STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145266	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fondulac Rehabilitation & Hcc	901 Illini Drive East Peoria, IL 61611

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38396 Based on interview and record review, the facility failed to report an allegation of staff to resident mental abuse to the state agency for one of three residents (R23) reviewed for abuse in the sample of 47. Findings include: The facility's Abuse Prevention Program policy, dated 11/28/16, documents The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This policy also documents Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, misappropriation or resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency or jurisdiction and (the state agency) immediately after forming the suspicion (but no later than two hours after forming the suspicion), otherwise the report must be made not later than 24 hours after forming the suspicion. R23's Cognitive assessment dated [DATE] documents R23 is cognitively intact. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/24 at 11:37 AM, R23 stated I was a resident at the facility until last Friday when I moved to my own apartment. The nurse (V8, Licensed Practical Nurse) works day shift is not liked by several residents. (V8) would always hold my medications and then laugh about it. (V8) would give me a hard time, mostly with medications and then laugh when I would get upset. She would laugh about how long it would take her and I take a lot of medications. She would make me the last person but for sure if I came up and asked for my medications then she would make me wait even longer on purpose and give me mine last. I spoke to the administrator (V1, Administrator in Training) about this, and I talked mostly to the Director of Nursing (V2) and Assistant Director of Nursing. I saw them go and talk to (V8) and then they both acted funny towards me afterwards. I don't know what she told them, but they believed her over me. This happened on 8/6/24 that I told (V3) all of this. On 8/19/24 at 11:00 AM, V1 (Administrator in Training) stated I do not have any abuse allegations or investigations since I have been here. I don't see where the prior there was any for the last year. But I have been here since June, and I don't have anything for Abuse. 08/19/24 1:53 PM, V10 (Certified Nursing Assistant, CNA) stated she was working on the day (R23) was very upset about (V8) being his nurse. V10 stated (R23) is normally a cool and calm resident with little complaint. That day however, he was very upset, angry and emotional. He said she (V8) is evil and had been verbally abusive. The ADON (V3) was aware. She was the one who gave him his medications that day and she was down there talking to him about the situation. On 8/19/24 at 2:02 PM, V3 (Assistant Director of Nursing) confirmed she talked to R23 at some point over the last three weeks about V8. V3 stated (R23) told me (V8) would not do his insulin and blood glucose checks the way he felt they should be done. There was a personality conflict there. He would call me on the facility phone and ask me to give his medications. (R23) refused to take them from (V8) because he said he didn't trust her. When he brought this to our attention, we talked with him and with (V8) and I stopped putting her on that hall until (R23) was out of the building. (R23) would tell me I am not going to take my medications from (V8), I don't trust her. (V1, Administrator in Training) is the Abuse coordinator. He did the investigation with us (V2 Director of Nursing and V3), and we determined that we would avoid conflict and keep her off of (R23's) hall until he discharged . On 8/19/24 at 2:11 PM, V1 confirmed he did not submit an Abuse report to the state agency when he was informed that R23 had conflicts with V8. V1 stated (R23) stated he didn't like (V8). He said when she works his hall, he didn't like her and (R23) didn't want (V8) to give him his medications. He did not like her personality. I didn't see that as abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38396 Based on interview and record the facility failed to immediately remove an employee accused of mental abuse from resident care and complete an abuse investigation for alleged staff to resident abuse for one of three residents (R23) reviewed for Abuse in the sample of 47. Findings include: The facility's Abuse Prevention Program policy, dated 11/28/16, documents The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This policy also documents Employees of this facility who have been accused of mistreatment, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents. Once the administrator or designee receives an allegation of mistreatment, neglect or abuse, including injuries of unknown or source and misappropriation of resident property; the administrator will appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident and follow the resident protection investigation procedures. R23's Cognitive assessment dated [DATE] documents R23 is cognitively intact. R23's Care Plan, dated 6/4/24, documents R23 was admitted on [DATE] and has a care plan of (R23) may display pattern of voicing allegations of mistreatment by caregivers. Intervention: Investigate statements/allegation per facility protocol. Check resident for any physical marks, injury, interview persons assigned to provide care. On 8/18/24 at 11:37 AM, R23 stated I was a resident at the facility until last Friday when I moved to my own apartment. The nurse (V8, Licensed Practical Nurse) works day shift is not liked by several residents. (V8) would always hold my medications and then laugh about it. (V8) would give me a hard time, mostly with medications and then laugh when I would get upset. She would laugh about how long it would take her and I take a lot of medications. She would make me the last person but for sure if I came up and asked for my medications then she would make me wait even longer on purpose and give me mine last. I spoke to the administrator (V1, Administrator in Training) about this, and I talked mostly to the Director of Nursing (V2) and Assistant Director of Nursing. I saw them go and talk to (V8) and then they both acted funny towards me afterwards. I don't know what she told them, but they believed her over me. This happened on 8/6/24 that I told (V3) all of this. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 11:00 AM, V1 (Administrator in Training) stated I do not have any abuse allegations or investigations since I have been here. I have been here since June, and I don't have anything for Abuse. 08/19/24 1:53 PM, V10 (Certified Nursing Assistant, CNA) stated she was working on the day (R23) was very upset about (V8) being his nurse. V10 stated He would complain about (V8) all the time. The day that he was most upset was when he was in the dining room. (R23) was yelling and complained of (V8) not giving him his medication and always chooses to give them to him last. He didn't want (V8) to be his nurse. It was either the fifth or the sixth of August that this incident with (R23) happened. The ADON (V3, Assistant Director of Nursing) gave him his medication that day because he refused to have (V8) as his nurse any longer. (R23) is normally a cool and calm resident with little complaint. That day however, he was very upset, angry and emotional. He said she (V8) is evil and had been verbally abusive. The ADON (V3) was aware. She was the one who gave him his medications that day and she was down there talking to him about the situation. On 8/19/24 at 2:02 PM, V3 (Assistant Director of Nursing) confirmed she talked to R23 at some point over the last three weeks about V8. V3 stated (R23) told me (V8) would not do his insulin and blood glucose checks the way he felt they should be done. There was a personality conflict there. He would call me on the facility phone and ask me to give his medications. (R23) refused to take them from (V8) because he said he didn't trust her. When he brought this to our attention, we talked with him and with (V8) and I stopped putting her on that hall until (R23) was out of the building. (R23) would tell me I am not going to take my medications from (V8), I don't trust her. (V1, Administrator in Training) is the Abuse coordinator. He did the investigation with us (V2 Director of Nursing and V3), and we determined that we would avoid conflict and keep her off of (R23's) hall until he discharged . On 8/19/24 at 2:11 PM, V1 confirmed he did not remove the employee (V8) from resident contact, interview other residents, or complete an abuse investigation when he was informed that R23 had conflicts with V8. V1 stated (R23) stated he didn't like (V8). He said when she works his hall, he didn't like her and (R23) didn't want (V8) to give him his medications. He did not like her personality. I didn't see that as abuse.