STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145273	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jacksonville Skld Nur & Rehab	1517 West Walnut Street Jacksonville, IL 62650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to provide adequate lighting for 1 of 3 residents (R63) reviewed for reasonable accommodations for residents in the sample of 40. The findings include: R63's Face Sheet, undated, documented that R63 was admitted to the facility on [DATE] with diagnosis of Polyneuropathy, Morbid obesity, Buerger's Disease, Myiasis, Major Depressive disorder, Arthropathy, restlessness and agitation. R63's Care Plan, dated 10/11/23, documented, R63 is focused on therapy and prefers to spend the majority of her free time resting in the comfort of her room involved in independent leisure pursuits. Interventions: Resident enjoys Reading scary books. It continues, 2/21/24 (R63) is at risk for falls related to (r/t) decreased mobility, History of Arthropathy, Polyneuropathy. Interventions: Provide adequate lighting, encourage use of call light, keep call light within reach, keep personal belongings within reach, provide verbal safety cues, provide/reinforce use of assistive devices: (Specify: Reacher, walker, cane, wheelchair, transfer pole, provide/reinforce use of non-skid footwear). R63's Minimum Data Set (MDS), dated [DATE], documented that R63 was cognitively intact and was dependent on staff for toileting, dressing, and transfers. R63 also required extensive assistance from staff for other Activities of Daily Living (ADLs). R63 was always incontinent of bowel and bladder. On 5/19/24 at 9:55 AM, R63's room appeared very dark and R63 stated the over bed lights in her room are burnt out. R63 stated that she told the maintenance man about it at least a month ago, and she was told that he was waiting on parts. On 5/20/24 at 1:10 PM, V18, Wound Nurse, is doing wound care for R63. V18 stated I need to buy a headlamp so I can see. It's dark in here. On 5/20/24 at 1:25 PM, While watching V18 provide wound care for R63, it appeared very dark in her room. R63 stated that she has no lights on her side of the room, her over the bed lights are out and that V19 Maintenance Director was aware and told her that parts are ordered to fix it. The only light in the room is one over the bed light on her roommate's (R19) bed and there is only one light bulb on there. R63 stated that at night, she has to use the television or her laptop computer for light or will just go to sleep because it's dark. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 1:30 PM, V19, Maintenance Director, stated that he was aware of R63's lights out and he has a work order to fix it. V19 stated that R63's lights over her head of bed uses three-foot Incandescence light bulbs and he is in the process of changing all over the bed lights to LED instead. V19 stated he is having trouble finding the correct size LED bulbs to go into the lights. When asked about just putting the regular bulbs back in until he can find the LED bulbs, V19 stated that he had to order them too, and they came in maybe a week or so ago, but he has been busy and hasn't had the time to put them in. V19 stated he will put them in immediately. This was brought up to V1, who followed up and made sure it was completed. On 5/20/24 at 2:50 PM, V1, Administrator, stated Yes, I would expect the maintenance man to replace light bulbs in resident's room when needed. The Maintenance Work Order, dated 4/26/24, documents 117 W has no working light above her bed. Stated it has been out for a week now. Priority: Critical. The facility's Resident Rights - Homelike Environment Policy, dated 7/18/22, documented, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment. b. Comfortable (minimum glare) yet adequate (suitable to the task) lighting. 4. Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable, and homelike environment. The lighting design emphasizes: a. Sufficient general lighting in resident-use areas; b. Task lighting as needed; c. Reduction in glare (through use of light filters, no wax floors); d. Even light levels; e. Maximum use of daylight; f. Night lighting to promote safety and independence; g. Dimming switches, where feasible.