STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145469	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paris Health and Rehab Center	1011 North Main Street Paris, IL 61944

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40385 Based on observation, interview, and record review the facility failed to promote dignity following meals for one of 28 residents (R132) reviewed for dignity in the sample list of 29. Findings include: On 7/21/24 at 9:07 AM R132 was lying in bed with a washcloth on R132's chest. R132's washcloth had a half dollar sized brown lump of pureed food and R132's mouth was covered in dried food debris. R132's dentures showed a red food/drink substance between R132's teeth and on R132's chin. On 7/21/24 at 9:10 AM R132 stated R132 did not like to be in this condition and R132 needed staff help to get cleaned up. On 7/23/24 at 12:13 PM R132 was sitting in the dining room being fed by staff. R132 had white whipped cream dripped down R132's shirt. On 7/23/24 at 12:48 PM R132 was sitting in a wheelchair in R132's room wearing the same soiled shirt. On 7/23/24 at 1:52 PM R132 was in bed wearing the same shirt which contained smears of whipped cream. R132's ongoing diagnoses list includes Dementia, right sided Hemiparesis/Hemiplegia, and Lymphedema. R132's Care Plan dated 7/9/24 documents R132 requires staff assistance for Activities of Daily Living. On 7/23/24 at 2:11 PM V2 Director of Nursing confirmed V2 expects staff to treat residents with dignity and confirmed R132 having food debris on the chest and mouth following meals is not dignified. V2 stated the staff should provide oral care after meals, changed R132's shirt, and cleaned up R132 when in that state. The facility's policy on dignity and resident rights was requested on 7/24/24. V1 Administrator provided The Illinois Long Term Care Ombudsman Program Resident Rights for People in Long Term Care Facilities dated November 2018 which documents Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to obtain consent for psychotropic medication use for five of five residents (R46, R55, R44, R36, R68) reviewed for psychotropic medications in the sample list of 29. Findings include: 1.) R46's Order Summary Report dated 7/23/24 documents orders for Abilify (antipsychotic) 10 milligrams (mg) by mouth once daily, started 6/1/24 and Clonazepam (antianxiety) 0.5 mg by mouth three times daily, started 6/20/24. There are no documented consents for these medication dosages in R46's electronic medical record (EMR). R46's EMR only contains Informed Consent for Psychotropic Medication forms dated 4/15/24 for Abilify 2 mg daily and 5/5/23 for Clonazepam 0.5 mg daily. On 7/24/24 at 10:45 AM-11:15 AM V2 Director of Nursing confirmed R46's Abilify and Clonazepam dosages were increased in May and June 2024. V2 stated the floor nurses are responsible for obtaining and documenting psychotropic medication consents upon admission, with new orders, and with any increase in dose or frequency of these medications. V2 confirmed R46 does not have documented consents for Abilify 10 mg daily or Clonazepam 0.5 mg three times daily. 2.) R55's Minimum Data Set, dated dated dated [DATE] documents R55 has severe cognitive impairment. R55's Order Summary Report dated 7/23/24 documents orders for Buspirone Hydrochloride (antianxiety) 5 mg three times daily, started on 2/24/24 and Lexapro (antidepressant) 20 mg by mouth daily, started on 1/3/24. There are no documented consents for these medications in R55's EMR. On 7/24/24 at 10:45-11:15 AM V2 confirmed R55 does not have documented consents for Buspirone and Lexapro. 32853 3.) R68's Medication Administration Record (MAR) dated 7/1/24 through 7/31/24 documents diagnoses including Personal History of Traumatic Brain Injury, Brief Psychotic Disorder, Other Seizures, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Parkinsonism and Vascular Dementia Unspecified Severity With Agitation. This MAR documents orders for Mirtazapine (antidepressant) oral tablet 15 mg (milligram) give 1 tablet by mouth one time a day for Depression/appetite with an order date of 10/25/23, Trazodone HCL (Hydrochloride) (antidepressant) oral tablet 100 mg give 1 tablet by mouth one time a day related to Vascular Dementia with an order date of 11/29/2023 and Risperdal (antipsychotic) oral tablet 0.5 mg give 1 tablet by mouth two times a day for Irritability with an order date of 2/7/2024. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R68's medical record does not contain a psychotropic medication consent for Mirtazapine and Trazodone. R68's Informed Consent for Psychotropic Medications for Risperdal 0.5 mg twice a day dated 2/12/24 has a hand written note on it that documents, Verbal Consent 2/12/24 0807 (R68) self. This consent does not indicate a diagnosis for this medication. R68's Minimum Data Set, dated dated dated [DATE] documents a BIMS (Brief Interview of Mental Status) score of 0/15. R68's Medication Administration Record (MAR) dated 5/1/24 through 5/31/24 documents an order for Rexulti (antipsychotic) 1 mg once a day for Mood with an start date of 5/22/24 and end date of 5/23/24 and an order for Rexulti 0.5 mg one time a day for 7 days with a start date of 5/22/24. This MAR documents R68 received Rexulti 0.5 mg from 5/23/24 to 5/29/24 and Rexulti 1 mg on 5/22/24, 5/23/24, 5/30/24 and 5/31/24. R68's Informed Consent for Psychotropic Medications documents for Rexulti 1 mg is dated 5/22/24 and V42, R68's family signed this consent form and wrote on it, would have appreciated a phone call to know and the consent form for the Rexulti 0.5 mg documents the same note by V42 and no date by V42's signature. On 7/21/24 at 1:00 PM, V42 stated that the facility started R68 on the Rexulti without her knowledge. V42 stated that she would have told them that he would have a bad reaction as he has not done well with antipsychotics in the past. On 7/24/24 at 2:00 PM, V2 confirmed that R68's consent for the Rexulti was not signed prior to starting the medication. V2 stated that she remembers he did not react good to that medication. 4.) R36's Order Summary Report dated 7/23/24 documents diagnoses including Senile Degeneration of Brain, Major Depression Disorder, Vascular Dementia with Behaviors and Generalized Anxiety Disorder. This Order Summary documents an order for Xanax oral tablet 0.5 mg, give 1 tablet by mouth at bedtime for Anxiety with a start date of 9/8/23. R36's medical record does not document a psychotropic medication consent for Xanax. On 7/24/24 at 2:00 PM, V2 confirmed there is not consent form signed for R36's Xanax. 5.) R44's Order Summary Report dated 7/22/24 documents diagnoses including Insomnia, Major Depressive Disorder and Chronic Respiratory Failure. This Order Summary Report documents an order for Xanax (antianxiety) Oral Tablet 0.5 mg, give 1 tablet by mouth at bedtime for Anxiety, with a start dated of 6/25/24, and an order for Xanax Oral Tablet 0.5 mg, give 1 tablet by mouth every 24 hours as needed for Anxiety with a start date of 6/26/2024. R44's medical record does not document a consent for Xanax scheduled or as needed. On 7/24/24 at 2:00 PM, V2 Director of Nursing confirmed there is no consent signed for R44's Xanax. The facility's Psychotropic Medications Chemical Restraints policy with a Revised date of 5/26/22 documents, In accordance with federal and state regulations, it is this facility's policy that residents will not be given unnecessary medications. Psychotropic/psychoactive medications will not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 34058 Based on observation and interview, the facility failed to post the required name, addresses, and telephone numbers for the state Protection and Advocacy Network in the facility. This failure has the potential to affect all 85 residents residing in the facility. Findings include: On 7/23/24 and 7/24/24, there was no posting for the state Protection and Advocacy Network (Equip for Equality) inside the facility in any of the halls, lounge areas, common areas, activity areas, nursing stations, nor office areas. On 7/24/24 at 9:56 AM, V1, Administrator, stated, I think it was up at one time because they used to send us a poster. Let me go look in the lounge. V1 returned and stated, There is a poster all nice and framed down in the lounge between the north and south halls, on the left side as you walk towards the north hall. On 7/24/24 at 10:00 AM, there was a bright purple Ombudsman poster in the location described by V1. When asked to clarify, V1 stated, Oh yes, that's what I meant, Ombudsman. So Equip for Equality, I will get one put up right now. The facility form Long-Term Care Facility Application For Medicare and Medicaid dated 7/22/24 documents 85 residents reside in the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on interview and record review, the facility failed to provide required Medicare Beneficiary Notices to residents whose Medicare Part A coverage was ending. This failure affects two residents (R78 and R384) out of three reviewed for beneficiary notices on a sample list of 29. Findings include: 1. R78's Beneficiary Protection Notification Review form (undated) documents R78 was admitted to the facility under Medicare Part A coverage on 4/16/24. This same form documents R78's last day of coverage under Medicare Part A was 5/14/24. R78's Nurses Progress Notes dated 5/6/24 documents, IDT (Interdisciplinary Team) met with (R78), husband, and daughter. Discussed care and no issues and (R78's) progress in healing and going home. Family would like (R78) to be discharged on [DATE]th (5/14/24). R78's Beneficiary Protection Notification Review did not include any type of a notice for Medicare non-coverage (NOMNC). On 7/23/24 at 1:17 PM, V25, Business Office Manager, stated, (R78) left the facility to go home voluntarily so I didn't give her any notice. I am not the person who normally would be giving out these notices but we didn't have a Social Services person at that time so I was just filling in. I wasn't present at the IDT meeting where they decided (R78) would be going home on 5/14/24. 