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	02/07/2025

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

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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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 41610 Based on interview, observation, and record review the facility failed to provide dignified dining services while maintaining resident's rights for 4 (R28, R66, R74, R79) of 21 residents reviewed for dining in a sample of 50. Findings include: 1.R28's Resident face sheet documents an admitted [DATE] with diagnoses including: dementia, anxiety disorder, and dysphagia oropharyngeal phase. R28's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 99 indicating R28 was unable to complete the interview. The same MDS documents that R28 requires supervision or touching assistance with eating and has a mechanically altered diet. On 02/02/25 at 12:40 PM and again at 12:56 PM, R28 picked up a piece of ham off of a used tray from an unknown resident and took a bite of the ham and walked away. 2. R79's Resident Face Sheet documents an admitted [DATE] with diagnoses including: encephalopathy, Alzheimer's disease, dementia, and cognitive communication deficit. R79's orders sheet documents a dietary order with a start date of 01/29/25 of regular diet, special instructions: double portions of protein and sides, finger foods in separate bowls. R79's care plan documents a problem area dated 06/26/2024 of R79 is at risk for impaired nutrition and hydration related to: R79 is on a regular diet with an approach dated 06/24/24 listed as diet as ordered by provider: double portions of protein and sides. Finger foods in separate bowls. R79's MDS dated [DATE] documents a BIMS score of 99 indicating resident was unable to complete the interview. R79's eating assistance is documented as supervision or touching assistance. On 02/02/25 at 12:03 PM, R28 took two pieces of ham (all of the ham) from R79's plate. R28 took a bite of one piece and walked away. On 02/02/25 at 12:06 PM, after being made aware that R28 took R79's ham V17 (Certified Nurse Aide) stated, she would call dietary and get him some more ham to eat. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/02/25 at 1:10 PM, V17 (Certified Nurse Aide) brought R79 some mechanical soft ham and stated, sorry there is no more regular (consistency) ham. R79 just stared at the ham and made no effort to eat it. V17 asked R79 if he wanted a peanut butter and jelly sandwich and R79 stated, yes. At 1:16 PM, R79 was given a peanut better and jelly sandwich and R79 started eating it. 3. R74's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, and cognitive communication deficit. R74's Physician's Order Summary Report documents a dietary order dated 12/20/23 of regular diet with regular consistency. On 02/02/25 at 12:25 PM, R28 grabbed a piece of ham off of R74's plate before R74 could cover her food with her arms to keep her from getting it and took a bite and walked away. R74 told R28 that was her food and to leave it alone. 4. R66's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, anxiety disorder and cognitive communication deficit. On 02/02/25 at 12:35 PM, R28 grabbed a piece of ham off of R66's plate, took a bite, and put it back onto R66's plate. R66 told R28 no, that is not your food, that is mine. After R28 took a bite of the ham and started putting the ham back onto R66's plate, R66 said, well keep it now, I don't want it back. After R28 put the ham back onto R66's plate, R66 pushed her plate away from her. On 02/06/25 at 1:40 PM, V4 (Licensed Practical Nurse) stated R28 typically takes food off of other resident's plates. They have to redirect her constantly. V4 stated, residents should not be allowed to take other resident's food. On 02/06/25 at 3:40 PM, V1 (Administrator) stated they do not have a policy for resident rights. The facility policy dated November 2021 titled, Staffing documents: 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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on observation, interview, and record review, the facility failed to identify specific medical conditions or symptoms necessitating the use of physical restraint and failed to release the restraint per the plan of care for 1 (R71) of 1 resident reviewed for restraints in a sample of 50. Findings include: R71's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, type 2 diabetes mellitus, adjustment disorder with mixed disturbance of emotions and conduct, anxiety disorder, and age related physical debility. R71's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 99 indicating R71 was unable to complete the interview. Section P, Restraints and Alarms, of the same MDS documents that Restraints and Alarms are not used. R71's Care Plan documents a problem area dated 11/11/24 of resident uses restraints due to cognitive decline and unaware of safety, at risk for injuries. Seat belt to w/c (wheelchair). Resident not able to undo on command. An approach dated 08/29/24 documents: remove restraints during activities of daily living, dining, and leisure activities and use safety device as ordered prn (as needed). R71's Order Summary Sheet document an order dated 09/03/24 of: ok to use self-releasing seat belt on w/c for safety awareness deficit. On 02/02/25 between 11:35 AM and 1:15 PM a continuous observation was made of R71 while in the dining room. R71's seatbelt was never undone and R71 never made any movement towards her food or her seatbelt, she made little movement with her arms. At 11:35 AM, R71 was addressed and asked how she was with no response, she just looked at surveyor with no movement. R71's seatbelt was buckled and she was sitting at the dining room table with her food sitting covered in front of her. At 1:01 PM, R71 started receiving assistance with her food and her seat belt was still buckled. On 02/03/25 between 11:20 AM and 12:15 PM a continuous observation was made of R71. At 11:20 AM, R71's seatbelt was buckled and R71 was sitting at the dining room table. At 11:22 AM, R71 was approached and asked how she was, R71 was leaned over in her wheelchair and did not respond, just opened her eyes briefly. At 12:05 PM R71's seatbelt was buckled and R71 was assisted with lunch. From 11:20 AM to 12:15 PM, R71's seatbelt was never undone while sitting in her wheelchair at a dining room table. On 02/04/25 at 11:15 AM R71 was sitting at the dining room table with the seatbelt fastened. At 11:30 AM, R71 was being assisted with lunch at a dining room table with her seatbelt still fastened. