STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145515	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freeburg Care Center	746 Urbanna Drive Freeburg, IL 62243

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on interview and record review, the facility failed to report an injury of unknown origin for 1 of 2 residents (R23) reviewed for abuse in the sample of 41. Findings include: On 8/27/24 at 11:00 AM, V1, Administrator stated she does not have any investigations of injuries of unknown origin or abuse investigations. R23's Face Sheet documents her diagnoses as Generalized Anxiety, Major Depressive Disorder, Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, with Other Behavioral Disturbances, Unsteadiness on Feet, and Muscle Weakness. R23's Minimum Data Set (MDS) dated [DATE] documents she is severely cognitively impaired and is dependent on staff for toileting, dressing, turning and positioning, and transfers. R23's undated Care Plan documents, Skin Integrity with goal of, The skin will remain intact. Interventions include, Continue with A&D Ointment or zinc oxide daily and as needed for protection, encourage good nutrition and hydration in order to promote healthier skin, monitor for signs and symptoms of infection, weekly skin checks, staff to observe skin daily. R23's Progress Note dated 6/15/24 at 10:22 PM document, Incident Note: (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note Text: This resident complained of pain to her right arm when staff was trying to get her ready for a transfer from wc (wheel chair) to bed this eve after supper. The CNAs (Certified Nursing Assistants) x 2 used a gait belt as per the resident's Kardex in her room and transferred her to her bed. Resident was able to bear weight to assist with the transfer. Once the CNAs undressed the resident to put her night gown on they noted a bruise to resident's right upper arm humerus area. This nurse assessed resident arm and right upper arm is noted with a 10 centimeter (cm) X 9 cm dark purple bruise. Resident is uncooperative as this is her normal behavior and will not cooperate in showing me if she has ROM (Range of Motion) to that right arm. Resident is able to move fingers on her right arm. (Medical Doctor (MD)) was notified and order received to get an x-ray stat of the area. This nurse did report to MD that resident does take Pradaxa 75 milligram (mg) twice a day as well. This nurse called (x-ray company) to order a stat xray of the right humerous and the order was put in as stat but the operator placing the order stated that no further test could be placed for tonight and reason was unavailable to this nurse. This nurse placed a call to (x-ray company management) and left a message to find out why no further testing could be done and I was not given a reason or a time frame on when I could expect it to be performed tomorrow. Resident resting now with eyes closed and no signs or distress noted. On 8/28/24 at 3:40 PM, V2, Director of Nursing (DON) and V3, Assistant Director of Nursing (ADON) came in to discuss R23's bruise she had on 6/15/24. V2 stated the bruise was first observed when staff were providing care for R23 on 6/15/24 and R23 was complaining of pain to her arm. V2 stated this was the first time any staff were aware that R23 had the bruise. V2 was agreeable that initially R23's bruise was an injury of unknown origin. She stated after an investigation they determined R23's bruise on her arm was most likely due to her being combative with care. She stated this was a common behavior by R23 when care was being provided. V2, DON provided the investigation/incident report on R23's bruise. R23's untitled report dated 6/15/24 documents (R23) Injury: Bruise to right upper arm 10 cm x 9 cm. DON Notified: (V2) Comment: Resident complained of pain-as her norm. CNAs x 2 transferred resident from w/c to bed for HS care. CNAs transferred x2 with gait belt and resident was able to bear weight. Once resident was undressed the CNAs noted bruise to right upper arm. This nurse assessed the area to find 10 cm x 9 cm dark purple bruise. Resident not cooperative on assessing ROM. Call place to (V36 Medical Doctor) and order received for stat x-ray to right upper arm. A statement at the bottom of this report documented, This is immediate notification of injury and a full investigation will follow within five days. There was no documentation that the Administrator was notified. This report was signed by V3, ADON who was working that day. R23's Skin Investigation Report dated 6/16/24 and documented: Situation: Resident complained of pain to right arm. Nurse investigated arm. Bruise 10 cm x 9 cm found. Resident recently transferred with gait belt and assist x 2 CNAs. MD notified and x-ray orders received. X-ray not available so sent to ER. Findings: Spoke with CNAs, (V10) on 6/17/24. Confirmed resident was combative with care and transfer. Interventions: Resident transfer status updated. Therapy initiated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hand written note dated 6/15/24 but untimed documented (V10 CNA) get up toileted x 3 on days. Per (V10) and (unknown CNA) noted after supper with HS (bed time) care. Bruise right upper arm by (V37, CNA) and (V38, CNA). Sent to (local hospital) for xray. On 8/30/24 at 8:55 AM ,V2, DON stated she talked to the CNAs who worked on 6/15/24 the next day about the bruise on (R23's) arm. V2 stated the CNAs reported that they had gotten (R23) up in the morning and she did not have a bruise on her arm . V2 