STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145571	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Health & Rehab Ctr	One Perryman Street Lebanon, IL 62254

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on Interview, Observation, and Record Review, the facility failed to provide dignity during feeding assistance and ensure resident call lights are within reach of the resident for 4 of 20 residents (R8, R65, R93, R94) reviewed for resident dignity in the sample of 44. The Findings Include: 1. On 1/26/25 11:45 AM, V6 (Restorative Certified Nursing Assistant/CNA) was seen standing between R65 and R93 at a dining room table. V6 stood and used her right hand to feed R93, then used her left hand to feed R65. R65's Care Plan, dated 1/23/25, documents R65 has a Self-Care Deficit with Interventions: Take to dining room for meals, Eating - Setup help / Cueing required. R65's Minimum Data Set (MDS), dated [DATE], documents R65 is cognitively intact and is dependent on staff for eating. 2. R93's Care Plan, dated 11/4/24, documents R93 has Self-Care Deficit with Interventions: Eating - Independent required. R93's MDS, dated [DATE], documents R93 has a severe cognitive impairment and required partial/moderate staff assistance for eating. On 1/26/25 at 12:15 PM, V2 (Director of Nursing/DON) was seen handing a chair to V6 and told her she was supposed to be sitting down in a chair while assisting the residents. 44556 3. R8's Face Sheet, original admitted [DATE], documented R8 has diagnoses of but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Type II diabetes mellitus with diabetic chronic kidney disease and diabetic polyneuropathy, adult failure to thrive, and pressure ulcer of sacral region, stage 4. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's MDS, dated [DATE], documented R8 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 13 out of 15 and is dependent on staff for most of her activities of daily living (ADLs). R8's Care Plan, admitted [DATE], documented R8 has Self-Care Deficit As Evidenced by: Needs assistance with ADLs Related to Hemiplegia & Hemiparesis Left Non-Dominant Side, Alzheimer's, Dementia, Morbid Obesity, Neuromuscular Dysfunction of Bladder, and bowel incontinence. Interventions include but not limited to Encourage R8 to use bell to call for assistance. On 01/27/25 at 09:41 AM, R8 is lying in bed with the head elevated. R8 did not have a call light within easy reach for her to call for assistance when needed. One call light was lying on the floor and the other was hooked to the privacy curtain between the beds. 4. R94's Face Sheet, admitted [DATE], documented R94 had diagnoses of but not limited to malignant neoplasm of brain, chronic obstructive pulmonary disease (COPD), and symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus. R94's MDS, dated [DATE], documented R94 is severely cognitively impaired with a BIMS of 06 out of 15 and requires substantial/maximal assistance with toileting hygiene, practical/minimal assistance with dressing, personal hygiene, supervision/touching assistance with walking 10 and 50 feet, and independent with bed mobility. He is occasionally incontinent of bladder and always continent of bowel. R94's Care Plan, admitted [DATE], documented R94 is at risk for falls and injuries related to (r/t) Medical Factors: Brain Cancer, Epilepsy, COPD, Emphysema, Interstitial Pulmonary Disease, Prediabetes, Chronic Kidney Disease Stage 3A, Hypertension, Hyperlipidemia, Low Back Pain, gastroesophageal reflux disease (GERD), and incontinence. Interventions include but are not limited to Keep call light within reach. On 01/26/25 at 10:24 AM, R94 was lying in his bed resting. His call light was not within easy reach for him to be able to call and ask for assistance if needed it was lying on the fall mat that was on the floor next to his bed. On 01/29/25 at 09:15 AM, V26 (Licensed Practical Nurse/Nurse Manager) stated most everyone on this hall can use their call light. She said R94 can use his light and R8 is blind so they hook her call light on her chest so she can find it, but she can use it. On 01/29/25 02:20 PM, V1 (Administrator) was asked what her expectations of the staff when it comes to residents having their call lights within easy reach? V1 said We follow our policy. The Facility's Meal Assistance policy, revised date of 02/17/20, documented Purpose: To provide guidance to facility staff on meal assistance and expectation. Policy: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation Dining Room Residents: 1. All residents will be encouraged to eat in the dining room. 2. Facility staff will serve resident trays and will help residents who require assistance with eating. 3. Resident who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. Not standing over residents while assisting them with meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's call light guidance policy, revised date of 08/20/22, documented Purpose: To provide guidance to all facility staff on the use, response and placement of call lights. It further documents Procedure: 2. A call light activation device shall be kept within resident reach while in resident rooms and bathrooms. The Facility's Resident Rights policy, revision date of 07/11/22, documented Purpose: To provide guidance to facility staff on resident rights. Policy: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence, b. be treated with respect, kindness, and dignity.

