

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Clark-Lindsey Village		STREET ADDRESS, CITY, STATE, ZIP CODE 101 West Windsor Road Urbana, IL 61801	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52228</p> <p>Based on observation, interview, and record review the facility failed to immediately notify the Power of Attorney of an injury. The facility also failed to notify the physician of a significant weight gain for two (R269, R15) of 16 residents reviewed for notification of changes on the sample list of 21.</p> <p>Findings include:</p> <p>1. On 2/3/25 at 11:35 AM, V41 (R269's Power of Attorney) stated when R269 was found with skin tears they did not call to notify her until 5:15 PM, but R269 got injured that morning.</p> <p>R269's incident report dated 1/27/25 documents, R269 was found with skin tears to both arms at 11:00 AM.</p> <p>R269's Health Status Note dated 1/27/25 at 5:12 PM, documents V41 was notified of R269's skin tears at 5:12 PM.</p> <p>On 2/4/25 at 1:56 PM, V2 (Director of Nursing) stated V41 was not notified of R269's skin tears immediately but was notified later in the day.</p> <p>51951</p> <p>2.) On 2/6/25 at 10:50 AM, R15 was transferred in the mechanical lift. R15's weight read 189 on the mechanical lift. V19 and V20 (Certified Nursing Assistants) attempted to put a pair of pants on R15 but they could not pull them up due to them not fitting.</p> <p>R15's weight logs document that R15 weighed 166.6 pounds on 10/13/24 and weighed 187 pounds on 2/1/25 (20.4 pound weight gain).</p> <p>R15's medical record does not document that the physician was notified of R15's weight gain.</p> <p>R15's Nutrition assessment dated [DATE] documents R15's current weight as 182.6 pounds reflecting a weight gain of 9.6% since 10/13/24's weight of 166.6 pounds. This note documents R15 is noted with a weight gain trend since admission in October. This note does not document that the physician was notified of the weight gain.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/6/24 at 12:44 PM, V1 (Administrator) confirmed that the physician was not notified of R15's weight gain.</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>52228</p> <p>Based on interview and record review the facility failed to implement their abuse prevention and prohibition policy for one (R269) of 16 residents reviewed for abuse on the sample list of 21.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention and Prohibition policy dated 1/30/23 documents upon receiving an allegation of abuse the facility will immediately notify the state agency and conduct an investigation. This policy also documents that all employees will receive abuse training during orientation.</p> <p>On 2/3/25 at 11:35 AM, V41 (Power of Attorney) stated R269 has been saying, Don't hurt me during cares. V41 stated she reported this to V2 (Director of Nursing) because she is concerned that R269 may be being abused.</p> <p>On 2/5/25 at 9:22 AM, V1 (Administrator) stated she received an allegation of abuse from V2 (Director of Nursing) on 2/1/25 concerning R269's statements of Don't hurt me. V1 stated she did not notify the state agency or investigate this allegation.</p> <p>R269's medical record did not document that the state agency was notified of R269's allegation of abuse or that this allegation was investigated.</p> <p>On 2/5/25 at 1:30 PM, V2 (Director of Nursing) stated she has been working in the facility for a month and has not received abuse training.</p> <p>The facility's abuse training record dated 2/5/25 does not document that V2 received abuse training.</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>52228</p> <p>Based on interview and record review the facility failed to report an allegation of abuse to the State Agency for one (R269) of 16 residents reviewed for abuse on the sample list of 21.</p> <p>Findings include:</p> <p>On 2/3/25 at 11:35 AM, V41 (Power of Attorney) stated R269 has been saying, Don't hurt me during cares. V41 stated she reported this to V2 (Director of Nursing) because she is concerned that R269 may be being abused.</p> <p>On 2/5/25 at 9:22 AM, V1 (Administrator) stated she received an allegation of abuse from V2 (Director of Nursing) on 2/1/25 concerning R269's statements of Don't hurt me. V1 stated she did not notify the state agency of this allegation.</p> <p>R269's medical record did not document that the state agency was notified of R269's allegation of abuse reported to V1 on 2/1/25.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>52228</p> <p>Based on interview and record review the facility failed to investigate an allegation of abuse for one (R269) of 16 residents reviewed for abuse on the sample list of 21.