STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145453	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace of McHenry Rehab	803 Royal Drive McHenry, IL 60050

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on interview and record review the facility failed to ensure a resident's request for Advance Directives regarding Cardiopulmonary Resuscitation (CPR) was accurately incorporated into the medical record for 1 of 1 resident (R28) reviewed for advance directives in the sample of 32. The findings include: R28's face sheet printed on [DATE] showed an admitted [DATE]. On [DATE], R28's eMAR (electronic medical record) was reviewed. The computer banner screen showed the code status as full code and DNR (Do Not Resuscitate). R28's [DATE] physician order tab showed an order dated [DATE] for: Code status: Attempt resuscitation/CPR (full code) The same tab showed a second order dated [DATE] for: Code status: Do not attempt resuscitation (DNR). R28's POLST (Practitioner Order for Life-Sustaining Treatment) was dated [DATE] and showed No CPR: Do not attempt Resuscitation. R28's care plan showed a focus area related to code status. R28 was documented as a full code and wishes to remain a full code. On [DATE] at 11:28 AM, V19 (Licensed Practical Nurse) stated resident code status is documented in the computer on the banner screen and under the physician order tab. The POLST can be viewed as well. V19 said that is how the nurses know if CPR should or should not be performed. V19 said it is important to know a resident's code status so that advance directive wishes are followed. On [DATE] at 11:35 AM, V5 (Memory Care Director/Social Services) stated resident code status is established upon admission by the nurses. V5 said social services meet with them or the family again to address the code status and be sure the wishes are in the computer system correctly. V5 said the code status choice is documented in computer on the banner screen, under the physician order tab, and on the scanned-in POLST form. V5 reviewed R28's code status in the electronic record and said, Hmmmm .I see she is both. That is absolutely a problem. V5 said any sort of contradiction would cause confusion in the event of an emergency. Any code status changes are done by the social service department and communicated to the floor nurses. V5 said the banner and the orders need to be correct. That is a serious problem. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Alden Terrace of McHenry Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 803 Royal Drive McHenry, IL 60050	

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:40 AM, V16 (Corporate Nurse Consultant) stated the nurses look under the electronic banner and physician orders for resident code status. It is important that the information is accurate, so any emergency situation is honored as the resident or the representative wishes. The facility's Advance Directives policy revision dated ,d+[DATE] states: 7. All advanced directive preferences will be documented in the resident's care plan and updated quarterly, annually, and upon any significant changes in cognition. 8. If the resident or resident representative chooses to initiate/change any advance directives, the Social Service Director/designee will document changes and update the plan of care.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 41639 Based on observation and interview, the facility failed to provide a clean, sanitary, and odor free environment for 1 of 1 resident (R99) reviewed for safe/clean/comfortable/homelike environment in the sample of 32 and 3 residents (R7, R97, R120) outside of the sample. The findings include: 1) On 5/14/24 at 10:19AM, R7's fitted bed sheet had 2 large yellow stains on it. R7's room had a strong urine odor present. On 5/15/24 at 9:37AM, R7's fitted bed sheets had the same 2 yellow stains and room odor that were present on 5/14/24. On 5/15/24 at 12:18PM, R7's fitted bed sheet had the same 2 yellow stains and additional brown stains present on them. R7's pillowcase had 2 brown stains on them that appeared to be from coffee. On 5/16/24 at 8:45AM, R7's fitted bed sheet and pillowcase had the same stains that were present on 5/14/24 and 5/15/24. R7 was not interviewable. 2) On 5/14/24 at 10:10AM, R97's fitted bed sheet had 2 large smears of brown and 1 large yellow stain. On 5/15/24 at 9:42AM, R97's fitted bed sheet had the same stains present as 5/14/24. On 5/16/24 at 8:48AM, R97's fitted bed sheet was in the same condition as 5/14/24. R97 was not interviewable. 3) On 5/14/24 at 10:15AM, R99 was observed laying in his bed with yellow stains on the side of the fitted sheet and one half full urinal on his garbage can next to his bed and one empty urinal in the bed with him next to his pillow. On 5/15/24 at 12:18PM, R99's fitted sheet had the same yellow stains as 5/15/24 and a large, dried, brown stain in the center of the sheet. On 5/16/24 at 8:45AM, R99's fitted sheet was in the same condition and had a blanket thrown over the stains. Underneath of the blanket were 2 additional wet, yellow stains. R99 was not interviewable. 4) On 5/14/24 at 10:19AM, R120's fitted sheet had yellow and brown stains in the center of the sheet. R120's room had a strong urine and feces odor that went out to the hallway near his room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 at 9:37AM, R120's sheets and room were in the same condition as 5/14/24 and he had two 1/2 full urinals hooked onto the left side of his bed. On 5/16/24 at 8:45AM, R120's sheets and room were in the same condition. R120 was not interviewable. On 5/16/24 at 8:47AM, V8 (Certified Nursing Assistant) stated, All of the residents get their bedding changed as needed and on shower days. Even if a resident refuses a shower we still change their bedding to make sure that's at least clean. On 5/16/24 at 8:48AM, V5 (Memory Unit Coordinator) stated, The residents bedding gets changed every shower day and as needed. We change it to try and be as clean as possible. Surveyor then toured R7, R97, R99, and R120's rooms with V5. V5 stated he agreed there was a strong odor in the respective rooms that was coming out into the hallway and that any reasonable person would not want to lay on those sheets or smell that odor. On 5/16/24 at 12:27PM, V2 (Director of Nursing) stated, Linens are changed as needed and for sure when soiled. If a resident is perspiring heavily we would offer a shower and change the sheets as well. The facility was unable to provide a policy regarding linen changes.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review, the facility failed to provide bathing assistance for 1 resident (R99), and failed to provide meal set-up and transfer assistance for 1 resident (R335). These failures apply to 2 of 5 residents reviewed for activities of daily living in the sample of 32. The findings include: 1) R99's electronic face sheet printed on 5/16/24 showed R99 has diagnoses including but not limited to dementia without behaviors, hypotension, muscle weakness, and wedge compression fracture of T11-T12 vertebra. R99's facility assessment dated [DATE] showed R99 has severe cognitive impairment, requires substantial assistance for bathing, and has no behaviors of rejecting care. R99's nursing progress notes for April 2024 and May 2024 showed no documentation related to R9 refusing showers. R99's care plan dated 11/14/22 showed, (R99) has an ADL (activities of daily living) self-care performance deficit due to diagnosis of dementia, muscle weakness, hypertension, malnutrition, heart disease, and fall . assist with ADL tasks as needed. R99's care plan dated 11/14/22 showed, I have potential for alteration in skin integrity related to the following factors: decreased mobility, impaired cognition, urine, and bowel incontinence .barrier cream to areas exposed to moisture/incontinence, pericare after incontinence episodes, requested family to bring in an electric razor. Assist resident with shaving. On 5/14/24 at 10:20AM, R99 was laying in his bed, unshaved, a urinal laying in the bed with him and a strong urine and body odor coming from him. On 5/14/24 at 12:32PM, R99 was laying in his bed in the supine position with his right leg bent and his foot flat on the bed. R99's groin was visible and was red and inflamed. R99 stated he is unsure of how long his skin has been like that. R99 was observed on 5/15/24 and 5/16/24 and had the same urine and body odor coming from him and his room. R99 did not receive shaving assistance or a shower throughout the survey period of 5/14/24-5/16/24. R99's shower days are Wednesday and Saturday. R99's physician's orders for May 2024 showed, 6/14/23 lotrisone cream-apply to right going topically at bedtime for skin condition. R99's shower documentation from 4/17/24-5/16/24 showed R99 had not received a shower since 5/5/24 (11 days). