STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Mount Vernon	1700 White Street Mount Vernon, IL 62864

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview, observation, and record review the facility failed to notify the physician of intravenous medications being unavailable for administration. The facility also failed to notify the physician for residents change in condition for 2 of 3 residents (R1, R16) reviewed for physician notification in a sample of 29. Findings include: 1. R1's document titled Admission Record documents an admitted [DATE]. R1's Order Summary Sheet documents diagnoses of Peritoneal Abscess, Anal Abscess, other specified sepsis, colostomy, hypertension, severe protein-calorie malnutrition, and anemia. R1's Minimum Data (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. R1's Order Summary Report dated February 2025, documents orders for Vancomycin (antibiotic) intravenous (IV) 1 gm (gram) two times a day for abdominal abscess, order date [DATE], start date [DATE], until [DATE]; and Unasyn (antibiotic) 3gm IV four times a day for abdominal abscess, order date [DATE], start date [DATE], until [DATE]. R1's Medication Administration Record (MAR) documents R1 was to receive IV (Intravenous) Vancomycin 1 gm (Gram) twice a day (Ordered on [DATE]). On [DATE] at 5:00PM the box was coded 9 see progress note, progress note at 5:38 documents medication not available. On [DATE] doses due at 8:00AM and 5:00PM are coded 9 see progress note, only progress note is at 6:18PM with medication not available. The date [DATE] at 5:00PM left blank, and [DATE] at 8:00AM coded 9 see progress note, progress note documents medication not given due to new dose not available. MAR documents a total of 5 missed doses of Vancomycin 1gm. R1's MAR documents R1 was to receive IV Unasyn 3 gm four times a day (Ordered on [DATE]). On [DATE] at 5:00PM and 9:00PM both doses coded 9 see progress note, progress notes medication not available for both doses. On [DATE] at 5:00AM, 11:00AM, 5:00PM, and 9:00PM all coded with 9 see progress notes, progress noted for doses missed at 5:00AM, 11:00AM and 9:00PM documents medication not available. On [DATE] at 5:00AM documents code 9 see progress notes, progress notes medication not available. MAR documents a total of 7 doses missed doses of Unasyn 3gm. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Progress Notes dated [DATE] through [DATE] were reviewed for the Physician notification of R1's medications not being administered due to unavailability. There was no documentation noted in R1's Progress Notes of the physician or the Nurse Practitioner (V17) being notified. On [DATE] at 11:20AM, R1 was alert and oriented to person, place, and time. R1 stated he did miss some of his IV (Intravenous) medications when he first admitted . R1 stated the pharmacy did not send them and I missed several doses the first few days and then one day last week I missed a dose due to pharmacy not bringing the medications. On [DATE] at 1:35PM, V2 (Director of Nursing) stated R1 receives IV antibiotics and was admitted with those orders. V2 stated R1 missed some doses the first couple of days because the pharmacy did not get the orders electronically and the medications were not in house. V2 stated she couldn't remember if she notified the doctor or not, but she knows as soon as they arrived the medications were started. V2 stated she thought the meds came in on [DATE] and R1 was admitted on [DATE]. V2 stated the problem was the facility was switching over to electronic records, but she was not aware there still needed to be a phone order faxed over to pharmacy and this is the reason the medications were not in to administer. On [DATE] at 1:58PM, V17 (Nurse Practitioner) stated she received a message on [DATE] to clarify IV medication orders, she instructed the facility to call the Infectious Control Physician at the discharging hospital and get clarifications. V17 stated she received another message shortly after informing her that all IV medications had been clarified and IV medications were to be continued. V17 stated she was not notified that the medications were not administered, or any doses were missed. 2. R16's document titled Admission Record documents an admitted [DATE] with diagnoses of Cerebral Palsy, Type 2 Diabetes Mellitus with Ketoacidosis, without coma, Hyperlipidemia, Hyperkalemia, Epileptic Syndrome, Quadriplegia, Acute Kidney Failure, Chronic Kidney Disease, Microcephaly. R16's MDS (Minimum Data Set) dated [DATE] includes a BIMS (Brief Interview for Mental Status) assessment that suggest BIMS should not be conducted as resident rarely/never understood. MDS documents R16 requires supervision assistance with eating. R16 requires partial/moderate assistance with wheeling manual wheelchair 50 feet with 2 turns and 150 feet. R16 requires substantial/max assist with oral hygiene, putting on/off footwear, roll from left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed -to- chair transfers, and toilet transfers. R16 is dependent for toileting hygiene, shower bathe self, and upper and lower body dressing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:59AM, V19 (Licensed Practical Nurse/LPN) stated she was working the dayshift 6A-6PM on [DATE]. V19 stated she was the charge nurse for R16. V19 stated R16 was fine through the earlier part of the day. V19 stated she really didn't know R16 that well. V19 stated around 3:00PM the CNA's reported to her that R16 wasn't acting right, and he looked bad. V19 stated she checked R16's blood sugar between around 3:,d+[DATE]:30PM and the glucometer just read HI. V19 stated she gave R16 12 units of regular insulin at this time and called the on-call physician but had to leave a message. V19 stated she also gave the 6 units of regular insulin that is scheduled at 4:00PM. V19 stated R16 was a little sluggish and was acting tired. R16 stated as she was waiting for the return call from the physician, she called V2 (Director of Nursing/DON) and V2 informed her that this has happened before with R16 and sometimes they send him to the hospital if the physician orders to send him. V19 stated, V2 told her just wait on the physician to call back and see what the physician wants to do. V19 was asked if she has had training at the facility on change of condition, blood glucose monitoring (how high does the glucometers read), and V19 stated she has not had any kind of any training at the facility. V19 stated she had no idea of how high the blood sugar is when it read HI. On [DATE] at 2:00PM, V19 stated she was not sure what number she called for the on-call MD on [DATE], it was on a note at the nurse's station. V19 stated she doesn't know about HUCU (Electronic Communication System used by the Facility) and communication like that and she has had no training on any of that stuff. V19 stated again she was advised by V2 to wait for the MD to call back and if she would have said sent to ER (emergency room), she would have sent R16 out. On [DATE] at 11:04AM, V22 (Registered Nurse/RN) stated she worked on [DATE], 6AM -6PM. V22 stated she received in report R16 had been running high blood sugars and insulin per orders was given report that the on-call physician was called, and a message was left to return call. V22 stated she went to R16's room around 6:30PM to check on R16, she stated she could arouse R16, and he would answer yes or no to questions. R16's blood sugar was checked at this time and reading was high. V22 stated she had put in another call to the on-call physician and left a message (unsure of what time). V22 stated she received a call back from a physician with orders for 12 units of insulin and recheck in a little while (unsure of physician's name). V22 stated she could arouse R16 at that time and he was unchanged from previous assessment. V22 stated she remembers rechecking R16's blood sugar about 45 minutes later and the blood sugar was down to 488. V22 stated she didn't call the physician back with results. V22 stated, I thought we were finally going in the right direction with the blood sugar going down. V22 stated sometime around 10:00 PM, she was summoned to R16's room by a CNA, upon entering room R16 was having a hard time breathing and heart rate was irregular, color was bad and R16 was nonresponsive. V22 stated at this time she and the CNA lowered R16 to the floor to prepare for CPR (Cardiopulmonary Resuscitation), when lowering R16 to the floor R16 stopped breathing. V22 stated CPR was started and help was called for from the other CNA's. When other CNA entered the room V23 asked her to call 911 and the CNA stated, CNAs are not allowed to call 911. V22 then stated the CNA took over chest compression and V22 went to call 911 and check R16's chart for code status. V22 stated code status was found and R16 was a DNR, so she went to the room and stopped CPR. EMS arrived and pronounced death at 10:30ish. V22 stated she remembers R16 having a strong sweet fruity smell as they were transferring him to the floor. V22 stated she has had no training at the facility on policies or resources to look them up. On [DATE] at 12:04PM, V15 NP (Nurse Practitioner) stated she was looking for messages on [DATE] on the call log and on her cell phone and no messages were left and there were no missed calls for this facility. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:20PM, a call was placed to the Physician Service office and spoke with the receptionist/secretary (V35) who stated she would send a call log for the date of [DATE] for this facility. The call log was received and did not show that the Physician Service office received any calls from the Facility log on [DATE]. On [DATE] at 9:25AM, V24 Medical Director stated V2 was asked how the on-call services work and V24 stated, The nurses have to use HUCU to reach the nurse practitioner and on weekends from 9PM to 6AM there is a number to call and usually I am the one on call. V24 was asked if he received any calls on [DATE] or after midnight on [DATE], V24 checked his records and personal phone and stated, No I did not. V24 was explained the condition of R16 and his high blood sugars. V24 stated, We can sometimes manage high blood sugars in the facility but if we give treatment and the condition doesn't change then they need to be sent to the hospital. V24 stated he believes the problem is with the nursing staff and some of them only being in the facility a few times. V24 stated the nurses need to be educated. The facility policy titled Medication Administration General Guidelines (undated) documents, if a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the MAR for that dosage is initialed or circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. The facility policy titled Physician- Family Notification-Change in Condition (revision date of [DATE]) documents Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/responsible party in a timely, efficient, and effective manner. Guidelines: The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is: (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on interview, and record review the facility failed to provide assistance with activities of daily living for 4 of 5 residents (R8, R18, R21, R28) reviewed for activities of daily living care in a sample of 29. Findings include: 1. R8's Admission Record documented an admitted [DATE] with diagnoses including: congestive heart failure, type 2 diabetes. R8's 2/14/24 Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of 13, indicating R8 was cognitively intact, and Section GG documented R8 dependent on staff for tub/shower transfer. On 3/5/25 at 3:40 PM, R8 said there had been times the facility was too short staff to assist her with showering. R8 said 2 to 3 weeks prior to this interview it was really bad and she had to go 7 to 9 days without a shower. R8 said about a week prior to this interview R8 needed to use the bathroom and had waited about 2 hours for staff to assist her. R8 stated (V40) was here that day and watched me have to wait. R8 said she was not sure if she had to wait for so long because the mechanical lift battery was dead or because the facility was short staffed. R8 stated have you ever had to sit in a wheelchair for 2 hours needing to poop? R8's GG ADL Documentation from 1/29/25 through 2/28/25 documented R8 received a shower/ bathing on 1/29/25, 2/1/25, 2/12/25, and 2/15/25. On 3/5/25 at 10:18 AM, V40 (Ombudsman) said while she was visiting the facility on 2/27/25 R8 was sitting in her wheelchair in the hallway. V40 said R8 asked her if she could assist R8 to the bathroom and V40 told R8 she could not. V40 said she watch R8 ask every staff that passed R8 to assist her to the bathroom and was told several times I'll get to you in a minute. V40 said she watch R8 ask staff for at least 30 minutes but V40 was not sure how long R8 had been sitting there needing to use the bathroom before V40 arrived. 2. R18's Admission Record documented an admitted [DATE] with diagnoses including: muscle wasting and atrophy, severe calorie malnutrition. R18's 2/6/25 MDS documented a BIMS score of 15, indicating R18 was cognitively intact, and R18 required substantial/ maximal assist with shower/ bathing. On 3/5/25 at 3:50 PM, R18 said there was not enough staff to assist her with showering/ bathing. R18 stated we go a long time without showers. R18's GG ADL Documentation from 1/29/25 through 2/28/25 documented R18 received a shower/ bathing on 1/31/25, 2/7/25, 2/18/25, 2/25/25, and 2/28/25. 3. R28's Admission Record documented an admitted [DATE] with diagnoses including: muscle wasting and atrophy, diabetes mellitus, dependence on renal dialysis. R28's 2/3/25 MDS documented a BIMS score of 14, indicating R28 was cognitively intact, and R28 required partial/ moderate assistance with shower/ bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/25 at 1:50 PM, R28 stated you can't get anyone to help you take a shower. R28's GG ADL Documentation from 1/29/25 through 2/28/25 documented R28 received a shower/ bathing on 1/29/25 and 2/1/25. 4. R21's Admission Record documented an admitted [DATE] and a discharge date of [DATE] with diagnoses including: congestive heart failure, need for assistance with personal care, reduced mobility. R21's 2/5/25 MDS documented a BIMS score of 15, indicating R21 was cognitively intact, and R21 was dependent on staff for shower/ bathing. R21's 2/5/25 MDS documented sit to stand, chair/ bed-to-chair transfer, toilet transfer, and tub/ shower transfer was not attempted due to medical condition or safety concern. On 3/11/25 at 3:20 PM, R21 said the staff were nice, there just wasn't enough of them. R21 said he went long periods of time without a shower but was unable to say how long. R21's GG ADL Documentation from 1/29/25 through 2/28/25 documented R21 received 1 shower/ bathing on 1/30/25. On 3/20/25 at 10:07 AM, V18 (Certified Nursing Assistant/ CNA) said the facility worked with only 2 CNA's and 2 Nurses about 2 days a week on average. V18 said if the facility only had 2 CNA's working on dayshift they could not provide the scheduled showers to residents or provide care for Activities of Daily Living (ADL) to residents in a timely fashion. V18 said the facility only had one battery for the mechanical lift. V18 said if a resident was dependent on the mechanical lift for transfer and the mechanical lift battery was dead the resident would have to wait until it was charged to be transferred. V18 said for past month to month and a half the facility only had one mechanical lift battery. On 3/20/25 at 10:15 AM, V46 (CNA) said she had been working in the facility for a couple weeks. V46 said dayshift was short staff a couple times a week with 2 CNA's and 2 Nurses. V46 said when there were only 2 CNA's working, they could not get the scheduled showers completed and all the necessary tasks completed. V46 said even on days when 3 CNA's were working, they could not get all the necessary tasks completed. V46 said there were supposed to be 4 CNA's on dayshift but that was rare. V46 said if dayshift could not get a resident's scheduled shower completed, they were supposed to pass it on to the nightshift CNA's. V46 said the night shift CNA's had a list of scheduled resident showers too and struggled to get those completed so V46 was unsure how they managed to get day shifts completed as well. V46 said the facility had one mechanical lift battery. V46 said she was told when she started if the mechanical lift battery was dead, and someone needed to be transferred with it she would tell the resident they would have to wait until the battery charged. On 3/6/25 at 9:36 AM, V1 (Administrator) said most of the CNA's and Licensed Nurses worked 12-hour shifts. V1 said the facility required 4 CNA's and 2 Licensed Nurses to work day shift. V1 said the facility worked short staffed more than she would like. V1 said 2 CNA's and 2 Licensed Nurse could not provide assistance with ADLs for all the residents in a timely fashion. V1 said if dayshift could not provide showers to residents during their shift, they should be passing them along to night shift so they can be completed but was not sure they always were completed. V1 said the facility was using agency staff but was not able to get the positioned covered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's 12/12/24 Resident Council meeting minutes documented in part . New (mechanical lift) batteries discussed . response.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview and record review, the facility failed to seek emergency care for a resident with Type 2 Diabetes Mellitus who was experiencing elevated blood sugars too high for accurate readings to be obtained with facility glucose monitoring device for 1 of 3 residents (R16) reviewed for change in condition in a sample of 29. This failure resulted in R16's death with cause of death listed as possible diabetic ketoacidosis. This failure resulted in an Immediate Jeopardy, which was identified to have begun on [DATE] when the facility failed to seek emergency care for R16 who was experiencing high blood sugar readings which lead to R16's death as possible diabetic ketoacidosis. V1 (Administrator), V33 (Regional Reimbursement), and V34 (Regional Clinical Nurse) were notified of the Immediate Jeopardy on [DATE] at 11:35 AM. The surveyor confirmed through observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on [DATE], but the noncompliance remains at Level Two due to additional time to evaluate implementation and effectiveness of training. Findings Include: R16's Admission Record documents an admitted [DATE] with diagnoses of Cerebral Palsy, Type 2 Diabetes Mellitus with Ketoacidosis, without coma, Hyperlipidemia, Hyperkalemia, Epileptic Syndrome, Quadriplegia, Acute Kidney Failure, Chronic Kidney Disease, Microcephaly. R16's MDS (Minimum Data Set) dated [DATE] includes a BIMS (Brief Interview for Mental Status) assessment that suggests BIMS should not be conducted as resident rarely/never understood. R16's MDS documents R16 requires substantial/max assist with oral hygiene, putting on/off footwear, roll from left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed -to- chair transfers, and toilet transfers. R16's MDS documents R16 is dependent upper and lower body dressing. R16's Physician Orders dated [DATE] to [DATE] documents orders for Humalog Kwikpen (insulin) 100 units/3 milliliters, inject 6 units subcutaneous three times a day (8:00AM, 11:00AM, and 4:00PM) with meals. Lantus (insulin) 100 units/milliliters, inject 23 units subcutaneous once daily (8:00AM). Fingerstick glucose monitoring three times a day (8:00AM, 11:00AM, and 6:00PM) with meals with sliding scale insulin including parameters: less than 150 =0 units, ,d+[DATE]= 2 units, ,d+[DATE]=4 units, ,d+[DATE]=6 units, ,d+[DATE]=8 units, ,d+[DATE]=10 units, and over 400 give 12 units and call the physician. R16's December medication administration Record (MAR) documents orders for Fingersticks Glucose Monitoring: TID (three times a day) with meals with sliding scale insulin at 8:00AM, 11:00AM, and 6:00PM. The Blood Glucose Monitoring System, User Instruction Manual on page 53 documents your blood sugar is more than 600mg/dl (milligrams per deciliter). Instructions to repeat test with new test strip. If the message shows, again contact your healthcare professional right away. If blood sugar is over 600mg/dl the monitor will read HI. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:59AM, V20 (Certified Nurse Assistant/CNA) stated we got R16 up that morning and he was acting ok but seemed tired. As the day progressed, he didn't seem right like yelling at us, so we told the nurse. V19 (Agency Licensed Practical Nurse/LPN) was the nurse, and she checked R16's BS (blood sugar) and it was high. We told the nurse that he needs to be sent out to the hospital, but V19 did not listen and said she was going to try some things first. V20 stated V19 would not listen to the CNA's and the nurse is just temporary and does not know the residents like we do. V20 stated R16 didn't eat much that day. Right before lunch is when R16 started getting worse. V20 stated in the evening V19 kept checking R16's blood sugar and it kept reading high. V20 stated V19 had never worked dayshift before so she did not know how R16 was during the day. On [DATE] at 11:59AM, V19 (LPN) stated she was working the dayshift 6A-6PM on [DATE]. V19 stated she was the charge nurse for R16. V19 stated R16 was mostly fine through the earlier part of the day. V19 stated she really didn't know R16 that well. V19 stated around 3:,d+[DATE]:30PM the CNA's reported to her that R16 wasn't acting right, and he looked bad. V19 stated she checked R16's blood sugar around 3:30PM and the glucometer just read HI. V19 stated she gave R16, 12 units of regular insulin at this time and called the on-call physician but had to leave a message. V19 stated at 4:00PM she gave 6 more units of regular insulin as scheduled. V19 stated R16 was a little sluggish and was acting tired. V19 stated as she was waiting for the return call from the physician, she called V2 (Director of Nursing/DON) and V2 informed her that this has happened before with R16 and sometimes they send him to the hospital if the physician orders to send to the emergency room . V19 stated that V2 said to just wait on the physician to call back and see what the physician wants to do. V19 was asked if she has had training at the facility on change in condition, blood glucose monitoring such as how high does the glucometers read, and V19 stated she has not had any kind of any training at the facility. V19 stated she had no idea of how high the blood sugar is when it read HI. V19 stated R16's vital signs were within normal limits, and she did not receive a return call from the physician during the remainder of her (day) shift that ended at 6PM. On [DATE] at 2:00PM, V19 stated she was not sure what number she called for the on-call physician on [DATE], it was on a note at the nurse's station. V19 stated she doesn't know about the facility's (electronic communication system) and communication like that. V19 stated, I was advised by V2 to wait for the physician to call back and if V2 would have said send R16 to the ER (emergency room), I would have sent him to the ER. V19 stated she gave report to V22 (Agency Registered Nurse/RN) when she came in at 6PM with information about R16's high blood sugars and a call placed to the on-call physician. (continued on next page)