</p> <p>Findings include:</p> <p>On 2/3/25 at 11:35 AM, V41 (Power of Attorney) stated R269 has been saying, Don't hurt me during cares. V41 stated she reported this to V2 (Director of Nursing) because she is concerned that R269 may be being abused.</p> <p>On 2/5/25 at 9:22 AM, V1 (Administrator) stated she received an allegation of abuse from V2 (Director of Nursing) on 2/1/25 concerning R269's statements of Don't hurt me. V1 stated she did not investigate this allegation of abuse.</p> <p>R269's medical record did not document that an investigation was conducted after an allegation of abuse was reported to V1 on 2/1/25.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>52228</p> <p>Based on observation, interview, and record review the facility failed to revise a care plan for one (R269) of 16 residents reviewed for care plans on the sample list of 21.</p> <p>Findings include:</p> <p>On 2/3/25 at 2:44 PM, R269's water pitcher contained regular water and was sitting on a bedside table next to R269.</p> <p>R269's physician order dated 1/24/25 documents an order for a pureed texture diet with nectar thickened liquids.</p> <p>R269's Care Plan revised on 1/23/25 documents R269 is receiving a mechanical altered texture diet. This Care Plan does not include revision that R269 is now receiving a pureed diet.</p> <p>On 2/6/24 at 12:20 PM, V7 (Care Plan Coordinator) stated that she did not update R269's care to reflect the change from a mechanically altered diet to a pureed diet when the order was changed. V7 stated that she made the changes to the care plan on 2/6/25.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>51951</p> <p>Based on interview and record review the facility failed to develop a plan of care which addressed potential adverse reactions to opioid medications, failed to monitor bowel movements, and failed to treat constipation for one of one resident (R220) reviewed for opioid medications on the sample list of 21.</p> <p>Findings include:</p> <p>The package insert for Hydrocodone-Acetaminophen 5-325 milligrams dated 8/2014 documents under Adverse Reactions that prolonged administration of this medication may produce constipation.</p> <p>R220's Care Plan dated 1/16/25 documents R220 has the potential for acute pain related to a recent hip fracture. This Care Plan and R220's medical record does not address the potential for adverse reactions to opioid medications including constipation.</p> <p>R220's Medication Administration Record for January 2025 and February 2025 documents, R220 received 5-325 milligrams of Hydrocodone-Acetaminophen (opioid medication) twice a day since 1/29/25.</p> <p>R220's Bowel and Bladder tracking record documents that R220 did not have a bowel movement from 1/31/24 to 2/5/25 (6 days).</p> <p>On 2/5/25 at 9:33 AM, V21 (Licensed Practical Nurse) confirmed that R220 is taking Hydrocodone-Acetaminophen 5-325 milligrams twice a day. V21 stated that R220 has not had a bowel movement since 1/30/25 and that R220 has not received any interventions to help R220 have a bowel movement.</p> <p>On 2/5/25 at 9:36 AM, V20 (Certified Nursing Assistant) reported that R220 did not have a bowel movement over the weekend. V20 reported that R220 hasn't had a bowel movement since 1/30/2025.</p> <p>On 2/5/25 at 10:03 AM, V21 stated that R220 has not had any interventions to treat or prevent constipation. V21 stated the facility has a bowel protocol and when a resident doesn't have a bowel movement for 72 hours then they will provide milk of magnesia or Miralax. V21 stated this was not initiated for R220.</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** 52228</p> <p>Based on observation, interview, and record review the facility failed to ensure proper wheelchair positioning to prevent a fall, failed to provide safe equipment, and failed to use a mechanical lift for transfers for one (R269) of 16 residents reviewed for accidents on the sample list of 21. These failures resulted in R269 requiring emergency room treatment after falling from a wheelchair and hitting R269's head on the floor. R269 sustained a head injury and a hematoma to the left forehead. These failures also resulted in R269 sustaining skin tears to the left and right forearm.</p> <p>Findings include:</p> <p>On 2/3/25 at 11:12 PM, R269 was sitting in a reclining wheelchair by the nurse's station. R269 had a yellowish - blue bruised raised area above the left eye. This bruising extended down the left side of R269's face to underneath of R269's chin. R269 had skin protective sleeves on the left and right arm. Black and yellowish bruising was seen underneath these sleeves.