stated (V10), CNA, described how (R23) was resistive to care and combative to the staff and he described how (R23) had swung her right arm back and hit him and she determined that the probable cause of (R23's) bruise was due to her hitting her arm on him. V2 stated she did not write down exactly what (V10) stated but immediately did the report. V2 stated she felt the investigation showed how (R23) sustained her bruise while being combative with care. On 8/30/24 at 10:10 AM, V1 stated (V3) told her about the bruise on (R23's) right arm and told her staff were constantly pulling (R23) up when she slid down in her wheel chair and that (R23) was on blood thinners and that is probably how she got the bruise. V1 stated that was a good enough explanation for her as to how (R23) got the bruise. On 8/30/24 at 10:20 AM, V3 stated the CNAs who were putting (R23) to bed on 6/15/24 came and got her and told her (R23) had a bruise on her right arm. She stated she went down and looked at it and it was a big purple bruise on (R23's) right upper arm. V3 stated she had not had any other staff report anything out of the ordinary related to (R23) during the shift and she did not know what caused the bruise. She stated she immediately notified the Medical Doctor, Administrator, (R23's) family and the Director of Nursing. V3 stated there was a problem with their x-ray company coming out so the MD gave orders to send to the emergency room because (R23) is on blood thinners. On 8/30/24 at 11:10 AM, V10, CNA stated he took care of (R23) on day shift on 6/15/24 and was informed they found a bruise on (R23's) right arm on that night. He stated he never observed a bruise on (R23's) right arm while he was taking care of her on that day. V10 stated he does not remember (R23) having any abnormal behaviors that day. He stated her normal behaviors was yelling out for no reason. V10 stated (R23) was not combative or resistive to care with him that day. He stated someone did call him the next day to ask if he knew anything about her bruise but he could not recall who called him. The facility's policy, Abuse Prevention Program Policy and Procedure updated 9/26/23 documents, Public Health shall be informed that an occurrence of potential mistreatment has been reported and is being investigated. An initial written report shall be sent to the Illinois Department of Public Health (IDPH) immediately. The written report should contain the following information if known at the time of the report: Any obvious injuries or complaints of injuries.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 The facility failed to ensure all bruises of unknown origin were thoroughly investigated for 1 of 3 residents (R48) reviewed for bruises of unknown origin in the sample of 41. Findings include: R48's Physician Order Sheet (POS for August 2024) documents a diagnosis of Major Depression disorder, severe with psychotic symptoms, pressure ulcer of left heel, Alzheimer disease, dementia in other disease classified elsewhere, unspecified severity, with other behavioral disturbances, psychotic disorder with delusions due to known physiological condition, and anxiety and bilateral primary osteoarthritis of hip. R48's Minimum Data Set (MDS) dated [DATE] documents she is severely impaired for cognition for activities of daily living, she has impairments on both sides, she uses a manual wheelchair. She is dependent on staff for eating, oral hygiene, toileting, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene, Rolling from left to right, sit to stand, chair to bed, toilet transfer tub/shower transfer, and she does not walk and is always incontinent of urine and bowel. R48's Care Plan: (R48) at risk for falls; due to poor safety awareness. Maintain safe environment to room/facility to prevent injuries, well lite environment. Observe resident for any unassisted transfers/ambulation status. Remind to wait assist and assists residents as needed. B & B (bowel and bladder) before meals/after and as needed. Keep resident clean and dry. Resident to use call lights when assist needed. Report any unsteady balance/gait to Nurse. Report any decline in safety awareness to Nurse (PRN). Use of 1/4 side rails times 2, check every two hours and as needed. R48's Skin/Wound Note dated 5/18/2024 at 1:28 PM, Note Text: 11 x 6 cm (centimeters) bruise noted to left shin during routine care. Staff reported to this nurse. Leg evaluated on pillow and V13, Nurse Practitioner notified and aware. Will monitor until healed. Author of this note was documented as V12, Licensed Practical Nurse (LPN). R48's Incident/Accident report date of incident 5/18/2024, Staff noticed a 11 x 6 cm light purple bruise to left skin during routine care. Staff reported resident leg was bumped by another resident's wheelchair. The incident report does not document who the staff member was when the injury occurred and or who the other resident was involved in the injury. R48's Incident/Accident report date of incident 5/18/2024 does not document the time or when the physician was notified, and the form was not completely filled out. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skin Injury Investigation Checklist undated does not document the name of the resident. There was no name, the form documents, Type of skin injury: 'bruise', staff assigned to resident (V10), certified nursing assistant (CNA) and (V11), CNA. How was skin injury found? During routine care. Resident's activity at the time of the skin injury; sitting in wheelchair. What the resident said happened: Unable to voice. Does the resident self-ambulate or self-propel wheelchair around the facility; 'No'. Was there a prior injury to this area recently? 