2. R384's Beneficiary Protection Notification Review form (undated) documents R384 was admitted to the facility under Medicare Part A coverage on 4/24/24. This same form documents R384's last day of coverage under Medicare Part A was 7/1/24. The facility's current 802 Resident Matrix dated 7/21/24 documents R384 remained as a resident of the facility after her Medicare Part A coverage ended. R384's Beneficiary Review did not include an Advance Beneficiary Notice (ABN) to allow R384 the option to choose to continue skilled therapy coverage, or not, and to chose if this therapy service would continue with the bill submitted to Medicare, or at personal expense if declined by Medicare, and the amount of charges that would be incurred for the therapy. On 7/23/24 at 1:17 PM, V25 stated, I have given these notices at other facilities and never gave the ABN, just the NOMNC, and I have never gotten a tag (citation) for it.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to protect the resident rights' to be free from verbal abuse by a visitor and another resident. These failures affect five of seven residents (R17, R55, R31, R40, R77) reviewed for abuse on the sample list of 29. Findings include: 1.) R17's Minimum Data Set (MDS) dated [DATE] documents R17's Brief Interview of Mental Status (BIMS) score as 15 out of a possible 15, indicating no cognitive impairment. R55's MDS dated [DATE] documents R55's BIMS score as two out of a possible 15, indicating severe cognitive impairment. R17's Allegation of Abuse Note dated 07/21/24 at 2:58 pm documents the following: Resident was observed to yell out spontaneously in the dining room. This was noted to be loud and little alarming. Resident Description: This resident responded to another resident who yelled out loudly in the dining room. This resident was observed to loudly state shut the hell up. Resident did state that yes I did say that to him. When asked about stating I'll kick your f****** (expletive) ass, he did not remember saying this. On 07/21/24 at 12:25 pm during dining observations, in a full dining room, R17 was seated at a table eating. R55 was seated at the next table, approximately 10 feet away from R17. As R55 sat at the his designated table, R55 was making loud noises and talking to himself. Immediately, R17 started yelling at R55. R17 stated Shut up, or I will shut you up. You wanna fight me, shut the hell up. R17 also stated You better shut the h*** (expletive) up or I'll slap the p*** (expletive) out of you. V41, Certified Nursing Assistant (CNA) approached (R17) and whispered to R17. You can not threaten people. R17 stated Okay, I won't threaten him, I will just kick his b*** (expletive) . At that time R17 was taken out of the dining room. V1, Administrator/ Abuse Prevention Coordinator was just outside the entryway of the dining room. V1 sat down at R55's table to comfort R55. V1, Abuse Coordinator stated to V41, CNA I reported (the verbal abuse) to myself. On 7/21/24 at 1:11 PM, V1 Administrator stated The residents do not deserve to hear that kind of language. We (facility) are going to have to come up with another plan for (R17). (R17) gets upset quickly and yells profanities sometimes. That could definitely be considered verbal abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/24 at 12:48 PM, V9, (R68's) Power of Attorney (POA) was seated in the dining room during meal service, and within hearing distance of R17 and R55. V9 stated There is no reason for (R17) to be yelling profanities like that. These residents do not need to hear that kind of language. There are residents who yell profanities sometimes, but they don't know what they are saying. (R17) knows what he is doing. On 7/23/24 at 10:20 am R17 stated That guy (R55) in the dining room the other day, that I (R17) yelled at, I (R17) just got aggravated with him (R55) because he was yelling out. He makes no sense at all. I got louder, because he would not shut up while I was trying to eat. They need to put that guy somewhere else when he eats. I have heard him do that before. I don't know what he is even saying. Staff have gone to him and reminded him to be quiet while everybody eats. They can usually get him something to eat, so he shuts up. I don't think staff understand what he (R55) is saying either. On 7/24/24 at 10:50 am, in review of the facility abuse prevention policy, and abuse reports and investigations, V1, Administrator / Abuse Coordinator, and V22, Regional Nurse Consultant/Regional Director of Operations acknowledged according to the facility policy, abuse means a willful act and it is not necessary for there to be an intent to harm a resident to be considered abuse. V1 and V22 confirmed R17 intentional and willfully yelled at R55 to shut up, therefore verbal abuse occurred. V22 also stated All residents in the facility are vulnerable, and therefore at risk for abuse. 2.) R31's MDS dated [DATE] documents R31's BIMS score as zero out of a possible 15, indicating severe cognitive impairment. R40's MDS dated [DATE] documents R40's BIMS score as eight out of a possible 15, indicating moderate cognitive impairment. On 07/21/24 at 1:45 pm V10, R40's Family Member stated (R40) has had two roommates (R31 and R77), over the past couple weeks. The first one I think was (R31), but don't quote me on that. The second one was moved in and out (of R40's room) the same day, and I have no idea what her (later identified as R77) name was. The first roommate (R31) was yelling at my wife (R40) and me (V10, Family Member). I was putting some stuff, I brought for my (R40) in her drawer. That woman (R31) just kept yelling. I told her to shut up a couple of times. She then threw a glass of water at me. (R40) was not phased really. She does not understand what is going on most of the time. The nurse (unidentified), I don't remember names half the time, came from the nurses station came down here (to R40's room), and told me I had to leave. I was leaving anyway so that was fine. There was a man (unidentified) in the doorway, so I think he was just there for added security or something. I am not usually loud. I am known to get a long with people. Easy going, until it comes to mistreating my (Family Member, R40). They moved that first lady (R31) out right away. Then moved the second lady in. I was not here at the time of the second situation (R40 verbal abuse by R77), but somebody (unidentified) from here called me and said that second lady was telling (R40)e to shut up and yelling. They moved her (R77) out of here too. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Final Report and Conclusion of Incident dated 7/18/24 documents through the investigation that facility recognized V10 willfully and intentionally (as defined in the facility policy as verbal abuse) yelled shut up at R31. The Final Report and Conclusion of Incident documents: It was noted that R40's visitor, V10 entered R40 and R31 shared room. R31 made a comment to the visitor, V10, that was unclear what R31 said to the visitor. V10 was reportedly observed (unidentified) to tell R31 to shut up or be quiet. R31 then threw a glass of water at V10, getting R40 wet. Residents were separated, and a permanent room move was made immediately. The visitor was asked to leave immediately pending investigation. On 7/24/24 at 10:50 am, in review of the facility abuse prevention policy, and abuse reports and investigations, V1, Administrator / Abuse Coordinator, and V22, Regional Nurse Consultant/Regional Director of Operations confirmed according to the facility policy, R31 was verbally abused by V10 because it was a willful deliberate act for V10 to yell shut up to R31. V22 also stated All residents in the facility are vulnerable, and therefore at risk for abuse. 