stated R14 eats other residents' food, and it was part of her job to monitor her. V25 stated she had taken over with the elopement book during lunch and it was hard to multitask. V25 stated she does the best she can, but it is hard especially when there are residents that are exit seeking. V25 stated they had a third CNA, but she had to leave early. When asked if two CNA's and a PA were enough staff to meet the needs of the residents timely, V25 stated, No, not when it is a day like today. On 5/6/25 at 1:37 PM, V26 (CNA) stated she clocked in for her shift at 1:00 PM and took R13 to the bathroom. V26 stated R13 had feces in her incontinence brief, and it was soaked with urine. V26 stated she also had to change R13's pants because they were wet. On 5/6/25 at 1:45 PM, V27 (LPN/Unit Manager) stated she was on lunch break when this surveyor arrived to the unit at 12:25 PM. V27 stated she started assisting with the lunch meal after her break. V27 was not sure what time that was. V27 stated R13 cries out and asks to go to the bathroom all the time. This surveyor reviewed V26's interview with V27 and V27 stated, she wouldn't say R13 doesn't have to go to the bathroom when she says she does. V27 stated she could have helped but she can't hear what is going on with her office door closed and if she leaves it open the residents are knocking stuff over. V27 stated they had three CNA's and a PA at the beginning of the shift but one of the CNA's had to leave early. When asked if two CNA's and a PA were enough staff to meet the needs of the residents, V27 stated they prefer three CNA's and a PA. On 5/5/25 at 11:38 AM, V17 (Anonymous) stated they didn't have enough staff to meet the needs of the residents timely. V17 stated they felt a lot of accidents and elopements could be avoided if they had more staff. V17 stated they had three CNA's and a PA working but sometimes they only have one or two CNA's. V17 stated on night shift they share a nurse between the Alzheimer's and Behavioral units and have one CNA on the behavioral unit and two on the Alzheimer's unit. V17 stated if they had more staff, they could monitor better and prevent behaviors and accidents. On 5/5/25 at 2:51 PM, V19 (CNA) stated they are low on staffing. V19 stated it is a never-ending problem. V19 stated all care including incontinence care and showers are delayed due to staffing issues. On 5/5/25 at 3:04 PM, V20 (CNA) stated when they don't have a PA on night shift it gets hectic. V19 stated when they are feeding residents, they can't stop feeding them and assist other residents. On 5/6/25 at 3:39 PM, V28 (CNA) stated she hadn't recently worked with just one CNA on the unit, but she had in the past. V28 stated they usually have two CNA's on night shift. When asked if they had enough staff to meet the needs of the residents, V28 stated, No. V28 stated they do the best they can, but a timely manner just isn't doable. V28 stated the residents are always upset with them because of the workload and staff not getting to them quickly. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/6/24 at 2:58 PM, V2 (Director of Nurses/DON) stated she thought staffing was better than it had been. V2 stated they did have one CNA leave early on 5/6/25 day shift because they were sick. This surveyor reviewed the observation of the noon meal with V2, and she stated activity staff should have been on the unit doing a sensory group during that time frame. V2 stated they normally divide the residents up and it works well. V2 stated she knew it was chaotic on the unit on 5/6/24 during the mealtime. V2 stated V22 (CNA) should have taken R13 to the bathroom instead of charting lunch. V2 stated they don't stop feeding because the meal will get cold, but someone should have taken over with feeding residents so the CNA's could have provided care. When this surveyor asked who would have fed residents, V2 stated the nurse manager. This surveyor explained to V2, the nurse V24 was meeting with V2 during that time frame, V2 stated V24 should have told her what was happening or stayed on the unit to help. When asked what the staffing was like on the weekends, V2 stated, Improving. This surveyor reviewed the daily staffing sheets with V2, and she stated they have 2-3 CNA's and a nurse and no PA on the weekends. V2 stated they don't have activities or administrative staff working on the weekends and the behavioral and Alzheimer's unit share a nurse on night shift. When asked if that was enough staff to meet the needs of the residents and monitor for behaviors, V2 stated, According to state regulations that is enough staff. R13's Resident Face Sheet with a print date of 5/6/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, moderate, with anxiety. R13's MDS (Minimum Data