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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Oakview Nursing & Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 1320 West 9th Street Mount Carmel, IL 62863 | |

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) |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765</p> <p>Based on observation, interview, and record review, the facility failed to ensure the shower rooms on 200 and 500 hall had hot water. This has the potential to affect all residents residing on halls 200 and 500.</p> <p>Findings Include:</p> <p>On 11/19/24 at 11:00 AM, this surveyor's and the facility's digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit.</p> <p>On 11/19/24 at 11:03 AM, V1 (Regional Director of Operations) checked the water temperatures in the shower room at the shower head using a cup to hold the water on the 500 hall, and the reading was 79.7 degrees Fahrenheit.</p> <p>On 11/19/24 at 11:22 AM, V1 checked the water temperature in the shower room at the shower head using a cup on 200 hall, and the reading was 84.5 degrees Fahrenheit.</p> <p>R3's Admission Record, with a print date of 11/20/24, documents R3 was admitted to the facility on [DATE] with diagnoses that include diabetes, morbid obesity, neuromuscular dysfunction, and chronic pain syndrome.</p> <p>R3's MDS (Minimum Data Set), dated 10/18/24, documents a BIMS (Brief Interview for Mental Status) score of 15, indicating R3 is cognitively intact. This same MDS documents R3 requires substantial/maximal assistance with showers.</p> <p>On 11/20/24 at 9:48 AM, R3 stated the water in her shower in her room was warm enough to take a shower some days and not on other days. R3 stated regional staff and V33 (Maintenance Director) had worked on it recently, and it was currently warm enough to shower, but that it typically would go back to being cold after a few days. R3 stated she was hopeful it was fixed this time. R3 stated when it wasn't working, the facility staff would have to take her to another hall to shower, since the common shower room on her hall did not have hot water either. R3 stated when they took her to another hall to shower, she would have to go through the common area where visitors and other residents sat and it was degrading. R3 stated the shower on her hall hadn't worked for awhile.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>R11's Admission Record, with a print date of 11/21/24, documents R11 was admitted to the facility on [DATE], with diagnoses that include traumatic brain injury, major depressive disorder, need for assistance with personal care, and reduced mobility.</p> <p>R11's MDS, dated [DATE], documents a BIMS score of 15, indicating R11 is cognitively intact. This same MDS documents R11 is dependent on staff for showers.</p> <p>On 11/19/24 at 1:51 PM, R11 stated they didn't have hot water in the shower room on his hall. R11 stated the facility staff would take him to another hall to shower.</p> <p>On 11/20/24 at 1:40 PM, V31 (LPN/Licensed Practical Nurse) stated they did have hot water most places, but she had complaints that one hall didn't have hot water.</p> <p>On 11/20/24 at 2:37 PM, V32 (CNA/Certified Nursing Assistant) stated they sometimes have hot water. V32 stated she couldn't remember the last time they could use the shower on 500 hall.</p> <p>On 11/20/24 at 2:52 PM, V33 (Maintenance Director) stated they had some issues with the hot water in the shower rooms on the 200 and 500 hall. V33 stated the highest he could get the temperature of the water in the 500 hall shower was 89 or 90 degrees Fahrenheit. V33 stated he has been working on the hot water for the 500 hall shower room for about a month. V33 stated he would get the temperature where it should be and it would stay for a couple of days, and then it would get cold again.</p> <p>The facility Matrix, dated 11/14/24, documents 18 residents reside on the 200 hall, and 13 residents reside on the 500 hall.</p> <p>The facility Water Temperatures, Safer of Policy, dated December 2009, documents, Tap water in the facility shall be kept within a temperature range to prevent scalding to residents. Policy Interpretation and Implementation 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than (no temperature documented), or the maximum allowable premature per state regulation .</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765</p> <p>Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 1 of 3 (R12) residents reviewed for abuse in the sample of 42.</p> <p>Findings Include:</p> <p>A facility Initial Report on R12 documents, On 10/28/24 at approximately 0830 am (8:30 AM), CNA (Certified Nursing Assistant) reported that she witnessed an unwanted contact between resident and staff member to his right shoulder. The resident was immediately assessed for injuries and none noted. The staff member was immediately removed from the floor and schedule until further notice. The PCP/POA/Police Department (primary care physician/power of attorney) and other reporting authorities notified Under investigation the report documents, The investigation in to this matter was conducted, and this is the result and final report. The alleged abuser (Activity Director/V6) was interviewed and she provided a statement saying that she walked by R12 and he reached out and slapped her on the bottom. She stated that she tapped him on the shoulder and exclaimed (R12), but did not do it with the intention of hurting him or in any mean fashion. As noted in the initial she was sent home on suspension once the statement was taken. After receiving that statement a review of the video in that area was conducted. There appears to have been an issue with the network during the time that the incident occurred and none of the cameras were functioning. After discovering the issue with the video the CNA that witnessed and reported the incident was interviewed. According to her when (R12) smacked the Activity Director (V6) on the bottom she turned and made contact with his shoulder. The Activity Director is still suspension and will be terminated. Consider this the final report on this incidents. The resident remains at his baseline.</p> <p>On 11/14/24 at 1:00 PM, V15 (CNA) stated she was walking up to the nurse's station when she observed R12 hit V6 (Activities Director) on her hip, and V6 hit R12 back on the shoulder. V15 stated she immediately told V2 (Director of Nursing) what had happened. V15 stated R12 was checked after the incident, but no one told her if there was an injury. V15 stated R12 had hit staff before, but he does it in a playful way. V15 stated she couldn't say if it was abuse, but she knows she is R12's advocate, so she reported it.</p> <p>On 11/21/24 at 1:51 PM, V2 (Director of Nursing) stated V15 (CNA) reported to her V6 (Activities Director) had hit R12. V2 stated she immediately took the information to V3 (Regional Clinical Director) who started the investigation. V2 stated V6 was immediately removed from contact with R12 and other residents. V2 stated R12 did not have any injury.