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to provide timely and complete incontinent care, including hand hygiene and glove changes for 5 of 5 (R23, R37, R48, R55, R180) reviewed for incontinence care in the sample of 40. The findings include: 1. R48's Face Sheet, undated, documented that R48 was admitted to the facility on [DATE] with the diagnosis of Brown-Sequard Syndrome, Hemiplegia and Hemiparesis, Intervertebral disc disorders with Myelopathy, Arthropathy, Morbid Obesity, Bronchitis, Hypertension (HTN), Heart Failure, and Benign Prostatic hyperplasia (BPH) with Urinary Tract symptoms. R48's Care Plan, dated 2/27/23, documented, (R48) has impaired urinary elimination related to (r/t) obstruction of urethra r/t BPH. (R48) was unable to use a urinal and will often place towels between my legs to urinate on. (R48) can make staff aware of my needs and when this has occurred. It continues, (R48) needs assist with his ADLs (Activities of Daily Living) r/t weakness, decreased endurance, diagnosis of Hemiparesis and obesity. Interventions: Transfer: (full body mechanical lift) required, Bed Mobility: Two-person assist for pulling resident up in bed; may require one or two-person assist for repositioning in bed depending on resident condition. Bathing: One-person physical assist required. It continues, (R48) has the potential for impaired skin integrity related to impaired mobility and decrease sensation resulting from hemiplegia. Interventions: Provide peri-care after each episode. R48's Minimum Data Set (MDS), dated [DATE], documented that R48 was cognitively intact and was dependent on staff for toileting, dressing, and transfers. R48 was always incontinent of both bowel and bladder. On 5/19/24 at 10:27 AM, R48 stated he uses a urinal at times but is also incontinent and has bowel movements (BM) in bed and will let the staff know with his call light. R48 stated that if it's during a mealtime, he has to sit in it a couple hours because the staff is in the dining rooms and assisting residents with eating. On 5/20/24 at 11:10 AM, R48 stated that he was incontinent of urine overnight while he was asleep. R48 stated that he woke up at 7:30 AM and was saturated in urine. R48 stated the staff came in asking him about breakfast, he told the Certified Nursing Assistants (CNAs) that he was wet, and they told R48 that they are doing breakfast right now, and that he will have to wait until after breakfast. R48 stated that the CNA then brought him his breakfast, and he had to eat his breakfast while saturated in urine. R48 stated that after breakfast, around 9:00 AM to 9:30 AM, the CNAs came in to get him up and take him to therapy, and that is when he finally got cleaned up. R48 stated that this happens a lot and that some staff will clean him up before he eats, and some will make you wait until after. R48 stated that it is Gross to sit in your urine while you eat. R48 stated that he has not been checked or cleaned up since the earlier time before therapy (9:00 to 9:30 AM) and that he is wet now and is waiting for lunch to be served. R48 stated that sitting in urine is gross, but sitting in your BM is not tolerable. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/24 at 11:50 AM, while this surveyor was observing from the hallway, R48 was heard telling V14, CNA, that he was wet and needed cleaned up, and V14 stated she will be back and left the room. R48 was delivered lunch shortly after and ate his lunch while saturated in urine. On 5/20/24 at 12:25 PM, R48 was still sitting in his wheelchair in his room, and had not been cleaned up yet. This Surveyor has been watching R48's room from the hallway and R48 has not been cleaned or checked. R48 stated he can use a urinal at times but when he goes to therapy, they put an incontinence brief on him, and he just goes in the brief. On 5/20/24 at 12:35 PM, V14, CNA, and V16, CNA, came in to assist R48 to bed via full body mechanical lift to get cleaned up. No hand hygiene was done as V14 donned gloves and began removing R48's pants, which were wet with urine. R48's incontinent brief was unfastened and appeared saturated with urine. R48 rolled to his left side, V14 used wet washcloths, sprayed the cloths with peri-cleaner, and then wiped R48's right buttock and anal area and did not dry the area. R48's skin appeared reddened, but no open sores noted. V14 tucked a new incontinent brief under R48, then changed her gloves with no hand hygiene completed in between glove changes. V14 applied moisture cream to R48's buttock and anal area. R48 was rolled back to his back and V14 wiped once under R48's abdominal roll, across his pubic area, once down left groin, once down right groin, around his penis, and around his scrotum but did not dry areas after being cleansed. R48 rolled to his right side and the soiled brief and pad were removed. R48's left buttock was not cleansed when he was on his right side. R48 was rolled back to his back side and onto the new brief. V16 provided powder to R48's abdominal roll, groins, and pubic area. Supplies were gathered, and both CNAs doffed their gloves with no hand hygiene done prior to leaving the room. Neither CNA did hand hygiene prior to or after resident care. 2. R55's Face Sheet, undated, documented that R55 was originally admitted to the facility on [DATE] with the diagnosis of Dysphagia, Congestive Heart Failure (CHF), Lumbar Spondylosis, Chronic Kidney Disease-stage 3, HTN, Urinary Tract