3.) R77's, Minimum Data Set (MDS) dated [DATE] documents R77's Brief Interview of Mental Status (BIMS) score as 15 out of 15 indicating R77 has no cognitive impairment. R40's, MDS dated [DATE] documents R40's BIMS score as eight out of a possible 15, indicating moderate cognitive impairment. The facility report Verbal Aggression Initiated date 7/18/24 documents: Nursing Description: CNA (V18, Certified Nursing Assistant) heard resident (R77) tell roommate (R40) to shut up. Resident Description: 'I told her 3-4 times to be quiet and then I told here (sic) (R40) to shut up'. On 7/23/24 at 9:57 am V18, Certified Nursing Assistant (CNA) stated (R40) screams out a lot during care. Her body is really stiff and we have to be really careful. She has to be transferred with the (mechanical lift). We (V18, and an unidentified staff member) had just transferred her (R40) to bed and changed (provided incontinence care) her. She (R40) usually calms down soon after care. We try to talk about something outside. She is not much for TV (television) but likes to look out her window. She (R40) calmed down and we left the room. That night, she started yelling again. I popped my head in her room, as I was going to answer another call light. Her TV was on and I told (R40) I would be back in a minute. I knew she was clean and dry and went to take care of another resident. About 10 minutes later, I could hear (R40's) roommate (R77) at the time, say please be quite twice to (R40). (R40) was screaming kind of like a siren. She has some Dementia and does that sometimes without any words. I then heard (R77) yell at (R40) to 'just shut up'. We immediately moved (R77) to the room she is in now, by herself. On 7/23/24 at 10:13 am, R77 stated R77 did get mad at R40 for yelling and told R40 to shut up. R77 then stated I was mad and she would not stop yelling out. I was very happy when they moved me to this other room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/24 at 10:25 am V20, Unit Assistance stated (R40) was yelling and (V18, CNA) seemed to calm her down after providing (R40's) care. (R40) kept yelling. (R40's) roommate, (R77) 'could be heard from down the hall, asking (R40) to be quite. Then (R77) got loud and told (R40) to 'just shut up'. We took her (R77) to another room and told the nurse (unidentified), and the administrator (V1 Administrator/Abuse Prevention Coordinator), because she is the abuse coordinator. On 7/24/24 at 10:50 am, in review of the facility abuse prevention policy, and abuse reports and investigations, V1, Administrator / Abuse Coordinator, and V22, Regional Nurse Consultant/Regional Director of Operations confirmed according to the facility policy, R40 was verbally abused by R77 because this was a willful, deliberate act for R77 to yell shut up at R40. V22 also stated All residents in the facility are vulnerable, and therefore at risk for abuse. The facility Abuse Policy dated as revised 01/09/24 documents the following: PURPOSE To provide guidance and Procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. RESPONSIBILITY The administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staff responsibility report any allegation or witnessed abuse Immediately to the Administrator (Abuse Coordinator) ABUSE POLICY This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. The facility same policy documents: DEFINITIONS The following definitions are based on federal and state laws, regulations, and interpretive guidelines. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means (210 ILCS 45/1-103). Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident (42 CFR 483.5). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish (42 CFR 483.12 Interpretive Guidelines). The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (42 CFR 483.5). -Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again (42 CFR 483.12 Interpretive Guidelines).

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to implement restraint reduction interventions, and failed to have consents and assessments for the use of body pillow restraints, for one of one resident (R61) reviewed for restraints in the sample list of 29. Findings include: On 7/23/24 at 10:12 AM, 10:30 AM and 10:45 AM R61 was seated in a wheelchair outside, participating in a group activity. A soft lap cushion was across R61's lap and threaded through the arm rests of R61's wheelchair. There there were no foot pedals on R61's wheelchair. On 7/23/24 at 11:40 AM V19, Certified Nursing Assistant (CNA) pushed R61 in a wheelchair from R61's hallway, into the dining room and up against a table. R61's soft lap cushion was in place. At 11:43 AM V19 confirmed V19 was R61's assigned CNA. V19 stated V19 had not provided any cares for R61 prior to transporting R61 to the dining room. V19 stated R61 was with R61's spouse earlier this morning and then has been outside participating in activities. V19 stated R61 uses the soft lap cushion and (seat cushion with raised center) because R61's knees are bent upward which causes R61 to slide down in R61's wheelchair. On 7/23/24 at 11:57 AM R61 was sitting at the dining room table with the soft lap cushion in place. On 7/23/24 at 12:13 PM V36 CNA was feeding R61 and R61's soft lap cushion remained in place. On 7/23/24 at 12:45 PM and from 12:51 PM until 1:01 PM R61 was sitting in R61's room with the lap cushion in place. On 7/23/24 at 1:04 PM-1:17 PM V18 and V19 CNAs entered R61's room and transferred R61 with a full mechanical lift from the wheelchair into bed. R61's wheelchair seat was rear tilted and contained a seat cushion with a raised center. R61's incontinence brief was wet with urine. V18 and V19 provided R61's incontinence care and placed a body pillow on each side of R61, which were underneath of the fitted sheet and between R61 and R61's raised edge mattress. R61's bed contained bilateral half siderails in the upright position. V18 and V19 lowered R61's bed to the floor and placed a mat on the floor. R61 was lying on R61's back and R61 made rocking movements. V18 stated R61 used a different lap cushion and a foot board prior to this cushion, and every ten minutes R61 would slide down in the wheelchair underneath of the lap cushion and R61 kicked off the footboard. V18 stated so, now we use this lap cushion. V18 and V19 both confirmed R61 is unable to self remove the lap cushion. V18 stated V18 transferred R61 out of bed around 9:30-10:00 AM and applied R61's lap cushion at that time. V18 and V19 both stated R61 uses the lap cushion all day once R61 is up in R61's wheelchair and confirmed R61 had not been toileted or transferred out of the wheelchair since R61 got out of bed this morning. V18 and V19 stated R61 usually lays down after lunch and sometimes after breakfast depending on if R61 is awake and participating in activities. V18 and V19 both stated the body pillows are used to prevent R61 from rolling out of bed and R61 is unable to remove the pillows. R61's Minimum Data Set (MDS) dated [DATE] documents R61 has severe cognitive impairment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R61's Care Plan dated 5/22/23 documents R61 uses a (seat cushion with raised center) and soft lap cushion related to positioning and sliding out of the wheelchair. This care plan includes interventions to remove the lap cushion for incontinence cares and lay R61 down in the afternoon; the seat cushion and lap cushion are restraints that are to be released every two hours when in use and per facility policy. R61's Care Plan dated 12/1/22 documents R61 is at risk for falls and includes an intervention dated 5/25/23 to use a body pillow at the edge of R61's bed to increase R61's safety awareness. Body pillow at edge of bed to increase (R61) safety awareness. This Care Plan documents R61's diagnoses includes Alzheimer's Disease and left sided Hemiplegia/Hemiparesis following Cerebral Infarction. R61's electronic medical record does not contain a physician's order, assessment, or consent for the use of body pillow restraints, and contains only two restraint assessments dated 5/18/24 and 6/20/24 for the lap cushion and seat cushion restraints. On 7/23/24 at 1:20 PM V2 Director of Nursing stated restraint assessments are done quarterly. V2 stated staff should release R61's restraints for repositioning between meals, every two hours, and when laid down after meals. V2 stated there have been changes in management staff and confirmed assessments have not been completed timely. V29 MDS/Care Plan Coordinator confirmed R61 does not have an assessment for R61's body pillows. V29 stated V29 did not consider the body pillows as a restraint since sometimes R61 is found with feet out of the bed and the body pillows out of place. On 7/23/24 at 1:50 PM V2 confirmed there is no consent for R61's body pillow restraints. The facility's Restraint Policy dated 8/23/22 documents Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. Note: When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e (for example), side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc (etcetera)) that may improve the symptoms. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reductions for restraint reduction, less restrictive methods of restraints, or total restraint elimination.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 34058 Based on interview and record review, the facility failed to document a resident's required discharge summary and recapitulation of stay. This failure affects one resident (R78) out of one reviewed for discharge on a sample list of 29. Findings include: R78's Nurses Progress Notes dated 4/16/24 documents R78 was admitted to the facility on this date (4/16/24). R78's Nurses Progress Notes dated 5/14/24 document R78 was discharged to home from the facility on this date (5/14/24). R78's electronic medical record did not include a discharge summary nor a recapitulation of stay. On 7/23/24 at 10:00 AM, V1, Administrator, looked through R78's computer record and stated, There is a form available in system but I do not see one was made (completed) for (R78). On 7/24/24 at 2:50 PM, V2, Director of Nursing, after searching the electronic and paper medical records for R78 stated, There was no discharge summary.