</p> <p>R12 was observed throughout the survey process, including on 11/14/24 and 11/18/24; R12 was not interviewable and did not show any signs or symptoms of distress.</p> <p>R12's Admission Record, with a print date of 11/12/24, documents R12 was admitted to the facility on [DATE] with diagnoses that include chronic kidney disease, Severe Intellectual Disability, autistic disorder, impulse disorder, bipolar disorder, unspecified speech disturbance, and restlessness and agitation.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R12's MDS (Minimum Data Set), dated 8/30/24, documents R12 has a severe cognitive deficit.</p> <p>R12's current Care Plan documents a Focus area, dated 8/30/24, of, Potential for communication difficulties d/x (diagnosis) I have the mentality of a three year old per my mother, severe intellectual disabilities, autism, anxiety, restlessness/agitation, non-verbal. This Focus area includes the following interventions, .I roll up to staff in my w/c (wheelchair) when I need to be changed. Date Initiated 8/30/24 . This same Care Plan documents a Focus area dated 8/30/24 of, I playfully will slap staff members bottoms, at times I do not realize how hard I slap. I do not mean any harm, I am just playing. The interventions for this Focus area all dated 8/30/24 are, Caregivers to provide opportunity for positive interaction and attention .I enjoy hugs and smiles from staff .Remove the resident from situations that may affect others negatively .Reward the resident for appropriate behavior .Speak to me in a calm, gentle voice if I slap too hard .</p> <p>The facility Abuse Prevention Policy and Procedures, dated 8/16/2019, documents, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, 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, neglect or abuse of our residents</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>32765</p> <p>Based on interview and record review, the facility failed to ensure residents were free from misappropriation of funds for 25 of 26 (R2, R5, R11, R21-R42) residents reviewed for misappropriation of funds in the sample of 42.</p> <p>Findings Include:</p> <p>A facility Initial Report documents: Date of incident 11/4/24. Under Status: At approximately 7:25 a (7:25 AM) it was reported by surveyor (name of surveyor) that she had a complaint about Administration at the facility stealing money. There were no specifics to the complaint, but the facility has opened an investigation into this matter. At this point there have been no reports of missing money. Quarterly trust statements were sent out on October 1, 2024, with no concerns reported. Investigation started, Medical Director, Local Police and Ombudsman have been notified. Final report will be sent within 5 days . After reviewing the trust, resident ledger, deposits, withdraw batches and bank statements, we do find some discrepancies with the trust. The local police have been updated on the findings at this point. Administrator (V4), resigned on, 10/18/24, and Business Office Manager, (V5) was terminated on 10/21/24, for theft of company time. We found that the Administrator (V4) was manually adding time to the Business Office Managers payroll on days that she did not work. After receiving a complaint from (State Survey Agency) on November 4th regarding the trust, a thorough investigation began. As stated, we have found some discrepancies with the trust account and are cooperating with the local police Administrator (V4) was removed from the account at the time of resignation, everyone authorized to sign from the trust account has been removed except Owner/CEO (Chief Executive Officer) (V37) .Final Report A complete audit of the resident trust fund was completed and it was noted that several residents had purchases listed in their account that the facility did not have the proper receipts for the transaction in question. The review of the entire trust fund revealed a total of \$5,124.97 unaccounted for by receipts. The entire amount was replaced by the facility. All POA's (Power of Attorney's), Family members and responsible parties were notified of the situation and informed that the facility replaced the funds. This is the final report on this incident.</p> <p>A spreadsheet titled, (name of facility) Trust Fund documents the following discrepancies in the resident trust fund accounts, R11-\$1627.37, R21 - \$166.72, R22- \$139.68, R23 - \$33.76, R24- \$47.20, R25 - \$16.99, R2 - \$121.09, R26 - \$74.06, R5 - \$81.81, R27 - \$117.33, R28 - \$216.48, R29 - \$57.21, R30 - \$143.79, R31 - \$129.85, R32 - \$14.88, R33- \$26.75, R34 - \$1826.00, R35 - \$138.00, R36 - \$18.00, R37 - \$18.00, R38 - \$28.00, R39 - \$18.00, R40 - \$18.00, R41- \$18.00, R42 - \$28.00.</p> <p>On 11/4/24 at 6:35 AM, V3 (Regional Clinical Director) stated they hadn't had any reports of resident funds missing. V3 stated they did discover V4 (former Administrator) added time to V5 (former Business Office Manager) time card that she hadn't worked. V3 stated V5 was terminated and V4 resigned.</p> <p>(continued on next page)</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>On 11/18/24 at 10:03 AM, V1 (Regional Director of Operations) stated they did discover there were amounts out of resident trust funds with no receipts to account for them. V1 stated they started the investigation and V4 (former Administrator) came to the facility to talk with him, and then went to the local police to talk with them. V1 stated the funds have all been put back into the accounts and are no longer missing. V1 had a check in his hand from V4 to replace the missing funds. V1 stated the amount that was was not able to be accounted for and was replaced was \$5,124.00.</p> <p>On 11/18/24 at 11:22 AM, when asked about the allegations of misappropriation of resident funds, V4 (former Administrator) stated she had a need and saw an opportunity to take the funds. V4 stated then it just got out of hand. V4 stated she came to the facility this morning and paid in full the amount V37 (CEO/Owner) said was owed. V4 stated no one else was knowingly aware of or involved in taking the resident funds.</p> <p>On 11/19/24 at 9:41 AM, when asked about money being taken from his trust found account by a staff member and replaced, R24 who was alert and oriented, stated he didn't have any issues or concerns with his money being taken.</p> <p>On 11/19/24 at 9:50 AM, when asked about money being taken from her trust found account by a staff member and replaced, R25 who was alert and oriented, stated she didn't have any issues or concerns with staff taking her money.</p> <p>On 11/19/24 at 1:51 PM, when asked about money being taken from his trust found account by a staff member and replaced, R11 who was alert and oriented, stated he didn't have any concerns with his money being taken by staff.</p> <p>On 11/19/24 at 2:25 PM, when asked about money being taken from his trust found account by a staff member and replaced, R37 answered yes/no questions, and answered no when asked if she had any concerns/issues with anyone taking her money.