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on interview and record review the facility failed to notify the facility Ombudsman monthly of a resident transfer to the hospital and failed to provide the resident and resident representative with a written notice of transfer. This failure has the potential to affect all 47 facility residents. Findings Include: 1. R25's facility Census List, provided by V9/Business Office Manager on 8/19/24 documents that R25 was transferred to a local hospital on 2/9/24 and on 6/8/24. No evidence of a facility notification to R26 of a transfer/discharge was present on R25's chart. 2. R35's facility Census List, provided by V9/Business Office Manager on 8/19/24 documents that R35 was transferred to a local hospital on 4/24/24, 7/6/24 and 8/6/24. No evidence of a facility notification to R26 of a transfer/discharge was present on R35's chart. On 8/20/24 at 11:09 A.M., V7/Social Services Director verified that the facility did not provide R25, R35 or their representatives with a written notice of transfer. At that time, V7/Social Services Director also confirmed that she had not sent notification to the local Ombudsman of monthly facility transfers/discharges. 38396 3. R45's electronic Census List documents R45 was sent from the facility to the hospital on 5/24/24, 6/17/24, 7/20/24 and 8/5/24. R45's current medical record does not document that a written notice of transfer was provided to R45 at the time of transfer on 5/24, 6/17, 7/20 or 8/5/24. 31283 4. R70's Progress Note dated 06/08/24 and timed 02:00 PM documents the following: [AGE] year-old male arrived per (local facility) transport. On 2 Liters of Oxygen via nasal cannula. Is No Known Allergies and on cardiac diet. Is a full code and per hospital weight of 104 pounds. Hospital Admitting Diagnosis: Cardiac Arrest possible due to cocaine abuse with acute respiratory failure post arrest, as well as hypertension episode. Arrived per wheelchair and was admitted to (facility room). On cardiac diet at this time. R70's Progress Note dated 06/08/24 and timed 06:30 PM documents, Resident complained of Shortness of Breath, Oxygen Saturation 79%. This nurse called 911 and resident was transported out. Resident took his belongings per him will not return. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R70's medical record did not contain documentation that a written notice of transfer was provided upon R70's transfer to the local hospital on 06/08/24, or documentation that the Ombudsman was notified of R70's transfer. On 08/20/24 at 04:30 PM, V1 (Administrator) stated a written notice of transfer was not provided to R70 upon his transfer to the local hospital on 06/08/24. V1 also confirmed that the Ombudsman was not made aware of R70's transfer.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on interview and record review the facility failed to provide a copy of the bed hold policy for residents discharging to the hospital, for four of four residents (R25, R35, R45 and R70), reviewed for bed holds, in the sample of 47. Findings Include: The facility Bed Hold Guarantee Policy, dated (revised) 8/1/17 directs staff, The resident, resident family or legal representative will be given the appropriate 'Notice of Bed Hold Policy" at the time of discharge or therapeutic leave, if possible, but notice will be given no longer than 24 hours after discharge or initiation of leave. 1. R25's medical record documents that R25 was hospitalized on [DATE] and 6/8/24. R25's medical record does not contain documentation of written notice to R25 or R25's resident representative, of the facility bed hold policy. 2. R35's medical record documents that R35 was hospitalized on [DATE], 7/6/24 and 8/6/24. R35's medical record does not contain documentation of written notice to R35 or R35's resident representative, of the facility bed hold policy. On 8/20/24 at 11:09 A.M., V7/Social Services Director verified that the facility did not provide R25 or R35 or his representative with a a Bed Hold Policy or a written Notice of Transfer. 38396 3. R45's electronic Census List documents R45 was sent from the facility to the hospital on 5/24/24, 6/17/24, 7/20/24 and 8/5/24. R45's current medical record does not document that a bed hold was provided to R45 at the time of transfer on 5/24, 6/17, 7/20 or 8/5/24. 31283 4. R70's Progress Note dated 06/08/24 and timed 02:00 PM documents the following: [AGE] year-old male arrived per (local facility) transport. On 2 Liters of Oxygen via nasal cannula. Is No Known Allergies and on cardiac diet. Is a full code and per hospital weight of 104 pounds. Hospital Admitting Diagnosis: Cardiac Arrest possible due to cocaine abuse with acute respiratory failure post arrest, as well as hypertension episode. Arrived per wheelchair and was admitted to (facility room). On cardiac diet at this time. R70's Progress Note dated 06/08/24 and timed 06:30 PM documents, Resident complained of Shortness of Breath, Oxygen Saturation 79%. This nurse called 911 and resident was transported out. Resident took his belongings per him will not return. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R70's medical record did not contain documentation that R70 was provided notice of the facility's bed hold policy prior to his transfer to the local hospital on 06/08/24. On 08/20/24 at 04:30 PM, V1 (Administrator) stated the facility's bed hold policy was not provided to R70 upon his transfer to the local hospital on 06/08/24.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31283 Based on interview and record review, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed for three of four residents (R1, R44 and R58) reviewed for PASARR screenings in the sample of 47. Findings include: 1. R1's current Physician's Orders document R1's current diagnoses to include: Schizophrenia and Psychosis. R1's current medical record has no documentation of a PASARR Level I completed. On 08/20/24 at 10:05 AM, V3 (Assistant Director of Nursing/ADON) stated the facility has no record of R1 ever receiving a PASARR Level I. 2. R58's current Physician's Orders document R58 was admitted to the facility on [DATE] with a diagnoses of Schizophrenia. R58's Notice of PASARR Level I Screen Outcome (dated 01/23/24) documents the following: Your PASARR Level I screening is complete. Your Level I screen shows you may have a serious mental illness or intellectual/developmental disability. You meet the criteria for Convalescent Care, and you may stay for up to 60 calendar days in nursing facility without further PASARR Assessment as long as you also require the level of services provided by a nursing facility. R58's medical record has no further documentation of any additional PASARR Level I screening completed once R58's stay at the facility exceeded 60 calendar days. On 08/20/24 at 10:30 AM, V3 (ADON) stated the facility has not reached out for an additional PASARR screening to be completed on R58, as previously indicated in R58's 01/23/24 PASARR Level I Screen Outcome. 38396 3. R44's current Care Plan, dated 8/8/24, documents R44 has a diagnosis of Bipolar Disorder and has a most recent admitted [DATE]. R44's Minimum Data Set assessment, dated 8/8/24, documents R44 has Delusions and Psychiatric/Mood Disorders of Anxiety, Depression and Bipolar Disorder. R44's medical record does not document a PASARR screen has ever been completed for R44. On 8/20/24 at 12:08 PM, V3 (ADON) stated I do not have a PASARR on (R44). I can't find it in any of our records. She has been here a while so we have a request out now to have a screen done for her.