'No'. Does the resident have any behaviors? No. The checklist does not documents which staff member told the other staff an incident had occurred or who the other resident involved was. On 8/29/2024 at 10:41 AM, V12, Licensed Practical Nurse stated, (V11) and (V10) came and got me and told me they had found a bruise on (R48's) leg while they were doing care. I went and looked at it and I did an incident report. I was watching the bruise and they did an investigation on her. (R48) did not walk and was unable to propel herself in the wheelchair. At the time of the incident (R48) was in a manual wheelchair with foot pedals. We think that at mealtime they accidentally hit her foot with the other resident. I do not know who the other resident was, or who the staff member was that was caring for (R48) while they were pushing the other resident under the table, and then they collided. (R48's) bruise was progressively getting worse and I called the Nurse Practitioner and she had me get an x-ray, and when the x-ray came back, we learned she had fractured her leg. I was in shock and blown away because I did not expect (R48's) foot to be fractured from colliding with another resident. On 8/29/2024 at 10:02 AM, all investigations for the bruise of unknown origin were requested. On 8/29/2024 at 2:02 PM, (V11), Certified Nursing Assistant stated, Me and (V10, CNA) were taking care of (R48). We got her up and took her to breakfast. (R48) was in a regular wheelchair with foot pedals. She was not able to propel herself. After breakfast the nursing aid, I do not know her name, she was agency, told me that she had bumped (R48's) leg at the dining room table that morning. When we took (R48) back to her room and laid her down, she winced and even though she could not talk she was grimacing, and you could tell her leg hurt her and she had a red/purple bruise. I went and got the nurse (V12) and had her look at it. (V12) was monitoring it and contacted the doctor and got an x-ray and later we found out she had a fracture. We were all in shock. On 8/29/2024 at 3:32 PM, V2, Director of Nursing stated, I do not have any interviews documented for (R48's) fracture. I did not get any statements from anyone, I did not realize I was supposed to do that as I am new to this position. On 8/30/2024 at 11:03 AM, V10, certified nursing assistant (CNA) stated, I remember taking (R48) back to her room after lunch and when laying her down we, (me and (V11, CNA) noticed a bruise on her leg. We immediately notified the nurse (V12, LPN). Before laying her down she had no prior pain or symptoms. After laying her down she would grimace when we touched the bruise. She cannot talk or tell you what had happened. No staff told me that there was any accident and or injury to (R48). I was working the night shift and I was very surprised to learn that she had a fracture. I am no longer employed at the facility. On 8/29/2024 at 3:42 PM, V1, Administrator stated, I remember the case, but I did not do the investigation, (V2) was in charge of the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/2024 at 2:40 PM, V13, Nurse Practitioner stated, The documentation on this case was poor and what we know is that (R48) had a fracture, and we were not sure how she got that fracture. There was a late entry and I have many issues with that because staff should have documented immediately if she was hit by accident or with other residents and at the end, we can only go by what is documented. It is hard to say and an unusual case. Without names and dates I just have issues. The Facility Abuse Policy updated 9/26/2023 documents, The facility affirms the right of our residents to be free from abuse, neglect, misappropriations of property, corporal punishment, and involuntary seclusion. The facility therefore prohibits mistreatment, neglect, or abuse of residents and has attempted to establish a resident-sensitive and secure environment. The purpose of this policy is to assure that the facility is doing all that is within our control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will done by: Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. Timely and thorough investigations of all reports of allegations of abuse. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. The Director and/or Assistant Director of nursing is responsible for reviewing the incident report and reporting any findings to the facility administrator. If the resident complaints of physical injuries or physical injuries are noted, the resident's physician and representative will be contacted for further instructions.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35156 Based on interview and record review the Facility failed to seek medical interventions in a timely manner for 1 of 5 residents (R48) reviewed for medical interventions in the sample of 49. This failure resulted in R48 sustaining a fracture and not being sent out to the hospital for two days and sustaining a fracture of her left ankle. Findings include: R48's Skin/Wound Note dated 5/18/2024 (Saturday) at 1:28 PM, Note Text: 11 x 6 cm (centimeters) bruise noted to left shin during routine care. Staff reported to this nurse. Leg elevated on pillow and V13, Nurse Practitioner notified and aware. Will monitor until healed. Author of this note was documented as V12, Licensed Practical Nurse (LPN). R48's Health Status Note dated 5/19/2024 (Sunday) at 7:49 AM, Note Text: Resident moaning with pain to left leg, +2 plus edema with warmth to touch. 