STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145243	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare Danville	801 North Logan Avenue Danville, IL 61832

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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** 31642 Based on observation, interview, and record review, the facility failed to ensure residents' rights to dignified activities of daily living. This failure affects six of six (R2, R38, R49, R72, R73, R77) residents reviewed for dignity on the sample list of 24. Findings include: The facility policy Resident Privacy and Dignity dated revised 3/2/24 documents the following: PURPOSE: To provide all residents with a home like environment that promotes dignity and respect to the residents of the facility. POLICY: To ensure that all residents are provided with dignity and privacy. RESPONSIBILITY: It is the responsibility of all staff to ensure that all residents have privacy and dignity. PROCEDURE: 1. All residents will be addressed and spoken to with dignity and respect at all times. All residents will be addressed by their preferred name during conversation. 2. Staff will knock on the resident's door prior to entering the resident's room. Staff will be invited into the resident's room if the resident is capable of the invitation. The staff will announce their presence after knocking to any resident that is unable to respond the the request for entrance. 3. Privacy will be maintained for all the resident's receiving ADLs such as bathing, dressing and peri care with the resident room/shower room door closed and curtain drawn. 4. Medically necessary procedures will be conducted in the resident's room/private setting. 5. Activities of daily living such as grooming, nail care, and hair care will be conducted in the resident's room/shower room unless the care has been initiated as a planned activity such as nail polishing and beauty day. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. All resident's rights will be honored throughout the resident's daily routine as listed on the Resident Rights for People in Long term Care Facilities. The facility Call Light Answering (No Pager) dated as revised 7/2023 documents the following: PURPOSE: To respond to the resident's request and needs. POLICY: All residents will have a staff member that is able to answer/and or see to the resident request and/or needs. RESPONSIBILITY: 1. It is the responsibility of the CNA (Certified Nurse's Aide), and or Nurses to answer the call lights/pagers to see what requests or needs the resident may have. 2. It is the responsibility of the Charge Nurse to ensure that the CNA answer the call lights/pager so that the needs and request of the resident have been met. 3. It is the responsibility of the Director of Nurses or Designee to ensure that the call lights/pages are answered in a reasonable time frame. 1. R49's Minimum Data Set (MDS) dated [DATE] documents the following: R49's Brief Interview of Mental Status (BIMS) score of 14 out of a possible 15, indicating no cognitive impairment. The same MDS documents R49 is always incontinent of bowel and bladder. R49's Care Plan dated 1/26/24 documents R49 requires one person physical staff assistance with bed mobility and directs staff to perform incontinence care every two hours as needed. 04/16/24 12:52 pm: R49 and R72 are roommates. R49 stated, The staff leave (R49's) call light on sometimes for hours. The longest was four hours, on evening shift. I had only been changed one time on day shift. They said evening shift would be in later to change me. Many times, they leave me lay for hours incontinent. One time my (V17, Family Member) came in and saw how filthy my bed was. I was covered in BM (feces). I'm frustrated when I lay like that. I was totally embarrassed when my (V17) saw all that. He (V17) went directly to the nurse and told them to take care of me as they would their own mother. It got better for a short while. I still have to go through it. Some days are worse than others. I get depressed after episodes like that. On 4/16/24 at 1:20 pm V6, Registered Nurse acknowledged R49 and R72 have been incontinent and not changed in a timely manner. V6 stated she believed it was because the residents refused, and staff were just honoring their resident rights. On 4/16/24 at 1:24 pm V5, Nurse Practitioner stated, Absolutely, a resident laying in incontinence for any length of time is a dignity issue, absolutely. On 4/18/24 at 12:00 pm V18, Activity Director stated the residents in the council group have complained several times in group that call lights take too long to be answered. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/18/24 at 12:25 pm V17 (R49 Family Member) stated, I can tell you it has happened several times. I have come in to visit and find my mother (R49) completely soiled. Her call light will be on. Her roommates (R72) call light too. They tell me it has been an hour sometimes. I have talked to the nurses several times. They always apologize and go in and get them cleaned up. I am not sure why this continues to happen. I don't know who the nurses are. I just know it shouldn't have happened again, after I have already made it clear. When they turn on their call light, they need help. No one should have to lay in their own excretions like that. 2. R72's (MDS) dated [DATE] documents the following: R72's BIMS score of 15 out of a possible 15, indicating no cognitive impairment. The same MDS documents R72 is always incontinent of bowel and bladder. R72s Care Plan dated 1/26/24 documents R72 requires one person physical assistance with bed mobility. The same care plan directs staff to keep resident clean and dry and provide incontinence care every two hours as needed. On 04/16/24 at 1:07 PM R72 (R49's roommate) was lying in bed. R72 stated, (R49) is not exaggerating. We (R49 and R72) can't walk. We put on our call light and wait hours to be changed (receive incontinence care). We only get changed once a shift. I can't tell you how bad it makes me feel. I can't stress enough to staff we need changed more than once a shift. On 4/16/24 at 1:20 pm V6, Registered Nurse acknowledged R49 and R72 have been incontinent and not changed in a timely manner. V6 stated she believed it was because the residents refused, and staff were just honoring their resident rights. The facility Resident Council Group Meeting Notes dated March 28, 2024 document the following: New Concerns for the month of March Third concern: Call lights being turned off, and CNA (Certified Nursing Assistant) say they will be back to assist but does (do) not return timely. 34058 3. On 4/16/24 at 2:04 PM, there was a prominent odor of feces in the room of R77. On 4/16/24 at 2:04 PM, V27, Family member of R77, stated, I think they (facility) are short of help. Nights and weekends are the worst, and the contract workers are bad too. The contract workers come in to work and then say they don't have to do this or that and end up walking out. I see a lot of the staff in here hiding in a corner or empty room and they will be on their phones. There have been times when I come in at 9:00 or 9:30 in the morning and my mom will be a smelly, poopy mess. When I go say something to the staff about it, they tell me they have to pass the food trays. Well, I say they should have gotten her cleaned up before breakfast. Today I came in later after lunch to give them a break from me saying stuff to them, but she was the same mess and so I cleaned her up when I got here. On 4/17/24 at 11:41 AM, there was a strong odor of feces in R77's room. On 4/18/24 at 2:50 PM, V27 stated, I see they are keeping (R77) clean today, they are just doing that because you are here, you should come out here at night or the weekend. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 4/17/24 at 10:09 AM, R38 stated, I don't think they have enough help, sometimes when I push the call light, I wait for over 30 minutes and that affects our care. R38's Minimum Data Set, dated dated dated [DATE] documents R38 received a score of 13 out of a possible 15 during a Brief Interview for Mental Status (BIMS), rating R38 as cognitively intact. 5. On 4/17/24 at 10:43 AM, R73 stated, Sometimes it takes hours for someone to come when I push the button to help change me and I don't want to sit in my own stuff when I push my call button it takes long times for someone to come answer. R73's Minimum Data Set, dated dated dated [DATE] documents R73 received a score of 13 out of a possible 15 during a BIMS, indicating R73 is cognitively intact. 6. On 4/17/24 at 11:21 AM, R2 stated, I sat in my wheelchair for 3 or 4 hours waiting for them to put me in bed. I started to feel weak and like I was going to pass out when I am up that long. They use the lifting machine to put me in bed or into the chair. I haven't been getting into the wheelchair much at all because I am afraid, they won't get me back out of it. R2's Minimum Data Set, dated dated dated [DATE] documents R2 received a score of 12 out of a possible 15 during a BIMS, rating R2 as between cognitively intact and moderately cognitively impaired.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review, the facility failed to accurately encode a resident's health status on the Resident Assessment Instrument (Minimum Data Set) regarding dialysis. This failure affects one of two residents (R92) reviewed for dialysis on the sample list of 24. Findings include: On 04/16/24 at 12:48 PM R92 had a dressing on R92's left upper arm. R92 stated the dressing is covering his dialysis port. R92 stated R92 goes to an outside facility for dialysis treatment three times per week. R92's Physician order Sheet dated 4/19/24 documents: Dialysis: Monday -Wednesday -Friday at (a local) Dialysis Center. R92's Minimum Data Set (MDS) dated [DATE] documents R92's Brief Interview of Mental Status score as 14 out of a possible 15, which indicates R92 has no cognitive impairment. The same MDS fails to document that R92 receives dialysis treatments. Dialysis coded incorrectly. On 4/19/24 at 1:12 pm V1, Administrator/ Registered Nurse acknowledged R92's MDS is not accurately encoded to reflect R92's current status of receiving dialysis treatments.