</p> <p>The facility Abuse Prevention Policy and Procedures, dated 8/16/2019, documents, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, 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, neglect or abuse of our residents</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765</p> <p>Based on interview and record review, the facility failed to ensure allegations of misappropriation of resident funds was reported to the Administrator for 1 of 26 (R4) residents reviewed for misappropriation of funds in the sample of 42.</p> <p>Findings Include:</p> <p>R4's Admission Record documents R4 was admitted to the facility on [DATE], with diagnoses that include diabetes, pressure ulcer, anxiety disorder, and difficulty walking. R4's Minimum Data Set, dated dated [DATE] documents R4 has a Brief Interview for Mental Status score of 15, which indicates R4 is cognitively intact.</p> <p>An undated facility Initial Report documents, Date of incident: unknown: I received a report from a state surveyor that one of our residents (R4) is reporting having money missing from his wallet. After speaking with the surveyor I went to (R4's) room and asked him when this occurred and he told me one time was ten days ago and another time was Thursday of last week. This is the initial report with investigation and final to follow. This same report documents under Final Report: After notifying local police, Ombudsman, and POA (Power of Attorney) an investigation was started into this incident. Staff was interviewed and no one had any information on where the money went. The resident was also interviewed for specifics regarding the missing money. The facility video was also reviewed and provided no indication on what happened to the money. (R4) originally said that he had a total of 140.00 dollars taken from him involving two separate times within a fairly close period of time. (R4's) son informed us that he believes he probably gave his father the 100 dollars but reports not knowing anything about the other 40.00 that his father says is missing. The facility has replaced the 100.00 and at this time have not been able to determine what happened with the original 100.00. This report form was completed by V1 on 11/7/24.</p> <p>On 11/14/24 at 1:43 PM, V17 (LPN/Licensed Practical Nurse) stated R4 reported to her on Sunday (11/10/24) that he had money missing. V17 stated she reported the allegation of missing money to V2 (Director of Nursing).</p> <p>On 11/14/24 at 2:53 PM, V1 (Regional Director of Operations) stated he didn't have any investigations related to R4's missing money.</p> <p>On 11/20/24 at 9:45 AM, R4 stated the facility administration had spoke with him concerning the missing money and replaced \$100.00. R4 stated he had reported the money was missing to two different staff members, but was not able to recall their names.</p> <p>On 11/21/24 at 1:51 PM, V2 (Director of Nursing) stated she did not have any recollection of V17 reporting to her R4 was missing money.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765</p> <p>Based on interview and record review, the facility failed to ensure incontinence care was provided timely and shampoo/body wash was readily available for 6 of 6 (R1, R3, R8, R10, R11, and R16) residents reviewed for Activities of Daily Living in the sample of 42.</p> <p>Findings Include:</p> <p>1. R3's Admission Record, with a print date of 11/20/24, documents R3 was admitted to the facility on [DATE], with diagnoses that include diabetes, morbid obesity, neuromuscular dysfunction of the bladder, anxiety disorder, chronic pain syndrome, and pressure ulcer of right buttock.</p> <p>R3's MDS (Minimum Data Set), dated 10/18/24, documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R3 is cognitively intact. This same MDS documents R3 is dependent on staff for toileting hygiene.</p> <p>R3's current Care Plan documents a Focus area of, The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit. Date Initiated: 07/30/2024. This Focus area includes the following interventions. Transfer: Mechanical Lift with staff assist x (times) 2 with all transfers. This care plan does not address R3's bowel and bladder care needs.</p> <p>On 11/4/24 at 8:50 AM, R3 stated it can take up to thirty minutes for the staff to answer call lights. R3 stated she had incontinence episodes a couple of times while waiting for staff to answer the call light.</p> <p>2. R8's Admission Record, with a print date of 11/14/24, documents R8 was admitted to the facility on [DATE], with diagnoses that include fracture of right femur.</p> <p>R8's MDS, dated [DATE], documents a BIMS score of 13, which indicates R8 is cognitively intact. This same MDS documents R8 requires partial/moderate assistance for toileting hygiene.</p> <p>R8's current Care Plan documents a Focus area of, I have episodes of bowel and bladder incontinence r/t (related to) need for assistance with ADL's, ulcerative colitis, hx (history) of UTI's (urinary tract infections), celiac disease, overactive bladder. Date Initiated: 10/17/2024. This Focus area includes the following interventions, .Incontinent: Check every two hours and as required for incontinence Date Initiated: 10/17/2024 .Answer call light promptly. Date Initiated: 10/17/2024 .</p> <p>On 11/14/24 at 11:37 AM, R8 stated it takes forever for staff to come to the room when she needs something. R8 stated she has pooped and peed on herself waiting for them.</p> <p>3. R16's Admission Record, with a print date of 11/20/24, documents R16 was admitted to the facility on [DATE], with diagnoses that include chronic respiratory failure, morbid obesity, heart failure, shortness of breath, and need for assistance with personal care.</p> <p>R16's MDS, dated [DATE], documents a BIMS score of 15, indicating R16 is cognitively intact. This same MDS documents R16 is dependent on staff for toileting hygiene.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>R16's current Care Plan documents a Focus area of, The resident has an ADL Self Care Performance Deficit. Date Initiated: 07/30/2024. This Focus area includes the following intervention, Transfer: Mechanical lift with staff assist x 2 with all transfers. Date Initiated: 07/30/2024. This Care Plan does not address R16's toileting care needs.</p> <p>On 11/4/24 at 8:37 AM, R16 stated, Yeah, they don't seem to care if I am sitting in piss. I sat for two hours from 5:00 to 7:00 PM. R16 stated she told staff she had to go and no one responded because they were getting the residents from the dining room first. R16 stated they would come in and turn her call light off and then never come back.</p> <p>On 11/4/24 at 5:05 AM, V7 (CNA/Certified Nursing Assistant) stated staffing isn't too good. V7 stated when they only have one CNA on a hall, call lights aren't answered timely.</p> <p>On 11/4/24 at 5:19 AM, V9 (CNA) stated they had five halls and one CNA per hall. V9 stated when they only have one CNA per hall, the residents needs aren't met timely. When asked what needs weren't met timely, V9 stated bed checks get done late.</p> <p>On 11/14/24 at 1:52 PM, V18 (CNA) stated he spoke with V2 (Director of Nursing/DON) last week about the hall that he normally works on. V18 stated the hall has vocal, needy residents. V18 stated when he is providing care for the more vocal residents, the other residents have to wait.