</p> <p>R269's Incident Report dated 1/29/25 documents that R269 was found on the floor in front of her reclining chair. A hematoma was noticed to the left temporal area and skin tear to the left knee. This incident report documents that R269 was watching television prior to the fall. This report documents R269 was sent to the emergency room for an evaluation.</p> <p>R269's emergency room visit notes dated 1/29/25 documents R269 was seen in the emergency room for a head injury due to a fall at the facility. These notes document R269 sustained a hematoma to the left forehead as a result of the fall.</p> <p>On 2/05/25 at 1:38 PM, V18 (Certified Nursing Assistant/CNA) stated just prior to R269's 1/29/25 fall, R269 was seen sitting comfortably watching television in a slight reclining position in the reclining wheelchair. V18 stated that the reclining wheelchair was not all the way reclined.</p> <p>On 2/04/25 at 1:56 PM, V2 (Director of Nursing) stated V2 investigated the cause of the fall occurring on 1/29/25. V2 stated she interviewed the CNAs (V18 and V45) who were caring for R269 at the time of the fall. V2 stated these interviews concluded that R269's reclining wheelchair was not reclined at the time of the fall. V2 stated it should have been reclined because R269 has poor core strength and R269 has been getting therapy for this. V2 stated she determined that R269 fell forward out of the chair due to poor core strength and the chair not being reclined.</p> <p>On 2/4/25 at 8:47 AM, V11 (Advanced Practice Nurse) was conducting an assessment on R269. V11 stated R269's injuries are consistent with the fall however he cannot see R269 being able to move self out of the reclining wheelchair if the chair was reclined.</p> <p>On 2/04/25 at 12:25 PM, V16 (Physical Therapist) stated that R269 has poor core balance, and that therapy has been working on strengthening. V16 stated that R269's reclining wheelchair should be fully reclined to prevent R269 from falling forward out of the chair.</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>R269's incident report dated 1/27/25 at 11:00 AM documents, R269 was found to have a skin tear measuring 15.3 centimeters to the left arm and a three-centimeter skin tear to the right arm. This incident report documents that the staff have observed R269 putting both arms through the openings underneath the wheelchair armrests. This report documents that the metal bolts underneath the arm rests had rough edges which could have possibly caused the skin tears.</p> <p>On 2/5/25 at 10:15 AM, V45 (CNA) stated that she assisted R269 to the bathroom on 1/27/25 and noticed dry blood on R269 right and left arms. V43 stated that R269 has a daily habit of putting her arms between under the armrests. V43 stated she didn't tell anyone about R269 repeated daily stuffing arms through the wheelchair armrest and the seat of the chair. V43 stated that she always wears short sleeve shirts and tended to slide down in the wheelchair. V43 stated that upon inspection the bolts under the armrest were sharp and consistent with the skin tears.</p> <p>On 2/04/25 01:56 PM, V17 (Assistant Director of Nursing) and V2 (Director of Nursing) stated that R269's wheelchair had sharp bolts underneath the arm rest on both the right and left side of the wheelchair. V2 stated V2 was working when R269 was found to have the skin tears. V2 stated it was determined that the skin tears were caused from the bolts on the wheelchair.</p> <p>On 2/5/25 at 12:58 PM, V9 (Maintenance Director) stated the facility does not have a process for ensuring that wheelchairs are safe prior to use.</p> <p>On 2/04/25 at 12:25 PM, V16 (Physical Therapist) stated that R269 was a sit to stand lift but then had a stroke, R269 returned to the facility on [DATE]. V16 stated R269 was made a full mechanical lift on 1/30/25. V16 stated R269's transfer status is written on a transfer directive sheet and taped to the back of the bathroom door.</p> <p>R269's Transfer Directive dated 1/30/25 documents R269 is a full mechanical lift for transfers.</p> <p>On 2/04/25 at 10:35 AM, V14 and V15 (Certified Nursing Assistants) transferred R269 with the sit to stand lift.</p> <p>On 2/04/25 at 11:07 AM, V14 and V15 transferred R269 with the sit to stand lift.</p> <p>On 2/04/25 at 1:56 PM, V2 (Director of Nursing) stated V14 and V15 should have transferred R269 with the full mechanical lift.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>51951</p> <p>Based on observation, interview, and record review the facility failed to perform hand hygiene and change gloves during and after incontinence care to prevent the risk for urinary tract infection for one (R15) of five residents reviewed for infection control in the sample list of 21.