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380 Based on observation, interview, and record review, the facility failed to provide PRN (as needed) dressing changes for a resident. This failure affects one resident (R7) reviewed for dressing changes in the sample list of 24. Findings include: R7's undated Medical Diagnoses Page documents R7's diagnoses as: Pyogenic Arthritis, unspecified, aftercare, following joint replacement surgery, Type 2 Diabetes Mellitus without complications, Morbid (severe) Obesity due to excess calories, Methicillin susceptible Staphylococcus Aureus Infection, Unspecified site, and presence of left artificial knee joint. R7's Physicians Order Sheet (POS) dated April 1, 2024 through April 30, 2024, documents R7's orders as: left knee: cleanse with wound cleanser, pat dry, then loosely pack with 1/4 inch iodoform packing strip, apply abdomen pad and wrap with gauze bandage roll, may secure dressing with elastic wrap daily and PRN if soiled or dislodged. R7's Minimum Data Set (MDS) dated [DATE], documents R7 is cognitively intact. On 4/17/24 at 9:15 AM, R7's left knee dressing appeared saturated with a light red and brown substance leaking through two abdominal pads, gauze wrap, and an elastic wrap. On 4/18/24 at 8:56 AM, R7's left knee dressing appeared saturated with a light red and brown substance leaking through two abdominal pads, gauze wrap, and an elastic wrap. At this same time, V14 Registered Nurse (RN) stated R7's (left knee) dressing is scheduled once a day and as needed but should have been changed before now since it appears saturated. On 4/18/24 at 10:33 AM, V12 Registered Nurse (RN) stated R7's left knee dressing appears saturated with fluids and should have been changed prior to now. V12 RN stated the order stated to change the dressing once a day and as needed but should be changed to more often. The facility's Dressing Change Policy dated Revised 2/24, documents the purpose of a dressing change is to protect the open wound from contamination, absorb and contain drainage, prevent infection, and promote healing.

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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** 31642 Based on observation, interview and record review the facility failed to provide and implement fall interventions to prevent falls for a resident. These failures affect one of one resident (R29) reviewed for accidents/supervision on the sample list of 24. Findings include: R29's Current (multiple dates) Diagnoses Sheet documents the following diagnoses: Malignant Neoplasm of the Head of the Pancreas, Secondary Malignant Neoplasm of Liver and Intrahepatic Bile Duct, Spinal Stenosis Lumbosacral Regions, Spinal Stenosis Cervical Region, Unspecified Abnormalities of Gait and Mobility, Other Abnormalities of Gait and Mobility. R29's Functional Assessment-admitted d 02/29/24 documents R29 requires supervision and touching assistance with toileting and chair to bed transfers. 29's Minimum Data Set (MDS) dated [DATE] documents the following: R29's Brief Interview of Cognitive status score of 13 out of a possible 15, indicating no cognitive impairment. The same MDS documents: Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. R29's Care Plan updated 4/11/24 documents (R29) is at high risk for falls related to Gait/balance problems and unaware of safety needs. R29's same Care Plan documents the following interventions to prevent further falls: recorder alarm to bed and check function every shift, stool softener daily, resident moved closer to the nurse's station, resident to wear non-skid socks, anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, and the resident needs prompt response to all requests for assistance. On 4/19/24 at 9:50 am V2, Director of Nursing (DON) reviewed R29's Fall Investigations dated 4/8/24, 3/28/24, 3/22/24, 3/18/24, and 3/2/24. V2, DON confirmed R29's falls were all unwitnessed. V2, DON stated R29's had no apparent injury until R29's fall on 4/8/24. R29's fall investigation dated 3/2/24 at 11:46 pm documents, Res (R29) was observed by staff on the floor in room between bedside and sink area. Room was appropriately lit. Res stated, 'I put myself here because I was waiting for you.' Res denied any pain and denied hitting head. Neuros (neurological assessment) started. No change in LOC (level of consciousness) to note. ROM (range of motion) x4 (bilateral upper and lower extremities) is equal and strong. IDT (Interdisciplinary Team) reviewed. Root cause was resident ambulating without her walker. Resident moved across from nurses' station so we can