STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quincy Healthcare & Sr Living	1440 North 10th Street Quincy, IL 62301

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35509 Based on interview and record review, the facility failed to answer the residents' call light system in a reasonable amount of time for six of six residents (R7, R32, R40, R42, R55, R69) reviewed in a sample of 38 residents. Findings include: The document, Resident Call Light, dated 9/2022, states, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Calls for assistance are answered as soon as possible, but no later than five minutes. Urgent requests for assistance are addressed immediately. Call light response times are reviewed as part of the Quality Assurance Performance Improvement. The Alarm Response Report, for the week of 8/18/24 through 8/24/24, documents that two call lights took over two hours before answered: one 2 hours 25 minutes and one 2 hours 36 minutes; seven call lights took one hour or more before answered: one 1 hour 57 minutes; one 1 hour 48 minutes; one 1 hour 37 minutes; one 1 hour 20 minutes; one 1 hour 5 minutes; two 1 hour 3 minutes; nine over 50 minutes; eight over 40 minutes; 14 over 30 minutes and 25 over 20 minutes. On 8/27/24 at 10:00 AM, during the Group Meeting, R7, R32, R42, R69 stated that they have waited for their call lights to be answered for over an hour or longer. R7 stated, I don't know what they are doing that they can't come into my room. Sometimes a Certified Nursing Assistant (CNA) will come in and turn off the light and tell me she'll be back, and it doesn't happen, or it takes a long time. R42 stated, It's frustrating when you really need help, and no one comes. R69 stated, I think the CNAs are nice, but where are they when I need one? R40 and R55 agreed that they also have waited long periods before their call light has been answered. R40 stated, I think 20 minutes wouldn't be too long to wait, but over that seems too much. On 8/28/24 at 11:40 AM, V2, Director of Nursing, stated, Call lights are to be answered in a reasonable amount of time. I don't know why they are not.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 35509 Based on interview and record review the facility failed to provide the Beneficiary Notice to two (R232, R329) of three residents reviewed out of a sample of 38 residents. Findings: The document, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, dated 9/2022, states, Residents are informed in advance when changes will occur to their bills. The facility issues the Skilled Nursing Facility Advance Beneficiary Notice Central Management System) CMS form 10055 for the following triggering events: A. Initiation - In the situation in which the director of admissions or benefits coordinator believes Medicare will not pay for extended care items or services that a physician has ordered, Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) is issued to the beneficiary before those non-covered extended care items or services are furnished to the beneficiary. B. Reduction - In the situation in which the facility proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or any items or services at the current level and/or frequency of care that a physician has ordered, the SNFABN is issues to the beneficiary before items or services to the beneficiary are reduced. C. Termination - In the situation in which the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services to a beneficiary that a physician has ordered and the beneficiary would like to continue receiving the care, the SNFABN is issues to the beneficiary before such extended care items or services are terminated. If the resident's Medicare covered Part A stay is ending, a Notice of Medicare Non-Coverage (CMS 10123) is issues to the resident at least two calendar days before benefits end. The Notice of Medicare Non-Coverage informs the resident of the pending termination of coverage and of his/her right to an expedited review by a Quality Improvement Organization. The facility will file a claim (demand bill) when requested by the resident/beneficiary. The resident/beneficiary is not charged during the demand bill process. On 8/28/24 at 2:15 PM, V22, Accounts Receivable, stated, I do not have the documentation of the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage for R232 or R329. I do not know when or what these residents were told when their (Medicare A) coverage was going to (terminate).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on interview and record review the facility failed to notify the facility Ombudsman, of Facility Discharges/Transfers, monthly and failed to provide the resident and resident representative with a written notice of transfer for five residents (R18, R33, R46, R66, and R75) of five residents reviewed for transfer/discharges in the sample of 38. Findings include: Transfer or Discharge Documentation policy dated December 2016, documents Policy Statement When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Policy Interpretation and Implementation 4. When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: b. That an appropriate notice was provided to the resident and/or legal representative. 1. R18's Nursing Note dated 5/21/24 at 1:55 AM documents R18 admitted to the hospital with the diagnosis of congestive heart failure, and urinary tract infection. There was no evidence in the medical record of a facility notification of a transfer/discharge to the family or ombudsman. R18's Nursing Note dated 5/29/24 at 1:49 PM documents R18 will be returning this afternoon to the facility after a hospital stay for Congestive Heart Failure, Urinary Tract Infection, Pneumonia, Bilateral Lower Extremity Swelling, and Fluid Overload. 2. R33's hospital transfer dated 8/20/24 at 12:16 PM documents R33 was discharged to the hospital. There was no evidence in the medical record of a facility notification of a transfer/discharge to the family or ombudsman. R33's Nursing Note dated 8/20/24 at 7:51 PM documents R33 was sent to the emergency room by ambulance with possible Dyspnea/Aspiration Pneumonia and Acute Renal Insufficiency. R33 Nursing Note dated 8/22/24 at 1:06 PM documents that R33 was admitted to the hospital on 8/20/24 with shortness of breath due to being COVID-19 (Coronavirus) positive, and a Urinary Tract Infection. 3. R75's Nursing Note dated 7/12/24 at 2:53 PM documents R75 was admitted to the hospital for Leukocytosis. There was no evidence in the medical record of a facility notification of a transfer/discharge to the family or ombudsman. R75's Nursing Note dated 7/15/24 at 12:28 PM documents R75 returned to the facility at 12:15 PM. 50430 4. R46's medical record documents that R46 was hospitalized on [DATE]. No evidence of a facility notification of transfer/discharge or ombudsman notification was present on R46's chart. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49187 5. R66's medical record documents that R66 was transferred to a local hospital on 8/15/24. No evidence of a facility notification of a transfer/discharge or ombudsman notification was present on R66's chart. On 8/27/24 at 2:19 PM, V6/Business Office Manager stated she is in charge of keeping track of the residents notice of transfers and bed holds when a resident is sent out to the hospital. V6 verified that the facility was unable to provide documentation that R18, R46, R66, and R75 or their representative was provided with a written notice of transfer/discharge when R18, R46, R66, and R75 was sent out to the hospital. 8/28/24 at 9:28AM, V18/Service Director stated she is in charge of sending the ombudsman a monthly list of discharges from the facility. V18 stated, I only send the local Ombudsman a monthly list of residents who discharge from our facility. I do not include resident transfers to the hospital on the monthly Ombudsman list. I didn't know I needed to. V18 verified she had not sent notification to the local Ombudsman of R18, R46, R66, and R75's discharges to the Hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on interview and record review the facility failed to provide a bed hold notification to the resident or resident representative for five of five residents (R18, R33, R46, R66, and R75) reviewed for hospital transfers in the sample of 38. Findings include: The Bed-Holds and Returns policy dated March 2022, documents Policy Statement Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. Policy Interpretation and Implementation 1. All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents are provided written information about these policies at least twice: a. well in advance of any transfer (e.g.(example), in the admission packet); and b. at the time of transfer (or, if the transfer was an emergency, within (twenty-four) 24 hours). Transfer or Discharge Documentation policy dated December 2016, documents Policy Statement When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Policy Interpretation and Implementation 4. When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: b. That an appropriate notice was provided to the resident and/or legal representative. 1. R18's Nursing Note dated 5/21/24 at 1:55 AM documents R18 admitted to the hospital with the diagnosis of congestive heart failure, and urinary tract infection. There was no evidence in the medical record of a bed hold notification given to the resident or residents representative. R18's Nursing Note dated 5/29/24 at 1:49 PM documents R18 will be returning this afternoon to the facility after a hospital stay for Congestive Heart Failure, Urinary Tract Infection, Pneumonia, Bilateral Lower Extremity Swelling, and Fluid Overload. 2. R33's hospital transfer dated 8/20/24 at 12:16 PM documents R33 was discharged to the hospital. There was no evidence in the medical record of a bed hold notification given to the resident or residents representative. R33's Nursing Note dated 8/20/24 at 7:51 PM documents R33 was sent to the emergency room by ambulance with possible Dyspnea/Aspiration Pneumonia and Acute Renal Insufficiency. R33 Nursing Note dated 8/22/24 at 1:06 PM documents that R33 was admitted to the hospital on 8/20/24 with shortness of breath due to being COVID-19 (Coronavirus) positive, and a Urinary Tract Infection. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R75's Nursing Note dated 7/12/24 at 2:53 PM documents R75 was admitted to the hospital for Leukocytosis. There was no evidence in the medical record of a bed hold notification given to the resident or residents representative. R75's Nursing Note dated 7/15/24 at 12:28 PM documents R75 return to the facility at 12:15 PM. 50430 4. R46's medical record documents that R46 was hospitalized on [DATE]. R46's medical record does not contain documentation of written notice to R46 or R46's resident representative, of the facility bed hold policy. 49187 5. R66's medical record documents that R66 was hospitalized on [DATE]. R66's medical record does not contain documentation of written notice to R66 or R66's resident representative, of the facility bed hold policy. On 8/27/24 at 2:19 PM V6/Business Office Manager stated she is in charge of keeping track of the residents notice of transfers and bed holds when a resident is sent out to the hospital. V6 verified that the facility was unable to provide documentation that R18, R33, R46, R66, and R75 or their representative was provided with a bed hold policy when R18, R33, R46, R66, and R75 were sent out to the hospital.

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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** 31682 Based on record review and interview the facility failed to obtain a level II PASRR (Pre-Admission Screening and Resident Review) screening for two of three residents (R32, R34) reviewed for Level II PASRR screening with the diagnosis of Mental Illness in the sample of 38. Findings include: The facility's Admission Criteria policy dated March 2019 documents, Policy Statement: Our facility admits only residents who's medical and nursing care needs can be met. Policy Interpretation and Implementation 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for MD, ID, or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitation services he or she needs, and whether placement in the facility is appropriate. d. The state PASARR representative provides a copy of the report to the facility. e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation. f. Once a decision is made, the state PASARR representative, the potential resident and his or her representative are notified. 1. R32's Face Sheet documents R32 was admitted to the facility on [DATE]. R32's Physician's Progress Notes dated 2-16-24 and signed by V19 (Physician) document, Suicidal Risk Assessment. Assessment: Schizoaffective Disorder. R32's Medical Record does not include evidence of a level II PASRR screening being obtained after R32 was diagnosed with Schizoaffective Disorder. On 08/28/24 at 11:15 AM V2 (Director of Nursing/DON) stated, There was no PASRR level II requested once (R32) was diagnosed with Schizophrenia. 2. R34's PASRR Level I Screen Outcome dated 1-4-24 documents, PASRR Level I Determination: Refer for Level II Onsite. Suspected or confirmed PASRR condition: Mental Health Disability. Current diagnoses: Schizophrenia, Anxiety Disorder, and Depressive Disorder. R34's Medical Record does not include evidence of a level II PASRR screening being obtained since R34's PASRR Level I Screen dated 1-4-24 indicated R34 needed a PASRR Level II to be completed onsite. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 11:15 AM, V2 (DON) stated, (R34) has not had a level II PASRR screening done. On 08/28/24 at 11:17 AM, V1 (Administrator-In-Training) stated, We (the facility) are not sure when to request level II PASRR Assessments.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430 Based on observation, interview, and record review the facility failed to provide therapy or restorative services to prevent a functional decline for one of one resident (R46) reviewed for Activities of Daily Living decline in the sample of 38. Findings include: Facilities' policy Activities of daily Living (ADLs), Supporting dated 3/2018, documents Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition demonstrate that diminishing ADLs are unavoidable. Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. R46's current Care Plan documents that R46 became a non-weight bearing mechanical lift on 1/12/24. Prior to R46's care plan dated 1/12/24, R46's Care Plan documented R46's transfer status was sit-to-stand lift with two staff assistance. R46's Minimum Data Set (MDS) assessment dated [DATE], 4/14/24 and 7/13/24 documents R46 has not received therapy or restorative services. On 08/26/24 at 1:30 PM, R46 stated she does not stand, and staff transfer her with a mechanical lift. On 8/28/24 at 8:30 AM, R46 stated that its harder now to transfer with the mechanical lift and R46 feels she can't do as much physically as she once could. R46 stated she would like to be able to do exercises to get stronger so she can stand. R46 stated that she has been using mechanical lift for transfers for six months. R46 stated she has not had physical therapy. R46 stated the facility hasn't provided her with therapy or exercises and would like the facility to provide them to her. On 8/27/24 at 9:40 AM, V8 (Licensed Practical Nurse) and V21 (Certified Nursing Assistant) transferred R46 with a mechanical lift from the bed to the wheelchair for an appointment. On 8/27/24 at 12:15 PM, V2 (Director of Nursing) stated R46 was made a mechanical transfer March 2024. V2 stated R46 was a sit to stand prior but she is unsure why she was changed to a mechanical lift. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 1:05 PM, V12 (Physical Therapist/ Director of Rehab) stated R46 was evaluated by Physical Therapy on 12/13/23 for weakness after a local hospital stay. Prior to hospitalization R46 was a sit to stand transfer. V12 stated R46 was not picked up by Physical Therapy due to altered mental status and unable to follow cues. V12 stated there were no orders for any other discipline to evaluate. V12 stated R46 was evaluated again by Physical Therapy on 12/29/23 for muscle weakness, decline and functional ability and V12 felt she was still unable to participate in therapy. V12 stated her plan was to monitor R46 until she was able to participate in therapy. V12 stated she was going to daily Interdisciplinary Team (IDT) meetings but V12's supervisor said it was affecting productivity so V12 was unable to attend (IDT) until about a month ago. V12 stated, If we (therapy) were having the daily meetings, we could have added (R46) to our case load once she felt better and prevented her decline. On 8/28/24 at 11:20 AM, V20 (Certified Nursing Assistant) stated the main decline that she notices about R46 is that she is unable to stand and bear weight to transfer and now uses a non-weight bearing mechanical lift. R46's medical record from 1/12/24 until 8/28/24 does not include an IDT meeting note reviewing R46's functional decline or therapy needs.

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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** 31682 Based on observation, interview, and record review the facility failed to perform weekly skin checks, obtain a treatment once a pressure ulcer was identified, and develop and implement pressure relieving interventions to prevent the development of pressure ulcers for one of seven residents (R41) reviewed for pressure ulcers in the sample of 38. Findings include: The facility's Prevention of Pressure Injuries policy dated April 2020, documents Purpose The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Skin Assessment 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs (Activities of Daily Living). e. Reposition resident as indicated on the care plan. Mobility/Repositioning 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. 2. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. 3. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions. Monitor 1. Evaluate, report and document potential changes in the skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis. R41's MDS (Minimum Data Set) assessment dated [DATE] documents R41 is moderately cognitively impaired. R41's Braden Scale assessment dated [DATE] documents R41 was a moderate risk of developing pressure ulcers. R41's Skin Integrity Care Plan dated 6-21-24 documents, I am at mild risk for skin breakdown. Please help me to reposition frequently to help relieve pressure to my skin. R41's Treatment Administration Records (TARs) dated 8-1-24 through 8-31-24 document, Weekly Skin Assessment every Monday between 6:00 PM through 6:00 AM. These same TARs document R41's skin assessment was not completed on Monday (8-19-24). R41's Wound assessment dated [DATE] documents, Type: Pressure Ulcer. Site: Left buttock. Length 0.5 cm (centimeters) by 0.5 cm width by zero depth. Stage II. R41's Nursing Home Encounter Note dated 8-26-24 and signed by V15 (Nurse Practitioner) documents, (R41) is a [AGE] year-old who is evaluated today for report of new wound (to) buttock. Left buttock new wound, Area is somewhat tender. (R41) sleeps in recliner. History of pressure injuries. Assessment/Plan open wound left buttock stage II decubitus. Pressure injury prevention; reposition every one to two hours, shift weight or tilt in chair every 15-30 minutes. Cushion in wheelchair. Apply zinc oxide barrier twice daily until healed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's Medical Record and TARs dated 8-1-24 through 8-31-24 do not include a treatment being administered to R41's left buttock pressure ulcer until 8-27-24 (four days after the pressure ulcer was identified). On 08/27/24 from 9:00 AM to 11:30 AM, R41 was sitting in a wheelchair in the hallway. R41 was sitting with pressure directly on both buttock during this time and was not re-positioned during this time. On 08/27/24 at 1:36 PM, V4 (Agency LPN/Licensed Practical Nurse) assisted R41 off the toilet to a standing position and cleansed R41's left buttock pressure ulcer with wound cleanser. R41's left buttock pressure ulcer was approximately 0.8 cm by 0.5 cm by 0.2 cm depth and pink in color. V4 then proceeded to apply a moisture barrier cream to R41's left buttock pressure ulcer. On 08/27/24 at 1:40 PM, V13 (CNA/Certified Nursing Assistant) stated, I did not know (R41) had an order to re-position every one to two hours or shift weight or tilt her chair every 15-30 minutes. I took care of (R41) today and did not shift (R41's) weight while she was in the wheelchair. (R41's) wheelchair does not tilt. On 08/27/24 at 1:47 PM, V14 (CNA) stated, I did not reposition or shift (R41's) weight today while she was in the wheelchair. I did not know I was supposed to. On 08/28/24 at 10:40 AM, V2 (Director of Nursing) stated, (R41's) pressure ulcer to the left buttock was facility acquired and was caused by pressure. (R41's) weekly skin check was not completed on 8-19-24 and (R41) did not have a treatment applied to the left buttock pressure ulcer until 8-27-24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Quincy Healthcare & Sr Living	1440 North 10th Street Quincy, IL 62301