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document dated 09/03/24 titled, Observation Detail List Report for R71 under Restraint/Adaptive Equipment Use it documents: is a restraint in use? With 'yes' checked; are restraints or adaptive equipment needed to control behavioral symptoms? With 'yes - rocking , constant up and down in chair with falls with injuries. If resident has any of the above conditions with behavioral manifestations, have attempts been made to control behavioral symptoms? With 'yes - bed and chair alarms, redirection, and verbal cues. If restraint or adaptive equipment is needed define what the device would be; with self-releasing seat belt listed. If restraint or adaptive equipment is needed, where would it be utilized with when in wheelchair checked. The section titled, Plan of Care documents: indicated care plan action taken, with the answer 'initiate plan of care' checked. On 02/04/25 at 1:40 PM, V17 (Certified Nurse Aide) stated she was unsure when R71's seatbelt should be undone or if R71 could undo the seatbelt on command. On 02/07/25 at 2:44 PM, V1 (Administrator) stated for a resident with a restraint they have to be able to get out of the restraint on their own, they have to be able to get out of it on command and if they have the ability to get up and walk around they should be allowed to. V1 stated he does not know the specifics with R71 but she should have been assessed for the restraint and have the ability to take it off and her abilities should be in her care plan. The facility policy dated 02/2012 titled, Restraint Use Guide documents: Nursing documentation is ongoing. The monthly summary, assessment, and care plan reviews should be done every three months at a minimum. This documentation needs to include the total numbers of minutes in a 24 hour period of the restraint is on. Documentation of the tiny things that are attempted to reduce the restraint needs to be put in the chart. Restraints add risk to the resident with increased injury potential if they fall. So, a restraint cannot be used to treat or prevent falls. Incidence of death due to strangulation, as well as other injuries, provides proof that restraints are not safety devices. So, restraints cannot be used for safety. Usually a resident with falls, safety risk or family wants the restraint has the medical symptom to provide the reason to use the restraint. It is up to nursing and therapy and the physician to document the needed information. Do not use these three areas as a reason for a restraint. 13. Record the amount of time in a 24-hour period the restraint is in place. Document when the restraint is released, such as for rest periods, bathing, 1:1 activities, and meals. Document how long the restraint is on at a time. If a resident only wears a restraint to get from the bed to the dining room, for less than an hour each time, be sure to document this. Part of reduction, is minutes out of the restraint. Facilities tend to record the resident as being in the restraint only, implying that the resident is restrained 24 hours a day.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview and record review, the facility failed to ensure an individual admitted with a mental illness diagnosis was referred to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination of need for any specialized services for 1 of 3 residents (R48) reviewed for PASARR requirements in a sample of 50. The Findings include: R48's Face Sheet dated 02/06/25 documents an admitted [DATE]. R48's Continuity of Care document dated 02/06/25 documents under problems a diagnosis of visual hallucinations effective 07/24/24 and Bipolar Disorder with an effective date of 08/01/24. R48's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 11 which indicates Moderately Impaired cognition. Section I under active diagnoses documents a diagnosis of bipolar disorder. R48's Illinois PASRR (Preadmission Screening and Resident Review) Level I form dated 07/24/24 under review states preadmission. Under mental health diagnosis it states check any of the following mental health conditions that are diagnosed or suspected for this individual now or in the past: other mental health diagnosis (do not include dementia) specify it documents Labile Mood. Ascend outcome documents Level I outcome as Refer for Level II Onsite. Rationale documents A PASARR level II evaluation must be conducted. That evaluation will occur as an onsite/face-to-face evaluation. R48's Notice of PASRR Level II outcome documents under PASARR determination: Level II -Excluded from PASARR-No diagnosis-No Loc (Level of Care). A document in R48's chart undated documents Agree with continued rule out. You do not have a severe mental health condition requiring evaluation through the PASRR process. You have a history of being diagnosed with Labile Mood and Visual Hallucinations per your History and Physical. However, these diagnoses are believed to be impacted by medical condition of Parkinson's disease, Lewy body disease, and memory loss. There is no evidence you have been given a severe mental health diagnosis noted within the Diagnostic and Statistical Manual of Mental Disorders by a doctor or similarly licensed professional in your current History and Physical. There is no evidence of any legal intervention/homelessness due to a serious mental health condition. You have no history of mental health services and/or psychiatric hospitalization noted due to a mental health condition. If a change occurs suggesting that you do have a severe mental health condition, then further evaluation through the PASARR process will be needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 10:55AM V7 (Social Service Director/SSD) stated a level II PASARR screen did not get done on R48. V7 said a Level II PASARR screen was scheduled to be done because it was recommended after the Preadmission Level I screen was done. V7 said that the Level II screen was not done, because R48 just had diagnosis of Labile Mood with some Hallucinations and they thought these diagnoses where related to some of R48's other diagnoses. V7 said that she wasn't aware that R48 received a new diagnosis of bipolar disorder on 08/01/24. V7 said that R48 should have had a new level I screen done and then a Level II screen. V7 said that staff did not notify her of the new diagnosis of Bipolar. V7 said that she has completed a new Level I with the diagnosis of Bipolar and that she will have a Level II screen completed for R48. The facility policy titled Resident Assessment-Coordination with PASARR Program dated 01/23 documents under Policy: The facility coordinates with the Preadmission Screening and Resident Review (PASARR) program to ensure that residents are appropriately placed in nursing homes for Long-Term Care. Policy explanation and Compliance Guidelines documents in part: 5. Any resident who exhibits a newly or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual authority for a Level II resident review.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48356 Based on observation, interview, and record review the facility failed to ensure that dependent residents receive eating and bathing assistance for 4 of 5 residents (R55, R63, R71 and R52) reviewed for Activities of Daily Living in the sample of 50. The findings include: 1. R55's Face Sheet dated 02/06/25 documents an admitted [DATE] with diagnoses in part of acute respiratory failure with hypoxia, heart failure, type 2 diabetes mellitus, morbid obesity, muscle weakness, other related mobility, other lack of coordination, and unsteadiness on feet. R55's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 15 which indicates R55 is cognitively intact. Section GG documents under shower/bathe self as dependent and Shower and Tub transfer as dependent. R55's Care Plan dated 01/13/25 documents a problem area titled Noncompliance: Resident (R55) refuses to get up for showers, use the commode, use the bedpan, or allow staff to use soap during peri care. Resident (R55) demands staff to use multiple wash clothes during peri care even after staff show resident that the washcloths are not soiled