see when she is up ambulating. Care plan updated. On 4/19/24 at 9:50 am V2 stated, We know (R29) does not wait for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's fall investigation dated 3/18/24 at 2:24 am documents: Went to answer call light, resident (R29) was sitting on floor next to bed. Predisposing Situation factor: Improper footwear. IDT reviewed. Root cause was resident slid off the side of the bed. Intervention is to place non-skid socks on resident. Care Plan updated. R29's fall investigation dated 3/22/24 at 5:10 am documents, Resident (R29) was very anxious trying to get her roommate up. This nurse (V23, Registered Nurse) heard her (R29) from around the corner calling her roommate's name. Shortly after there was a loud thump. Resident had fallen in the walkway next to her TV (television) and was lying on her left side. Resident's (R29) walker was behind her left shoulder. The same investigation documents R29 originally complained of left shoulder pain that subsided by the next time vital signs were obtained. IDT reviewed. Root cause was resident was ambulating in her room without assistance. Intervention to place alarm to bed d/t (due to) impaired cognition to alert staff when resident is ambulating. Care plan updated. R29's fall investigation dated 3/28/24 at 4:05 am documents R29 had improper footwear on and was found sitting on her bottom by the sink in resident room after washing her hands. Root cause was resident standing at sink washing her hands and feeling weak. Intervention is for the resident to have baby wipes to wash her hands. Care plan updated. On 4/19/24 at 9:50 am V2, Director of Nursing stated, I should have addressed the improper footwear as part of the root cause. All ambulatory residents with a history of falls should have non-skid footwear when up and ambulating. R29's fall investigation dated 4/8/24 documents on 4/8/24 at 11:32 pm R29 had an unwitnessed fall. R29 was found on the floor laying on her left side with her head in the bathroom doorway. R29 hit her head, had a raised area on her forehead and a nose bleed. Sent to the hospital. IDT document root cause of fall as follows: (R29) was ambulating to the bathroom without assistance. Resident stated she had been to the bathroom multiple times trying to have a bowel movement. Intervention is to place resident on stool softener per (V7, Physician) ambulated to the bathroom without assist of staff. R29's hospital emergency room notes dated 04/8/24 document R29 was evaluated post-fall at the facility. R29's Hospital records document R29 was positive for Facial Swelling, Forehead Hematoma, Dizziness and Constipation and R29 returned to the facility with head injury instructions due to Hematoma, and direction to follow-up with resident complaint of constipation. On 4/19/24 at 9:50 am V2 DON, stated V2 should have included an intervention for staff to assist R29 with toileting, more frequently to address R29 getting up on her own to go to the bathroom on 04/08/24. On 4/19/24 at 11:15 am V25, Occupational Therapist stated V25 completed R29's initial assessment on 3/1/24 the day after R29 admitted to the facility. V25 stated R29 was somewhat confused at first as she was admitted from the hospital. V25 stated, She used a walker at the time. She has never been independent with ambulation. She should have always had assistance. We continued to work with (R29). She started Chemotherapy and just got weaker and weaker. She has to use a wheelchair now. We discharged her from Occupational and Physical therapy 3/27/24. She continues to be one assist with transfers and uses a wheelchair for mobility. On 4/19/24 at 11:30 am V26, Physical Therapy Assistant stated, (V26) provided (R29's) therapy. At first, she had some hallucinations. Within the first couple sessions, she had clear cognition. As therapy continued, she was weaker and weaker due to Chemotherapy. She had reached her maximum potential. She always needed physical staff assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/19/24 at 12:35 pm V7, Physician acknowledged R29 has had five falls. V7, Physician stated, Residents as (R29) at high risk for falls should be supervised more closely, to prevent further falls and more serious injury. On 4/18/24 at 11:00 am R29 was lying in bed. R29 had purple and green bruising around R29's eyes, and on R29's forehead and the bridge of R29's nose. R29's feet were outside the blanket and R29 had on regular socks. Both room call lights were on the floor, three feet away from R29 and the bed alarm was not attached to resident bed pad. The bed alarm box was on the floor under R29's bed. R29's wheelchair was four feet away from her bed and unlocked. R29 stated she has had several falls including one at home before she admitted to the facility 2/29/24. R29 stated, The call light isn't usually within my reach. It wouldn't matter anyway. When I put my call light on, I wait forever. The last fall I had, a