STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145370	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Rehab & Hlth Care Ctr	11 Hawthorne Lane Sullivan, IL 61951

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. 20892 Based on interview and record review, the facility failed to ensure the residents were informed of and understood their rights, while living in the nursing home. This failure has the potential to affect all 71 residents residing in the facility. Findings include: On 9/11/24 at 11:00 AM, during the resident group meeting, (R10, R12, R38, R40 and R48) stated, No, we don't get our resident rights told to us during Resident Council meetings. We received a booklet when we were first admitted but that was a while ago. Resident Council meeting minutes dated for the month of April, May, June, July, August and September 2024 did not document Resident rights were discussed during the Resident Council meeting. V8, Activity director stated on 9/12/24 at 11:29 AM No I do not go over the Residents Rights in our meetings, The facility's Illinois Long-Term Care Ombudsman Program, Residents' Rights for People in Long Term Care Facilities, revision date 11/2018 documents As an individual living in a long-term care facility, you retain the same rights as every citizen of Illinois and of the United States. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 9/10/24 documents 71 residents reside in the facility.

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 20892 Based on interview and record review, the facility failed to deliver mail to residents on Saturdays. This failure has the potential to affect all 71 residents residing in the facility. Findings include: On 9/11/24 at 11:00 AM, during the resident group meeting (R10, R12, R38, R40 and R48) were present and stated, We do not get mail on Saturdays. On 9/12/24 at 1:30 PM V1 Administrator stated, The residents do not get the mail on Saturdays due to the post office does not deliver the mail to us on Saturdays. On 9/12/24 at 2:47 PM, V20, Local Post Office Mail Clerk stated, Yes, we deliver mail to the nursing home on Saturdays. We put the mail in their mail box. The facility's Illinois Long-Term Care Ombudsman Program, Residents' Rights for People in Long Term Care Facilities, revision date 11/2018 documents, Your facility must deliver your mail promptly. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 9/10/24 documents 71 residents reside in the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on interview and record review the facility failed to notify a family representative of a decrease in dosage of antipsychotic medication. This failure affected one of one resident (R35) reviewed for family notification on the sample list of 28. Findings include: R35's Minimum Data Set, dated dated dated [DATE] documents R35 has moderate cognitive impairment. R35's Medication Administration Record (MAR) dated September 2024 documents the following: Risperdal (antipsychotic, Risperidone) Oral Tablet, Give 0.25 mg by mouth. three times a day related to Bipolar Disorder, Unspecified Schizoaffective Disorder, (and) Schizophrenia Unspecified. -Start Date 03/26/2024. -D/C (discontinue) Date 09/04/2024. R35's same September MAR documents R35's Risperdal Oral Tablet, give 0.25 mg by mouth, two times a day (decreased frequency, documented three times a day above). Start Date 09/05/2024 at 0800 am. D/C Date 09/09/2024 (Monday) at 1:02 pm. R35's same September MAR documents R35 did not receive the noon dose from 9/5/24, 9/6/24, 9/7/24, or 9/8/24 due to the Physician Order decrease medication noted above. On 9/11/24 at 12:10 pm V15, R35's Family Representative/Guardian stated the following: I was pretty upset this past weekend and talked to (V1, Administrator/Registered Nurse). I came in to visit (R35) Saturday (9/7/24). (R35) was just staring out in space and couldn't talk. I come in several times a week. The past three times she (R35) has been totally out of it, and gets really anxious, with a fixed stare. I don't know what she is seeing. She doesn't talk when she gets like that. When I talked to (V1) Monday (9/9/24), I found out the facility stopped giving (R35) her Risperdal at lunch. They did not call me. I would have immediately told them 'No'. (R35) has been on Risperdal for years. She is [AGE] years old. She functions best when she has been given all her doses (noon Risperdal). They should have called me. On 9/12/24 at 11:15 am V1, Administrator/ Registered Nurse and V2, Director of Nursing both stated the facility did not know they needed the family members approval to decrease R35 Risperdal. V1, Administrator /Registered Nurse stated, The facility got a phone call from (V15, R35's Family Representative) Monday. (V15) said (R35) was throwing things at (V15) when she visited on Saturday. I told her (V15) then, we (the facility) decreased her (R35's) Risperdal. We got an order to put (R35) back on Risperdal TID (three times a day), back from what was the gradual dose reduction attempt to BID (two times a day). We thought we had to do a GDR (gradual dose reduction), no matter what the family would say. The facility policy Notification for Change in Resident Condition or Status dated 12/07/17 documents the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: 1. The facility and/or facility staff shall promptly notify appropriate individuals(i.e., Administrator, Director of Nursing, Physician, Guardian, Health Care Power of Attorney, etc.)' of changes in the resident's condition medical/mental condition and /or status. The same policy documents: Procedure: The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: f. A need to alter the resident's medical treatment significantly. 