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on observation, interview, and record review the facility failed to develop and implement services to maintain and/or improve range of motion limitations for one of one resident (R49) reviewed for limitations in range of motion in the sample of 38. Findings include: The facility's Restorative Nursing Services policy dated 07/2017 documents, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. Restorative goals may include but are not limited to supporting and assisting the resident in adjusting or adapting to changing abilities, developing, maintaining, or strengthening his/her phycological and psychological resources, maintaining his/her dignity, independence, and self-esteem, and participating in the development and implementation of his/her plan of care. R49's Physician's Orders dated 8-27-24 document R49 has the diagnoses of Hemiplegia following a Cerebral Infarction affecting the right dominant side and Muscle Wasting. R49's MDS (Minimum Data Set) assessment dated [DATE] documents R49 is cognitively intact, has functional limitations in range of motion to one of the upper extremities, and does not receive passive or active range of motion restorative programs or therapy. R49's current Care Plan does not address R49's limitations in range of motion to the upper extremity. On 08/26/24 at 11:15 AM, R49 was sitting on the edge of the bed. R49 was unable to open his right hand completely. R49 stated, I have arthritis and my hands gets stiff. I do not get any exercises from staff. On 08/27/24 at 02:42 PM, V16 (Restorative Aide) stated, (R49) does not receive range of motion exercises and is not on a restorative program to receive range of motion.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview, and record review the facility failed to place an oxygen sign for one resident (R18), failed to ensure a nebulizer mask and nebulizer tubing was changed every seven days and stored in a bag between uses for one resident (R27), and failed to date oxygen tubing/humidifier bottles per facility policy for three residents (R18, R69, and R330) of four residents reviewed for respiratory care, in the sample of 38. Findings Include: The Respiratory Therapy Prevention of Infection policy dated November 2011, documents The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. General Guidelines 1. Distilled water used in respiratory therapy must be dated in an initialed when opened and discarded after twenty-four (24) hours. Infection Control Considerations Related to Oxygen Administration 3. [NAME] bottle with date and initials upon opening and discard after twenty-four (24) hours. The Oxygen Administration policy dated October 2010 documents the purpose of this procedure is to provide guidelines for safe oxygen administration. Equipment and Supplies 4. No Smoking/Oxygen in Use signs. Steps in the Procedure 2. Place an Oxygen in Use sign on the outside of the room entrance door. Close the door. 3. Place an Oxygen in Use sign in its designated place on or over the resident's bed. Administering Medications through a Small Volume (Handheld) Nebulizer policy dated October 2010 documents The purpose of this procedure is to safely end aseptically administer aerosolized particles of medication into the resident's airway. Steps in the procedure 30. Change equipment and tubing every seven days, or according to facility protocol. 1. On 8/26/24 at 10:50 AM, R18 was sitting in his wheelchair wearing oxygen. There was no date on the oxygen tubing or humidifier bottle. V4/Agency Licensed Practical Nurse/LPN verified the tubing and bottle were not dated. On 8/28/24 at 12:20 PM, R18 was sitting in his room wearing oxygen. V23/LPN verified there was no oxygen sign on R18's door or in his room. V23 also stated there should be an oxygen sign on the door for all residents that use oxygen. R18's current electronic Medical Record documents R18 was readmitted to the facility on [DATE] with the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure with Hypoxia, and Essential (Primary) Hypertension. R18's Physician Order dated 7/2/24 documents, oxygen at 2 (two) liters per minute by nasal cannula continuously. On 8/27/24 at 12:10 PM, V2/Director of Nursing stated that the humidification bottle attached to oxygen concentrator and oxygen tubing are supposed to be marked with the date they are changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50430 2. R69's Physician orders dated 8/27/24 documents to change weekly tubing and mask change. On 08/26/24 at 10:07 AM, R69's oxygen tubing, nebulizer tubing, and nebulizer mask were undated. R69's nebulizer mask was also unbagged. 3. On 08/27/24 at 12:00 PM, oxygen tubing was lying on the floor in R330's room undated. Nasal cannula was uncovered lying on R330's floor. R330's humidification bottle was attached to the concentrator and was undated. On 8/26/24 at 10:15 AM, V8 (Licensed Practical Nurse) stated she was unaware that oxygen and nebulizer tubing needed to be dated. On 8/26/24 at 10:15 AM, V8 confirmed that the oxygen tubing, nebulizer tubing, and nebulizer mask was undated and unbagged and R330's nasal canula was lying on the floor and R330's humidification bottle was undated. 49187 4. R27's current POS (Physician Order Sheet) documents a Physician order for Albuterol Sulfate Solution 0. 63 milligram/3 milliliter inhale one applicatorful by inhalation route four times per day as needed. On 08/26/24 at 10:30 AM, R27's nebulizer mask and tubing were lying on R27's nightstand unbagged and undated. On 8/26/24 at 10:55 AM, V3/Registered Nurse verified R27's nebulizer mask and tubing were undated and unbagged. V3 stated, The night shift should change and date the nebulizer masks and tubing every seven days and the nebulizer mask should be bagged in a brown bag when not in use.