Infections (UTI), and Osteoarthritis. R55's Care Plan, dated 10/16/23, documented, (R55) has a self-Care Deficit as evidenced by: Needs assistance with ADLs. Interventions: Toilet Use: Two-person physical assistance required, Transfer: Mechanical lift required with two staff assist. R55's MDS, dated [DATE], documented that R55 had a severe cognitive impairment and was dependent on staff for toileting, bathing, dressing, and transfers. R55 was always incontinent of both bowel and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/24 at 10:38 AM, V8, CNA, and V9, CNA, were seen getting R55 cleaned up and dressed for lunch. V8 did not do hand hygiene prior to donning gloves and caring for R55. V8 initially brought in a couple washcloths, ran the sink water in the restroom to get it warm, wet the washcloth and then placed it over the headboard. R55's pants were pulled down and her incontinent brief was unfastened and tucked between her legs. V8 wiped each groin once and once across pubic area, stopped and covered R55 up and left the room to get more washcloths without drying wet areas. V9 now entered to assist V8 and donned gloves with no hand hygiene done prior to. V8 came back with more towels and washcloths, donned gloves, again without doing any hand hygiene, put washcloths in a plastic bag, added water to bag, then added peri-wash to the cloths in the bag. V8 then wiped R55's pubic area and once down each groin again and did not dry the areas. V9 had to tell V8 to wipe down the middle of R55's vagina, so V8 got a wet washcloth and very minimally wiped once down the middle with no spreading of the labia nor was the areas dried. R55 was then rolled to her left side, and the incontinence brief was removed, which appeared saturated with urine. V8 wiped R55's buttocks and anal area without drying areas, and then with the same gloves on, walked to the restroom and opened the door to wet more washcloths in sink, then came out and changed her gloves, no hand hygiene was done. V8 donned gloves and wiped R55's anal area again with a wet wash cloth and did not dry the area. V8 then used the same gloves again to get a clean incontinence brief and bed pad, then doffed her gloves, and turned R55 to her right side. V9 then wiped R55's left buttock but did not dry it, fastened the incontinence brief, pulled R55's pants up. Both CNAs left R55's room without any hand hygiene completed. 42108 3. R37's Care Plan, dated 1/29/2024, documented, (R37) has Self-Care Deficit As Evidenced by: Needs assistance with ADLs (activities of daily living) r/t (related to) impaired mobility d/t (due to) recent illness. It continues, Personal Hygiene - One person physical assist required. R37's Minimum Data Set, dated dated [DATE], documented that R37 was cognitively intact and was dependent on staff for toileting. On 5/20/2024 at 10:21 AM, V17, Certified Nurse Assistant (CNA), performed incontinent care. R37 was incontinent of urine and bowel. V17 asked R37 to turn over. R37 turned on his left side. Using a wet washcloth, V17 wiped R37's anal area, but did not dry area. V17 then applied barrier cream to R37 buttocks without cleansing area. V17 then assisted R37 onto his right side and removed a heavily urine and bowel soiled pad. V17 then with a dry washcloth wiped the top of R37's left hip. V17 then applied clean gown and pulled a cover over R37. V17 gathered R37's soiled linen from the floor and left the room. V17 did not cleanse all areas of incontinence including R37's buttocks, penis, groin and peri area. 4. R180's Care Plan, dated 5/15/2024, documented, (R180) has Self-Care Deficit As Evidenced by: Needs assistance with ADLs Related to weakness, decreased mobility. It continues, Toilet Use: one person physical assistance required. R180's Skilled Care assessment, dated 5/19/2024, documented that R180 was alert and oriented to person, place, and time. It also documented that R180 was incontinent and requires assistance with toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/2024 at 9:50 AM, V7, CNA, perform incontinent care. R180 was incontinent of bladder. V7 using a wet washcloth and peri wash spray cleansed R180's pubic area and down the right side of the outer labia. V7 then using a wet washcloth and peri wash cleansed down the front of R180's vaginal area. R180 lifted her buttocks off the bed and V7, using a wet washcloth and peri wash, wiped one swipe between the middle of R180's buttocks. All without benefit of drying the areas that were cleansed. V7 did not clean all areas of incontinence. V7 did not cleanse R180's groin, inner labia, entire outer labia, buttocks and inner thighs. On 5/22/2024 at 1:00 PM V1, Administrator, stated that she would expect the staff to clean all areas that urine and feces touch, buttocks, peri area, groin, vaginal, penis and scrotum. V1 stated that she would expect the staff to dispose of soiled linen in a bag. V1 stated that it is not appropriate to throw soiled linen on the floor. The facility's Perineal Care Competency 525, not dated, documented, 11. Female perineal care a. If resident is soiled with feces, place resident on side and dean perineum and rectal area. b. Change water and discard soiled linen appropriately. c. Change gloves d. Turn resident on her back e. Ask resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees, the perineal area can be washed with the resident on the side with legs flexed. f. Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back. Rinse and pat dry with towel. g. If resident is able to use bed pan place resident on bedpan and pour clean warm water or cleansing solution over the vulva and perineum. h. Dry the area well, remove bedpan, and position resident on back. 12. Male perineal care a. If resident is soiled with feces, place him on side and clean perineum and rectal area. b. Change water and discard soiled linen appropriately c. Change gloves d. Turn. resident on his back e. Ask resident to separate his legs and flex knees. If he is unable to spread his legs and flex knees, the perineal area can be washed with the resident on the side with legs flexed. f. Gently wash pubis and penis. If uncircumcised pull back foreskin and wash gently. Carefully dry and return foreskin to normal position. Make sure shaft of penis is dry. g. Ask resident to bend and separate knees. Help resident if required. Wash scrotum carefully. Rinse and pat dry. 13. Help position resident onto back. 14. Remove protective pad under buttocks, remove gloves. 15. Replace top bed linen. 16. Make resident comfortable. 17. Place call light in reach. 18. Document procedure in medical record. 32874 5. On 5/20/2024 at 11:07AM, V20, CNA and V21 CNA were providing incontinent care to R23 in her bed in her room. Both V20 and V21 CNAs both sanitized hands prior to donning gloves. A basin of soapy water sitting was on table at end of bed with bottle of peri wash oand a towel. V21 CNA stated he had put body soap in the water. V21 undid R23's adult diaper, R23 was dry. V20 CNA then took soapy wash cloth and went down left groin then right groin, R23 then started urinating in the diaper. So V20 then started the process over. V20, CNA then cleansed R23's left groin then right groin. V20 did separate and cleanse the labia. V20 did not rinse the soapy water off R23 nor did she dry R23. R23 was then rolled onto her side. V20 cleansed R23. V20 did not rinse soapy water off R23. V20 then dried R23's buttocks. R23's Minimum Data Set, dated dated [DATE], documented that R23 was dependent on staff for toileting. It also documented that R23 was frequently incontinent of urine. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23's Care plan, dated 4/25/2023, documented that R23 was incontinent of Bowel / Bladder. R23's care plan also documented an intervention, dated 4/25/2023, of clean peri-area with each incontinence episode. On 05/22/24 at 10:59 AM, V21, CNA, stated that if they use body soap and not the peri wash during incontinent care the resident should be rinsed. The facility incontinence care policy dated, revised 5/16/2022, documented, All incontinent residents will receive incontinence care in order to keep skin clean, dry and free of irritation and/or odor. Incontinent care will be provided as required. The policy documents soap and water (peri wash) washcloth and towel, lotion (Vaseline.) The policy documents perform hand hygiene. apply gloves, wash all soiled skin areas and dry very well, especially between skin folds; changing gloves and perform hand hygiene as required to prevent cross contamination. Apply protective skin lubrication and rub well into skin., perform hand hygiene.

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F 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to provide Oxygen to residents that required oxygen for 2 of 5 residents (R26, R56), reviewed for respiratory care in the sample of 40. This failure resulted in R26 becoming cyanotic with a low oxygen saturation of 51%. The Findings Include: 1. R26's Face Sheet, undated, documents R26 was originally admitted to the facility on [DATE] with diagnosis of Motor Neuron Disease, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Osteoporosis, Atherosclerotic Heart Disease (ASHD), Sleep Apnea, Chronic Inflammatory Demyelinating Polyneuritis, Arthropathy, Primary Lateral Sclerosis, Major Depressive disorder, Anxiety disorder, Hypertension, Pneumonia, Malignant neoplasm of bronchus and lung, Pulmonary embolism, Venous Thrombosis and Embolism, and Dependence on Supplemental Oxygen. R26's Care Plan, dated 8/26/20, documented that R26 has shortness of breath lying flat related and with exertion due to COPD. It continues to document that R26 has oxygen