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31283 Based on interview and record review, the facility failed to develop a care plan addressing target behaviors exhibited, anticoagulant use, and psychotropic medication use for four of 19 residents (R4, R7, R12, and R49) reviewed for care plan accuracy in the sample of 47. Findings include: The facility's Comprehensive Care Planning, dated 11/1/17, documents, It is the policy of the facility to comprehensively assess and periodically reassess each resident admitted to this facility. The results of this resident assessment shall serve as the basis for determining each resident's strengths, needs, goals, life history and preferences to develop a person-centered comprehensive plan of care for each resident that will describe the services that are to be furnished to attain or maintaining the resident's highest practicable physical, mental, and psychosocial well-being. 1. R49's current Physician's Orders document the following medication order: Eliquis (anticoagulant) 5 milligrams (mg) take one tablet by mouth twice daily. R49's current care plan does not address the use of R49's Eliquis. On 08/20/24 at 11:19 AM, V5 (Licensed Practical Nurse/Minimum Data Assessment Coordinator/Care Plan Coordinator) verified that R49 has no care plan in place. V5 then stated she is currently not developing care plans for any resident at the facility who take the anticoagulant, Eliquis. R49's current Diagnosis Report documents R49's diagnoses to include: Schizophrenia; Schizoaffective Disorder; Mood Disturbance and Anxiety; and Depression. R49's current care plan has no mention of any target behaviors displayed by R49, and has no documentation of any behavioral interventions in place. On 08/21/24 at 08:40 AM, V3 (Assistant Director of Nursing) stated that R49 occasionally displays the following behaviors: hoarding, agitation when someone interferes with his hoarded items, and withdrawn/self isolates. V3 stated that none of R49's target behaviors are noted on his current care plan and should be. 50962 2. R4's Physician orders, dated 8/2024, document R4 has an order to receive Eliquis (anticoagulant) 5mg by mouth twice a day. R4's Current Care Plan, as of 8/20/24, has no comprehensive care plan for the use of an anticoagulant. On 08/21/24 at 08:46 AM, V5 (Care Plan Coordinator) stated that there is no care plan for the use of R4's anticoagulants. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R7's Physician orders, dated 8/2024, documents R7 has orders to receive Aripiprazole (antipsychotic) 15mg by mouth at bedtime, Buspar (antianxiety) 10mg two tablets by mouth three times a day, Klonopin (antianxiety) 0.5mg by mouth in the evening, Luvox (antidepressant)100mg by mouth twice a day, Luvox 50mg by mouth at noon, and Remeron (antidepressant) 7.5mg by mouth six times a week omitting Wednesdays. R7's current care plan, as of 8/21/24, has no comprehensive care plan for the use of antipsychotic, antidepressant, and antianxiety medications. On 8/21/24 at 10:30 AM, V5 (Care Plan Coordinator) confirmed that R7's care plan had no documentation of a comprehensive care plan addressing R7's use of antidepressant, antianxiety, and antipsychotic medications. 4. R12's Physician orders, dated 8/2024, documents R12 has orders to receive Sertraline (antidepressant) 100mg by mouth in the morning with Sertraline 50mg for total dose equaling 150mg. R12's current care plan, as of 8/21/24, has no documentation of comprehensive care plan addressing R12's use of an antidepressant. On 08/20/24 at 1:00 PM, V5 (Care Plan Coordinator) confirmed that R12's care plan had no documentation of a comprehensive care plan addressing R12's use of antidepressant.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32061 Based on observation, interview and record review, the facility failed to ensure physician ordered daily skin checks and scheduled pressure ulcer treatments were completed and a pressure ulcer care plan was developed for three of three residents (R34, R35, R44) reviewed for pressure ulcers in the sample of 47. Findings include: The facility's Decubitus Care/ Pressure Areas policy, dated 1/2018, documents It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote healing of any pressure ulcer. This policy also documents The pressure area will be assessed and documented on the Treatment Administration Record (TAR) or the Wound Documentation Record. Initiate physician order on treatment sheet. When a pressure ulcer is identified additional interventions must be established and noted on the care plan in an effort to prevent worsening or re-occurring pressure ulcers. The facility's Comprehensive Care Plan Planning policy, dated 11/1/17, documents It is the policy of (the facility) to comprehensively assess and periodically reassess each resident admitted to this facility. The results of this resident assessment shall serve as the basis for determining for determining each Resident's strengths, needs, goals, life history and preferences to develop a person-centered comprehensive plan of care for each resident that will describe the services that are to be furnished to attain or maintaining the resident's highest practicable physical, mental, and psychosocial well-being. The facility policy, Pressure Sore Prevention Guidelines, dated (revised) 01/18 documents, It is the facility policy to provide adequate interventions for the prevention of pressure ulcers for residents who are identified as High or Moderate risk for skin breakdown as determined by the Braden Scale. The nurse will complete a skin assessment on all residents upon admission, then weekly for four weeks. After the weekly skin assessments are completed they must be done with an Annual, Quarterly and Significant Change Assessment. The following guidelines will be implemented for any resident assessed as a Moderate or High skin risk: Daily skin checks. Any resident scoring a High or Moderate risk for skin breakdown will have scheduled skin checks on the Treatment Record. Skin checks will be completed and documented by the nurse. 1. R34's current Physician Order Sheet, dated August 2024 includes the following diagnoses: Spastic Cerebral Palsy, Malnutrition, Epilepsy and Scoliosis. This same form also includes the following physician orders: Skin check once daily. R34's most current Braden Scale for Predicting Pressure Ulcer Risk form, dated 6/11/24 documents, TOTAL SCORE= 13 (16 and less is High Risk). R34's Treatment Administration Record dated 8/1/24- 8/17/24 documents 10 of 17 physician ordered daily skin checks as not being performed by facility staff. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 10:15 A.M., V2/Director of Nurses (DON) verified the missing documentation indicating staff failed to perform the required daily skin checks. 2. R35's current Physician Order Sheet, dated August 2024 includes the following diagnoses: History of Bilateral Knee Amputation, Chronic Kidney Disease, Type 1 Diabetes Mellitus, Chronic Diastolic Heart Failure and Depression with Anxiety. This same form also includes the following physician orders: Skin check once daily. R35's most current Braden Scale for Predicting Pressure Ulcer Risk form, dated 7/16/24 documents, TOTAL SCORE= 17 (17-20 is Moderate Risk). R35's Treatment Administration Record dated 8/11/24- 8/17/24 documents 3 of 7 physician ordered daily checks as not being performed by facility staff. On 8/20/24 at 10:15 A.M., V2 (DON) verified the missing documentation indicating staff failed to perform the required daily skin checks. 