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 8:47AM, V8 (Certified Nursing Assistant) stated, Residents are given a shower twice a week and as needed. If a resident refuses a shower, we report it to the nurse and try to reproach them. I at least try to give them a bed bath. I know (R99) refuses his sometimes but we should keep trying because he really needs them. On 5/16/24 at 8:48AM, V5 (Memory Unit Coordinator) stated, All residents are given a shower at least once a week but we try to get them twice a week. I do agree there is a strong odor coming from (R99's) room and that we should really be trying to get him cleaned up with a sponge bath at the very least. On 5/16/24 at 12:27PM, V2 (Director of Nursing) stated, If residents are visibly soiled or there is an odor coming from them then it's been too long for them to not have a shower. 11 days is far too long to go without a shower and any reasonable person would feel gross if they didn't shower for that long. The facility's policy titled, Bath, tub or shower dated 09/20 showed, Policy: 1. To provide cleanliness and comfort to the resident. 2. To assist the resident in bathing. 3. To prevent body odors. 4. To stimulate circulation and provide a mild form of exercise. 5. To observe the resident's skin condition. 39537 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 5/14/24 at 12:38 PM, R335 was sitting in her wheelchair, in her room. R335's wheelchair was diagonally positioned near the foot of her bed, facing the head of her bed. R335's bed linens were pulled back and her cell phone was resting on the foot of the bed, attached to a charger. The surveyor asked R335 how her day was going and she replied, Crappy! I have a major complaint. I'm not happy. It takes 2 of them (facility staff) to get me out of bed. One of them was (V18 - PT (Physical Therapy)). R335 said she was tired and hurting after therapy and wanted to lay down in bed. R335 said she got back to her room around 12:00 PM and turned on her call light. R335 said a sweet, young lady, came in to answer her call light. R335 said she told her that she wanted to lay down because she was tired. R335 said she pulled back my blankets for me and plugged in my phone, but said I needed the assistance of 2 staff members and she would need to get help. R335 stated, She hasn't been back yet and no one has come in to help me back to bed. R335's back was to the wall with her TV on it. R335's overbed table was positioned against that wall. There was a meal tray on R335's overbed table. The surveyor asked R335 if the tray was her lunch. R335 replied, I don't think so, it's probably still my breakfast tray. Pull up the lid and look. The surveyor lifted the tray and told R335 it was her lunch (pepper steak, rice, and mixed vegetables. R335 replied, Well how am I supposed to eat when it's way back there. See why I'm so frustrated. I've been trying to wait patiently, but this is getting ridiculous. I just had surgery on my leg about a week ago and I have an appointment this Thursday to see what's going on with my leg. I can't just move myself or I would. What time is it? The surveyor provided the time. R335 replied, See what I mean, that's too long to wait. I decided I'm giving them until 1 PM to come in here and help me to bed, then I'm calling the number for complaints. (R335 stated V1 (Administrator's) first name.) That should make something happen. The surveyor stood near the nurses' station with view of R335's door. Several staff members passed up and down the hall from 12:50 PM to 1:08 PM including, V8-V10 (CNAs - Certified Nursing Assistants), V11 (CNA in training), V19 (LPN - Licensed Practical Nurse), and V1 (Administrator). At 1:08 AM, V9 (CNA) entered R335's room. At 1:12 PM, R335's wheelchair was positioned in front of her overbed table and she was eating her lunch. R335 stated, My favorite tech [V9] came to see why I wasn't eating and I told him that I was waiting to get to bed. He explained that it was important for me to eat and he would come back to help me back to bed after I ate something. So we'll see how long it takes for him to come back. He helped me get set up to eat. On 5/15/23 at 10:37 AM, R335 was lying in bed. The surveyor asked if she was assisted back to bed after she ate yesterday. R335 stated, I'm not sure exactly what time it was, but I do know it was more than an hour from the time I first asked. R335's Facesheet dated 5/16/24 showed diagnoses to include, but not limited to intertrochanteric fracture of the right femur, right hip replacement, diabetes, shock, weakness, hypothyroidism, history of falling, anxiety, and history of brain cancer. R335's facility assessment dated [DATE] showed she was cognitively intact. R335's Resident Transfer Evaluation dated 5/14/24 showed, she required 2 person assistance for transfers with a slide board. R335's Care Plan initiated 5/14/24 showed she transferred with a slide board and 2 person assist due to weakness. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R335's Care Plan initiated 7/14/23 showed she had limited ability to manage and complete ADLs and functional tasks due to balance deficits. R335's Care Plan initiated 8/1/23 showed she had the potential for fluctuating ADL (Activities of Daily Living) status secondary to osteoporosis and a history of right femur fracture. The interventions include, Assist resident with ADLs as needed. On 5/15/24 at 10:40 AM, V14 (RN) said R335 was alert and oriented and able to make her needs known. V14 said R335 would be able to tell you what is going on with her. V14 said R335 had surgery about a week ago and the hardware in her hip had to be replaced. V14 said the CNAs should be assisting the residents with tray set up and lunch and should assist the resident back to bed if they ask. V14 said R335 does have pain and shouldn't have had to wait over an hour to lay down On 5/16/24 at 9:10 AM, V9 (CNA) said he went into R335's room on Tuesday to encourage her to eat. V9 stated, I explained that she takes pain pills and if she doesn't eat something they she will keep getting nauseous. I don't know why they left the tray behind her like that. I encouraged her to eat and she said she would. Then I would help her get back to bed. V9 said R335 is alert and oriented and able to make her needs known, but she needs assistance of 2 staff members to transfer her. V9 said R335 prefers to stay in her room and she doesn't go to the dining room to eat. On 5/16/24 at 11:01 AM, V16 (Corporate Nurse Consultant) said if a resident is tired after therapy and asking to lay down then the staff should assist them in getting back to bed. V16 said she doesn't like to assign a time limit for care to occur, but over an hours is too long. V16 said if a resident eats in their room, then the CNA delivering the tray would assist the resident with setup. V16 said the tray shouldn't be left in the room, behind the resident. At 12:00 PM, V2 said the facility did not have an ADL policy. An ADL policy was requested and not received.