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to transcribe pressure ulcer treatment orders onto the Treatment Administration Record, document wound dressing changes, notify the physician of a dislodged wound graft, implement pressure relieving interventions, assess wounds weekly, and prevent cross contamination during wound treatment administration for residents. Theses failures affect three of three residents (R14, R46, R230) reviewed for pressure ulcers in the sample list of 29. Findings include: The facility's Pressure Ulcer Identification, Prevention and Treatment policy dated 8/31/23 documents the charge nurse/designee is responsible for pressure ulcer and document pressure ulcer measurements weekly. This policy includes the use of support services to prevent pressure ulcers including pressure redistribution/offloading. The weekly pressure ulcer assessments should include characteristics, tissue type, treatment, preventative measures, and physician and resident representative notification of wound regression. 1.) R14's Order Summary Report dated 7/1/24-7/31/24 documents an order with a discontinued date of 7/17/24 to cleanse right heel wound, apply collagen, cover with abdominal pad and wrap with gauze, daily and as needed. This Order Summary includes an order dated 7/17/24, may change clear dressing to right heel as needed, do not remove anything below the clear dressing as this will be done weekly by (V23 Wound Nurse Practitioner). R14's Wound Assessment and Plan dated 7/17/24, and recorded by V23, Wound Nurse Practitioner documents R14's right heel stage three pressure ulcer measured 4.1 centimeters (cm) long by 2.5 cm wide, and V23 applied a wound graft, saline moistened gauze, oil emulsion dressing, and clear dressing to R14's right heel wound. This note documents nurses and R14 were instructed not to disturb the wound graft. R14's Wound Assessment and Plan dated 7/24/24 documents R14's right heel wound measured 4 cm by 2.5 cm and a wound graft treatment was reapplied. There is no documentation that R14's, 7/17/24 right heel treatment order was transcribed onto R14's July 2024 Treatment Administration Record (TAR). There is no documentation in R14's electronic medical record that R14's right heel dressing was changed on 7/23/24 or that V23 was notified that the right heel wound graft was dislodged on 7/23/24. On 7/23/24 at 9:42 AM V15 Registered Nurse stated R14's right heel wound is not healed and the treatment order recently changed to a wound graft that is covered with a clear dressing. V15 stated the night nurse (V16, Licensed Practical Nurse) changed R14's wound dressing last night, because drainage had seeped through. V15 confirmed R14's right heel treatment order dated 7/17/24 was entered incorrectly, therefore the order was not transcribed onto R14's TAR. V15 stated the order entered will need to be corrected to populate to the TAR. On 7/23/24 11:03 AM V20, Unit Aide lifted R14's right foot. A gauze wrap dressing dated 7/23 was on R14's right heel. [NAME] drainage seeped through to the outer portion of wound dressing. R14 was not wearing heel protectors and R14's heels were not floated to prevent pressure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/24 at 11:15 AM V15 administered R14's right heel wound treatment. R14's right heel was wrapped with a gauze dressing dated 7/23/24 with brown drainage seeping through. V15 removed the outer dressing and abdominal pad that was covering R14's right heel wound. The wound did not contain the wound graft, saline soaked gauze, oil emulsion dressing as ordered,and confirmed by V15. V15 cleansed the open, red/pink wound and applied an abdominal pad and gauze wrap. R14 stated R14's dressing had drainage that soaked through and last evening, and was the first time the dressing had been changed since it was applied the week prior by V23. V15 stated she questions if V16 did not realize that the wound graft was dislodged, and V15 will need to report this to V23. V15 confirmed V23 should be notified any time the graft is dislodged/removed. V23 stated physician notification should be documented in the nursing notes. On 7/23/24 at 11:59 AM V15 stated V15 notified V23 who gave a one time order to cleanse the wound with normal saline and apply collagen until V23 re-evaluates the wound tomorrow. 32853 2.) R230's Order Summary Report dated 7/24/24 documents diagnoses including Type 2 Diabetes Mellitus, Severe Protein Calorie Malnutrition and Pressure Ulcer of Sacral Region Stage 4. This Order Summary documents an order for a wound treatment to the Coccyx one time a day to cleanse area with normal saline/wound cleanser, apply antifungal powder to periwound, brush off excess, pat with skin protectant, apply collagen to wound bed followed by 1/4 (inch) pale yellow packing strip, cover with an abdominal dressing and secure with tape dated 7/19/24. R230's Skin Risk assessment dated [DATE] documents R230 is at moderate risk for skin impairment. R230's Wound Assessment and Plan of Care dated 5/8/24 documents a stage 4 pressure ulcer to the Sacrum with an onset date of 12/20/23 measuring 1.9 cm (centimeters) x (by) 1.3 cm x 0.1 cm with undermining from 6 o'clock to 7 o'clock. The next measurements documented for R230 are as follows: 5/22/24, 14 days later, of 2 cm x 1 cm x 0.4 cm with undermining from 11 o'clock to 1 o'clock. 6/5/24, 14 days later, of 1.9 cm x 1 cm x 0.2 cm with undermining from 11 o'clock to 1 o'clock. R230's measurements on 6/12/2 4 are documented as 2.0 cm x 0.9 cm x 0.2 cm. 6/26/24, 14 days later, of 1.9 cm x 0.9 cm 0.2 cm with undermining from 5 o'clock to 6 o'clock. There are no further measurements as R230 was in the hospital. On 7/23/24 at 1:35 PM, V8 Registered Nurse completed the dressing change for R230's Sacral wound. R230 was lying in bed with slipper socks on. R230's pressure relieving boots were on the dresser. On 7/24/24 at 9:55 AM, V2 Director of Nursing confirmed R230 should have heel protectors on when he is in bed. V2 could not explain why there were not weekly wound measurements for R230. 31642 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) R46's Minimum Data Set (MDS) dated [DATE] documents R46's Brief Interview of Mental Status score as 15 out of a possible 15, indicating no cognitive impairment. The same MDS, Section M, B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. B-1 documents R46 has one Stage II pressure Ulcer. The same MDS Section, M-1200 documents R46 has a pressure reducing device for her chair. R46's Care Plan revised 06/04/24 documents the following: Problem, Actual Pressure Ulcer; Site (s): Rear left thigh. Interventions include: W/C (wheelchair) Pressure redistribution cushion. On 07/21/24 09:47 AM, R46 is lying in a bariatric bed, on an air mattress. R46 stated My problem now is, I can't get an air cushion or a good pressure relief cushion in my wheelchair. I have asked OT (Occupational Therapy) and PT (Physical Therapy). They say my insurance won't pay for it. I (R46) only get up, out of bed, once a day for a couple hours. You can see my wheelchair only has a bed pillow in it. It is not comfortable. It feels like I am setting on pebbles or something. R46 points to R46's bariatric wheelchair in the corner of R46's room. R46's wheelchair has a flat bed pillow but no pressure relief device/cushion. At this time, V44, and V41, Certified Nursing Assistants (CNA) entered R46's room with the full-body mechanical lift and transferred R46 to R46's wheelchair with the flat bed pillow. V41 and V44, CNA's lowered R46 into the wheelchair without adding a pressure relief cushion. On 7/23/24 at 10:45 am R46's was laying in bed. R46's wheelchair continued to have a flat bed pillow. R46's had no pressure relief cushion present in the wheelchair. V15, Registered Nurse (RN) gathered supplies, provided minimal assistance in positioning R46 in a full side lying position to administer R46's pressure ulcer treatment. R46's left upper posterior leg/buttocks crease had a Stage II pressure ulcer. R46 had a quarter size Stage II pressure ulcer that appeared to have new skin down the center with two dime size raw-beefy red open areas. V15, RN completed R46's pressure ulcer treatment, as ordered by V23, Wound Nurse Practitioner. V15, RN confirmed there is no pressure relief cushion in R46's wheelchair. R46 stated There had been (pressure relief cushion in the wheel chair) but not for months. On 7/23/24 at 11:00 V17, Director of Therapy Services/ Certified Occupational Therapy Assistant confirmed R46 had no pressure relief cushion in R46's wheelchair, in her room, or in R46's closet. V17 stated R46 insurance does not cover the cost, but the facility will have to pay for a new cushion for R46's wheelchair. On 7/23/24 at 11:17 am V22, Nurse Consultant/Regional Director of Operations stated We will order a specific bariatric pressure relief cushion for (R46). She should have had one, since she has a pressure ulcer.