11 x 6cm purple bruise to left shin, increased edema and bruising today. Notified NP. Called POA, notified of change at this time and voiced understanding stated she is out of town today and keep her updated. R48's Health Status Note dated 5/20/2024 at 9:34 AM, Note Text: Received a new order to obtain x-ray of left tib/fib 2 views. Author of this note was V12. (This was two days later after the incident). R48's Health Status Note dated 5/20/2024 at 10:45 AM, Note, Text: (Company) x-ray here obtained 2 views of tib/fib at this time. R48's Health Status Note dated 5/20/2024 at 11:39 AM, Note Text: NP (V13) here received new order to send resident to ER (emergency room for evaluation and treatment related to left shin x-ray results. R48's Health Status Note dated 5/20/2024 at 11:51 AM, Note Text: Called POA (Power of Attorney), notified of resident fracture left leg and new order to send to (hospital) for evaluation and treatment. Resident transferred out to ER (emergency room) at this time. On 8/29/2024 at 10:41 AM, V12, Licensed Practical Nurse stated, (V11) and (V10) came and got me and told me they had found a bruise on (R48's) leg while they were doing care. I went and looked at it and I did an incident report. I was watching the bruise and they did an investigation on her. (R48) did not walk and was unable to propel herself in the wheelchair. At the time of the incident (R48) was in a manual wheelchair with foot pedals. We think that at mealtime they accidently hit her foot with the other resident. I do not know who the other resident was, or who the staff member was that was caring for (R48) while they were pushing the other resident under the table, and then they collided. (R48's) bruise was progressively getting worse and I called the Nurse Practitioner and she had me get an x-ray, and when the x-ray came back, we learned she had fractured her leg. I was in shock and blown away because I did not expect (R48's) foot to be fractured from colliding with another resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/29/2024 at 2:02 PM, (V11), Certified Nursing Assistant stated, Me and (V10, CNA) were taking care of (R48). We got her up and took her to breakfast. (R48) was in a regular wheelchair with foot pedals. She was not able to propel herself. After breakfast the nursing aid, I do not know her name, she was agency, told me that she had bumped (R48's) leg at the dining room table that morning. When we took (R48) back to her room and laid her down, she winced and even though she could not talk she was grimacing, and you could tell her leg hurt her and she had a red/purple bruise. I went and got the nurse (V12) and had her look at it. (V12) was monitoring it and contacted the doctor and got an x-ray and later we found out she had a fracture. We were all in shock. On 8/30/2024 at 2:40 PM, V13, Nurse Practitioner stated, The documentation on this case was poor and what we know is that (R48) had a fracture, and we were not sure how she got that fracture. There was a late entry and I have many issues with that because staff should have documented immediately if she was hit by accident or with other residents and at the end, we can only go by what is documented. It is hard to say and an unusual case. In the beginning I just thought it was a bruise because there was no fall. No staff told me when she was in pain until the next day. When I first got the call, I was out of town, but then on Monday I was in the facility and when I saw her I sent her out immediately when I learned she had a fracture. The Facility Change of Condition MD/NP Policy updated 5/20/2023 docuemnts, Immediate notification: Any symptom, sign or apparent discomfort, that is: acute, or sudden onset, and a marked change (i.e. more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. This would include abnormal vital signs, labs, respiratory distress, significant weight loss/gain, pain, fall, pain with wound care, changes in wound appearance, food/liquid intake reduced, abnormal x-rays. A full list is located at nurse station. The nurse would notify the MD/NP by phone of any condition that needs immediate attention. Resident POA or resident representative will be notified immediately. Non-Immediate Notification: New or worsening symptoms that do not meet the above criteria. Example vital signs normal, labs normal. This would allow the nurse to update the MD/NP by Mediprocity or phone call. Documentation will be done for the resident and the situation as well as the Administrator, DON or ADON being notified of any changes.