STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145437	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Princeton	515 Bureau Valley Parkway Princeton, IL 61356

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34048 Based on observation, interview and record review the facility failed to provide for personal dignity during a transfer for one (R19) of 17 residents reviewed for dignity in a sample of 49. Findings include: The facility's Dignity policy, revised 4/23/28, documents that the facility shall promote care for the residents in a manner and in an environment the maintains or enhances each resident's identity and respect in full recognition of this or her individuality. This form documents that staff carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth. The Facility's Resident Rights policy, undated, documents that (the Resident) you have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care. On 6/10/24 at 1:30pm, V6, Certified Nursing Assistant, was pushing R19 down the hall on a shower chair. R19's dress was pulled up to her upper waist. R19's upper thighs and buttocks were uncovered. On 06/11/24, at 9:42am, R19 stated she is hardly ever covered when in the shower chair, going to the shower room. R19 verified that she does not like that. On 6/11/124 at 10:00am, V6 verified that R19 should have been covered with a bath blanket while being transported from her room to the shower room.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 33973 Based on interview and record review, the facility failed to ensure residents have knowledge of who the Grievance Official is, how to file a Grievance and where the forms are located for four (R11, R22, R54, and R60) of four residents reviewed for Grievances in a sample of 49. Findings include: The facility's Grievances policy, revised 9/25/17, documents Purpose: To ensure prompt resolution of all grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their stay at this campus .Guidelines: The resident has the right to voice grievances to this facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal .Grievances may be filed orally (meaning spoken), in writing, or anonymously. Grievances may also be filed anonymously through the Corporate Compliance Hotline .An appointed Grievance Official (usually Social Service Director) is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations and maintaining the confidentiality of all information associated with grievances. On 6/11/24, at 9:57am, the survey Group Meeting was held in the facility with four residents (R11, R22, R54, and R60) present. During this meeting all four residents agreed that they did not know who the Grievance Official is, how to file a grievance nor where the forms were kept. R11 asked Where do you get the forms? The facility's Resident Council Minutes dated from 6-29-23 to 5-30-24 do not include any discussion on how to file a grievance. 06/11/24 1:40 PM V4 Activity Director confirmed the Resident Council meeting minutes do not include any discussion of how to file a Grievance. On 6/11/24, at 12:52pm, V14 Social Service Director/SSD stated the following: I am the Grievance Officer. Any time a grievance occurs I go talk to the resident and bring a sheet. I let the new residents know about how to file a grievance. V14 is unaware there are residents who do not know how to file. I guess I need to round more. I have not discussed the topic at Resident Council but maybe that's what I should do.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on interview and record review, the facility failed to perform a PASARR (Pre-Admission Screening and Resident Review) rescreen after the emergence of a newly diagnosed severe mental illness for two of two residents (R59 and R61) reviewed for PASARR screening, in the sample of 49. Findings include: The facility policy, Preadmission Screening and Annual Resident Review (PASARR), dated (reviewed) 11-13-18 documents, It is the policy to screen all potential admissions on a individualized basis. As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review screening process (Level 1) for all new and readmissions per requirement to determine if the individual meets the criteria for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Annually and with any significant change of status, the facility will complete the PASARR Level 1 screen for those individuals identified per the Level 11 screen requiring specialized services. 1. R59's current Physician Order Sheet, dated June 2024 documents that R59 was admitted to the facility on [DATE] with the following diagnoses: Bipolar Disorder. R59's current PASAAR screen, provided by V1/Administrator on 6/11/24, documents R59 was originally admitted to (another) Skilled Nursing Facility on 5/3/23 with no diagnosis of Severe Mental Illness. R59's PASSAR screen at that time documented, Your Level 1 screen shows low-level behavioral health symptoms which appear to be situational. The nursing facility will watch your symptoms/behaviors to see if they improve or resolve within 30-60 days of this screen. If they do not, a nursing facility staff member must submit another Level 1 screen to Maximus. This is called a status change. The status change will decide if you need a PASRR Level 11 evaluation for serious mental illness. On 6/11/24 at 12:27 P.M., V14/Director of Social Services verified that R59 has not had a PASAAR rescreen upon admission to the facility, despite R59's diagnoses of severe mental illness. 