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	145517	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Mount Vernon	1700 White Street Mount Vernon, IL 62864

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:04AM, V22 (Agency Registered Nurse/RN) stated she worked on [DATE], 6AM -6PM. V22 stated she received in report that R16 had been running high blood sugars and insulin per orders was given and the on-call physician was called, and a message was left for a return call. V22 stated she went to R16's room around 6:30PM to check on R16, she stated she could arouse R16, and he would answer yes or no to questions. R16's blood sugar was checked at this time and the reading was HI. V22 stated she had put in another call to the on-call physician and left a message. V22 stated she received a call back from a physician around 7:30PM and received orders to give another dose of 12 units of insulin, in addition to the scheduled dose of 6 units and recheck in a little while. V22 said that she was not sure who the physician was that called. V22 stated she did not document the physician's name in the medical record and did not write the orders given to her on the Physician Order Sheet. V22 stated she was the only nurse in the facility for that shift. V22 stated she could arouse R16 at that time and he was unchanged from previous assessment at around 6:30PM. V22 stated she remembers rechecking R16's blood sugar about 45 minutes later, approximately 8:15PM and the blood sugar was down to 488. V22 stated, I thought we were finally going in the right direction with the blood sugar going down. V22 stated, Sometime around 10:00 PM, I was called to R16's room by a CNA, upon entering room R16 was having a hard time breathing, heart rate was irregular, color was bad and R16 was nonresponsive. V22 stated at this time she and the CNA lowered R16 to the floor to prepare for CPR (Cardiopulmonary Resuscitation), when lowering R16 to the floor, R16 stopped breathing. V22 stated CPR was started and help was called for from the other CNA's. When the other CNA entered the room V22 asked her to call 911 and the CNA stated, CNAs are not allowed to call 911, so that CNA took over chest compression and V22 went to call 911 and check R16's chart for code status. V22 stated code status was found and R16 was a DNR (Do Not Resuscitate) so she went to the room and stopped CPR. V22 stated EMS (Emergency Medical Service) arrived and pronounced death around 10:30ish. V22 stated she remembers R16 having a strong sweet fruity smell as they were transferring him to the floor. V22 stated she has had no training at the facility on policies or resources to look up policies. On [DATE] at 1:20PM, V21 (Certified Nurse Assistant/CNA) stated, she came into work on [DATE] at 6:00PM and shortly after getting to work she saw R16. V21 stated R16 was not responding to the staff and his color was not good. V21 described R16's color as not a good color and sort of gray. V21 stated, As the evening went on there really was not many changes with R16. V21 stated, I was working on another hall when I heard someone yell and when I got down there, the nurse was doing chest compressions on R16. When another CNA got in there, she took over chest compressions and the nurse went to check the chart to see if R16 was a DNR or a Full Code. The nurse returned stating R16 was a DNR, so the CPR stopped. When EMS arrived, they checked R16 and stated to leave R16 in the floor until cleared by the coroner. V21 stated, When I got report from the day shift CNA's, the CNA's reported that R16 was not doing good at all and the CNA's tried to get the dayshift nurse to send him to the emergency room , but she wanted to try some other things first. V21 stated this was an agency nurse and they do not know the residents like we do. On [DATE] at 4:20PM, V25 (CNA) stated she was working the night R16 passed. V25 stated she worked 6PM -6AM that day. V25 stated she had checked in on R16 a few times and R16 was sleeping. V25 stated when she went in to do bed check on R16 she noted he was gray in color and not responding. V25 stated she was unsure of the time. V25 stated she yelled for help, and everybody came. V25 stated they moved him to the floor and started CPR. V25 stated they did CPR for about 15 minutes until EMS arrived then they stopped CPR. V25 stated R16 had been out to the hospital multiple times in the past because of his blood sugars. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:18PM, V2 (DON) stated she remembers the phone call she received from V19 LPN on [DATE]. V2 stated it seems like it was somewhere around 5:00PM. V2 stated V19 was an agency nurse that informed her that R16's blood sugar was reading HI and that she had followed doctor's orders and had given him insulin and was waiting on the physician to call her back. V2 stated she asked how R16 was doing, and the nurse stated his vital signs seemed to be normal. V2 stated the nurse stated she thought he was acting ok to her. V2 stated she told the nurse that if she felt like he needed to be sent out that she could do that or just wait on the physician to call back with orders. V2 was asked if she had investigated R16's death records. V2 stated, I read the nurses notes because she didn't see anything really concerning. V2 stated she talked with the night nurse V22 after R16 passed. V2 stated the night nurse said R16 acted fine at 6:00pm when she arrived at work and then V22 was called to his room later and she called 911. V2 stated she thought V22 had called back the doctor or the doctor called her and order more insulin. V2 stated she had seen where his blood sugar went down a bit after V22 gave the ordered insulin. V2 stated his blood sugar was down in the 400's after that. V2 was asked if she would have sent him out with the high blood sugars, V2 stated, If he was not acting right, I would have. V2 stated his blood sugars reading high meant it was over 500. V2 was asked how high the glucometers reads and V2 stated, I believe 500 or 550 but I would have to read the book on that to make sure. V2 was informed the Owners' Manual to the glucometer states these glucometers read up to 600 then automatically go to read HI. V2 stated Wow! V2 stated she would have sent him out knowing his blood sugar was over 600. V2 stated she feels it was a long time for the physician to get back with the facility and this is unusual, and she would have sent him out. V2 stated R16 had started making a pattern of having DKA (Diabetic Ketoacidosis) and he had been placed in ICU (Intensive Care Unit) with an Insulin drip over the last several months, with the last time was [DATE]. V2 stated R16 was normally very active, talking to the staff, V2 stated he had the mind of a child, and we all loved him. V2 was asked if the (Nurses Agency Staffing Organization) nurses receive any or are required to complete any training at the facility level, V2 stated the only requirement is a valid nurse's license. V2 stated she doesn't like to have agency nurses in her facility working because they don't know the residents usually, but we don't have a choice right now. On [DATE] at 1:45PM, V1 (Administrator), stated she has been employed at the facility for 5 years and she was very familiar with R16. V1 stated she had not investigated R16's death. V1 stated R16 had been sent to the hospital several times for elevated blood sugars, DKA, and R16 would get treated and return. V1 was handed R16's progress notes from the day he expired. V1 was asked to read the progress notes. V1 then stated, I would have sent him out at 488 but I would have sent him out before that when the blood sugar was too high to read on the glucometer. V1 stated she and V15 (Nurse Practitioner/NP) had talked about this after his death and R16's life expectancy was only to live until his 20's, he was in his 50's and he had many health issues. V1 stated the nurse that was working that day was an agency nurse. V1 stated, I would have sent him out and if they would have sent him out when it was high, he would still be alive, but I was very familiar with R16 and knew his medical issues. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:50PM, V23 (R16's sister/Power of Attorney) stated R16 was her brother, and he had resided in the facility for a few years. V23 stated up until the last several months the care was good and R16 was thriving, but the last several months had been bad. The facility has a lot of nurses that only work occasionally, and they do not know the residents or how to care for them. V23 stated on [DATE] she came to visit R16 in the afternoon and R16 did not seem himself and seemed very tired. V23 stated she thought maybe he was just sleepy as no staff said anything to her about his blood sugars or anything being wrong. V23 stated, The next thing I knew I got a call between 10:30PM and 11:00PM that my brother had passed. V23 stated R16 was in the hospital recently with Ketoacidosis on [DATE]. V23 stated if R16 doesn't get his insulin right his blood sugars get too high. On [DATE] at 9:25AM, V24 (Medical Director), was asked if he was familiar with R16. V24 stated, That name does not ring a bell, I don't know him. V2 was asked how the on-call services work and V24 stated, The nurses have to use (facility notification system) to reach the nurse practitioner and on weekends from 9PM to 6AM there is a number to call and usually I am the one on call. V24 was asked if he received any calls on [DATE] or after midnight on [DATE], V24 checked his records and personal phone and stated, No I did not. V24 was explained the condition of R16 and his high blood sugars. V24 stated, We can sometimes manage high blood sugars in the facility but if we give treatment and the condition doesn't change then they need to be sent to the hospital. V24 stated he believes the problem is with the nursing staff and some of them only being in the facility a few times. V24 was asked if he thought that hindered communication with physicians and he stated, Yes if they do not know our system. V24 was asked when the last time he made rounds in the facility to see the residents and V24 stated, I do not see the patients, the Nurse Practitioners see the patients and they work through me. I only come per requirement quarterly for the meeting. V24 stated the facility should have done a better job with R16, and I am sorry for his death. V24 stated education needs to be done and corrected. On [DATE] at 12:04PM, V15 (NP) stated she was looking for messages on [DATE] on the call log and on her cell phone and no messages were left and there were no missed calls for this facility for [DATE]. On [DATE] at 2:20PM, a call was placed to the Physician Service office and spoke with the receptionist/secretary (V35) who stated she would send a call log for the date of [DATE] for this facility. The call log was received and did not show that the Physician Service office received any calls from the Facility log on [DATE]. R16's Nurses Notes authored by V19 dated, [DATE] at 5:50PM, documents, right before dinner had started it was time for me to check R16's. I checked his blood sugar, and the monitor said high. So I check it again on another finger and it still said high. I looked at his chart to see his sliding scale, I followed the sliding scale and called the on-call doctor like it stated on his order. I called and left and voicemail for the on-call doctor letting him know what was going on and what he would like for me to do next. I checked R16's vital signs before I called the doctor, and his vital signs were wnl (within normal limits). While waiting on the call back I checked R16's blood sugar again 40 minutes later after given insulin, and it still said high. So, I called the DON and told her what was going on and she said he had issues with his blood sugar being high before. While doing shift change, I informed the on-coming nurse about what was going on and that she should receive a call from the doctor soon. I also charted what was going on, on the shift change sheet. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R16's Nurses Notes authored by V22, dated [DATE] at 1:00AM, documents report received at approximately 6PM from the day shift nurse that resident's blood sugar had been running high today and most recent blood sugar reading prior to evening meal read hi on the blood glucose monitoring machine. Dayshift nurse reports calling provider on call for further insulin orders. Call back from PCP (Primary Care Provider) received at approx. 7:30PM with new orders for additional 12 units insulin x 1. Insulin given per orders RUQ (right upper quadrant) abd (Abdomen). At that time resident able to respond yes/no to questions asked. No active distress. Respirations even and unlabored, heart RRR (regular rate and rhythm), BS (Bowel Sounds) per 4 quads. Skin color WNL. Recheck of blood sugar at approx. 8:30PM with result of 488. No change in condition from an hour ago. No acute distress. During med pass CNA's notified this nurse that resident looked terrible. Upon entering resident's room, he was laying in bed color pale resp uneven and labored, fruity/sweet smell odor noted to resident's breath, unresponsive, heart irregular rate and rhythm. V/S (Vital signs) ,d+[DATE], 56, 28, 96.2 unable to obtain O2 (Oxygen) sat. Resident moved to the floor in anticipation of CPR if required, while this writer and CNA moved resident to floor, he stopped breathing, chart checked for code status and rescue breaths given. POLST (Physician's Order for Life Sustaining Treatment) form - DNR (Do Not Resucitate). No further breaths given. Emergency responders/fire department arrived at facility at approx. 10:33PM. Time of death 10:33PM. This writer called sister/guardian at 10:35 PM and 11:15, sister returned call to facility and spoke with this nurse with situation relayed. Sister began crying and stated she was glad for being able to see him this morning for a visit and was thankful to all facility staff for care given to brother. On-call after hours MD (medical doctor) called x2 awaiting call back. This nurse called local funeral home and body removed from facility at approximately 12:45AM. R16's [DATE] MAR (Medication Administration Record) documents on [DATE], R16's blood sugar at 8:00AM has numbers that are scribbled out but looks like 200 written beside the scribbles with V19's initials. On [DATE] at 11:00AM, the MAR documents blood sugar of 272 with initials of V19. There was no amount of sliding scale insulin documented to be given at that time, however the scheduled Humalog Kwikpn 6 units at 11:00AM and initialed by V19. On [DATE] 4:00PM, the MAR documents 6 units of Humalog Insulin was given as scheduled and initialed by V19, and at 6:00PM fingerstick glucose monitoring is initialed by V19 and results were scribbled out. On [DATE] at 2:00PM, V19 was asked about the blood glucose monitoring checks being scribbled out on MAR and V19 stated she did not do that. R16's December MAR contains no documentation that 12 units of Humalog insulin were given around 4:00PM on [DATE]. The MAR does document at 7:30PM on [DATE] R16 received 12 units of Humalog due to blood sugar reading Hi on Blood Glucose monitoring machine. R16's State of Illinois Certificate of Death includes a date of death for [DATE], and cause of death Probable Diabetic Ketoacidosis. Time of death 10:33PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Physician- Family Notification-Change in Condition Policy with a revision date of [DATE], documents in part: The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse Practitioner; and if known, notify the resident's legal representative or an interested family member when there is: .(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); Life-threatening conditions are such things as a heart attack or stroke. Clinical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression. (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before). (D) A decision to transfer or discharge the resident from the facility. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: Facility administrator was in-serviced by Regional Reimbursement Consultant on [DATE] on ensuring that glucometer values out of normal range are communicated to the attending physician or authorized designee in a timely, efficient and effective manner. Facility administrator was in-serviced by Regional Reimbursement Consultant on [DATE] on ensuring that licensed nursing personnel will inform the physician or authorized designee with any change in condition of the resident in an effective, timely and efficient manner. Facility administrator was in-serviced by Regional Reimbursement Consultant on [DATE] on medications being administered in accordance with the good nursing principles and practices and only by persons legally authorized to do so and only after they have been properly oriented to the facility's medication distribution system. Facility's administrator in-serviced by Regional Reimbursement Consultant on [DATE] on using nursing judgement to seek emergency treatment when appropriate. Facility Administrator initiated in-servicing on [DATE] for nursing staff on using nursing judgement to seek emergency treatment when appropriate. Facility Administrator initiated in-servicing on [DATE], for all nursing staff, on ensuring glucometer values out of normal range are communicated to the attending physician or authorized designee in a timely, efficient and effective manner to be completed before the start of their next shift. Facility Administrator initiated in-servicing on [DATE], for all nursing staff, on medications being administered in accordance with the good nursing principles and practices and only by legally authorized to do so and only after they have been properly oriented to the facility's medication distribution system, to be completed before the start of their next shift. Facility policy for physician notification has been reviewed by Regional Director of Operations and has been found to be in compliance on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility completed an audit of all diabetic residents to ensure that their blood sugars are within therapeutic range and a weekly audit will be per formed by the DON or designee weekly for four weeks. Quality Assurance and Performance Improvement (QAPI) plan has been revised to include that the facility will ensure residents experiencing an acute critical situation receive timely emergency care and lacks a process for physician notification and receiving orders in an acute situation. QAPI revisions will be discussed at the next QAPI meeting in [DATE]. Monitoring will be ongoing in the morning Quality Assurance (QA) meeting by the QA team (Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Minimum Data Set (MDS)), the QA team will review the 24-hour report and follow up on any changes in condition to ensure that proper care was received and proper procedures were followed.