</p> <p>Findings include:</p> <p>R15's Care plan dated 11/18/25 documents R15 has a history of Urinary Tract Infections.</p> <p>On 2/5/25 at 10:39 AM, R15 was assisted to the toilet by V19 and V20 (Certified Nursing Assistants). V19 and V20 put on gloves and placed the straps for mechanical lift under R15 and secured R15 into the mechanical lift. V19 and V20 then moved the mechanical lift holding R15 into the bathroom. V19 and V20 then removed their gloves, used hand sanitizer, and applied new gloves. V20 then removed R15's pants and R15's urine soiled incontinence brief and tossed it into the trash. V20 then cleansed R15's perineal area. V19 and V20 then lowered the mechanical lift to the toilet and walked out of the bathroom to allow R15 privacy. At this time V20 did not change his gloves or sanitize his hands. Then with these same gloves, V20 went back into the bathroom and put on a clean incontinence brief on R15.</p> <p>On 2/5/25 at 11:05 AM, V20 stated, I should have put on a clean pair of gloves before cleaning (R15) and applying a new incontinence brief.</p> <p>The Facility's hand hygiene policy dated 3/3/15 documents the consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infection.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on interview and record review the facility failed to document behaviors and implemented nonpharmacological interventions prior to increasing antidepressant dosage and failed to attempt a Gradual Dose Reduction (GDR) for one of five residents (R6) reviewed for unnecessary medications in the sample list of 21.</p> <p>Findings include:</p> <p>The facility's Psychotropic Medication policy dated 3/28/18 documents psychotropic medications will be used to treat diagnosed and documented specific conditions and will not be administered unless documented behavioral programming with nonpharmacological interventions was attempted and unsuccessful. GDRs will be attempted annually after the first year unless clinically contraindicated.</p> <p>R6's active diagnoses list includes Dementia, Anxiety, and Insomnia. R6's Minimum Data Set, dated dated [DATE] documents R6 has moderate cognitive impairment and had no behaviors during the review period.</p> <p>R6's active physician orders documents orders for Remeron (antidepressant) 30 milligrams (mg) give one tablet by mouth daily as of 7/8/24 and Sertraline (antidepressant) 100 mg by mouth daily as of 1/4/23. There is no documentation in R6's medical record that a GDR in Sertraline was attempted within the last year or documented declination by a physician.</p> <p>R6's Nursing Note dated 7/8/2024 at 6:44 PM documents a new order to increase Remeron from 15 mg to 30 mg. There is no documentation in R6's progress notes that R6 had behaviors during June and July 2024 or unsuccessful nonpharmacological interventions that were attempted prior to the increase in Remeron on 7/8/24.</p> <p>R6's Psychotropic Medication Interview dated 7/8/24 documents Remeron 30 mg daily at bedtime, R6's family requested this medication, and R6 had poor appetite and crying.</p> <p>R6's June 2024 and July 2024 Medication Administration Records (MARs) document targeted behaviors, including crying. These MARs do not document R6 had behaviors and nonpharmacological interventions implemented prior to the increase in Remeron.</p> <p>On 2/5/15 between 9:43 AM and 9:55 AM V1 (Administrator) and V8 (Assistant Administrator) were requested to provide documentation for Sertraline GDR attempts or provider declination with clinical rational, behaviors and nonpharmacological interventions implemented prior to the increase in Remeron for R6.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/5/25 at 11:48 AM V8 provided R6's psychotropic assessment dated [DATE] and confirmed dose was increased for poor appetite and crying. V8 stated behaviors and nonpharmacological interventions should be documented in the nursing notes. At 12:35 PM V8 confirmed R6's June and July 2024 MARs document no behaviors occurred and V8 had no other documentation to provide for R6's behaviors and nonpharmacological interventions attempted prior to increasing Remeron. V8 confirmed there was no documentation that R6 had a GDR in Sertraline within the last year or declination by a provider.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50322</p> <p>Based upon observation, interview, and record review the facility failed to store refrigerated schedule II medications behind double locked compartments, failed to ensure stock medications were not expired, and failed to ensure medications were properly stored in the medication room or medication cart for three (R3, R5, and R11) of six residents reviewed in a sample of 21.