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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** 32853 Failures at this level required more than one deficient practice statement. A. Based on interview and record review the facility failed to implement fall prevention interventions to prevent falls/injuries for one of three residents (R39) reviewed for falls in the sample list of 29. Findings include: a. The facility's Fall - Clinical Protocol with a revised date of March 2018 documents, A comprehensive assessment (Fall Risk Assessment) will be completed on each resident at Admission, Readmission, Quarterly, after a suspected change in condition and after an incident of concern. R39's Care Plan with an initiated date of 10/19/21 documents diagnoses including Cerebral Infarction without Residual Deficits, Hemiplegia and Hemiparesis, Paraplegia and Vascular Dementia. This Care Plan documents R39 has a self care deficit as evidenced by needing extensive assistance with ADLs (Activities of Daily Living) related to CVA (Cerebral Vascular Accident), Impaired Decision Making, Pain and Weakness with an intervention for bed mobility of two person physical assistance required dated 7/24/21. R39's Fall Risk assessment dated [DATE] documents R39 is at high risk for falls. The facility's Accident/Incident log provided on 7/22/24 documents R39 sustained a fall on 2/18/24 but R39's Nurse's Notes do not document any information regarding this fall. The facility's Fall Investigation Report dated 2/18/24 documents V37 Agency Certified Nursing Assistant (CNA) yelled out for the nurse. V15 Registered Nurse (RN) entered R39's room and R39 was on the floor on his back. This report documents after assessing R39, V37 and V15 assisted R39 back to bed with the full mechanical lift. This report also documents that staff were educated to always have two persons when rolling/providing care to R39. This report documents that R39 stated the CNA was cleaning him. This report documents V37 was changing bed linens and R39 rolled out of bed on the opposite side of the CNA. This report documents there was a small scrapped area measuring 2 cm (centimeters) X (by) 2 cm with bruising noted on R39's right elbow. A portable x-ray was ordered. On 7/23/24 at 11:02 AM, V15 stated regarding R39's fall on 2/18/24 that she was alerted by the Agency CNA (V37) and when she entered the room R39 was on the floor. V15 stated that V15 had positioned R39 in the center of the bed before she rolled him over. V15 confirmed there were no siderails up. V15 stated that R39 was sent to the emergency room for evaluation because he was complaining of elbow pain but there was no fracture. V15 confirmed that there was just one CNA providing R39's care when he rolled out of bed. On 7/24/24 at 9:55 AM, V2 Director of Nursing confirmed that R39's Care Plan documented that there should have been two staff providing cares for R39 when he rolled out of bed on 2/18/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41970 B. Based on observation, interview, and record review the facility failed to appropriately store personal items, smoking materials, and develop a smoking care plan for a resident. This failure affects one of one resident (R37) reviewed for smoking in the sample list of 29. Findings include: b). On 7/21/24 at 10:50 AM R37's loose tobacco was sitting on a small table in his room. R37's bedroom door was open. R37's lighter was sitting on his dresser. R37 stated They (facility) let me keep my lighter as long as I roll my own cigarettes. They (facility) told me that if I stop rolling my own, then I will have to give up my lighter. They told me about a month after I moved in that I had to wear an apron when I smoke. On 7/22/24 at 10:45 AM R37 was sitting in his wheelchair in his room with a bag of loose tobacco, a pocket knife in the open position and a cigarette lighter on his dresser. On 7/22/24 at 10:47 AM R37 stated They (staff) know I have had my lighter. I need it to light my cigarettes. They also know that I have my pocket knife. It always sits out ready to be used, on top of my dresser. I use it to open the bag of tobacco. I roll several cigarettes and keep them in my cup. (R37 showed six rolled cigarettes in a plastic drinking cup). When I go out to smoke, I roll my cigarettes up in a washcloth. When I get done smoking, whatever (tobacco) I have left in the last cigarette, I bring back inside. I empty out the remainder of the loose tobacco, out of the used cigarette butt and throw it back in the bag of loose tobacco. I just take the paper from the cigarette and the butt and throw that in the garbage. (R37 shows a small garbage can lined with a plastic garbage bag with several used cigarette butts inside). R37 closed the pocket knife and then took both the pocket knife and lighter and placed them in the third drawer of his dresser. R37's Minimum Data Set, dated dated dated [DATE] documents R37 as cognitively intact. R37's Care Plan does not include a problem, goal, or interventions for R37's smoking prior to 7/22/24 (during this survey). On 7/22/24 at 10:50 AM V12 Licensed Practical Nurse (LPN) confirmed R37 had a cigarette lighter, rolled cigarettes and a pocket knife in an open position laying on R37's dresser and table in his room. On 7/22/24 at 12:30 PM V1 Administrator stated R37 should not have had a pocket knife or lighter. V1 stated the pocket knife and lighter have been confiscated by the facility. V1 stated the facility has a policy that prohibits residents from keeping lighters and/or weapons in their rooms. On 7/24/24 between 10:45 AM and 11:15 AM V2 Director of Nursing stated residents who smoke should have a smoking care plan. V2 confirmed R37 did not have a smoking care plan prior to 7/22/24. The facility policy titled 'Smoking Policy' revised 3/11/24 documents residents may not store their own smoking materials. Smoking materials for residents will be stored in a designated location within the facility.

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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. 32853 Based on observation, interview and record review the facility failed to prevent tension to male urethra during urinary catheter care by failing to remove the catheter tubing from a residents leg mounted anchor during care and failed to stabilize catheter tubing during cleansing for one of one resident (R73) reviewed for catheter care in the sample list of 29. Finding include: The facility's Indwelling Catheter Care policy with a revised date of 10/7/22 documents, Purpose: To provide guidance to facility staff on the care of residents with an indwelling (urinary) catheter within the facility to prevent catheter-associated urinary tract infections. R73's Order Summary Report dated 7/22/24 documents diagnoses including Hydronephrosis with Renal and Ureteral Calculous Obstruction, Obstructive and Reflux Uropathy, Dementia, Alzheimer's and Unspecified Urethral Stricture. This Order Summary does not document orders for Urinary Catheter Care. On 7/23/24 at 10:30 AM, V27 and V28 Certified Nursing Assistants (CNAs) prepared to perform Urinary Catheter care for R73. R73 was laying in bed with the Urinary Catheter tubing attached to the right thigh with a thigh anchor. V27 did not remove the tubing from the anchor prior to cleaning R73's penis, catheter enter site. As V27 cleaned around the head of the penis the tubing pulled taut. R73 flinched and moaned. When V27 cleaned the catheter tubing, V27 did not hold the tubing at the penis to avoid pulling on the tubing. V27 pulled the wash cloth away from the penis and pulled on the urinary catheter tubing. R73 flinched as this was being done. On 7/23/24 at 1:25 PM, V2 Director of Nursing stated that the CNA's should remove the Urinary Catheter tubing from the thigh anchor prior to performing catheter care and they should hold the tubing at the penis while cleaning the tubing to prevent from tugging on the tubing.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34058 Based on observation and interview, the facility failed to post their required daily nurse staffing information. This failure has the potential to affect all 85 residents residing in the facility. Findings include: On 7/23/24 there was not a posting containing the required nurse staffing information. On 7/23/24 at 3:36 PM, V22, Regional Consultant, stated, I don't know about the posting but I will ask (V1, Administrator), she is in a meeting right now. At 345 PM, V22 stated, According to (V1) it turns out they do not have the staffing posting but they will get it up right now. On 7/24/24 at 9:46 AM, V1, Administrator, stated, (V22) did tell me about the staffing posting yesterday and we are going to get one up right outside the office there. The facility form Long-Term Care Facility Application For Medicare and Medicaid dated 7/22/24 documents 85 residents reside in the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 40385 Based on interview and record review the facility failed to develop a policy for medication regimen reviews (MRRs), repeatedly failed to maintain pharmacy recommendation documentation, and follow up on pharmacy recommendations for three of five residents (R46, R55, R70) reviewed for unnecessary medications in the sample list of 29. Findings include: 1.) R46's Electronic Medical Record (EMR) includes MRRs dated 3/18/24 and 4/24/24 that document recommendations were made by the pharmacist. There is no documentation in R46's EMR, as of 7/24/24, what specific recommendations were made or that these recommendations were reported to R46's physician. R46's Pharmacist Recommendation form dated 12/29/23 documents: Resident (R46) hospitalized recently with AMS (altered mental status), Confusion and Lethargy and is receiving the following narrow therapeutic index medication (last Valporic Acid Level on file dated 3-2023; no Ammonia Level on file): Divalproex DR Tablet 500 mg (milligrams) PO (by mouth) BID (twice daily) for Bipolar. Recommend drawing Valporic Acid and Ammonia Levels to monitor therapy. Thank you, Response: ( ) Draw Valporic Acid and Ammonia Levels ____ _ ( ) Repeat Valporic Acid and Ammonia Levels every __ Months ( ) No changes as benefits outweigh the risks There is no documentation that the R46's 12/29/23 recommendation was reported to R46's physician or that Valporic Acid and Ammonia levels were drawn after this date until April 2024. On 7/24/24 at 10:45-11:15 AM V2 Director of Nursing stated V2 receives pharmacy recommendations by electronic mail at the end of each month. V2 then distributes these forms to the floor nurses to follow up with the physician. V2 stated these forms aren't always returned, and V2 has had difficulty keeping up with the pharmacy recommendations. V2 confirmed R46's Depakote and Ammonia levels were not drawn after the 12/29/23 recommendation until April 2024. 