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 35156 Based on interview and record review the Facility failed to ensure a resident was not injured while being pushed in their wheelchair during meal service for 1 of 4 residents (R48) reviewed for accidents in the sample of 41. This failure resulted in R48 sustaining a fracture to her left leg while being pushed by staff in her wheelchair. Findings include: R48's Physician Order Sheet (POS for August 2024) documents a diagnosis of Major Depression disorder, severe with psychotic symptoms, pressure ulcer of left heel, Alzheimer disease, dementia in other disease classified elsewhere, unspecified severity, with other behavioral disturbances, psychotic disorder with delusions due to known physiological condition, and anxiety and bilateral primary osteoarthritis of hip. R48's Minimum Data Set (MDS) dated [DATE] documents she is severely impaired for cognition for activities of daily living, she has impairments on both sides, she uses a manual wheelchair. She is dependent on staff for eating, oral hygiene, toileting, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene, Rolling from left to right, sit to stand, chair to bed, toilet transfer tub/shower transfer, and she does not walk and is always incontinent of urine and bowel. R48's Care Plan: (R48) at risk for falls; due to poor safety awareness. Maintain safe environment to room/facility to prevent injuries, well lite environment. Observe resident for any unassisted transfers/ambulation status. Remind to wait for assist and assist residents as needed. B & B (bowel and bladder) before meals/after and as needed. Keep resident clean and dry. Resident to use call lights when assist needed. Report any unsteady balance/gait to Nurse. Report any decline in safety awareness to Nurse (PRN). Use of 1/4 side rails times 2, check every two hours and as needed. R48's Skin/Wound Note dated 5/18/2024 at 1:28 PM, Note Text: 11 x 6 cm (centimeters) bruise noted to left shin during routine care. Staff reported to this nurse. Leg elevated on pillow and V13, Nurse Practitioner notified and aware. Will monitor until healed. R48's Incident/Accident report date of incident 5/18/2024, Staff noticed a 11 x 6 cm light purple bruise to left shin during routine care. Staff reported resident leg was bumped by another resident's wheelchair. R48's Health Status Note dated 5/19/2024 (Sunday) at 7:49 AM, Note Text: Resident moaning with pain to left leg, +2 plus edema with warmth to touch. 11 x 6 cm purple bruise to left shin, increased edema and bruising today. Notified NP. Called POA, notified of change at this time and voiced understanding stated she is out of town today and keep her updated. R48's Health Status Note dated 5/20/2024 at 9:34 AM, Note Text: Received a new order to obtain x-ray of left tib/fib 2 views. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R48's Health Status Note dated 5/20/2024 at 10:45 AM, Note, Text: (Company) x-ray here obtained 2 views of tib/fib at this time. R48's Health Status Note dated 5/20/2024 at 11:39 AM, Note Text: NP (V13) here received new order to send resident to ER (emergency room for evaluation and treatment related to left shin x-ray results.) R48's Health Status Note dated 5/20/2024 at 11:51 AM, Note Text: Called POA (Power of Attorney) notified of resident fracture left leg and new order to send to (hospital) for evaluation and treatment. Resident transfer out to ER (emergency room) at this time. R48's Skin Wound Note Late Entry, created date 5/21/2024 at 10:36 AM, Staff reported resident sliding down in wheelchair, left lower leg bumped by another resident's wheelchair pedal while in dining room for lunch. Light red/purple abrasion noted. Resident assessed by this nurse, no acute distress noted. R48's Skin Investigation Report dated 5/18/2024 documents, On 5/18 resident wheeled to lunch by CNA when wheeled up to table left leg bumped a wheelchair, a light red/purple bruise noted by nurse. On 5/19/2024 bruises are now 11 cm x 6 cm. Resident shows signs and symptoms of pain with transfers, NP notified, order for x-ray leg received on 5/20/2024, after x-ray transferred to ER (emergency room). Findings: Resident was transferred with gait belt of assist of 2. CNA's Interviews with (V12), (V11) (V26) all agree. Resident did walk with restorative staff on 5/18. Verified on camera. Resident returned to facility with order to follow up with ortho. Interventions: Resident was provided care until EMS (emergency medical services) arrived to transport to ER (emergency room) upon return resident transfer status was updated. Ortho f/u (follow up) to be made. R48's Orthopedic Paperwork documents, R48 was admitted to the hospital on 5/28/2024 and discharged on [DATE], Procedure performed, 'left tibia closed reduction and intramedullary nailing'. This patient is a [AGE] year-old female with unknown mechanism of injury, presenting with a left tibia fracture. Chief complaint: Left leg pain and swelling. R48's Skin Injury Investigation Checklist undated with no name documents, Type of skin injury: 'bruise', staff assigned to resident (V10), certified nursing assistant (CNA) and (V11), CNA. How was skin injury found? During routine care. Resident's activity at the time of the skin injury; sitting in wheelchair. What the resident said happened: Unable to voice. Does the resident self-ambulate or self-propel wheelchair around the facility; 'No'. Was there a prior injury to this area recently? 'No' R48's Initial Incident Report dated 5/20/2024, Staff reported that (R48) resident had a bruise noted to lower left leg. Nurse V12, Licensed Practical Nurse (LPN)) reported to (V13) Nurse Practitioner that bruise had gotten larger, so NP ordered x-ray of lower leg. The x-ray report came back and shows a fracture. (R48) was sent to (hospital) for evaluation and treatment. (R48) later that same day returned to this facility with an order to follow up with an orthopedic doctor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R48's Final Incident Report, Resident (R48) was admitted to (Facility), March 21, 2019 and has been a long term care resident since then. Her admitting diagnosis for care was dementia. On 5/18/2024 the assigned staff to (R48), (V12, LPN), (V10, CNA), (V11, CNA) and (V10, CNA) reported to (V12, LPN) after meal that (R48) was sliding down in