</p> <p>On 11/14/24 at 2:03 PM, when asked if they had enough staff to meet the needs of the residents timely, V20 (CNA) stated they didn't. V20 stated when they only have one CNA per hall then they have to help each other out, which puts them behind providing timely care for the residents on their hall. V20 stated incontinence care is not provided timely and call lights aren't answered timely.</p> <p>On 11/14/24 at 2:23 PM, V21 (CNA) stated they don't have enough staff to provide timely care. When asked what care wasn't provided timely, V21 stated incontinence care was not provided timely.</p> <p>On 11/14/24 at 2:27 PM, V22 (CNA) stated incontinence care was not provided timely when they had one CNA working on each hall.</p> <p>On 11/20/24 at 3:14 PM, V34 (Assistant Director of Nursing) stated there are times they only have one CNA working on each hall.</p> <p>On 11/21/24 at 10:17 PM, V36 (Registered Nurse) stated she works night shift and most nights they have one CNA per hall. V36 stated if they have anyone call in then they are short handed and it makes it harder to provide timely care, including incontinence care.</p> <p>On 11/21/24 at 1:51 PM, when asked if one CNA per hall was enough to meet the needs of the residents timely, V2 (Director of Nursing) stated she believed that changed daily. V2 stated she was sure it didn't feel like enough staff to accommodate them. V2 stated two minutes can seem like twenty, and twenty minutes can seem like two hours. When asked if she had any reports of staff not being able to provide timely care, V2 stated she had not had any complaints they weren't able to complete a specific task. V2 stated she tries to have extra staff during hours that it is needed. V2 stated it was hard to judge with CNA's since we all gripe and complain.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>The facility undated Perineal Care policy documents. The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation and to observe the resident's skin condition.</p> <p>4. R1's Admission Record, with a print date of 11/20/24, documents R1 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, cardiac arrhythmia, atrial fibrillation, and weakness. R1's MDS, dated [DATE], documents a BIMS score of 04, which indicates a severe cognitive deficit. This same MDS documents R1 is dependent on staff for showers.</p> <p>R10's Admission Record, with a print date of 11/21/24, documents R10 was admitted to the facility on [DATE] with diagnoses that include osteomyelitis, diabetes, contractures of muscle, and Alzheimer's disease. R10's MDS, dated [DATE], documents R10 has a severe cognitive deficit. This same MDS documents R10 is dependent on staff for showers.</p> <p>R11's Admission Record, with a print date of 11/21/24, documents R11 was admitted to the facility on [DATE] with diagnoses that include traumatic brain injury, major depressive disorder, need for assistance with personal care, and reduced mobility. R11's MDS, dated [DATE], documents a BIMS score of 15, indicating R11 is cognitively intact. This same MDS documents R11 is dependent on staff for showers.</p> <p>On 11/19/24 beginning at 2:34 PM, the facility storage supply closets including the clean utility rooms were observed with V2 (Director of Nurses) present throughout the observations. There were no bottles of shampoo body wash observed in the brief room, the clean utility room on the 500 hall, and the clean utility on the 600 hall. There was one bottle of shampoo/body wash located in the clean utility room on the 300 hall, and one bottle located in the clean utility room on the 200 hall. There were large bottles of body wash/shampoo located in the shower room on the 400 hall that appeared to have been purchased at a local store.</p> <p>On 11/19/24 at 2:48 PM, V27 (Unit Director) stated the body wash located in the shower room on the 400 hall had been purchased by staff and/or family. V27 stated she wasn't sure how long it had been since they had facility purchased shampoo/body wash on the 400 hall.</p> <p>On 11/19/24 at 2:44 PM, V35 (CNA/Certified Nursing Assistant) stated she brings her own shampoo and body wash into the facility to use, and denied issues with supplies.</p> <p>On 11/19/24 at 2:51 PM, V24 (CNA) stated they have some body wash/shampoo in resident rooms and in the brief room. V24 stated they sometimes have issues with having enough wipes, but they usually have enough shampoo/body wash.</p> <p>On 11/19/24 at 2:53 PM, V2 (Director of Nursing) observed R1's room including in his bathroom, bedside table, and dresser drawers, with no shampoo/body wash located.</p> <p>On 11/19/24 at 2.55 PM, R10 and R11's room was observed by V2 (DON) including the bathroom, bedside table, and dresser drawers, with no body wash/shampoo located.</p> <p>On 11/19/24 at 2:55 PM, V2 (DON) stated they should have body wash/shampoo, and two bottles would not be enough for the residents currently residing at the facility, but she was sure they had more in other resident rooms.</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions were implemented to prevent pressure ulcers and hand hygiene was performed per current standards of practice when administering treatments for 3 of 3 (R1, R4, and R7) residents reviewed for pressure ulcers in the sample of 42.</p> <p>Findings Include:</p> <p>1. R1's Admission Record, with a print date of 11/20/24, documents R1 was admitted to the facility on [DATE], with diagnoses that include Alzheimer's Disease, atrial fibrillation, urinary incontinence, weakness, and dementia.</p> <p>R1's MDS (Minimum Data Set), dated 11/8/24, documents a BIMS (Brief Interview for Mental Status) score of 04, which indicates a severe cognitive deficit. This same MDS documents R1 is at risk for pressure ulcers with treatments documented as pressure reducing device for chair and bed, turning and repositioning program, and application of ointments/medications.</p> <p>R1's current Care Plan documents a Focus area of, The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit. Date Initiated: 08/09/2024. This Focus area includes the following interventions; . Bed Mobility: Substantial/maximal assist. Date Initiated: 08/31/2024 .Transfer: The resident requires total assistance with transfers. Date Initiated: 08/31/2024 R1's current Care Plan does not address how often R1 should be repositioned to prevent skin breakdown.</p> <p>R1's Braden Scale for Predicting Pressure Score Risk, dated 8/9/2024, documents a score of 16, indicating R1 is at low risk of skin breakdown.</p> <p>On 11/18/24 at 10:53 AM, R1 was observed with V23 (Licensed Practical Nurse/LPN/Infection Preventionist/IP) present. R1 was sitting in his wheelchair and was assisted to a standing position by V25 (CNA/Certified Nursing Assistant) and V23 (LPN/IP). R1 had a bowel movement, so they assisted him to lay down and provided incontinence care. R1 had a red area on his right hip. V23 pressed on the red area, and the area did not blanch. V23 stated R1 had probably been sitting in his wheelchair since he got up that morning. V23 stated if day shift got R1 up, it would have been between 6:30 and 7:00 AM.