38396 3. On 8/18/24 at 11:05 AM, R44 was sitting in her room in a wheelchair. R44 was pleasantly confused with conversation. R44's Wound Assessment Plans, dated 8/12/24, document R44 has an active left foot lateral pressure injury with 100% eschar and an active stage three right hip pressure injury. R44's Treatment Administration Record (TAR), dated 8/2024, documents R44 has an order for Weekly Skin Documentation on back of TAR Wednesday. This administration record documents from 8/1/24-8/19/24, one skin check was completed (two missed scheduled skin checks). This same TAR documents R44 has an order to Right hip cleanse with Normal Saline or wound cleanser, pat dry and apply Calcium Alginate (medicated dressing) and dry dressing three times a week Tuesday, Thursday, Saturday. This administration record documents from 8/6/24-8/19/24, three scheduled hip wound treatments were not administered. This same TAR documents R44 has an order to Left lateral foot cleanse with Normal Saline or wound cleanser, pat dry and apply gauze for padding/dry dressing three times a week, Tuesday, Thursday, Saturday. This administration record documents from 8/1/24-8/19/24, three scheduled foot wound treatments were not administered. R44's current care plan, dated 8/8/24, does not document a care plan for R44's pressure ulcer. R44's significant change Minimum Data Set (MDS) assessment, dated 8/8/24, documents R44 does not have any pressure ulcers. On 8/20/24 at 2:08 PM, V4 (Licensed Practical Nurse) administered dressing changes to R44's left foot and right hip wounds. V4 confirmed the TAR for August 2024 contains several holes in administration documentation. V4 stated I round for wounds weekly and that is all. (R44) has had these pressure ulcers. I am not the one responsible for daily treatments. Whoever is working the floor is responsible for the scheduled treatment administrations. I have seen the holes in charting on the TAR where it looks like several were treatments were missed. They should be charting the treatments on the TAR, otherwise we cannot prove that they are being done. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 9:55 AM, V5 (Minimum Data Set/ Care Plan coordinator) stated I do not have (R44's) pressure ulcer coded on her 8/8/24 MDS or on her care plan and that is something that should be on there. Any staff can add to the care plan and wounds should go right to the care plan when they discover a wound.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50962 Based on observation, interview and record review the facility failed to perform hand hygiene during suprapubic catheter care for one of two residents (R7) reviewed for urinary catheters in a sample of 47. Findings include: The facility's Standard Precautions policy, dated 4/11/22, documents Procedure: 1. Handwashing: wash hands after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed between resident contacts and when otherwise indicated to avoid transfer of microorganism to other residents or environments. It maybe necessary to wash hands between task and procedures on the same resident to prevent cross-contamination of different body sites. 3. Gloves: Wear gloves (clean , nonsterile gloves are adequate) when touching blood, body fluids, secretions, excretions and contaminated items. Put on clean gloves just before touching mucous membranes and nonintact skin. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use , before touching noncontaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. R7's care plan, dated 8/16/24, documents R7 has a suprapubic catheter for the diagnoses of Neurogenic Bladder and Obstructive Uropathy. The care plan also documents a goal for R7 to show no signs and symptoms of urinary infection. On 08/20/24 at 10:15 AM, V4 LPN (Licensed Practical Nurse) removed a gauze dressing saturated with bloody drainage from R7's supra pubic catheter insertion site. Then, V4 removed her gloves, and without performing hand hygiene proceeded to apply a new pair of gloves. V4 continued to perform suprapubic catheter care. V4 removed her gloves, and again without performing hand hygiene proceeded to apply new gloves. Then, V4 applied a new clean gauze dressing to R7's suprapubic catheter insertion site. V4 stated she should have performed hand hygiene between all glove changes and stated that R7 has a history of urinary tract infections. R7's urinalysis, dated 7/19/24, documents abnormal urinalysis with growth of 60-70,000 CFU/ml (Colony-Forming Unit per milliliter) of Providencia Stuartii .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35509 Based on interview and record review, the facility failed to have a Registered Nurse for eight consecutive hours in a 24 hour period on four of 31 days per the Facility's July Nursing Schedule. This has the potential to affect all 63 residents living in the facility. Findings. The Facility Assessment, dated 8/12/24, states, The facility's plan to ensure sufficient staff to meet the needs of the residents at any given time. The Facility's 2024 July Nurses Schedule shows there are no Registered Nurses working on four weekend days: 7/06/24, 7/07/24, 7/20/24, 7/21/24. On 8/21/24 at 12:05 PM, V3, Assistant Director of Nursing, stated, Yes, we did have gaps in the July schedule that we did not have Registered Nurse Coverage. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 8/18/24, signed by V1, Administrator, documents 63 residents currently reside within the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32061 Based on observation, interview and record review, the facility failed to perform the required nurse shift to shift controlled substance reconciliation for 19 of 19 residents, (R2, R3, R8-R10, R13, R17, R19, R22, R25, R34, R37, R43, R44, R47, R50, R52, R59 and R65) reviewed for controlled substances in a sample of 47. FINDINGS INCLUDE: The facility policy, Controlled Substances, dated (reviewed) 11/6/18 directs staff, It is the policy of the facility that all drugs listed as Schedule II drugs are subject to specified handling, storage, disposal and record keeping. The drugs in Schedule II will be counted and reconciled by the nurse coming on duty with the nurse that is going off duty. These records shall be retained for at least one (1) year. On 08/18/24 at 9:21 A.M., a review of the facility A Hall and C Hall narcotic Shift Change Accountability Record Sheet for Controlled Substances for August 2024, for residents residing in the facility A Hall and C Hall, shows missing, nursing documentation, to confirm facility nurses performed the required shift to shift controlled substance reconciliation, on August 1-10 and 12-17, 2024. At that time, V6/Licensed Practical Nurse confirmed the missing documentation. A review of the facility Controlled Substances Proof of Use sheets for the facility, documents that R2, R3, R8-R10, R13, R17, R19, R22, R25, R34, R37, R43, R44, R47, R50, R52, R59 and R65 all receive a controlled substance from facility nurses. On 8/20/24 at 10:35 A.M., V2/Director of Nurses confirmed the missing documentation to the facility August 2024 nurse shift to shift controlled substance sheet for A Hall and C Hall.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50627 Based on interview and record review, the facility failed to ensure a licensed pharmacist reviewed a resident's medication regimen monthly for six consecutive months for one of five residents (R57) reviewed for unnecessary medications in a sample of 47. Findings include: The Facility Psychotropic Medication Policy, dated 11/28/17, documents, Nursing Administration will meet with the consultant Pharmacist on a monthly basis to discuss any resident who may need or is due for a possible medication reduction. R57's current medical record, as of 8/20/24, has no documentation of R57 having any Medication Regimen Reviews completed by a licensed pharmacist for the months of March, April, May, June, July, and August 2024. On 8/20/2024 at 9AM, V2 (Director of Nursing) confirmed that for the time span of 2/2024-8/2024, R57 only had one medication regimen review completed by a licensed pharmacist in February 2024.