girl (unidentified) took me in the bathroom and put me on the stool. She told me to put my call light on when I finished. I turned my bathroom call light on and waited thirty minutes. No one came back. I waited and waited till my butt was sore. I went to get up, the wheelchair was not locked. As it (wheelchair) slid, I got dizzy and fell . The staff were in the hall picking up meal trays. I could hear them. I know that is a busy time. I can't remember which meal it was. I don't remember much after the fall. ER (Hospital emergency room) did a scan of my head. I had a goose egg in the middle of my forehead. It was almost as big as my fist and still has not gone away completely. It took three days for me to think straight after that fall. R29 stated, The fall before that, I had just gone into the bathroom by myself, because I had the bedroom call light on for a very long time and no one came. I put my bathroom call light on when I was finished. No one came. I know they are busy, but I don't want to set on the stool all night. No one came. I fell at the bathroom door, doing the best I could at the time. That fall I ended up on my bottom. The third fall I was going to get undressed and ready for bed. I fell in the middle of my room and landed on my hand. My wrist was hurt and so was my thumb. I get therapy for (because of) that fall. R29 stated she does not have non-slip socks, but someone mentioned getting some for her to wear at night when she isn't wearing shoes. On 4/18/24 at 11:20 am V6 Registered Nurse (RN) assessed R29's room. V6 RN confirmed R29's bed alarm is under her bed unplugged, R29 does not have any non-skid socks on, or in her room, and both call lights are too far for R29 to reach. V6, RN stated, As far as her (R29's) wheelchair, it is not locked, and positioned away from her bed because she is a high fall risk. Some residents are fall risk, we don't put their wheelchairs by their bed, because we want them to use the call light and wait for help. It is personalized for each resident. (R29) is a high fall risk. On 4/19/24 at 9:50 am V2, DON stated she was not aware R29's bed alarm was under her bed and not plugged in. V2 stated she will talk to nursing staff to ensure they are checking R29's alarm is functioning when R29 is in bed. V2 stated her expectation is that all R29 interventions, are implemented according to her care plan. The facility Call Light Answering (No Pager) policy, dated as revised 7/2023, documents the following: PURPOSE: To respond to the resident's request and needs. POLICY: All residents will have a staff member that is able to answer/and or see to the resident request and/or needs. RESPONSIBILITY: 1. It is the responsibility of the CNA, and or Nurses to answer the call lights/pagers to see what requests or needs the resident may have. 2. It is the responsibility of the Charge Nurse to ensure that the CNA answer the call lights/pager so that the needs and request of the resident have been met. 3. It is the responsibility of the Director of Nurses or Designee to ensure that the call lights/pages are answered in a reasonable time frame.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380 Based on interview and record review, the facility failed to administer two physician ordered intravenous antibiotic medications on two consecutive days resulting in a delay in treatment for one resident (R7) of one resident reviewed for significant medication errors in the sample list of 24. Findings include: R7's undated Medical Diagnoses Page documents R7's diagnoses as: Pyogenic Arthritis, unspecified, aftercare, following Joint Replacement surgery, Type 2 Diabetes Mellitus without complications, Morbid (severe) Obesity due to excess calories, Methicillin susceptible (resistant) Staphylococcus Aureus infection, Unspecified site, presence of left artificial knee joint. R7's Minimum Data Set (MDS) dated [DATE], documents R7 is cognitively intact. R7's Physicians Order Sheet (POS) dated April 1, 2024 through April 30, 2024, documents R7's orders as: Vancomycin Hydrochloride (HCl) Intravenous (IV) Solution, use 1000 milligrams (mg) intravenously one time a day related to Pyogenic Arthritis, unspecified aftercare following joint replacement surgery until 05/08/2024, administer via peripherally inserted central catheter (PICC) at 100 milligrams (mg)/200 milliliter (ml) at 200/hour and Ertapenem Sodium Injection Solution Reconstituted 1 gram (GM) Ertapenem Sodium use 1 gram intravenously one time a day related to Unilateral Primary Osteoarthritis, Left Knee, Pyogenic Arthritis, unspecified until 05/06/2024. R7's Medication Administration Record (MAR) dated April 1, 2024 through April 30, 2024, documents Ertapenem Sodium Injection Solution Reconstituted 1 GM (Ertapenem Sodium) Use 1 gram intravenously, one time a day as see nursing notes which documents on 4/9/24 at 7:04 PM, PICC line infiltrated. IV not given. R7's Medication Administration Record (MAR) dated