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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** 39537 Based on observation, interview and record review the facility failed to complete dressing changes for (R53) and failed to have preventative measures in place for a resident (R74) with non-pressure wounds for 2 of 6 residents reviewed quality of care in the sample of 32. The findings include: 1. On 5/15/24 at 10:20 AM, R53 was self-propelling his wheelchair in the hallway, near his room. R53 had a left above the knee amputation. R53 was wearing a black tennis shoe on his right foot with a gauze dressing noted extending from the shoe. The skin on R53's right ankle and lower shin was red and shiny. R53 said he had an infection in his leg and probably will have to have more toes cut off. R53 said he's been dealing with the wounds for a long time. R53 said the dressing to his right foot is only changed every couple of days. R53's Facesheet dated 5/16/24 showed diagnoses to include, but not limited to: amputation surgical aftercare, left above the knee amputation, PVD (peripheral vascular disease), Stage 3 CKD (Chronic Kidney Disease), diabetes, protein-calorie malnutrition, and mini-strokes. R53's facility assessment dated [DATE] showed he had moderate cognitive impairment and did not have a rejection of care behavior. R53's Physician Order Sheet dated 5/16/24 showed orders to paint his right 2nd, 3rd, and 5th toes with Betadine daily. R53's May 2024 TAR (Treatment Administration Records) showed R53's treatments to his right 2nd, 3rd, and 5th toes were not completed on 5/3, 5/4, 5/7, and 5/10. R53's Progress Notes were reviewed and did not contain entries on 5/3, 5/4, 5/7, or 5/10 about dressing changed or refusals of care. R53's Wound assessment dated [DATE] showed non-pressure wounds to his right 2nd toe (2 x 1 x 0 cm), right 3rd toe (3 x 1 x 0 cm), and right 5th toe (1 x 1 x 0 cm). This document showed these wounds had 100% necrotic/eschar tissue. This document showed the treatment plan was to cleanse with normal saline and paint with Betadine daily and as needed. R53's Podiatry Note dated 4/19/24 showed that R53 had an angiogram with the vascular surgeon, presents with gangrene to his right 3rd toe and new gangrene changes to his right 4th and 5th toe. This note showed R53 continues to smoke 4-5 cigarettes a day, has a history of PVD, had a history of having his right great toe amputated, and was deemed a poor surgical candidate by the vascular surgeon. This document showed that if R53's foot continued to decline, the plan of care will be a right above the knee amputation. R53's Care Plan initiated 4/7/24 showed R53 had an actual skin alteration to his right 2nd and 5th toes. The interventions included, Treatment as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 9:14 AM, V14 (RN - Registered Nurse) said the dressing changes should be documented on the TAR, after the treatment is completed. V14 stated, There is no way to know if the dressing was actually done, if it doesn't get charted. V14 said the nurses should follow the physician orders for the wound care treatments. On 5/16/24 at 9:35 AM, V17 (RN) said R53 had a history of PVD and diabetes and had necrotic toes. V17 said the floor nurses complete the dressing changes, except on the day the Wound Care Provider does rounds. V17 said dressing changes or treatments should be documented on the TAR. V17 said the dressing changes allow for the nurse to clean the wound, assess it, and promote the healing process. V17 said dressing changes and wound treatments also reduce the risk of infection. On 5/16/24 at 10:55 AM, V16 (Corporate Nurse Consultant) said R1's chronic non-pressure wounds were a long story. V16 said R53 had a history of amputation prior to admission to the facility. V16 said R53 is followed by the Wound Care Provider, Podiatrist, and a Vascular surgeon. V16 said they are no longer able to provide any aggressive vascular surgeries because R53 is not a good candidate. V16 said the daily wound care and dressing changes/treatments should be signed off on the TAR. V16 said it is possible there will be a progress note too. V16 said the dressing changes and treatments should be completed as ordered. The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations dated 3/2/21 showed, Policy: .3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized care plan . 20042 2. On 5/15/24 at 10:02 AM, R74 was laying on her back in bed. R74's heels were not offloaded and were resting on the mattress. R74 had offloading boots on the floor in the corner of her room. On 5/15/24 at 1:47 PM, R74 was laying on her back in bed. R74's heels were not offloaded and were resting on the mattress. R74's heel boots were sitting in the chair in her room. R74 stated her heel was sore. R74 stated it would be okay if staff put a pillow under her legs to keep her heels up off from the mattress. On 5/15/24 at 1:54 PM, V3 DON (Director of Nursing) stated heels should be offloaded all the time. V3 stated If the resident doesn't want to wear the off-loading boots staff should offer something else to offload the heels. If the resident complains of pain, they should let the nurse know right away. I would expect the CNA (Certified Nursing Assistant) to offer to put a pillow under the resident (to off-load heels) and then let the resident know that they will tell the nurse. The Skin/Wound Progress Note dated 5/14/24 at 2:32 PM for R74 showed, open right heel wound with yellow/brown drainage; 3.2 x 1.5 x 0.1. Resident is noted with open wound to right heel, offloading boots in place, treatment changed per provider due to previously stable discoloration is now open with drainage. Resident to be seen by wound NP (Nurse Practitioner), continue with preventative measures. The Care Plan for R74 dated 4/14/24 showed, R74 has potential for alteration in skin integrity related to a history of pressure injury to left buttock as well as a history of diabetic ulcer to right heel. Elevate heels off bed (non-arterial). Inspect skin daily with care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Face Sheet dated 5/15/24 for R74 showed medical diagnoses including cerebral arteritis, anemia, chronic kidney disease, type 2 diabetes mellitus, epilepsy, polyneuropathy, hyperlipidemia, neuromuscular dysfunction of bladder, retention of urine, anxiety, chronic kidney disease - stage 4, hypertension, muscle weakness, transient ischemic attack, gout, and repeated falls. The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations policy (3/2/21) showed, implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan.