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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** 49664 Based on observation, interview and record review, the facility failed to implement new fall interventions for a resident who was a high risk for falls for 1 of 3 residents (R25) reviewed for falls in the sample of 29. This failure resulted in R25 being sent to the hospital for a fall that that resulted in a new hyper density in the posterior right globe and swelling/hematoma to the right scalp. Findings include: R25 's document titled Admission Record documents R25 was admitted to the facility on [DATE] with diagnoses including Anemia, Chronic Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, History of Falls, Unspecified Dementia, History of Transient Ischemic Attack, Legal Blindness, and Cerebral Infarction without residual deficits. R25's MDS (Minimum Data Set) dated 12/17/24, documents under section C (cognition patterns) that R25 has long term and short-term memory problems, cognitive skills for daily decision-making are marked severely impaired, and no BIMS (Brief Interview for Mental Status) was completed due to resident unable to participate. Section GG documents, functional limitation in range of motion shows impairment on both sides, of lower extremities. R25 has mobility by wheelchair. MDS documents R25 is, upper and lower body dressing, putting on/taking footwear, rolling left and right, sit to lying, and chair-bed-to chair transfer. Section H Bladder and Bowel documents always incontinent of bladder and always incontinent of bowels. Section J health condition, under Fall history/any falls since on Admission/Entry or Reentry or prior assessment, documents R25 has not had any falls since admission/entry or the prior assessment. Number of falls since admission/Entry or Reentry or Prior Assessment is left blank. Section M Skin Condition documents resident is on a turning and repositioning program. Section P Restraints and Alarms documents R25 had no alarms such as bed alarms, chair alarms, floor mat alarm, motion sensor alarm, or wander/elopement alarm. R25's Care Plan documents under Focus, resident is at risk for falls related to cognitive impairment and unaware of safety needs, 3/7/2025 resident unwitnessed fall out of bed, scoop mattress placed on bed, date initiated 7/18/2024, Revision date on 3/13/2025, with same date for canceled. Interventions: Resolved (with no date) 1/2 side rail to help with bed mobility and improve safety per POA (Power of Attorney) request. The residents call light is within reach and encourage the resident to use it for assistance as needed, anticipate and meet the resident's needs, follow fall policy, observe nonverbal signs of restlessness that may precipitate movement and attempts to stand /walk unattended, OT (Occupational Therapy) to evaluate and treat as ordered, review information on past falls and attempt to determine cause of falls, record possible root cause, after remove any potential causes of possible and up ad lib with 1 assist. R25's Fall Risk assessment dated [DATE] documents score of 21 which instructions read :10 Points or More= High Risk Score. R25's, 7/17/2024 fall risk assessment documented a score of 24, and R25's 5/21/2024 assessment documented a score of 12. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R25's Unwitnessed Fall report dated 3/7/25 documents, at 4:00PM, Incident description: Unwitnessed fall from bed. 4:00PM resident's roommate came to Admin office stating that resident was in the floor next to her bed. Resident was hoyer lifted from floor to bed by nurse and CNA's. Resident is unable to give description. Immediate action: POA (Power of Attorney) declined to send to ER (emergency room) to eval and treat. Scoop mattress placed on bed. Neuro checks initiated. Approx 4:00AM on 3/8/2025, resident was sent to ER related to change in condition/change in neuro assessment. Injuries observed at time of incident Bruise to top of scalp and face. Predisposing Environmental Factors is marked none. Predisposing Physiological Factors is marked none. Predisposing Situation Factors is marked none. On 3/14/2025 at 1:20PM, V31(Certified Nurse Assistant/CNA) stated she was working the day R25 had a fall. V31 stated she and V21 had laid R25 down around 2:00PM that afternoon. V31 stated R25 was incontinent of bowel and bladder and required 2 people to transfer because R25's legs were bent. V31 stated R25 did not ever move very much in the bed. V31 stated R25 used to have a small siderail but it was removed recently. V31 stated the rail had been there a long time but R25 had not been able to use the rail for bed mobility for quite some time. V31 stated the rail was there to keep R25 in the bed but it was taken off. V31 stated R25 's family requested that the bed be moved up against the wall as well. V31 stated R25 had fallen one other time a while back but she was unaware of the intervention that was put into place. V31 stated when he had laid R25 down, R25 was facing the wall on her right side, and closer to the wall. V31 said when she entered the room when she heard that R25 had fallen, R25 was lying in the floor in the same position, on her right side with knees bent. V31 stated R25 had her eyes open but was not screaming and yelling like she normally does when someone touches her. V31 stated she has no idea how R25 fell out of bed as she normally never moves. On 3/14/2024 at 2:12PM, V20 (CNA) stated she was working on the day R25 fell . V20 stated she and V31 laid R25 down around 2:00PM and they positioned her on her right side facing the wall and about in the middle of the bed. V20 stated she had never seen R25 move by herself. V20 stated as they were making rounds between 3:30PM -4:00PM to get residents up for supper we found R25 lying on the floor facing the wall on her right side. V20 stated in the past if R25 would get mad she would move her legs from side to side. V20 stated R25 used to have a side rail and her bed against the wall to keep her from falling, but the rail was removed recently. V20 was asked if any other fall interventions were put into place like alarms, lower bed, or a fall mat and V20 stated not that she knew of. V20 stated R25 was not able to get out of bed by herself as her knees were contracted. V20 stated R25 always screamed and yelled when anyone touched her as she did not like to be bothered. V20 stated they summoned the nurse to R25's room and the nurse assessed R25, then R25 was hoyer lifted back to the bed with 2 assists. V20 stated R25 was totally dependent on the staff for all her care. On 3/14/2025 at 2:29PM, R9 who was alert to person, place and time, stated she was in the room on the evening R25 fell out of bed. R9 stated R25 never moved much at all anymore. R9 stated, she was snoozing and reading, remembered looking up and R25 was lying on the floor on her left side facing R9. R9 stated she always tried to check on R25 frequently as she was old. R9 stated she went to tell V1 (Administrator) as fast as she could that R25 was on the floor. R9 stated the nurses came and got the hoyer and lifted her back to bed. R9 stated she believed R25 slipped out of bed, and she couldn't stand at all. (continued on next page)

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	145517	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/13/2025 at 2:30PM, observed R25 lying in bed on right side, facing the wall, in fetal-like position. At that time the right side of bed was up against the wall with no side rail noted but concave mattress in place. R25 had noted bruising/swelling noted to right eye and right side of head with noted hematoma. R25 was not responding to verbal stimuli. Hospice nurse present at time of observation. R25's document titled Nurses Notes documents on 3/7/2025 at 5:57 PM, resident roommate came out of room and notified CNA that resident was in the floor and had rolled out of bed. Resident was found lying on right side with hematoma to right side of head and swelling and bruising to right eye. Notified POA due to this nurse feeling like resident wound need to go to emergency room for eval due to resident being on Eliquis (blood thinner). POA stated to hold off that he was going to come up here and check on R25. POA showed up about 10 minutes later and stated he did not want her sent to the emergency room at this time. Provider notified. On 3/8/2025 at 2:47 AM, upon taking residents vital signs blood pressure decreased to 92/50, pulse 58, respirations 16, temperature 97.7 and Oxygen saturations at 89-91% room air, resident not responding to blood pressure cuff being applied or tough. Called POA and updated POA on resident's condition, stated we recommend R25 being seen at the emergency room , possible brain bleed related to blood thinners and fall. POA stated to monitor her and call him back in 1 hour with vital signs after redoing them, will continue to monitor. On 3/8/2025 at 3:40AM, went to check on resident, resident's vital signs are as follows: blood pressure 87/42/ pulse 63, respirations 16, temperature 97.7, oxygen saturations 85% on room air, resident is still not responding to touch. Bruising, swelling remains to right eye and right side of head. Called POA back with new vital signs per POA requested update, had to encourage POA for resident to be seen. POA stated to send R25 to local emergency room for eval and treat. Notified MD on electronic messaging system, called ambulance for transport and called local hospital to give report on R25. On 3/8/2025 at 9:30AM, resident returned to facility from local hospital via ambulance. POA at bedside. CNAs assisted with repositioning resident for comfort. On 3/8/2025 at 9:40AM, Vital signs Oxygen saturations 96% on room air, pulse 86, respirations 24 and blood pressure 98/58. The only medication change/orders when resident came back from local hospital, were to stop taking Eliquis (blood thinner). Bruising and swelling, and hematoma continues to right peri orbital and scalp area. Bruising noted to right hand and bilateral arms and right leg. Resident is on a scoop mattress. POA present at bedside and updated V15 NP (Nurse Practitioner) of readmit. Documents from local hospital titled CT (Computerized Tomography) Head without Contrast dated 3/8/2024 at 6:10AM, documents under Impression: No CT evidence of acute intracranial abnormality. There is new hyper density in the posterior right globe. Can not exclude acute hemorrhage. Recommend ophthalmologic evaluation. Right frontal scalp and right periorbital soft tissue swelling/hematoma. Document titled Nurses Notes dated 3/9/2025 at 7:38PM, spoke with POA about V15 asking if family wanted hospice and POA stated it would be a good idea. POA chose hospice team and to consult tomorrow. Document titled Hospice Admission Summary dated 3/11/2025, documents terminal diagnosis of: Cerebral Atherosclerosis with code status documented of DNR (Do Not Resuscitate). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Policy titled Fall Prevention Program with revision date of 11-21-2017, documents purpose as: To assure the safety of all residents in the facility, when possible. The program will include ensures which determine the individual needs of each resident by assessing the risk of falls and implantation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Program will monitor the program to assure ongoing effectiveness. Section titled Fall/safety interventions may include but are not limited to documents, to inform family of risk factors and reinforce interventions a needed.

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on interview and record review, the facility failed to provide safe administration of peritoneal dialysis by qualified trained staff as ordered by a physician for 1 (R22) of 3 residents reviewed for dialysis in the sample of 29. This failure resulted in R22 experiencing severe shortness of breath requiring transfer to local hospital, R22 receiving intubation and mechanical ventilation for respiratory failure to prevent imminent deterioration and further organ dysfunction from hypoxia and hypercarbia. This failure resulted in an Immediate Jeopardy, which was identified to have begun on 10/22/24 at 11:15 AM when V29 (Registered Nurse/RN) and V30 (Licensed Practical Nurse/LPN) manually infused 2.5 liters of dialysate fluid into R22's peritoneal space (totaling approximately 4 liters of dialysate fluid in R22's peritoneal space) causing R22 to experience shortness of breath and be transferred to the hospital for further treatment. This past non-compliance occurred from 10/22/24 to 10/31/24. V1 (Administrator) and V7 (Regional Director of Operations) were notified of the Immediate Jeopardy on 3/18/25 at 4:00 PM. The Surveyor confirmed by observation, interview, and record review that the immediacy was removed on 10/31/24. Findings include: R22's New Admission Information documented an admitted [DATE]. R22's Cumulative Diagnosis Log documented diagnoses that included sepsis, peritonitis, and dependence on dialysis. R22's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. On 3/11/25 at 2:45 PM, V33 (Regional Reimbursement) said the facility was not able to produce R22's Care Plans due to a change of ownership and was now unable to access the electronic medical records. On 3/12/25 at 2:14 PM, V2 (Director of Nursing/DON) said when she came into the facility on [DATE] the nursing staff were having some issues with R22's Peritoneal Dialysis (PD) infusion due to the PD cycler alarming through the night. V2 said she was told by V30 (LPN) that due to R22's PD cycler alarming, V30 had called V28 (Dialysis Company Registered Nurse). V2 said around 9:30 AM to 10:00 AM, V28 called the facility requesting to speak with V2 to give new orders for R22. V2 said the facility did not have the bag of dialysate that V28 gave an order for and had to go to the dialysis company to pick up the bag of dialysate. V2 said she returned to the facility and V29 (RN) was the nurse caring for R22. V2 said she gave V29 the order for a 1.5 liter PD manual fill and asked V29 if V29 was familiar with how to set and infuse a PD manual fill because V2 was not familiar with infusing PD solution with gravity. V2 said V29 said she was used to completing PD manual fills and had completed them in the past. V2 said R22 received 2.5 liters of PD dialysate, started to have some shortness of breath, and was sent to the hospital for further evaluation. V2 said she had never completed a PD manual fill of dialysate at that time. V2 said she had received training from the dialysis company for PD but the training only included how to hook a resident up to the PD cycler. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/13/25 at 10:13 AM, V30 (LPN) said R22's peritoneal cycler machine messed up. V30 said she called the dialysis company and was unable to fix it when the dialysis company said to come to the dialysis facility to get a bag of dialysate solution for R22. V30 said V2 brought R22's dialysate solution back to the facility. V30 said V29 (RN) asked V30 if V30 could walk V29 through how to put the fluid into R22's peritoneal space. V30 said V2 did not speak to V30 about R22's peritoneal dialysis order when she returned from the dialysis facility. V30 said V29 was the staff that approached her to assist with infusing R22's dialysate fluid. V30 said she did not check R22's orders because R22 was not her patient and V30 was only there to tell V29 how to hook up the manual dialysate tubing to R22 because V29 had not been trained. V30 said she had not received any training by the dialysis company on how to manually fill or drain a peritoneal dialysis patient. V30 said after R22 had been hooked up to the bag of dialysate fluid V29 infused the whole bag (2.5 L). V30 said R22 became short of breath and was transferred to the hospital. V30 said when she was on the phone with the dialysis company earlier in the day the dialysis nurse had not told V30 how much dialysate fluid to infuse. V30 stated the dialysis nurse just said come get a bag to put in. On 3/7/25 at 11:53 AM, V29 (RN) said she was caring for R22 on 10/22/24. V29 said she had received information in report from the night shift nurse R22's Peritoneal Dialysis (PD) cycler had been alarming throughout the night and V29 would need to follow up with the dialysis company to make sure R22's PD cycle had completed and ask if there were any new orders if it hadn't. V29 said she called the dialysis company and told them R22 had trouble with the PD cycler and V30 (LPN) took over the phone call. V29 said V2 came into the facility with a box from the dialysis company and placed it in R22's room. V29 said she was hard of hearing and deaf in one ear. V29 said she did not know what V2 said to her. V29 said she and V30 went to R22's room and V29 hooked R22's PD catheter up to the bag of dialysate and V30 unclamped the tubing infusing R22 with the dialysate. V29 said she was not sure how much dialysate was supposed to be infused. V29 said the dialysate bag was a 2.5-liter bag and if only 1 liter or however much was supposed to be put in was ordered why would V2 not have told the nurse (V29) who was going to be completing the treatment. V29 said after the dialysate was infused into R22, R22 looked like R22 was in fluid overload. V29 said R22 became hypotensive and short of breath with very low blood oxygen saturations. V29 said she put oxygen on R22 and called an ambulance to transport R22 to the hospital. V29 stated I was just observing. I didn't hook (R22) up. I just connected it. (V30) unclamped it and the fluid started going in. V29 said the whole 2.5 liters of dialysate was infused in R22 and no orders were written so V30 could not have known how much to infuse. V29 said she had not received any training on dialysis. V29 said training was completed through the dialysis company and due to V29 being a float nurse from a sister facility no dialysis training was ever offered to V29. V29 said she thought V30 was certified in dialysis. V29 said during the facility's investigation V29 was told R22 was supposed to receive 1.5 liters of the manual fill dialysate solution but nothing was written in R22's medical record. V29 said she had been in communication with V28 (Dialysis Company RN) and V29 had given V28 some of the readings from R22's PD cycler but when V28 started asking more questions she handed the call off to V30. V29 said she was not sure if there were any infusion directions in R22's Medication Administration Record. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/14/25 at 4:31 PM, V32 (Nephrologist) said overfilling of dialysate fluids can cause lung problems and discomfort with breathing. V32 said extra fluid in the abdomen pushes on the diaphragm and causes discomfort with breathing and can make it difficult. V32 said he knew R22 and R22 was already compromised respiratory wise as R22 just had pneumonia and had pulmonary edema. V32 said the normal amount of fluid left in the abdomen is 1.5 liters. V32 said the facility is supposed to follow the orders from the dialysis center. V32 said the dialysis center faxes over the orders to the facility and the facility should not be doing dialysis without current orders. V32 said if a nurse does not know how to perform or was never trained in peritoneal dialysis they should not perform the dialysis and should call the dialysis center. On 3/13/25 at 10:42 AM, V36 (Emergency Department Physician) said he was the Physician treating R22 on 10/22/24. V36 said he was not made aware by the facility R22's peritoneal space had been overfilled. V36 said the more fluid in the abdomen would push up on the diaphragm making it difficult to breathe. V36 said R22's CT (Computed Tomography) scan documented moderate volume ascites (fluid in the abdomen). V36 said, looking at R22's CT scan, they called it moderate, but it looks like a lot. V36 said the fluid in R22's abdomen would have made it harder to breath. V36 said R22's CT scan of the lungs did show pneumonia with consolidations in bilateral lungs, but the extra fluid would have made it even harder to breath. R22's dialysis company's Progress Note dated 10/22/24 at 8:30 AM documented in part Patient had been discharged from the hospital on 10/21/24. RN unaware of discharge from the hospital back to SNF (Skilled Nursing Facility). (V30/LPN) . called and states 'We are having trouble with the patient's machine. It has been alarming for 20-30 minutes and it has not completed the last fill. The whole treatment is done but it hasn't done the purple bag' Writer advised (V30) to terminate the treatment and instructed to do a manual last fill. Discussed with (V30) supplies that were needed and would need to be picked up from dialysis facility . spoke with (V2/DON). Discussed with her the conversation of the above with (V30). And RN concerned supplies had not been picked up. (V2) then asked about a manual last fill that should be put into the peritoneum. Writer gave instructions at this time. Last fill would be 1.5L or 1500ml. It would not have to be manually drained, that it would drain during the initial drain with treatment this evening . R22's 10/21/24 through 10/22/24 dialysis company's Treatment Summary Report documented a cycler total on 10/22/24 at 8:48 AM of 1552 ml being in R22's peritoneal space. On 3/13/25 at 9:00 AM, V1 (Administrator) said the facility was unable to produce any orders for R22 from the dialysis company. V1 said after reviewing R22's medical record no orders for what peritoneal dialysis solutions were being administered was ever written on R22's September 2024 or October 2024 Physician's Order sheets. V1 said she did not know how staff were completing R22's peritoneal dialysis with no written orders. R22's Physician's Orders documented a 10/22/24 order documenting in part . T.O. (Telephone Order) Administer 1.5 L (Liters) of purple bag . manually. Hold purple bag night of 10/22/24 . R22's Nurse's Notes dated 10/22/24 at 11:15 AM and completed by V2 (DON) documented in part . This nurse received a call from (V28 Dialysis Registered Nurse) at (dialysis company) who gave T.O. to do a manual fill of 1500 ml (1.5L) to (R22). This nurse was instructed to come to (dialysis company) and pick up bag needed for manual fill . (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R22's Nurse's Note dated 10/22/24 at 11:50 AM completed by V2 documented in part . This nurse returned to facility with dialysis bag needed for manual fill . this nurse placed unopened box in (R22's) room and explained to (R22) what (dialysis company) wanted (V29/RN) floor nurse to do for her next appointment on 10/23/24. This nurse spoke to (V29) about what orders (V28) at (dialysis company) gave and what supplies were brought back . R22's Physician's Orders dated 10/1/24 through 10/31/24 included a 10/22/24 order documenting in part . Administer 1.5 L (1500 ml) of purple bag (dialysate fluid) .manually . No other orders for peritoneal dialysis were documented. R22's Medication Administration Record (MAR) dated 10/1/24 through 10/31/24 documented no orders for peritoneal dialysis other than the 10/22/24 order for 1.5 L manual fill. R22's Nurse's Note dated 10/22/24 at 12:30 PM completed by V29 documented in part .(R22) was doing well this AM had visitor, awake, conversating. No (signs/symptoms) of distress. Was called to room by staff. (R22) was noted to be in respiratory distress (blood oxygen saturation) in the 70's placed on (oxygen at 5 Liters via nasal cannula oxygen saturation) wouldn't go above 81. States 'I can't breath' (Blood pressure) 88/42 . Lung fields sound tight to auscultation . Sending to (hospital emergency department) . R22's Nursing Home to Hospital Transfer Form dated 10/22/24 completed by V29 documented in part . Additional Relevant Information . Just completed (peritoneal dialysis) last bag by gravity she said she feels like her stomach is about to blow up. Unable to breath (blood oxygen saturation) in the 70's. Placed on (5 Liters of oxygen blood oxygen saturation) 70's-81 . R22's Emergency Department Encounter dated 10/22/24 documented in part . presents to the (Emergency Department with) severe shortness of breath . is dusky and diffusely cyanotic (oxygen saturation) 80's on (15 liters of oxygen via non-rebreather) on arrival, panting . abdominal distention noted . repeating help me . (R22) was intubated due to respiratory distress . R22's Progress Notes & Medical Decision Making form dated 10/22/24 documented in part . Seen and assessed on arrival, weak inspiratory effort, dusky and mottled on arrival. Intubated due to severe respiratory failure . R22's hospital Progress Note dated 10/22/24 at 6:00 PM by dialysis nurse documented in part . Initial drain >3900 ml abdomen is no longer firm . Reported (initial drain) volume to primary RN . R22's ICU (Intensive Care Unit) Progress Note dated 10/23/24 documented in part .Assessment and Plan . Pulmonary: Acute hypoxemic respiratory failure: intubated due to respiratory distress. Continue managing the mechanical ventilation for respiratory failure to prevent imminent deterioration and further organ dysfunction from hypoxia and hypercarbia . Renal: . Nephrology is following. ?excessive (sic) dialysate instillation at NH (Nursing Home) as 4L removed overnight . R22's ICU Progress Note dated 10/26/24 documented in part .Assessment . Acute respiratory failure with hypoxia status post intubation on mechanical ventilation, extubated 10/25/24 . (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R22's hospital Discharge Summary dated 10/4/24 through 10/21/24 documented a 10/21/24 chest Xray documenting in part . Impression: Suggestion of small bilateral pleural effusion with bibasilar atelectasis or pneumonia . The facility's 10/30/24 final report regarding R22's 10/22/24 incident documented in part . On 10/22/24 at approximately (3:00 PM) this administrator was notified that (R22) was noted to be in respiratory distress and was being sent to the (hospital) for evaluation . Investigation reveals that (R22) was connected to the dialysis cycler at approximately (8:00 AM). The cycler continued to alarm, was turned off and (dialysis company) notified. At approximately (11:15 AM) the facility received orders from (dialysis company) for a manual fill of 1. 5 L bag. (V2) picked up supplies from (dialysis company) which were (sic) 2.5 L bags. (V29) and (V30) connected (R22) to the manual fill bag at approximately (12:00 PM). At approximately (12:30 PM) (V29) was notified by staff (R22) appeared to be in (respiratory) distress . sent to (hospital) for evaluation . In conclusion, the facility was able to substantiate that (R22) experienced an adverse reaction secondary to receiving a manual fill during peritoneal dialysis . The surveyor confirmed through interview and record review that the facility took the following actions, which were initiated on 10/23/24 and completed on 10/31/24 to remove the Immediate Jeopardy: The contract for dialysis was terminated with the facility 10/31/2024. Facility Administrator (V1) and Director of Nursing (V2) reviewed all the residents at the time of the event and no other residents were receiving PD (peritoneal dialysis) services at the time of the event and no other residents have received PD services since this event. Facility Administrator (V1) and Director of Nursing (V2) were in-serviced by (dialysis company) on manual fill PD on 10/24/2024. Both nurses involved in the event were suspended pending investigation 10/23/2024 and terminated on 10/28/2024. Facility policy for dialysis was reviewed by Regional Director of Operations and found to be in compliance on 10/24/2024. QA (Quality Assurance) meeting was held on 10/24/2024 with (dialysis company) and policies and procedures were reviewed. Administrator or designee will review PD patients weekly times 4 weeks.