her wheelchair at meal so they repositioned her while in the dining room. While repositioning her (R48) (bumped the shin of her left leg on another resident's wheelchair pedal). Nurse assessed resident at the time. Noted a small, light bruise that measured approximately 11 cm x 6 cm and small abrasion. Nurse monitored the bruise and filled out incident report as per policy. (State), NP, Administrator, DON and all notified in a timely manner. On 5/19/2024 staff noted bruise had grown in size and notified nurse (V12). V12 informed (V13, NP) of bruise as well as POA. R48's Accident/Incident Report reported to State on 5/20/2024 documents, Staff reported that (R48) had a bruise noted to lower left leg. Nurse (V12) reported to (V13) that bruise had gotten larger, so NP ordered an x-ray of left lower leg. The x-ray report came back and shows a fracture. (R48) was then sent to the hospital for evaluation and treatment, (R48) later that same day returned to this facility with an order for follow up with an orthopedic doctor. (R48) was admitted to (Facility) on 3/21/2019 and has been a long-term care resident since then. Her admitting diagnosis for care was dementia. On 5/18/2024 the staff assigned to (R48) were (V12, LPN), (V10, CNA), (V11, CNA), and (V14, CNA), who reported to (V12) that (R48) was sliding down in her wheelchair at meal, so they repositioned her while in dining room. While repositioning her (R48) bumped her shin of her left leg on another resident's wheelchair pedal. Nurse assessed leg at that time. Noted a small, light purple bruise that measured approximately 11 cm x 6 cm and small abrasion. Nurse monitored the bruise and filled out incident report as per policy. R48's Radiology Report with a report date of 5/20/2024 at 10:55 AM, Findings: Proximal tibia/fibula fractures with mild displacement. Mild soft tissue swelling. Conclusion: Acute appearing proximal tibia/fibula fractures as noted. On 8/29/2024 at 10:41 AM, V12, Licensed Practical Nurse stated, (V11) and (V10) came and got me and told me they had found a bruise on (R48's) leg while they were doing care. I went and looked at it and I did an incident report. I was watching the bruise and they did an investigation on her. (R48) did not walk and was unable to propel herself in the wheelchair. At the time of the incident (R48) was in a manual wheelchair with foot pedals. We think that at mealtime they accidentally hit her foot with the other resident. I do not know who the other resident was, that was while they were pushing the other resident under the table, and then they collided. (R48's) bruise was progressively getting worse and I called the Nurse Practitioner and she had me get an x-ray, and when the x-ray came back we learned she had fractured her leg. I was in shock and blown away because I did not expect (R48's) foot to be fractured from colliding with another resident. On 8/29/2024 at 2:02 PM, V11, Certified Nursing Assistant stated, Me and (V10, CNA) were taking care of (R48). We got her up and took her to breakfast. (R48) was in a regular wheelchair with foot pedals. She was not able to propel herself. After breakfast the nursing aid, I do not know her name, she was agency, told me that she had bumped (R48's) leg at the dining room table that morning. When we took (R48) back to her room and laid her down, she winced and even though she could not talk she was grimacing, and you could tell her leg hurt her and she had a red/purple bruise. I went and got the nurse (V12) and had her look at it. (V12) was monitoring it and contacted the doctor and got an x-ray and later we found out she had a fracture. We were all in shock. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/30/2024 at 9:33 AM, V26, Registered Nurse (RN) stated, I was working the Medicaid Hall that day. When I saw the bruise on R48's leg for the first time I was not sure what or why it had happened. She could not propel herself in the chair or move her legs and she could not tell you what happened. She could not talk. She had a history of sliding down in her chair that is why she is now in a geriatric chair. I heard something about a staff member bumping her leg but I am not sure who the staff member was. I remember sending a message to the Nurse Practitioner. We were all in shock when we learned her leg was fractured. On 8/30/2024 at 11:03 AM, V10, Certified Nursing Assistant (CNA) stated, I remember taking (R48) back to her room after lunch and when laying her down we, (me and (V11, CNA) noticed a bruise on her leg. We immediately notified the nurse (V12, LPN). Before laying her down she had no prior pain or symptoms. After laying her down she would grimace when we touched the bruise. She cannot talk or tell you what had happened. No staff told me that there was any accident and or injury to (R48). I was working the night shift and I was very surprised to learn that she had a fracture. I am no longer employed at the facility. On 8/30/2024 at 2:40 PM, V13, Nurse Practitioner stated, The documentation on this case was poor and what we know is that (R48) had a fracture, and we were not sure how she got that fracture. There was a late entry and I have many issues with that because staff should have documented immediately if she was hit by accident or with other residents and at the end, we can only go by what is documented. It is hard to say and an unusual case. Without names and dates I just have issues. I would not expect a resident to be injured while being pushed in a wheelchair. The Facility Abuse Policy updated 9/26/2023 documents, Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment. Timely and thorough investigations of all reports of allegations of abuse. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. The Director and/or Assistant Director of nursing is responsible for reviewing the incident report and reporting any findings to the facility administrator. If the resident complaints of physical injuries or physical injuries are noted, the resident's physician and representative will be contacted for further instructions. The Accident/Incident Policy revised 12/2023 documents, All accidents or incidents that result in an injury or illness must be reported to the Administration, DON (Director of Nursing), or ADON (Assistant Director of Nursing). The DON will make an initial report of the incident and report it to (State) through facility Reported Incdient. The following data, as it may apply, must be included in the Accident/Incident Report form: Date and time accident/ incident occurred circumstances surrounding accident/incident. Where the incident/accident occurred. Name (s) of any witness (es) and his/her account of the accident or incident.

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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. 35156 Based on observation, interview, and record review the facility failed to ensure food was stored and prepared in a manner which prevents potential contamination. This has the potential to affect all 99 residents living in the facility. Findings include: On 8/27/2024 at 9:13 AM, tour of the facility was conducted. In the kitchen in the sink were 5 large industrial clear bags of frozen chicken. Water was running over one bag, but the other four bags did not have any water running on them. The temperature of the water was taken with a calibrated metal thermometer and the water was 100.0 degrees Fahrenheit (F). There was not a stopper in the sink and the water was running straight down into the drain. The frozen chicken was not submerged in the water. There was about 1/2 of water in the sink with the water running. Not all of the chicken was in water. On 8/27/2024 at 9:22 AM, in the walk-in refrigerator was a moving tray and on the tray on the top shelves were small clear plastic cups with an orange substance inside of the cups. The orange cups were not covered and were exposed in the air of the refrigerator. There was no date and or label and there were 4 trays with a total of 92 cups. On the next to bottom shelf of the cart was a large industrial box labeled 8 piece cut glazed chicken. The box was leaking, and the entire tray was covered with a bloody liquid that was leaking from the cardboard box. On 8/27/2024 at 9:24 AM, there was a clear container of pineapple with the use by date of 8/11/2024 that was still in the walk-in fridge. On 8/27/2024 at 9:25 AM, there was a clear, large industrial container of corn kernels with no date and/or label. On 8/27/2024 at 9:28 AM, above the stove the hoods were shiny and greasy and in need of a cleaning. On 8/27/2024 at 9:29 AM, V25, [NAME] stated, The menu calls for chicken and I am not sure what happened but the chicken was spoiled and so we are trying to thaw new chicken so we can follow the menu. I am not sure how or why the chicken was spoiled. Our Dietary Manger is not working today, she does not normally work on Tuesdays. We were just trying to get the chicken thawed. On 8/27/2024 at 10:32 AM, V24, Dietary Manager stated, I would expect all food to be dated and labeled. I am not sure what happened with the chicken, but the staff should not have tried to defrost the chicken in the sink without taking into consideration the water temperatures and ensuring they were doing it the correct way. On 8/29/2024 at 8:51 AM, V24 stated, I am not sure when the hoods were last cleaned. I would expect the hoods to always be clean and free of grease. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Meat and Vegetable Cookery Policy undated documents, Meat is defrosted using safe thawing methods (never at room temperature): In the sink, under clean running water <70 F (Fahrenheit). The Labeling and Dating Foods 2020 documents, All food stored will be properly labeled according to the following guidelines. Once a case is opened, the individual, refrigerated food items are dated with the date the item was received into the facility and placed in/on the proper storage unit utilizing the 'first in- first out' method of rotation. Once the package is opened, it will be redated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date. Prepared food or opened food items should be discarded when: The food item is older than the expiration date. The US FDA (Food and Drug Administration) 2022 code documents, 3-501.13 Thawing. Except as specified in (D) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be thawed: (A) Under refrigeration that maintains the FOOD temperature at 5oC (41oF) or less Pf; or (B) Completely submerged under running water: (1) At a water temperature of 21oC (70oF) or below Pf, (2) With sufficient water velocity to agitate and float off loose particles in an overflow Pf, and (3) For a period of time that does not allow thawed portions of READY-TO-EAT FOOD to rise above 5oC (41oF) Pf, or (4) For a period of time that does not allow thawed portions of a raw animal FOOD requiring cooking as specified under 3-401.11(A) or (B) to be above 5oC (41oF), for more than 4 hours including: (a) The time the FOOD is exposed to the running water and