anymore from bowel movement. She (R55) demands to be wiped multiple times more, causing staff to feel uncomfortable with giving peri care due to possibly being sexually inappropriate behavior. Approaches for this problem area include in part actively involve the resident in care. Encourage resident to use bedpan/commode or to get up for showers. There was no problem area in R55's Care Plan addressing R55 being dependent with showers and/or bathing. R55's Point of Care history for showers and bathing dated 02/04/25 documents on 02/01/25 total dependence 2 plus persons physical assist for complete bed bath, 01/28/25 activity did not occur, 01/27/25 activity did not occur, 01/25/25 total dependent 2 plus person physical assist for complete bed bath, 01/21/25 activity did not occur, 01/18/25 activity did not occur, 01/13/25 total dependence 2 plus persons physical assist complete bed bath, 01/09/25 total dependence 2 plus persons physical assist complete bed bath, 01/06/25 activity did not occur, 01/02/25 activity did not occur, 12/30/24 activity did not occur, and 12/28/25 activity did not occur. The facility sheet titled Nightshift Showers documents R55 is to have a shower on Tuesday and Saturday. On 02/02/25 at 02:00PM, R55 stated that she did not get a shower on 02/01/25. R55 said that they didn't have enough staff to give her a shower or a bed bath on 02/01/25. R55 stated she hasn't had a shower in about a month or two. R55 said she does get bed baths every now and then. R55 said that she would like to take a shower, but she is two persons assist with transfers because she is a mechanical lift, and they only have two staff on night shift, and she doesn't want to take away from the other residents. R55 said that she is ok with the bed baths. On 02/02/25 at 2:00PM, R55 appeared to have oily hair, no body odor was noted. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R63's Face Sheet dated 02/06/25 documents an admitted [DATE] with diagnoses in part of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus, and repeat falls. R63's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 09 which indicates severely impaired cognition. Section GG documents dependent with shower/bath self. Tub/shower transfers as not applicable. R63's Care Plan dated 12/24/24 with a problem of Resident (R63) needs substantial assistance to total dependent for most activities of daily living. Resident (R63) is able to feed himself. Approaches documents in part assist as needed with ADL's. R63's Point of Care history for showers and bathing dated 02/04/25 documents 02/01/25 activity did not occur, 01/29/25 at 1:42PM activity did not occur, 01/29/25 at 11:02PM total dependence 2 plus persons assist complete bed bath, 01/27/25 activity did not occur, 01/25/25 activity did not occur, 01/22/25 25 total dependence 2 plus persons assist complete bed bath, 01/18/25 activity did not occur, 01/15/25 at 12:06PM total dependence 2 plus persons assist complete bed bath, 01/15/25 at 9:41PM total dependence 2 plus persons assist complete bed bath, 1/12/25 total dependence 2 plus persons assist complete bed bath, 01/08/25 activity did not occur, 01/05/25 activity did not occur, 01/01/25 activity did not occur, 12/29/24 activity did not occur, 12/25/24 activity did not occur, 12/22/24 activity did not occur, 12/15/24 activity did not occur, 12/11/24 activity did not occur, 12/08/24 activity did not occur, 12/06/24 total dependence 2 plus persons assist complete bed bath. The facility sheet titled Nightshift Showers documents R63 is to have a shower on Wednesday and Saturday. On 02/02/25 at 02:15PM R63 who was alert and oriented to person, place and time stated that he did not get a shower or bed bath on 02/01/25 because they didn't have enough staff. On 02/06/25 at 2:21PM, R63 who was alert and oriented to person, place and time stated that he doesn't get showers or bed baths often. R63 said that he might get a bed bath occasionally. R63 stated that he doesn't remember the last time he had a bed bath or shower. R63 said that he doesn't think they have enough help to give the showers or bed baths. On 02/06/25 at 2:21PM, R63 appeared to have oily hair, half grown beard, his face was dry and flaking and he had odor noted to his body. On 02/06/25 at 12:55PM, V6 (Certified Nurse Assistant/CNA) stated that she just started working at the facility on 02/03/25. V6 said that she knows that showers did not get done on 02/05/25 because they did not have enough staff at the facility to be able to get them done. V6 stated that they had extra help today so they were able to get some of the showers that didn't get done yesterday done today. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/05/25 at 12:56PM, V24 (CNA) stated they didn't have enough staff yesterday to be able to get the showers done. V24 said they had some extra staff today so they was able to get some of the showers from yesterday done. V24 said that she is not sure if all of R55 and R63's shower are done all the time or not. V24 said she does know that they had a hard time getting R63's showers done a while back because they didn't have a big enough shower chair for R55. V24 said they have a big enough shower chair now. V24 said that R63's shower task showed to be done on day shift, but he is not a day shift shower, so she put in charting that activity did not occur. On 02/05/25 at 1:00PM, V26 (CNA) stated that all resident should have showers twice a week.V26 said normally showers are done but if we are short of staff they might not get done but she tries to always get hers done. V26 said that she knows that some residents who's showers are on night shift get mainly bed baths. On 02/06/25 at 2:30PM, V2 (Director of Nursing/DON) stated that she doesn't know why R55's point of care shower sheets document activity did not occur often. V2 said unless she didn't want a shower or refused it. V2 stated that showers should of gotten done on 02/01/25. V2 said that they should have had enough staff here to be able to get the showers done. V2 said she did not know why R55's point of care documentation for 02/01/25 documents that R55 received a complete bed bath when R55 stated that she did not receive a shower or bed bath that night. V2 stated that she did not know why R63's point of care history for showers and bathing document on several occasions that R63 did not receive a shower. V2 stated that R55 and R63 are a night shift showers. V2 said that she just checked the charting on R63 and for some reason his task was popping up on day shift to sign out. V2 said that she doesn't know why the task was populating to day shift when he is a night shift shower. V2 said that could be the reason so many of R63's documentation states the activity did not occur. V2 said that night shift should of checked the night shift shower sheet and still gave R63's showers or bed bath. V2 said that she didn't have no other documentation proving that R63 received a shower or bed bath. V2 said that all residents are to get showers two times a week. On 02/06/25 at 4:20PM, V27 (CNA) stated that he did not give R55 a shower on 02/01/25 even though on the point of care shower documentation states that R55 received a complete bed bath by him. V27 said that he marked off that he gave a complete bed bath thinking he would be able to get to the bed bath before the night was over on 02/01/25. V27 