33985 2.) R61's Admission History and Physical, dated 11/9/2023, documents, R61 was admitted with a diagnosis of Severe Major Depression with Anxiety, and Suicidal Intent. R61's Progress Notes from the psychiatry clinic, dated 11/29/2023, documents, R61 has the following diagnosis: Major Depressive Disorder, recurrent and moderate, Generalized Anxiety Disorder, Post traumatic stress disorder, Major Neurocognitive Disorder and Suicidal Ideations. R61's Physician Order Sheets, dated 6/12/2024, documents the following medication regimen for R61: Fluoxetine HCL Oral Capsule 40MG (milligram) one time a day for Major Depressive Disorder, Mirtazapine Oral Tablet 7.5MG (milligram) give one tablet in the evening for Major Depressive Disorder, Olanzapine Oral Tablet 5MG one time a day for Major Depression, recurrent severe, Sertraline HCL Tablet 25MG (milligram) for Major Depressive Disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R61's Care Plan, dated 5/18/2024, documents: I use psychotropic medications related to Major Depressive Disorder. R61's Psychiatry Note History, dated 11/29/2024, documents,History of Present Illnesses: Major Depressive Disorder, Post Traumatic Stress Disorder, Anxiety Disorder, and Neurocognitive Disorder R61's Notice of PASRR level 1 screen Outcome, dated 11/9/2023, documents the following: PASSR Level 1 Determination- No Severe Mental Illness. R61's Preadmission Screening and Resident Review, dated 11/9/2023, Diagnosis: No mental health diagnosis is. known or suspected. On 6/13/2024 at 11:30AM V1/Administrator stated, Yes, R61 should have a new PASRR done because R61 has a long history of severe mental illness.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34048 Based on interview and record review the facility failed to perform physician ordered daily weights for one of one resident (R19) reviewed for daily weights in a sample of 49. Findings include: On 6/10/24 at 9:30am, R19 was sitting up in her chair with her feet resting on the floor. Edema was noted on R19's bilateral feet, ankles and to mid-calf. On 6/11/24 at 1:00pm, R19 sitting in her recliner with her feet resting on the floor. On 6/12/24 at 1:00pm, R19 remained up in the recliner with her feet resisting on the floor. Pitting edema noted on her bilateral feet and lower legs. R19 verified that she is not weighed every day as ordered. R19 verified that occasionally she goes to the facility scale to get weighed. R19's Physician Order Sheet, dated 12/19/23, documents to do daily weights (order on the MAR/Medication Administration Record) and notify the medical doctor or the nurse practitioner if resident has a weight gain of 3 pounds in a day or 5 pounds in a week, every day on day shift for Congestive Heart Failure Program related to Chronic Diastolic Congestive Heart Failure. R19's MAR, dated 12/20/23 through 12/31/23, has only one weight documented as being completed on 12/30/24. R19's MAR, dated 1/1/24 through 1/31/24, has only two weights documented. R19's MAR, dated 2/1/24 through 2/29/24, documents 11 daily weights being done. R19's MAR, 3/1/24 through 3/31/24, documents that 24 out of 31 daily weights were done. R19's MAR, dated 4/1/24 through 4/30/24, documents that 20 daily weights were done. R19's 5/1/24 through 5/31/24 documents that only six of 31 weights were done. R19's MAR, dated, 6/1/24 through 6/13/24, has nine of 13 weights were completed. R19's emergency room Progress Notes, dated 1/26/24, documents the following diagnosis: Acute CHF (Congestive Heart Failure) Exacerbation, Dyspnea and Hypoxia on Exertion. R19's hospital notes, documents that R19 weighed 268.8 pounds on 1/26/24 and 256.4 pounds on 1/30/24. R19 was educated on the importance of daily weights, low sodium diet and exercise. R19's Cardiovascular Progress Notes, dated 1/29/24, documents that R19's weight in the past was 225 pounds and current weight is 268 pounds. R19 has been at a skilled nursing facility and there has not been a lot of weight assessment and management there. On 6/11/24 at 11:00am, V2, Director of Nursing, stated that R19's daily weights are not being done consistently. On 6/12/24 at 2:00pm, V1, Administrator, stated that R19's weights are not being done as ordered. V1 stated that R19's daily weights need to be done and her edema assessed. V1 stated that R19 follows up [NAME] cardiologist. V1 stated that R19's diuretics are changed often due to her kidney and heart concerns.