therapy related to Ineffective gas exchange. It continues, Interventions: Oxygen Settings: O2 via Nasal Cannula (NC) as per MD (Physician) orders, give medications as ordered by physician. Monitor/document side effects and effectiveness. It continues, (R26) has COPD, Asthma, sleep apnea, and recent acute episode of respiratory failure with hypoxia. She uses oxygen, inhaler, nebulizers, and positioning. Interventions: Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness, head of bed elevated to 40 to 50 degrees or resident's preference or out of bed upright in a chair during episodes of difficulty breathing, monitor for s/sx (signs/symptoms) of acute respiratory insufficiency: Anxiety, confusion, restlessness, SOB at rest, cyanosis, somnolence, nebulizer treatments per MD orders, Oxygen Settings: O2 via 2 liters daily via nasal cannula. On 5/20/24 at 9:38 AM, R26 was sitting in her wheelchair in her room with her nasal cannula (NC) in her nose with no sound of oxygen (O2) coming out of it. The nasal cannula was hooked up to a portable tank hanging on the back of her wheelchair and was completely empty, with the needle on gauge seen all the way to the left side in red, indicating empty. R26 was asked if she could feel anything coming out of her nasal cannula, and she was unsure if there was anything or not. There was no humidifier attached to the oxygen concentrator. On 5/20/24 at 9:48 AM, V11, Registered Nurse (RN)/Hospice Nurse, was seen visiting R26 and stated (R26) is usually on between 2 to 5 Liters (L) /NC to keep her oxygen saturation above 89 to 90%. On 5/20/24 at 9:48 AM, V12, Licensed Practical Nurse (LPN), was notified about R26's O2 being off because the portable tank was empty. V12 confirmed that the portable tank was empty and attached R26's NC to the O2 concentrator sitting behind her. V12 obtained an oxygen saturation on R26 which read 88% and V12 increased the O2 to 2.5 L/NC with O2 saturation reading above 90% afterwards. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/21/24 at 10:28 AM, R26 was seen sitting in her wheelchair with her head down, difficult to arouse, shallow breathing, and her fingertips were bluish in color. R26's nasal cannula was in her nose and attached to the portable oxygen tank which was totally empty and had no oxygen coming out of the tank. The oxygen concentrator is behind her and is currently off with a nasal cannula attached and lying on the floor. V12, LPN, was notified and went in to assess R26. V12 stated Yes, the tank is empty. (R26) doesn't tolerate being off her oxygen that is why her fingers are blue. V12 took off R26's nasal cannula and grabbed the nasal cannula that was connected to the O2 concentrator lying on the floor and put it into R26's nose and turned on the oxygen at 4 liters/minute. V12 attached a pulse oximeter to R26 which showed an oxygen saturation of 51% and a heart rate at 96. After approximately five to ten minutes, R26's oxygen saturation went up to 88% and her heart rate went down to 88. V12 stated she was going to call the Hospice Nurse to tell her that R26 was without oxygen for a while and her oxygen saturations had dropped. On 5/21/24 at 10:45 AM, V2, Director of Nursing (DON), was notified of the incident involving R26 and stated Please tell me they didn't pick the nasal cannula off the floor and put it in her nose. We will be doing some in-services. On 5/21/24 at 10:50 AM, V1, Administrator, walked into the office where surveyors were sitting and stated, I already know (about R26 situation), and we are doing an audit right now. On 5/22/24 at 8:35 AM, V4, Assistant Director of Nursing (ADON), stated We all pitch in to bring residents back from the dining room to their room, but whatever staff brings the resident on oxygen back to their room, should be telling the nurse that the resident is back and needs their oxygen back on. On 5/22/24 at 8:45 AM, V25, RN, stated When a resident on oxygen comes back from the dining room, they should be switched over from the portable tank to the concentrator. The aids should tell the nurse that the resident is back in their room. On 5/22/24 at 8:48 AM, V26, CNA, stated I'm not supposed to touch the oxygen, so if I bring a resident on oxygen back, I go tell the nurse to switch it over. I'm not going to lie, there may be times when I'm busy and forget to tell the nurse. On 5/22/24 at 10:50 AM, V1, Administrator, stated, I would expect the staff to ensure that any resident getting transferred while on a portable oxygen tank, returns to their room and is switched over to the concentrator. I would expect the staff member doing the transfer to notify the nurse that the resident is back and then would expect the nurse to take care of the residents oxygen needs. R26's Physician Order (PO), dated 3/15/24, documents Change Nebulizer mask/HHN (high humidity nebulizer) & tubing weekly, place in bag when not in use (Change bag weekly). Every Sunday for Infection Control and as needed for Infection Control Visibly soiled or damaged. R26's PO, dated 3/15/24, documents Oxygen: Rinse and Replace Intake filter every week. Change oxygen tubing and humidifier weekly. Every night shift, every Sunday for Infection Control. R26's PO, dated 3/15/24, documents Oxygen at 2-5 LPM (liters per minute) via nasal cannula as needed for SOB (shortness of breath)/Wheezing. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R26's PO, dated 3/15/24, documents Oxygen: Pulse Ox (O2 Sat) As Needed For Shortness of Breath / Wheezing. R26's PO, dated 5/21/24, documents Oxygen PRN: if in use, ensure portable tank is full and functioning properly prior to meals. Transfer to concentrator in room at HS (hours sleep). R26's PO, dated 5/21/24, documents Continuous oxygen at 2-5 LPM via nasal cannula. Every shift for Shortness of breath. R26's Nursing Note, dated 5/21/24 at 10:54 AM, documented, Call to hospice (company) to make aware of low SPO2. Resident was placed on concentrator and SPO2 increased to 89-90% on 4 L, heart rate 85-90. Resident was reevaluated 10 minutes later and SP02 was 93% HR 80s. Lowered O2 to 3L and SPO2 is now 94-97%. Left message and awaiting return call from (hospice). DON aware. On 5/22/24 at 10:50 AM, V1, Administrator, stated that the facility does not have a policy on transporting a resident while on oxygen. 42108 2. R56's Care Plan, dated 2/6/2024, documented, (R56) has DX (diagnosis) of COPD (Chronic Obstructive Pulmonary Disease). It continues, O2 via nasal cannula as ordered. R56's MDS, dated [DATE], documented that R56 was cognitively impaired, required oxygen, and required assistance with ADL's. R56's POS, dated 1/26/2024, documented, Oxygen at 2 LPM via Nasal cannula continuous. May wean to room air as tolerated every shift. It continued, dated 5/21/2024, Oxygen PRN: if in use, ensure portable tank is full and functioning properly prior to meals. Transfer to concentrator in room at HS. On 05/19/24 at 3:02 PM, R56 was sitting in her room in her wheelchair. R56's oxygen tank was empty. V23, R56's daughter, went and got R56 a full tank. On 5/19/24 at 3:05 PM, V23, R56's daughter, stated that they allow R56's tank to go empty in the dining room and take her (R56) to her room and do not refill the tank. V23 also stated that the tank is always empty, and she (V23) has to get her new ones everyday she visits. The facility's Oxygen Administration Procedure Policy, undated, documented, The purpose of this procedure is to provide guidelines for safe oxygen administration. Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure. 1. Portable oxygen cylinder. It continues, 3. Humidifier bottle. Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of Cyanosis. 2. Signs or symptoms of hypoxia. It continues, Steps in the Procedure: 5. Check the tubing connected to the oxygen cylinder to assure that is free of kinks. 6. Turn on the oxygen. It continues, 9. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. Ensure the tubing and humidifying jar/container are dated. 10. Periodically re-check water level in humidifying jar.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42108 Based on observation, interview, and record review, the facility failed to properly store medication and failed to label a Tuberculin vial and Insulin vials. This has the potential to affect all 83 residents living in the facility. Findings include: On 05/19/2024 at 10:29AM the facility's 100-Hall Medication Storage Room was inspected. The refrigerator located in the 100-Hall medication room contained the following: 1. One open and partially used multi dose vial of Tuberculin. The vial was in the refrigerator, no open date on the vial. The Tuberculin Purified Protein Derivative, (Mantoux), Tubersol package insert, dated April 2016, documents A vial of Tubersol which has been entered and in use for 30 days should be discarded. On 5/19/2024 at 10:30 AM the Medicare medication cart was inspected. The cart contained the following: 2. R8's open and partially used multi dose Lantus vial. No open date. 3. R71's open and partially used multi dose Gargling vial. No open date. 4. R37's open and partially used multi dose Humalog vial. No open date. 5. R182's open and partially used multi dose Lantus vial. No open date. On 5/19/2024 at 10:36 AM V6, Licensed Practical Nurse, (LPN), stated, that the Tuberculin (TB) is a stock medication. V6 stated, that the TB medication is a stock medication and used for all residents in the facility. V6 stated, that unless they have an allergy all residents get a TB shot at least yearly. V6 stated, that this would be the medication that would be used. V6 verified that the multi dose vial was open and in use. V6 stated, that she had not used the insulin