April 1, 2024 through April 30, 2024, documents Vancomycin HCl IV solution on 4/10/24 at 8:00 AM as see progress notes which documents at 1:13 PM, awaiting PICC replacement. This same MAR for Vancomycin IV has no documentation at all for the 8:00 AM dose showing if it was given or not and/or why it was not given. R7's Aerobic Culture (gram stain reflex) dated 3/13/24, documents culture site from left knee synovial tissues, positive for Staphylococcus Aureus-Methicillin-Resistant Staphylococcus Aureus (MRSA). R7's Nursing Notes dated 4/10/24 at 1:13 PM, documents use 1000 mg intravenously one time a day related to Pyogenic Arthritis, unspecified aftercare following joint replacement surgery until 05/06/2024, administer via PICC, 1000mg/250ML at 250ML/hour, awaiting PICC replacement. R7's nursing notes dated 4/10/2024 at 2:37 PM, documents isolation precautions continue for MRSA, treatment continue to left knee as ordered, awaiting PICC replacement. R7's Administration Note 4/10/2024 at 4:14 PM, documents Ertapenem Sodium Injection Solution Reconstituted 1 GM, use 1 gram intravenously one time a day related to Unilateral Primary Osteoarthritis, left knee for Pyogenic Arthritis unspecified until 05/06/2024, awaiting new PICC line. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Nursing Note dated 4/11/2024 10:23 AM, documents writer contacted V28 orthopedic medical doctor regarding resident missing prior doses of antibiotic and unknown time entity to place PICC line, awaiting call back from nurse. R7's Nursing Note dated 4/11/2024 1:25 PM, documents writer contacted entity regarding PICC line placement, entity states that they have no order. Order, face sheet, and consent form faxed. On 4/17/24 at 10:33 AM, V12 Registered Nurse (RN) stated R7 missed a few IV antibiotic doses. On 4/18/24 at 8:56 AM, R7 stated the facility had missed some doses of R7's IV antibiotic medication but doesn't know the exact dates. On 4/18/24 at 1:32 PM, V2 Director of Nursing stated R7's peripherally inserted central catheter (PICC) line was removed on 4/9/24 due to the PICC line being infiltrated and R7's arm being swollen. V2 stated forms were faxed to entity that comes to do PICC line placement and on 4/10/24 this entity still had not received the request. V2 stated the entity stated they did not have anyone to come out to place the PICC line at this time. V2 stated V6 Registered Nurse (RN) contacted the entity and that they would be out on 4/11/24 which they did at 3:00 PM. V2 stated the PICC line is for two antibiotics for a wound infection. V2 confirmed R7 did not receive the IV antibiotic Ertapenem on 4/9/24 or 4/10/24 and R7 did not receive IV Vancomycin on 4/10/24 or 4/11/24. V2 stated R7 should have been sent to the hospital for a new PICC line so R7 could continue to receive the ordered IV antibiotics. Best practice written by a Doctor of Pharmacy (V29) dated 10/24/23, documents the effectiveness of antibiotic treatment depends on a person taking it correctly and missing several doses of an antibiotic can result in ineffective treatment and potentially contribute to antimicrobial resistance. This best practice also states antibiotics are essential medications that doctors prescribe to help prevent and treat bacterial infections and missing several doses of antibiotics may negatively affect the effectiveness of the treatment.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 31642 Based on observation, record review and interview, the facility failed to employ a clinically, qualified Director of Food and Nutrition Services. This failure has the potential to affect all 96 residents residing in the facility. Findings include: On 4/16/24 at 10:10 am V8, Dietary Manager (DM) was actively supervising dietary operations in the facility kitchen. V8 stated the facility has had a lot of staff turnover in the kitchen and V8 has not had time to even compete the first module of the required DM education. On 4/16/24 at 10:15 am V8 assessed the commercial table top mixer and confirmed there is a buildup of rust, grease, and food debris on the under-plate directly over the multi-gallon commercial bowl. V8 stated, This will be addressed. It definitely needs attention. V8 confirmed the commercial can opener has a build-up on grease, metal fragments and rust in the gears, silver laminate coating peeling off the can opener blade and upper shaft of the can opener. The sleeve, that hold the table top commercial can opener shaft, has a build-up of brown and black grease-like substance. On 4/16/24 at 10:30 am V1, Administrator stated is aware V8, DM does not have her Dietary Manager course, does not have a bachelor's degree or the experience to qualify as the dietary manager. V1 stated V8, DM has been enrolled since last year, in an on line Dietary Manager classes. The facility Long-Term Care Facility Application for Medicare and Medicaid date 4/16/24 documents 96 residents reside in the facility.