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50627 Based on observation, interview and record review, the facility failed to document a diagnosis and target behaviors to warrant the use of an antipsychotic medication, provide justification for the continued use of an antipsychotic medication, and attempt a gradual dose reduction of psychotropic medications for three of seven residents (R7, R49, R60) reviewed for psychotropic medications in the sample of 47. Findings include: The facility's Psychotropic Medication Policy, dated/revised November 28th, 2017, documents, It is the policy of this facility that residents shall not be given unnecessary drugs. Unnecessary drugs are any drug used: 1. In an excessive dose, including in duplicate therapy. 2. For excessive duration. 3. Without adequate indications for its use. 4. Without adequate indications for its use. 5. In the presence of adverse consequences that indicate the drugs should be reduced or discontinued. The policy also documents, 7. Any resident receiving such medications shall have a psychiatric diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others, destructive to property, or if emotional problems exist which cause the resident frightful distress. 8. The Behavioral Tracking sheet of the facility will be implemented to ensure behaviors are being monitored. 9. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue the drugs. Any at a minimum of every quarter by the interdisciplinary team. 10. Reductions shall be attempted at least twice in one year, unless the physician documents the need to maintain the resident regimen according to the Regulatory Guidelines for such. In addition, the policy documents, 19. Any resident receiving any psychotropic medication will have certain aspects of their use and potential side effects addressed in the resident's care plan at least quarterly. The care plan will identify target behaviors causing the use of psychotropic medications. The care plan will address the problem, approaches, and goals to address these behaviors. Any suspected problems will be reported to the physician. Attempts to rule out social and environmental factors as causative agents will be made in the care plan assessment. 1. R60's Physician Order Sheet, order dated 8/2024, documents R60 has orders for quetiapine (Seroquel) (antipsychotic medication) 25 mg (milligrams) one tablet by mouth twice a day. R60's Physician Order Sheet has no diagnosis documented for the use of R60's Seroquel. R60's Care Plan, dated 6/25/24, does not document that R60 receives antipsychotic medication. R60's Behavior Tracking Record, dated June 2024, documents R60's Target Behavior is monitor for a mood and behavior. R60's Behavior Tracking Record, dated July 2024, documents R60's Target Behavior is restive to cares resident new admit please report all mood and behaviors. R60 has no behavior episodes documented in both her June and July 2024 Behavior Tracking Records. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/24 at 10:40 AM, R60 was in her room on her bed. R60 was quiet, calm, and conversing with no issues. R60 did not display any outward behaviors. On 8/20/24 at 11:30AM, V13 (Certified Nursing Assistant) stated that R60 never shows any type of negative behavior or violence or says anything inappropriate towards other residents. V13 also stated, Sometimes she can have an attitude when it's time to get up and get around, but I wouldn't call that any type of behavior. On 8/20/2024 at 11:40AM, V3 (Assistant Director of Nursing/ADON) stated that she does not know why R60 was receiving Seroquel. V3 also stated that R60 doesn't have behaviors or a diagnosis that would warrant the use of Seroquel. V3 stated the only behaviors she was aware of was, R60 can be very repetitive and does not remember what she has said. 31283 2. R49's current Diagnosis Report documents R49's diagnoses to include: Schizophrenia; Schizoaffective Disorder; Mood Disturbance and Anxiety; and Depression. R49's current Physician's Orders document the following medication order: Clozaril (antipsychotic, date of order 06/12/22) 1500 milligrams twice daily. R49's Monthly Behavior Tracking Records (dated February 2024 - August 2024) do not document any target behaviors or a consistent pattern of adverse behaviors displayed by R49. These same forms had multiple days throughout each month that were left blank, and R49's Behavior Tracking Record (dated May 2024) is completely blank for the entire month. R49's current care plan has no mention of any target behaviors displayed by R49 and has no documentation of any behavioral interventions in place. From 08/19/24 - 08/21/24, multiple observations of R49 were conducted, and no adverse behaviors were displayed by R49 during this time. R49's Consultation Report (dated 05/30/24) does not address the suggested gradual dose reduction for R49's Clozaril. On 08/21/24 at 08:40 AM, V3 (ADON) stated that R49 occasionally displays the following behaviors: hoarding, agitation when someone interferes with his hoarded items, and withdrawn/self isolation. V3 stated R49 is not a harm to himself or others, and he has been, pretty stable with not a lot of behaviors. V3 stated that none of R49's target behaviors are noted on his Behavior Tracking Record, or his care plan and should be. V3 also confirmed that R49 does not have a consistent pattern of any adverse behaviors documented, and several days on R49's Behavior Tracking Records are blank with nothing documented. V3 then stated that R49 has been on the same dose of Clozaril since June 2022, and no gradual dose reduction has been attempted when suggested. 50962 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R7's Physician orders, dated 8/2024, documents that R7 has orders to receive: Aripiprazole (antipsychotic) 15mg by mouth at bedtime with a start date of 3/1/23; Luvox (antidepressant) 100mg by mouth twice a day with a start date of 8/13/21; Luvox 50mg by mouth daily at noon with a start date of 8/13/21; Remeron (antidepressant) 7.5mg by mouth six times a week omitting Wednesdays with a start date of 2/18/22. R7 Behavior tracking records, dated June-August 2024, documents that R7 is being monitored for behaviors of irritability, restlessness, and self-injury. The records also document that during this time span R7 only had two occurrences of behaviors. On 8/18/24 at 10:00 AM, R7 was sitting up in his wheelchair in the dining room. R7 was calm, pleasant but had repetitive verbalizations during conversation regarding his stroke. R7 answered questions when spoken to and no outward behaviors were displayed. On 08/20/24 at 10:15 AM, while V4 LPN (Licensed Practical Nurse) performed R7's supra pubic catheter care R7 was pleasant and interacted appropriately with V4. R7's Pharmacy consultation reports, dated 3-28-24, 4-30-24, 5-30-24, and 6-28-24, all document the following, R7 has received Aripiprazole 15mg po (by mouth) q (every) hs (night), Fluvoxamine (Luvox) 100mg po BID (twice a day) and 50 mg po once daily at Noon, and Mirtazapine (Remeron) 7.5mg po q hs 6 days per week for depression with impulse control disorder since March 2023 when the Aripiprazole was reduced. Recommendation: Please attempt a gradual dose reduction (GDR) for the above medications, perhaps by reducing the Aripiprazole to 10mg po q HS when current supply is finished. Rationale for Recommendation: CMS (Centers for Medicaid and Medicare Services) requires that antipsychotics, used to treat an enduring condition other than dementia, be evaluated at least quarterly with documentation regarding continued clinical appropriateness. Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence (e.g., GDR is attempted in 2 separate quarters, with at least 1 month between attempts, within the first year in which an individual is admitted on a psychotropic medication or after the prescriber has initiated such medication, unless clinically contraindicated). Also, all four of R7's pharmacy consultation reports have no documentation of a physician's response to the pharmacist's recommendations. On 8/21/24 at 10:40 a.m., V2 (Director of Nursing) stated that R7's fluvoxamine (Luvox), aripiprazole, and mirtazapine have not had a gradual dose reduction in the last year, and they are all past due to be reduced. V2 also stated that R7's pharmacy recommendations should document the doctor's response, however R7's do not have any documentation of the doctor acknowledging nor responding to the pharmacist's recommendation.