said that he didn't have enough time to give R55 a shower or bed bath that night. V27 said that he didn't give R63 a shower or bed bath that night either. V27 said that he did not have enough time to complete that either. V27 said that they have 2 staff members working to take care of over 30 residents at night. V27 said that if the residents aren't left up when he gets to the facility that he doesn't usually give them a shower he just gives them a bed bath. V27 said that he usually gets to the facility at 7pm. V27 said he doesn't always get all the showers done for the week. V27 said that he tries to at least get the one shower or bed bath a week done. V27 said that R55 gets a bed bath at least once a week. V27 said that he uses a shower cap with the soap in it to wash her hair in bed. V27 stated that he knows this isn't ideal to wash a resident hair like this all the time, but at least it is getting done. V27 said that if he don't get to the shower before the resident goes to bed or wakes up he is not going to wake them up in the middle of the night to give a shower or bed bath. V27 said it's hard to try to get the showers done in the morning because they are trying to get everything done and mornings are crazy and it's hard to get showers done then. V27 said he doesn't know off hand if R63 was a night shift shower or not. V27 said that he knows he gave R63 a partial shower not too long ago sometime this month. V27 said he does the best he can with what time and people he has. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Bathing a Resident dated 07/2014 documents under policy It is that policy of (Company Name) that residents will receive a shower/bath will be scheduled regularly and PRN (as needed) Procedure documents in part 10. Assist the resident in showering/bathing if necessary. 41610 3. R71's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, type 2 diabetes mellitus, adjustment disorder with mixed disturbance of emotions and conduct, anxiety disorder, and age related physical debility. R71's MDS dated [DATE] documents a BIMS score of 99 indicating resident was unable to complete the interview. R71's eating assistance is documented as supervision or touching assistance-helper provides verbal cues or touching/ steadying assistance as resident completes activity. R71's care plan documents a problem area of R71 has a BMI (Body Mass Index) that is less than 20 with an approach dated 12/24/24 listed as: provide setup help, cueing, physical help, etc. (etcetera) assistance for meals dated 09/30/24. R71's care plan documents a problem dated 12/24/24 of R71 requires a mechanically altered diet with an approach of provide prn (as needed) assistance for meals dated 09/24/24. R71's Physician's Order Report documents a dietary order of regular diet with mechanical soft consistency dated 09/23/24. On 02/02/25 at 12:03 PM, R71's food was sitting in front of her covered with a plate cover with R71 making no attempt at uncovering or eating the food. On 02/02/25 at 12:26 PM, R71's food was sitting in front of her covered with a plate cover with R71 making no attempts towards food. On 02/02/25 at 12:34 PM, R66 offered R71 some of her food, but did not put it close enough to her mouth for her to eat it. R71's food was sitting in front of her covered with a plate cover. On 02/02/25 at 12:47 PM, R66 removed the plate cover from R71's food and put a spoon in it and stated, here, you going to eat. At 12:56 PM, R66 stated well and moved R71's plate from in front of her to the other side of the table. On 02/02/25 at 12:54 PM, V2 (Director of Nursing) asked R71 if she was hungry and R71 stated, yes. V2 realized R71's food had been uncovered and moved and ordered R71 a new tray. On 02/02/25 at 1:01 PM, R71 was brought a new tray and received assistance eating her food. 4. R52' Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, Alzheimer's disease, major depressive disorder, and feeding difficulties. R52's Physician's Order Report documents a dietary order dated 12/12/24 of regular diet with a consistency of pureed diet. R52's MDS dated [DATE] documents a BIMS score of 99 indicating resident was unable to complete the interview. R52's eating assistance is documented as: dependent. On 02/02/25 at 11:28 AM, the dietary cart left the kitchen for (the dementia unit). (continued on next page)

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Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/02/25 at 12:55 PM, V15 (Registered Nurse) finished assisting a resident with their lunch and went to the dietary cart, (that has remained open) and took R52's tray over to him asked him if he was hungry and R52 stated, yes and started assisting him with lunch. On 02/06/25 at 1:40 PM, V4 (Licensed Practical Nurse) stated residents should not have to wait over an hour for assistance with food. The facility policy dated November 2021 titled, Staffing documents: 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation, and record review the facility failed to provide adequate supervision to residents during mealtime to ensure resident safety for 1 of 21 residents (R28) reviewed for dining in a sample of 50. Findings include: R28's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, anxiety disorder, and dysphagia oropharyngeal phase. R28's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 99 indicating R28 was unable to complete the interview. The same MDS documents that R28 requires supervision or touching assistance with eating and requires a mechanically altered diet. R28's Care Plan documents another problem area of: resident requires a mechanically altered diet dated 12/24/2024 with interventions listed of: diet: mech (mechanical) soft and provide prn (as needed) assistance for meals with start dates of 12/24/24. R28's Care Plan documents another problem area of: resident is cognitively impaired due to dementia with a start date of 12/24/2024 with an intervention listed of: observe whereabouts with a start date of 12/24/2024. R28's Physician's Order Report dated 01/06/25 - 02/06/2025 documents a dietary order with a start date of 12/19/2024 and an end date listed as open ended of: consistency: mechanical soft. On 02/02/25 at 12:03 PM, R28 took two pieces of ham that was between one quarter of an inch to one half an inch thick from R79's plate, observed to have a regular consistency diet. R28 took a bite of one piece and walked away with one piece in each hand. On 02/02/25 at 12:25 PM, R28 grabbed a piece of ham that was between one quarter of an inch to one half an inch thick off of R74's plate, observed to have a regular consistency diet, before R74 could cover her food with her arms to keep her from getting it. R28 then took a bite and walked away. On 02/02/25 at 12:35 PM, R28 grabbed a piece ham that was between one quarter of an inch to one half an inch thick off of R66's plate, observed to have a regular consistency diet. R28 took a bite of the ham and put it back onto R66's plate. On 02/02/25 at 12:40 PM and again at 12:56 PM, R28 picked up a piece of ham, observed to be of regular consistency, off of a tray used by an unknown resident and took a bite of the ham and walked away. On 02/02/25 at 12:40 PM, V16 (Certified Nurse Aide) observed R28 take the piece of ham, told her no and tried to start picking up some of the used trays and tried to redirect R28 back to her food. On 02/02/25 at 1:10 PM, V16 (CNA) stated R28 has taken food from other residents before. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/25 at 1:40 PM, V4 (Licensed Practical Nurse) stated R28 typically takes food off of other resident's plates. They have to redirect her constantly. The facility policy dated December 2024 titled, Consistency Modified Diets Policy documents: The following diets are modified in texture to promote ease of chewing and swallowing. No two patients/residents are alike; therefore, diets must be individualized based on their chewing/swallowing ability . Mechanical soft: this diet is used for patients/resident with limited chewing ability. Foods menus include ground moist meats, poultry and fish (without bones), canned fruits and vegetables, well-cooked, soft vegetables, finely chopped fresh fruits and vegetables as tolerated, soft breads and desserts. The facility policy dated November 2021 titled, Staffing documents: 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 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** 48356 Based on observation, interview, and record review the facility failed to provide sufficient staff to provide care for Activities of Daily Living (ADL) and provide supervision and assistance during meals. This failure has the potential to affect all 78 residents residing in the facility. The findings include: 1. R55's Face Sheet dated 02/06/25 documents an admitted [DATE] with diagnoses in part of acute respiratory failure with hypoxia, heart failure, type 2 diabetes mellitus, morbid obesity, muscle weakness, other related mobility, other lack of coordination, and unsteadiness on feet. R55's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 15 which indicates R55 is cognitively intact. Section GG documents under shower/bathe self as dependent and Shower and Tub transfer as dependent. R55's Care Plan dated 01/13/25 documents a problem area titled Noncompliance: Resident (R55) refuses to get up for showers, use the commode, use the bedpan, or allow staff to use soap during peri care. Resident (R55) demands staff to use multiple wash clothes during peri care even after staff show resident that the washcloths are not soiled anymore from bowel movement. She (R55) demands to be wiped multiple times more, causing staff to feel uncomfortable with giving peri care due to possibly being sexually inappropriate behavior. Approaches for this problem area include in part actively involve the resident in care. Encourage resident to use bedpan/commode or to get up for showers. No problem area addressing R55 is dependent with shower and/or bathing. R55's Point of Care history for showers and bathing dated 02/04/25 documents on 02/01/25 total dependence 2 plus persons physical assist for complete bed bath, 01/28/25 activity did not occur, 01/27/25 activity did not occur, 01/25/25 total dependent 2 plus person physical assist for complete bed bath, 01/21/25 activity did not occur, 01/18/25 activity did not occur, 01/13/25 total dependence 2 plus persons physical assist complete bed bath, 01/09/25 total dependence 2 plus persons physical assist complete bed bath, 01/06/25 activity did not occur, 01/02/25 activity did not occur, 12/30/24 activity did not occur, 12/28/25 activity did not occur. The facility sheet titled Nightshift Showers documents R55 is to have a shower on Tuesday and Saturday. On 02/02/25 at 02:00PM R55 stated that she did not get a shower on 02/01/25. R55 said that they didn't have enough staff to give her a shower or a bed bath on 02/01/25. R55 stated she hasn't had a shower in about a month or two. R55 said she does get bed baths every now and then. R55 said that she would like to take a shower, but she is two persons assist with transfers because she is a mechanical lift, and they only have two staff on night shift, and she doesn't want to take away from the other residents. R55 said that she is ok with the bed baths. On 02/02/25 at 2:00PM R55 appeared to have oily hair, no body odor was noted. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. R63's Face Sheet dated 02/06/25 documents an admitted [DATE] with diagnoses in part of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus, and repeat falls. R63's Minimum Data Set (MDS) dated [DATE] documents in Section C a Brief Interview for Mental Status (BIMS) score of 09 which indicates severely impaired cognition. Section GG documents dependent with shower/bath self. Tub/shower transfers as not applicable. R63's Care Plan dated 12/24/24 with a problem of Resident (R63) needs substantial assistance to total dependent for most activities of daily living. Resident (R63) is able to feed himself. Approaches documents in part assist as needed with ADL's. R63's Point of Care history for showers and bathing dated 02/04/25 documents 02/01/25 activity did not occur, 01/29/25 at 1:42PM activity did not occur, 01/29/25 at 11:02PM total dependence 2 plus persons assist complete bed bath, 01/27/25 activity did not occur, 01/25/25 activity did not occur, 01/22/25 25 total dependence 2 plus persons assist complete bed bath, 01/18/25 activity did not occur, 01/15/25 at 12:06PM total dependence 2 plus persons assist complete bed bath, 01/15/25 at 9:41PM total dependence 2 plus persons assist complete bed bath, 1/12/25 total dependence 2 plus persons assist complete bed bath, 01/08/25 activity did not occur, 01/05/25 activity did not occur, 01/01/25 activity did not occur, 12/29/24 activity did not occur, 12/25/24 activity did not occur, 12/22/24 activity did not occur, 12/15/24 activity did not occur, 12/11/24 activity did not occur, 12/08/24 activity did not occur, 12/06/24 total dependence 2 plus persons assist complete bed bath. The facility sheet titled Nightshift Showers documents R63 is to have a shower on Wednesday and Saturday. On 02/02/25 at 02:15PM, R63 who was alert and oriented to person, place and time stated that he did not get a shower or bed bath on 02/01/25 because they didn't have enough staff. On 02/06/25 at 2:21PM, R63 who was alert and oriented to person, place and time stated that he doesn't get showers or bed baths often. R63 said that he might get a bed bath occasionally. R63 stated that he doesn't remember the last time he had a bed bath or shower. R63 said that he doesn't think they have enough help to give the showers or bed baths. On 02/06/25 at 2:21PM, R63 appeared to have oily hair, half grown beard, his face was dry and flaking and he had odor noted to his body. On 02/06/25 at 12:55PM, V6 (Certified Nurse Assistant/CNA) stated that she just started working at the facility on 02/03/25. V6 said that she knows that showers did not get done on 02/05/25 because they did not have enough staff at the facility to be able to get them done. V6 stated that they had extra help today so they were able to get some of the showers that didn't get done yesterday done today. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/05/25 at 12:56PM, V24 (CNA) stated they didn't have enough staff yesterday to be able to get the showers done. V24 said they had some extra staff today so they was able to get some of the showers from yesterday done. V24 said that she is not sure if all if R55 and R63's shower are done all the time or not. V24 said she does know that they had a hard time getting R63's showers done a while back because they didn't have a big enough shower chair for R55. V24 said they have a big enough shower chair now. V24 said that R63's shower task showed to be done on day shift, but he is not a day shift shower, so she put in charting that activity did not occur. V24 said she does not feel that they have enough staff to be able to meet the care needs of the residents. V24 said that they have people call in. V24 said the staffing shortage is random no pattern sometimes it's good and other times it's horrible. On 02/05/25 at 1:00PM, V26 (CNA) stated that all residents should have showers twice a week.V26 said normally showers are done but if we are short of staff they might not get done but she tries to always get hers done. V26 said that she knows that some residents who's showers are on night shift get mainly bed baths. V26 said that the facility does not have enough staff to be able to meet the needs of the residents. On 02/06/25 at 2:30PM, V2 (Director of Nursing/DON) said that they technically have enough staff to be able to meet the needs of the residents per the census. V2 stated that she doesn't know why R55's point of care shower sheets document activity did not occur often. V2 said unless she didn't want a shower or refused it. V2 stated that showers should of gotten done on 02/01/25. V2 said that they should have had enough staff her to be able to get the showers done. V2 did not know why R55's point of care documentation for 02/01/25 documents that R55 received a complete bed bath when R55 stated that she did not receive a shower or bed bath that night. V2 stated that she did not know why R63's point of care history for showers and bathing document on several occasions that R63 did not receive a shower. V2 stated that R55 and R63 are a night shift shower. V2 said that she just checked the charting on R63 and for some reason his task was popping up on day shift to sign out. V2 said that she doesn't know why the task was populating to day shift when he is a night shift shower. V2 said that could be the reason so many of R63's documentation states the activity did not occur. V2 said that night shift should have checked the night shift shower sheet and still gave R63's showers or bed bath. V2 said that she didn't have any other documentation proving that R63 received a shower or bed bath. V2 said that all residents are to get showers two times a week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/06/25 at 4:20PM, V27 (CNA) stated that he did not give R55 a shower on 02/01/25 even though on the point of care shower documentation it states that R55 received a complete bed bath by him. V27 said that he marked off that he gave a complete bed bath thinking he would be able to get to the bed bath before the night was over on 02/01/25. V27 said that he didn't have enough time to give R55 a shower or bed bath that night. V27 said that he didn't give R63 a shower or bed bath that night either. V27 said that he did not have enough time to complete it either. V27 said that they have 2 staff members working to take care of over 30 residents at night. V27 said that if the residents aren't left up when he gets to the facility that he doesn't usually give them a shower he just gives them a bed bath. V27 said that he usually gets to the facility at 7pm. V27 said he doesn't always get all the showers done for the week. V27 said that he tries to at least get the one shower or bed bath a week done. V27 said that R55 gets a bed bath at least once a week. V27 said that he uses a shower cap with the soap in it to wash her hair in bed. V27 stated that he knows this isn't ideal to wash a resident hair like this all the time, but at least it is getting done. V27 said that if he doesn't get to the shower before the resident goes to bed or wakes up he is not going to wake them up in the middle of the night to give a shower or bed bath. V27 said it's hard to try to get the showers done in the morning because they are trying to get everything done and mornings are crazy and it's hard to get showers done then. V27 said he doesn't know off hand if R63 was a night shift shower or not. V27 said that he knows he gave R63 a partial shower not too long ago sometime this month. V27 said he does the best he can with what time and people he has. The facility policy titled Bathing a Resident dated 07/2014 documents under policy It is that policy of (Company Name) that residents will receive a shower/bath will be scheduled regularly and PRN (as needed) Procedure documents in part 10. Assist the resident in showering/bathing if necessary. 41610 3. R28's Resident face sheet documents an admitted [DATE] with diagnoses including: dementia, anxiety disorder, and dysphagia oropharyngeal phase. R28's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 99 indicating R28 was unable to complete the interview. The same MDS documents that R28 requires supervision or touching assistance with eating and has a mechanically altered diet. On 02/02/25 at 12:40 PM and again at 12:56 PM, R28 picked up a piece of ham off of a used tray from an unknown resident and took a bite of the ham and walked away. 4. R79's resident face sheet documents an admitted [DATE] with diagnoses including: encephalopathy, Alzheimer's disease, dementia, and cognitive communication deficit. R79's orders sheet documents a dietary order with a start date of 01/29/25 of regular diet, special instructions: double portions of protein and sides, finder foods in separate bowls. R79's care plan documents a problem area dated 06/26/2024 of R79 is at risk for impaired nutrition and hydration related to: R79 is on a regular diet with an approach dated 06/24/24 listed as diet as ordered by provider: double portions of protein and sides. Finger foods in separate bowls. R79's MDS dated [DATE] documents a BIMS score of 99 indicating R79 was unable to complete the interview. R79's eating assistance is documented as supervision or touching assistance. On 02/02/25 at 12:03 PM R28 took two pieces of ham (all of the ham) from R79's plate. R28 took a bite of one piece and walked away. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/02/25 at 12:06 PM after being made aware that R28 took R79's ham V17 (Certified Nurse Aide) stated, she would call dietary and get him some more ham to eat. On 02/02/25 at 1:10 PM R79 was brought some mechanical soft ham and stated, sorry there is no more regular ham. R79 just stared at the ham and made no effort to eat it. V17 (Certified Nurse Aide) asked R79 if he wanted a peanut butter and jelly sandwich and R79 stated, yes. At 1:16 PM R79 was given a peanut better and jelly sandwich and R79 started eating it. 5. R74's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, and cognitive communication deficit. R74's order sheet documents a dietary order dated 12/20/23 of regular diet with regular consistency. On 02/02/25 at 12:25 PM R28 grabbed a piece of ham off R74's plate before R74 could cover her food with her arms to keep her from getting it and took a bite and walked away. R74 told R28 that was her food and to leave it alone. 