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NAME OF PROVIDER OR SUPPLIER Alden Terrace of McHenry Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 803 Royal Drive McHenry, IL 60050	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on observation, interview, and record review, the facility failed to ensure a resident's heels were offloaded for 1 of 7 residents (R30) reviewed for pressure ulcers in the sample of 32. The findings include: R30's Admission Record, printed by the facility on 5/16/24, showed she had diagnoses including Alzheimer's disease, aphasia (a language disorder that affects a person's ability to understand and express language, reading, and writing), anxiety disorder, and psychotic disorder with hallucinations due to known physiological condition. R30's facility assessment dated [DATE] showed she is dependent on staff for toileting, bathing, upper and lower body dressing, bed mobility, and personal hygiene. The assessment showed R30 had an unstageable, deep tissue pressure injury. R30's care plan initiated on 4/8/2021 showed she had a deep tissue injury to her right heel. The care plan showed R30 had a history of pressure injuries to her left heel and sacral area. On 5/16/24 at 9:43 AM, R30 was sitting in her geriatric hospice chair in the dining room during the activity program. R30 had non-skid socks on both feet. R30 did not have any pressure relieving device on either of her feet and both of her heels were touching the footrest on her geriatric chair. At 10:15 AM, V23 (R30's husband) was sitting next to her in the dining room. V23 said the pressure-relieving boots were not on her when he came to the facility around 10:00 AM. V23 said he asked one of the staff members to go get (R30's) pressure-relieving boots and put them on her. On 5/16/24 at 9:14 AM, V4 (Licensed Practical Nurse/Corporate Wound Consultant) said R30 had a previous pressure injury to her right heal that healed and then reopened. V4 said R30 had previous pressure injuries to her buttock, left heel, and sacral area previously. V4 said R30's current wound was identified on 2/7/24 as purple colored intact skin with blood filled blister measuring 4.5 centimeters (cm) x 2.7 cm. At 9:30 AM, V4 said resident's on hospice are more prone to skin breakdown. V4 verified that R30 was on Hospice Care. On 5/16/24 at 11:40 AM, V4 (Licensed Practical Nurse/Corporate Wound Consultant) said right now with R30's pressure injury, her heels should be offloaded. V4 said it is important to keep the blood flow optimized to R30's heels, because she already has a pressure ulcer there. On 5/16/24 at 11:58 AM, V3 (Director of Nursing-DON) said staff should have had R30's boots on and her heels should have been elevated back to keep pressure off that area, and to help with blood flow. V27's (facility Wound Doctor) wound notes dated 5/15/23 showed R30 had a pressure ulcer on her right heel that was an unspecified stage measuring 1.0 centimeter (cm) x 0.5 cm x 0.1 cm The plan of care listed on V27's notes showed OFF LOADING (in bold letters) torso, lower extremities and general body. The notes listed offloading heels with heel protectors or pillow as one of the preventative measures that were in place for R30. Another measure was Avoid bony prominence under direct pressure.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review, the facility failed to perform a safe transfer for 1 resident (R74), failed to perform safe smoking assessments for 2 residents (R53, R125) and failed to intervene when a resident was tipping his wheelchair for 1 resident (R17). These failures apply to 4 of 4 residents reviewed for safety/supervision in the sample of 32. The findings include: 1) R17's electronic face sheet printed on 5/16/24 showed R17 has diagnoses including but not limited to atrial fibrillation, Alzheimer's disease, dementia with agitation, anemia, polyneuropathy, heart failure, atherosclerotic heart disease, pacemaker, hypertension, and bradycardia. R17's facility assessment dated [DATE] showed R17 has severe cognitive impairment. On 5/14/24 at 12:15PM, R17 was sitting at the dining table with both of his wheels locked on his wheelchair. R17 was pushing back from the table and tipping his wheelchair backwards. R17 was agitated and yelling at other residents at his table. Multiple facility staff were in the dining room serving lunch to all of the residents and did not intervene when R17 was tipping his wheelchair backwards. On 5/16/24 at 8:53AM, R17 was pushed against the dining table in his wheelchair with both of the brakes locked. R17 was tipping his wheelchair backwards while multiple staff members were in the dining room. No staff intervened to prevent R17 from tipping backwards in his chair. On 5/16/24 at 9:04AM, V22 (Registered Nurse) stated R17 is able to unlock his wheelchair on his own but staff need to tell him to do it. Surveyor observed R17 with V22 instructing R17 to unlock his wheels and he was able to do so with clear direction. V22 then locked R17's wheelchair wheels again. V22 stated it is a safety concern if R17 is tipping his wheelchair back and staff should be intervening when he does it so he doesn't tip himself backwards onto the floor. R17's fall documentation from January 2024-5/15/24 showed R17 has had 9 falls from his wheelchair. R17's nursing care plan dated 1/16/24 showed, (R17) is at risk for falls due to diagnosis of atrial fibrillation, Alzheimer's, dementia, polyneuropathy, anemia, heart failure, hypertension, and malignant neoplasm of prostate. When patient is awake do not leave unattended to prevent getting up, possible room changes closer to nurse's station, and ensure resident is pushed up to a table when not with staff. On 5/16/24 at 12:27PM, V2 (Director of Nursing) stated, When you are dealing with a resident with dementia, you have to constantly remind them to do things. If a resident wheelchair is locked and can't move their wheelchair, they would need close supervision to ensure they don't tip backwards. This is definitely a concern that he could tip all the way back and staff should be reminding him to unlock his wheels if they see him tipping backwards. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled, Management of falls dated 08/2020 showed, The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. 20042 2. On 5/14/24 at 12:48 PM, R74 was sitting in her wheelchair in her room waiting to go to bed. R74 stated V7 CNA was her certified nursing assistant today and he lifted her up himself and put her in her chair. R74 stated they don't use a gait belt; they never use that. V25 (R74's spouse) stated he is at the facility every day, three times per day. V25 stated R74 was tired, and they were waiting for V7 to transfer her to bed. V25 stated everyone is different on how they transfer R74. Some staff will give her a hug, lift her up and transfer her. V25 stated the female CNAs were the ones that use the sit-to-stand to transfer her. R74 stated V7 lifted her today and put her in her wheelchair. R74 stated V7 did not use a gait belt or the sit-to-stand. On 5/14/24 at 12:55 PM, V6 CNA and V7 CNA came into R74's room with a stand lift machine. They put a sling around the resident that was very loose. V6 and V7 transferred R74 from her wheelchair to her bed; the sling slid up on the resident. V6 stated R74 is to be transferred using the sit-to-stand. There was an SS on the white board above R74's bed showing a sit-to-stand is to be used for transfers. On 5/15/24 at 1:54 PM, V3 DON (Director of Nursing) stated staff know how