</p> <p>On 11/18/24 at 11:10 AM, V24 (CNA) stated she was the CNA providing care to R1 that morning. V24 stated R1 was up in his wheelchair when she arrived to the facility at 6:00 AM. V24 stated she pushed R1 to breakfast and then left the facility and went to class. V24 stated V25 (CNA) covered her hall while she was gone. V24 stated when she got back from class, right before 10:00 AM, R1 was in the lobby in his wheelchair. V24 stated she took him to his room and was checking and changing residents, but hadn't gotten to R1 yet. V24 stated R1's pressure ulcer preventions were to keep him clean and dry and to turn and reposition him every two hours. V24 stated R1 was not able to reposition himself.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/18/24 at 11:16 AM, V23 (LPN/IP) stated R1 needed to be laid down between meals. When asked why R1 hadn't been put in bed after breakfast, V23 stated she thought the issue was V25 was covering two halls, and was buried in call lights.</p> <p>On 11/18/24 at 2:37 PM, V25 stated she wasn't told she was to cover R1's hall while V24 was gone. V25 stated she had not provided any care to R1 prior to the observation at 10:53 AM.</p> <p>2. R4's Admission Record, with a print date of 11/20/24, documents R4 was admitted to the facility on [DATE] with diagnoses that include diabetes, morbid obesity, hypertension, unstageable pressure ulcer of left heel, and acute osteomyelitis of left ankle and foot.</p> <p>R4's MDS, dated [DATE], documents a BIMS score of 15, which indicates R4 is cognitively intact.</p> <p>R4's current Care Plan documents a Focus area of, I have actual skin impairment to skin integrity/wound Date Initiated: 08/25/2024. The interventions documented for this Focus area include; .Administer treatments as ordered and monitor for effectiveness. Date Initiated: 08/25/2024 .</p> <p>On 11/18/24 at 1:59 PM, V23 (LPN/IP) was observed administering treatment to R4's left heel. V23 removed the old dressing, changed her gloves, cleaned the area with wound cleanser, changed her gloves, applied betadine and a clean dressing and doffed her gloves. V23 did not hand sanitize or wash her hands with each glove change.</p> <p>On 11/18/24 at 2:18 PM, V23 (LPN/IP) stated she didn't perform hand hygiene between glove changes, and it was probably because she was nervous.</p> <p>3. R7's Admission Record, with a print date of 11/20/24, documents R7 was admitted to the facility on [DATE], with diagnoses that include Castleman's disease, dementia, heart disease, hypertension, atria fibrillation, and osteoarthritis.</p> <p>R7's MDS, dated [DATE], documents a BIMS score of 05, indicating R7 has a severe cognitive deficit. This same MDS documents R7 requires substantial/maximal assistance from staff for bed mobility, is at risk for skin breakdown and has the treatments to prevent skin breakdown are documented as; pressure reducing device for chair and bed and application of ointments/medications.</p> <p>R7's current Care Plan documents a Focus area of, Potential for impairment to skin integrity r/t (related to) incontinence, need for assistance with mobility. Date Initiated: 07/01/2024. This Focus area does not include an intervention to turn and reposition. This same Care Plan documents a Focus area of, Potential for episodes of bowel and bladder incontinence Date Initiated: 07/01/2024. The interventions for this Focus area include, Incontinent: Check every two hours and as required for incontinence .Date Initiated: 07/01/2024.</p> <p>On 11/19/24 at 2:32 PM, V38 (Family Member) stated she had cameras in R7's room to monitor his care. V38 stated R7 was assisted up in his wheelchair and taken out of his room for up to 12 hours one day. V38 stated R7 appeared exhausted when he was brought back to his room. V38 stated R7 could sit in his chair for a couple of hours, but then he would begin to get tired.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/20/24 at 3:14 PM, V34 (Assistant Director of Nurses) stated R7's daughter had a concern R7 had been left in his wheelchair for a long period of time. V34 stated she didn't know the outcome of the allegation since she frequently worked the floor and isn't always involved in the outcome of concerns.</p> <p>On 11/21/24 at 1:51 PM, V2 (Director of Nursing) stated she wasn't aware of any concerns related to R7 being left in the wheelchair for a long period of time.</p> <p>The facility Handwashing/Hand Hygiene policy, dated 8/2015, documents, This facility considers hand hygiene the primary means to prevent the spread of infection 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: .after removing gloves .a</p> <p>The facility Prevention of Pressure Ulcers/Injuries policy, dated 7/2017, documents, The purpose of this procedure is to provide information regarding identification of pressure ulcers/injury risk factors and interventions for specific risk factors Mobility/Repositioning 1. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition, and tolerance, and the resident's stated preference. 2. At lease every hour, reposition residents who are chair-bound or bed-bound with the head of the bed elevated 30 degrees or more. 3. At least every two hours, reposition residents who are reclining and dependent on staff for repositioning</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from falls with serious injury, transferred safely with a mechanical lift using two staff members, and fall interventions were implemented to prevent falls for 4 of 4 residents (R3, R4, R8, and R9) reviewed for falls in a sample of 42. This failure resulted in R9 falling backwards out of the transport van approximately three feet onto the ground, which resulted in a fracture of her back in two places.</p> <p>Findings Include:</p> <p>1. R9's Admission Record, with a print date of 11/20/24, documents R9 was admitted to the facility on [DATE], with diagnoses that include diabetes, fibromyalgia, hypertension, and difficulty in walking.</p> <p>R9's MDS (Minimum Data Set), dated 10/11/24, documents a BIMS (Brief Interview for Mental Status) score of 15, indicating R9 is cognitively intact.</p> <p>A facility Initial Report, with an incident date of 11/11/24 for R9, documents, (R9) was transported per facility vehicle to doctors appointment. Upon returning to facility when exiting vehicle resident fell out of van onto concrete. Initial report, investigation and final report in 5 days .Investigation: On 11/11/24, resident was being assisted from the transportation van when she fell backwards from the exit door, coming to land on the ground. Upon interview with the Transportation Aide, it was noted that the ramp was on ground level and not engaged with the van exit door. Further investigation noted the Transportation Aid had just unloaded one of the two residents and did not engage the ramp to the exit door prior to attempting to unload the second resident. The resident was assessed for injury including neuro-checks which were within baseline for resident. Related to complaints of pain, the resident PCP (primary care physician) was notified and orders received to send to the hospital for evaluation. While at the hospital, the resident was noted to have fx (fracture) of T7 and T8. Resident was admitted to the hospital and returned to the facility on [DATE]. Resident has orders for pain management and immobilization brace to be worn per PCP orders. Education on transportation safety was provided to all individuals involved in transportation and any disciplinary action needed has been completed. This is the final report.