2.) R55's EMR includes MRRs dated 2/26/24, 4/24/24, and 5/27/24 that document recommendations were made by the pharmacist. There is no documentation in R55's EMR as of 7/24/24, as to what specific recommendations were given on these dates or that the recommendations were reported to R55's physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R55's Pharmacist Recommendation form dated 4/24/24 documents: Resident (R55) experienced a recent fall, and receives the following medications that may increase the risk of falling: Omeprazole (associated with bone loss and fractures) Escitalopram (may cause drowsiness) Quetiapine, Zyprexa (high anticholinergic burden that may lead to falling; may cause orthostatic hypotension) Please reevaluate continued use of these medications at current doses. Consider a trial discontinuation of low dose Seroquel and/or discontinuing Omeprazole. Please consider periodic checks for possible orthostatic hypotension, take BP reclining and then standing. A drop of 20 points In systolic or 10 points in diastolic pressure indicates orthostatic hypotension which may cause and/or contribute to falls. This form documents V40 Nurse Practitioner signed the form on 7/24/24. 3.) R70's EMR includes MRRs dated 1/30/24, 4/24/24, and 6/25/24 that document recommendations were made by the pharmacist. There is no documentation in R70's EMR as of 7/24/24, as to what specific recommendations were given on these dates or that the recommendations were reported to R70's physician. R70's Pharmacist Recommendation form dated 4/24/24 documents R70 has received Donepezil 20 mg daily and to consider changing the order to 23 mg daily or reduce to 20 mg daily. This form documents V40 signed the form on 7/24/24. On 7/23/24 R46's, R55's, and R70's pharmacy recommendations for the MRRs listed were requested. On 7/24/24 the facility's policy regarding pharmacy reviews/recommendations was requested. On 7/24/24 at 10:20 AM V22 Regional Director of Operations/Consultant Nurse provided R70's Pharmacy Recommendation form dated 6/25/24 to consider dose reduction for Seroquel, Hydroxyzine, or Aricept. V22 stated that was the only pharmacy recommendation that V22 was able to locate for R46's, R55's, and R70's requested MRRs. V22 stated this is V22's first week in the facility and moving forward pharmacy recommendations will be given to V22, V1 Administrator and V2 Director of Nursing. V22 stated the pharmacy recommendations should be followed up with the provider ideally within 72 hours and uploaded into the resident's EMR. V22 stated V22 is unsure what pharmacy recommendations were made (for R46, R55, and R70 on the dates listed), and V22 has requested the forms from the facility's consulting pharmacy. On 7/24/24 at 12:40 PM V1 Administrator stated the facility does not have a policy regarding pharmacy reviews/recommendations.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40385 Based on interview and record review the facility failed to complete psychotropic medication assessments, ensure appropriate diagnosis or behaviors to warrant the use of an antipsychotic, attempt gradual dose reductions (GDRs), and identify/track specific targeted behaviors for five of five residents (R55, R70, R36, R46, R68) reviewed for psychotropic medications in the sample list of 29. Findings include: 1.) R46's Order Summary Report dated 7/23/24 documents orders for Abilify (antipsychotic) 10 milligrams (mg) by mouth once daily started 6/1/24, Clonazepam (antianxiety) 0.5 mg by mouth three times daily started 6/20/24, Geodon (antipsychotic) 40 mg twice daily started 6/16/24, and Divalproex Sodium (mood stabilizer) 500 mg twice daily started 9/1/23 for Bipolar. There are no documented psychotropic medication assessments for these medications in R46's electronic medical record prior to 7/23/24. R46's May and June 2024 Medication Administration Records (MARs) document Abilify was increased from 2 mg daily to 5 mg daily on 5/21/24 and then to 10 mg daily on 5/31/24. These MARs document Clonazepam was increased from 0.25 mg three times daily to 0.5 mg three times daily on 6/21/24. There is no documentation in R46's electronic medical record (EMR) of increased behaviors that occurred during this time and the unsuccessful nonpharmacological interventions that were attempted prior to increasing these medications. R46's Minimum Data Set (MDS) dated [DATE] documents there have been no reduction attempts for R46's antipsychotic medications. R46's EMR does not document GDRs for Abilify, Clonazepam, or Divalproex Sodium or documented clinical rational from a provider stating why a GDR would be contraindicated. R46's Nursing Notes document the following: R46 was treated for a urinary tract infection from 5/15/24-5/17/24. On 6/16/24 R46 cursed at staff and refused to allow staff to provide toileting assistance after R46 urinated on the floor. R46 would not answer staff's questions and R46 told staff, R46 was a government spy and that someone tried to kill R46 earlier. R46 called emergency services and reported R46 was having a baby. R46 was unable to be redirected (does not specify interventions attempted). R46 was transferred to the emergency room and orders were given for Geodon 40 mg twice daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 10:45-11:15 AM V2 Director of Nursing (DON) stated V2, and V29, MDS Coordinator oversee psychotropic medication monitoring. V2 stated psychotropic medication assessments should be completed quarterly and documented under the assessments section of the resident's EMR. V2 stated R46 has a diagnosis of Bipolar and behaviors include being accusatory, hallucinations including that R46 is giving birth, making telephone calls trying to give R46's money away. V2 stated R46's behaviors have improved and only occur occasionally. V2 stated V2 was unsure if there have been any GDRs for R46's Abilify, Clonazepam, and Divalproex. V2 confirmed R46's increase in Abilify and Clonazepam in May and June 2024. V2 was unable to say what behaviors supported the increase of these medications. V2 reviewed R46's nursing notes and stated on 6/16/24 R46 believed R46 was having a baby, staff were unable to redirect R46, and R46 was transferred to the emergency room . V2 confirmed staff did not document what nonpharmacological interventions were attempted to respond to R46's behavior. V2 stated the Certified Nursing Assistants should document behaviors and interventions on the behavior tracking forms. On 7/24/24 at 2:50 PM V2 stated V2 was unable to locate documentation for GDRs for R46's psychotropic medications. V2 stated V2 had no other documentation to provide, other than R46's behavior tracking reports, to support the Abilify and Clonazepam increases. 2.) R55's MDS dated [DATE] documents R55 has severe cognitive impairment and there have been no antipsychotic reduction attempts. R55's Care Plan revised 6/8/24 documents R55's behaviors include aggression towards staff during cares, refusing medications and staff assistance with Activities of Daily Living, physical aggression/threatening behavior towards staff/residents, yelling/verbal noises, throwing walker and other objects, delusions, hallucinations, and believing items are stolen. Making accusatory comments is the only identified targeted behavior listed on R55's ongoing behavior tracking. R55's May-July 2024 behavior tracking is vague and does not identify R55's specific behaviors and specific nonpharmacological intervention to use to respond to each behavior. R55's Order Summary Report dated 7/23/24 documents orders for Seroquel (Antipsychotic) 25 mg daily initiated 4/5/23, Lexapro (antidepressant) 20 mg daily initiated 1/4/24, and Buspirone Hydrochloride 5 mg three times daily initiated 2/24/24, and Zyprexa (antipsychotic) 5 mg three times daily initiated 2/24/24 for persistent mood disorder, post traumatic stress disorder, and chronic anxiety. R55's January 2024 MAR documents Lexapro 20 mg daily since 1/3/24, Buspirone 5 mg three times daily since 1/3/24, Zyprexa 5 mg three times daily since 1/3/24, and Seroquel 25 mg daily since 4/4/23 R55's Psychotropic Medication Review/GDR Review dated 1/3/24 is the only documented assessment for Zyprexa. R55's Psychotropic Medication Review/GDR Review dated 1/8/24 is the only documented assessment for Seroquel. There are no other documented psychotropic medication assessments in R55's EMR. R55's Nursing Note dated 7/21/2024 at 12:59 PM documents R55 was involved in a verbal altercation with another resident, R55 was yelling out and the other resident yelled to shut the h*** (expletive) up. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 10:45-11:15 AM V2 stated R55 has diagnoses of Post Traumatic Stress Disorder and Dementia with Mood Disturbances and behaviors that are mainly anger and yelling out. V2 confirmed the January 2024 psychotropic medication assessments are the only documented assessments for R55. V2 confirmed R55's behavior tracking only identifies accusatory statements as R55's targeted behavior. V2 confirmed R55's behavior tracking is vague and it does not include R55's other behaviors and specific nonpharmacological interventions to respond to each behavior. Documentation for R55's GDRs was requested at this time. On 7/24/24 at 2:50 PM V2 stated V2 was unable to locate documentation for R55's GDRs. 3.) R70's MDS dated [DATE] documents R70 has severe cognitive impairment and no antipsychotic reductions have been attempted. R70's ongoing census documents R70 admitted to the facility on [DATE]. R70's Care Plan revised on 7/22/24 documents R70's behaviors include throwing objects, resisting cares, anxiety, and aggression. Throwing objects is the only identified behavior noted on R70's ongoing behavior tracking. R70's ongoing behavior tracking is vague and does not identify R70's other behaviors as targeted behaviors and specific/personalized nonpharmacological interventions to respond to each behavior. R70's Order Summary Report dated 7/24/24 documents orders for Fluoxetine Hydrochloride (antidepressant) 20 mg daily as of 9/7/23, Seroquel 100 mg twice daily as of 9/6/23, Hydroxyzine Pamoate 50 mg three times daily as of 2/24/24 for depression and anxiety related to dementia with mood disturbances. There is no documentation regarding GDRs for these medications in R70's EMR, besides a pharmacy recommendation dated 6/25/24. This pharmacy recommendations documents R70 had a recent fall; consider GDR for Seroquel, Hydroxyzine, and Aricept; consider periodic checks for possible orthostatic hypotension which can contribute to falls. This form is signed by V40 Nurse Practitioner who declined the recommendation and notes patient is stable. V40 did not document a clinical rational as to why this GDR would be contraindicated. There are no psychotropic medication assessments in R70's EMR. On 7/24/24 at 10:45-11:15 AM V2 was asked what behaviors and diagnoses R70 has to support the use of antipsychotic medication. V2 stated R70 has Dementia with Mood Disturbance, Anxiety, and Depression; R70 doesn't want staff in R70's room, R70 is verbally abusive towards staff, and yells loudly. V2 confirmed R70 does not have behaviors that involve risk for self harm or harming others to support the use of antipsychotic medication. V2 confirmed R70's behavior tracking is not personalized and does not include all of R70's targeted behaviors and nonpharmacological interventions to respond to these behaviors. V2 confirmed psychotropic medication assessments have not been completed for R70. Documentation for R70's GDRs was requested. On 7/24/24 at 2:50 PM V2 stated V2 was unable to locate documentation for R70's GDRs. On 7/24/24 at 10:20 AM V22 Regional Director of Operations/Consultant Nurse confirmed the providers should document a clinical rational for contraindications to GDR request. 32853 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R36's Order Summary dated 7/23/24 documents diagnoses including Senile Degeneration of Brain, Major Depressive Disorder, Vascular Dementia Unspecified Severity with Other Behavioral Disturbance and Generalized Anxiety Disorder. This Order Summary documents orders for Abilify (antipsychotic) Oral Tablet 10 MG (milligrams), give 10 mg by mouth one time a day for Depression with a start date of 7/8/23, Remeron (antidepressant) Oral Tablet 30 MG, give 1 tablet by mouth one time a day for Insomnia with a start date of 4/15/24, Sertraline HCL (Hydrochloride) Tablet (antidepressant) 100 MG, give 2 tablets by mouth in the evening for Depression with a start date of 6/19/24 and Xanax (antianxiety) Oral Tablet 0.5 MG, give 1 tablet by mouth at bedtime for Anxiety. R36's Minimum Data Set (MDS) dated [DATE] documents an admitted [DATE]. This MDS documents R36 has received antipsychotic medication since the most recent admission/reentry and has not received a gradual dose reduction. This MDS documents that R36 has had no behaviors. The only psychotropic medication assessments in R36's medical record were those developed on 7/23/24 (during the survey). R36's medical record does not document any evidence of a gradual dose reduction attempt for any of the psychotropic medications. R36's Behavior documentation does not document targeted behaviors for monitoring and there are no behaviors documented in the R36's medical record. On 7/24/24 at 2:00 PM V2 Director of Nursing (DON) confirmed there are no Gradual Dose Reduction attempts for R36 and confirmed V2 could not find any behavior tracking for R36. 5. R68's Medication Administration Record (MAR) dated 7/1/24 through 7/31/24 documents diagnoses including Personal History of Traumatic Brain Injury, Brief Psychotic Disorder, Other Seizures, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Parkinsonism and Vascular Dementia Unspecified Severity With Agitation. This MAR documents orders for Mirtazapine (antidepressant) oral tablet 15 mg (milligram) give 1 tablet by mouth one time a day for Depression/appetite with an order date of 10/25/23, Trazodone HCL (Hydrochloride) (antidepressant) oral tablet 100 mg give 1 tablet by mouth one time a day related to Vascular Dementia with an order date of 11/29/2023 and Risperdal (antipsychotic) oral tablet 0.5 mg give 1 tablet by mouth two times a day for Irritability with an order date of 2/7/2024. R68's Minimum Data Set (MDS) dated [DATE] documents an admitted [DATE]. This MDS documents R68 has received antipsychotic medication since the most recent admission/reentry and has not received a gradual dose reduction. This MDS documents R68 does have verbal, physical and other behaviors. R68's medical record documents one psychotropic medication assessment for Rexulti dated 6/20/24 and does not document any other psychotropic medication assessments for R68's other psychotropic medications since admission. On 7/24/24 at 2:00 PM, V2 DON confirmed there are no gradual dose reduction attempts and no psychotropic medication assessments for R68.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility repeatedly failed to administer an antibiotic as ordered for one of one resident (R73) reviewed for following Physician's Orders in the sample list 29. Findings include: The facility's Physician Medication Orders policy with a revised date of April 2010 documents, Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. On 7/21/24 at 12:09 PM, V43 R73's family stated that the facility did not administer R73's Vancomycin as it was ordered by the hospital. V43 stated that they gave the wrong dose of Vancomycin and then switched to a lower dose too soon. R73's hospital discharge orders dated 7/4/24 documents orders for Vancomycin (antibiotic) 50 mg (milligrams)/ml (milliliters) oral solution, take 10 mls (500 mg total) by mouth every 6 hours for 1 day. Then Vancomycin 100 mg/ml oral solution, take 5 mls (500 mg total) by mouth every 6 hours for 10 days, start on 7/5/24. Then Vancomycin 125 mg capsule by mouth 4 times a day for 7 days, start on 7/15/24. R73's Minimum Data Set (MDS) dated [DATE] documents R73 was readmitted to the facility on [DATE]. R73's Medication Administration Record (MAR) dated 7/1/24 through 7/31/24 documents orders for Vancomycin 50 mg/ml, give 5 ml every 6 hours for 10 days (250 mg total). This MAR documents that this incorrect dose was not started until 7/5/24 at 12:00 PM and R73 only received two doses on 7/5/24 of the Vancomycin 250 mg. This incorrect dose, was administered for four and a half more days, 7/6/24 through 7/10/24 at 6:00 AM. This MAR documents an order for Vancomycin 50 mg/ml, give 10 mls (500 mg total) every 6 hours for 5 days with a start date of 7/10/24. This dose was started on 7/10/24 at 12:00 PM and was given again at 6:00 PM then continued for four and a half more days, 7/11/24 through 7/15/24 at 6:00 AM. This Vancomycin dose (500 mg) should have been administered from 7/5/24 through 7/14/24 four times a day. This MAR documents an order for Vancomycin 25 mg/ml, give 5 mls (125 mg total) every 4 hours for 7 days. This MAR documents this dose was started on 7/15/24 at 8:00 PM and was given on 7/16/24 through 7/21/24 6 times a day and was given 5 times on 7/22/24 instead of the 4 times that was ordered by the hospital on discharge. On 7/24/24 at 2:00 PM, V2 Director of Nursing confirmed R73's Vancomycin was not administered as ordered by the Physician from the hospital discharge orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31642 Based on observation, interview, and record review, the facility failed to prevent the potential for cross-contamination and foodborne illness, by failing to maintain the facility commercial can opener and commercial plate warmer/storage wells in a sanitary manner, free of food-like debris and rust. The facility also failed to maintain dishware and glassware in a clean, sanitary manner free from dust, paint and caulking chips. The facility also failed to wear hair covering while preparing food. These failure affects all 85 residents residing in the facility. Findings include: 1.) On 07/21/24 at 07:55 am, during the initial kitchen tour of the facility, V4, Cook/ Dietary Assistant was plating residents food. V4 had a full, thick, black beard. V4 did not have on a beard/hair cover on. V4 stated I did not know I was suppose to cover my beard. 