STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parc Joliet	222 North Hammes Joliet, IL 60435

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on interviews and record reviews, the facility failed to inform, provide written information, and formulate Advanced Directives upon admission for 1 resident (R116) in a sample of 35. The findings include: R116 is a [AGE] year old male admitted to the facility on [DATE], with diagnoses including malignant neoplasm of the larynx, spinal stenosis, dysphagia oral pharyngeal phase, suicidal ideations, anemia, and major depressive disorder. On 09/04/24 at 11:02 AM, R116 had no POLST (Physicians Orders for Life Sustaining Treatment) or Advanced Directives in his electronic health record, and the facility's Advanced Directives book showed no records for R116. R116's face sheet showed R116 was a full code, and R116's 7/22/24's Physician's order showed full code. On 09/05/24 at 08:55 AM, R116 denied ever being asked from the facility what his wishes were for life sustaining treatments in case of an emergency. R116 also denied ever signing any Advanced Directives forms. R116 said he did not want to have any life sustaining treatment if it meant that he would be on life support or become handicapped. On 09/05/24 at 10:51 AM, V1 (Administrator) said upon admission, the facility is to find out the resident's wishes for life sustaining treatment in an emergency, so the staff can follow those wishes. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Advance Directive Life Sustaining Treatment and End of Life Care Policy and Procedure, dated 6/6/18, showed, the facility is to provide residents information on Advanced Directives including the Power of Attorney for Healthcare and Living Will. The facility also educates residents and families about their rights concerning their rights to refuse or accept medical or surgical treatment and to formulate advanced directives including Do Not Resuscitate orders (DNR) . Staff will review this material with the resident and family and provide needed education at the time of admission. Staff are responsible for following this policy procedure and honoring the individuals advanced directives choices. The policy showed under Policy and Procedure 1. Upon Admission: A. Designated staff will review advanced directive options and the statement of Illinois law addressing advanced directives and life sustaining treatment with the resident and or representative. Staff will provide the resident and or representative with the information regarding advanced care planning which will address types of advanced directives, treatment options and refusal of treatment. Information will be reviewed and the resident and or representative will be asked to sign and acknowledge that they have received the information on advanced care planning. An Advanced Directive form (as provided by the healthcare facility) will be completed with resident and or legal representative to verify treatment options as well as code status (full code vs. DNR using the POLST document). Appropriate information will be added to the physician order sheet (POS).

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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** 46003 Based on observation, interview, and record review, the facility failed to provide incontinence care and grooming assistance to dependent residents. This applies to 6 of 8 residents (R20, R34, R39, R87, R92 and R128) reviewed for incontinence care and grooming assistance in a sample of 35. Findings include: 1. R39 admitted to the facility on [DATE] with diagnoses that includes hemiplegia, morbid obesity, diabetes mellitus, cerebral infarction, dysphagia, bipolar disorder, neurogenic bowel, neuromuscular dysfunction of bladder, hypertension and hyperlipidemia. R39's MDS (Minimum Data Set), dated 7/28/24, indicates she is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15. Per the MDS, R39 is completely dependent on staff for assistance with toileting hygiene and bathing. R39's current care plan, dated 8/6/24, states resident experiences bladder and bowel incontinence. Interventions include assist with toileting needs promptly. Provide incontinence care after each incontinence episode. Check resident at regular intervals every 2-3 hours and as needed. On 9/03/24 at 2:48 PM, R39 stated it takes the staff too long to get her cleaned. R39 stated the last time she received incontinence care was 8:15 AM. On 9/03/24 at 2:56 PM, V26 and V27 CNA (Certified Nursing Assistants) were observed providing incontinence care to R39. R39 stated she had two incontinences brief on by her choice. Both incontinence briefs were saturated with urine. The two mattress pads under R39 were also saturated with urine. R39 had a moderate amount of soft brown stool between