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on observation, interview and record review, the facility failed to use appropriate alternatives prior to installation of bed rails, adequately assess and monitor residents for risk of injury/entrapment prior to installation, ensure adherence to appropriate dimensions and manufacturer's recommendations, and failed to obtain a physician order for use of bed rails for 6 (R2, R3, R4, R7, R8, R9) of 9 residents reviewed for bed rails in the sample of 29. This failure resulted in R2's death by positional asphyxiation, when R2 was found in the sitting position on the floor beside the bed with legs straight out and head and neck between mattress and bed rail. This failure also has the potential for risk of serious harm/injury and possible death for R3, R4, R7, R8 and R9. This failure resulted in an Immediate Jeopardy, which was identified to have begun on [DATE] when the facility added side rails to R2's bed without proper assessment and installation per manufacturer's recommendations which resulted in R2's death via asphyxiation on [DATE]. V1 (Administrator), V34 (Regional Clinical Director), V16 (Regional Minimum Data Set Coordinator), and V33 (Regional Reimbursement) were notified of the Immediate Jeopardy on [DATE] at 9:57am. The surveyor confirmed through observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on [DATE], but the noncompliance remains at Level Two due to additional time to evaluate implementation and effectiveness of training. Findings include: 1. R2's Admission Record documented an admitted [DATE], and included diagnoses of Parkinson's Disease, Type 2 diabetes mellitus, morbid obesity, dementia, and hydrocephalus. R2's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Under Functional Abilities and Goals, the MDS documented R2 had no impairment to upper and lower extremity, R2 used a wheelchair (w/c) for mobility, R2 required partial/moderate assistance for eating and oral hygiene, was dependent for toilet hygiene, bath/showers, lower body dressing, putting on and taking off footwear, and personal hygiene, and R2 required substantial/maximal assistance for upper body dressing. Under Cognitive Patterns, the MDS documented R2 exhibited no physical or verbal behaviors, and under Restraints and Alarms, a 0 was entered to indicate not used for bed rails as well as any bed, chair, or other alarm. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's Baseline Care Plan dated the day of admission ([DATE]) had the following items checked: Assist of 2+ for bed mobility, Assist of 2+ and Dependent for transfer, Ambulation was marked N/A (not applicable), and Assist of 1 and Wheelchair were checked for Locomotion. Under the section titled Identified Safety Risks: Safety Plan of Care, the following boxes were checked: High Risk Fall Assessment, Poor Safety Awareness, Fall History, Gait, Balance, and Weakness. The section titled Enabler/Positioning Device/Positioning Cushion/Alarm/Safety Device Plan of Care is incomplete with nothing checked for any assessments or devices in use. This baseline care plan is blank in the section for any updates and signatures. Problem areas identified on [DATE] included: R2 requires staff assist with ADL's (Activities of Daily Living), R2 is at risk for falls, risk for injury from falls r/t (related to) unsteady gait/Parkinson's/history of falls, R2 is at risk for uncontrolled movement r/t Parkinson's, R2 has impaired cognition, and confusion at times r/t Parkinson's Dementia. Interventions for these identified areas included assist with bed mobility, transfers, bathing/toileting, etc., call light and personal items in reach (all dated [DATE]); Proper Footwear (dated [DATE]) and Pin Alarm (dated [DATE]). This care plan had no documentation addressing the use of side rails for R2. The next Care Plan for R2 documented Focus areas initiated on [DATE] that included R2 was a Full Code, had impaired cognitive function r/t dementia, Parkinson's, and hydrocephalus, and noted R2's Parkinson's affected speech and thought processes. This Care Plan did not include information regarding R2's risk for falls or history of falls and did not include any documentation addressing the use of side rails. The facility document titled Physical Restraint/Enabler Consent has R2's name and a date of [DATE] (date of admission) written in. The Reason for Restraint/Enabler: is documented as ,d+[DATE] side rails and the Type of restraint/enabler: is documented as positioning and bed mobility. The consent further states Please be advised all residents using physical restraints/enablers will be assessed for a reduction program. All reductions will be based on the assessment performed by a Licensed Nurse in the facility . The consent is signed by V9 (R2's Power of Attorney/POA) . The facility's [DATE] Fall Log documented R2 had a fall on [DATE] at 10:00AM, location Residents room, root cause is weakness/loss of balance, intervention in place is educated nursing staff to assure patient is wearing proper footwear. The facility's [DATE] Fall Log documented R2 had a fall on [DATE] at 3:30PM. Location resident's room, root cause was attempting to sit on side of bed independently, intervention is orders obtained for pin alarm to person while awake. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R2's Bed Rail/Transfer Bar Evaluation dated [DATE] is a two page document with instructions that state to Check all that apply in last 7 days. This document includes handwritten check marks, but also has handwritten Y (yes) and N (No) answers in some of the boxes. Under Medical Need Affecting Bed Mobility/Transfer Safety the following items have a check mark: Weakness, Pain, difficulty moving to a sitting position on the side of the bed, difficulty with balance sitting on bed and/or getting in/out of bed, poor trunk control, difficulty/unable to move legs in bed without device, changes in blood glucose levels, knees buckle, and mattress requires/suggests use of side rails. The following items are marked N for no: Difficulty/Unable to move trunk in bed without device, visual deficit, orthostatic hypotension and/or vertigo, musculoskeletal disorders affecting resident (fractures/contractures, etc.), neurological disorders causing involuntary movements, and history of falls in last 30 days. Under Mental Status Affecting Bed Mobility/Transfer the following items have a check mark: Able to make needs known, fluctuations in level of consciousness and altered/poor cognitive status. N is marked for Able/Willing to participate in bed mobility. Under Alternative Attempted Prior to Bed Rail/Transfer the following items have a check mark: Assisted Transfer, Frequent Staff monitoring/assisted turning and positioning while in bed, and reminders to use call light. The following items are marked N for no: Physical or Occupational Therapy, Restorative Care, Bedside Commode and/or Urinal/Bedpan, periodic assisted toileting, altered bed height, transfer bar and trapeze. Under indications for bed rail/transfer bar, all items are marked N for no and include: bed rails do not appear to be indicated at this time, at least two medical needs exist and two alternatives have been attempted ., resident has been evaluated-does not overhang bed-able to turn comfortably, serves to remind resident to seek help-unaware of physical limits, serves as Enabler - unable to enter or exit bed independently without enabler use, serves as Enabler to promote independence in turning side to side and puling self to lying/sitting and resident expresses desire to have the side rail for security. On the 2nd page under Benefits of Bed Rail/Transfer Bar Use, the following items are checked: Enhanced functional ability-decrease dependence on others for ADL's (Activities of Daily Living), Reduce injury related to random/unpredictable movements during transfers and prevent injury to self or others. Under Entrapment Considerations during use, N for no is marked for the following questions: Is resident at risk for climbing over rails?, Is there a Neurological Disorder causing involuntary movements?, Is Resident combative with care?, Is Resident known to have any thrashing, jerking or unpredictable physical movements that may cause entanglement in bar? Y or yes was answered in response to the following questions: Does the bar prevent resident from exiting bed? (Yes = Restraint-Additional complications may be possible obtain consent-CP (care plan) accordingly) and Does the bar interfere with the resident's access to their own body? (Yes = Restraint-Additional complications may be possible obtain consent-CP accordingly). The bottom of the 2nd page of the evaluation has four sections to indicate quarterly review, each stating The IDT (Interdisciplinary Team) has reviewed the resident's capabilities, needs and preferences in relation to bed rail use and has determined with boxes for the team to choose No Bed Rail Indicated, Benefits of enabler outweigh risks; consent obtained for: Assist Bar: Bilat (bilateral) Rt (right) Lt (left), Full Side Rail: Bilat, Rt, Lt, ,d+[DATE] Side Rails: Bilat, Rt, Lt, ,d+[DATE] Side Rails: Bilat, Rt, Lt, an area for comments, and an area for staff signature, initials and date. These four sections on R2's evaluation are left blank, therefore incomplete. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A second Bed Rail/Transfer Bar Evaluation was completed the next day on [DATE] and some items were answered differently on this evaluation, such as difficulty/unable to move legs in bed without device and knees buckle were both answered N for no. The whole section under Alternative Attempted Prior to Bed Rail/Transfer had no alternatives checked, and Bed rails do not appear to be indicated at this time was checked. The differences under the Benefits of Bed Rail/Transfer Bar Use documents: enhanced safety during ADLS, and reduced potential for falls. Again, the bottom four sections of this evaluation form where the IDT reviews and makes determinations regarding bed rails were left blank with nothing selected and no staff signatures, initials or dates. The local Fire Department incident report documents an EMS (Emergency Medical Services) call with an incident date of [DATE] at 1:04 AM. Under Patient Narrative, the following is documented: Responded to nursing home facility for male patient unresponsive, not breathing. Upon arrival, find [AGE] year-old male supine on floor next to bed. Nursing staff performing chest compressions and ventilations with BVM (bag-valve-mask). Patient is pulseless and apneic. Skin is cold and cyanotic. Cardiac monitor applied showing asystole. Nursing staff reports possible down time 45 minutes or more. Resuscitation efforts discontinued; medical control contacted to confirm. Staff reports patient had been found with most of his body on the floor, with head and upper torso stuck between bed and bed rail. Coroner contacted via dispatch. Cleared scene with nursing staff awaiting communication with coroner. End of Report. R2's Progress Notes dated [DATE] at 3:25AM, documented the following Late Entry: At approximately 0100 (1:00AM), CNA (Certified Nurse Assistant) alert this nurse that resident needed immediate assist. This nurse immediately ran into resident room and saw the resident in a compromised position. Resident appeared to be in sideways sitting position with head between grab bar and mattress. Resident unresponsive and no pulse palpable. Resident lowered to the floor. CPR (Cardiopulmonary Resuscitation) initiated. All staff alerted EMS alerted. This nurse and other nurse continued CPR until EMS arrived. Time of Death 0110 (1:10AM). IDT (Interdisciplinary Team) notified. EMS notified coroner. Family Notified. The Medical Examiner/Coroner Certificate of Death documented R2's date of death was [DATE] and time of death was 1:15AM. Under Cause of Death, Part 1, a. documented Positional Asphyxiation, due to or as a consequence of b. found in a seated position on floor beside bed, due to or as a consequence of c. legs straight out and head and neck between mattress and bed rail. Part 2 lists the following under Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part 1 Diabetes, hypertension, Parkinson's, dementia, and obesity. The manner of death is documented as Accidental with date of injury listed as [DATE], time of injury listed as 1:00AM, and place of injury listed as Nursing Home. The death certificate was certified by V5 (Coroner) on [DATE]. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 11:10 AM, V5 (Coroner) stated he was the one that determined the cause of death for R2. V5 stated he was notified by EMS that the resident (R2) was expired upon arrival and R2 was very cold to touch. V5 stated EMS relayed that the nurses were doing CPR upon their arrival but the efforts were stopped upon assessment due to the condition of R2. V5 stated the EMS estimated R2 had been expired for at least 45 minutes upon their assessment. V5 stated he came to the facility and met with the nurse (V3 - Licensed Practical Nurse/LPN) who was working the night of R2's death. V5 stated V3 demonstrated the position of R2 when V3 entered the room and the position of R2's head in between the mattress and the bedrail. V5 stated the nurse demonstrated the position of R2's body as sitting on the floor with his legs straight out and body turned sideways with head caught in between the mattress and bedrail, which made it difficult to impossible for R2 to breathe. V5 stated R2's cause of death was positional asphyxiation. V5 stated he had the EMS report and has reviewed all records. V5 stated the cause of death was due to R2's head being trapped between the mattress and bedrail causing positional asphyxiation. On [DATE] at 12:56PM V2 (Director of Nursing/DON) was asked who at the facility does the Side Rail assessments and who decides if they are needed. V2 stated she wasn't familiar with Side Rail Assessments, and she was not sure who does them. V2 was asked who obtains the consents and again V2 stated she wasn't sure. V2 was asked if there was documentation regarding alternative interventions attempted prior to implementing side rails or where that documentation would be and V2 stated she was not aware of any such documentation, but she would look for it. V2 was asked if she completed side rail assessments for R2, to which she responded No. V2 stated she is new in the position since October or November of 2024, and she was not sure who does assessments or consents. V2 stated she assumes bed rails are used for bed mobility. On [DATE] at 1:34PM, V1 (Administrator) was asked for the incident/investigation report on R2's incident that occurred on [DATE]. V1 stated we did not do one because we did not think his death was related to a fall or any type of injury. V1 was asked if there was an incident report made on this occurrence and V1 stated no. On [DATE] at 2:20PM, V3 (LPN) stated she was the nurse in charge of R2's care on the morning R2 expired ([DATE]). V3 stated she was an agency nurse but had worked at this facility several times. V3 stated she was summoned to (R2's) room at approximately 1:00AM by V11 (CNA) and the V11 stated R2 was needing assistance. V3 stated when she entered R2's room, he was noted to be in a compromised position. V3 was asked to explain what she meant by that and V3 stated R2 was sitting on his bottom on the floor with his legs stretched out and he was sort of turned with his head lodged between the mattress and handrail. V3 stated R2 did not have a pulse or respirations. V3 stated she and V11 had to lift R2 up to get his head and torso out of the rail so she could lay him flat on the floor to start CPR. V3 stated R2 was cold to touch. V3 stated she had already sent V12 (CNA) to call 911 while she continued CPR. V3 stated when EMS arrived, they stopped the CPR and called the coroner. V3 stated the bed R2 was in was a very old-style bed. V3 stated the siderail present on the bed was the old brown metal ones that mount on the bed and were very big. V3 stated there was a large gap between the mattress and siderail, estimating it was at least a 6-inch gap. V3 stated it was the most horrible thing she has ever seen as a nurse. V3 stated she notified V1 and V2 of R2's incident and his death. V3 stated the staff that were working that night told her R2 has tried to get out of bed numerous times in the past. When questioned if R2 had an alarm, V3 stated she was not aware of an alarm and no alarm was sounding. V3 stated she met with the coroner at the facility a few days after the incident and reenacted the position R2 was in and his condition when she entered the room. V3 stated she knew it was due to his head being stuck between the rail and mattress and it was asphyxiation. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 10:05AM, V1 stated she received a call from V11 at 1:09AM on [DATE] and V11 stated R2 was hanging out of bed gasping for air, and it did not look good. V11 stated CPR was being started. The next call was from V3 at 1:50AM stating R2 had expired. V1 stated when I went in with the coroner for the reenactment, I knew something major had happened. V1 stated I also thought something was up when the coroner kept coming into the facility. V1 stated R2 had a history of throwing his legs out of the bed. V1 was asked what intervention was put into place for R2 throwing his legs out of bed and V1 stated there are no interventions for that, but it is sort of a common thing for people to do that. V1 stated R2 had a clip-on alarm when he was up in his wheelchair. V1 stated R2 would not have had that while in bed. V1 stated the clip-alarm was for a fall intervention. V1 stated R2 had siderails on for positioning, he would help roll himself in bed. V1 stated maintenance puts on the siderails and we do routine checks on siderails. V1 stated I don't know about the gaps on siderails, but maintenance does all of that. V1 stated, R2 had an air mattress on his bed. V1 was asked if she knew the manufacturers recommendation for side rails with the air mattress and V1 stated no, I don't know anything about gaps. V1 was asked what process they use to determine who needs side rails and V11 stated well sometimes the family wants them on so we put them on, and sometimes physical therapy may recommend. V1 said there should be a side rail assessment, consent, and (physician) order completed at the time of installation of siderails. On [DATE] at 12:41PM, V6 (Maintenance Director) stated he is the person that puts on the side rails. V6 was asked who sends him the work order or request for side rails, and V6 stated either a CNA, Nurse, or Administrator just comes and tells him who needs side rails put on. V6 stated he went to other facilities that have closed and got all the side rails he could find as he was told to gather all of them and bring them to this facility. V6 stated these side rails are very old but so are the beds. V6 stated he did not receive any Owner's Manual or specifications on the side rails or beds from the other facilities. V6 stated he had not seen any specs on the beds, side rails, or mattresses in the facility. V6 was asked if he checks the gap when he installs the side rails and V6 stated all I know is that the side rails must be 4 inches from the headboard. V6 was asked what the gap space was for between the side rail and mattress and V6 stated he didn't know anything about that. V6 stated he is told to keep a few vacant beds with side rails installed for any new admissions. V6 was asked if he checks the side rails monthly or routinely and V6 stated I was asked that same question this morning by V1 and I told her I did not know anything about needing to do that, so no I never go check the side rails. I will start doing that from now on. V6 stated I did find a book under my desk that has the logs to check side rails and gaps, but it has not been kept up or has not been done for a long time, the last one done was in 2023. V6 was asked if he remembers putting R2's side rails on and V6 stated No I really don't remember if I did, and chances are they were already on the bed. V6 was asked if he at any time checked R2's siderails and V6 stated No. V6 stated he started the job in October of 2024, and he is learning as he goes. V6 was asked if he could show this surveyor the bed that R2 was last in before he expired and V6 stated No I couldn't be sure as we switch beds all the time. V6 stated he doesn't even recall what type of bed R2 had or what type of side rails were on his bed. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 1:35PM, V2 (DON) stated she got notified by V3 (LPN) that R2 had passed. V2 stated R2 was a full code, and they did CPR but he did not make it. V2 stated V3 reported that R2 was found with no vitals, so they lowered him to the floor and started CPR while V12 (CNA) called 911, then EMS took over and stopped working on R2. V2 stated that V3 said R2's head was against the rail, and he was in a compromised position. It looked to her like R2 may have sat on the side of the bed and slid down onto the floor. She stated he had to be moved away from the rail to get him to the floor. He had an air mattress on the bed at the time. V2 stated R2 did have an order for a pin alarm to be on during hours R2 was awake. V2 said I don't think you use a pin alarm in the bed on residents. The next workday I went in and looked at the room and looked at the progress note and contacted the CNAs to start getting statements. V2 stated she also had to get documents for the coroner. V2 said At this point my opinion is that you really can't strangulate from a siderail. I feel like this was cardiac. I am afraid an event happened prior to him slipping. I have seen him move himself around with no issues. V2 stated she was not sure what type of bed R2 was in at the time he expired. V1 stated, I do know that he had an air mattress on. V2 stated she has never been trained on gap measurements for beds with side rails and did not know that these had to be checked. On [DATE] at 2:32PM, V8 (Registered Nurse/RN - Resident Care Coordinator/RCC) stated she cared for R2 several times. V8 stated R2 had started sitting on the side of bed and trying to get up recently. V8 stated R2's health issues were bad when he first admitted but he was getting much better. R2's wife visited every day but recently she was in the hospital herself. V8 stated she only remembered R2 having one fall. V8 stated I assume he had the siderails because he tried to get out bed, but his side rails were too big, they were just too big for the bed. V8 said the nurses do the siderail assessments and the MDS Coordinator decides if they need siderails. V8 stated side rail consents are in the admission packet, so we automatically get them signed for permission for siderails upon admission in case they ever need side rails. V8 stated she was told by V3 that R2 coded, and it was very unfortunate. V8 stated R2 was alert with confusion and no behaviors or hallucinations. V8 said that daily R2 would constantly throw his legs out (of bed). V8 stated when she worked and R2 would start throwing his legs out of the bed, she would have the staff get him up in his wheelchair. V8 stated she was not aware of R2 having an alarm of any kind. V8 stated there should be side rail assessments completed with a consent and orders before side rails are installed on any resident. On [DATE] at 2:44PM, V9 (Family/Power of Attorney/POA) stated she doesn't remember when or why R2 had bed rails put on his bed. V9 stated no staff ever told her why but she thought it was because R2 kept trying to get out of bed. V9 stated she doesn't ever remember signing a consent for side rails. V9 stated she visited R2 every day. V9 stated she was told of one fall, and they did not tell her of any interventions. V9 stated she asked for an alarm for R2 while in bed because R2 would try to get out of bed. V9 stated R2 had confusion most of the time. V9 was asked if she ever attended a care plan meeting and she replied she was never told of such a meeting, and it would have been nice to have one. V9 stated she just doesn't understand why they had the side rails on except to keep him in the bed. V9 stated the plan was to get R2 back home so she and her daughter could provide care for him at home. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 7:53 PM, V11 (CNA) stated she was working on [DATE] when R2 expired. V11 stated she is the one that found R2. V11 stated she had done a bed check on R2 at 10:00PM, and the next time she went into R2's room was around 1:00AM when she had walked by and seen his feet were not in the bed. V11 stated R2 was constantly throwing his legs out of bed and trying to get up. V11 stated when she entered R2's room at around 1:00AM, she saw him sitting on the floor beside the bed sort of sideways with his neck caught between the bed rail and bed frame. V11 stated it was like he was hung by his neck, but his body was on the ground. V11 stated R2 was not breathing, and she noted he was discolored. V11 stated she ran and got the nurse and she and the nurse had to lift R2 up to get his neck out from the bedrail because it was stuck. V11 stated they finally got him loose and started CPR. V11 was asked if she knew why R2 was out of the bed and V11 stated yes R2 was really wet, and he was poopy too. V11 was asked if anyone else had checked on R2 between 10:00PM and 1:00AM and V11 stated I don't know. V11 stated they really aren't assigned a specific hall; they all just work together. V11 stated she thinks R2 was on a special mattress but doesn't know the name of it. V11 stated there was a big gap between the mattress/bed rail and bed frame and was big enough for his head and neck to fit in and get stuck in. V11 stated R2 has had ,d+[DATE] rails on his bed for a long time and they were the big old rails too. V11 stated R2 was confused and did not usually use a call light. V11 didn't know anything about an alarm for R2. V11 stated she called V1 and explained what had happened and she stated she told V1 that R2 was found hung in the side rail and he expired but they were doing CPR. On [DATE] at 8:54 AM, V14 (LPN) stated she was working the morning of [DATE] at the time R2 expired. V14 stated she was summoned to R2's room to assist with CPR for R2. V14 said when she entered the room CPR was in progress and she took over helping the other nurse (V3). V14 stated she didn't notice R2 being extremely cold, but she did notice his color was bad. V14 stated once EMS got there, the paramedics took over and stopped CPR as it was evident R2 was expired. V14 stated she remembered when she stood up her pants were wet from urine that was on the floor from R2. V14 stated she was not familiar with R2 as she has never worked the hall R2 was on. On [DATE] at 8:21AM, V1 stated maintenance had not been checking the specification on the beds, mattresses, or side rails before installation. V1 stated the Side Rail Installation assessment should be done by maintenance prior to installation. V1 stated she does not believe she has the specifications for the beds or bed rails due to the equipment being so old and most of the beds in use came from other facilities that closed. V1 stated she would try to find them but does not know if she will find them as she has never seen them. V1 stated she plans on taking off all side rails in use due to safety. On [DATE] at 8:45AM, V6 (Maintenance Director) stated he does not measure the beds, mattresses, or side rails before installation of side rails. V6 stated he put most of the side rails that are in use on the beds. V6 stated some of the beds he brought from other facilities already had side rails in place, so they just left them on. V6 stated he does not check the weight or height of the residents either. V6 stated he does not have the specifications on the beds, mattresses, or side rails that are in use currently in the facility. V6 stated he brought most of the beds in use from other facilities along with side rails and he did not get the specifications or Owners Manuals on the beds or bed rails. (continued on next page)