2.) On 07/21/24 at 8:05 am, during the same initial kitchen tour, in the dishwasher area of kitchen, there were four trays, with approximately 36 plastic drink glasses on each tray. The drink glasses on each of the four trays were stuck together in stacks and visibly wet. There was a metal electrical tube-like bar attached to the wall that spanned approximately four feet across and above the dishwasher area for clean dishes. The metal tube-like bar was covered in dark gray dust-like particles and dangled in one inch strings of dust from the metal tube-like bar. There was loose, chipped, chunks of caulking and paint chips on the wall above the clean dish area of the dishwashing station. V5, Dietary Assistant/Cook confirmed the glasses were wet when stacked. V5 stated Those glasses are suppose to be dried separated on trays. We have a new dish machine and it needs to be calibrated to dry the dishes faster. V5, Dietary Assistant/Cook also confirmed the hanging strings of dust, chipped caulking and paint chips above the clean end of the dishwasher station. V5 stated This needs to be fixed. 3.) On 7/22/24 at 1:25 pm on the follow-up tour of the kitchen with V6, Dietary Manager (DM), the facility's table-top commercial can opener had rust build-up and a dark brown grease-like substance in the gears. The same can opener had the silver veneer peeling off half way up the one and a half inch blade. The blade tip silver veneer was completely off and exposed bare metal. V6, DM stated I see it. I will take care of that now. 4.) On 7/22/24 at 1:35 pm during the same tour of the kitchen, there was multiple storage racks of clean dishes up against a wall. The wall was approximately eight feet long by eight feet high. The paint was buckled and chipping in a four foot by four foot section, above the clean dish racks. There was an accumulated strings of gray dust-like substance dangling from a trim board approximately four feet up the same wall with clean dish racks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145469	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paris Health and Rehab Center	1011 North Main Street Paris, IL 61944

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5.) On 7/22/24 at 1:40 pm during the same tour of the kitchen with V6, DM there was a commercial (approximately) three foot wide, by three and a half feet tall, two- well plate warmer at the end of the cooks line. The two-well plate warmer contained presumably clean plates in one of the plate warmer wells. Each well had springs that expand and retract as plates are added or removed. The plate well springs were corroded with rust and a thick brown grease-like substance. The plate wells shared the bottom of the double well plate warmer. There was a soiled bath sized towel with a brown substance, bunched up on the left side of the well. The right side bottom of the well, had large three to four inch pieces and fragment approximately one inch pieces of two large dinner size broken glass plates. The bottom of the well was corroded with rust and a brown grease-like substance. V5, Dietary Assistant/Cook stated We don't use the warmer on the plate warmer, but we use (plate warmer) it daily, to hold the clean plates as we serve the meals. V6, Dietary Manager stated We need to just get rid of that all together. We will get something else to hold the plates for meal service. The facility Manual FNS Quick Resource Tool, Cleaning, Sanitizing and Proper Hair Restraint revised 09/01/21 documents the following: STANDARD: Food contact surfaces are properly cleaned and sanitized before and after use, in order to help prevent food-borne illness and minimize bacterial growth. Non-food contact surfaces are cleaned per individual facility cleaning schedule to maintain optimal cleanliness of kitchen equipment. Employees must wear a hair restraint in food preparation areas. Cleaning of kitchen equipment is done as needed and checked weekly per kitchen audit. Done monthly by the facilities dietician. The facility form Long-Term Care Facility Application For Medicare and Medicaid dated 7/22/24 documents 85 residents reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380 Based on interview and record review, the facility failed to have the required documentation in their Facility Assessment. This failure has the potential to affect all 85 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE], does not include the following required documentation: types of diseases listed for services, department and job structure listed,overall acuity listed, competencies to provide the level and types of care needed for residents, ethnic cultural factors that may affect care, and personnel and the education and/or training and any other competencies related to resident care. On 7/24/24, at 11:38 AM, V1 Administrator stated this is what we have (for the Facility Assessment) (which did not include the above listed information). The facility's The Long Term Care Facility Application for Medicare and Medicaid dated 7/22/24, documents there are 85 residents residing in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35380 Based on interview and record review the facility failed to trend the facility's monthly infections. This failure has the potential to affect all 85 residents residing in the facility. Findings include: The facility did not provide an Infection Control Surveillance and Monitoring Policy and no documents were provided for how the facility trends monthly infections to prevent further infection throughout the facility. The facility's Resident Infection Control and Antimicrobial Log dated 1/15/24 - 7/16/24, does not document the summary for total number of infections or the type of infections. There is no doucmented log for the identified pattern/trend and interventions. This log does not document a summary for the infections during these months. On 7/23/24 at 10:30 AM, V2 Director of Nursing/Infection Preventionist, stated V2 has not completed the trending for the facility's infections for this time frame. The facility's The Long Term Care Facility Application for Medicare and Medicaid dated documents there are 85 residents residing in the facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 35380 Based on interview and record review, the facility failed to development and implement a facility-wide antibiotic stewardship program. This failure has the potential to affect all 85 residents residing in the facility. Findings include: On 7/22/24, the facility was asked to provide their Antibiotic (ATB) Stewardship Policy and program. On 7/23/24 at 10:30 AM, V2 Director of Nursing (DON) stated V2 does not have the information requested regarding an Antibiotic Stewardship Program which includes standards, policies and procedures, that are current and based on the facility assessment and national standards. V2 also stated there is no log for staff who have infections or illnesses, there is no documentation of ongoing analysis of surveillance data and documentation of follow-up activity in response, and no ongoing review for ATB stewardship program. The facility's The Long Term Care Facility Application for Medicare and Medicaid dated 7/22/24 documents there are 85 residents residing in the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 35380 Based on interview and record review, the facility failed to offer residents Influenza and Pneumococcal immunizations annually or upon admission and failed to provide educational material and consents for these vaccinations. This failure has the potential to affect all 85 residents residing in the facility. Findings include: R17 has no documented Influenza, Pneumococcal, or COVID vaccines being offered or given, no consents, and no documented pre-vaccine education. R18 has no documented Influenza, Pneumococcal, or COVID consents and no documented pre-vaccine education. R21 has no documented vaccinations given or offered, no consent forms, and no documented pre-vaccine education. R49 has no consents for Influenza, Pneumococcal, or COVID vaccines and no documented pre-vaccine education. R56 has no documentation given or offered for Influenza, Pneumococcal, and COVID vaccines and no documented pre-vaccine education. On 7/23/24 at 10:30 AM, V2 Director of Nursing/Infection Preventionist, stated V2 does not have the information requested regarding updated immunization information, consents not completed for all residents, vaccines not offered to all residents, historical documented on some vaccines with no evidence of trying to obtain current information, no documentation of residents receiving educational immunization information regarding vaccines, and consent forms not being up to date. The facility's The Long Term Care Facility Application for Medicare and Medicaid dated 7/22/24 documents there are 85 residents residing in the facility.