the time needed for preparation for cooking Pf, or (b) The time it takes under refrigeration to lower the FOOD temperature to 5oC (41oF) Pf. 4-204.11 Ventilation Hood Systems, Drip Prevention. Exhaust ventilation hood systems in FOOD preparation and WAREWASHING areas including components such as hoods, fans, guards, and ducting shall be designed to prevent grease or condensation from draining or dripping onto FOOD, EQUIPMENT, UTENSILS, LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES. The Long Term Care Facility for Application Form for Medicare and Medicaid Form (CMS 671) dated 8/27/2024 documents there were 99 residents living in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35156 Based on observation, interview and record review the Facility failed to ensure proper infection control guidelines were being followed for 6 of 22 residents (R20, R48, R28, R38, R42 and R60) reviewed for infection control in the sample of 41. Findings include: 1. On 8/27/2024 at 12:11 PM, V39, Certified Nursing Assistant (CNA) was feeding (R42). V39 was wearing a mask and was resting her elbows on the dining room table and both of her hands were on her cheeks. She then proceeded to feed R42 without disinfecting and/or washing her hands. On 8/27/2024 at 12:15 PM, V39, reached over the table and touched R42's bib and then proceeded to feed another resident without disinfecting and/or washing her hands. Then after touching her face again she proceeded to feed R42 without disinfection and /or washing her hands. 2. On 8/30/2024 at 10:33 AM, wound care was provided by V35, Licensed Practical Nurse (LPN). R48's door had a sign on the door documenting EBP (Enhanced Barrier Precautions) and instructed staff to wear PPE (Personal Protective Equipment) including mask, gloves and gowns. V35 was not wearing any gown while providing wound care. On 8/30/2024 at 10:55 AM, V2, Director of Nursing stated, (R48) was on EBP (Enhanced Barrier Precautions) and she would expect for all staff to wear gloves, mask and gowns for all treatments. 42834 3. On 8/27/2024 at 12:00PM, V32 Certified Nursing Assistant (CNA), was sitting at a table providing feeding assistance to R20 and R60. V32 began feeding R20 a spoonful of food and immediately began feeding R60 a spoonful of food. No hand hygiene was completed between feedings. V32 wiped R20's mouth with a cloth. V32 was handling multiple cups and utensils. No hand hygiene completed before V32 began feeding R60. No hand sanitizer on table or nearby. On 8/27/2024 at 12:05PM, V33, Certified Nursing Assistant, CNA, was sitting at a table providing feeding assistance to R28 and R38. V33 began feeding R28 with a spoon and immediately began feeding R38 with a spoon. No hand hygiene was completed between feedings. V33 touched R38's clothing protector and face, with no hand hygiene completed prior to feeding R28. No hand sanitizer on table or nearby. On 8/30/2024 at 8:45AM, V27, Certified Nursing Assistant, CNA, stated We are taught to use hand sanitizer between feeding residents. On 8/30/2024 at 8:40AM, V2, Director of Nursing, DON, stated The CNAs feeding residents are to use hand sanitizer between feeding residents or touching residents. They are to use the same hand to feed a resident and the other hand to feed the other resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's undated Hand Hygiene policy states Handwashing will be regarded by this facility as the single most important means of preventing the spread of infection. Staff will follow the facility's established hand hygiene procedures to prevent the spread of infection and disease to other staff, residents, and visitors. Hands should be washed for at least 20 seconds using soap and water under the following conditions: Before having direct contact with a resident. After having direct contact with a resident. After handling items potentially contaminated with blood, body fluids, excretions, or secretions. Hand sanitizers containing at least 60% alcohol may be used when soap and water is not readily available. Facility's undated Resident Feeding policy states Residents who are unable to feed themselves will be fed by approved personnel with attention to safety, comfort, and dignity. Staff will sit when feeding residents. Facility's Infection Control Policy updated 7/31/2024 states The facility must establish an infection prevention and control program that must include, at a minimum, the following elements: Written standards, policies, and procedures, for the program, which must include, but are not limited to: The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food if direct contact will transmit the disease, The hand hygiene procedures are to be followed by staff involved in direct resident contact. The Enhanced Barrier Precautions (EBP) Policy and Procedure undated documents, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs), CMS notes that facilities have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents. Enhanced barrier precautions (EBP) are an infection control measure designed to reduce transmission of multidrug-resistant organisms (MDROs) in the nursing homes. Enhanced Barrier Precautions involve gown and gloves use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices. High-contact resident activities include Wound care: any skin opening requiring a dressing. Gowns and gloves will be available immediately near or outside of the resident's room. Enhanced barrier precautions should be used for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.