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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. 49187 Based on interview, observation and record review, the facility failed to provide ongoing communication with the dialysis center, monitor a dialysis access site, document observations post-dialysis, and ensure a care plan was implemented regarding monitoring, care, and emergency management of a dialysis access site for one of two residents (R25) reviewed for dialysis in the sample of 38. Findings Include: The facility's Hemodialysis Catheters-Access and Care Of policy, dated 2/2023, documents Care of AVFs (arteriovenous fistula) and AVG (arteriovenous graft): 3. Care involves the primary goals of preventing infection and maintaining patency of the catheter (preventing clots). 4. To prevent infection and/or clotting: a. Keep the access site clean at all times. d. Check for signs of infection (warmth, redness, tenderness, or edema) at the access site when performing care at regular intervals. h. check patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access. Care Immediately Following Dialysis Treatment: 2. If dressing becomes wet, dirty, or not intact, the dressing shall be changed by a licensed nurse trained in the procedure. (Note: Check with state nurse practice act to determine licensure and competency requirements.) 3. Mild bleeding from site (post-dialysis) can be expected. Apply pressure to insertion site and contact dialysis center for instructions. 4. If there is major bleeding from site (post-dialysis), apply pressure to insertion site and contact emergency services and dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive. Documentation: The nurse should document in the resident's medical record every shift as follows: 1. Location of catheter. 2. Condition of dressing (interventions if needed). 3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being give. 5. Observations post-dialysis. The facility's End-Stage Renal Disease, Care of a Resident with policy, dated 9/2010, documents Policy Statement: Residents with End-Stage Renal Disease (ESRD) will be care for according to currently recognized standards of care. Policy Interpretation and Implementation. 5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Dialysis Transfer Agreement, dated 3/11/10, documents Facility shall ensure that all appropriate medical, social, administrative and other information accompany all designated residents at the time of transfer to (dialysis) Center. This information shall include, but is not limited to, where appropriate, the following: Appropriate medical records, including history of the designated resident's illness, including laboratory and x-ray findings; Treatment presently being provided to the designated resident, including medications and any changes in a patient's condition (physical or mental), change of medication, diet or fluid intake; Any other information that will facilitate the adequate coordination of care, as reasonably determined by the center. This policy also documents Center will develop a written protocol governing specific responsibilities, policies, and procedures to be used in rendering dialysis services to designated residents at Center, including but not limited to, the development and implementation of a designated resident's care plan relative to the provision of dialysis services. Facility will provide for the interchange of information useful or necessary for the care of the designated resident and will inform Center of a contact person at facility whose responsibilities oversight of provision of dialysis services by Center to the designated residents of the facility. R25's POS (Physician Order Sheet), dated 8/28/24, documents R25's diagnoses to include End Stage Renal Disease and Dependence of Renal Dialysis. R25's current care plan has no interventions in place regarding monitoring, care, or emergency management of R25's dialysis access site in her left upper arm. R25's electronic medical record does not document communication with the dialysis center is being done every Tuesday, Thursday, and Saturday. R25's electronic medical record does not document any pre or post dialysis monitoring or observations to R25's access site. This record also does not contain any documentation of communication between the facility and R25's dialysis administration center. On 8/28/24 at 11:00AM, R25 was sitting in her recliner in her room watching television. R25 stated she attends hemodialysis at a local dialysis facility on Tuesday, Thursday, and Saturdays. R25 pointed at her left upper arm and stated that dialysis staff are individuals that monitor and care for her access site located in her left upper arm. R25 stated, (the facility) staff never look at my access site. On 8/28/24 at 10:20 AM, V4/Agency Licensed Practical Nurse stated she is not aware of any dialysis communication between the dialysis center and the facility on R25. V4 stated, I was not aware we needed to monitor (R25's) access site or document post-dialysis in (R25's) medical record. I have not been doing this. On 8/28/24 at 11:20 AM, V2/Director of Nursing stated (the facility) does not send any communication plan to dialysis and they do not send any forms back. V2/Director of Nursing verified there is no evidence of documentation in R25's electronic medical record of staff monitoring R25's dialysis access site or staff documenting on R25 post dialysis. V2 confirmed R25's care plan does not include specifics regarding monitoring or emergency care of R24's dialysis access site.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 31682 Based on observation, interview, and record review the facility failed to obtain physician ordered scheduled medications from the pharmacy for four of four residents (R15, R53, R63, and R76) reviewed for pharmacy services in the sample of 38. Findings include: The facility's Pharmacy Services Overview policy dated April 2019 documents, Policy Statement: The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. 1. Pharmaceutical services consist of processes of receiving and interpreting prescriber's orders, acquiring, receiving, storing, controlling, reconciling, compounding (e.g. (example), intravenous antibiotics), dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications, biologicals, chemicals. 2. The facility shall contract with a licensed consultant pharmacist to help get, obtain, and maintain timely and appropriate pharmacy services that support resident's needs, are consistent with current standards of practice, and meet state and federal requirements. 3. Pharmacy services are available to residents 24 (twenty-four) hours a day, seven days a week. 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. 1. R53's Physician's Orders dated 8-26-24 document, Order date 6-18-24: Levothyroxine 50 mcg (micrograms) one tablet daily for the diagnosis of Hypothyroidism. R53's Medication Administration Record (MAR) dated 8-1-24 through 8-26-24 documents R53's Levothyroxine 50 mcg was not administered as scheduled on 8-26-24 due to the medication being unavailable. On 08/26/24 at 9:15 AM, V4 (Agency LPN/Licensed Practical Nurse) was administering R53's scheduled medications. R53's Levothyroxine 50 mcg was not available in the medication cart. V4 stated, (R53's) Levothyroxine 50 mcg tablet is not available. We (the facility) have been having problems with the pharmacy getting the facility medications. 