2. The nurse supervisor/charge nurse will notify the Director of Nursing, Physician, and unless otherwise instructed by the resident the residents next of kin or representative when the resident has any of the afore (above) mentioned situations.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to resolve a resident representative grievance to provide a specialized wheelchair in a timely manner. This failure affects one of one residents (R35) reviewed for grievances on the sample list of 28. Findings include: R35's Minimum Data Set, dated dated dated [DATE] documents R35 has moderate cognitive impairment and requires a wheelchair for mobility. R35's Grievance/Complaint Report signed by V1, Administrator, submitted to the facility by V15, Family Representative/Guardian, dated initially 2/14/24 and also dated as unresolved on 5/15/24 documents the following: Family requested a new wheelchair. Explained to (V15) that public aid (insurance) would pay for a new one every three years and to use (R35's) money for her (R35's) funeral expenses, so (V15) didn't have to pay for it (wheelchair). The same Grievance/Complaint Report signed by V1, Administrator, documents: Change out wheelchair to whatever (R35) wants that day. Explained to (V15) as soon as she can have one through public aid, we would get her (R35) fitted and (sic) a new one (wheelchair). (R35) will tell (MDS above, documents R35 is moderately cognitive impaired). CNA's (Certified Nursing Assistants what she wants and how she wants it (sic) in regard to her w/c (wheel chair). The same grievance documents, Comments: On-going - (R35) is able to get a new w/c in September 2025 (a year from current survey). Date of Communication to Complainant (V15); every week or two. On 09/11/24 at 12:10 pm V15, R35's Family Member/Guardian stated, The wheelchair (R35) had was falling apart. I went to (V1, Administrator) four or more months ago (documented above 02/14/24 and 5/15/24). She (V1, Administrator) has been giving me the run around ever since. I can't tell you how many excuses (V1, Administrator) has come up with. (R35) has been put in whatever wheelchair they can find in the hall. She had been in one (wheelchair) last week and now this one. It is not good. This one is filthy (noted sticky substance on one arm of the wheelchair) and has no padding (confirmed as resident sat slumped in wheelchair bedside, next to V15). I don't know if she will ever get one that fits her (R35) and is comfortable. (V15) turned to (R35) and asked, Does this wheel chair feel comfortable? R35 responded no. V15 then stated, The original one (wheelchair) she had was very nice, in its day. It was padded on the seat and back. It was just getting to small for (R35) and tattered. I really don't get why they can't find something comfortable for her (R35) while we wait to get the new one. We are still waiting. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 12:30 pm V1, Administrator confirmed V15 filed a grievance on behalf of R35, regarding a new specialty wheelchair because R35 had gained a lot of weight and no longer fits in the original specialized wheelchair. V1 stated the facility corporation would not pay for a new wheelchair for R35, due to the corporations financial issues. V1 stated, I am sure, none of the wheelchairs we have here are as comfortable as (R35) previous wheelchair. (R35's) was fitted specifically for her. We have an OT (Occupational Therapy Department) now, that measured (R35) for a new wheelchair, a couple weeks ago. I can get that evaluation (dated 8/28/24, six and a half months after the grievance was filed) for you. R35's Occupational Therapy Evaluation dated 8/28/24 documents: Desired Change in Condition of Risk Area: Customized seating evaluation completed with (private company) seating and mobility presents due to pt (patient) gaining weight and outgrowing chair. Custom chair recommended to accommodate RUE (right upper extremity) ROM (range of motion) limitations, contractures R (right) digit, lateral flexion to right and left cervical rotation, posterior pelvic tilt, obliquity, hip swaying, lateral lean, scoliosis, and inability to fit in old custom chair impacting safety and independence for self-care. (type of wheelchair as follows) Tilt in space with pressure relieving cushion, custom molded seat, leg rests with cushion and support throughout, right arm moveable arm trough to be in place and head /neck support. Skilled OT evaluation only while waiting for chair arrival and custom seat and mold assessment. The facility undated Resident Grievances/Complaint policy documents, Grievance and Complaint investigations shall be completed within 15 days by the investigator who shall distribute copies of the report to Administrator and Social services Director. The Social Service Director shall keep complete form on file.