Set) dated 2/5/25 documents a BIMS (Brief Interview for Mental Status) score of 01, indicating R13 has a severe cognitive deficit. This same MDS documents R13 is frequently incontinent of urine and bowel and requires substantial/maximal assistance with toileting hygiene and partial/moderate assistance with toilet transfer. R13's current Care Plan documents a Problem area with a start date of 11/21/2024 of, Resident exhibiting Behaviors as seen by: Wandering, yelling out Help me significant number of times throughout the day and night. Refusing meds (medications), Physical aggression towards staff. This same Problem area includes the following interventions with start dates of 11/21/2024, Encourage family support and/or involvement . encourage resident to keep involvement in activities of choice .Encourage resident to vent feelings, fears, frustrations prn (as needed) Notify MD (physician) as needed .Provide meds as ordered and monitor effectiveness .Psychiatric consult as needed .1:1 visits as needed for reassurance .Call light within reach while in room .Check for pain Observe for changes in appetite, signs of withdrawal, crying and tearfulness, decreases in social interactions, and changes in routine . This same Care Plan includes a Problem area with a start date of 08/13/2024 of, Resident needs set up/supervision to substantial assistance for Activities of Daily Living. This Problem area includes the following intervention with a start date of 8/13/2024 of, Assist as needed with toileting . R14's Resident Face Sheet with a print date of 5/6/25 documents R14 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, moderate, with other behavioral disturbances and cognitive communication deficit. R14's MDS (Minimum Data Set) dated 3/14/25 documents R14 is moderately impaired in cognitive skills for daily decision making. R14's current Care Plan documents a Problem area with a start date of 3/20/24 of, Resident is cognitively impaired due to: Dementia. This Problem area includes the following interventions with start dates of 3/20/24, Call resident by name upon each interaction Observe for response .Verbal cues as needed Allow ample time for resident to respond .Simple YES/NO questions and commands Observe whereabouts . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R15's Resident Face Sheet with a print date of 5/6/25 documents R15 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia and Alzheimer's disease with late onset. R15's MDS dated [DATE] documents a BIMS score of 03, indicating R15 has a severe cognitive deficit. R15's current Care Plan documents a Problem area with a start date of 2/17/2022 of Resident is cognitively impaired due to: Dementia. This Problem area includes the following interventions with start dates of 2/17/2022, Call resident by name upon each interaction .Observe for response .Verbal cues as needed .Allow ample time for resident to respond .Simple YES/NO questions and commands .Observe whereabouts 2. R8's Resident Face Sheet with a print date of 5/6/25 documents R8 was admitted to the facility on [DATE] with diagnoses that include bipolar disorder, alcohol abuse, depression dizziness, dissociative and conversion disorder, fibromyalgia, and abnormalities of gait and mobility. R8's Observation Detail Report dated 5/7/25 documents a BIMS score of 07, indicating R8 has a severe cognitive impairment. R8's current Care Plan documents a Problem area with a start date of 5/1/25, Category: Falls Resident is at risk for falling R/T (related to): History of Falls. This same Problem area includes the following interventions with a start date of 5/5/25, Immediate Intervention: Pressure alarms IDT Intervention: Bed and Chair Alarms. R8's Safety Events-Event-Fall and Investigation report dated 5/5/25 documents under Notes, 5/6/2025 12:20 AM, At 2120 (9:20 PM), upon entering the room observed res (resident) lying on the floor by the recliner with the table knocked down. Res apparently attempted to ambulate independently and lost a (sic) balance falling to the floor. Head to toe assessment performed. Neuro (neurological) check WNL (within normal limits) Res stated that she hit her head on the floor. No redness, bruising or raised area noted to the back of the head. Res confused and responded inappropriately. No apparent injuries were noted. Assisted back to the recliner . Res moved to Rm (room) (number) for tonight per DON (Director of Nurse) suggestion, so she can be closely monitored by the nurses' desk .Chair alarm in place to the recliner. Demonstrated how to use call light several times and was reminded to use it for assistance. Resting quietly at present in the recliner with legs up. Call light in reach. On 5/6/25 at 11:42 AM, V5 (RN/Registered Nurse) stated she