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32061 Based on observation, interview and record review, the facility failed to implement interventions to reduce a residents' risk of a fall and safety interventions for transfer for two of five residents (R3, R26) and failed to follow their elopement policy, failed to document the testing of the elopement device and doors and failed to ensure an elopement device was in place for one (R31) of one residents reviewed for elopement in a sample of 49. Findings include: The facility policy, Fall Prevention Program, dated (revised) 11-21-17 directs staff, To assure safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assuasive devices are utilized as necessary. Fall/safety interventions may include but are not limited to: Transfer conveyances shall be used to transfer residents in accordance with the plan of care. Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan. Footwear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid. 1. R3's current Physician Order Sheet, dated June 2024 documents R3's diagnoses as: Paroxysmal Atrial Fibrillation, Left-Bundle Branch Block, Occlusion and Stenosis of Right Carotid Artery, History of Transient Ischemic Attack, Cerebral Infarction, Severe Vascular Dementia, Generalized Anxiety Disorder. R3's Fall Risk Assessments, dated 8/5/23, 9/24/23, 12/14/23, 12/16/23 and 3/16/24 document R3 as being high risk for falls. R3's (facility) Fall Occurrences dated 8/5/23, 9/24/23, 12/14/23, 12/16/23 document R3's witnessed/unwitnessed falls in the past year. R3's current Care Plan, dated 3/25/24 includes the following Focus area: ADL (Activities of Daily Living) deficit related to dementia. Also included are the following Interventions: (R3) uses a mechanical lift for transfer assist for episodes of increased weakness. The same Care Plan also includes the following Focus area: Ensure that (R3) is wearing appropriate, non-skid footwear. On 6/10/24 at 9:36 A.M., V 11 and V12/Certified Nursing Assistants (CNA) prepared to transfer R3 from the bed to the wheelchair. Without applying a gait belt and without applying no non-skid socks on R3's feet, grabbed resident under arms at which time R3 yelled, Ow loudly and then V11 and V12 repositioned him back on bed. Grabbing R3 a second time under arms and repositioned him on bed and R3 loudly yelled, Ouch, that hurts. Third CNA (V13) brought mechanical lift in room for use and 2 other CNAs applied gait belt at that time and pulled R3 to standing potion, while yelling Ow. R3 did not bear any weight on his legs as 2 CNAs turned and placed R3 in chair. At that time, V13 said, You should have used the (mechanical lift) on him. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	33973 2. The facility's Fall Prevention Program, revised 11/21/17, documents Safety interventions will be implemented for each resident identified at risk. R26's current Physician Order Sheet/POS documents diagnoses including but not limited to Unspecified Dementia, Severe, with agitation; Conversion Disorder with Seizures or Convulsions; Major Depressive Disorder, recurrent, mild; and Anxiety Disorder, unspecified. R26's current Physician Order Sheet/POS documents Helmet: resident must wear when out of bed; document all refusals. Every day and night shift related to Conversion Disorder with Seizures or Convulsions . May remove while in bed. On 6/10/24, at 11:30am, R26 sat in the dining room without a helmet on her head. On 6/10/24, at 1:50pm, V15 Licensed Practical Nurse/LPN, looked up R26's physician orders and stated, It says she is to have it when out of bed and document if refuses. On 6/10/24, at 2:00pm, V20 LPN verified that R26 is not wearing her helmet. V20 stated, Usually the girls (Certified Nursing Assistants/CNAs) will tell me if she refused the helmet, and they did not tell me that. She is supposed to wear it when out of bed. R26's clinical record does not document that R26 refused to wear the helmet on 6/10/24. On 6/10/24, at 2:09pm, R26 sat in the dining room without a helmet. 3. The facility's Elopement Device policy, revised 9/13/19, documents Purpose: To establish procedures for ensuring personal elopement devices are used in accordance with identified risk, physician orders and to ensure the security system is inspected to identify malfunctions should they occur. Responsibility: All Facility Staff. Policy: It is the policy of this facility to use elopement alert systems and devices when an assessment has identified the risk of elopement. Procedure: 1. Elopement alert devices will be used as an interventional tool to prevent resident elopements .3. The elopement alert exit door device will be inspected for proper working daily by maintenance and manager on duty .4. The inspection and status of the test will be recorded on a facility-approved log located at the front desk. Maintenance staff and manager on duty will be responsible for maintaining this log .6. The Wanderguard sensors located at the elevators and front door will be checked daily by maintenance and manager on duty and recorded in the log located at the front desk .8. The functionality of the device on resident arm or leg will be checked daily by social services and manager on duty. R31's Physician Order Sheet/POS documents diagnoses that include but are not limited to Alzheimer's disease with late onset; Dementia; Major Depressive Disorder; Restlessness and Agitation. This POS also includes (Wander alarm) on at all times. (Wander alarm) check every shift for decreased safety awareness/elopement risk dated 10/17/23. R31's Minimum Data Set/MDS assessment, dated 4/17/24, documents that a wander/elopement alarm is used daily. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's Elopement Risk Assessment, dated 4/25/24, documents R31 is at high risk and should be on care plan - wander alert right ankle. R31's current Care Plan includes but is not limited to R26 is an elopement risk/wanderer related to Alzheimer's disease. Interventions include but are not limited to: Wander alert, left ankle. On 6/10/24, at 1:30pm R31 is in bed without any wander alarm bracelet to either ankle; none on wrists. R31 said he wasn't wearing one. On 6/10/24, at 3:05pm, R31 is standing in the hall near the nurses' station as V20 Licensed Practical Nurse/LPN confirmed R31 is not wearing an alarm device on any of his limbs. She stated He takes it off. He wears it for that side exit door because he will go out that door and has. V20 does not remember when that was. V20 confirmed that V20 charted that he was wearing his alarm device and stated, It was on his wrist. V20 looked in his room at this time with this writer and there was no alarm device found. R31's Progress Note, dated 10/15/23, documents (R31) has been increasingly wandering around front door exit of building. Also found past the first door today, 6pm. 15 min safety checks implemented. On 6/11/24, at 12:52pm, V14 Social Service Director/SSD stated (R31) is not compliant with keeping the alert device on ever since he first came. He came on 2/2/23 and had it placed on 2/4/23. On 6/11/24, at 2:55pm V2 Director of Nursing/DON stated the following: I become aware of when he takes off the device when they document it in the progress notes. He got it placed when he was followed by staff out that door to smoke in October. Staff are to replace it right away when removed. If one is unavailable, they are to monitor him more closely. Nurses are to document that it is on his body and functioning. Maintenance checks the devices with the doors. there are three doors - the front one and two that lead to the parking lot. V2 is not sure how often nurses are to check them - according to however it is ordered. Confirmed that if it was not documented then it wasn't done. R31's Treatment Administration Records/TARs, dated October 2023-February 2024 and April 2024-June 2024 document multiple missing signatures verifying that R31's wander alarm was on and functioning. On 6/13/24, at 2:15pm, V2 DON confirmed the multiple lack of signatures on the above TARs confirming that R31's wander alarm was on R31 and functioning. On 6/12/24, at 8:44am, V10 Maintenance Director stated he tests the door alarms for the Wanderguards every day that V10 is here. V10 confirmed that he is here Monday through Friday, so the doors are not tested by Maintenance on the weekends. The facility's Test Record Door Alarm and (named) Alarm Systems logs, dated October 2023 to current do not include any documentation of the door alarms being tested on the weekends. On 6/12/24, at 3:30pm V1 Administrator stated that the managers on duty are the ones who test the doors on the weekends. They do not sign off on the log. V1 is unable to produce documentation that the doors are being tested on the weekends by the managers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24, at 3:24pm V14 Social Service Director/SSD read the Elopement Device policy and stated she has never been told that she is to test the functionality of the wander alarm devices and is not doing it.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 33973 Based on observation, interview and record review, the facility failed to ensure ordered nutritional drink for a resident with weight loss was offered for one (R26) of one resident reviewed for nutrition in a sample of 49. Findings include: The facility's undated Nutrition Intervention Program (NIP) policy documents Policy: Residents identified as needing additional nutrition interventions will be started on the NIP Program. Identified Residents include, but not limited to 1. Significant weight loss at 1 month, 3 month, 6 months. This policy also states, The nutrition interventions can be initiated by the food service manager, dietician, or nursing staff. R26's current Physician Order Sheet/POS documents diagnoses including but not limited to Unspecified Dementia, Severe, with agitation and Conversion Disorder with Seizures or Convulsions. R26's Minimum Data Set/MDS assessment, dated 4/4/24, documents R26 is severely cognitively impaired, requires supervision or touching assistance for eating, and that R26 had a significant weight loss, not physician prescribed. R26's Registered Dietician note, dated 4/15/24, documents that R26 has had a significant weight loss of 14. 