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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** 44967 Based on Interview, Observation, and Record Review, the Facility failed to provide feeding assistance to Activities of Daily Living (ADL) Dependent residents requiring feeding assistance for 4 of 8 residents (R11, R24, R37, R59) reviewed for feeding assistance in the sample of 44. The Findings Include: 1. On 1/26/25 at 11:45 AM, R24 was seen sitting at the dining room table with his lunch tray and was not touching his food. When asked about being the only staff member assisting residents, V6 (Certified Nursing Assistant/CNA) stated I usually have someone helping me but not sure where she is. R24 was just staring at his plate and did not pick up his fork to eat. V6 would see this and yell to R24, sitting at another table, to take a bite. R24's Care Plan, dated 11/8/24, documents R24 has Self-Care Deficit with Interventions: Eating - Setup help/Cueing required. R24's Minimum Data Set (MDS), dated [DATE], documents R24 has a moderate cognitive impairment and requires Supervision/Touching Assistance for eating. 2. On 1/26/25 at 11:45 AM, R59 was seen sitting at a dining room table with his lunch tray and was not touching his food. When asked about being the only staff member assisting residents, V6 (CNA) stated I usually have someone helping me but not sure where she is. At 12:00 PM, V5, CNA, came into the dining room and sat with R59 who immediately began eating once assisted. R59's Care Plan, dated 12/29/24, documents R59 has Self-Care Deficit with Interventions: Eating - One-person physical assist required. R59's MDS, dated [DATE], documents R59 has a severe cognitive impairment and requires substantial/maximal assistance from staff for eating. On 1/29/25 at 8:52 AM, V13 (CNA) stated that R24, R59, R65, and R93 all eat in the small dining room because they require feeding assistance and staff is supposed to be in there assisting them. 42108 3. R11's Care Plan, dated 1/29/2025, (R11) has Self-Care Deficit As Evidenced by: Needs assistance with ADLs Related to Dementia, Chronic Kidney Disease Stage 3A, Peripheral Vascular Disease, Atherosclerotic Heart Disease, Hypertension (HTN), Hypothyroidism, Hyperlipidemia, Anemia, History of Pulmonary Embolism, Anxiety, Depression, Insomnia, Low Back Pain, Cervical Spondylosis, Lumbar Spondylosis, Essential Tremor, Osteoarthritis, Neuromuscular Dysfunction of Bladder, Irritable Bowel Syndrome, GERD, and incontinence. Resident refuses medication at times. Resident refuses care at times. Resident prefers bed in high position. Resident refuses shower at times. Eating - Supervision required. [NAME] is at risk for altered nutrition and hydration related to diagnosis of Alzheimer's Disease, moderate protein-calorie malnutrition, CKD, Anemia, vitamin deficiency. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's MDS, dated [DATE], documents that R11 is cognitively impaired and requires supervision or touching assistance for eating. On 1/27/2025 from approximately at 8:30 AM observed R11 lying in bed. R11's breakfast tray was in front of R11 on the overbed table. A bowl of hot cereal with the lid on top, a ball of meat with gravy was on the tray untouched. The eggs were untouched and there was partially eaten toast. There was no staff present. On 1/27/2025 at approximately 8:40 AM when asked how the food was, R11 responded she guess it was fine. When asked about why the food was not eaten. R11 stated that she would like to eat more but she needed help. R11 stated that they come in and out but never stay. On 1/27/2025 at approximately 8:55 AM R11 lying in bed, eyes closed sleeping in the bed with the tray in front of her. No change in the food on the tray. V18 (CNA) entered the room and asked R11 if she was done. R11 opened her eyes and said yes. V18 removed the tray from room. On 1/29/2025 at 9:02 AM V2 (Director of Nursing) stated that she would address this with the staff and make sure that R11 is getting assistance with her meals. 4. R37's Care Plan, dated 11/19/2024, (R37) As Evidenced by: Needs assistance with ADLs Related to Morbid Obesity, Dementia, Chronic Kidney Disease Stage 3, Atherosclerotic Heart Disease, Hypertension, Atrial Fibrillation, Heart Failure, Presence of Cardiac Pacemaker, Peripheral Vascular Disease, Hyperlipidemia, Anemia, Major Depressive Disorder, Lymphedema, BPH, Flaccid Neuropathic Bladder, Obstructive Reflex Uropathy, and bowel incontinence. 