works 12-hour night shift, and it is her and two CNAs for the two halls on the long-term care unit. When asked if that was enough staff to meet the needs of the residents timely, V5 stated when she is passing medications and a resident who requires assist of two needs help and alarms are going off it would help if they had another staff member. V5 stated it can be hard to hear the alarms if she is down the halls. When asked if they had any falls that occurred due to them not being able to provide timely care, V5 stated, Yes, it happened last night. V5 stated the two CNAs were in a room providing care to a resident and she was down the hall passing medications. V5 stated a residents family member told her there was an alarm going off on the other hall and she couldn't hear it. V5 stated R8 had fallen and luckily there was no injury. V5 stated R8's chair alarm was sounding when she got to the room, and it was as loud as it would go but she still couldn't hear it on the other hall. V5 stated they moved her to a room near the nurse's station after the fall so they could monitor her better. V5 stated if the two CNA's are in a room providing care and she is passing medications there is a delay in answering call lights. V5 stated they can provide showers, but it is after everyone is put to bed so probably around 10:30 or 11:00 and resident will refuse because they don't want to get up and take a shower after going to bed. V5 stated there are certain times they are so busy and can't attend to residents on the other hall so if they had another CNA that could monitor it would help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/6/24 at 2:58 PM, V2 (DON) stated she was working when R8 fell . V2 stated she had a resident family member tell her he heard a loud thump, and it was R8's bedside table that had fallen over. V2 stated she went to check on R8 and her alarm was sounding but it wasn't loud with the door closed. V2 stated she assessed R8, and she didn't have any injuries, so she got assistance, and they helped her to the recliner. V2 stated they moved R8 to a room closer to the nurse's station. V2 stated there were two CNA's and a nurse working when R8 fell . V2 stated the CNAs were assisting another resident at the time and the nurse was passing medications. V2 stated two CNA's and one nurse were enough to meet the needs of the residents on that unit. On 5/5/25 at 11:57 AM, V18 (RN) stated they don't have enough staff to meet the needs of the residents timely. V18 stated the care is provided just not in a timely manner. V18 stated there were 29 residents that resided on the unit, and it was her and one CNA working. V18 stated approximately 13 residents required some type of assistance with activities of daily living. On 5/5/25 at 12:52 PM, V13 (CNA) stated they don't have enough staff to monitor the residents. V13 stated for the residents who require a two person assist she gets the nurse or a CNA off another unit. V13 stated she does incontinence checks at 9 AM and 11 AM and provides showers after 1 PM if the other CNA comes in as scheduled. On 5/5/25 at 11:50 AM, R26 who was alert to person, place and time, stated he doesn't need any assistance with care, but they may not have enough staff to meet the needs of other residents. R26 stated The staff are over run at times. On 5/6/25 at 3:33 PM, (V1) Administrator stated when staff are feeding residents they can't assist other residents. V1 stated the nurse or DON could go help and he wasn't sure what they were meeting about but they could have met a different time. V1 stated he believed they had enough staff to meet the needs of the residents timely if they did what they were trained to do, divided tasks, and delegated. The facility Daily Assignment Sheets document from 4/23/25 through 5/5/25 documents the following staffing for night shift- one CNA on the behavioral unit, two CNA's on the Alzheimer's unit, and two CNA's on the long term care unit. The facility Staffing policy dated 11/2021 documents, Policy: The facility provides adequate staffing to meet needed care and services for our resident population and according to regulatory staffing requirements . Procedure: 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met and schedules adequate staff to meet or exceed individual state requirements.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure residents with dementia received the necessary person-centered care and services consistent with the resident's goals and symptomology for 3 of 3 (R13, R14, and R15) residents reviewed for dementia care in the sample of 26. Findings Include: (continued on next page)