8% x 2 months and 10.5% x 4 months. She is receiving whole milk TID (three times per day), super cereal with breakfast, and health shake with lunch and supper for extra kcal (kilo calories) to help maintain her weight. Will continue to monitor. No (further) recommendation. On 6/10/24, at 11:30am - 12:05pm, R26 sat in the dining room for lunch. R26's meal tray contained a health shake and container of milk with her food. R26's milk was open with a straw; the health shake remained closed as R26 occasionally picked at the food. No attempts by staff to open/offer the health shake. On 6/10/24, at 12:16pm, V11 Certified Nursing Assistant/CNA removed R26's meal tray and placed it in the cart for the finished meal trays. R26's unopened health shake remained on this tray. On 6/10/24, at 1:46pm, V11 CNA stated the following: I did not assist (R26) to eat at lunch time. She needs some assistance, and we usually do but sometimes she refuses and it causes behaviors. I usually mix her (health) shake into her milk so she will drink it, but it was frozen. V11 was not sure if V11 could get another one that wasn't frozen. V11 verified V11 put R26's unopened health shake on the cart for finished meal trays. On 6/12/24, at 11:57am, R26 sat in the dining room dozing with meal in front of her including an unopened health shake. On 6/12/24, at 12:10pm R26's meal tray is in the cart for finished meal trays with the health shake still unopened. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24, at 12:15pm, V17 Licensed Practical Nurse/LPN stated that V17 got R26 to drink some of her milk (half of it). V17 confirmed V17 did not mix the health shake in the milk. On 6/10/24, at 2:15pm, V20 LPN stated It is the CNAs responsibility to make sure the resident drinks the (health) shake as far as I know. It comes from the kitchen staff if ordered by the dietician for weight management since these residents with dementia tend to lose weight.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Princeton	515 Bureau Valley Parkway Princeton, IL 61356

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on interview and record review, the facility failed to perform an ongoing assessment of the resident's respiratory status for one resident of one resident (R44) reviewed for oxygen therapy, in a sample of 49. Findings include: The (undated) facility policy, Oxygen Therapy General Standard directs staff, Purpose: To provide adequate tissue oxygenation for problems associated with Reduced oxygen carrying capacity of blood. A licensed nurse will conduct ongoing resident assessments for oxygen administration. A pulse oximeter will be used to determine oxygen saturation levels. R44's current Physician Order Sheet dated June 2024 document R44's current diagnoses as: Chronic Obstructive Pulmonary Disease. This same form documents an order for R44's oxygen therapy, Oxygen 3L (Liters) via NC (Nasal Cannula) PRN (As Needed), to maintain SPO2 (Saturation of Peripheral Oxygen) above 88%. R44's Medical Record documents, 6/11/2024 90%, 6/10/2024 96%, 5/14/2024 95.0%, 5/7/2024 95.0%, 5/6/2024 96.0%, 5/4/2024 95.0%, 5/3/2024 94.0%. No other assessment of R44's respiratory status is present. A review of R44's Medication Administration Records for May and June 2024 shows no documentation of R44's SPO2 levels. On 5/11/24 at 4:15 P.M., V2/Director of Nurses verified R44 was admitted to the facility on [DATE], received oxygen therapy at 3 liters continuously and no ongoing SPO2 levels were monitored by staff until 6/10/24.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 32189 Based on observation, interview and record review, the facility failed to assess a resident's dialysis fistula as ordered for one of one residents (R51) reviewed for dialysis, in a sample of 49. Findings include: The Assessment of Resident policy, revised 4/18/22, documents 9. Document resident comments, complaints as appropriate and assessment findings in the nursing progress notes. 10. Notify the physician of significant findings and request necessary change in orders. 12. Initiate Nursing Interventions. On 5/2/24, a Physician ordered Check Bruit and Thrill (a vibration that is palpated above or below the fistula (dialysis access site) to ensure blood flow) of dialysis fistula to left forearm every shift (Y=positive/N=negative) every day and night shift for fistula monitoring. On 6/12/24 at 9:00 AM, V18 (Registered Nurse) demonstrated in the Electronic Medical Record how the bruit and thrill assessments were documented. After the bruit and thrill assessment was entered as completed or not completed, another screen auto populated and asked the question Is behavior observed. V18 stated I don't even know what that means. On 6/12/24 at 9:45 AM, V3 (Assistant Director of Nursing) reviewed R51's physician's order for the bruit and thrill assessments and stated the order requires a Behavior Observed assessment which should be marked yes for a positive thrill and bruit and no for a negative thrill and bruit. The Medication Administration Record (MAR) documents between 5/1/24 and 5/31/24, 39 of 62 bruit and thrill assessments and between 6/1/24 and 6/11/24, 18 of 21 bruit and thrill assessments were documented as No. It was unable to be determined if the bruit and thrill assessment was conducted as ordered or if No referred to the absence of a bruit or thrill. On 6/12/24 at 10:35 AM, R51 states the staff assess R51's fistula Maybe once a day. Not twice. It's not always done (fistula assessment) but sometimes it is.