her buttocks, and her perineum was pink but blanchable. On 9/03/24 at 4:05 PM, V26, CNA, stated she had just started her shift at 2 PM and had not provided care to R39 during the day. 2. R128 admitted to the facility on [DATE], with diagnoses that includes multiple sclerosis, insomnia, muscle wasting and atrophy, chronic kidney disease, difficulty walking and malaise. R128's MDS (Minimum Data Set), dated 6/10/24, indicates he is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 14. R128's MDS indicates he requires partial staff assistance personal hygiene which includes shaving. The care plan, dated 6/10/24, states R128 has a self-care deficit related to multiple sclerosis and requires set up with dressing, grooming and hygiene. On 9/03/24 at 11:02 AM, R128 had beard and mustache. R128 stated he has asked staff to assist him to shave but they don't help because they think he can do it himself. R128 stated his multiple sclerosis makes it difficult to shave himself. R128 states he must ask V29, Visitor, for assistance when he is visiting another resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/03/24 at 11:19 AM, V29 stated he assists R128 with shaving and cutting his hair because he saw he had a need. V29 stated he comes to the facility to visit another resident, not R128. On 9/04/24 at 3:50 PM, V26, CNA (Certified Nursing Assistant), stated R128 can shave himself and has not asked her for assistance. On 9/05/24 at 9:43 AM, V25, CNA, stated R128 does not require any care assistance. On 9/05/24 at 12:25 PM, V3, DON (Director of Nursing), stated, (R128) is pretty much independent. The facility provides his medications and meals. He has multiple sclerosis and has spasticity flair ups. Staff should assist him with shaving if he asks. Visitors are not expected to assist residents with shaving. It is unacceptable for visitors to provide care assistance because the staff are not. The facility policy Activities of Daily Living (ADLS), dated 9/2020, purpose is to preserve ADL function, promote independence, and increase self-esteem and dignity. 41384 3. R20's 7/19/24 MDS (Minimum Data Set) showed her cognition is intact, and her MDS section GG showed she needs assistance for personal hygiene. R20's 8/8/23 care plan showed a self-care deficit (ADLs/Mobility) (assistance in daily living) related to diagnoses including type 2 Diabetes, insomnia, anemia, osteoarthritis, and hypertension with interventions including supervision or touching assistance with ADL tasks. On 09/03/24 at 11:26 AM, R20 was observed with long jagged fingernails. R20 said it has been months since she has had them cut and she would like for the staff to cut them. On 09/05/24 at 10:38 AM, V1 (Administrator) said R20's nails should not have been long and jagged. V1 said the nails should be trimmed and clean for safety, dignity, and for infection control. 48526 4. R34's Faces Sheet showed diagnoses of cerebral infarction, hypertension, depression, anxiety disorder, chronic pain syndrome, osteoarthritis, muscle wasting and atrophy, vascular dementia, and abnormalities of gait and mobility. R4's MDS, dated [DATE], showed R34 had moderate cognitive impairment. The same MDS showed R34 required substantial/maximal assistance from staff with personal hygiene. R34's Restorative Assessment, dated 08/29/24, showed R34 required assist with hygiene. R34's Self Care Deficit care plan, initiated 04/25/24, showed interventions: one assist with dressing/hygiene tasks. Encourage resident to participate as much as safely able with ADL hygiene tasks, and moderate to max assist with dressing/grooming tasks. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/03/24 at 11:01 AM, R34 was in bed. R34's hair was greasy and uncombed. R34 had an accumulation of facial hair. R34 said the staff shaves him, and he had not had a shave for a while. R34 had a dark colored substance underneath his fingernails on both hands. R34 said he wanted to be shaved and his fingernails cleaned. On 09/05/24 at 10:11 AM, R34 was in his room, sitting in a wheelchair. R34's hair remained greasy and uncombed. R34 continued to have an accumulation of facial hair, and his fingernails remained with a dark colored substance underneath them. On 09/05/24 at 10:14 AM, V13 (Licensed Practical Nurse) said, The resident should not have an accumulation of facial hair. (R34's) hair should not be uncombed and greasy. The hair should be washed twice a week on his shower day. R34's hair should be combed every day. Residents should not have dirty nails. If nails are dirty, bacteria can grow in there, and they could get an infection. On 09/05/24 at 10:17 AM, V20 (CNA) said, Residents should not have long facial hair, and their hair should be washed and combed. It can be a dignity issue, and the hair can get matted on the face and the head. The