</p> <p>On 11/20/24 at 1:31 PM, V30 (CNA/Certified Nursing Assistant/Transport Aide) stated she was working the day R9 fell . V30 stated there were two residents in the van. V30 stated she unloaded one of the residents then went back into the van to unload R9. V30 stated she assumed the staff member on the ground raised the lift, but she didn't. V30 stated she pushed R9 out of the van and R9 fell on to the ground back first. V30 stated she jumped out of the van and the other staff member ran to get assistance.</p> <p>On 11/20/24 at 3:14 PM, V34 (Assistant Director of Nursing) stated she was working when R9 fell , but wasn't outside when the incident occurred. V34 stated she came outside afterwards to wait with R9 until the ambulance arrived. V34 stated R9 was laying and talking with the staff until the emergency medical technicians started to move her, and then R9 was screaming and yelling in pain.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/20/24 at 12:54 PM, R9 stated she had been transported to the hospital for an iron transfusion, and when she returned to the facility, there was another resident in the van with her. R9 stated the other resident was in a motorized wheelchair and was gotten off the van first. R9 stated she was facing forward in the van and couldn't see behind her. R9 stated she was pushed out of the van and fell three feet backwards onto the concrete. R9 stated when her head hit the ground it felt like it exploded. R9 stated she still gets dizzy when she gets up. R9 stated she was in a lot of pain when she fell and still is. R9 stated she broke her back in two places. R9 stated she had bruises everywhere. R9 stated they decided not to do surgery, but to try the brace first.</p> <p>R9's Progress Note, dated 11/11/24, documents, Note Text: Resident was being unloaded from wheelchair van after appointment, wheelchair ramp was still lowered to the ground, transportation began helping resident to the ramp, not realizing wheelchair ramp was still on the ground, resident than fell in wheelchair backwards off the van to the wheelchair ramp and concrete. EMS (emergency medical services) was contacted immediately for transport, Staff assisted resident to remain in position while awaiting for the (local ambulance company) EMS, vitals obtained, no bleeding noted. (local ambulance company) arrived, stabilized resident to back board, resident was transferred to (local hospital) .</p> <p>R9's local hospital record documents a CT (computed tomography) of R9's lumbar spine, dated 11/11/24. This report documents under Findings: An acute fracture is seen along the superior endplate of T8 extending posteriorly to involve bilateral pedicles are resulting in mild anterior displacement of the vertebral body. There is also a fracture of the anterior osteophyte at T7-8 disc space level. Fracture is unstable. Remaining thoracic and lumbar spine, appears intact. No significant neural compromise is seen. Moderate to marked spondylotic changes are seen in the lower lumbar spine.</p> <p>2. R3's Admission Record, with a print date of 11/20/24, documents R3 was admitted to the facility on [DATE], with diagnoses that include diabetes, morbid obesity, neuromuscular dysfunction of the bladder, anxiety disorder, chronic pain syndrome, and pressure ulcer of right buttock.</p> <p>R3's MDS (Minimum Data Set), dated 10/18/24, documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R3 is cognitively intact. This same MDS documents R3 is dependent on staff for toileting hygiene.</p> <p>R3's current Care Plan documents a Focus area of, The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit. Date Initiated: 07/30/2024. This Focus area includes the following interventions. Transfer: Mechanical Lift with staff assist x (times) 2 with all transfers.</p> <p>On 11/4/24 at 8:50 AM, R3 stated they don't have enough staff to meet the needs of the residents. R3 stated she is currently using a mechanical lift for transfers, but is learning how to use the sliding board. When asked if they had ever only had one staff to transfer her when using the mechanical lift, R3 stated, Unfortunately. When asked if she knew why they only had one staff for the transfer, R3 stated, lack of staff.</p> <p>3. R4's Admission Record, with a print date of 11/20/24, documents R4 was admitted to the facility on [DATE], with diagnoses that include diabetes, morbid obesity, hypertension, unstageable pressure ulcer of left heel, and acute osteomyelitis of left ankle and foot.</p> <p>R4's MDS, dated [DATE], documents a BIMS score of 15, which indicates R4 is cognitively intact.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>R4's current Care Plan documents a Focus area of, The resident has an ADL Self Care Performance Deficit Activity Intolerance, Pain. Date Initiated: 07/30/2024. This Focus area includes an intervention of, Transfer: Mechanical lift with assist x 2 for transfers. Date Initiated: 07/30/2024.</p> <p>On 11/4/24 at 9:01 AM, R4 stated he uses the mechanical lift to transfer. R4 stated sometimes they only have one staff to do it. R4 stated one night one staff came in and got him rolled with the mechanical lift pad under him, laying flat on the bed, left to get help, and didn't come back for 45 minutes. R4 stated his back began to hurt from laying flat so long. R4 stated yesterday they only had one staff to transfer him. R4 stated sometimes they will hand him the control to hit the button while they pull him back in his chair, when they only have one staff for the transfer.</p> <p>On 11/4/24 at 5:05 AM, V7 (CNA/Certified Nursing Assistant) stated he has had to transfer residents who use a mechanical lift by himself at times due to not having enough staff.</p> <p>On 11/4/24 at 5:15 AM, V8 (CNA) stated she has had to transfer residents who use a mechanical lift by herself at times.</p> <p>On 11/4/24 at 5:19 AM, V9 (CNA) states she transfers residents who use a mechanical lift by herself quite often, due to not having enough staff.</p> <p>On 11/14/24 at 1:52 PM, when asked if he had ever transferred a resident who required a mechanical lift by himself, V18 (CNA) stated he signed papers on Tuesday night that he wouldn't.</p> <p>On 11/20/24 at 3:14 PM, V34 (Assistant Director of Nursing) stated there should be two staff transferring residents who require a mechanical lift for transfers.</p> <p>On 11/21/24 at 1:51 PM, V2 (Director of Nursing) stated there should be two staff present when transferring a resident using a mechanical lift. V2 stated she wasn't aware staff were transferring residents with only one staff, and once she became aware of it she retrained staff.