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50962 Based on interview and record review the facility failed to administer physician ordered insulin to a resident (R12) with a diagnosis of Type Two Diabetes Mellitus with Diabetic Chronic Kidney disease for one of one resident reviewed for insulin use in a sample of 47. This failure resulted in R12's emotional distress feeling like the facility was going to kill him because he wasn't getting his insulin as ordered and resulted in multiple abnormal laboratory values that reflected hyperglycemia. Findings include: The facilities Adverse Drug Reactions and Medication Discrepancy policy dated 11/6/18 documents, Procedure: 1. A medication discrepancy/error has been made when one of the following occurs: wrong medication administered, wrong dose administered, medication administered by wrong route, medication administered to wrong resident, medication administered at wrong time, and medication not administered. The facilities Medication Administration policy, undated documents, The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given. Procedure: Medications must be prepared and administered within one hour of the designated time or as ordered; after a drug is given, record the date, time, name of drug, dose and route on the resident's individual medication administration record; document any medications not administered for any reason by circling initials and documenting on the back of the MAR (medication administration record) the date, the time, the medication and dosage, reason for omission and initials; notify the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason. According to the CDC's (Centers for Disease Control) Testing for Diabetes and Prediabetes: A1C, dated 5/15/24, The A1C test measures your average blood sugar levels over the past 3 months. When sugar enters your bloodstream, it attaches to hemoglobin, a protein in your red blood cells. Everybody has some sugar attached to their hemoglobin, but people with higher blood sugar levels have more. The A1C test measures the percentage of your red blood cells that have sugar-coated hemoglobin. Your red blood cells regenerate roughly every 3 months. That's why the A1C test measures your blood sugar levels from that time period. A1C results: The following ranges are used to diagnose prediabetes and diabetes: Normal: below 5.7% (percent); Prediabetes: 5.7% to 6.4%; Diabetes: 6.5% or above. When living with diabetes, your A1C also shows how well managed your condition is. Your A1C can estimate your average blood sugar: A1C% 9=Estimated average glucose of 212. A1C goals: For most people with diabetes, the A1C goal is 7% or less. Your doctor will determine your specific goal based on your full medical history. Higher A1C levels are linked to health complications, so reaching and maintaining your goal is key to living well with diabetes. On 08/18/24 at 9:59 AM, R12 was smiling and pleasant at first but became angry and belligerent when asked about his use of insulin. R12 was distressed explaining about staff not doing his insulin correctly. R12 does not feel that he is getting his insulin and that they (nurses) are going to kill him. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R12's current care plan documents R12 has a diagnosis of Type Two Diabetes Mellitus with Diabetic Chronic Kidney Disease. Care Plan also documents the intervention to administered diabetes medication as ordered by the doctor, and to monitor/document for side effects and effectiveness. R12's physician orders dated 08/2024, documents that R12 has orders for Tresiba Flextouch 100u/ml (units/milliliter) 50 units subcutaneous in the am and 20 units subcutaneous at bedtime, Trulicity 3mg (milligrams)/0.5ml give 0.5ml subcutaneous every week on Saturday, Insulin Lispro Kwikpen 100u/ml per sliding scale starting at blood glucose level of 200 four times a day and blood glucose level checks four times a day. R12's Medication Administration Record, dated May 5/1/24 to 5/31/24, has no documentation of blood glucose level checks done for 40 of 124 opportunities, 9 of 62 opportunities of no Tresiba insulin being administered, and 65 of 124 opportunities of no Lispro sliding scale insulin being administered. R12's Medication Administration Record, dated June 6/1/24 to 6/30/24, has no documentation of blood glucose level checks done for 48 of 120 opportunities, 7 of 60 opportunities of no Tresiba insulin being administered, 3 of 5 opportunities of Trulicity insulin not being administered, and 59 of 124 opportunities of no Lispro sliding scale insulin being administered. R12's Medication Administration Record, dated July 7/1/24 to 7/31/24, has no documentation of blood glucose level checks done for 65 of 124 opportunities, 2 of 62 opportunities of no Tresiba insulin being administered, 3 of 4 opportunities of Trulicity insulin not being administered, and 59 of 124 opportunities of no Lispro sliding scale insulin being administered. R12's Medication Administration Record, dated August 8/1/24 to 8/19/24 2024, has no documentation of Lispro sliding scale insulin being administered for 11 of 76 opportunities. R12's Fasting Glucose laboratory results, dated 4/23/24, documents R12's blood glucose level is high at 132 (range 65-99). The laboratory results also document the physician's response to the high glucose level to obtain a hemoglobin A1C. R12's Fasting Glucose laboratory results, dated 7/30/24, documents R12's blood glucose level is high at 169 (range 65-99). R12's Hemoglobin A1C laboratory results, dated 8/5/24, documents R12's Glycohemoglobin-HGBA1C level is high at 9.3 (range 4.1-6.1%). R12's medical records has no documentation of a hemoglobin A1C being done prior to these results. On 08/20/24 at 12:44 AM, V3 (Assistant Director of Nursing) stated that the expectation for the nurses when it comes to documenting blood glucose levels and units of insulin given is they (nurses) will initial the box for blood glucose level and write the level and then in a separate box the nurses will initial and document the amount of insulin units given. V3 stated that if the glucose level and insulin units are left blank it can be interpreted as not completed. V2 (Director of Nursing) was present and agreed with V3's statement. (continued on next page)

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	145266	A. Building B. Wing	08/21/2024

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 08/21/24 at 08:18 AM, V21 (R12's physician) stated he had ordered a Hemoglobin A1C based on R12's glucose level on a Basic Metabolic Panel in April, and his expectation was to have it done next lab day. V21 is aware that R12's Hemoglobin A1C was not done until 8/5/24 and the level of 9.3 which he states is higher than expected and he wants it 8 or below. V21 stated that not receiving insulin or having routine monitoring of blood sugars could have an effect on R12's hemoglobin A1C levels.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 32061 Based on interview and record review, the facility failed to obtain physician ordered laboratory tests for one of one resident (R67) reviewed for lab monitoring in a sample of 47. Findings Include: The facility policy, Laboratory Tests, dated (reviewed) 9/27/2017 directs staff, Appropriate laboratory monitoring of disease processes and medications requires consideration of many factors including concomitant disease(s) and medications(s), wishes of the resident and family and current standards of practice. Laboratory testing will be completed in collaboration with Medicare guidelines, pharmacy recommendations and physician orders. Obtain laboratory orders upon admission, readmission and PRN (as needed) for medication and condition monitoring per the physician's order. R67's Admission Physician Order Sheet/POS, dated 7/16/24 includes the following diagnoses: Acute Hypoxic Respiratory Failure, Diabetic Ketoacidosis, Acute Kidney Injury, Diabetes Mellitus, Dizziness and Weakness. This same POS also includes the following physician orders for labs: CMP (Complete Metabolic Profile) and CBC (Complete Blood Count) on 7/19/24. A review of R67's Medical Record on 8/19/24 indicates no lab test results are available. On 8/19/24 at 1:45 P.M. V2/Director of Nurses confirmed the missing lab test for R67. V2/Director of Nurses stated, Staff missed getting that lab ordered for (R67).