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V24 (LPN/Licensed Practical Nurse) was standing behind the nurse's station and told this surveyor she had to take a card of medications to the Director of Nurses/DON, and she would be right back. At 12:26 PM, the exit door in the dining room started to alarm and there were two unknown residents attempting to exit. V25 left the dirty dishes on the cart with R15 standing next to them and went to the door to redirect the other two residents. R15 started moving the dirty dishes around, stacking them in different places and wiping them off with her bare hands. R15 smeared food on her hands and began rubbing them together while continuing to move dirty dishes and wipe at the food scraps left on the plates. At 12:27 PM, R13 stopped an unknown staff member who entered the unit and asked them where she was supposed to go. R13 told this staff member she was about to pee my pants. This unknown staff member told R13 they would get to her as soon as they could. R15 continued to move the dirty dishes and wipe the scraps of food off with her fingers. At 12:28 PM, V25 (PA) went back to the dining room and washed R15's hands. At 12:29 PM, R13 self-propelled her wheelchair out of the dining room and through the common area surrounding the nurse's station. R13 was crying out, I got to go to the bathroom. Why can't I go to the bathroom. Someone help me. R13 was visibly upset. V21 (Dietary Manager) entered the unit and R13 said Help me someone, help me. V21 told R13 she would get someone to help her. An unknown male resident opened a bathroom door and told R13 to come here. R13 told this resident she couldn't go in the bathroom without permission. Throughout this observation, V22 and V23 (Certified Nursing Assistants/CNA's) were feeding residents in the dining room. At 12:31 PM, R13 yelled, Help, I am going to pee in the floor. V25 (PA) got a book off the nurse's station and started documenting in it, while observing residents in the dining room/common area. R13 continued to yell for help. At 12:33 PM, an unknown resident attempted to pull the fire alarm located down the hallway and other unknown residents were wandering the hallways entering and exiting resident rooms. At 12:35 PM, R13 stated, It is an awful place when you can't get waited on in the nursing home. The same unknown male resident attempted to get R13 to enter the bathroom again. R13 told this resident she wasn't going in there without permission and yelled, Help. V22 and V23 continue to feed residents in the dining room, V24 (LPN) had not returned to the unit, V25 (PA) continued to document in the binder. An unknown male resident attempted to push R13's wheelchair. V25 told R13 she would have to wait to use the bathroom because other residents couldn't assist her to the toilet. R14 who had been pacing the hallways and entering and exiting resident rooms, walked into the dining room, and started eating mashed potatoes off a partially eaten plate of food that had been left on a table. V21 (Dietary Manager) stated R14 was on a mechanical soft diet and that wasn't her plate of food. V21 redirected R14 from the plate and removed the plate from the table. At 12:41 PM, V22 and V23 continue to feed residents in the dining room, V25 continued to document in the binder, multiple residents were wandering the hallways entering and exiting resident rooms. At 12:44 PM, R13 asked for help again with no response from staff. R14 walked to another table in the dining room and took a bite of another unknown residents' food. V27 (LPN-Licensed Practical Nurse/Unit Manager) stopped R14 after the first bite. V27 removed the plate and turned away, R14 went to another table and started eating another resident's food. At 12:46 PM, V27 stopped R14, took the spoon away from R14, and told R14, No, no. R14 began to pace the hallways again with other residents. At 12:48 PM, R13 cried out, Help, help, help. At 12:49 PM, R13 told V21 (Dietary Manager) Help me, help me. I just peed myself. V21 moved R13's wheelchair next to a chair in the common area and sat down next to R13 and began to talk with her. At 12:55 PM, an exit door alarm sounded, unknown residents were attempting to exit. At 12:58 PM, V22 (CNA) walked behind the nurse's station and logged onto computer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145135	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 12:59 PM, V22 (CNA) stated R13 yells out for help even if the staff have just taken her to the bathroom. V22 stated she had been told R13 was asking to toilet, and she would take her after she charted lunch. On 5/6/25 at 1:02 PM, V23 (CNA) stated they had three CNA's when they came to work this morning but one got sick and had to leave early. V23 stated they currently have two CNA's and one PA working. When asked if that was enough staff to meet the residents needs timely, V23 