nails should be clean. All ADL's should be performed every day and on shower days. 5. R87's Face Sheet showed diagnoses of acquired absence of right leg above knee, malignant neoplasm of bronchus or lung, vascular dementia, hypertension, congestive heart failure, and senile degeneration of brain. R87's MDS, dated [DATE], showed R87 had moderate cognitive impairment. The same MDS showed R87 required substantial/maximal assistance from staff with personal hygiene. R87's Restorative Assessment, dated 08/22/24, showed R87 required assist with bathing and hygiene. R87's Self Care Deficit care plan, initiated 02/07/24, showed interventions: one assist with dressing/hygiene tasks. Encourage resident to participate as much as safely able with ADL hygiene tasks, provide moderate assist with dressing/hygiene tasks. On 09/03/24 at 2:09 PM, R87 was in his room, sitting in a wheelchair. R87's fingernails on both hands were long. R87 said the nurses in the facility clip his fingernails, and he had not had them clipped in a while. R87 said he wanted his fingernails clipped. On 09/05/24 at 10:27 AM ,R87's fingernails to both hands remained long. R87 said he had just received a shower. R87 said he wanted his nails cut so he would not scratch himself when he is itchy. On 09/05/24 at 10:28 AM, V21 (CNA) said, 'Residents fingernails should not be long. Residents can scratch themselves if their nails are long. We clip them whenever they are long. On 09/05/24 at 3:30 PM, V3 (DON) said, Residents fingernails should not be long. Residents can cut themselves, get skin tears, and infections if their fingernails are long. The staff is expected to perform nail care on shower days and as needed. 6. R92's Face Sheet showed diagnoses of demyelinating disease of central nervous system, need for assistance with personal care, diabetes, morbid obesity, myelopathy, hypertension, polyarthritis, fusion of spine, spinal stenosis, and low back pain. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R92's MDS, dated [DATE], showed R92 had moderate cognitive impairment. The same MDS showed R92 required supervision or touching assistance from staff with personal hygiene. R92's Restorative Assessment, dated 08/24/24, showed R92 required supervision/cues with hygiene and is dependent with bathing. The same assessment showed R92 was in a restorative dressing and grooming program. R92's grooming care plan, initiated 05/31/22, showed grooming goal: R92 will perform shaving/wash face wit set-up assist and encouragement six to seven times days/week, as tolerated. Interventions: encourage resident to participate as much as able safely. R92's Self Care Deficit care plan, initiated 05/17/22, showed interventions: one assist with dressing/hygiene tasks. Encourage resident to participate as much as safely able with ADL hygiene tasks. On 09/03/24 at 2:16 PM, R92 was in bed. R92 had an accumulation of long facial hair. R92's hair was greasy and uncombed. R92 said he could not remember the last time he had a shower. He said he would love to be shaved. The facility's Activities of Daily Living Policy, dated 09/2020, showed: Purpose 1. To preserve ADL function, promote independence, and increase self-esteem and dignity.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to provide timely foot care to meet the needs of all residents. This applies to 4 resident (R46, R35, R20, and R13) reviewed for podiatry services in a sample of 35 residents. The findings include: 1. R46's Face sheet shows she was admitted to the facility on [DATE], with primary diagnosis of quadriplegia. R46's MDS (Minimum Data Set), dated 7/1/24, shows her cognition is intact, she has impairments to both upper and lower extremities, and she requires maximal assistance for personal hygiene. R46's Care Plan, initiated on 10/11/2023, shows she has self-care deficit due to quadriplegia. Interventions include provide max assistance with grooming tasks. R46's last and only podiatry note was reviewed from visit date of 2/27/24. Podiatrist wrote R46 presented with thick, discolored, dystrophic nails. Podiatrist trimmed R46's nails and wrote for follow up visit in 9 weeks. A 9 week follow up visit would have occurred on or around 4/30/24, but resident has not yet had a follow up podiatry visit. On 9/3/24 at 2:41 PM, R46 said, I don't get to see the podiatrist a lot. I have been here almost a year and I have only seen the podiatrist once. R46 said she thought the last time she was seen by the podiatrist was in March 2024. R46 said she needed the podiatrist to come again, and she didn't understand why it took so long. R46's toenails were observed to be thick and dark in color, and about a half inch over the tip of her skin and curling over/under with dirt and debris under the nails. R46 said she had mentioned to V22 (Social Services) she needed to see the podiatrist and hadn't been seen since March. 