pen as they are scheduled for evenings. V6 stated, that the pen once put in use should have the resident name on it and the open date. V6 stated, that the TB multi dose vial and the insulin pens have different expiration days once open. V6 stated that the expiration date decreases. V6 stated that the open date lets them know when that date is. On 5/22/24 at 9:08 AM V25, Registered Nurse, stated that when opening a new Tuberculin multi dose vial, an open date or expiration date is placed on the box. V25 stated that once opened the use by date shortens to 30 days. V25 stated that the date lets them know when the use by date ends. V25 states that when removing an insulin pen from the box and it is not individually labeled the nurse is to place the open date or expiration date on it. V25 stated that once the vial is open the use by date shortens and the date that is placed on the vial when open lets them know when that is. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Medication Storage policy, dated 8/23/22, documents Policy: The facility stores all drugs and biologicals in a safe, secure, and orderly manner and in accordance with state and federal regulations. It also documents, POLICY INTERPRETATION AND IMPLEMENTATION 2. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 4. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals shall be returned to the dispensing pharmacy or destroyed. 5. Medications shall be administered prior to the manufacturer's expiration date. The CMS Long Term Care Facility Application for Medicare and Medicaid dated 05/19/2024, documents, the facility's Census 83.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32874 Based on observation, interview and record review the facility failed to properly dispose of soiled linens, and cleanse hands between glove changes for 4 of 8 residents (R23, R48, R55 and R37) reviewed for infection control in the sample of 40. Findings include: 1. On 5/20/204 at 11:07AM, during incontinent care V20, Certified Nursing Assistant, (CNA), was providing incontinent care and R3 started, urinating, V20 removed gloves and donned new gloves. V20 did not sanitize hands prior to donning new gloves. R23's Minimum Data Set, (MDS), dated [DATE], documents, that R23 is dependent on staff for toileting. R23's MDS documents, that R23 is frequently incontinent of urine. R23's Care plan dated 04/25/2023, documents R23 is incontinent of Bowel/Bladder, related to Functional. R23's Care Plan documents, intervention dated 04/25/2023, to Clean peri-area with each incontinence episode. 44967 2. R48's Face Sheet, undated, documents R48 was admitted to the facility on [DATE] with the diagnosis of Brown-Sequard Syndrome, Hemiplegia and Hemiparesis, Intervertebral disc disorders with myelopathy, Arthropathy, Morbid Obesity, Bronchitis, Hypertension (HTN), Heart Failure, and Benign Prostatic hyperplasia (BPH) with Urinary Tract symptoms. R48's Care Plan, dated 2/27/23, documents R48 has impaired urinary elimination related to (r/t) obstruction of urethra r/t BPH. R48 is unable to use a urinal and will often place towels between my legs to urinate on. R48 can make staff aware of my needs and when this has occurred. It continues R48 needs assist with his Activities of Daily Living (ADLs) r/t weakness, decreased endurance, diagnosis of Hemiparesis and obesity. Interventions: Transfer: (full body mechanical lift) required, Bed Mobility: Two-person assist for pulling resident up in bed; may require one or two-person assist for repositioning in bed depending on resident condition. Bathing: One-person physical assist required. It continues R48 has the potential for impaired skin integrity related to impaired mobility and decrease sensation resulting from hemiplegia. Interventions: Provide peri-care after each episode, R48's Minimum Data Set (MDS), dated [DATE], documents R48 is cognitively intact and is dependent on staff for toileting, dressing, and transfers. R48 is always incontinent of both bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/24 at 12:35 PM, V14, CNA, and V16, CNA, came in to assist R48 to bed via full body mechanical lift to get cleaned up. No hand hygiene was done as V14 donned gloves and began removing R48's pants, which were wet with urine. R48's incontinent brief was unfastened and appeared saturated with urine. R48 rolled to his left side, V14 used wet washcloths, sprayed the cloths with peri-cleaner, and then wiped R48's right buttock and anal area. R48's skin appeared reddened, but no open sore noted. V14 tucked a new incontinent brief under R48, then changed her gloves with no hand hygiene completed in between glove changes. V14 applied moisture cream to R48's buttock and anal area. R48 was rolled back to his back and V14 wiped once under R48's abdominal roll, across his pubic area, once down left groin, once