6. R66's resident face sheet documents an admitted [DATE] with diagnoses including: dementia, anxiety disorder and cognitive communication deficit. On 02/02/25 at 12:35 PM R28 grabbed a piece off R66's plate took a bite of the ham and put it back onto R66's plate. R66 told R28 no, that is not your food, that is mine. After R28 took a bite of the ham and started putting the ham back onto R66's plate, R66 said, well keep it now, I don't want it back. After R28 put the ham back onto R66's plate, R66 pushed her plate away from her. 7. R71's resident face sheet documents an admitted [DATE] with diagnoses including: dementia, type 2 diabetes mellitus, adjustment disorder with mixed disturbance of emotions and conduct, anxiety disorder, and age related physical debility. R71's MDS dated [DATE] documents a BIMS score of 99 indicating resident was unable to complete the interview. R71's eating assistance is documented as supervision or touching assistance. R71's care plan documents a problem area of R71 has a BMI (body mass index) that is less than 20 with an approach dated 12/24/24 listed as: provide setup help, cueing, physical help, etc. (etcetera) assistance for meals dated 09/30/24. R71's care plan documents a problem dated 12/24/24 of R71 requires a mechanically altered diet with an approach dated provide prn (as needed) assistance for meals dated 09/24/24. R71's order sheet documents a dietary order of regular diet with mechanical soft consistency dated 09/23/24. On 02/02/25 at 12:03 PM R71's food was sitting in front of her covered with a plate cover with resident making no attempts towards food. On 02/02/25 at 12:26 PM R71's food was sitting in front of her covered with a plate cover with resident making no attempts towards food. On 02/02/25 at 12:34 PM R66 offered R71 some of her food, but did not put it close enough to her mouth for her to eat it. R71's food was sitting in front of her covered with a plate cover. On 02/02/25 at 12:47 PM R66 removed the plate cover from R71's food and put a spoon in it and stated, here, you going to eat. At 12:56 PM R66 stated, well and moved R71's plate from in front of her to the other side of the table. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/02/25 at 12:54 PM V2 (Director of Nursing) asked R71 if she was hungry and R71 stated, yes. V2 realized R71's food had been uncovered and moved and ordered R71 a new tray. On 02/02/25 at 1:01 PM R71 was brought a new tray and received assistance eating her food. 8. R52' resident face sheet documents an admitted [DATE] with diagnoses including: dementia, Alzheimer's disease, major depressive disorder, and feeding difficulties. R52's physician order report documents a dietary dated 12/12/24 of regular diet with a consistency of pureed diet. R52's MDS dated [DATE] documents a BIMS score of 99 indicating resident was unable to complete the interview. R52's eating assistance is documented as: dependent. On 02/02/25 at 11:28 AM the dietary cart left the kitchen for the Garden unit (the dementia unit). On 02/02/25 at 12:55 PM V15 (Registered Nurse) finished assisting a resident with their lunch and went to the dietary cart, (that has remained open) and took R52's tray over to him asked him if he was hungry and R52 stated, yes and started assisting him with lunch. On 02/02/25 at 1:10 PM R77 stated, they need more staff. On 02/02/25 at 1:30 PM V15 (Registered Nurse) stated, another aide would be helpful. On 02/06/25 at 1:40 PM V4 (Licensed Practical Nurse) stated R28 typically takes food off of other resident's plates. They have to redirect her constantly. V4 stated, residents should not be allowed to take other resident's food and residents should not have to wait over an hour for assistance with food. The facility policy dated November 2021 titled, Staffing documents: 1. Out 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. The Long Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 2/4/25 documents that there are 78 residents residing in the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on observation, interview and record review the facility failed to provide the diet as ordered for 3 (R28, R66, and R71) of 21 residents reviewed for dining in a sample of 50. Findings include: 1. R28's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, anxiety disorder, and dysphagia oropharyngeal phase. R28's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) of 99 indicating R28 was unable to complete the interview and requires supervision or touching assistance with eating. R28's Physician Order Report dated 01/06/25 - 02/06/2025 documents a dietary order with a start date of 12/19/2024 and an end date listed as open ended of: consistency: mechanical soft. On 02/03/25 at 11:30 AM R28 received her lunch with broccoli pieces that were approximately two inches long. 2. R71's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, type 2 diabetes mellitus, adjustment disorder with mixed disturbance of emotions and conduct, anxiety disorder, and age-related physical debility. R71's MDS dated [DATE] documents a BIMS score of 99 indicating R71 was unable to complete the interview. R71's eating assistance is documented as supervision or touching assistance. R71's Care Plan documents a problem area of R71 has a BMI (Body Mass Index) that is less than 20 with an approach dated 12/24/24 listed as: provide setup help, cueing, physical help, etc. (etcetera) assistance for meals dated 09/30/24. R71's Care Plan also documents a problem area dated 12/24/24 of R71 requires a mechanically altered diet with an approach dated provide prn (as needed) assistance for meals dated 09/24/24. R71's order sheet documents a dietary order of regular diet with mechanical soft consistency dated 09/23/24. On 02/03/25 at 11:56 AM, R71 received her lunch with broccoli pieces that were approximately two inches long. On 02/06/25 at 1:04 PM, V14 (Dietary Manager) stated the spreadsheet she was given has the same listed for the vegetable for the regular diet and for the mechanical soft but, the recipe for the mechanical soft states to mince the vegetables. The facility document titled, Diet Spreadsheet Short Name format dated Monday 02/03/2025 documents: lunch: reg/NAS/CC (regular/no added salt/consistent carbohydrates): salmon patty 1 each, rice pilaf #8 scoop, broccoli 4z (ounce) spoodle, wheat bread 1 slice, snickdl (snickerdoodle) cookie 1 each and margarine 1 each. Mech (mechanical) soft: grnd (ground) slmn ptty (salmon patty) #8 scp (scoop) 2 flz gvy (fluid ounce gravy) rice pilaf #8 scoop, broccoli 4z (ounce) spoodle, wheat bread 1 slice, snickdl cookie 1 each and margarine 1 each. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated production recipe titled, Broccoli & Cauliflower Minced & Moist documents: 3. Pulse or grind until all food pieces are tender and <4 mm (millimeters). 