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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. 31642 Based on observation, record review and interview, the facility failed to maintain facility kitchen equipment in a clean, sanitary condition, to prevent potential cross-contamination and food-borne illness. This failure has the potential to affect all 96 residents residing in the facility. Findings include: On initial tour of the facility kitchen at 9:30 am. V9, Cook stated both the facility commercial sized, table top mixer and commercial table-top can opener were considered clean. 1. On 4/16/24 at 10:15 am V8, Dietary Manager joined the initial tour of the kitchen and assessed the commercial table top mixer. V8 confirmed there is a buildup of rust, grease, and food debris on the underplate directly over the multi-gallon commercial mixing bowl. V8 stated, This will be addressed. It definitely needs attention. 2. On 4/16/24 at 10:25 am V8, DM confirmed the commercial can opener has a build-up on grease, metal fragments and rust in the gears, silver laminate coating peeling off the can opener blade and upper shaft of the can opener. Rust was also present on both the can opener blade and upper shaft. The can opener shaft holder sleeve had a build-up of a brown and black grease- like sticky substance, throughout the walls of the can opener sleeve. V8 stated, This needs cleaned up too. The facility Long-Term Care Facility Application for Medicare and Medicaid (4/16/2024) documents 96 residents reside in the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, record review and interview the facility failed to maintain complete and accurate medical records for one of two residents (R92) reviewed for dialysis/medical records on the sample list of 24. Findings include: R92's Minimum Data Set (MDS) dated [DATE] documents R92's Brief Interview of Mental Status score as 14, out of a possible 15, which indicates R92 has no cognitive impairment. On 04/16/24 at 12:48 pm, R92 had an undated gauze wound dressing on R92's left upper arm. R92 stated the dressing is covering his dialysis fistula port. R92 stated R92 goes to an outside facility for dialysis treatments, three times per week. R92 also stated the facility nurses do not assess R92's dialysis port fistula patency by thrill (feel for a vibration) and bruit (listen with a stethoscope). R92's Physician Order Sheet (POS) dated 4/19/24 documents: Dialysis: Monday -Wednesday -Friday at (a local) Dialysis Center R92's POS documents: Dialysis: Check Dialysis Site Q (every) Shift for s/s of infection, every shift. R92's same POS documents: Dialysis: Palpate AV (Artery/Vein connection) Shunt - Check for Bruit & Thrill, Order Date- 03/25/2024 at 4:39 pm. (incomplete physician order for how often R92's thrill and bruit checks are to be completed.) R92's Treatment Administration Record (TAR) dated 4/1/24- 4/30/24 documents: April 1 -16, 2024 there are no nurse initials to indicate R92's Bruit and Thrill assessments for patency were completed. An X symbol populates the entire TAR 4/1/24 through 4/30/24). On 4/17/24 at 11:05 am V2, Director of Nursing (DON) stated the nurses are supposed to sign off the TAR. This has not been signed off when they checked R92's dialysis port for thrill and bruit. V2 said the physician put the order in to the electronic medical record wrong, leaving nowhere for the nurses to initial the assessments. The facility policy DIALYSIS PROTOCOL revised August 2022 documents the following: PURPOSE: To provide guidance to the facility on how to care for the dialysis resident within the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	POLICY: All residents who need dialysis will be properly cared for within the facility. RESPONSIBILITY: It is the responsibility of nursing to provide care for the dialysis resident.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 35380 Based on interview and record review the facility failed to have required members attend Quarterly Quality Assurance (QAA) meetings. This failure has the potential to affect all 96 residents residing in the facility. Findings include: The Long-Term Care Facility Application for Medicare and Medicaid dated 4/16/24, documents 96 residents reside in the facility. The facility provided quarterly QAA meeting attendance forms dated 6/6/23 through 4/20/24, documents no Infection Preventionist present on 6/26/23, and verbal review only by the Medical Director on 11/21/23 and 4/20/24. On 4/17/24 at 11:47 AM, V1 Administrator stated V1 she did not know the Medical Director. The MD couldn't do a verbal review and did not know the MD had to be present in person or video. V1 confirmed the April QAA done 4/20/23, only had a verbal review from the medical director and the June 6/26/23 QAA did not have the Infection Preventionist present 11/21/23 and only had the MD's verbal review. On 4/19/24 at 1:00 PM, V1 Administrator stated the facility's QAA Committee list documents the following members need to be present for the QAA meetings: Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Medical Director, Consultant Pharmacist, Minimum Date Set (MDS)/Care Plan Coordinator, Human Resource Director, Business Office Manager, Community Liaison, Social Service Director, Activity Director, Social Service and Activity Consultant, Maintenance Director, Dietary Supervisor, Registered Dietician, Director of Rehabilitation, and Medical Records Designee.