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33973 Based on interview and record review, the facility failed to ensure residents on Psychotropic medications have supporting diagnoses and identified targeted behaviors with monitoring for three (R26, R33 and R44) of three residents reviewed for Psychotropic medications in a sample of 49. Findings include: The facility's Psychotropic Medication - Gradual Dosage Reduction, revised 2/1/18, documents Purpose: To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standards of practice, and are prescribed at the lowest therapeutic dose to treat such conditions. Guidelines: The plan to alternatives to psychotropic medication and/or use of psychotropic shall be incorporated into the care plan with suitable goals and approaches. This will be initiated by the resident's needs/problems, goals and approaches as it relates to the use of psychotropic drug use. 1. R26's Physician Order Sheet/POS documents an order, dated 5/29/24, for Seroquel 50mg (Milligrams), give 75mg by mouth two times a day related to Unspecified Dementia, Severe, With Agitation; Major Depressive Disorder, Recurrent, Mild. R26's POS also documents an order, dated 5/28/24, for Olanzapine Oral Tablet 5mg, give one tablet by mouth every 12 hours as needed for agitation for 14 days. R26's current Care Plan does not include any alternate therapies to attempt for behaviors or any identified target behaviors. On 6/10/24 at 11:30am and 6/12/24 at 11:57am, R26 sat quietly at a dining room table without any behaviors noted. On 6/12/24, at 2:05pm, V2 Director of Nursing/DON stated V2 does not know if the diagnoses of Major Depressive Disorder and Severe Agitation are correct diagnoses or not. V2 is unable to provide documentation for R26's targeted behaviors or alternate therapies attempted. On 6/12/24, at 2:10pm, V1 Administrator stated R26's Seroquel and Olanzapine do not have correct diagnoses. 32061 2. R33's current Physician Order Sheet, dated June 2024 documents the following diagnoses: Paranoid Schizophrenia, Dementia. Also included are the following physician orders: Risperdal (Antipsychotic) 4 MG by mouth two times daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's Care Plan, dated 6/28/22 does not include documentation for specific targeted behaviors for monitoring or non-pharmalogical approaches attempted prior to the start of the antipsychotic medication. An observation of R33 on 6/7/24 at 11:30 A.M., on 6/8/24 at 8:30 A.M. and again at 11:45 A.M. shows R33 seated at a table in the facility Safe Unit Dining/Activity Room calmly eating her meal, conversing with other staff and residents. 3. R44's current Physician Order Sheet, dated June 2024 documents the following diagnoses: Mood Disorder, Anxiety, Dementia. Also included are the following physician orders: Haldol Lactate Oral Concentration 2.5 ML (Milliliters) by mouth two times daily and Quetiapine 25 MG one tablet in the morning and three tablets at bedtime. R44's Care Plan, dated 5/3/24 does not include documentation for specific targeted behaviors for monitoring or non-pharmalogical approaches attempted prior to the start of the antipsychotic medication. An observation of R33 on 6/7/24 at 8:45 A.M. and at 1:00 P.M. shows R33 up and about in his room, watching television. R33 was calm and engaged in conversation easily. On 6/12/24 at 2:30 P.M., V2/Director of Nurses verified that R33 and R44's medical record contained no documentation for targeted behaviors or alternate therapies attempted prior to the start of antipsychotic medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 32061 Based on observation, interview and record review, the facility failed to ensure medications were stored and labeled correctly. This failure has the potential to affect all 28 residents (R3, R10, R14-17, R26, R27, R29, R31, R33, R35, R36, R38-R40, R44, R46-R49, R52, R53, R57, R59, R65, R68 and R121) currently residing in the facility Safe Unit. Findings include: The (revised) 7/2/19 facility policy, Medication Storage directs staff, Purpose: To ensure proper storage, labeling and expiration dates of medications, biological's, syringes and needles. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines will respect to expiration dates for opened medications. Facility should record the date opened on the medication container when the medication has a shortened expiration date once opened. Facility should ensure that medications are stored at their appropriate temperatures according to the United States Pharmacopoeia guidelines for temperature ranges. Refrigeration: 36- 46 degrees. On 6/10/24 at 9:29 A.M., V15/Licensed Practical Nurse (LPN) opened the locked door to the (facility) Back Hall Medication Room. A refrigerator with no temperature log present contained a thermometer in an open freezer section, that was iced to the shelf. V15/LPN, wiggling the thermometer back and forth, was able to loosen and read the thermometer. At that time V15/LPN verified she did not check the temperature of the refrigerator today and had never been instructed to check and record the temperature. On a shelf a 5 ML (Milliliter) bottle of undated Tuberculin, Purified was opened with 1/2 of the contents missing. At that time, V15/LPN verified the undated bottle. A review of the facility Back Hall Medication Refrigerator for January, February, March, April, May and June 2024 documents missing refrigerator temperatures. On 6/13/24 at 9:41 A.M., V2/Director of Nurses verified the temperature of the medication storage refrigerator was to be checked once daily by the night shift nurse. At that time, V2/DON also verified the opened, undated Tuberculin solution and the missing temperatures for January, February, March, April, May, and June 2024. A facility Room Roster dated 6/10/24 and provided by V1/Administrator documents 28 residents currently reside on the facility Safe Unit.