stated, No. V23 stated We had people hollering to go to the bathroom while we were feeding, and we aren't allowed to stop feeding to take them to the bathroom. This surveyor reviewed with V23 the observation of the noon meal and asked her if that was a typical day. V23 stated it was but if they have a third CNA it is better, but it would be even better if they had four. V23 stated they couldn't keep up with all the residents. V23 stated R13 hollers out a lot but she can tell when she urinates. V23 stated residents wander into other rooms because they don't have enough staff to monitor them. On 5/6/25 at 1:13 PM, this surveyor reviewed the mealtime observation with V24 (LPN) and asked her if this was a typical day. V24 stated R13 yells out for help frequently and was previously on a bladder training program. V24 stated R14 got extra trays at mealtimes because she was always hungry. V24 stated it wasn't right for her to get into other people's food and it was dangerous. V24 stated staff need to stop what they are doing and help. When asked if they were allowed to stop feeding residents to provide needed care to other residents, V24 stated she only worked on Tuesdays, so she wasn't sure if something had changed, but they used to stop and help residents. On 5/6/25 at 1:23 PM, this surveyor reviewed the observation with V22 (CNA) and asked if that was a typical day and if so, why. V22 stated, Well, I am feeding and can't stop feeding and they (Administration) aren't out here helping us anymore. V22 stated residents wander in and out of other resident rooms. When asked if they ever had activities for the residents, V22 stated, they do an activity occasionally in the morning. V22 stated they painted nails this morning but that is the only activity they had. V22 stated they used to have activities all day long but not anymore. V22 stated they do take residents to the sensory room before lunch, but she didn't think they did that on 5/6/25. V22 stated they only do the sensory room on weekdays. On 5/6/25 at 1:31 PM, V25 (PA) stated she is not allowed to provide direct resident care, she is only there for extra eyes and support. V25 stated R13 constantly asks to go the bathroom, even after they have just taken her. V25 stated she went to the door to redirect the residents attempting to exit, and when she returned R15 was scraping food off the plates with her fingers. V25 stated R14 eats other residents' food, and it was part of her job to monitor her. V25 stated she had taken over with the elopement book during lunch and it was hard to multitask. V25 stated she does the best she can, but it is hard especially when there are residents that are exit seeking. On 5/6/25 at 1:37 PM, V26 (CNA) stated she clocked in for her shift at 1:00 PM and took R13 to the bathroom. V26 stated R13 had feces in her incontinence brief, and it was soaked with urine. V26 stated she also had to change R13's pants because they were wet. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 1:45 PM, V27 (LPN/Unit Manager) stated she was on lunch break when this surveyor arrived at the unit at 12:25 PM. V27 stated she started assisting with the lunch meal after her break. V27 was not sure what time that was. V27 stated R13 cries out and asks to go to the bathroom all the time. This surveyor reviewed V26's interview with V27 and V27 stated, she wouldn't say R13 doesn't have to go to the bathroom when she says she does. V27 stated could have helped but she can't hear what is going on with her office door closed and if she leaves it open the residents are knocking stuff over. On 5/5/25 at 11:38 AM, V17 (Anonymous) stated they didn't have enough staff to meet the needs of the residents timely. V17 stated if they had more staff, they could monitor better and prevent behaviors and accidents. On 5/6/25 at 2:44 PM, V15 (Activities Director) reviewed the activity calendar with this surveyor and said they at 10 they do fitness/fun, 10:30 music memories, 11:00 filling station, and 11:30 sensory group. V15 stated she did nails this morning. When asked why she did nails instead of fitness/fun, V15 stated she did the afternoon activity in the morning. V15 stated at 10:00 am she was ordering supplies and at 11:30 she was trying figure out why an activity aid wasn't on their assigned unit. V15 stated it was hectic. V15 stated they usually have one activity each day that doesn't occur as it should on the unit because it is very hectic, and they are helping calm the residents down. V15 stated they have a few select residents that are difficult to keep engaged. The facility undated (name of unit) Daily Schedules documents the following activity schedule, Tuesday and Thursday 10:00 Fitness Fun/Active Games, 10:30 Music and Memories, 11:00 Filling