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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. 31642 Based on observation, interview and record review the facility failed to wear a gown during high-contact resident wound care activities in accordance with the physician order, and the infection control enhanced barrier precaution policy. This failure affected one of three residents (R9) reviewed for pressure ulcers/wounds on the sample list of 24. Findings include: R9's Diagnosis Sheet dated 4/18/24 documents the following diagnoses: Type II Diabetes Mellitus with Diabetic Neuropathy, Type II Diabetes Mellitus with Diabetic with Polyneuropathy, Atherosclerosis of Native Artery with Intermittent Claudication, Bilateral Legs, Gangrene Not elsewhere Classified, Acquired Absence of Unspecified Finger(s), Acquired Absence of Unspecified Left Leg Below Knee, Acquired Absence of Right Leg Below Knee, and Phantom Limb Syndrome with Pain. R9's Physician Order Sheet (POS) dated 4/17/24 documents the following: Enhanced Barrier Precautions (EBP) in place during high-contact care activities that provides opportunities for transfer of MDROs (Multi-Resistant organisms that are resistant to multiple antibiotics and antifungal) from/to high risk residents with wounds and/or indwelling medical device that are at especially high risk for both acquisition of and colonization of MDROs, every shift for wound. The same POS documents: Coccyx (Stage II Pressure Ulcer): Cleanse with wound cleanser, apply Medihoney and calcium alginate, cover with DCD (dry contact dressing), Daily and PRN (as needed) if soiled or dislodged, one time a day for wound and every 24 hours as needed. The same POS documents: Left AKA (further amputation, Left Above Knee amputation of the previous Left Below Knee Amputation): Cleanse with wound cleanser pat dry, apply non adherent gauze, wrap with kerlix and secure with (name brand elastic) wrap. Daily and PRN if soiled or dislodged, one time a day for surgical wound. LAKA: Monitor dressing. Ensure that dressing is clean, dry, and intact, every shift for wound management until 04/18/2024 11:59 pm. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 1:04 pm R9 had an infection control enhance barrier precautions sign on R9's bedroom door. R9 had a small dresser outside his room that contained personal protection equipment. The personal protective equipment included paper gowns. V12, Registered Nurse/Wound Nurse (RN) and V13, Certified Nursing Assistant Coordinator entered R9's room after using hand sanitizer and donning gloves. V12 and V13 did not don the gowns. R9 laid in a back lying position. R9 had a healed, right below knee amputation. R9 had a fresh, new, left above knee amputations that was wrapped in an elastic bandage. V12, RN removed R9's visibly soiled, bloody elastic bandage and the underlying saturated gauze dressing. R9 had approximately 15 metal staples present that closed R9's surgical wound. R9 had two blisters superior to the staples. V12, RN stated the blisters are new. V12 completed R9's Left AKA with surgical dressing without cross contamination. V12, RN used hand sanitizer and donned new gloves. V12 did not put on a gown. R9 used the bed rail and was assisted by V13 and V12 to a left side lying position. V13 held R9's side lying position, placing her hands on R9's hip and back. V12 removed R9's coccyx pressure ulcer dressing. R9 had a moist red coccyx stage pressure ulcer approximately quarter in size. V12 completed R9's coccyx treatment as the physician orders stated, without cross contamination. V12 completed hand hygiene and stepped out of R9's room. V12 stated, I always wear a gown when I do my wound treatments. We (V12 and V13) should have during (R9's) treatment. I realized a little too late that I forgot to put one (gown) on when I did (R9's) treatment. I have never been watched by a surveyor before. I was a little nervous. That is all I can say. That still doesn't make it ok. I know it (wearing a gown) is a big infection control issue. All residents with wounds are on enhanced barrier precautions. I am aware, I should have had a gown on. The facility policy IC (Infection Control) - Enhanced Barrier Precautions (EBP) dated as revised 10-21-2022, documents the following: GENERAL: EBP expand the use of PPE (Personal Protective Equipment) and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices, regardless of MDRO colonization, as well as, for residents with MDRO infection or colonization. RESPONSIBLE PARTY: Infection Preventionist, DON, Nursing. POLICY: EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Use of eye protection may be necessary when splash or spray may occur but is not necessary in other situations. High-contact resident care activities requiring gown and glove use among residents that trigger EBP use include: * Dressing. * Bathing/showering. * Transferring. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Providing hygiene. * Changing linens. * Changing briefs or assisting with toileting. * Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. * Wound care: any skin opening requiring a dressing. Gown and gloves are not required for resident care activities other than those listed above, unless otherwise necessary for adherence to standard precautions. Residents on EBP are not restricted to their rooms or limited from participation in group activities.