2. R35's Face sheet shows she was admitted to the facility on [DATE]. R35's MDS, dated [DATE], shows her cognition is intact and she has an impairment on one side of both upper and lower extremities. R35's Care Plan, initiated on 8/4/23, shows she has a self-care deficit related to history of stroke. R35's POS (Physician Order Sheet) shows an order, dated 10/5/23, that resident may see podiatrist. R35's first podiatry note was reviewed from visit date of 5/14/24. Podiatrist wrote R35 presented with painful, thick, discolored, dystrophic nails. Podiatrist documented he trimmed R35's nails as short as possible to her tolerance and he wrote for follow up visit in 9 weeks. The time frame from R35's admission, to her first podiatry visit was approximately 41 weeks, or just over 9 months. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/3/24 at 1:32 PM, R35 said it took the facility staff 8 months to get in touch with a podiatrist to cut her toenails. R35 said she had been at the facility for about a year, and the podiatrist had only just seen her about 2 months ago to cut her toenails. R35 said because it took so long to see the podiatrist she is losing her big toenails on both feet; the toenails are falling off. R35 said the podiatrist told her he was going to come every 2 months from now on. R35 said V22 (Social Services) told her she had tried emailing and contacting the podiatrist multiple times during those 8 months. On 9/5/24 at 11:21 AM, V22 (Social Services) said the podiatrist comes once a month to the facility. V22 said the last time R46 was seen by podiatry was on 2/27/24, just over 6 months ago. V22 said the first time podiatry saw R35 was on 5/14/24, 9 months after she was first admitted . V22 said when R35 first was admitted it took a longer time for her to be seen by podiatry, but V22 was not R35's Social Worker at that time, so she did not know why. V22 said the podiatrist told her all residents in the facility can be seen every 2 months no matter what insurance they carry. The facility's policy titled, Foot Care Assessment, dated 11/2022, states, Policy: It is the policy of the nursing department to perform an assessments of the resident's feet at the time of admission, updated quarterly, and when significant changes occur. Purpose: To identify treatable conditions, prevent infections, provide treatment, and comfort . Procedure: .5. Examine the resident's feet .8 . Refer to podiatrist if needed . 41384 3. R20's electronic health record showed she is an [AGE] year old female with diagnoses including type 2 diabetes. R20's 8/2/23 physician's order showed, may see podiatrist. R20's 7/19/24 MDS (Minimum Data Set) showed her cognition is intact, and her MDS section GG showed she needs assistance for personal hygiene. On 09/03/24 at 11:26 AM, R20 was observed in her bed with her toenails long and jagged. R20 said she asked the podiatrist in June to cut her toenails, and he told her he could not, because she was not on the list. On 09/05/24 at 12:15 PM, V22 (Social Service Department) said on 9/5/24, she saw R20's toenails were long and on 8/27/24, R20 was not on the list of residents who received nail care from the facility's podiatrist. On 09/05/24 at 10:38 AM, V1 (Administrator) said R20's nails should not have been long and jagged, and she should have been seen by the podiatrist. V1 said the nails should be trimmed and clean for safety, dignity, and for infection control. 46003 4. R13 admitted to the facility on [DATE], with diagnoses that includes multiple sclerosis, major depressive disorder, hyperlipidemia, chronic obstructive pulmonary disease, convulsions, anxiety, hypertension, osteoarthritis of knee, and neuromuscular disorder of the bladder. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's MDS (Minimum Data Set), dated 7/24/24, indicates R13 has moderate cognitive impairment. The MDS indicates R13 requires substantial staff assistance dressing her lower body, putting on and taking off footwear. On 9/03/24 at 12:34 PM, R13 stated she was still in her gown because she was waiting to see the podiatrist. R13's toenails were long and jagged. V30, Family Member, stated she informed facility staff the previous week R13 needed her toenails cut. V30 did not remember the name of the staff member she informed. On 9/05/24 at 9:37 AM, V28, CNA (Certified Nursing Assistant), removed R13's shoes. R13's toenails were still long and jagged. R13's physician order, dated 1/18/24, states she may see podiatrist. The facility did not provide this surveyor documentation of last podiatry visit to R13 or upcoming schedule.