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 31642 Based on observation, interview and record review the facility failed to remove secured hand mitten restraints according to the plan of care, for one of one residents (R17) reviewed for restraint on the sample list of 28. Findings include: R17's Current Diagnoses Sheet documents the following: Quadriplegia (incomplete, resident can still move her arms as evidenced below) Unspecified, Intracranial Injury With Loss Of Consciousness Of Unspecified Duration, Sequela, Tracheostomy Status, and Gastrostomy Status. R17's Current Physician Order Sheet documents the following: Nursing Intervention: May use Appliances: Wheelchair; Bilateral Full Side rails; Mittens: Trach; Padded Side Rails, No Directions Specified Active as of 10/18/2022. R17's Care Plan dated as revised 8/24/24 documents the following: The resident uses mittens to bilateral hands for safety and prevention of extubating G-Tube/Trach r/t TBI and neurological devastation. Resident frequently pulls (therefore, incomplete quadriplegia) Trach and G-tube. She is unable to fully comprehend the consequences of her actions. Intervention includes: Mittens USE: Apply bilateral mittens and release every 2 (two) hours and prn (as needed). Document mitten use and release as per facility protocol, and the resident needs monitoring, assistance and supervision when mittens are off to ensure G-Tube and Trach are not self-extubated. On 9/11/14 at 11:35 am R17 was seated in the sun room with bulky, padded glove-like pillowed hand mitts on that were securely tied at the wrist. On 9/11/24 at 1:30 pm R17 was lying in bed with bulky, padded glove-like pillowed hand mitts on that were securely tied at the wrist. On 9/11/24 at 1:35 pm V10, CNA confirmed observation of R17 in bed with the same bulky padded glove-like hand mitts on, that were securely tied at the wrist. V10 stated, We don't take (R17's) mitts off except on her shower days, because she will pull out her g-tube. When asked if staff remove R17's glove like mitts every two hour as the care plan directs. V10 stated, No, only on her shower days. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 1:35 pm V1, Administrator/Registered Nurse entered R17's room and removed R17's bulky padded glove-like mitts. R17s fingernails on both hand were long, approximately 1.5 centimeters, smooth shaped, and soiled with a brown substance under each nail. V1 stated R17 likes her nails long and her fingernails get cleaned on showers days and prn (as needed). V1 stated, I can't say what other nurses do, but when I do her (R17's) feeding I take the mitts off for the whole time I'm feeding her. When asked how often R17's Medication Administration Records would document V1 had administered R17's feeding, V1 stated, I don't know, but it wasn't every two hours, like she's care planned to have them off. V1 exited R17's room and was asked if R17 could remove the hand mitten restraints on command, as they prevent her from accessing her upper body and face. V1 re-entered R17's room and asked R17 if she can remove the hand restraint mitts. R17 attempted to remove the hand restraints four times. R17 used her mouth and tried to bite the ties that secured the same bulky padded, pillowed glove-like hand restraint mittens. The bulky padded, pillowed glove-like hand restraint mittens were firmly tied around R17's wrist. R17 was asked, after the four unsuccessful attempts to remove the restraint mittens, if staff remove her hand restraint mittens regularly, R17 shook her head no. The facility PHYSICAL RESTRAINT/ENABLER POLICY dated revised 7/24/2018 documents the following: Definition of Physical Restraint: Physical restraints is any manual method, or physical or mechanical device, equipment or material attached or adjacent to the resident's body, which the individual cannot remove easily and which restricts freedom of movement or normal access to his or her body. A device that may constitute a physical restraint may include, but is not limited to: bed rails, self-release waist restraints, soft waist restraints, lap top cushions, vest restraints, (name brand geriatric)-chair with tray table, arm restraints, leg restraints, personal alarms and hand mitts. Also, physical restraint may include a device which prevents the resident from rising, such as placement of a chair or bed so close to a wall if it prevents the resident from rising out of the chair or voluntarily getting out of bed, placement of a concave mattress so that the resident cannot independently get out of