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	145517	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Mount Vernon	1700 White Street Mount Vernon, IL 62864

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 9:00AM, V13 (MDS Coordinator) stated she does not do the initial Side Rail Assessments or consents; these are included in the admission packets and the floor nurses do all assessments upon admission. V13 stated she does the quarterly assessments. V13 stated she does the care plans too. V13 stated she doesn't have all the side rails put on the care plans as she is behind and just started mid-November. V13 was asked if she could provide a list of when the siderails were installed on each residents' beds and V13 stated she has never seen a list or log of when the siderails were put in place on any of the residents and without orders it is impossible to determine. On [DATE] at 9:14AM, V12 (CNA) stated she was working the night R2 expired. V12 stated there were 3 CNAs and 2 Nurses working that night. V12 stated she and another CNA were just coming in from a smoke break when V11 (CNA) came running and told them to get to R2's room to help with CPR. V12 stated when she entered the room, R2 was lying on the floor beside the bed and V3 was performing chest compressions. V12 stated she was directed to call 911, so she did and stayed on the phone with the dispatcher until EMS arrived approximately 6 minutes after she called. V12 stated she followed them to the room and after EMS assessed R2 they stopped CPR. V12 was asked when she last saw R2 alive and V12 stated at 10:00PM she helped with a bed check on R2. V12 was asked if she had checked on him in between 10:00PM and 1:00AM and V12 stated No. V12 stated the CNA's usually get bed checks done every 3 hours. V12 was asked how R2 was at 10:00PM and she stated, he was his normal self, confused but very nice. V12 stated R2 was constantly throwing his legs out of bed and trying to get out of bed. On [DATE] at approximately 8:00AM, V1 stated they found where R2's bed was moved to another room. On [DATE] at approximately 10:52 AM, this surveyor and V6 (Maintenance Director) observed the bed that R2 was in at the time he expired. The bed had an air loss mattress on it with metal ,d+[DATE] side rail in place and gaps were observed between the mattress and the side rails. V6 was asked to measure the gap on the left side between the mattress and the side rail (as this was the side of the bed where R2's head/neck was caught). The gap measured approximately 4 ,d+[DATE] inches. This surveyor then sat on the air mattress on the left side and the gap expanded to 5 inches. This surveyor reached out to grab the left side rail and it was loose and moved outward, so V6 was asked to measure again and noted a 7 ,d+[DATE]-inch gap. R2's Physician Orders dated ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE] had no documented orders for side rails. 2. R3's Admission Record documented an admitted [DATE] and included diagnoses of Ischemic Cardiomyopathy, Depression, Anxiety, Vascular Dementia, and Insomnia. R3's MDS dated [DATE] documented a BIMS score of 2, indicating R3 has severe cognitive impairment. Under Functional Abilities and Goals, the MDS documented R3 was dependent for rolling left to right, the ability to roll from lying on back to left and right side and return to lying on back on the bed, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. R3 was also dependent for eating, oral hygiene, toileting, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Under Restraints and Alarms, R3's MDS documented a 0 to indicate bed rails are not used. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R3's current Care Plan documented the following Focus areas: R3 has impaired cognitive function/dementia or impaired thought processes r/t vascular dementia, has a communication problem r/t HOH (hard of hearing), receives Hospice services, and is high risk for falls including risk factors of medication and dementia (all initiated [DATE]). Interventions for the high risk for falls focus area include Pad bed alarm and w/c alarm. R2 not to be alone in room in w/c due to will try to transfer self without help and possibly fall. Must be put to bed and CNA's t [TRUNCATED]