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 33973 Based on interview and record review the facility failed to provide snacks at bedtime for all residents. This failure has the potential to affect all facility residents. The facility policy, Snacks, undated, documents Policy: Between meal snacks are available to residents per the planned menu or resident preference. Purpose: Too offer additional nourishment between meals. Procedure: 1. The Food and Nutrition Department will send snacks to the nursing stations at the appropriated times .3. Bedtime snacks will be sent to the nursing station(s) in bulk. These snack items are to be offered to each resident. Per facility policy, acceptance or refusals of snacks are to be documented. The facility's Certified Nursing Assistant (CNA) Job Description documents Essential Duties and Responsibilities: Provide assistance with serving meals and feeding; providing fresh water an nourishment between meals. On 6/11/24, at 9:57am, the survey Group Meeting, R11, R22, and R54 agreed they are not offered any bedtime snack. During this meeting, R60 stated I don't get any at bedtime. And the nurse told me I should have a snack at bedtime. I have not seen any snacks sitting out. On 6/11/24, at 1:03pm, V6 Dietary Manager/DM stated we send out snacks (animal crackers, grahams, wafers) with drinks around 7 or 7:30pm for bedtime snacks. My kitchen staff take trays to the halls and the CNAs are to pass them out. On 6/13/24, at 9:40am, V6 DM stated the kitchen provides bedtime snacks for all of the residents. On 6/11/24, at 3:10pm, V2 Director of Nursing/DON stated the CNAs are to offer and pass the bedtime snacks. They probably document it under tasks whether or not it was accepted or refused as per policy. The facility's Long-Term Care Facility Application for Medicare and Medicaid (Center for Medicare and Medicaid/ Services/CMS form 671), dated 6/10/24, and signed by V16 Minimum Data Set Assessment Coordinator, documents 66 residents currently reside in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34048 Based on observation, interview and record review the facility failed to implement a cleaning procedures and schedule for the kitchen and failed to use appropriate utensils while plating lunch. This has the potential to affect 66 residents residing in the facility. Findings include: The facility's Cleaning Procedures, undated, documents that food service equipment shall be washed, rinsed, and sanitized according to standard procedures. The facility's Cleaning Instructions Ceilings and Walls, dated 2020, documents ceiling and walls will be cleaned on a regular basis. This form documents that walls will be cleaned daily using hot, soapy water to remove dirt, spatters, and food stains, or as needed. Wall will be cleaned and sanitized monthly, or as needed. Use hot, soapy water to wash, then rinse with clean, warm water. In food preparation areas, wipe down with sanitizing solution and allow to air dry. On 06/10/24 at 9:30am, each oven and steamer in the kitchen had black burnt crumbs in the floor. A brown greasy like substance ran down the doors of each oven. The ventilation hood above the cooking area had a brown greasy build up on it. The wall behind the dishwasher had brown/black streaks running down the wall. There was a black crumbly substance on the floor and wall under the dishwasher. There was a brown fuzzy substance on the covering above the dishwasher. On 6/10/24 at 11:45am, V19, Cook, washed her hands and applied gloves. V19 then grabbed a plate dished up and covered the food. V19 grabbed a dinner roll with her gloved hand. V19 repeated this process several times. V19 stated that she should have used tongs to grab the dinner rolls, not her gloved hands. On 6/10/24 at 1:00pm, V5, Dietary Manager, stated that she does not know the last time the kitchen was cleaned. V5 was unable to supply a cleaning schedule. On 6/11/24 at 11:00am, V1, Administrator, stated that the kitchen did not have a cleaning schedule in place. The Long-Term Care Facility Application for Medicare and Medicaid form, dated 6/10/24, documents that 66 residents reside in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 33985 32189 Facility failures resulted in two deficient practices. A.) Based on record review and interviews the facility failed to follow their policy on Water Management Program for Prevention of Legionella Growth, and perform preventative maintenance to stop the growth and spread of Legionella. This has the potential