to transfer a resident because they can go into the task section to see how they transfer. V3 stated the Kardex is another way staff can find out how a resident transfer. Staff should follow the resident's care plan on how they should transfer. It would be a safety problem to not transfer a resident according to their care plan. The care plan dated 4/14/24 for R74 showed, R74 transfers via the standing lift due to diagnoses of seizures, hypertension, epilepsy, muscle weakness, and repeated falls. Attach the harness belt snuggly around the resident. Have resident place feet on the support plate, (assist as necessary) with shins against the shin support. Use a standing lift when assisting resident to transfer. The MDS (Minimum Data Set) dated 4/8/24 for R74 showed she needs substantial/maximal assistance for sit to stand positioning and for chair/bed -to- chair transfer. The Face Sheet dated 5/15/24 for R74 showed medical diagnoses including cerebral arteritis, anemia in chronic kidney disease, type 2 diabetes mellitus, epilepsy, polyneuropathy, hypertensive chronic kidney disease, mixed hyperlipidemia, neuromuscular dysfunction of the bladder, encephalopathy, acute metabolic acidosis, retention of urine, elevated white blood cell count, hypokalemia, hypomagnesemia, altered mental status, anxiety disorder, chronic kidney disease stage 4, hyperlipidemia, conversion disorder with seizures or convulsions, peripheral autonomic neuropathy, hypertension, chronic pain syndrome, malignant neoplasm of sigmoid colon, colostomy status, transient ischemic attack, gastroesophageal reflux disease, muscle weakness, and abnormalities of gait and mobility. The Sit To Stand Machine Lift policy (1/14/21) showed, position the belt around the resident's lower back, just above the belt line. Fasten the belt tight enough to fit caregivers fingers between the belt and resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/24 the facility did not have a resident safety policy. 39537 3. On 5/15/24 at 1:23 PM R53 was sitting in his wheelchair, in the dining room waiting for the smoke break. V15 (Activity Aide) assisted a female resident to the courtyard in her wheelchair, then returned to the dining room for the residents waiting. V15 went into the activity room and obtained a clear box with the resident's cigarettes and lighters. V15 informed the waiting residents that it was time for the break and they self-propelled their wheelchairs to the courtyard. R53 was seated in his wheelchair. R53 had a left above the knee amputation. R53's right foot had a gauze dressing, peeking out of his black tennis shoe. R53 was handed 2 cigarettes and lighter. R53 lite his cigarette and the activities staff supervised the break. R53's Facesheet dated 5/16/24 showed he was admitted on [DATE] and had diagnoses to include, but no limited to: amputation surgical aftercare, left above the knee amputation, PVD (peripheral vascular disease), Stage 3 CKD (Chronic Kidney Disease), diabetes, protein-calorie malnutrition, and mini-strokes. R53's facility assessment dated [DATE] showed he had moderate cognitive impairment and did not have a rejection of care behavior. R53's Smoking Agreement dated 2/13/24 showed he read and understood the guidelines of the facility's smoking program. This form was not an assessment of R53's ability to safely smoke. R53's Assessments tab was reviewed. There was no Smoking Assessment completed for R53. R53's Care Plan initiated 4/29/24 showed he was assess to be a safe smoker (R53's EMR did not contain a smoking assessment). The interventions included, Assess resident's ability to smoke safely, hold own cigarettes and smoke per facility guidelines upon admission, quarterly, annually, and as needed . On 5/16/24 at 9:14 AM, V14 (RN - Registered Nurse) said the Activities' staff supervises the smoke breaks. V14 stated, I know they keep the cigarettes and lighters locked up in their office and Social Services does the assessments. The smoking assessments are done to ensure the residents are safe to smoke and they won't burn themselves or try to smoke with their oxygen tank. I think the Smoking Assessments should be under the Assessment tab. On 5/16/24 at 9:35 AM, V17(RN) said the nurse completes the Smoking Agreement on admission. V17 said it was part of the Admission Checklist, but she wasn't sure about a Smoking Assessment. V17 reviewed R53's Assessments tab in the EMR (Electronic Medical Record) and stated, I don't see a smoking assessment for him. V17 reviewed the list of available assessments and stated, It looks like there is a Smoking Assessment that can be completed, but he doesn't have one. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ON 5/16/24 at 9:50 AM V5 (Memory Care Director) said he is new to the Memory Care Director and was previously Social Services. V5 said the facility's smoking program is a team approach between Social Services and Activities. V5 said Social Services have the resident sign a smoking contract on admission and review the rules with them. V5 said the Smoking Assessment is typically completed by Social Services upon admission. V5 said he was not sure of the schedule for Smoking Assessments after admission. V5 said he would have to ask V1 (Administrator). V5 said the Smoking Assessments should be documented in the Assessments tab of the EMR. V5 reviewed R53's Assessments and said he did not see a Smoking Assessment for R53, only a Smoking Agreement. V5 said the Smoking Agreement is not an assessment. The Smoking Assessment is done to determine the residents ability to safely smoke and R53 should have one. The facility's Smoking Policy dated 8/2023 showed, The facility will assess hazards and risk factors associated with smoking, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care to minimize the risks of incidents/accidents associated with smoking. Procedure: 1. Upon admission to the facility, resident and/or their representative will be oriented to the facility's rules related to smoking and will sign an agreement to abide by facility's rules . 3. If the resident is identified as a smoker, a smoking risk assessment . will be completed upon admission, annually, significant changes, and upon any change in the resident's smoking behavior . 34491 4. R125's Admission Record, printed by the facility on 5/16/24, showed he was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, type 2 diabetes mellitus, a stage 4 pressure injury to his sacrum, weakness, vascular dementia, and adjustment disorder with anxiety. R125's name was on the Smoking List provided during the survey. On 5/15/24 at 9:10 AM, R125 was observed in his room. R125 said the facility staff hold onto his cigarettes and lighter. R125 said the residents are not allowed to hold onto their smoking supplies. On 5/15/24, a smoking assessment was not found in R125's electronic medical record under the assessment tab, the miscellaneous tab, or in the progress notes. On 5/16/24 at 11:25 AM, V5 (Memory Care Director) said he used to be the facility's Social Service Director (SSD). V5 said about a month prior he switched to his current position. V5 said the SSD does the smoking assessments for the new admissions, for any residents that smoke who have a significant change in their condition, and annually. V5 said he did not do a smoking assessment for R125. V5 verified that a smoking assessment was not done for R125 until 5/16/24. V5 said R125 already had a care plan in place that was initiated on 4/29/24. V5 was asked how R125 could be designated as a safe smoker if there was no smoking assessment completed. V5 said that is a good question, adding The smoking assessment is officially what identifies if a resident is safe with smoking. All R125's care plans were requested from V5. No care plan addressing R125's smoking was provided. On 5/16/24 at 12:00 PM, V3 (Director of Nursing-DON) said smoking assessments should be completed at least on admission, quarterly and if any change in the resident's condition. V3 said We need to figure out if the resident is a safe smoker.