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 49664 Based on interview and record review, the facility failed to ensure the physician reviews the resident's plan of care and sign and date orders. This failure has the potential to affect all 50 residents residing in the facility. The findings include: On 3/6/2025 at 10:01AM, V8 (Registered Nurse/Resident Care Coordinator) was asked if the V24 reviews the plan of care of the residents or reviews the physician orders and signs those, V8 stated no, (V15) does all of that. V8 validated the signatures on the physician orders reviewed were the signatures of V15. On 3/6/2025 at 11:08AM, V1 (Administrator) was asked if V24 (Medical Director) reviews the plan of care or signs the Physician Orders for the residents, V1 stated No he does not. V1 stated all of that is done by the V15 (Nurse Practitioner). On 3/6/2024 at 3:05 PM, V16 (Minimum Data Set/Float Nurse) was asked if she could pull up any physician's orders in the Electronic Health Record that were signed by the physician. V16 brought back her computer and had physician's orders that were needing to be signed electronically. V16 stated as you can see there have been no physician orders signed by V24 or other physicians since the facility went with electronic medical records on 1/29/25. On 3/7/2025 at 9:25AM, V24 (Medical Director) was asked when the last time he made rounds in the facility to see the residents and V24 stated I do not see the patients, the Nurse Practitioners see the patients and they work through me. V24 said he only comes per requirement for the quarterly meetings. V24 said that the reimbursement is poor so the nurse practitioners do the rounds. On 3/6/2025 at 1:02PM, V15 stated she signs the physician orders and reviews plan of care for the residents. R4, R8, R9, R11, R12, R16, and R17's paper medical records for October 2024, November 2024, and December 2024 were reviewed, including physician orders. All orders were noted to be signed by the V15 (Nurse Practitioner). There were no progress notes signed by V24 noted in the resident's records. The facility Medical Director Agreement dated 6/1/24 and signed by V24 documents under Article III Services of Physician section (i) Provision of Physician Services including (but not limited to) .(ii) Review of resident's overall condition and program of care at each visit, including medications and treatments; (iii) Documentation of progress notes with signatures; (iv) Frequency of visits, as required; (v) Signing and dating all orders, such as medications, admission orders, and re-admission orders. The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 49664 Based on interview and record review, the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. This failure has the potential to affect all 50 residents residing in the facility. Findings include: On 3/6/2025 at 11:08AM, V1 (Administrator) was asked if V24 (Medical Director) makes rounds in the facility. V1 stated No, he comes for the quarterly QA (Quality Assurance) meetings and that is all. V1 stated that V24 said in a QA meeting that he is still within regulations because the Nurse Practitioner sees the residents. On 3/6/2025 at 10:01AM, V8 (Registered Nurse/Resident Care Coordinator) stated she does not make rounds with a physician. V8 stated that V24 (Medical Director) only comes to the facility for quarterly QA meetings. V8 stated she makes rounds with V15 (Nurse Practitioner) every other Thursday, and on the opposite Thursdays she does Telehealth for the residents that need to be seen. On 3/6/2025 at 9:30AM, R11 stated he has been in the facility over a year. R11 stated he has never seen a physician since he has been admitted . R11 stated he has seen V15 (Nurse Practitioner) once in a while. R11 stated I think it is pathetic that the doctor can't come by and check on me. R11 was alert to person, place, and time. On 3/6/2025 at 9:32AM, R18 stated she would be going home tomorrow. R18 stated she was here for therapy after a fall at home. R18 stated her total time stayed was 5 weeks. R18 stated I have never seen a doctor during my stay or a nurse practitioner. R18 was alert to person, place, and time. On 3/6/2025 at 9:35AM, R8 stated I saw (V15) a couple of weeks ago but I have never seen a physician and I don't think they have a doctor. R8 stated all I have seen is an x-ray technician and a Nurse Practitioner. R8 was alert to person, place, and time. On 3/6/2025 at 9:40AM, R19 was asked if she knows the last time she was seen by a physician. R19 stated I haven't seen a doctor since I have been here and I have only seen (V15) once but that was to ask a question, (V15) was not actually here to see me. R19 stated she has been in the facility since October 2024. R19 was alert to person, place, and time. On 3/6/2025 at 9:44AM, R10 stated the last time she was seen by a physician was a long time ago. R10 stated she has been at the facility since September 2024 and has not been seen by a doctor in this facility. R10 stated she has not been seen by the Nurse Practitioner either. R10 was alert to person, place, and time. On 3/6/2025 at 9:48AM, R20 stated he was admitted in November 2024. R20 stated he has not been seen by a physician since he has been at the facility but he was seen a month ago by V15. R20 was alert to person, place, and time. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/7/2025 at 9:25AM, V24 (Medical Director) was asked when the last time he made rounds in the facility to see the residents and V24 stated I do not see the patients, the Nurse Practitioners see the patients and they work through me. V24 said he only comes per requirement for the quarterly meetings. V24 said that the reimbursement is poor so the nurse practitioners do the rounds. R4, R8, R9, R11, R16, R12, and R17's paper medical records for October 2024, November 2024, and December 2024 were reviewed. There were no progress notes signed by V24 noted in the resident's records. The facility Medical Director Agreement dated 6/1/24 and signed by V24 documents under Article III Services of Physician section (i) Provision of Physician Services including (but not limited to) . (iv) Frequency of visits, as required. The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide or arrange emergency care by a doctor 24 hours a day. 49664 Based on interview and record review, the facility failed to ensure the medical director was available 24 hours a day for emergencies. This failure has the potential to affect all 50 residents residing in the facility. The findings include: On 3/4/2025 at 11:59AM, V19 (Licensed Practical Nurse) stated on 12/22/2024 around 3:00PM the CNA's reported to her that R16 wasn't acting right, and he looked bad. V19 stated she checked R16's blood sugar between around 3:00-3:30PM and the glucometer just read HIGH. V19 stated called the on-call physician but had to leave a message. V19 stated as she was waiting for the return call from the physician, she called V2 (Director of Nursing/DON) and V2 informed her that this has happened before with R16 and sometimes they send him to the hospital if the physician orders to send him. V19 stated, V2 told her just wait on the physician to call back and see what the physician wants to do. On 3/6/2025 at 2:00PM, V19 stated she was not sure what number she called for the on-call physician on 12/22/25, it was on a note at the nurse's station. V19 stated she doesn't know about (name of the Electronic Communication System used by the Facility) and communication like that and she has had no training on any of that stuff. V19 stated again she was advised by V2 to wait for the MD to call back and if she would have said sent to ER (emergency room), she would have sent R16 out. On 3/6/2025 at 11:04AM, V22 (Registered Nurse) stated she worked on 12/22/2024, 6AM -6PM. V22 stated she received in report that R16 had been running high blood sugars and that the on-call physician was called, and a message was left to return call. V22 stated she went to R16's room around 6:30PM to check on R16, she stated she could arouse R16, and he would answer yes or no to questions. R16's blood sugar was checked at this time and reading was high. V22 stated she had put in another call to the on-call physician and left a message and was unsure of the time. V22 stated she received a call back from a physician with orders for insulin and recheck in a little while but she was unsure of the physician's name. On 3/7/2025 at 9:25AM, V24 (Medical Director) stated his phone has been accidentally silenced, so he hasn't been able to be reached for a couple of days. V24 was asked how the on-call services work and stated, The nurses have to use (name of the Electronic Communication System used by the Facility) to reach the nurse practitioner and on weekends from 9PM to 6AM there is a number to call and usually I am the one on call. V24 was asked if he received any calls on 12/22/2024 or 12/23/2024, V24 checked his records and personal phone and stated, No I did not. The facility Medical Director Agreement dated 6/1/24 and signed by V24 documents under Article III Services of Physician section (i) Provision of Physician Services including (but not limited to) .Availability of physician services 24 hours a day in case of emergency. The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on interview, and record review the facility failed to provide a sufficient level of nursing staff to provide timely assistance with activities of daily living. This failure has the potential to affect all 50 residents residing in the facility. Findings include: On 3/20/25 at 10:07 AM, V18 (Certified Nursing Assistant/ CNA) said the facility worked with only 2 CNA's and 2 Nurses about 2 days a week on average. V18 said if the facility only had 2 CNA's working on dayshift, they could not provide the scheduled showers to residents or provide care for Activities of Daily Living (ADL) to residents in a timely fashion. On 3/20/25 at 10:15 AM, V46 (CNA) said she had been working in the facility for a couple weeks. V46 said dayshift was short staff a couple times a week with 2 CNA's and 2 Nurses. V46 said when there were only 2 CNA's working, they could not get the scheduled showers completed and all the necessary tasks completed. V46 said even on days when 3 CNA's were working, they could not get all the necessary tasks completed. V46 said there were supposed to be 4 CNA's on dayshift but that was rare. V46 said if dayshift could not get a resident's scheduled shower completed, they were supposed to pass it on to the nightshift CNA's. V46 said the night shift CNA's had a list of scheduled resident showers too and struggled to get those completed so V46 was unsure how they managed to get day shifts completed as well. On 3/6/25 at 9:36 AM, V1 (Administrator) said most of the CNA's and Licensed Nurses worked 12-hour shifts. V1 said the facility required 4 CNA's and 2 Licensed Nurses to work day shift. V1 said the facility worked short staffed more than she would like. V1 said 2 CNA's and 2 Licensed Nurse could not provide assistance with CNA's for all the residents in a timely fashion. V1 said if dayshift could not provide showers to residents during their shift, they should be passing them along to night shift so they can be completed but was not sure they always were completed. V1 said the facility was using agency staff but was not able to get the positions covered. 1. On 3/5/25 at 3:40 PM, R8 said there had been times the facility was too short staff to assist her with showering. R8 said 2 to 3 weeks prior to this interview it was really bad and she had to go 7 to 9 days without a shower. R8's Admission Record documented an admitted [DATE] with diagnoses including: congestive heart failure, type 2 diabetes. R8's 2/14/24 MDS documented a BIMS score of 13, indicating R8 was cognitively intact. R8's GG ADL Documentation from 1/29/25 through 2/28/25 documented R8 received a shower/ bathing on 1/29/25, 2/1/25, 2/12/25, and 2/15/25. 2. On 3/5/25 at 3:50 PM, R18 said there was not enough staff to assist her with showering/ bathing. R18 stated we go a long time without showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R18's Admission Record documented an admitted [DATE] with diagnoses including: muscle wasting and atrophy, severe calorie malnutrition. R18's 2/6/25 MDS documented a BIMS score of 15, indicating R18 was cognitively intact. R18's GG ADL Documentation from 1/29/25 through 2/28/25 documented R18 received a shower/ bathing on 1/31/25, 2/7/25, 2/18/25, 2/25/25, and 2/28/25. 3. On 3/4/25 at 1:50 PM, R28 stated you can't get anyone to help you take a shower. R28's Admission Record documented an admitted [DATE] with diagnoses including: muscle wasting and atrophy, diabetes mellitus, dependence on renal dialysis. R28's 2/3/25 MDS documented a BIMS score of 14, indicating R28 was cognitively intact. R28's GG ADL Documentation from 1/29/25 through 2/28/25 documented R28 received a shower/ bathing on 1/29/25 and 2/1/25. 4. On 3/11/25 at 3:20 PM, R21 said the staff were nice, there just wasn't enough of them. R21 said he went long periods of time without a shower but was unable to say how long. R21's Admission Record documented an admitted [DATE] and a discharge date of [DATE] with diagnoses including: congestive heart failure, need for assistance with personal care, reduced mobility. R21's 2/5/25 MDS documented a BIMS score of 15, indicating R21 was cognitively intact. R21's GG ADL Documentation from 1/29/25 through 2/28/25 documented R21 received 1 shower/ bathing on 1/30/25. The facility's February 2025 Day Shift CNA Schedule documented 2 CNAs working on the 14, 17, 21, 22, 25, 26, and 28. The facility's undated Facility Assessment Tool documented in part . Staffing plan . Direct care staff . 1:11 ratio Days (total licensed or certified) . 1:11 ratio Evenings . The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview, observation, and record review the facility failed to obtain and administer Intravenous medications as ordered by the physician to 1 of 3 residents (R1) in a sample of 29. Findings include: R1's document titled Admission Record documents an admitted [DATE]. Document titled Order Summary Sheet documents diagnoses of Peritoneal Abscess, Anal Abscess, other specified sepsis, colostomy, hypertension, severe protein-calorie malnutrition, and anemia. R1's Order Summary Report dated February 2025, documents orders for Vancomycin (antibiotic) Intravenous (IV) 1 gm (gram) two times a day for abdominal abscess, order date 1/31/2025, start date 1/31/2025, until 2/14/2025. Unasyn 3gm IV four times a day for abdominal abscess, order date 1/31/2025, start date 1/31/2025, until 2/14/2025. R1's MDS (Minimum Data Set) dated 2/6/2025 includes a BIMS (Brief Interview for Mental Status) score of 15 indicating cognition intact. On 2/13/2025 at 11:20AM, R1 stated he did miss some of his IV medications when he first admitted . R1 stated the pharmacy did not send them and he missed several doses the first few days and then one day last week he missed a dose due to pharmacy not bringing the medications. R1 stated his pain is under control and it is ordered as needed so when he needs a pain pill the nurses always bring it. R1 stated pain was at a 4 at time of interview and stated that is tolerable for him. At this time R1 was lying in bed watching television. Observed IV medication bags hanging on IV pole, bags were empty with 2/13/2025 date on them. Medications had already infused. On 2/14/2025 at 1:35PM, V2 (Director of Nursing) stated R1 receives IV antibiotics and was admitted with those orders. V2 stated R1 missed some doses the first couple of days because the pharmacy did not get the orders electronically and the medications were not in house. V2 stated she couldn't remember if she notified the doctor or not, but she knows as soon as they arrived the medications were started. V2 stated she thought the medications came in on 2/2/2025 and R1 was admitted on [DATE]. V2 stated the problem was the facility was switching over to electronic records, but she was not aware there still needed to be a phone order faxed over to pharmacy and this is the reason the medications were not in to administer. R1's Medication Administration Record (MAR) documents R1 was to receive IV (Intravenous) Vancomycin 1 gm (Gram) twice a day (Ordered on 1/31/2025). On 1/31/2025 at 5:00PM the box was coded 9 see progress note, progress note at 5:38 documents medication not available. On 2/1/2025 doses due at 8:00AM and 5:00PM are coded 9 see progress note, only progress note is at 6:18PM with medication not available. The date 2/3/2025 at 5:00PM left blank, and 2/6/2025 at 8:00AM coded 9 see progress note, progress note documents medication not given due to new dose not available. MAR documents a total of 5 missed doses of Vancomycin 1gm. (continued on next page)

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	145517	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Mount Vernon	1700 White Street Mount Vernon, IL 62864