the bed, or using a position change alarm and the resident is afraid to move to avoid setting off the alarm. The same policy documents: 13. Release the physical restraint at minimum of every two hours. During this period resident shall be ambulated (if applicable) repositioned, toileted or changed, and/or skin care and nursing care provided, as appropriate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 20892 Based on interview and record review the facility failed to develop and implement an individualize care plan to include an indwelling urinary catheter for a resident. This failure affects one (R39) of 20 residents reviewed for care plans in a sample of 28. Findings include: The Physician's Orders Sheet (POS) dated September 24 documents R39 has the following diagnosis: Retention of Urine and Unspecified Urinary Tract Infection. The same POS has the order for R39 to have a urinary catheter 16 French with 10 milliliter bulb. Change every 28 days and whenever necessary. The order was dated 8/9/24. R39's care plan dated 9/12/24 did not have a category plan and interventions documented for R39's urinary indwelling catheter. On 9/12/24 at 2:15 PM. V7, Minimum Data Set/Care plan Coordinator stated V1, Administrator told V7 on September 12, 2024 about R39's care plan not covering R39's catheter. V7 corrected the care plan by adding information to the Care plan for R39's catheter care. The facility's policy titled Comprehensive Care Planning with the revision date of 11/1/17 documents under section 1: a. The Comprehensive Care Plan shall be reviewed after each Annual, Significant Change and Quarterly MDS (Minimum Data Set) and revised as necessary to reflect the residents' current medical, nursing, and mental and psychosocial needs as identified by the IDT (Interdisciplinary Team). V1, Administrator stated on 9/12/24 at 1:30 PM stated I told V7 to correct R39's care plan to reflect the use of the urinary catheter.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 31642 Based on observation, interview and record review the facility failed to provided Activities of Daily Living assistance (ADL's) for six out of seven residents (R12, R17, R32, R38, R40 and R48) reviewed for ADL's assistance on the sample list of 28. Finding include: 1. R17's Current Diagnoses Sheet documents the following: Quadriplegia Unspecified, Intracranial Injury with Loss Of Consciousness Of Unspecified Duration, Sequela, Tracheostomy (surgically inserted airway access tube in the neck) Status, and Gastrostomy (surgically inserted feeding tube in the abdomen) Status. R17's Care Plan History form dated 8/2/23 documents the following: PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on 1-2 staff for personal hygiene and oral care. On 09/10/24 at 10:18 am during the initial tour of the facility, R17 was lying in bed. R17 had a Tracheostomy tube noted on the anterior aspect of her neck. R17 also had Gastrostomy feeding tube and Tracheostomy suction machine set-up on her bedside table. R17 had bilateral hand mitten restraints. R17 was non-verbal. R17 had crusted white matter adhering to her lips. The corners of R17's mouth and lips were cracked and dry in appearance. R17 responded with a head shake no when asked if anyone has cleaned her mouth this morning. R17 then opened her mouth. R17's bottom teeth are covered in dried yellow crusted substance and the mucous membranes of R17's oral cavity are dry and cracked. When asked if her mouth was sore, she shook her head no. When asked if she likes to have her mouth cleaned. R17 nodded her head yes. On 9/11/24 at 10:15 am R17 was reclined in a specialized wheel chair in the day room with other residents. R17 continued with a build-up of a dry crusted substance on her lower teeth. R17's mouth was not all the way open. R17 lips remain crusted. This surveyor whispered to R17 to ask if R17 received mouth care since the day before when this surveyor met R17. R17 shook her head no. On 9/11/24 at 10:20 am V9, Licensed Practical Nurse (LPN) confirmed she is R17's nurse. V9, LPN confirmed R17's mouth condition. V9 stated, Yes, she needs oral care. She bites the swabs we use or won't open her mouth. It is a behavior she has. When asked if she was notified by the CNA's that R17 declined mouth care, V9 stated, No, but I think they document it. On 9/11/24 at 10:25 am V10, Certified Nursing Assistant (CNA) confirmed she is R17's CNA. V10 stated she came in this morning to work at 6:00 am and did not clean R17 mouth. V10 went through R17's dresser drawers and bed side table and confirmed there are no oral care swabs or tooth care product anywhere in R17's supplies. V10, CNA confirmed there are no oral care supplies and stated, I have not seen any swabs in her room for a long time. We should probably get them stocked up in here. She is a g-tube (receives oral intake by Gastrostomy tube) and her mouth is really bad. We do other people's oral care but sometimes (R17) doesn't like it. I don't know if her mouth is sore or not. My guess is it (R17's mouth) probably is. It looks like it would be. V10, CNA stated she nor any other CNA's chart R17 declined oral care. V10 stated, I wouldn't even know where to chart it. We probably should tell the nurse when she refuses. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 11:30 am V11, Psychiatric Nurse Practitioner stated, (R17) is cognitively impaired therefore declining oral care is not a behavior that can be modified by (R17). This is very important for staff to understand. They should be modifying their (staff) behavior to meet the needs of this resident (R17). She is totally dependent on staff for her care. The staff are expected to find out why she is declining. It could be the approach to meet the resident oral care needs, the time of day care it is offered, as simple as the products they are using. Does she have mouth pain? The facility is responsible in meeting all her (R17's) care needs. 35380 2. During the resident group meeting with residents on 9/11/24 at 11:04 AM, R32, R38, R40, R48 stated they do not get showers every week like they are supposed to, and some people have gone three weeks without a shower. Residents stated they should receive a shower/bath twice a week and only receive one. On 9/10/24 at 10:19 AM R12 stated R12 has not had a shower or bed bath, nothing, since she has been here about 3 weeks. On 9/11/24 at 1:30 PM, R12 stated, after asking about R12's shower that morning, I (R12) stated I (R12) feels like a new person after finally getting a shower. On 9/12/24 at 1:11 PM, when V1 was asked about the shower sheets and no documentation on the shower sheets, V1 stated if there is no documentation, they (the baths/showers) were not done. The following residents did not receive these baths/showers: R12 - from 8/7/24-9/14/24, R12 had three out of eleven baths/shower (should have had) given; R32 - from 8/18/24-9/10/24, R32 had three out of seven baths/shower (should have had) given; R38 - from 8/17/24-9/11/24, R38 had three out of seven baths/shower (should have had) given; R40 - from 8/2/24-9/10/24, R40 had six out of twelve (should have had) baths/shower given; R48 - from 8/8/24-9/10/24, R48 had three out of eleven (should have had) baths/shower given. There is no documentation of what was done/offered if a resident refuses a bath/shower. The facility's Bath/Shower Policy dated reviewed 3/20/23, documents to ensure adequate hygiene needs are met and to notify the charge nurse if a resident refuses a bath/shower and why.

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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. 31642 Based on observation, interview and record review the facility failed to assess new, facility acquired Stage II pressure ulcers upon notification, resulting in a delay in initiating a pressure ulcer treatment in a timely manner. This failure affected one of two residents (R14), reviewed for pressure ulcers on the sample list of 28. Findings include: R14's Physician Order Summary (POS) report dated 9/13/24 documents the following diagnoses: Diabetes Mellitus II with Diabetic Polyneuropathy, Spinal Stenosis, Cervicalgia, Obesity, and Unspecified Quadriplegia. There was no pressure ulcer treatment documented in R14's medical record or on R14's POS until after the observations and interviews below. On 9/10/24 at 1:45 pm V4, V5, and V16, Certified Nursing Assistants (CNA) transferred R14 via full mechanical lift from R14's wheelchair to bed. V16 CNA and V5 CNA donned gloves after hand washing, pulled resident pants down to calf while V4 prepared washcloths with no rinse cleaner for urinary indwelling catheter and peri-care. V5 CNA completed catheter care. V5 and V16 repositioned R14 to a left side lying position. R14 was incontinent of feces. V16 and V5 repositioned R14 to a right side lying position during posterior peri-care. R14 had a one half inch long by two inch wide open pressure area on the bony prominence, lateral to R14's buttocks crease. R14 also had a red open slit that extended from R14's coccyx down two and a half inches. V16, CNA stated, He (R14) did have a dressing on the pressure ulcers this morning when I gave him a shower. I (V16) showered him about 7:30 am. I told the nurse. I can't remember which nurse (later identified as V2, Director of Nursing), but I remember telling one of them that the dressing (no documentation in medical record of a current pressure ulcer treatment) was off. On 9/10/24 at 2:25 pm DON assessed R14 coccyx and buttocks pressure ulcers (approximately seven hours after notification by V16, CNA). V2, DON confirmed pressure areas and stated, He (R14) has had areas (pressure ulcers), but they were healed. (confirmed 8/23/24 by Wound Physician note). V2, DON stated,I know (R14) had his shower this morning and the CNA (V16) told me he had open areas. I probably should have look at his butt (buttocks) sooner, but I was working the floor and passing meds (medication). I just didn't have time to look at them. R14's Skin Assessment Evaluations dated 9/10/24 at 3:50 pm (documented eight hours after