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observations, interview, and record review, the facility failed to apply splints to prevent contractures. This applies to 2 of 2 residents (R95 and R85) reviewed for contractures in a sample of 35. The findings include: 1. R85's electronic health record showed she is a [AGE] year old female with diagnoses including Alzheimer's disease, type 2 diabetes, seizures, and hereditary and idiopathic neuropathy. R85's 8/15/24 MDS (Minimum Data Set) section GG showed R85 is dependent in all care. R85's 5/14/24 care plan showed resident would benefit from participation in the following restorative programs: splint right palm protector, (8/20/24-waiting for left palm protector) due to impaired cognition, and impaired communication with interventions including assistance with left palm protector, apply every morning daily. On 09/03/24 at 11:27 AM, R85 was observed in bed asleep, with both her left and right hands contracted and no devices on her hands. On 09/05/24 at 09:14 AM, R85 was observed in her bed again, with no devices in her hands. On 09/05/24 at 09:15 AM, V12, CNA (Certified Nurse's Assistant), said R85 did not have on her palm protectors today because she did not know where they were. On 09/05/24 at 10:43 AM, V1 (Administrator) said R85 should have palm protectors on at all times to stop the hands from contracting further. 2. R95's 2/6/24 Physician Order showed, may participate in restorative programs. R95's 4/13/24 care plan showed resident would benefit from participation in the following restorative programs: Splint due to generalized weakness with interventions including splint: Will tolerate left hand splints daily. On 09/04/24 at 09:25 AM, R95 was observed in bed with his left hand contracted, and no device in his hand. On 09/05/24 at 09:20 AM, R95 again was observed in his bed with no device to his left hand, and a splint was observed on his bed side table. On 09/05/24 at 09:26 AM, V13 (Nurse) said, If restorative doesn't put (R95'sO splint on him, then the nursing staff can put it on. V13 said this should be done to keep R95's hand from contracting more. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/24 at 10:48 AM, V1 said R95's splint should be on to decrease his contractures and for his safety. The facility's ADL (assistance in daily living) policy, dated 9/2020, showed the purpose is to preserve ADL function, promote independence, and increase self-esteem and dignity. The policy showed under Contracture Prevention and Management Skills, observe for alterations and skin integrity and implement preventive measures as needed.

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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** 46003 Based on observation, interview, and record review, the facility failed to utilize safety interventions and maintain an environment free of trip hazards. This applies to 2 of 5 residents (R14 and R135) reviewed for accidents and hazards in a sample of 35. Findings include: 1. R135 admitted to the facility on [DATE], with diagnoses that includes intervertebral disc displacement, hyperlipidemia, alcohol abuse, hypertension, insomnia, adult failure to thrive, history of transient ischemic attack, and cerebral infarction without residual deficits. R135's MDS (Minimum Data Set), dated 6/30/24, indicates he is cognitively intact and uses a walker for mobility. R135's MDS indicates he requires supervision or touching assistance from staff while walking. The care plan, dated 7/15/24, stated R135 is at risk for falls interventions include to anticipate and meet the individual needs of the resident. On 9/03/24 at 10:58 AM, a blower fan was in the middle of the hallway, with the electrical cord stretching past two resident rooms. R135 was walking independently down the hallway with his walker and maneuvered around the blower fan. On 9/05/24 at12:25 PM, V3, DON (Director of Nursing), stated she was responsible for putting the blower fan in the middle of the hallway to dry the floor from a toilet that leaked when she worked the previous night. 2. R14 admitted to the facility on [DATE], with diagnoses that include metabolic encephalopathy, dystonia, mild cognitive impairment, scoliosis of spine, cognitive communication deficit, history of traumatic brain injury, spastic quadriplegic cerebral palsy, apraxia, dysphagia, contracture, muscle spasm and depression, insomnia, generalized anxiety, and history of falling. R14's MDS (Minimum Data Set), dated 8/14/24, indicates he is cognitively impaired and completely dependent on staff for care needs. The care plan, dated 8/20/24, indicates R14 is at risk for falls with interventions that include floor mats on both sides of bed. On 9/03/24 at 10:59 AM, R14 was in bed, with his fall mats located against the wall underneath his television. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/03/24 at 12:10 PM, V31, CNA (Certified Nursing Assistant), provided incontinence care to R14, and did not place the fall mats on either side of R14's bed prior to exiting the room. On 9/04/24 on 3:50 PM, R14's fall mats were located up against the wall under his television. V26, CNA, stated fall interventions for R14 includes floor mats. V26 stated the mats for R14 should be on the floor on both sides of his bed and not against the wall under his television. On 9/05/24 at 12:25 PM, V3, DON (Director of Nursing), stated R14 is at risk for falls with interventions that include fall mats on both sides of his bed. V3 stated the mats should always be in place when he is in the bed, as he has fallen before and has the potential to hurt himself. The facility policy Safety and Supervision of Residents, dated 11/2023, states the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on observation, interview, and record review, the facility failed to provide humidification with oxygen therapy to avoid nasal dryness. This applies to 1 of 1 resident (R59) reviewed for respiratory therapy in a sample of 35. The Findings Includes: R59 is a [AGE] year-old female, with very mild cognitive impairment, as per the Minimum Data Set (MDS), dated [DATE]. R59 was admitted with an admitting diagnosis, including asthma, congestive heart failure, sleep apnea, and dyspnea. On 09/03/24 at 02:22 PM, R59 was in her bed, with oxygen therapy with a nasal cannula (NC) at 2.5 liters per minute (L/M) without any humidification. On 9/5/24 at 9:45 AM, R59 was observed again in her bed, with NC at 2.5 L/M. R59 stated her nares are dry. On 09/05/24 at 11:30 AM, V3 (Director of Nursing / DON) stated, Our policy is to administer oxygen with humidification. We have couple of people refused to have humidification. I will check to see if (R59) was refusing the humidification. On 09/05/24 at 12:56 PM, R59 stated, They never gave me humidification with my oxygen therapy. I never refused humidification with my nasal cannula. On 09/05/24 at 01:15 PM, V3 stated, I couldn't find any documentation to prove (R59) was refusing humidification. The facility presented Oxygen Therapy, dated 8/14, documented the equipment needed for Oxygen therapy, including Humidifier bottles.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to properly label/date/seal/store items, remove expired items, and clean and address standing water by drain to avoid flies in the kitchen. This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671), dated [DATE], documents the total census was 153 residents. On [DATE] at 11:31 AM, V22 (Social Services) verified the facility has 3 strict NPO (Nothing By Mouth) residents; all other residents eat from the facility kitchen. On [DATE], starting at 10:34 AM, the facility kitchen was toured in the presence of V16 (Dietary Manager) and the following was found: In the refrigerator: 1. 24 fresh whole eggs with no date. 2. A medium sized silver bin of unlabeled and undated ground meat. V16 said he thought it was ground turkey. In the dry storage: 3. Standing water by drain in the floor located next to the door/entrance to the dry storage. There was a blanket on the floor surrounding the drain that the staff put down to try to prevent the water from spreading, but there was water leaking out around the blanket and on the floor at the entrance to the room. 4. Small black flies flying around food on shelves near the cookies and canned items. V16 said he saw flies in the dry storage about a month prior, but had not noticed flies since then. 5. Two opened 25 ounce packages of assorted sandwich cremes not properly sealed. 6. Six 32 ounce bags of raisins located on bottom shelf with dust/crumbs/sticky debris on outside of packages. All bags of raisins had expiration date of [DATE]. 7. One 4.7 ounce box of 10 taco shells with expiration date of [DATE]. 8. One 7.3 ounce box of macaroni and cheese with expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. One 6 ounce box of chicken stuffing with consume by date of [DATE]. 10. A 1 gallon jug of concord grape jelly with multiple visible splotches of peanut butter and jelly on the outside of the jug and on the handle. Surveyor was unable to pick up the jug without getting food debris on hands. 11. On the other side of the dry storage room more small black flies were noted flying around the powdered cake mixes. In the freezer: 12. A clear plastic water bottle was found on the shelf in the freezer half full of a pink liquid. V16 (Dietary Manager) said the bottle belonged to a dietary aide who likes his koolaid and he leaves it in here. V16 said the personal food item should not be stored in the freezer with the resident food. By the dishwasher: 13. The top of the dishwasher has visible layers of dirt and debris. There is a pair of used gloves on top of the dishwasher and an opened bottle of water. 