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's MAR documents R1 was to receive IV (intravenous) Unasyn 3 gm four times a day (Ordered on 1/31/2025). On 1/31/2025 at 5:00PM and 9:00PM both doses coded 9 see progress note, progress notes medication not available for both doses. On 2/1/2025 at 5:00AM, 11:00AM, 5:00PM, and 9:00PM all coded with 9 see progress notes, progress noted for doses missed at 5:00AM, 11:00AM and 9:00PM documents medication not available. On 2/2/2025 at 5:00AM documents code 9 see progress notes, progress notes medication not available. MAR documents a total of 7 doses missed doses of Unasyn 3gm. R1's Progress Notes dated 2/1/2025 at 2:57PM, documents, [sic] This nurse called pharmacy to check on status of patient's medication being delivered at 2:45PM. Pharmacy rep told this that pharmacist would give call back. [sic] Currently awaiting call back. Author V2. R1's Progress Notes dated 2/1/2025 at 5:25PM documents awaiting order clarification on multiple meds from provider and pharmacy. Author V1. R1's Progress Notes dated 2/15/2025 at 11:18PM documents, this nurse received call back from pharmacy in IV department with pharmacy on 2/1/2025 at 3:20PM. Pharmacy informed this nurse that the IV department does not have access to PCC (Point Click Care) as the regular pharmacy does, that IV medications will need to be sent via telephone order. This nurse asked pharmacy to STAT (without delay) medication once orders were received. This nurse told medication would be STAT delivery once orders received via telephone order/fax. This nurse passed along to nurse working floor, V1 (Administrator) LPN (Licensed Practical Nurse) and V1 faxed order for IV medications to pharmacy on 2/1/2025 approximately 4:00PM. Pharmacy Policy titled Receipt of Interim/STAT/Emergency Deliveries dated with revision date of 8/1/2024. Under subtitle of procedure, #1 Facility should immediately notify pharmacy when facility receives from a physician/prescriber a medication order that may require an interim/stat/emergency delivery. If necessary medication is not contained within facility's interim/stat/emergency supply, and facility determines an interim/stat/emergency delivery is necessary, facility should arrange with pharmacy for one of the following actions: For pharmacy to include the interim/stat/emergency medication in an earlier scheduled delivery or a special delivery as required, or for pharmacy delivery by contract courier, or for pharmacy to arrange for the medication to be dispensed and delivered by a third party pharmacy to ensure timely receipt.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview, observation, and record review the facility failed to ensure physician's orders were followed for administering Intravenous medications and insulin to 2 of 3 residents (R1 and R21) reviewed for medications in a sample of 29. Findings include: 1. R1's document titled Admission Record documents an admitted [DATE]. Document titled Order Summary Sheet documents diagnoses of Peritoneal Abscess, Anal Abscess, other specified sepsis, colostomy, hypertension, severe protein-calorie malnutrition, and anemia. R1's Order Summary Report dated February 2025, documents orders for Vancomycin (antibiotic) intravenous (IV) 1 gm (gram) two times a day for abdominal abscess, order date 1/31/2025, start date 1/31/2025, until 2/14/2025. Unasyn (antibiotic) 3gm IV four times a day for abdominal abscess, order date 1/31/2025, start date 1/31/2025, until 2/14/2025. R1's MDS (Minimum Data Set) dated 2/6/2025 includes a BIMS (Brief Interview for Mental Status) score of 15 indicating cognition intact. On 2/13/2025 at 11:20AM, R1 stated he did miss some of his IV medications when he first admitted . R1 stated the pharmacy did not send them and he missed several doses the first few days and then one day last week he missed a dose due to pharmacy not bringing the medications. R1 stated his pain is under control and it is ordered as needed so when he needs a pain pill the nurses always bring it. R1 stated pain was at a 4 at time of interview and stated that is tolerable for him. On 2/14/2025 at 1:35, V2 (Director of Nursing/DON) stated R1 receives IV antibiotics and was admitted with those orders. V2 stated R1 missed some doses the first couple of days because the pharmacy did not get the orders electronically and the medications were not in house. V2 stated she couldn't remember if she notified the doctor or not, but she knows as soon as they arrived the medications were started. V2 stated she thought the meds came in on 2/2/2025 and R1 was admitted on [DATE]. V2 stated the problem was the facility was switching over to electronic records, but she was not aware there still needed to be a phone order faxed over to pharmacy and this is the reason the medications were not in to administer. On 2/21/2025 at 1:58PM, V17 (Nurse Practitioner/NP) stated she received a message on 1/30/2025 to clarify R1's IV medication orders, she instructed the facility to call the Infectious Control Physician at the discharging hospital and get clarifications. V17 stated she received another message shortly after informing her that all IV medications had been clarified and IV medications were to be continued. V17 stated she was not notified that the medications were not administered, or any doses were missed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Medication Administration Record (MAR) documents R1 was to receive IV (Intravenous) Vancomycin 1 gm (Gram) twice a day (Ordered on 1/31/2025). On 1/31/2025 at 5:00PM the box was coded 9 see progress note, progress note at 5:38 documents medication not available. On 2/1/2025 doses due at 8:00AM and 5:00PM are coded 9 see progress note, only progress note is at 6:18PM with medication not available. The date 2/3/2025 at 5:00PM left blank, and 2/6/2025 at 8:00AM coded 9 see progress note, progress note documents medication not given due to new dose not available. MAR documents a total of 5 missed doses of Vancomycin 1gm. R1's MAR documents R1 was to receive IV (intravenous) Unasyn (antibiotic) 3 gm four times a day (Ordered on 1/31/2025). On 1/31/2025 at 5:00PM and 9:00PM both doses coded 9 see progress note, progress notes medication not available for both doses. On 2/1/2025 at 5:00AM, 11:00AM, 5:00PM, and 9:00PM all coded with 9 see progress notes, progress noted for doses missed at 5:00AM, 11:00AM and 9:00PM documents medication not available. On 2/2/2025 at 5:00AM documents code 9 see progress notes, progress notes medication not available. MAR documents a total of 7 doses missed doses of Unasyn 3gm. Policy titled Medication Administration General Guidelines no date on document, documents, medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). Under section for documentation, #6 documents, if a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the MAR for that dosage is initialed or circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. 2. R21's Admission Record documents an admitted [DATE] and discharge date of [DATE]. R21's Admission Record documents diagnoses including CHF (Congestive Heart Failure), malignant neoplasm of prostate, chronic atrial fibrillation, aortic stenosis, muscle wasting and atrophy, cardiomyopathy, Diabetes Mellitus II, hypertension, atrioventricular block, cardiac defibrillation, hyperlipidemia, lymphedema, anemia, vitamin D deficiency, testicular hypofunction, need for assistance with personal care, reduced mobility, insomnia, and shortness of breath. R21's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 12, indicating that R21 has moderate cognitive impairment. Section GG of the same MDS documents that R21 is dependent with toilet hygiene, shower/bathing, rolling left and right, sit to lying, and lying to sitting. R21's Care Plan documents under focus that R21 has Diabetes Mellitus, date initiated 2/6/2025 with a goal of R21 will have minimal complications related to diabetes through the review date, initiated 2/6/2025. Documented interventions include: avoid exposure to extreme heat or cold, and check all of body for breaks in skin and treat promptly as ordered date initiated 2/6/2025. There were no other interventions documented for the focus area of Diabetes Mellitus. On 3/11/2025 at 3:20PM, R21 was interviewed at the new Long Term Care facility where he currently resides. R21 stated the hospital did not send orders for his sliding scale insulin and the staff did not get the orders until the last day (3/6/25). R21 stated he had contacted his endocrinologist during his stay, and she had given orders for the sliding scale to be resumed but the staff never put in the orders. R21 could not recall the date but recalls contacting the endocrinologist and the nurse talked to them on his phone and the nurse was given orders for sliding scale insulin. R21 stated his blood sugars ran high the whole time he was there. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's Order Summary Report dated 3/21/25 documents orders for the date range of 1/29/25 through 3/31/25. This report documents an order for Insulin Lispro injection solution Pen-injector solution 100 units/milliliter, inject per sliding scale: if 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, greater than 401 then call MD (physician), subcutaneously before meals and at bedtime for diabetes dated 3/6/25. R21's Order Summary Report documents scheduled routine insulin orders since R21's admission on 1/29/25 but there are no other orders for Lispro Sliding Scale Insulin documented on this report with an order date prior to 3/6/25. R21's Medication Administration Record (MAR) dated 2/1/2025-2/28/2025 documents, may use readings for Accu-Check's from patient's personal (name of continuous glucose monitoring device) instead of sticking patient's fingers before meals and at bedtime with start date of 2/1/2025. Documented accu checks for R21 started on 2/1 /2025 and range from the lowest blood sugar of 35 to the highest blood sugar of 400. There was no documentation of an order for a sliding scale dose of Lispro Insulin on the February MAR. R21's MAR dated 3/1/2025-3/31/2025 documents blood sugars ranging from 118 - 400. The order for the sliding scale of Lispro Insulin dated 3/6/25 was documented on the March MAR per the Order Summary Report. Per the Centers for Disease Control (CDC) website (https://www.cdc.gov/diabetes/diabetes-testing/index.html) the normal fasting blood sugar is 99 mg/dL (milligrams per deciliter) or below. On 3/11/2025 at 2:22PM, V8 (Registered Nurse/Resident Care Coordinator) stated she remembers caring for R21. V8 stated she was not working when he first admitted on [DATE] but did work a few days after he admitted . V8 remembers fixing the insulin orders because the orders from the hospital were not correct, they did not include discharge orders for the sliding scale insulin. V8 said that R21 said he was supposed to be on sliding scale insulin. V8 stated I remember (R21) was running high, so we got the sliding scale for him added. V8 stated a few days after R21 was admitted , R21 called his Endocrinologist on his personal cell phone, and she received the orders for sliding scale. V8 stated I remember telling the family if I would have been here when he admitted it would have been fixed sooner. V8 said that R21 already had a scheduled order of 3 units either before or at meals. V8 stated she normally doesn't work the hall R21 was resided on, so she didn't know the orders for sliding scale were not completed. On 3/11/2025 at 2:26 PM, V8 was asked to review R21's MAR with this surveyor to see when she wrote the orders for the sliding scale. R21's MAR was reviewed and V8 pointed out the orders, the orders were dated for start date on 3/6/2025, the day of discharge. V8 stated I guess those did not get done back when I thought I put them in. V8 stated she normally doesn't work the hall R21 was resided on, so she didn't know the orders for sliding scale were not completed. On 3/21/2025 at 2:12PM, V2 (Director of Nurses) asked if she was aware that R21 was to have sliding scale insulin, and she stated no. V2 stated there was no order for sliding scale until 3/6/2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration General guidelines (undated), documents medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have neem properly oriented to the facility's medication distribution system. Under Administration it documents medications are administered in accordance with written orders of the prescriber.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088 Based on observation, interview, and record review the facility failed to provide food in accordance with the planned menus. This failure has the potential to affect all 50 residents residing in the facility. Findings include: On 3/5/25 at 12:03 PM, the noontime meal service was started. The steam table contained a small amount dry plain chicken breast, breaded fish, mashed potatoes, peas, green beans, and the dessert being mandarin oranges. No rolls or bread was being served. The facility's Week at a Glance Week 2 documented Wednesday 3/5/25 noontime meal was planned to be chicken cordon bleu casserole, buttered peas, dinner roll/ margarine, orange sherbert. On 3/5/25 at 1:50 PM, V43 (Cook) was asked why she did not serve the chicken cordon bleu casserole and V43 said she did not have enough chicken or the other ingredients to make it. V43 was asked why no roll was served and V43 said the facility did not have any rolls and was unsure why no bread was served. V43 said why mandarin oranges were served instead of orange sherbet and V43 said the facility did not have any orange sherbet. V43 said the facility would substitute at least one meal a week due to not having enough ingredients to make the planned meal. V43 was asked for the recipes for what was supposed to be served and for what was served and V43 started looking through a binder of recipes. V43 said there was no organization to the recipe binder and was not able to find recipes. On 3/6/25 at 10:13 AM, V45 (Dietary Manager) said the facility ordered deliveries of food twice a week to make the planned menus. V45 said when she placed the food delivery order she was confused and ordered some ingredients for a different week of menus and some ingredients for the right week of menus. V45 said if there were not enough ingredients to make a planned meal, she expected staff to swap the planned meal for a different planned meal on the menus that the facility did have ingredients for and to let her know so she could plan what meals would be served on what days. V45 said she was not sure why V43 had not served rolls with the 3/5/25 noontime meal due to the facility having a whole bag of rolls in the freezer. 2. The facility's Week at a Glance Week 2 documented Wednesday 3/5/25 evening meal was planned to be Italian sausage, sauteed peppers and onions, potato salad, bread/ margarine, and snickerdoodle blondie bars. On 3/5/25 at 2:00 PM, V38 (Cook) said he was making the evening meal. V38 said the facility did not have any potato salad so he was planning to substitute it with mashed potatoes. V38 said the facility did not have any peppers and onions and he was going to substitute it with California vegetable blend. V38 said the facility did not have any eggs so the snickerdoodle blondie bars would have to be substituted for something else. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. The facility's Diet Spreadsheet Week 3 Day 20 for the 3/14/25 evening meal documented the evening meal was planned to be chicken tenders, BBQ sauce, fresh potato wedges, buttered corn, bread/ margarine. On 3/14/25 at 3:15 PM, V44 (Cook) was placing biscuits on a baking tray. V44 was asked what was going to be served for the evening meal and V44 said she was serving biscuits, gravy, and hashbrowns. V44 was asked why she was not serving the planned meal of chicken tenders, fresh potato wedges, buttered corn, and bread and V44 said the facility did not have enough chicken tenders to feed all the residents and she had been instructed to serve the biscuits and gravy instead. The facility's March 2025 Menu Substitution Log documenting . Date . Item to be replaced . item replaced with . meal . reason . initials . RD (Registered Dietitian) signature . was blank. The facility's February 2025 Menu Substitution Log documented on 2/9/25 Mexican rice was substituted with mashed potatoes and 2/25/25 pulled pork was substituted for with sloppy joe sandwiches due to the facility having no pulled pork. This documented had a note written at the top right corner of the page documenting in part . Sub like items i.e. grain for grain . On 3/5/25 at 2:15 PM, R20 said the food was bad in the facility. R20 said the noontime meal's breaded fish was served cold and did not look good. R20 said he couldn't eat it. R20 said he kept food in his room for meals like this. R20 said the meals served did not make sense like the dietary staff didn't know what they were doing. R20 said the facility did not pass out menus to let residents know what was going to be served and R20 would have to guess what the mystery meat was on his plate. R20's Admission Record documented an admitted [DATE] with diagnoses including: cerebral infarction, severe protein calorie malnutrition. R20's 3/4/25 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating R20 was cognitively intact. On 3/4/25 at 1:50 PM, R28 said the food was terrible. R28 said the facility served the same things all the time. R28 said the residents were served leftovers from the noontime meal for the evening meal a few weeks prior to this investigation. R28 said the always available menu was a joke. R28 said if you don't like what is served the only option is a grilled cheese sandwich because the dietary staff would say they didn't have anything else available. R28's Admission Record documented an admitted with diagnoses including: muscle wasting and atrophy, diabetes mellitus, dependence on renal dialysis. R28's 2/3/25 MDS documented a BIMS score of 14, indicating R28 was cognitively intact. On 3/5/25 at 3:40 PM, R8 said the food did not taste good and there was little variety. R8 said she had heard the facility was trying to spend less money on food and that is why meals had become worse. R8's Admission Record documented an admitted [DATE] with diagnoses including: congestive heart failure, type 2 diabetes. R8's 2/14/24 MDS documented a BIMS score of 13, indicating R8 was cognitively intact. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/5/25 at 3:50 PM, R18 said she had trouble swallowing and was on a mechanical soft diet. R18 said she was served the same things all the time. R18 said for the noontime and evening meals she was served mashed potatoes every day. R18 said she was only at the facility for rehabilitation and I'm going home soon so I just choke it down until I can get out of here. R18's Admission Record documented an admitted [DATE] with diagnoses including: muscle wasting and atrophy, severe calorie malnutrition. R18's 2/6/25 MDS documented a BIMS score of 15, indicating R18 was cognitively intact. The facility's undated Menus policy documented in part . Policy: Menus are planned in advance and are followed as written to meet the needs of the residents . Procedure: . Menus are planned at least fourteen (14) days in advance or per state regulation and posted as per regulation . Menus are served as written unless changed due to an unpopular item on the menu, an item could not be procured, or in the event of a special meal. The Dietary Manager/ Registered Dietitian documents the substitution . The Registered Dietitian should approve the menu substitution/s on the Menu Substitution form . Menus are posted in a central location in the facility . Menus are planned with 6 oz of protein, 6 servings of grains, and 5 fruits/ vegetable servings per day . The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43088 Based on observation, interview, and record review the facility failed to provide food at palatable temperatures. This failure has the potential to affect all 50 residents residing in the facility. Findings include: On 3/4/25 at 1:17 PM, the kitchen was toured. The steam table in the kitchen was 3 compartments with no pan in the center compartment and the right compartment had a silver pan that did not appear to be the correct size for the compartment because it did not sit flush with the steam table. On 3/4/25 at 1:25 PM, V37 (Dietary Aide) said a couple months prior to this investigation the steam tables left compartment's water pan had rusted through and started to leak causing the middle compartment to no longer work. V37 said staff had put a large pan over the water pan in the left compartment and continued to use it. V37 said the water pan in the right compartment had fallen through a couple months prior to this investigation and staff had used an oversized pan over what was left of the water pan to be able to put food on the steam table. On 3/4/25 at 1:29 PM, V38 (Cook) said staff would try to keep food on the stove until they were ready to serve and would try to serve as quickly as possible. V38 said with the middle compartment of the steam table not working and the side compartments not working well once the food got cold there was really nothing staff could do about it. V38 said the steam table had been broken since he started on 1/6/25. On 3/5/25 at 12:05 PM a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit. On 3/5/25 at 12:22 PM a test tray was requested and was the first tray made and placed on the cart for hall tray delivery. On 3/5/25 at 12:33 PM, the last resident's meal tray was delivered from the cart containing the test tray. The test tray contained a piece of breaded fish, mashed potatoes, peas, and mandarin oranges. When the tray was uncovered the breaded fish's temperature was 110.6 degrees Fahrenheit and when tasted was cold and mushy. On 3/5/25 at 1:50 PM, the noontime meal service was completed. The end of the tongs used to serve the breaded fish were covered with a large amount of moist fish breading. V39 (Dietary Aide) was asked to sample a piece of the breaded fish and confirmed the fish and the breading on the fish were mushy. V39 said V39 would not like to eat anymore of the breaded fish. On 3/5/25 at 10:18 AM, V40 (Ombudsman) said she had spoken with V1 (Administrator) in January of 2025 about several residents having complaints of food being served cold due to the steam table not working. V40 said V1 said she was aware of the steam table being broken but staff were doing the best they could with the broken steam table. V40 said V1 then said the facility did not have the money to fix the steam table. (continued on next page)

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	145517	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Mount Vernon	1700 White Street Mount Vernon, IL 62864