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 35509 Based on observation, interview and record review, the facility failed to serve foods as written on the menu. This has the potential to affect all 63 residents living in the facility. Findings: The Facility's Week at a Glance, dated 8/18/24, Week four, Luncheon Menu, states, Oven Fried Chicken Breast; Mashed Potatoes; Chicken Gravy; Mixed Vegetables; Roll/Margarine; Pie (menu does not specify what kind of pie as required). Residents were served: Plain Baked Chicken (no breading); Mashed Potatoes; Carrots; Bread; Strawberry Pie. On 8/18/24 at 12:35 PM, V5, Dietary Manager, stated, I don't know why the chicken was plain, carrots were served instead of mixed vegetables and bread was served instead of rolls. The frozen mixed vegetables didn't come in, but we do have canned mixed vegetables; there are frozen rolls in the freezer that could have been used. I'll talk to the cook. He's new and doesn't know things. On 8/19/24 at 10 AM, during the Group Interview with Resident Council, R3, R10, R11, R15, R29, R33, R38, all complained that often the menu will say one thing, and another will be served. R15 stated, When you ask why something on the menu wasn't what we were served, we are told that the truck didn't come in or that the cook wanted to make something else. They don't like it when you ask them about what we get to eat. On 8/18/24 at 11:45 AM, V5, Dietary Manager, stated, Yes, we write down all of the substitutions. When the substitution book was reviewed there were few entries and the Registered Dietitian had not signed off as required for the substitutions. One of the entries was Strawberries and Bananas. The substitution was Banana Pudding (which is not a substitute for a serving of fruit unless half of eight-inch banana was in each serving. This was a flavored Pudding. When asked why fruit was not substituted V5 said, oh, we did but did not specifically what the fruit was. This was not written in the substitution book. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 8/18/24, signed by V1, Administrator, documents 63 residents currently reside within 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. 35509 Based on observation, interview and record review, the facility failed to ensure use of a safe sanitation solution; place food on the steam table at the appropriate time; maintain clean appliances/fixtures in the kitchen; label, date and appropriately package all opened food; use only institutional approved storage containers; date, label and discard as required, all food items in the resident's floor refrigerator. This has the potential to affect all 63 residents living in the facility. Findings: The document Food from Outside Sources/Personal Food Storage, dated 4/2017, states, Food and beverages brought in from outside sources, that are to be stored in the facility refrigerators and freezers, will be checked by a dietary staff member. Any suspicious or obviously contaminated food or beverage will be discarded immediately. Food and beverages will be labeled with the resident's name, food item and date. These foods and or beverages will be placed on a designated tray/shelf. Facility storage procedures apply. On 8/18/24 at 11:15 AM, the floor refrigerator (for resident's use) had a strong sour odor and contained the following food items: opened 2.5 ounce cheese package, no label or date; two restaurant take-out containers with a chopped chicken meal no label, that had a slimy appearance and sour odor; two plates of dried spaghetti with a sour smell; a restaurant purchased sandwich, unknown filling which was dried out, hard, loosely covered and dated 7/25/24; a murky bottle of water that slices of lemon had been added, lemon skins had turned brown, no label or date; a bag of grapes, cherries and strawberries, loosely covered, no labels of ownership or date; an unidentified glass of pink substance in the freezer without a label or date; several items in the freezer that do not have labels of resident ownership or date they were received: one pound tube of sausage; a box containing six premade cheeseburgers; Containers of grocery store labeled ice cream, opened, no label or date. On 8/18/24 at 11:30 AM, V11, Dietary Manager, and V2, Director of Nursing, confirmed that these items should have been discarded and should have been labeled with dates. V11 stated, I'm not responsible for the items that are put into the resident's refrigerator on the floor. The document In-Place Equipment, dated 4/2013, states, to mix a chlorine solution, mix at a rate of one teaspoons of bleach per gallon of water. Water temperature should be 75 degrees Fahrenheit. (For in-place equipment) the chlorine level is 100 parts per million (ppm). (note this is for in-place equipment only). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/18/24 at 9:30 AM, V20, Cook, mixed a sanitation solution. V20 opened a bottle of bleach and, using the cap, not a measuring spoon, poured chlorine into the bucket of water. The test strip was black, indicating over 200 parts per million (ppm), which is considered to be at a poisonous level. V11, Dietary Manager, instructed V20 to dump some of the water out of the bucket and add more water to it. V20 did so and when the solution was retested the level was still over the required level. V11 told V20 to dump out the solution and make another bucket of sanitation solution with a smaller amount of chlorine. When asked, V20, who speaks little English, was unable to state if he always checked the level of chlorine or what the level of chlorine tests at or should test at in the sanitation buckets. The document, Storage, dated 10/2020, states, It is the policy of this facility that food shall be stored (to) provide the best preservation. Food shall be stored at the proper temperature and for appropriate lengths of time to protect quality of food. Store (food) in covered, labeled and dated containers under refrigeration or (in the) freezer. The document, Refrigerator and Freezer Storage, dated 10/2014, states, Any item placed in the refrigerators must be covered, labeled and dated with a date-marking system that tracks when to discard perishable foods. [NAME] container with the name of the item. [NAME] the date that the original container is opened or date of preparation. Label refrigerated, potentially hazardous food with the day/date by which the food shall be consumed or discarded (maximum of seven days from time of preparation/opened). Designated Dietary employee is to check, pull and throw away any potentially hazardous foods that have been in the refrigerator longer than seven days. On 8/18/24 at 9:40 AM, the following items were in the reach in and walk in refrigerators: a 46 ounce container of thickened water, one third remaining, no label dated with marker, 7/18/24; A 46 ounce container of thickened orange juice, one half remaining no label, dated with marker, 7/20/24; one pound of cheese slices, no wrapper or container, no label or date; a five pound container of sour cream, one half remaining, no label or open date; a one pound container of Parmesan cheese, one third remaining, no label or open date. V11, Dietary Manager, confirmed these items needed labels/dates and should be discarded. I don't think some of these items (thickened liquids) need to be discarded, though. On 8/18/24 and 9:50 AM, the stock room had the following items: A large garbage can, no liner, three fourths full, was used for oats. The lid was cracked and was missing part of its rim, exposing the oats to the environment. Five cereal containers had numerous labels that had been left on. These old stickers were readable, showing various types of cereal other than what the container held. The label only stated what the item was, no open date. The flour container, one half full and a bag of streusel topping, one fourth full were not dated or labeled. An empty, scrunched Parmesan cheese container, not an institutional required container, was being used for sugar. V11 acknowledge these things stating, I will remind the staff to label and date food items. We'll need to check the dates of food. On 8/18/24 at 10:00 AM, the steam table already had the chicken, pureed chicken, ground chicken sitting in place. V20, Cook, indicated that he had put the chicken into the steam table at 8:30 AM. V11, Dietary Manager, stated that the chicken they serve comes pre-cooked and only needs to be heated before serving. V20, who speaks or understands very little English was unable to say if he routinely put foods on the steam table early. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The document Kitchen Sanitation, dated 10/2020, states, It is the policy of (this facility) to comply with Public Health Standards of Sanitation Regulations. The Food Service Manager will monitor sanitation of the Dietary Department on a daily basis. The Food Service Manager shall provide cleaning instructions for each area and piece of equipment in the kitchen. On 8/18/24 at 9:15 AM, the interior baffles and the wall of stainless steel surrounding the baffles, which is over the range, ovens, and food preparation area, had a layer of dust. The fans, blowing air directly on the food preparation area and clean dishes area of the dish machine, had a layer of black, greasy dust over the grill. V11, Dietary Manager, stated, I'll tell Maintenance to come in a clean the area. The facility's Long-Term Care Facility Application for Medicare and Medicaid Form CMS (Centers for Medicare and Medicaid Services) 671 dated 8/18/24, signed by V1, Administrator, documents 63 residents currently reside within the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32061 This failure resulted in two deficient practice statements. A. Based on observation, interview, and record review the facility failed to perform hand hygiene during medication administration for two residents (R22 and R35) of three reviewed for medication administration, in a sample of 47. B. Based on observation, interview and record review, the facility failed to implement Enhanced Barrier Precautions throughout the facility to protect vulnerable residents and prevent the spread of multi-drug resistant organisms (MDROs). This failure has the potential to affect all 63 residents residing in the facility. Findings include: A. The facility policy, Standard Precautions, dated (reviewed) 4/11/22 directs staff, Standard precautions will be instituted to prevent the spread and contamination of pathogenic microorganisms in a manner that voids transfer to residents, personnel and environment. Gloves: Wear gloves when touching blood, body fluids, secretions, and contaminated items. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. The facility policy, Medication Administration, dated 11/18/17 directs staff, Avoid touching medication. If contact with the medication is likely, prepare medication using gloves. On 8/18/24 at 9:21 A.M., V6/Licensed Practical Nurse (LPN) prepared to administer mediations for R22. V6/LPN removed one tablet each of Amlodipine 10 MG (Milligrams), Clopidogrel 75 MG, Farxiga 10 MG, Furosemide 40 MG, Gabapentin 100 MG, Sertraline 25 MG, and Hydrocodone 5/325 MG from individual prepackaged bubble packs directly into her bare hands and then placed them into a small, plastic medication cup. V6/LPN then removed one tablet each of Ferrous Sulfate 325 MG, Loratadine 10 MG, Acidophilus 500 MG, and Vitamin D3 50 MCG (Micrograms) from facility stock bottles directly into her bare hands and placed them into the same medication cup. V6/LPN then primed an insulin pen with Lantus Insulin 20 Units and a second Insulin pen with Novolog Insulin 4 Units and entered R22's room. V6/LPN poured the pills into R22's mouth while she was lying in bed, placed a straw into her mouth and instructed R22 to take the medication. After that, without performing hand hygiene or applying gloves, V6/LPN swabbed R22's abdomen with an Alcohol swab, injected the Lantus Insulin, swabbed another area on R22's abdomen, injected R22 with the Novolog Insulin, adjusted R22's bed covers and exited R22's room. Without performing hand hygiene, V6/LPN then poured one tablet of Tylenol 500 MG directly into her hand, placed the tablet in a plastic cup and handed the cup to R35 who took the pill. At that time, V6/LPN verified she had touched R22's and R35's medications with ungloved hands and administered R22's Insulin without applying gloves. 38396 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. The facility's Enhanced Barrier Precautions policy, dated 7/13/23, documents Enhanced Barrier Precautions (EBP) should be used when contact precautions do not apply, for the residents with any of the following: Open wounds that require a dressing change, Indwelling medical devices, Infection or colonized with MDRO (Multi-Drug-Resistant Resistant Organisms). Enhanced Barrier Precautions require use of gown and gloves during high-contact resident care activities that provide opportunities for the transfer of MDRO's to staff hands and clothing. EBP is primarily intended for care that occurs within a resident's room, when high-contact resident care activities are bundled together. This policy also documents High Contact care activities include: Dressing, Bathing/Showering, Transfers, Hygiene, Changing linens, Changing briefs or toileting, Caring for medical devices (such as: central lines, urinary catheters, feeding tubes, tracheostomies, drainage tubes, ports), Wound Care (pressure ulcers, diabetic ulcers, unhealed surgical wounds, chronic venous stasis wounds), Skilled Therapies. Procedure: Educate staff on EBP. Identify residents with an infection or colonized with a MDRO, residents with medical devices or chronic wounds that do not require contact precautions. Post approved EBP signage that indicates high-contact activities. Ensure that disposable or washable isolation gowns and gloves are available to healthcare providers, where high contact resident care activities may be required. Keep a container or hamper inside resident's room for healthcare providers to dispose of PPE. On 8/18/24 at 11:08 AM, R45 was in his room lying in bed. R45's indwelling urinary catheter bag was dangling on bed rail below the mattress, draining urine. R45's room did not contain any EBP signage or PPE inside or outside of R45's room. On 8/19/24 at 10:08 AM, V14 (Licensed Practical Nurse) stated, Enhanced Barriers sounds foreign to me. They are not doing that here. On 8/20/24 at 10:15 AM, V4 (Licensed Practical Nurse) performed R7's supra pubic catheter care with dressing change. V4 stated that R7 has a history of urinary tract infections. V4 did not wear a gown during cares, no Enhanced Barrier sign was on R7's door and no other PPE was available except for gloves. On 8/20/24 at 2:08 PM, V4 completed R44's pressure ulcer dressing changes. V4 confirmed R44's pressure wound on her hip is open and was staged at a stage three upon discovery. V4 did not wear a gown throughout R44's care. R44's room did not contain any signs for EBP, and no PPE was present inside or outside of the room. V4 stated No one is on TBP (transmission-based precautions) right now. I don't know about the EBP requirements. On 8/21/24 at 9:40 AM, V3 (Assistant Director of Nursing) provided a list that documented R35 and R44 currently have open wounds and R7 and R45 have indwelling urinary catheters. V3 confirmed she and V2 (Director of Nursing) handle the facility's infection control procedures. V3 stated We are aware what EBP's are and that any residents who have indwelling urinary catheters, open lines like feeding tubes or central lines and anyone who may develop an open wound should be in EBP. I guess I wasn't aware that it is not being implemented throughout the facility, but it should be. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 8/18/24 and signed by V1 (Administrator in Training) documents 63 residents reside in the facility.