Station, 11:30 Sensory Group, 1:30 Hand Spa. Monday Wednesday, and Friday 9:30 Fitness Fun/Active Games, 10:30 Table Games/Puzzles, 11:00 Fold and Sort, 11:30 Sensory Group, 1:30 Daily Creations. On 5/6/24 at 2:58 PM, this surveyor reviewed the observation of the noon meal with V2 (Director of Nurses/DON). V2 stated they had a CNA go to the hospital on day shift. When asked what her expectations would be V2 stated activities should have been down there doing a sensory group. V2 stated the CNA sitting at the desk should have taken R13 to the bathroom. V2 stated they should have told her what was happening so she could have helped. V2 stated they don't have activities on the weekends. Reviewed V15 (Activity Director's) interview with V2 and V2 stated they wouldn't have to redirect residents if they provided activities like they should. (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Resident Face Sheet with a print date of 5/6/25 documents R13 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, moderate, with anxiety. R13's MDS (Minimum Data Set) dated 2/5/25 documents a BIMS (Brief Interview for Mental Status) score of 01, indicating R13 has a severe cognitive deficit. This same MDS documents R13 is frequently incontinent of urine and bowel and requires substantial/maximal assistance with toileting hygiene and partial/moderate assistance with toilet transfer. R13's current Care Plan documents a Problem area with a start date of 11/21/2024 of, Resident exhibiting Behaviors as seen by: Wandering, yelling out Help me significant number of times throughout the day and night. Refusing meds (medications), Physical aggression towards staff. This same Problem area includes the following interventions with start dates of 11/21/2024, Encourage family support and/or involvement . encourage resident to keep involvement in activities of choice .Encourage resident to vent feelings, fears, frustrations prn (as needed) Notify MD (physician) as needed .Provide meds as ordered and monitor effectiveness .Psychiatric consult as needed .1:1 visits as needed for reassurance .Call light within reach while in room .Check for pain Observe for changes in appetite, signs of withdrawal, crying and tearfulness, decreases in social interactions, and changes in routine . This same Care Plan includes a Problem area with a start date of 08/13/2024 of, Resident needs set up/supervision to substantial assistance for Activities of Daily Living. This Problem area includes the following intervention with a start date of 8/13/2024 of, Assist as needed with toileting . R13's current Care Plan does not include progressive person-centered interventions related to the diagnosis of dementia. R14's Resident Face Sheet with a print date of 5/6/25 documents R14 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, moderate, with other behavioral disturbances and cognitive communication deficit. R14's MDS dated [DATE] documents R14 is moderately impaired in cognitive skills for daily decision making. R14's current Care Plan documents a Problem area with a start date of 3/20/24 of, Resident is cognitively impaired due to: Dementia. This Problem area includes the following interventions with start dates of 3/20/24, Call resident by name upon each interaction Observe for response .Verbal cues as needed Allow ample time for resident to respond .Simple YES/NO questions and commands Observe whereabouts . R14's Care Plan does not document person centered progressive interventions related to the diagnosis Dementia. R15's Resident Face Sheet with a print date of 5/6/25 documents R15 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia and Alzheimer's disease with late onset. R15's MDS dated [DATE] documents a BIMS score of 03, indicating R15 has a severe cognitive deficit. R15's current Care Plan documents a Problem area with a start date of 2/17/2022 of Resident is cognitively impaired due to: Dementia. This Problem area includes the following interventions with start dates of 2/17/2022, Call resident by name upon each interaction .Observe for response .Verbal cues as needed .Allow ample time for resident to respond .Simple YES/NO questions and commands .Observe whereabouts R15's current Care Plan does not document progressive personalized interventions related to the diagnosis of dementia. The facility Dementia-Clinical Protocol dated 2/2012 documents under Treatment/Management, 1. For the individual with confirmed dementia, the staff and physician will identify a plan to maximize remaining function and quality of life. Under Monitoring and Follow-Up, the Protocol documents, 1. The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician. 2. The physician will help staff adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, etc.