14. On [DATE] at 12:13 PM, small black flies were again seen flying around in the dry storage room and shown to V16. On [DATE] at 2:56 PM, V16 (Dietary Manager) said he discourages staff from keeping their personal food in the facility kitchen, and it should be kept in the staff refrigerator located in the staff break room. V16 said all food items should be labeled and dated to make sure they are safe to serve to the residents and won't make them sick. V16 said all opened food items should be sealed tightly to make sure no bugs or flies get into the food and contaminate it. V16 said all expired foods should be thrown away so they are not served to the residents with the potential to cause illness. V16 said it is the responsibility of the staff member who receives/stocks the food items to throw away the expired items when they restock. V16 said the kitchen staff are supposed to clean the kitchen as part of their daily duties, and they are not cleaning thoroughly enough. V16 said the standing water in the dry storage is a concern because of staff safety and drain flies. V16 said the outside of the jelly container should be wiped clean so that it doesn't attract flies. V16 said he had never seen any fly traps set up in the kitchen. During this interview with V16, small black flies were seen in the resident hallway. The facility's policy titled, Dating & Labeling, dated ,d+[DATE], states, Policy: The facility will follow safe handling and storage of PHF/TCS foods. Procedure: . All items not in their original containers will be labeled. Food labels should include the common name of the food or a statement that clearly and accurately identifies it. The facility's policy titled, Storage of Refrigerated/Frozen Foods dated ,d+[DATE] states, Policy: The facility will follow safe handling and storage of refrigerated and frozen foods. Procedure: .Foods in the refrigerator will be covered, labeled and dated . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy titled, Guidelines for Labeling Unopened and Opened Food Items, dated ,d+[DATE], states, Policy: Foods will be labeled upon delivery to the facility and then labeled with an opened and use by date according to the food storage guidelines or use-by-date on the container once the food has been opened. Purpose: To assure the staff are using food that has not expired and meets food safety criteria. Procedure: Staff will utilize the food storage guidelines for storing food upon delivery. Once opened the food will be store accordingly . Any items past the use by date will be discarded immediately. All foods that are opened are to be wrapped or put in a sealed container for storage to prevent contamination. The facility's policy titled, Storage of Dry Foods/Supplies, dated ,d+[DATE], states, Policy: The facility will follow safe handling and storage of dry foods and supplies. Procedure: Facility shall have a room/area designated for storage of dry goods such as single serve items, canned goods and packaged foods that are not PHF/TCS. The area should be clean, well ventilated, dry and free from contaminants . Opened products will be labeled and stored in tightly covered containers or individually wrapped . Employees are not permitted to eat/drink in the dry food storage area . The facility's policy titled, Cleaning Schedule Policy, dated ,d+[DATE], states, Purpose: To assure the kitchen is kept clean and meets state regulations monthly. Procedure . The cleaning schedule will be used by all staff to assure that the kitchen is maintained with cleanliness and sanitized as needed .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed to label, date, discard expired food/beverages, and complete daily temperature logs for resident's personal refrigerators. This applies to 2 of 2 residents (R2 and R51) in the sample of 35. The findings include: 1. R2's Face Sheet showed diagnoses of asthma, chronic pain due to trauma, dysphagia, schizophrenia, major depressive disorder, anxiety, epilepsy, hypertension, heart failure, and hemiplegia/hemiparesis. R2's MDS (MDS/Minimum Data Set), dated [DATE], showed R2 was cognitively intact. The same MDS showed R2 had an impairment on one side of her upper extremities, and an impairment on side of her lower extremities. On [DATE] at 11:10 AM, R2 had a personal refrigerator in her room. The refrigerator contained two cartons of chocolate milk, with an expiration date of [DATE] and [DATE]. The refrigerator had one carton of white milk, with expiration date [DATE]. R2 had two bowls of shredded cheese in the refrigerator without a date and label. R2 said the staff comes and checks the temperature of the refrigerator every day, but does not clean it. R2 said she drinks the cartons of milk that are in the refrigerator. On [DATE] at 9:52 AM, the two cartons of expired chocolate milk and one carton of white milk remained in the