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 33761 Based on observations, interview and record review the facility failed to ensure a urinary catheter bag did not come in contact with the floor, failed to ensure the catheter bag was not above the level of the bladder, and failed to ensure a urinary catheter bag was emptied before urine backed up past the tubing. This applies to 2 of 5 residents (R74, R92) reviewed for catheter care in the sample of 32. The findings include: 1. R92's Face Sheet shows his diagnoses to include: stage 3 chronic kidney disease, obstructive and reflux uropathy, nodular prostate with lower urinary tract symptoms, and retention of urine. On 5/14/24 at 12:00 PM, R92 was in bed with his urinary catheter bag hanging on the side of his bed. The catheter bag was full to the top but not yet into the tubing. On 05/15/24 at 1:19 PM, R92 said, the CNA's (Certified Nursing Assistant) didn't dump the urine bag yesterday in time before it came all the way up the tube and backed up past the catheter. I pressed the call light because I felt bladder pressure, and finally a CNA dumped it. On 05/15/24 at 12:15 PM, R92 was in bed with his urinary catheter bag hanging on the side of his bed. The catheter bag was 3/4 full. The same day at 2:15 PM, the catherter bag, and the tubing was totally full. R92's call light was on. On 05/15/24 at 12:15 PM, R92 said, he feels pressure in his bladder, like he has to urinate. 05/15/24 at 2:17 PM, V24 RN (Registered Nurse) said, the urinary catheter bag should be emptied before it backs up into the resident because it could cause an infection. 05/16/24 at 12:05 PM, V3 DON (Director of Nursing) said, the CNA's should check the catheter bag at beginning of shift and a couple times a shift. V2 said, the CNA's are going to check on resident every 2 hours anyway, then why not peek at the bag to see if it needs emptying. V3 said, having the urine back up into the bladder is an infection risk. 05/16/24 at 12:17 PM, V6 CNA said, the CNA's are suppose to check the urine bag every time they go in the room. V6 said, having the urine back up into the bladder could cause a UTI (Urinary Tract Infection). R92's 11/7/23 Care Plan shows R92 is at risk for bladder distention, incomplete emptying of the bladder and/or UTI secondary to benign prostatic hypertrophy, nodular prostate. One intervention is to encourage prompt and complete bladder emptying. R92's 5/9/24 Care Plan shows R92 requires the use of an indwelling catheter due to a diagnosis of obstructive and reflux uropathy. One intervention is to empty the urinary catheter bag every shift and as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/2020 Indwelling Catheter Policy and Procedure shows, to empty drainage bags at least once each shift and as needed. R92's 5/1/24 MDS (Minimum Data Set) shows R92 is cognitively intact. 20042 2. On 5/14/24 at 12:48 PM, R74 was sitting in a wheelchair in her room. R74 had an indwelling urinary catheter drainage bag in a dignity bag under her wheelchair. V6 CNA (Certified Nursing Assistant) and V7 CNA came into R74's room with a stand lift machine. They put a sling around the resident. They took the drainage bag out of the dignity bag and put it on the floor. V6 and V7 used the stand lift to move R74 out and away from her chair towards her bed with the catheter bag dragging on the floor from under her wheelchair. V6 told V7 that the drainage bag was on the floor. V7 picked the drainage bag up and laid it on R74's bed. They lowered R74 onto the bed, picked up the drainage bag and placed it in the dignity bag. V7 stated he saw that the catheter drainage bag was on the floor and it should not be on the floor for infection control. V7 stated he noticed the bag laying on the bed at the end of the bed where the bag is is higher than her hips and bladder. V7 stated urine can go backwards and they have to keep the drainage bag below level of bladder. On 5/15/24 at 1:54 PM, V3 DON (Director of Nursing) stated the catheter drainage bag should be kept below bladder, hang on bed and not on floor. V3 stated the drainage bag should never be on the floor because it is a violation and infection control issue. V3 stated the drainage bag should be below the bladder so there isn't any reflux of urine that can cause infections. The care plan dated 4/14/24 for R74 showed, R74 requires the use of an Indwelling (suprapubic) Catheter due to diagnosis of neuromuscular dysfunction. Change catheter according to facility protocol. Enhanced barrier precautions will be implemented during high contact resident care activities. Monitor color, consistency, and odor of output and document. No other interventions were listed for the catheter. The Antibiotic Therapy Note dated 3/25/24 for R74 showed she was treated with intravenous ceftriaxone for seven days for a urinary tract infection. The Face Sheet dated 5/15/24 for R74 showed medical diagnoses including cerebral arteritis, anemia in chronic kidney disease, type 2 diabetes mellitus, epilepsy, polyneuropathy, hypertensive chronic kidney disease, mixed hyperlipidemia, neuromuscular dysfunction of the bladder, encephalopathy, acute metabolic acidosis, retention of urine, elevated white blood cell count, hypokalemia, hypomagnesemia, altered mental status, anxiety disorder, chronic kidney disease stage 4, hyperlipidemia, conversion disorder with seizures or convulsions, peripheral autonomic neuropathy, hypertension, chronic pain syndrome, malignant neoplasm of sigmoid colon, colostomy status, transient ischemic attack, gastroesophageal reflux disease, muscle weakness, and abnormalities of gait and mobility. The facility's Indwelling Catheter policy (9/20) showed, place drainage bag below the level of the resident's bladder to facilitate drainage and minimize stasis of urine.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review, the facility failed to intervene for a resident experiencing behaviors for 1 of 1 resident reviewed for dementia care in the sample of 32. The findings include: R17's electronic face sheet printed on 5/16/24 showed R17 has diagnoses including but not limited to atrial fibrillation, Alzheimer's disease, dementia with agitation, anemia, polyneuropathy, heart failure, atherosclerotic heart disease, pacemaker, hypertension, and bradycardia. R17's facility assessment dated [DATE] showed R17 has severe cognitive impairment and experiences physical and verbal behaviors. R17's nursing care plan dated 3/15/24 showed, Resident has the potential for/history of physical aggression towards others. Poor impulse control. Complete behavior tracking when behavior occurs. Observe resident behavior/interactions around other residents and monitor for aggressive behaviors. Remove resident from any potential situation which could precipitate aggressive behavior. On 5/14/24 at 12:08PM, R17 began yelling at R45 to stop singing so loud. R17 then began banging on the table, tipping his wheelchair back, and yelling, SHUT UP! SHUT UP! SHUT UP! At 12:15PM, R17 continued yelling at R45 to stop