3. R66's Resident Face Sheet documents an admitted [DATE] with diagnoses including: dementia, anxiety disorder, and cognitive communication deficit. R66's Physician Order Report documents a dietary order dated 01/29/25 of regular diet with regular consistency with special instructions: nutritional shake twice daily at lunch and dinner and finger foods every meal portions in bowls. R66's Care Plan documents a problem of nutritional status dated 01/30/25 of: R66 is at risk for impaired nutrition and hydration related to: R66 is on a regular diet with an approach dated 01/30/25 of: diet as ordered by provider: finger foods every meal portions in bowls. On 02/02/25 at 11:37 AM, R66 received mashed potatoes with gravy, green beans, ham, and a roll. On 02/02/25 at 12:40 PM, R66 ate her roll and a piece of her ham, she did not attempt to eat her mashed potatoes and gravy. On 02/06/25 at 1:04 PM V14 (Dietary Manager) stated, with the new dietician they use, it is a telehealth program and the dietician does not come to the facility. They no longer have a finger food menu to follow, so they just try to find items for them or give them the regular menu. Having a menu to follow would be helpful. V14 stated, they had to substitute mashed potatoes for the scalloped potatoes and crushed pineapple for the strawberry shortcake. On 02/06/25 at 3:51 PM V29 (Registered Dietician) stated, she did not realize the facility did not have a finger foods spreadsheet to follow, she will have to send them one. They should have a finger food spreadsheet to know what to give the residents with that dietary order. She stated mashed potatoes and gravy would not be optimal to eat as a finger food item. The facility document titled, Diet Spreadsheet Short Name format dated Sunday 02/02/2025 documents: lunch: reg/NAS/CC (regular/no added salt/consistent carbohydrates): baked ham 3z slice, sclpd pots (scalloped potatoes) 4z spoodle, green beans 4z spoodle, choice of roll 1 each, straw (strawberry) shortcake 1/4 c (cup) str (strawberries) margarine 1 each. The policy dated 12/2016 titled, Menus and Food Preparation documents: meals shall be prepared according to the facility approved menu. The menu shall be approved by the Registered Dietitian licensed in the state of practice. Corresponding recipes shall be used in conjunction with meal service. When semi-convenience foods are used (such as oatmeal, farina, cake mixes), the manufacturer directions shall be followed. Food shall be prepared by methods that conserve nutritive value, flavor and appearance and in a form designed to meet individual needs. Food shall accommodate resident allergies, intolerances, and preferences. Food and drinks served hall be palatable, attractive and at a safe and appetizing temperature. Purpose: to ensure resident nutritional needs are met in conjunction with resident preferences. To ensure standards of practice in conjunction with American Medical Association and American Dietetic Association are met.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39744 Based on observation, interview, and record review, the facility failed to use appropriate infection control practices during resident care for 4 of 9 (R1, R22, R26, R78) residents reviewed for resident care observations in a sample of 50. Findings include: 1. On 2/4/2025 at 8:30am, V3 (Licensed Practical Nurse) prepared morning medications to pass to R26, but did not wash her hands or sanitize her hands prior to preparing the medications. After R26 took her medications, V3 picked up R26's medication cup and water cup by the upper rims and tossed the used medication cups in the trash. Next, V3 prepared medications for R22. V3 did not wash or sanitize her hands and administered the medications to R22. When R22 was finished taking the medications, V3 handled R22's used medication and water cups by the upper rims and tossed them in the trash. At 8:49am, V3 was observed scratching her face and messing with her own hair. V3 then prepared R78's medication and did not wash or sanitize her hands. V3 administered R78's medications. When R78 finished taking the medications, V3 grabbed R78's used medication and water cups by the used rims and tossed them into the trash. On 2/4/2025 at 9:00am, V3 said she was nervous and did not realize she was not sanitizing her hands in between passing residents their medications. On 2/4/2025 at 1:30pm, V2 (Director of Nursing) said it was her expectations for the nursing staff to sanitize their hands by washing or using alcohol based hand rub in between patient care and in between passing resident's their medications. V2 said performing hand washing or hand sanitization in between residents is considered a standard practice for nurses. 2. R1's Admission Record documented R2 was admitted to this facility on 7/3/2024 with diagnoses of right femur fracture, paranoid schizophrenia, type two diabetes mellitus and neuromuscular dysfunction of bladder with indwelling urinary catheter, open wound to the (left) buttock. R1's MDS (minimum data sheet) dated 11/7/2024 documented R1 has a BIMS (brief interview for mental status) score of 15 out of 15 total which indicated R1 is cognitively intact. This same MDS documented R1 needs substantial to maximum assistance from staff for toileting, showering and uses an indwelling urinary catheter. A form titled Wound Care Telemedicine Follow up Evaluation with service provided date of 1/29/2025 documented R1 has an open wound to his left buttock. On 2/4/2025 at 1:00pm, R1's bedroom door was noted to have signage indicating R1 is on Enhanced Barrier Precautions. The signage documents the following: Enhanced Barrier Precautions, providers and staff must wear gloves and a gown for the following high-contact resident care activities: Dressing, Bathing, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or Assisting with Toileting, Device Care or Use (Central Line, Urinary Catheter, Feeding Tube, Tracheostomy) and Wound Care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/2025 at 12:30pm, V4 (Licensed Practical Nurse/Wound Care Nurse) entered R1's room to perform wound care to R1's open, left buttock wound. V4 washed her hands and donned clean gloves, but did not don a protective gown to perform the care. Immediately after performing the care, V4 was asked to describe the principles of enhanced barrier precaution as it related to R1's care and V4 answered that she did not know the answer and was not very familiar with enhanced barrier precautions. When asked if V4 had received training on enhanced barrier precautions, V4 answered yes. On 2/4/2025 at 1:00pm, V5 (Certified Nursing Assistant) entered R1's room to perform indwelling catheter care for R1. V5 washed her hands and donned gloves but did not don a protective gown as needed for enhanced barrier precautions. Immediately after performing the catheter care, V5 was asked if she had received training on enhanced barrier precautions and V5 answered yes. V5 was asked to explain the principles of enhanced barrier precautions and V5 answered that she did not know what enhanced barrier precautions were. On 2/4/2025 at 1:20pm, R1 said the staff never wear protective gowns when they perform any of his care. On 2/4/2025 at 1:30pm, V2 (Director of Nursing) said it was her expectations for the staff who perform resident care to use proper infection control measures. V2 said V3, V4 and V5 all need further training on infection control procedures and enhanced barrier precautions. Facility policy dated April 1, 2024 documented the following: Enhanced barrier precautions are used in combination with standard precautions and expand the use of personal protective equipment to donning of gown and gloves during high-contact resident care activities that provide opportunities for the transfer of multi-drug resistant organisms from staff hands and clothing. Enhanced barrier precautions will be used for any resident who meets the following criteria: infection colonization, chronic wounds and indwelling medical devices, such as urinary catheters, feeding tubes and central lines. Enhanced barrier precautions are performed for the following high-contact resident care activities: Chronic wound care and indwelling medical devices care.