identification) documents the following measurements: Coccyx, (marked as) 'other' (measurement) eight centimeters (cm) long by 0.0 centimeters (cm) wide (slit), (and) a Stage II Pressure injury (no location identified, but was observed above, as lateral bony area, to the right buttocks crease) partial thickness skin loss, one centimeter long by .2 (observed approximately two inch, above) wide. The facility policy Decubitus Care/Pressure Areas dated January 2018 documents the following: Policy: 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. Responsibility: Licensed Nursing Personnel (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: 1.) Upon notification of skin breakdown, the QA (Quality Assurance) form for Newly Acquired Skin Condition will be completed and forwarded to the Director of Nursing. 2.) The pressure ulcer will be assessed and documented on the Treatment Administration Record or Wound Documentation Record. The same policy documents: 5.) Documentation of the pressure area must occur upon identification.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 35380 Based on observation and record review, the facility failed to maintain NPO (nothing by mouth) status by administering a medication to a resident with a tracheostomy. This failure affected one resident (R15) during medication pass observation. Findings include: R15's Physician Order Sheet (POS) dated 9/13/24, documents medication administration per G-tube (gastrostomy), crush medications, cocktail and administer s bolus per MD (medical doctor). This same POS documents Gastrostomy tube (G-tube) (placement) 11/1/22, and Tracheostomy (placement) 11/1/22. R15's Dietary Admission/Quarterly Evaluation dated 8/20/24, documents R15 is NPO, tube feeding, diagnosis of Dysphagia, brain injury, and dependent. R15's Care Plan dated 9/13/24, documents R15 is not to have anything by mouth. There is no documentation in R15's Care Plan of R15 having a Tracheostomy. On 9/11/24 at 11:33 AM, V2 Director of Nursing (DON), was observed during a medication pass was giving R15 medications. R15's POS documents an order for Hyoscyamine 0.125 milligrams sublingual, give one tablet twice a day. V2 placed one Hyoscyamine tablet under R15's tongue and proceeded to give R15's other medications per G-tube. V2 then left R15's bedside and washed V2's hands in the restroom. During the time V2 was in the restroom, R15 began coughing, appearing red, and appeared to not be able to catch R15's breath. While R15 was violently coughing out phlegm and the Hyoscyamine tablet came out of R15's mouth. The facility's Medication Administration policy dated Revised 11/18/17, documents one of the seven rights (for nurses) for medication administration include the right route. The article entitled, What Does NPO mean in Medical Terms dated 7/27/24, from Nursing.com, documents NPO means nothing by mouth. NPO is a critical directive in healthcare settings indicating that a patient should not consume any food, beverages, or oral medications, accurate documentation of NPO orders and any changes is vital for continuity of care and if the NPO order needs to be modified, the healthcare provider should update the order and inform the team promptly.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 34058 Based on observation, interview, and record review, the facility failed to employ a qualified Director of Food and Nutrition Services. This failure has the potential to affect nearly all 71 residents residing in the facility, who consume food prepared in the facility kitchen (with the exception of four residents who receive nothing by mouth). Findings include: On 9/10/24 at 9:22 AM, V1, Administrator, confirmed there was no Dietary Manager for the facility. On 9/10/24 at 9:50 AM, V3, Cook, was seen actively managing and directing dietary personnel and food preparation activities in the facility kitchen. V3 stated, I do not have a CDM (certified dietary manager) certificate, all I have is an FSS (food service sanitation) certificate. V3 confirmed the FSS was an 8 hour cooking sanitation training, not managerial in nature. V3 reported not meeting the state requirements for a Director of Food Service (Dietetic Service Supervisor) by further stating, I have no formal training or education, just a GED (graduate equivalency diploma) is about all I have, I have no military experience, I have never taken any kind of 90 hour course, I don't have a CFPP (Certified Food Protection Professional, (CDM equivalent). V3's valid certificate was documented as completing the standards for Food Protection Manager (FSS equivalent). There were food storage, food sanitation, and equipment cleanliness issues identified in the facility kitchen (reference F812). The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 9/10/24 documents 71 residents reside in the facility. On 9/13/24 at 9:30 AM, V1, Administrator, and V2, Director of Nursing, conferred and agreed, There are four residents (R2, R15, R17, and R49) who are NPO (nothing by mouth) and never receive a meal tray.