singing and pointed at R65 and shouted, Stop smiling at me! R17 then picked up an empty plastic coffee mug and threw it at R65 but did not hit her. Several staff members were in the dining area assisting residents with lunch and did not intervene. R65 then stuck her tongue out at R17 and he stated, I HATE YOU! R17 continued to sit at the same table throughout the remainder of the noon meal. On 5/16/24 at 12:23PM, V22 (Registered Nurse) stated, For (R17) we try to redirect him as much as we can and ask for help to give 1:1 attention. If he is in distress we would give him an as needed medication. If he is experiencing behaviors, we should try to remove him from the other residents when agitated because it affects the other residents as well and he could become combative towards other residents. On 5/16/24 at 12:27PM, V2 (Director of Nursing) stated, If a resident is becoming agitated, I would want the aides to let the nurse know, try to identify triggers, offer an as needed medication, and remove the resident from the situation that is making them agitated. A lot of times it's just unmet basic needs. I'm glad (R17) didn't hit any residents with the coffee mug but he very well could have and his behaviors were not handled appropriately as staff left him with a group of residents that he could have potentially become physical towards. The facility's undated policy titled, Behavior symptom tracking, assessment and the behavior management program showed, Procedure: 1. Upon witnessing any maladaptive moods and/or behaviors, staff's first priority is to maintain safety of residents, staff and visitors. Any necessary interventions, as trained, to maintain safety will be performed. This may include direct intervention .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34891 Based on observation, interview, and record review the facility failed to administer medications as ordered by not documenting a medication was given and not administering a medication at the scheduled time. There were 25 opportunities with 2 errors resulting in an 8% error rate. This applies to 1 of 6 residents (R47) observed in the medication pass. The findings include: R47's face sheet printed on 5/16/24 showed diagnoses including but not limited to heart failure, diabetes mellitus, irritable bowel syndrome, diverticulosis, and hypertension. R47's May 2024 physician orders showed an order for one docusate sodium oral capsule 100 milligram to be given every 24 hours for bowel management. The order showed one losartan potassium oral tablet 50 milligrams to be given one time a day for hypertension. On 5/15/24 at 8:35 AM, V14 (RN-Registered Nurse) administered R47's scheduled 9 AM medications. V14 gave a total of 9 pills which included one docusate capsule. V14 did not dispense or give the losartan potassium tablet. At 11:21 AM, R47's medication administration report (MAR) was reviewed. There was no documentation of the docusate capsule given. The report showed the losartan was not given at the scheduled time. On 5/15/24 at 12:55 PM, V14 (RN) stated she should have documented the docusate was given at the time she gave it. V14 said she should have charted that in real time so that it was not forgotten. V14 said the pills were dispensed and counted together, so she was not sure how she missed given the losartan. On 05/16/24 at 10:50 AM, V3 (Director of Nurses) stated medications should be documented as soon as they are given and before moving onto the next resident. That is the standard and expected nursing method. V3 said medications should be given within a one-hour window of the scheduled time. That is important to ensure the medication is working as it is supposed to. The effectiveness can be lower it if is not given as ordered. The facility's Medication Administration policy dated 01/2022 states under the procedure section: 5. Each dose administered shall be properly recorded on the residents MAR, TAR, or eMAR, immediately following administration. 8. Medications are administered within one hour of prescribed time. Unless otherwise specified by the physician, routine medications are administered according to established medication administration schedule.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Alden Terrace of McHenry Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 803 Royal Drive McHenry, IL 60050	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 34891 Based on observation, interview, and record review the facility failed to label and store medications according to their policy for 2 of 4 medication carts reviewed for medication storage. The findings include: On 5/15/24 at 9:53 AM, the 100-hall medication cart was reviewed with V20 (RN-Registered Nurse) present. The top drawer of the cart had three medication cups filled with pills. One cup held nine greenish-black tablets, one held four tan tablets, and one held four red capsules. All three cups were unlabeled. V20 said she guessed the pills were iron, a laxative, and multivitamins but was for sure. V20 stated she did not realize they were in the cart and was not sure where they came from. V20 said she had no idea who the pills belonged to or why they were not in the proper containers. V20 said there is the potential for administration mistakes, and they should not be in the cart without labeling. On 5/15/24 at 10:26 AM, the memory cart unit medication cart was reviewed with V19 (Licensed Practical Nurse) present. The top drawer of the cart had four prepackaged medications laying inside. Two of the medications were doxycycline (antibiotic) and four were seroquel (antipsychotic). None of the packets had any resident name or information stating who they belonged to. V19 said the packets should be in the individual resident's dispenser boxes and not loose in the drawer. V19 said there is no way to know who they belong to. There is the potential for resident's to be given the wrong dose or be missing medications when they are not labeled. On 5/16/24 at 10:40 AM, V3 (Director of Nurses) stated nurses should not be dispensing medications prior to the scheduled time. V3 said if a medication cannot be given after it is dispensed, the nurse should destroy it right away. Unlabeled medications have the potential to be given inadvertently to the wrong person. V3 stated the medication carts should be reviewed each day. On coming nurses should dump out any medications that they did not dispense. There is no way to know the integrity or dosage unless they dispensed it. It is also an infection control concern if nurses are unsure of who has touched a medication prior. V3 said all medications should clearly state the name of the resident. There is a big potential for errors when medications do not have the name of who they belong to. The facility's Storage/Labeling/ Packaging of Medications policy date 01/2022 states: 7. Each resident's medications are stored in original containers and must be properly labeled.