</p> <p>The facility Safe Lifting and Movement of Residents policy, dated 7/2017, documents, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate technique and devices to lift and move residents. The policy does not address how many staff should be present to transfer a resident requiring a mechanical lift.</p> <p>4. R8's Admission Record, with a print date of 11/14/24, documents R8 was admitted to the facility on [DATE] with diagnoses that include fracture of right femur.</p> <p>R8's MDS, dated [DATE], documents a BIMS score of 13, indicating R8 is cognitively intact.</p> <p>R8's current Care Plan documents a Focus area of, I have a closed displaced fracture of the right femoral neck r/t (related to) fall prior to entering the facility Date Initiated: 10/09/24. This Focus area documents an intervention of, non skid strips in front of commode. Date Initiated 10/21/2024.</p> <p>On 11/14/24 at 11:37 AM, this surveyor observed R8 sitting on the edge of her bed with a bedside commode sitting next to her bed. The bedside commode had urine and feces in it. There were no non-skid strips on the floor next to or near the bedside commode.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145376 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/25/2024 |
| NAME OF PROVIDER OR SUPPLIER Oakview Nursing & Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 1320 West 9th Street Mount Carmel, IL 62863 | |
| 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) | | |
| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/21/24 at 1:51 PM, when asked why there weren't any non-skid strips in front of R8's commode, V2 (Director of Nursing) stated R8 wasn't using the commode; she was using the bedside commode and they were on the Maintenance Directors list to get put down, but they just hadn't been yet.</p> <p>The facility Falls and Fall Risk, Managing policy, dated 3/2018, documents, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling and to try to minimize complications from falling Resident-Centered approaches to managing falls and fall risk. 1. The staff, with input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765</p> <p>Based on observation, interview, and record review, the facility failed to ensure there was sufficient staff to meet the needs of the residents timely. This failure has the potential to affect all 78 residents currently residing at the facility.</p> <p>Findings Include:</p> <p>The facility Resident Matrix dated 11/14/24 documents 78 residents currently reside at the facility.</p> <p>1. R1's Admission Record, with a print date of 11/20/24, documents R1 was admitted to the facility on [DATE], with diagnoses that include Alzheimer's Disease, atrial fibrillation, urinary incontinence, weakness, and dementia.</p> <p>R1's MDS (Minimum Data Set), dated 11/8/24, documents a BIMS (Brief Interview for Mental Status) score of 04, which indicates a severe cognitive deficit. This same MDS documents R1 is at risk for pressure ulcers with treatments documented as pressure reducing device for chair and bed, turning and repositioning program, and application of ointments/medications.</p> <p>R1's current Care Plan documents a Focus area of, The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit. Date Initiated: 08/09/2024. This Focus area includes the following interventions; . Bed Mobility: Substantial/maximal assist. Date Initiated: 08/31/2024 .Transfer: The resident requires total assistance with transfers. Date Initiated: 08/31/2024 R1's current Care Plan does not address how often R1 should be repositioned to prevent skin breakdown.</p> <p>R1's Braden Scale for Predicting Pressure Score Risk, dated 8/9/2024, documents a score of 16, indicating R1 is at low risk of skin breakdown.</p> <p>On 11/18/24 at 10:53 AM, R1 was observed with V23 (Licensed Practical Nurse/LPN/Infection Preventionist/ IP) present. R1 was sitting in his wheelchair and was assisted to a standing position by V25 (CNA/Certified Nursing Assistant) and V23 (LPN/IP). R1 had a bowel movement so they assisted him to lay down and provided incontinence care. R1 had a red area on his right hip. V23 pressed on the red area, and the area did not blanch. V23 stated R1 had probably been sitting in his wheelchair since he got up that morning. V23 stated if day shift got R1 up, it would have been between 6:30 and 7:00 AM.</p> <p>On 11/18/24 at 11:10 AM, V24 (CNA) stated she was the CNA providing care to R1. V24 stated R1 was up in his wheelchair when she arrived to the facility at 6:00 AM. V24 stated she pushed R1 to breakfast and then left the facility and went to class. V24 stated V25 (CNA) covered her hall while she was gone. V24 stated when she got back from class, right before 10:00 AM, R1 was in the lobby in his wheelchair. V24 stated she took him to his room and was checking and changing residents, but hadn't got to R1 yet. V24 stated R1's pressure ulcer preventions were to keep him clean and dry and to turn and reposition him every two hours. V24 stated R1 was not able to reposition himself.</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>On 1/18/24 at 11:16 AM, V23 (LPN/IP) stated R1 needed to be laid down between meals. When asked why R1 hadn't been put in bed after breakfast, V23 stated she thought the issue was V25 was covering two halls and was buried in call lights.</p> <p>On 11/18/24 at 2:37 PM, V25 stated she wasn't told she was to cover R1's hall while V24 was gone. V25 stated she had not provided any care to R1 prior to the observation with this surveyor at 10:53 AM.</p> <p>2. R3's Admission Record, with a print date of 11/20/24, documents R3 was admitted to the facility on [DATE], with diagnoses that include diabetes, morbid obesity, neuromuscular dysfunction of the bladder, anxiety disorder, chronic pain syndrome, and pressure ulcer of right buttock.</p> <p>R3's MDS (Minimum Data Set), dated 10/18/24, documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R3 is cognitively intact. This same MDS documents R3 is dependent on staff for toileting hygiene.</p> <p>R3's current Care Plan documents a Focus area of, The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit. Date Initiated: 07/30/2024. This Focus area includes the following interventions. Transfer: Mechanical Lift with staff assist x (times) 2 with all transfers. This care plan does not address R3's bowel and bladder care needs.</p> <p>On 11/4/24 at 8:50 AM, R3 stated it can take up to thirty minutes for the staff to answer call lights. R3 stated she had incontinence episodes a couple of times while waiting for staff to answer the call light.</p> <p>On 11/4/24 at 8:50 AM, R3 stated they don't have enough staff to meet the needs of the residents. R3 stated she is currently using a mechanical lift for transfers, but is learning how to use the sliding board. When asked if they had ever only had one staff to transfer her when using the mechanical lift, R3 stated, Unfortunately. When asked if she knew why they only had one staff for the transfer, R3 stated, lack of staff.</p> <p>3. R4's Admission Record, with a print date of 11/20/24, documents R4 was admitted to the facility on [DATE], with diagnoses that include diabetes, morbid obesity, hypertension, unstageable pressure ulcer of left heel, and acute osteomyelitis of left ankle and foot.