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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. 34058 Based on observation, interview, and record review, the facility failed to implement food storage and leftover tracking processes, failed to maintain bulk food cleanliness, and failed to maintain kitchen equipment cleanliness to prevent the potential for food contamination. These failures affect nearly all 71 residents residing in the facility who consume food prepared in the facility kitchen (all with the exception of four residents who receive nothing by mouth). Findings include: On 9/10/24 at 10:00 AM, there were no dates on the food items stored in the facility dry storage area to indicate when the items were received. V3, Cook, stated, We are supposed to be using a 'first in first out' rotation, we really should be dating everything when received but it really just depends on who puts things away. On 9/10/24 at 10:05 AM, there was a rolled plastic bag of partially used mixed salad in the facility's walk-in refrigerator which was not dated or labeled to indicate when the bag was opened, nor when the contents should be used by. V3 stated, We are supposed to be dating all leftovers, we really just try to not keep any leftovers, so I don't know who put that in there. On 9/10/24 at 10:10 AM, the microwave interior was splattered with numerous spots of an unidentified dark red substance. When questioned what the substance was, V3 stated, I don't know exactly what that is either (tomato soup, barbeque sauce, spaghetti sauce) but a lot of times we come in and go to use the microwave and there is stuff all over from someone else. On 9/10/24 at 10:10 AM, there was an 8 ounce plastic cup inside the bulk sugar bin in direct contact with the sugar. V3 stated, We should not leave anything in there, that should not be in there, almost every day I have to come in and take a cup out of the sugar or flour. On 9/12/24 at 10:40 AM, there was a 6 ounce Styrofoam bowl in the bulk flour bin in direct contact with the flour. Also noted was a large pan of gravy cooking on the range with a smaller pan of flour next to it. At 11:20, V1, Administrator, removed the Styrofoam bowl from the bulk flour and asked V16, Cook, if it was him who left the foam bowl in the flour. V16 responded, I used the bowl to scoop the flour today. On 9/12/24 at 10:40 AM, there were copious strands of lint and dust covering and hanging from the fire suppression outlets under the range hood, directly above the cooking gravy. There were copious clumps of lint and dust along, and hanging from, the 7 foot length of the central grease track under the range hood, and copious amounts of stranded and clumped lint and dust on, and hanging from, the fire suppression supply pipes and heat sensor. V1, Administrator, stated, Life safety just wrote me for that same thing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy Food Storage dated 10/2020 documents, All items will be dated upon receipt to ensure stock is rotated properly. This same policy documents, Store leftovers in covered, labeled, and dated containers. This policy documents, Do not leave serving utensils or tools in food containers. The facility's policy Refrigerator and Freezer Storage dated 10/2014 documents, Place any item to be stored in correct sized container, cover all containers. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 9/10/24 documents 71 residents reside in the facility. On 9/13/24 at 9:30 AM, V1, Administrator, and V2, Director of Nursing, conferred and agreed, There are four residents (R2, R15, R17, and R49) who are NPO (nothing by mouth) and never receive a meal tray.