2. R15's Physician's Orders dated 8-26-24 document, Order date 5-28-24: Spiriva 18 mcg by inhalation once daily at 8:00 AM for the diagnosis of Chronic Obstructive Pulmonary Disease. R15's MAR dated 8-1-24 through 8-26-24 documents R15's Spiriva 18 mcg was not administered as scheduled on 8-26-24 at 8:00 AM due to the medication being unavailable. On 08/26/24 at 9:32 AM, V4 was administering R15's scheduled medications. R15's scheduled Spiriva 18 mcg (micrograms) inhaler was not available in the medication cart. V4 stated, I am not able to give (R15) her Spiriva inhaler. It is not available. I will have to order it from the pharmacy and hope it comes in tomorrow. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R76's Physician's Orders dated 8-26-24 document, Order date 5-23-24 Metoprolol Succinate ER (Extended Release) 100 mg (milligrams) 1.5 tablets daily at 8:00 AM for the diagnosis of Hypertension. Order date 5-23-24: Finasteride five mg one tablet daily at 8:00 AM for the diagnosis of Benign Prostatic Hyperplasia, 5-23-24 Order date: Eliquis five mg (0.5 tablet) twice daily for the diagnosis of Chronic Atrial Fibrillation, Order date 7-26-24: Juven seven grams two times daily for the diagnosis of a Stage Two Pressure Ulcer, Order date 5-29-24: Potassium Chloride ER 10 meq (milliequivalent) daily for the diagnosis of Hypokalemia, and Order date 8-14-24: Allopurinol 100 mg two tablets daily for the diagnosis of Gout. R76's MAR dated 8-1-24 through 8-26-24 documents R76's Metoprolol Succinate ER 100 mg (1.5 tablets), Finasteride five mg one tablet, Eliquis five mg (0.5 tablet), Juven seven grams, Potassium Chloride ER 10 meq, and Allopurinol 100 mg two tablets were not administered as scheduled at 8:00 AM on 8/26/24 due to the medications being unavailable. On 08/26/24 at 09:53 AM, V4 stated, I was unable to give (R76) his Metoprolol Succinate ER 100 mg tablet, Finasteride five mg tablet, Eliquis five mg tablet, Juven seven-gram powder, Potassium Chloride ER 10 meq tablet, or Allopurinol 100 mg (two tablets) this morning as the medications were unavailable. 4. R63's Physician's Orders dated 8-27-24 document, Order date 3-22-24: Furosemide 20 mg one tablet daily at 12:00 PM for the diagnosis of Localized Edema. R63's MAR dated 8-1-24 through 8-26-24 documents R63's Furosemide 20 mg one tablet was not administered as scheduled on 8-26-24 at 12:00 PM due to the medication being unavailable. On 08/27/24 at 9:35 AM, V4 stated, (R63's) Furosemide 20 mg was not available on 8-26-24 at noon. I had to re-order it (Furosemide 20 mg) from pharmacy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on observation, interview, and record review the facility failed to document targeted behaviors and diagnoses to justify the use of antipsychotic medications, perform antipsychotic evaluations and assessments, and perform gradual dose reductions of scheduled antipsychotic medications for two of two residents (R27 and R41) reviewed for the use of antipsychotic medications with the diagnosis of Dementia in the sample of 38. Findings include: The facility's Psychotropic Medication Use policy dated July 2022, documents Residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation 1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying, and responding to adverse consequences. 5. Use of psychotropic medications (other than antipsychotics) are not increased when efforts to decrease antipsychotic medications are being implemented. 10. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 11. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. Resident Evaluations 1. Situations which may prompt an evaluation or re-evaluation of the resident include a. admission or re-admission; b. a clinically significant change in condition/status; c. a new, persistent, or recurrent clinically significant symptom or problem; d. a worsening of an existing problem or condition; e. an unexplained decline in function or cognition; f. a new medication order or renewal of orders; or g. an irregularity identified in the pharmacist's medication regimen review. 2. The evaluation may include (for example): a. an evaluation of resident status (co-morbid conditions, symptoms, psychiatric diagnosis; etc. (etcetera); b. resident goals and preferences; c. allergies and potential medication or food interactions; d. history of medication use; and e. need for palliative or end of life support. 3. When determining whether to initiate, modify, or discontinue medication therapy, the IDT (Interdisciplinary Team) conducts an evaluation of the resident. The evaluation will attempt to clarify whether: a. other causes for symptoms (including symptoms that mimic a psychiatric disorder) have been ruled out; b. signs and symptoms are clinically significant enough to warrant medication therapy; c. a particular medication is clinically indicated to manage the symptoms or condition; and d. the actual or intended benefit of the medication is understood by the resident/representative. 4. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. a. the staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Tapering Medications and Gradual Drug Dose Reduction policy dated July 2022 documents, Policy Statement 1. After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. 2. All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as gradual dose reductions (GDR). 3. Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Policy Interpretation and Implementation 4. The staff and practitioner will consider tapering under certain circumstances, including when: a. the resident's clinical condition has improved or stabilized; b. the underlying causes of the original target symptoms have resolved; c. non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms; or d. a resident's condition has not responded to treatment or has declined despite treatment. 6. The physician will order appropriate tapering of medications, as indicated. 10. Residents who use psychotropic medications shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the use of such drugs. Pertinent behavioral interventions will also be attempted. (Behavioral interventions refer to non-pharmacological attempts to influence an individual's behavior, including environmental alterations and staff approaches to care.) 11. Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated. 1. R41's Physician's Orders dated 2-1-24 through 4-29-24 document, Quetiapine (Seroquel/Anti-Psychotic Medication) 50 mg (milligrams) twice daily for the diagnosis of Dementia with Delusional Disorder. R41's Progress Notes dated 4-29-24 and signed by V15 (Nurse Practitioner) document, Diagnoses: Acute Confusion. Dysuria. Moderate Dementia with Psychotic Disturbance. New orders: Urinalysis clean catch. Complete Metabolic Profile. Increase Seroquel to 75 mg twice daily for Dementia with Psychosis. R41's Progress Notes dated 8-26-24 and signed by V15 document, Diagnoses: Open wound left buttock stage II Decubitus. Incontinence bowel and bladder. Dementia with Psychosis/Delusion, Arthritis joint pain, history of repeated falls, and history of urinary tract infections. New Orders: Increase Seroquel 100 mg twice daily for Dementia with Psychosis/Delusion. CT (Computed Tomography) head and brain due to altered mental status and Dementia. R41's MDS (Minimum Data Set) Assessments dated 5-1-24 and 8-1-24 document R41 is moderately cognitively impaired, has had no behaviors that cause a risk of harm to self or others and does not have any physical, verbal, or other behaviors. This same MDS documents R41 received an antipsychotic medication that has not had a GDR and does not have physician documentation as to why a GDR (Gradual Dose Reduction) is clinically contraindicated. R41's Medical Record does not include any antipsychotic medication assessments or evaluations or documentation of IDT (Inter-Disciplinary) meetings, as directed by the facility policy, to discuss whether or not other causes for symptoms have been ruled out, the signs and symptoms are clinically significant enough to warrant medication therapy, whether a particular medication is clinically indicated to manage the symptoms or condition, or whether or not the actual or intended benefit of the medication is understood by the resident/representative. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's current Care Plan does not include documentation of the targeted behaviors for the use of R41's Seroquel. On 08/26/24 at 11:31 AM, R41 was sitting in her recliner in her room sleeping. On 08/27/24 at 9:00 AM and 11:30 AM, R41 was sitting in a wheelchair in the hallway, sleeping. On 08/26/24 at 11:29 AM, V9 (CNA/Certified Nursing Assistant) stated, (R41's) only behavior is that she yells out at times. (R41) is easily re-directed when we take her on walks or get her a snack. On 08/26/24 at 11:32 AM, V10 (CNA) stated, (R41) only yells out sometimes that someone is on her back. (R41) is easily re-directed. (R41) sleeps a lot. On 08/27/24 at 11:30 AM, V2 (Director of Nursing) stated, (R41's) Care Plan does not include (R41's) targeted behaviors to justify the use of (R41's) Seroquel and (R41) was not assessed for underlying conditions prior to increasing (R41's) Seroquel. (R1's) Seroquel has been increased twice in the prior year. No GDR attempt has been made. On 08/27/24 at 2:16 PM, V1 (Administrator-In-Training) stated, We (the facility) did not have IDT meetings to discuss (R41's) behaviors or to rule out underlying conditions prior to increasing (R41's) Seroquel twice. The facility does not do anti-psychotic drug assessments or evaluations. 49187 2. R27's current Face Sheet documents R27 has an admitted [DATE]. R27's Physician Orders dated 9/28/23 documents an order for Seroquel (ant-psychotic medication) 37.5mg (milligrams) by mouth at bedtime for the diagnosis of Major Depressive Disorder and Dementia with other behavior disturbance. R27's MDS (Minimum Data Set) assessment dated [DATE] documents R27 is moderately cognitively impaired and has no behavioral symptoms that impact the resident or others, cause significant risk of injury to herself or others, or interfered with R27's cares. R27's current Care Plan does not include the targeted behaviors or non-pharmacological interventions to address targeted behaviors for the use of R27's Seroquel. R27's Behavior Tracking Reports dated 5/1/24 to 8/26/24 document to monitor R27 for behaviors of anxiety and depression. These same Behavior Tracking Reports document R27 has had no behaviors. R27's Medical Record does not include any anti-psychotic medication assessments or evaluations or documentation of IDT meetings, as directed by the facility policy, to discuss whether or not other causes for symptoms have been ruled out, the signs and symptoms are clinically significant enough to warrant medication therapy, whether a particular medication is clinically indicated to manage the symptoms or condition, or whether or not the actual or intended benefit of the medication is understood by the resident/representative. (continued on next page)

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	145457	A. Building B. Wing	08/28/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 1:28 PM, R27 was sitting in R27's wheelchair in the assisted dining room. R27 was preparing to eat lunch. R27 had no behaviors at this time. On 8/27/24 from 10:00 AM to 10:20 AM, R27 was observed lying in her bed. R27 had no behaviors observed during this time. On 8/27/24 at 12:33PM, V16/Restorative Aide stated, I have worked here for [AGE] years, so I have taken care of (R27) since she has been here. I have not witnessed any behaviors from (R27) except maybe some anxiousness, but not often. 8/27/24 at 12:35PM, V3/Registered Nurse stated, I have not witnessed or have known of any behaviors from (R27). On 8/27/24 at 11:00 AM, V2/Director of Nursing stated, (R27's) Care Plan does not include targeted behaviors for the use of Seroquel. (R27's) diagnoses of Major Depressive Disorder and Dementia with other Behavioral Disturbance is not appropriate diagnoses for the use of an anti-psychotic. I haven't even witness (R27) have behaviors. Typically, antipsychotics should be used for residents with a psychotic diagnoses like Schizophrenia. R27 verified the facility does not do anti-psychotic drug assessments or evaluations. 8/27/24 at 11:25 PM, V17/Social Service Director Assistant and V18/Social Service Director stated they are the ones who develop the behavior tracking programs. V17 and V18 verified R25 does not have targeted behaviors on her behavior tracking logs for the use of Seroquel (anti-psychotic). V18 stated, I only put to monitor for Anxiety symptoms and Depression symptoms on (R25's) behavior tracking.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 35509 Based on interview and record review, the facility failed to offer snacks to residents; failed to ensure resident preferences were met while eating in rooms (due to COVID in the building); failed to ensure that resident meals were complete including beverages when served; failed to deliver ice water to the residents during each shift for six of six residents (R7, R32, R40, R42, R55, R60) reviewed for snacks and meals in a sample of 38. Findings include: The document, Frequency of Meals, dated 7/2024, states, Each resident will receive three meals daily, in accordance with resident needs, preferences, requests and plan of care. Alternative meals will be offered to residents. Residents will also be offered nourishing snacks. Nourishing snacks will be available for residents who need or desire additional food between meals. Evening snacks will be offered routinely to all residents. The facility will choose the snacks that are served at bedtime. However, the dietician and food services manager will solicit input from the residents and/or the resident council. The document, Snacks (Between Meal and Bedtime), Serving, dated 9/2010, states, The purpose is to provide the resident with adequate nutrition. Document any special request(s) made by the resident concerning his or her eating time or food likes and dislikes. Report information in accordance with facility policy and professional standards of practice. The 8/06/24 Resident Council Minutes state, Nursing: Residents stated they are not getting fresh ice water regularly, memorandum filled out and turned into the Director of Nursing and the Administrator. On 8/27/24 at 10:00 AM, during the Group Meeting, R60 stated, I don't get snacks in the evening. When I first came here, they told me that I would get snacks of my choice. At first, I did. Now I don't get any. R32 stated, I wish we could get snacks; I get hungry in the evening. R40 stated, We have to eat in our rooms because of COVID. If there's something missing on my tray or I don't like what is served, it's too bad because they won't get me anything else. There's been several meals that I didn't get any beverages at all. R42 stated, I would like to get ice water more often. I think they are supposed to bring us ice water during each of the shifts but sometimes I don't get any at all or just once a day. All six residents, R7, R32, R40, R42, R55, and R60, agreed with the above statements. R7 commented, I think all of us get frustrated when we get the wrong (food item) or not what we ordered (for the meal). I also think it's bad that we aren't getting beverages at meals like we do in the dining room or ice water. I can ask for things but some of the residents don't. On 8/27/24 at 11:30 AM, V27, Dietary Manager, stated, I had not heard that residents were not getting snacks, getting beverages at meals or that they haven't been getting what they wanted to eat for meals. I'll need to check into this. We don't give snacks like we used to - I have staff send cookies or graham crackers or something like that. Residents requested too many different things for snacks, so we made it simpler. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 10:40 AM, V2, Director of Nursing stated, Yes, residents should be getting fresh ice water during each shift or more often. I don't know why they aren't.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 32875 Based on interview and record review, the facility failed explain the arbitration agreement to the resident, or their representative in a form or manner they could understand, state in the arbitration agreement that the agreement can be rescinded within 30 days of signing it, and failed to have the resident, or their representative acknowledge if they understood the agreement. This had the potential to affect all residents residing in the facility. Findings include: The Binding Arbitration Agreements dated November 2023 documents Residents (or representatives) are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. Policy interpretation and implementation 5. The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement, including that the resident may be giving up his or her right to have a dispute decided in a court proceeding (i.e. (example), litigation). 6. The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a form and manner that he or she understands, taking into consideration the resident's (or representative's) language, literacy, and stated preference for learning. 7. After the terms and conditions of the agreement are explained, the resident or representative must acknowledge that he or she understands the agreement before being asked to sign the document. a. A signature alone is not sufficient acknowledgement of understanding. b. The resident (or representative) must verbally acknowledge understanding, and the verbal acknowledgment documented by the staff member who explains the agreement. 8. Residents (or representatives) are provided 30 days after signing to fully review and rescind any agreement not understood at the time of admission. The process for withdrawing from the agreement is included in the agreement, including the timeframe for withdrawal, the contact person or department for communicating intent to withdrawal, and what the resident (or representative) should expect to receive as confirmation that the agreement has been terminated. (continued on next page)

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	The Contract Between Resident and (the facility) not dated documents Section XI. Dispute Resolution Resident shall select one of the following dispute resolution options: A. Binding Arbitration. Except as prohibited by applicable law, the Resident agrees that any action, dispute, claim, or controversy related to the quality of health care services provided pursuit to this Contract (e.g.(example), whether in contract or in tort, statuary for common law, legal or equitable, or otherwise) now existing or hereafter arising between Resident and (the facility), any past, present or future incidents, omissions, acts, errors, practices or occurrences causing injury to either party whereby the other party or its agents, employees or representatives may be liable, in whole or in part, or any other aspect of the past, present or future relationships between the parties shall be resolved by binding arbitration administered by a neutral arbitrator approved by both Resident and (the facility). The cost of the arbitration will be divided equally between Resident and (the facility). The decision of the arbitrator will be final. The site of the arbitration shall be at the following location mutually agreed to by the parties: (not filled in) This arbitration contract is made pursuant to the transaction in Interstate commerce and shall be governed by the Federal Arbitration Act. The parties voluntarily and knowingly waive any right they have to a jury trial. The parties also agree that neither will have the right to participate as a representative or member of any class or claimants pertaining to a claim subject to arbitration under this Contract. Or B. Legal Proceedings. Except as prohibited by applicable law, the Resident agrees that any action, dispute, claim or controversy related to the quality of health care services provided pursuant to the Contract (e.g., whether in contrast or in tort, statuary or common law, legal or equitable, or otherwise) now existing or hereafter arise between Resident and (the facility), any past, present or future incidents, omissions, acts, errors, practices or occurrences causing injury to either party whereby the other party or its agents, employees or representatives may be liable, in whole or in part, or any other aspect of this of the past, present, or future relationships between the parties shall be resolved by maintaining a civil suit in court, provided that any such suit shall be filed in a State or Federal Court of competent jurisdictions located in Illinois. Nothing, however, shall prevent the parties from agreeing at the time the dispute, claim or controversy arises, to proceed with arbitration. On 8/26/24 at 9:50 AM, V25 Marketing/Admissions stated that there are two choices a resident or their representative has when it comes to dispute resolutions. They (resident/resident representative) can either choose to use an arbitrator (option A) or can choose to get their own lawyer (option B). V7 does not tell them (resident/representative) they are giving up there right to sue the facility if they sign the arbitration agreement. V7 tells them to read the choices and they can decide which one they want to sign. V7 also stated that he has been doing this job for about four months and V25 thinks there has only been one resident/representative that chose to use an arbitrator. On 8/27/24 at the Resident Council Meeting there were six residents in attendance R7, R32, R40, R42, R55, and R60. All six stated they have not been told anything about an arbitration agreement and they do not know what it is. None of the residents knew if they or their representative had signed it. On 8/28/24 at 8:55 AM, V26/R73's Power of Attorney stated that she was not told she was giving up R73's rights to litigation through the courts. V26 stated she would have liked to have known that information and would not have made the choice to use arbitration for any disputes. (continued on next page)

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	On 8/28/24 at 9:10 AM, V25/Marketing/Admissions stated that it is not in the Arbitration part of the contract that the resident can rescind the arbitration agreement in 30 days. There is also not a place for the resident or resident's representative to acknowledge if they understand the arbitration agreement. R73's Contract Between Resident and (the facility) dated 5/8/24, documents that V26/R73's Power of Attorney chose option A and signed the binding arbitration agreement. The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 8/26/24 and signed by V1/Administrator in Training documents 76 residents currently reside within the facility.