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on observation, interview and record review the facility failed to provide incontinent care in a manner to prevent infection, failed to wash a resident's hands after they were contaminated during care, and failed to wear the appropriate personal protective equipment (PPE) while providing direct care for a resident on enhanced barrier precautions for 2 of 2 residents (R30, R22) reviewed for infection control in the sample of 32. The findings include: 1. R30's Admission Record, printed by the facility on 5/16/24, showed she had diagnoses including Alzheimer's disease, aphasia (a language disorder that affects a person's ability to understand and express language, reading, and writing), incontinence without sensory awareness, diaper dermatitis, anxiety disorder, and psychotic disorder with hallucinations due to known physiological condition. R30's facility assessment dated [DATE] showed she is dependent on staff for toileting, bathing, upper and lower body dressing, bed mobility, and personal hygiene. The assessment showed R30 was always incontinent of bowel and bladder. R30's incontinence care plan, initiated on 6/10/2019, showed she is incontinent of bowel and bladder. The care plans showed staff are to provide incontinence care after each incontinent episode, apply moisture barrier to skin, and monitor for excoriation near peri area. R30's Hospice care plan, initiated on 1/16/2024, showed she requires hospice care due to a diagnosis of senile degeneration of brain. On 5/14/24 at 1:23 PM, V26 (Certified Nursing Assistant-CNA) and V6 (CNA/Scheduler) transferred R30 from her geriatric hospice chair to her bed via a mechanical sling lift to provide incontinence care for R30. After pulling down R30's pants and removing her urine soiled incontinent brief, V26 grabbed two wet wipes from the package. V26 wiped R30's left groin area, flipped the wipes over and wiped R30's right groin area. V6 and V26 then rolled R30 onto her left side. V26 grabbed two more wipes and wiped R30's buttocks. V26 did not clean R30's pubic, or middle vaginal area. R30 placed her hands in her pubic area several times during incontinence care while V6 and V26 were removing the soiled brief and placing the clean brief on R30. No barrier cream was applied to R30s' skin during incontinence care and neither V6, nor V26 cleaned R30's hands prior to covering her up and exiting R30's room. On 5/16/24 at 11:54 AM, V3 (Director of Nursing-DON) said she would have used a different wipe for each location. V3 said V26 should have cleaned R30's middle area first then changed gloves used a new wipe and repeated the process with each location. V3 said V6 and V26 should have cleaned R30's hands while providing care because her hands were contaminated. On 5/16/24 at 9:32 AM, V4 (Licensed Practical Nurse/Corporate Wound Consultant) said with R30 being on hospice care she is prone to skin breakdown. V4 said it is important to make sure incontinent care is done thoroughly. All of our residents need to be cleaned thoroughly during incontinence care. It is important to make sure the resident's hands are cleaned if contaminated during incontinent care because they could put their hands in their mouth. V4 added, Dementia patients are a little impulsive and unaware with their movements. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 12:09 PM, V6 said V26 should have cleaned R30's middle vaginal area during incontinence care, because it needs to be cleaned thoroughly to prevent skin breakdown and infection. V6 said he and V26 should have washed R30's hands. V6 said R30 is not cognitively intact. She could put her hands in her mouth, or on her face. The facility's 9/2020 policy and procedure titled Perineal Care showed Female Perineal Care: a. Ask resident to separate her legs and flex knees. If she is unable to spread her legs and flex knees, the perineal area can be washed with the resident on her side. b. Put on gloves. c. Utilize appropriate cleansing solution or wipe. d. Separate the labia. Clean downward from front to back with one stroke. Repeat c and d until area is clean .e. Rinse (if applicable) and pat dry with towel. f. Turn resident on side. g. Utilize appropriate cleansing solution or wipe. h. Clean anal area. Clean from front to back. Repeat g. and h. until area is clean. The facility's 6/4/2020 policy and procedure titled Hand Washing and Hand Hygiene showed Appropriate hand hygiene is essential in preventing the spread of infectious organisms in healthcare settings. Guidelines: 1. Hand hygiene must be performed after touching blood, body fluids, secretions excretions, and contaminated items . 39537 2. On 5/14/24 at 10:35 AM, R22's door had an EBP sign outside the door, but no isolation bin outside the door or PPE (personal protective equipment) supply visible near the door. R22 was sitting in his wheelchair, watching TV. R22's arms were contracted toward his chest and his legs where bent inward. R22 had a catheter drainage bag hooked under his wheelchair. On 5/16/24 at 8:58 AM, V9 and V12 (CNAs - Certified Nursing Assistants) were at R22's bedside, wearing gloves. V12 was standing on the far side of R22's bed and V9 was nearest the door. V9 and V12 had already transferred R22 to the bed. Both V9 and V12's scrubs were in contact with R22's bed linens as they moved him. R22 had a T-shirt on and incontinence brief. R22's incontinence brief was removed and V9 provided catheter care. (V9 was not wearing a gown). After V9 completed catheter care, V9 and V12 turned R22 side to side to change his incontinence brief and position him in the bed. V9 and V12 did not have gowns on throughout R22's care. V9 and V12 exited R22's room. The surveyor asked V9 what the EBP sign meant. V9 replied, That sign is for [R22] because he has a catheter. We should be wearing a gown when we provide care to him. The surveyor asked V9 why they did not wear gowns during R22's care and replied, Because I did not have any gowns (pointing to R22's door and lack of isolation bin). How can I wear a gown I don't have? R22's Facesheet dated 5/16/24 showed diagnoses to include, but not limited to: CHF (Congestive Heart Failure); cerebral palsy; cardiomyopathy; dysphagia; obstructive and reflux uropathy; benign prostatic hyperplasia with lower urinary tract symptoms; generalized muscle weakness; retention of urine; and encounter for fitting and adjustment of urinary device. R22's Physician Order Sheet dated 5/16/24 showed he had an order for EBP for device care or use of the urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 10:44 AM, V16 (Corporate Nurse Consultant/Infection Preventionist) said the facility had an overflowing supply of PPE. V16 said EBP are put in place for residents with chronic wounds and indwelling medical devices to prevent the risk of spreading MDROs (Multi-drug Resistant Organisms). V16 said R22 is on EBP because he had an indwelling catheter. V16 said the staff should be wearing gown and gloves when completing high contact activities such as transfers, incontinence care, and catheter care. V16 said V9 and V12 should have been wearing gowns during R22's care. V16 stated, The EBP sign is placed on the door to notify the staff for the precautions. We had a skills lab a week ago and we covered EBP. They should know better. The facility's Enhanced Barrier Precautions Policy dated 12/14/23 showed, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes. As well as to prevent MDRO acquisition of those with an increased risk of acquiring MDROs including residents with a chronic wound or an indwelling medical device. Guidelines: .1. EBP involves gown and gloves use during high contact resident care activities for residents known to be infected or colonized with MDROs when contact precautions do not otherwise apply. As well as residents with a chronic wound and/or indwelling medical device . Procedure: 1. High-Contact Resident Care Activities include the following: . c. Transferring. e. Providing hygiene. f. Changing briefs or assisting with toileting. g. Device care or use: central line, urinary catheter, feeding tube, trach/vent/ h. wound care .