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/5/25 at 2:15 PM, R20 said when he received his noontime meal tray the fish was cold and did not look good. R20 said the food was always cold when it arrived to his room. R20 said if it is really bad like today, I ask for something else because cold fish is not appetizing. R20's 3/4/25 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating R20 was cognitively intact. On 3/5/25 at 2:28 PM, R29 said the food was always cold when he received it in his room. R29 said the fish was cold when he received his noontime meal tray earlier that day. R29's 12/13/24 MDS documented a BIMS score of 10, indicating R29 was moderately cognitively impaired. On 3/5/25 at 3:40 PM, R8 said the food was always cold when it arrived to her room. R8 said she could ask staff to warm the food up but she would have to ask them every time they brought in a meal tray and staff did not have time for that. R8's 2/14/24 MDS documented a BIMS score of 13, indicating R8 was cognitively intact. On 3/5/25 at 3:50 PM, R18 said the food was always cold when it was delivered to her room. R18 said she was only at the facility for rehabilitation and I'm going home soon so I just choke it down until I can get out of here. R18's 2/6/25 MDS documented a BIMS score of 15, indicating R18 was cognitively intact. The facility's 2020 Monitoring Food Temperatures for Meal Service policy documented in part .Monitoring Food Temperature for Meal Service . g. Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 (degrees Fahrenheit) or greater to promote palatability for the resident . The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49664 Based on interview and record review, the facility failed to investigate and report a resident death to the Department, failed to seek emergency services for a resident experiencing a change of condition, failed to implement new fall interventions, failed to obtain orders for a resident receiving peritoneal dialysis (PD) along with training staff on emergency PD procedures, failed to maintain communications with facility medical director during off hours, failed to provide routine training to staff, and failed to provide an Administrator the training needed to direct the day to day functions at the facility. The failure has the potential to affect all 50 residents living in the facility. Findings include: The [DATE] Midnight Census Report documented 50 residents residing in the facility. 1. R2's Admission Record documents as admitted [DATE], includes diagnoses of Parkinson's Disease, Type 2 diabetes mellitus, morbid obesity, dementia, and hydrocephalus. R2's Progress Note dated [DATE] at 3:25AM, late entry at approximately 1:00AM, documents CNA (Certified Nurse's Assistant) alert this nurse that resident needed immediate assist. This nurse immediately ran into resident room and saw the resident in a compromised position. Resident appeared to be in sideways sitting position with head between grab bar and mattress. Resident was unresponsive and no pulse palpable. Resident lowered to the floor. CPR (Cardiopulmonary Resuscitation) initiated. All staff alerted (Emergency Medical Services) alerted. This nurse and other nurse continued CPR until EMS arrived. Time of Death 1:10AM. IDT (Interdisciplinary Team) notified. EMS notified coroner. A local Fire Department report documents [DATE] 1:04AM call received. [DATE] at 1:12 AM posture: laying, heart rate 0, respiratory rate 0. 1:13AM 3 lead Echo obtained. Patient (R2) narrative: Responded to nursing home facility for male patient (R2) unresponsive, not breathing. Upon arrival, find [AGE] year-old male supine on floor next to bed. Nursing staff performing chest compressions and ventilations with BVM (bag valve mask). Patient (R2) is pulseless and apneic. Skin is cold and cyanotic. Cardiac monitor applied showing asystole. Nursing staff reports possible down time 45 minutes or more. Resuscitation efforts discontinued; medical control contacted to confirm. Staff reports patient had been found with most of his body on the floor, with head and upper torso stuck between bed and bed rail. Coroner contacted via dispatch. Cleared scene with nursing staff awaiting communication with coroner. End of Report. R2's Medical Examiner/Coroner Certificate of Death dated [DATE], documents date of death [DATE], time of death 1:15AM. The cause of death documents 1 a. Positional Asphyxiation, b. found in a seated position on floor beside bed, c. legs straight out and head and neck between mattress and bed rail. 2. Diabetes, hypertension, Parkinson's, dementia, and obesity. A date of injury is documented as [DATE], time of injury 1:00AM, place of injury, Nursing home. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1:34PM, V1 (Administrator) was asked if she sent a report on R2's incident on [DATE] to the Department. V1 stated, We did not do one because we did not think his death was related to a fall or any type of injury. V1 then stated she asked her boss if they needed to send a reportable and was told no because his death was not related to a fall or injury. On [DATE] at 9:45AM, V1 asked this surveyor what the regulations were for side rails. This surveyor told V1 she could find that information in the SOM (State Operations Manual). V1 asked what the SOM was. Surveyor explained the SOM is the primary source for survey and certification rules and guidance used in nursing homes. V1 stated she has never seen that book. Surveyor explained it may be on her computer and she should reach out to the Regional Administrator for direction. V1 asked this surveyor if she could supply the death certificate for R2, surveyor advised her to reach out to her resources for that information. On [DATE] at 10:05AM, V1 stated she received a call from V11 at 1:09AM on [DATE] and V11 stated R2 was hanging out of bed gasping for air, and it did not look good. V11 stated CPR was being started. The next call was from V3 at 1:50AM stating R2 had expired. V1 stated when I went in with the coroner for the reenactment, I knew something major had happened. V1 stated I also thought something was up when the coroner kept coming into the facility. V1 stated R2 had a history of throwing his legs out of the bed. V1 was asked what intervention was put into place for R2 throwing his legs out of bed and V1 stated there are no interventions for that, but it is sort of a common thing for people to do that. V1 stated R2 had a clip-on alarm when he was up in his wheelchair. V1 stated R2 would not have had that while in bed. V1 stated the clip-alarm was for a fall intervention. V1 stated R2 had siderails on for positioning, he would help roll himself in bed. V1 stated maintenance puts on the siderails and we do routine checks on siderails. V1 stated I don't know about the gaps on siderails, but maintenance does all of that. V1 stated, R2 had an air mattress on his bed. V1 was asked if she knew the manufacturers recommendation for side rails with the air mattress and V1 stated no, I don't know anything about gaps. V1 was asked what process they use to determine who needs side rails and V1 stated well sometimes the family wants them on so we put them on, and sometimes physical therapy may recommend. 2. R16's Admission Record documents an admitted [DATE] with diagnoses of Cerebral Palsy, Type 2 Diabetes Mellitus with Ketoacidosis, without coma, Hyperlipidemia, Hyperkalemia, Epileptic Syndrome, Quadriplegia, Acute Kidney Failure, Chronic Kidney Disease, Microcephaly. R16's State of Illinois Certificate of Death includes a date of death for [DATE], and cause of death Probable Diabetic Ketoacidosis (DKA). Time of death 10:33PM. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:59AM, V19 (Licensed Practical Nurse/LPN) stated she was working the dayshift 6A-6PM on [DATE]. V19 stated she was the charge nurse for R16. V19 stated R16 was mostly fine through the earlier part of the day. V19 stated she really didn't know R16 that well. V19 stated around 3:00PM the CNA's reported to her that R16 wasn't acting right, and he looked bad. V19 stated she checked R16's blood sugar between around 3:,d+[DATE]:30PM and the glucometer just read HI. V19 stated she gave R16 12 units of regular insulin at this time and called the on-call physician but had to leave a message. V19 stated she also gave the 6 units of regular insulin that is scheduled at 4:00PM. V19 stated R16 was a little sluggish and was acting tired. R16 stated as she was waiting for the return call from the physician, she called V2 (Director of Nursing/DON) and V2 informed her that this has happened before with R16 and sometimes they send him to the hospital if the physician orders to send him. V19 stated, V2 told her just wait on the physician to call back and see what the physician wants to do. V19 was asked if she has had training at the facility on change of condition, blood glucose monitoring (how high does the glucometers read), and V19 stated she has not had any kind of any training at the facility. V19 stated she had no idea of how high the blood sugar is when it read HI. On [DATE] at 2:00PM, V19 stated she was not sure what number she called for the on-call MD on [DATE], it was on a note at the nurse's station. V19 stated she doesn't know about HUCU (Electronic Communication System used by the Facility) and communication like that and she has had no training on any of that stuff. V19 stated again she was advised by V2 to wait for the MD to call back and if she would have said sent to ER (emergency room), she would have sent R16 out. On [DATE] at 11:04AM, V22 (Registered Nurse/RN) stated she worked on [DATE], 6AM -6PM. V22 stated she received in report R16 had been running high blood sugars and insulin per orders was given report that the on-call physician was called, and a message was left to return call. V22 stated she went to R16's room around 6:30PM to check on R16, she stated she could arouse R16, and he would answer yes or no to questions. R16's blood sugar was checked at this time and reading was high. V22 stated she had put in another call to the on-call physician and left a message (unsure of what time). V22 stated she received a call back from a physician with orders for 12 units of insulin and recheck in a little while (unsure of physician's name). V22 stated she could arouse R16 at that time and he was unchanged from previous assessment. V22 stated she remembers rechecking R16's blood sugar about 45 minutes later and the blood sugar was down to 488. V22 stated she didn't call the physician back with results. V22 stated, I thought we were finally going in the right direction with the blood sugar going down. V22 stated sometime around 10:00 PM, she was summoned to R16's room by a CNA, upon entering room R16 was having a hard time breathing and heart rate was irregular, color was bad and R16 was nonresponsive. V22 stated at this time she and the CNA lowered R16 to the floor to prepare for CPR (Cardiopulmonary Resuscitation), when lowering R16 to the floor R16 stopped breathing. V22 stated CPR was started and help was called for from the other CNA's. When other CNA entered the room V23 asked her to call 911 and the CNA stated, CNAs are not allowed to call 911. V22 then stated the CNA took over chest compression and V22 went to call 911 and check R16's chart for code status. V22 stated code status was found and R16 was a DNR, so she went to the room and stopped CPR. EMS arrived and pronounced death at 10:30ish. V22 stated she remembers R16 having a strong sweet fruity smell as they were transferring him to the floor. V22 stated she has had no training at the facility on policies or resources to look them up. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 1:45PM, V1 (Administrator), stated she has been employed at the facility for 5 years and she was very familiar with R16. V1 stated she had not investigated R16's death. V1 stated R16 had been sent to the hospital several times for elevated blood sugars, DKA, and R16 would get treated and return. V1 was handed R16's progress notes from the day he expired. V1 was asked to read the progress notes. V1 then stated, I would have sent him out at 488 but I would have sent him out before that when the blood sugar was too high to read on the glucometer. V1 stated she and V15 (Nurse Practitioner/NP) had talked about this after his death and R16's life expectancy was only to live until his 20's, he was in his 50's and he had many health issues. V1 stated the nurse that was working that day was an agency nurse. V1 stated, I would have sent him out and if they would have sent him out when it was high, he would still be alive, but I was very familiar with R16 and knew his medical issues. 3. R25 's document titled Admission Record documents R25 was admitted to the facility on [DATE] with diagnoses including Anemia, Chronic Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, History of Falls, Unspecified Dementia, History of Transient Ischemic Attack, Legal Blindness, and Cerebral Infarction without residual deficits. R25's Unwitnessed Fall report dated [DATE] documents, at 4:00PM, Incident description: Unwitnessed fall from bed. 4:00PM resident's roommate came to Admin office stating that resident was in the floor next to her bed. Resident was hoyer lifted from floor to bed by nurse and CNA's. Resident is unable to give description. Immediate action: POA (Power of Attorney) declined to send to ER (emergency room) to eval and treat. Scoop mattress placed on bed. Neuro checks initiated. Approx 4:00AM on [DATE], resident was sent to ER related to change in condition/change in neuro assessment. Injuries observed at time of incident Bruise to top of scalp and face. Predisposing Environmental Factors is marked none. Predisposing Physiological Factors is marked none. Predisposing Situation Factors is marked none. On [DATE] at 2:58PM, V1 stated she was the one that R9 came to when R25 had the fall. V1 stated R25 used to have a side rail to keep her from getting out of bed and had her bed up against the wall. These were to keep R25 from falling. V1 stated R25 had several falls before she came to the facility, and she even came to the facility because of a fractured hip. V1 was asked if the side rail and bed up against the wall were fall interventions and V1 stated yes. V1 was asked what intervention were put in place for fall prevention after the side rail was removed, V1 stated We did nothing. V1 was asked if she was aware of R25's fall risk score and level of risk and V1 stated, No. Presented V1 with R25's fall risks assessments from admission with last one being done on the day of fall [DATE] and before that [DATE]. The fall assessments showed R25 had always been a fall risk. V1 stated R25 had not had any other falls since admission other than [DATE]. V1 stated the bed rails were up as a restraint because R25 could not use for bed mobility. V1 stated the son understood all of this but the daughter did not. V1 was asked since the side rail was used to prevent falls did, she feels there should have been another intervention put in place at the time the side rail was removed and V1 stated, It probably should have but we did put in an intervention of a concave mattress after the fall to prevent another fall from occurring. V1 stated she is not sure how R25 fell out of bed because she never moved much at all. V1 stated R25 was not able to use the side rail for bed mobility either. 4. R22's New Admission Information documented an admitted [DATE]. R22's Cumulative Diagnosis Log documented diagnoses that included sepsis, peritonitis, and dependence on dialysis. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 2:45 PM, V33 (Regional Reimbursement) said the facility was not able to produce R22's Care Plans due to a change of ownership and was now unable to access the electronic medical records. On [DATE] at 2:14 PM, V2 (Director of Nursing/DON) said when she came into the facility on [DATE] the nursing staff were having some issues with R22's Peritoneal Dialysis (PD) infusion due to the PD cycler alarming through the night. V2 said she was told by V30 (LPN) that due to R22's PD cycler alarming, V30 had called V28 (Dialysis Company Registered Nurse). V2 said around 9:30 AM to 10:00 AM, V28 called the facility requesting to speak with V2 to give new orders for R22. V2 said the facility did not have the bag of dialysate that V28 gave an order for and had to go to the dialysis company to pick up the bag of dialysate. V2 said she returned to the facility and V29 (RN) was the nurse caring for R22. V2 said she gave V29 the order for a 1.5-liter PD manual fill and asked V29 if V29 was familiar with how to set and infuse a PD manual fill because V2 was not familiar with infusing PD solution with gravity. V2 said V29 said she was used to completing PD manual fills and had completed them in the past. V2 said R22 received 2.5 liters of PD dialysate, started to have some shortness of breath, and was sent to the hospital for further evaluation. V2 said she had never completed a PD manual fill of dialysate at that time. V2 said she had received training from the dialysis company for PD, but the training only included how to hook a resident up to the PD cycler. On [DATE] at 9:00 AM, V1 (Administrator) said the facility was unable to produce any orders for R22 from the dialysis company. V1 said after reviewing R22's medical record no orders for what peritoneal dialysis solutions were being administered was ever written on R22. [DATE] or [DATE] Physician's Order sheets. V1 said she did not know how staff were completing R22's peritoneal dialysis with no written orders. 5. On [DATE] at 10:22AM, V1 was asked how often V24 (Medical Director) is in the facility. V1 stated, He is only here quarterly for QA (Quality Assurance) and then he leaves. V1 was asked if he is the Medical Director, and she stated, Yes. V1 was asked if he makes rounds and she stated, No the Nurse Practitioner makes rounds. V1 was asked if V24 ever reviews plan of care and V1 stated, No. V1 stated the facility is duo-certified, and the Nurse Practitioner sees the Medicare residents when they need to be seen. V1 stated V24 does not make rounds. V1 was asked for a log of doctor visits and V1 stated they do not have a log. On [DATE] at 9:25AM, V24 (Medical Director) stated his phone has been accidentally silenced, so he hasn't been able to be reached for a couple of days. V24 was asked how the on-call services work and stated, The nurses have to use (name of the Electronic Communication System used by the Facility) to reach the nurse practitioner and on weekends from 9PM to 6AM there is a number to call and usually I am the one on call. V24 was asked if he received any calls on [DATE] or [DATE], V24 checked his records and personal phone and stated, No I did not. 6. The facility's in-services provided by V1 Administrator, were reviewed. There was no documentation effective communication training was conducted, that QAPI training was conducted, that Compliance and Ethics training was conducted and there was no documentation of training to meet the resident's behavioral health care needs conducted. The facility's Facility assessment dated [DATE] documents under Staff Training/Education and Competencies to include annual in-service and competencies for all Certified Nursing Assistants. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 3:07 PM, V7 (Regional Director of Operations) stated they did not complete effective communication training with the facility staff, they did not complete QAPI training with the facility staff, they did not complete Compliance and Ethics training with the facility staff, they did not complete training to meet the resident's behavioral health care needs with the facility staff and stated the annual required CNA in-services and competencies were due in [DATE] and were not completed. 7. On [DATE] at 2:50 PM, V1 was questioned about the facility assessment. V1 said she was unsure what the facility assessment was or what its purpose was. V1 said she had not received any training on the facility assessment. V1 said she had not really received any training on her administrative duties at all since taking the position. V1 said she would like to have some training so she could act more independent without having to call a corporate person for everything. On [DATE] at 11:13 AM, V7 (Regional Director of Operations) V7 stated that her license is now hanging at 2 facilities, this one and the sister facility. V7 stated V1 has applied for her temporary license but has only received a letter but the license is not posted yet on the State Agency website. V7 stated she hopes they get posted soon. On [DATE] at 2:40PM, V1 explained she had gotten a letter in January of 2025 that stated congratulations on temporary license, but her license is not posted. V1 stated when she called a few days ago to the licensure board she was told her application was being reviewed. V1 stated she was not sure what was going on but does not know if she is the temporary Administrator or not. V1 stated she was under the impression that V7's license was hanging there until her temporary license was completed. On [DATE] at 11:56 AM, V1 provided her Licensed Nursing Home Administrator's Temporary License by the State of Illinois, Department of Financial and Professional Regulation (IDFPR) documenting an expiration date of [DATE]. The facility's [DATE] Administrator job description documented in part . Summary: The Administrator directs the day to day functions of the facility in accordance with current federal and local guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times . Essential Duties and Responsibilities: . Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities in accordance with guidelines issued by the governing board . Ensure that all employees, residents, visitors, and the general public follow the facility's established policies and procedures . review and check competence of workforce and make necessary adjustments/ corrections as required or that may become necessary . Ensure that physicians are in compliance with facility policies governing the admission, medical treatment, visit requirements, plan of care, orders, etc . Review accident/ incident reports . Ensure that the facility is maintained in a clean and safe manner for resident comfort and convenience by assuring that necessary equipment and supplies are maintained to perform such duties/ services .

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to conduct ongoing training in effective resident care communications for all staff. This failure has the potential to affect all 50 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] documents under Staff Training/Education and Competencies to include effective communication training for direct care staff. The facility's in-services provided by V1 Administrator, was reviewed. There is no documentation effective communication training was conducted. On 2/20/25 at 3:07 PM, V7 (Regional Director of Operations) stated they did not complete effective communication training with the facility staff. The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Axiom Healthcare of Mount Vernon	1700 White Street Mount Vernon, IL 62864

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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 32765 Based on interview and record review the facility failed to conduct ongoing training in Quality Assurance and Performance Improvement (QAPI) for all staff. This failure has the potential to affect all 50 residents residing in the facility. Findings include: The facility's in-services provided by V1 Administrator, was reviewed. There is no documentation QAPI training was conducted. On 2/20/25 at 3:07 PM, V7 (Regional Director of Operations) stated they did not complete QAPI training with the facility staff. The 2/12/25 Midnight Census Report documented 50 residents residing 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 32765 Based on interview and record review the facility failed to conduct ongoing training in Compliance and Ethics for all staff. This failure has the potential to affect all 50 residents residing in the facility. Findings include: The facility's in-services provided by V1 Administrator, was reviewed. There is no documentation Compliance and Ethics training was conducted. On 2/20/25 at 3:07 PM, V7 (Regional Director of Operations) stated they did not complete Compliance and Ethics training with the facility staff. The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. Building B. Wing	03/25/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to conduct required in-service training and competencies for Certified Nursing Assistants (CNA). This failure has the potential to affect all 50 residents residing in the facility. Findings include: The facility's Facility assessment dated [DATE] documents under Staff Training/Education and Competencies to include annual in-service and competencies for all Certified Nursing Assistants. The facility's in-services provided by V1 Administrator, was reviewed. There is no documentation the required in-service training and competencies for CNA's was conducted. On 2/20/25 at 3:07 PM, V7 (Regional Director of Operations) stated the annual required CNA in-services and competencies were due in September 2024 and were not completed. The 2/12/25 Midnight Census Report documented 50 residents residing 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 32765 Based on interview and record review the facility failed to conduct ongoing training for all staff, to meet the resident's behavioral health care needs. This failure has the potential to affect all 50 residents residing in the facility. Findings include: The facility's in-services provided by V1 Administrator, was reviewed. There is no documentation of training to meet the resident's behavioral health care needs was conducted. On 2/20/25 at 3:07 PM, V7 (Regional Director of Operations) stated they did not complete training to meet the resident's behavioral health care needs with the facility staff. The 2/12/25 Midnight Census Report documented 50 residents residing in the facility.