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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. 31642 Based on observations, interviews and record review the facility failed to implement enhanced barrier precautions that required personal protective equipment to be used during care for residents with Tracheostomy airway access, Gastrostomy feeding tubes, pressure ulcers, urinary catheters and intravenous access port. This failure affected five of five residents (R12, R14, R15, R39 and R62) reviewed for enhanced barrier precautions on the sample list of 28. Findings include: 1.) On 09/10/24 at 9:30 am R14 seated in a bedside recliner. R14 has an indwelling urinary catheter bag attached to the foot rest of the recliner. The urine in R14's urinary catheter tubing is cloudy with an excessive amount of sediment present. R14 does not have an Enhanced Barrier Precaution (EBP) signage posted in or out side R14's room to alert staff entering R14's room to provide care. There is no Personal Protective Equipment (PPE) set up of equipment present inside or outside R14's room, that staff are required to wear during care. On 9/10/24 at 1:45 pm V4, V5, and V16, Certified Nursing Assistants (CNA) transferred R14 via full mechanical lift from R14's wheelchair to bed. V16, CNA and V5, CNA donned gloves after hand washing but did not don gowns. V5, CNA completed R14's indwelling urinary catheter care removing and donning gloves when appropriate but did not wear gowns. V5 and V16, CNA's repositioned R14 to a left side lying position. R14 was incontinent feces. V5, CNA and V16 continued posterior peri-care without gowns on. As V16 and V5 repositioned R14 to a right side lying position during posterior peri-care, R14 had two pressure ulcers, one on R14's coccyx and one on his right inner buttocks. V5 went to notify V2, Director of Nursing (DON) of the pressure ulcers. V4, CNA squatted down to the floor. V4, CNA opened the valve on R14's indwelling urinary catheter bag and emptied R14's urinary catheter bedside drainage bag into a plastic graduate measuring container. R14's cloudy urine, that contained an excessive amount of sediment, splashed against the sides of the measuring graduate and measured 450 cubic centimeters. V4, V5, and V6, CNA's remained in R14's room, without gowns on, to assist V2, DON with positioning R14 during pressure ulcer assessment and measurement. On 9/10/24 at 2:25 pm V2, DON entered R14's room without a gown. V2, DON washed her hands and donned gloves but did not don a gown. V2 confirmed open areas and stated R14 has had previous pressure ulcers in the same areas which had recently healed. V2 measured R14's newly opened pressure ulcer, washed her hands and left the room to obtain a physician order pressure ulcer treatments. O 9/10/24 at 2:35 pm V2, DON confirmed the V4, V5, V6, CNA's and herself did not wear gowns. V2 stated V2 did not feel gowns were necessary during R14's care. 35380 2. R12's Physician Order sheet (POS) dated 9/1/24-9/30/24, documents change midline (intravenous access) dressing weekly and as needed and every night for placement. 3. R15's POS dated 9/1/24-9/30/24, documents Tracheostomy, change every 90 days and as needed and enteral feeding (g-tube) twice a day at 60 milliliters (ml) an hour for sixteen hours a day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R39's POS dated 9/1/24-9/30/24, documents (name brand urinary indwelling catheter) output every shift. 5. R62's POS dated 9/1/24-9/30/24, documents enteral feed (g-tube) twice a day. Throughout the survey 9/10/24-9/12/24 there were no signs posted to guide staff to follow Enhanced Barrier Precautions and don and doff Personal Protective Equipment (PPE) during care. On 9/12/24/ at 10:10 am V1, Administrator stated, The reason why the residents are not in isolation (enhanced barrier precaution) is due to, it would be the whole building, except seven residents. The CNA's would be in gowns their entire shift. The facility's Enhanced Barrier Precautions (EBP) Policy dated 7/13/23, documents EBP should be used when contact precautions do not apply for residents with the following: Indwelling Medical Devices and Opened Wounds that Require Dressing Changes. This policy also documents that EBP require use of a gown and gloves during high contact care activities that provide opportunities for the transfer of MDRO's (Multidrug-resistant Organisms) to staff hands and clothing. This policy also documents high-contact care activities include: caring for medical devices such as central lines, ports, urinary catheters, feeding tubes, tracheostomies, drainage tubes, incontinence/toileting, and wound care.