to affect all 66 residents that reside at the facility. B.) Based on observation, interview, and record review, the facility failed to place signage in a location to clearly identify the category of transmission-based precautions, instructions for PPE (Personal Protective Equipment), to instruct visitors to see the nurse prior to entering the resident's room for one resident (R64) that required transmission-based precautions in a sample of 49 residents and failed to ensure Personal Protective Equipment was donned per policy, and non-contaminated supplies were safe for wound care for one residents (R32) observed for wound care in a sample of 49 residents. Findings include: A) The facility policy, Water Management Program for Prevention of Legionella Growth, revised (5/17/2024) documents the following: Purpose: To identify and reduce the risk of Legionella growth and spread. Preventative maintenance will be performed as applicable: The following will be verified and documented at least once weekly: 1.) The domestic hot water boiler storage tanks verified to be set between 140-160 degrees Fahrenheit. 2.) Thermostat indicating the temperature of water entering the circulating system at the mixing valve is at 120 Fahrenheit or above. 3.) Eye wash stations will be inspected and flushed weekly. 4.) Ice machines will be inspected and cleaned internally at least every 3 -6 months and as needed for leakages or contamination. 5.) Cooling tower (if applicable) will be inspected at least weekly to ensure proper functioning and chemical distribution. 6.) Weekly sanitizing of medical devices such as CPAP (continuous positive airway pressure). The facility was unable to provide a flow diagram of the buildings water system. On 6/12/2024 at 8:45AM V10 (Maintenance Director) stated, I do not have any other information to show that I have been doing any of the preventative maintenance protocols, according to the policy. I just started the eye wash weekly inspection on 5/29/2024. I have not done any temperatures for the water boiler or temperatures of the water entering the circulating system at the mixing valve. The ice machine should be inspected and cleaned every 3-6 months, but that has not been done. I am pretty sure that the weekly sanitizing of medical devices has not been done either. The Long-Term Care Facility Application for Medicare and Medicaid form, dated 6/10/24, documents that 66 residents reside in the facility. B.) 1. R64's Physician Order Sheet, dated 6/1/24 through 6/30/24, documents Foley catheter 16 French with 10CC (centimeter) to drainage and gravity for a diagnosis of urine retention. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	And Enhanced Barrier Precautions- for an indwelling foley catheter every day and night shift. On 6/10/2024 at 1:30P.M., R64's entry door lacked signage to identify the category of transmission-based precautions, instructions for PPE (Personal Protective Equipment) and instructions to see the nurse prior to entering the resident's room. The Isolation Room Set Up policy, revised 5/30/14, documents It is the policy of this facility to set up isolation precautions. Procedure: 7. Place sign on door to resident's room for visitors to inquire at nurse's desk prior to entering room. On 6/13/2024 at 1:55 PM V1/Administrator stated, Yes, there needs to be signage on the door when Enhanced Barrier Precautions are in use. The sign was on the wrong door. It is fixed now. B) 2. The Dressing Change (Clean/Non-Sterile) policy, reviewed 1/9/18, documents 2. Prepare a clean, dry work area at bedside. 3. Bring supplies into resident's room. Individual resident supplies may be placed on the over bed table after it has been disinfected and/or a protective barrier placed on the table. 7. Prepare/open any necessary supplies and place on top of clean barrier. 17. In the event more than one wound is present, each wound site is considered a separate treatment. A new pair of non-sterile gloves will be used for the cleaning of each site. The Enhanced Barrier Precautions policy, effective 4/3/24, documents Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multi-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The Donning & Doffing PPE (Personal Protective Equipment) guidance, no date, documents 3. Put on isolation gown. Tie all of the ties on the gown. On 5/1/24, a Physician ordered Enhanced Barrier Precautions (chronic wound, indwelling catheter) every day and night related to multi-resistant organisms in the urine. On 5/10/24, a Physician ordered wound care for the sacral wound and for the right buttock wound. 06/11/24 at 1:10 PM, an open box of latex gloves was observed to be opened and lying open side down on the floor in R32's room. V6 (Certified Nurse Aide/CNA) was observed to be providing cares for R32 without having the Personal Protective Gown fully donned and ties were not tied. On 6/11/24 at 1:17 PM, V8 (Licensed Practical Nurse) was observed to pick the box of gloves up off the floor, placed the box of gloves on the clean surface with the dressing change supplies, donned the gloves from the opened box that had been on the floor and conducted wound care on R32.