</p> <p>Findings include:</p> <p>Facility policy titled general guidelines for Medication Storage dated 2/8/23 states schedule II medications are to be stored in separate, permanently affixed area and are under a double lock. This policy also documents outdated medications are to be immediately removed from stock, disposed of and reordered from pharmacy if necessary.</p> <p>1) On 2/4/25 at 10:43 AM, V12 (Licensed Practical Nurse) opened medication storage room with key and opened the unlocked medication refrigerator. The unlocked refrigerator contained two bottles of liquid Lorazepam (schedule II control antianxiety medication) for R3 and R11. There was an open box of bisacodyl (laxative) suppositories labeled 1/2025 in black marker and an unlabeled bag of acetaminophen suppositories with expiration date of 6/2024 on shelf.</p> <p>On 2/4/25 at 10:50 AM, V12 stated the date handwritten on the box is the expiration date and verified the bisacodyl medication had expired four days prior and verified acetaminophen suppositories had expired eight months ago. V12 removed these medications at that time. V12 stated these medications are stock for all residents and was unaware that they were expired. V12 stated she would have to order more from the pharmacy stating this was the current stock.</p> <p>On 2/4/25 at 12:00 PM V2 (Director of Nursing) verified that the expired medications should have been disposed of and the medication fridge should be locked.</p> <p>52228</p> <p>2.) On 2/3/25 at 11:45 AM, R5 was lying in the bed. An Albuterol Sulfate 90 microgram inhaler was sitting on a bookcase next to the bed. R5 stated that it is no longer used and is just stored on the bookcase.</p> <p>The facility's medication storage policy dated 2/8/23 documents medications will be kept secure in the medication room or medication cart.</p> <p>The facility resident daily census dated 2/3/25 documents 20 residents in house on certified unit.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Clark-Lindsey Village		STREET ADDRESS, CITY, STATE, ZIP CODE 101 West Windsor Road Urbana, IL 61801	

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>52228</p> <p>Based on observation, interview, and record review the facility to provide diet and liquids in the correct form for one (R269) of 16 residents reviewed for nutrition on the sample list of 21.</p> <p>Findings include:</p> <p>R269's Hospital Discharge record dated 1/21/25 documents R269 has dysphagia (difficulty swallowing). These records document an order for minced and moist consistency foods, moderately thickened liquids, and no straws.</p> <p>On 2/03/25 at 12:04 PM, V41 (R269's Power of Attorney) stated after R269 had a Stroke the physician changed R269's diet order to a pureed diet with thickened liquids and it is not followed by the facility. V41 stated that this diet order includes not allowing R269 to have a straw. V41 stated that they give R269 regular water with a straw and have given her regular green beans.</p> <p>V2's (Director of Nursing) follow-up email to V41 dated 1/31/25 documents concern that on 1/23/25, R269 was given non-pureed food and regular water with a straw.</p> <p>On 2/3/25 at 2:44 PM, R269's water pitcher contained regular water and was sitting on a bedside table next to R269. At that time, V14 (Certified Nursing Assistant) confirmed the water was not thickened.</p> <p>R269's physician order dated 1/24/25 documents an order for a pureed texture diet with nectar thickened liquids.</p> <p>On 2/4/25 at 8:41 AM, V11 (R269's Advanced Nurse Practitioner) stated he wrote the order for the pureed diet with nectar thick liquids because he was notified that the facility was not following the diet orders from the hospital and that R269 was given whole green beans.</p> <p>On 2/4/25 at 1:56 PM, V2 stated after R269's hospital stay (1/15/25-1/21/25) R269 had a diet change that included a purred diet with thickened liquids. V2 stated R269 was not supposed to use a straw. V2 confirmed that there have been concerns that R269's new diet has not been followed and that R269 was given regular foods and water and was given a straw.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51951</p> <p>Based on observation, interview, and record review the facility failed to ensure that dietary staff wore the appropriate hair restraints to prevent the potential physical contamination of food, food-contact surfaces, and equipment. This failure has the potential to affect all 20 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's Dining Services Hair Restraint Policy dated 1/19/24 documents that all staff involved in food preparation, service and handling must wear the appropriate hair restraints at all times. Acceptable hair restraints include hairnets, chef hats, or other secure coverings that fully contain and restrain hair.