</p> <p>R4's MDS, dated [DATE], documents a BIMS score of 15, which indicates R4 is cognitively intact. R4's current Care Plan documents a Focus area of, The resident has an ADL Self Care Performance Deficit Activity Intolerance, Pain. Date Initiated: 07/30/2024. This Focus area includes an intervention of, Transfer: Mechanical lift with assist x 2 for transfers. Date Initiated: 07/30/2024.</p> <p>On 11/4/24 at 9:01 AM, R4 stated he uses the mechanical lift to transfer. R4 stated sometimes they only have one staff to do it. R4 stated one night one staff came in and got him rolled with the mechanical lift pad under him, laying flat on the bed, left to get help and didn't come back for 45 minutes. R4 stated his back began to hurt from laying flat so long. R4 stated yesterday they only had one staff to transfer him. R4 stated sometimes they will hand him the control to hit the button while they pull him back in his chair, when they only have one staff for the transfer.</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>On 11/4/24 at 5:05 AM, V7 (CNA/Certified Nursing Assistant) stated he has had to transfer residents who use a mechanical lift by himself at times due to not having enough staff.</p> <p>On 11/4/24 at 5:15 AM, V8 (CNA) stated she has had to transfer residents who use a mechanical lift by herself at times.</p> <p>On 11/4/24 at 5:19 AM, V9 (CNA) states she transfers residents who use a mechanical lift by herself quite often, due to not having enough staff.</p> <p>On 11/14/24 at 1:52 PM, when asked if he had ever transferred a resident who required a mechanical lift by himself, V18 (CNA) stated he signed papers on Tuesday night that he wouldn't.</p> <p>On 11/20/24 at 3:14 PM, V34 (Assistant Director of Nursing) stated there should be two staff transferring residents who require a mechanical lift for transfers.</p> <p>On 11/21/24 at 1:51 PM, V2 (Director of Nursing) stated there should be two staff present when transferring a resident using a mechanical lift. V2 stated she wasn't aware staff were transferring residents with only one staff, and once she became aware of it she retrained staff.</p> <p>4. R8's Admission Record, with a print date of 11/14/24, documents R8 was admitted to the facility on [DATE], with diagnoses that include fracture of right femur.</p> <p>R8's MDS, dated [DATE], documents a BIMS score of 13, which indicates R8 is cognitively intact. This same MDS documents R8 requires partial/moderate assistance for toileting hygiene.</p> <p>R8's current Care Plan documents a Focus area of, I have episodes of bowel and bladder incontinence r/t (related to) need for assistance with ADL's, ulcerative colitis, hx (history) of UTI's (urinary tract infections), celiac disease, overactive bladder. Date Initiated: 10/17/2024. This Focus area includes the following interventions, .Incontinent: Check every two hours and as required for incontinence Date Initiated: 10/17/2024 .Answer call light promptly. Date Initiated: 10/17/2024 .</p> <p>On 11/14/24 at 11:37 AM, R8 stated it takes forever for staff to come to the room when she needs something. R8 stated she has pooped and peed on herself waiting for them.</p> <p>5. R16's Admission Record, with a print date of 11/20/24, documents R16 was admitted to the facility on [DATE], with diagnoses that include chronic respiratory failure, morbid obesity, heart failure, shortness of breath, and need for assistance with personal care.</p> <p>R16's MDS, dated [DATE], documents a BIMS score of 15, indicating R16 is cognitively intact. This same MDS documents R16 is dependent on staff for toileting hygiene.</p> <p>R16's current Care Plan documents a Focus area of, The resident has an ADL Self Care Performance Deficit. Date Initiated: 07/30/2024. This Focus area includes the following intervention, Transfer: Mechanical lift with staff assist x 2 with all transfers. Date Initiated: 07/30/2024. This Care Plan does not address R16's toileting care needs.</p> <p>(continued on next page)</p> | | |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>On 11/4/24 at 8:37 AM, when asked if she had any concerns with the care she received at the facility, R16 stated, Yeah, they don't seem to care if I am sitting in piss. I sat for two hours from 5:00 to 7:00 PM. R16 stated she told staff she had to go and no one responded because they were getting the residents from the dining room first. R16 stated they would come in and turn her call light off, and then never come back.</p> <p>On 11/4/24 at 5:05 AM, V7 (CNA/Certified Nursing Assistant) stated staffing isn't too good. V7 stated when they only have one CNA on a hall, call lights aren't answered timely.</p> <p>On 11/4/24 at 5:19 AM, V9 (CNA) stated they had five halls and one CNA per hall. V9 stated when they only have one CNA per hall the residents needs aren't met timely. When asked what needs weren't met timely, V9 stated bed checks get done late.</p> <p>On 11/14/24 at 1:52 PM, V18 (CNA) stated he spoke with V2 (Director of Nursing/DON) last week about the hall that he normally works on. V18 stated the hall has vocal, needy residents. V18 stated when he is providing care for the more vocal residents the other residents have to wait.</p> <p>On 11/14/24 at 2:03 PM, when asked if they had enough staff to meet the needs of the residents timely, V20 (CNA) stated they didn't. V20 stated when they only have one CNA per hall then they have to help each other out which puts them behind providing timely care for the residents on their hall. V20 stated incontinence care is not provided timely and call lights aren't answered timely.</p> <p>On 11/14/24 at 2:23 PM, V21 (CNA) stated they don't have enough staff to provide timely care. When asked what care wasn't provided timely, V21 stated incontinence care was not provided timely.</p> <p>On 11/14/24 at 2:27 PM, V22 (CNA) stated incontinence care was not provided timely when they had one CNA working on each hall.</p> <p>On 11/20/24 at 3:14 PM, V34 (Assistant Director of Nurses) stated there are times they only have one CNA working on each hall.</p> <p>On 11/21/24 at 10:17 PM, V36 (Registered Nurse) stated she works night shift and most nights they have one CNA per hall. V36 stated if they have anyone call in, then they are short handed and it makes it harder to provide timely care, including incontinence care.</p> <p>On 11/21/24 at 1:51 PM, when asked if one CNA per hall was enough to meet the needs of the residents timely, V2 stated she believed that changed daily. V2 stated she was sure it didn't feel like enough staff to accommodate them. V2 stated two minutes can seem like twenty, and twenty minutes can seem like two hours. When asked if she had any reports of staff not being able to provide timely care, V2 stated she had not had any complaints they weren't able to complete a specific task. V2 stated she tries to have extra staff during hours that it is needed. V2 stated it was hard to judge with CNA's since we all gripe and complain.</p> <p>The facility Assignment sheet for RN/LPN/CAN/NA (sic) documents one CNA per hall on 11/11 and 11/12/24 from 6 PM to 6 AM and one CNA per hall 11/16 and 11/17/24 from 12:00 AM until 6:00 AM.</p> | | |