refrigerator. On [DATE] 10:40 AM, V17 (Housekeeping Manager) said the Housekeeping department is responsible for cleaning the refrigerators in all the residents rooms. V17 said they remove all old and expired foods and drinks. V17 said he did not know R2 had expired milk in the refrigerator. V17 said R2 could become sick if she drank the expired milk. V17 said all food that is in the refrigerators should be dated and labeled. On [DATE] at 11:12 AM, V16 (Dietary Manager) said all food stored in resident's refrigerators should be dated and labeled. V16 said he did not know R2 had two bowls of shredded cheese without a date in the refrigerator. V16 said residents can become sick if they eat old food. The facility did not provide a policy for personal refrigerators. 41384 2. On [DATE] at 11:02 AM, R51 was observed in his room. On the inside of his personal refrigerator was an open bottle of salad dressing. On the outside of the refrigerator was the temperature logs for [DATE] and [DATE]. On the [DATE] temperature log there were no record of temperatures being taken for [DATE], & [DATE] through [DATE]. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:41 AM, V1 (Administrator) said the temperature should be checked and recorded everyday on the temperature log. V1 said this should be done to make sure the temperature is in proper range, so the food does not spoil.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on observation, interview, and record review, the facility failed to follow its Enhance Barrier Precautions (EBP) Guidelines by staff not wearing gowns during wound care to EBP resident,s and not having a trash can inside the resident room and near the exit for discarding PPE after removal. The facility also failed to maintain effective hand hygiene during resident care. This applies to 2 of 4 residents (R95 and R124) reviewed for infection control practices in a sample of 35. The findings include: 1. R124 is a [AGE] year-old male with severe cognitive impairment as per the Minimum Data Set (MDS), dated [DATE]. R124 was admitted with an admitting diagnosis, including cerebral infarction, dysphagia, and gastrostomy tube (GT) feeding. On 9/4/24 at 9:58 AM, R124's entry door was observed with an EBP sign to wear gloves, gown, and mask to provide high-contact resident care activities. On 9/4/24 at 10:00 AM, V5 (Wound Care Nurse) and V8 (Certified Nursing Assistant / CNA) provided wound care to R124's sacral wound without wearing a gown. On 09/04/24 at 10:35 AM, V3 (Director of Nursing / DON) stated, For the hands-on care to EBP residents, the staff should wear gloves, gown, N95 mask. The wound care nurse (V5) and V8 should have wear gowns. The facility presented Enhanced Barrier Precaution Policy and Procedure re,vised on 8/15/24, documents: Procedure. 1. EBP requires the use of gowns and gloves during high-contact resident care activities. High-contact resident care activities include wound care. Any skin opening requiring dressing. 41384 2. On 09/04/24 at 09:25 AM, R95 was receiving incontinence care from V10 and V14 CNAs (Certified Nurses' Assistants). V10 cleaned R95's perineal area and buttocks and then took off her gloves and put on new gloves. V10 then put a clean bed pad and a new brief under R95. This was done without cleaning her hands after providing incontinence care. V14 was then observed removing R95 soiled brief and bed pad and then pulling the new pad and new brief from under R95 with the same dirty gloved hands. V10 then was observed with the same uncleaned gloved hands using R95's bed control and readjusting R95 in his bed. Then both V10 and V14 with their dirty gloved hands adjusted R95's bedding before leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/24 at 09:37 AM, V10 said she should have cleaned her hands before putting on the clean gloves to prevent cross contamination. On 09/04/24 at 09:40 AM, V14 said she should have removed the dirty gloves, cleaned her hands, and put on clean gloves before touching the clean items after she had touched the dirty items to prevent cross contamination. On 09/05/24 at 12:25 PM, V1 (Administrator) said when going from dirty to clean, staff should remove their gloves clean their hands, and then put on clean gloves before continuing to clean items. The facility's Perineal/Incontinence Care policy (11/23) showed, after cleansing residents' perineal area, remove gloves and perform hand hygiene and apply clean gloves. The facility's Hand Hygiene policy (11/23) showed, to provide proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections. Wash hands before and after applying gloves, after handling potentially contaminated with blood, body fluids or secretions, before moving from a contaminated body site to a clean body site during resident care, example after providing peri-care.