</p> <p>On 2/4/2025 at 3:04 PM, V22 (Cook) was preparing food and was walking to and from the stove and the food storage areas. V22 was observed wearing a stocking cap, the stocking cap covered the top of V22's head and there was three inches of gray curly hair that loosely hung beneath the stocking cap down V22's neck.</p> <p>On 2/4/2025 at 3:13 PM, V24 (Dining Services Supervisor) was observed in the food preparation areas with no beard net covering V24's gray facial hair that covered the lower half of V24's face.</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 2/3/25 documents there are 20 residents residing in the facility.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51951</p> <p>Based on observation, interview, and record review staff failed to prevent potential cross contamination by failing to change gloves and perform hand hygiene for two (R8 and R15) of sixteen residents reviewed for infection control on sample list of 21.</p> <p>Findings include:</p> <p>The facility's hand hygiene policy dated 3/3/15 documents hand hygiene should occur before and after assisting with personal care, coming in contact with intact skin surface, after wiping nose, after handling soiled items, and before and after removing gloves.</p> <p>1. On 2/5/25 at 10:39 AM, V19 and V20 (Certified Nursing Assistants) provided incontinence care to R15. R15's incontinence brief was saturated with urine. V20 removed this brief and threw it in the trash can. V20 then provided perineal care to R15. After completing the incontinence care, V20 did not remove his gloves or wash his hands. With these same gloves on, V20 touched the mechanical lift and remote, walked out of the bathroom, transferred R15 into bed, touched R15's linens, put a pair of pants on R15, and placed R15's pillows under R15's head.</p> <p>On 2/5/25 at 11:05 AM, V20 stated V20 should have removed his gloves and sanitized his hands after providing incontinence cares to R15.</p> <p>2. On 2/5/25 at 8:15 AM, V20 (Certified Nursing Assistant) was walking down the hallway. V20 had a clear bag containing soiled briefs in his ungloved right hand while pushing R8 into the spa room. V20 had a glove on the left hand. V20 placed R8 in the spa room's doorway and then walked to a soiled utility room to throw away the bag of soiled briefs. V20 then calibrated the scale and then assisted R8 onto scale. At no time, did V20 perform hand hygiene or apply new gloves.</p> <p>On 2/5/25 from 9:37 AM, V20 walked down the hallway wearing gloves. V20 touched his nose, adjusted his mask and his glasses, and then wiped his gloved hands on his clothing and picked up a tablet. V20 used the tablet and returned the tablet to the docking station. V20 then proceeded to enter R2's room. At no time, did V20 remove the soiled gloves or perform hand hygiene.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>52228</p> <p>Based on observation, interview, and record the facility failed to ensure a wheelchair was in safe operating conditions for one (R269) of 16 residents reviewed on the sample list of 21. This failure also had the potential to affect all 20 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's Long-term Care Facility Application for Medicare and Medicaid dated 2/3/25 documents there are 20 residents residing in the facility.</p> <p>R269's incident report dated 1/27/25 at 11:00 AM documents, R269 sustained skin tears to the left and right forearms due to metal bolts with rough edges on the underside of the wheelchair arms of R269's wheelchair.</p> <p>On 2/4/25 at 1:56 PM, V17 (Assistant Director of Nursing) and V2 (Director of Nursing) stated that R269's wheelchair had sharp bolts underneath the arm rest on both the right and left side of the wheelchair. V2 stated she is unaware of where the wheelchair is at this time but will find it.</p> <p>On 2/5/25 at 12:58 PM, V9 (Maintenance Director) stated there has not been a work order for the wheelchair that caused R269's skin tears. V9 stated he is unsure where the wheelchair is currently located.</p> <p>On 2/5/25 at 1:30 PM, V2 (Director of Nursing) stated that they think they found the wheelchair today in the physical therapy office and that this wheelchair could have been used for any of the residents in the facility. V2 stated she is not sure if this wheelchair is the wheelchair that caused the skin tears to R269's arms and it could still be in circulation for any of the residents to use.</p>		