down right groin, around his penis, and around his scrotum. R48 rolled to his right side and the soiled brief and pad were removed. There was no wiping of R48's left buttock when he was on his right side. R48 was rolled back to his back side and onto the new brief. V16 provided powder to R48's abdominal roll, groins, and pubic area. Supplies were gathered, and both CNAs doffed their gloves with no hand hygiene done prior to leaving the room. Neither CNA did hand hygiene prior to or after resident care. 3. R55's Face Sheet, undated, documents R55 was originally admitted to the facility on [DATE] with the diagnosis of Dysphagia, Congestive Heart Failure (CHF), Lumbar Spondylosis, Chronic Kidney Disease-stage 3, HTN, Urinary Tract Infections (UTI), and Osteoarthritis. R55's Care Plan, dated 10/16/23, documents R55 has a self-Care Deficit as evidenced by: Needs assistance with ADLs. Interventions: Toilet Use: Two-person physical assistance required, Transfer: Mechanical lift required with two staff assist. R55's MDS, dated [DATE], documents R55 has a severe cognitive impairment and is dependent on staff for toileting, bathing, dressing, and transfers. R55 is always incontinent of both bowel and bladder. On 5/19/24 at 10:38 AM, V8, CNA, and V9, CNA, was seen getting R55 cleaned up and dressed for lunch. V8 did not do hand hygiene prior to donning gloves and caring for R55. V8 initially brought in a couple washcloths, ran the sink water in the restroom to get it warm, wet the washcloth and then placed it over the headboard. R55's pants were pulled down and her incontinent brief was unfastened and tucked between her legs. V8 wiped each groin once and once across pubic area, stopped and covered R55 up and left the room to get more washcloths. V9 now entered to assist V8 and donned gloves with no hand hygiene done prior to. V8 came back with more towels and washcloths, donned gloves, again without doing any hand hygiene, put washcloths in a plastic bag, added water to bag, then added peri-wash to the cloths in the bag. V8 then wiped R55's pubic area and once down each groin again. V9 had to tell V8 to wipe down the middle of R55's vagina, so V8 got a wet washcloth and very minimally wiped once down the middle with no spreading of the labia. R55 was rolled to her left side, and the incontinence brief was removed, which appeared saturated. V8 wiped R55's buttocks and anal area, and then with the same gloves on, walked to the restroom and opened the door to wet more washcloths in sink, then came out and changed her gloves, no hand hygiene was done. V8 donned gloves and wiped R55's anal area again and use the same gloves again to get a clean incontinence brief and bed pad, then doffed her gloves, and turned R55 to her right side. V9 then wiped R55's left buttock, fastened the incontinence brief, pulled R55's pants up. Both CNAs left R55's room without any hand hygiene completed. 42108 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R37's Care Plan, dated 01/29/2024, documents, R37 has Self-Care Deficit as Evidenced by: Needs assistance with ADLs, (Activities of Daily Living), r/t, (related to), impaired mobility d/t, (due to), recent illness. It also, documents, Personal Hygiene - One-person physical assist required. R37's Minimum Data Set, dated dated [DATE], documents, that R37 is cognitively intact and dependent on staff for toileting. On 05/20/2024, at 10:21AM observed V17, Certified Nurse Assistant, (CNA), perform incontinent care. R37 was incontinent of urine and bowel. V17 asked R37 to turn over. R37 turned on his left side. Using a wet washcloth, V17 wiped, R37's anal area and threw urine and feces soiled washcloth on floor beside the bed. V17 then applied barrier cream to R37 buttocks. V17 then assisted R37 onto his right side and removed a heavily urine and feces soiled pad and threw it on the floor. V17 then with a dry washcloth wiped the top of R37's left hip and threw it on the floor. V17 then applied clean gown and pulled cover over R37. V17 gathered R37's urine and feces soiled linen from the floor and left the room. The facility's Perineal Care Competency 525, not dated, documents 12. Male perineal care a. If resident is soiled with feces, place him on side and clean perineum and rectal area. b. Change water and discard soiled linen appropriately. The facility's Handwashing/Hand Hygiene policy, not dated, documents Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with blood or bodily fluids; k. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; l. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. It also documents Applying and Removing Gloves l. Perform hand hygiene before applying non-sterile gloves. 2. When applying, remove one glove from the dispensing box at a time, touching only the top of the cuff. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.