2/25/2022 Eating - Independent required. R37's MDS, dated [DATE], documents that R37 is mildly cognitively impaired and requires set up or clean up assistance with meals. On 1/26/2025 at approximately 8:40 AM R37 was sitting in a chair in R37's room. R37's breakfast tray was in front of R37. R37's drink is covered. R37 was eating cereal with his hands. On 1/26/2025 at R37 stated that he doesn't get enough to eat. When asked why he is was eating with his hands R37, R37 stated that it is easier. On 1/29/2025 at 1:04 PM R37 was sitting in his room with the meal tray in front of him, in R37's reach. R37's bowls remained covered. R37 was not eating. On 1/29/2025 at 1:04 PM R37 stated that his hands are sore, and he can't close them enough to grasp the silverware. R37 stated that the plastic is hard for him to grasp, and he doesn't always eat his meal because he can't open everything. R37 stated that he has pain in his hands and the staff don't always help. (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 ADL Support policy, dated 5/2/23, documents Policy: Resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews, observations, and record reviews the facility failed to follow wound care orders for 1 out of 1, (R87), reviewed for quality of care in a sample of 44. Findings include: R87 was admitted to the facility on [DATE] with diagnosis of, in part, chronic multifocal osteomyelitis of left ankle/foot, cellulitis, type two diabetes mellitus with foot ulcer and neuropathy, peripheral vascular disease and acquired absence of right leg above knee. R87's Minimum Data Set (MDS) dated [DATE], documented he is cognitively intact, requires substantial/maximal assistance from staff for lower body dressing, and is dependent on staff assistance for putting on/taking off footwear. R87's care plan dated 12/30/25 documented R87 has diabetic ulcers to the left heel and left dorsal mid foot relate to diabetes and lack of sensation to affected area. R87's interventions for the ulcers are documented as follows: Enhanced Barrier Precautions (EBP), Observe/document wound: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene at least weekly, document progress in wound healing on an ongoing basis, notify medical doctor (MD) as indicated, observe/document/report as needed any signs/symptoms of infection: green drainage, foul odor, redness and swelling, red lines coming from the wound, excessive pain, fever, observe/document/report as needed changes in wound color, temp, sensation, pain, or presence of drainage and odor, and treatment as ordered. On 1/27/25 at 9:41 AM, R87's left foot dressing was not intact, the rolled gauze was dangling on the floor as he sat in his chair. The gauze is saturated with a moderate amount of yellow/serous fluid and does not have a date on it. R87 stated he is on intravenous antibiotics for his left foot wound infection currently. On 1/27/25 at 12:56 PM, V14 (Wound Care Nurse) went into R87's room to provide wound care. The old dressing continued to be not intact, the rolled gauze was dangling off R87's left foot and his heel wound saturated through all the layers of the gauze with a moderate to large amount of yellow drainage. V14 removed the entire old dressing which did not include bordered gauze or an abdominal pad. V14 stated the dressing should have include an elastic wrap which was also not in place. On 1/27/25 at 12:59 PM, V14 stated the nurses know the current wound care orders and know to apply an elastic wrap. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R87's orders dated 1/24/2025 at 7:19 PM and 7:21 PM documented the following, Cleanse left trans metatarsal amputation site with wound cleanser, normal saline or soap and water, pat dry. Apply skin barrier to peri-wound, allow to dry prior to application of primary or secondary dressing. Apply silver sulfadiazine, Collagen Hydrogel, Collagen Particles to wound bed, cover with calcium alginate sheet (cut to fit) and Bordered Gauze dressing. Secure with Rolled Gauze dressing and 4 elastic bandage. Change daily and as needed. Cleanse Left Heel with wound cleanser, normal saline or soap and water, pat dry. Apply skin barrier to peri-wound allow to dry prior to application of primary or secondary dressing. Apply silver sulfadiazine, Collagen Hydrogel, and Collagen Particles to wound bed, cover with Calcium Alginate sheet (cut to fit area), abdominal pad, and rolled gauze dressing. Wrap foot in 4 elastic bandage, transitioning to 6 elastic bandage as you wrap the remainder of the lower extremity. Daily and as needed. On 1/29/25 at 10:28 AM, V14 stated she expects staff to follow out wound care orders as written by the provider. On 1/29/25 at 3:00 PM, V1 stated the facility does not have a policy on treatment and care for diabetic ulcers.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on observations, interviews, and record reviews the facility failed to provide treatment and services to prevent and/or heal pressure ulcers for 1 out of 1 resident (R10) reviewed for treatment/services to prevent/heal pressure ulcers in a sample of 44. Findings include: R10 was readmitted to the facility on [DATE] from the hospital with diagnosis of, in part, surgical aftercare on the digestive system, calculus of bile duct with cholecystitis, biliary acute pancreatitis, acute and chronic respiratory failure, and transient cerebral ischemic attack. R10's Minimum Data Set (MDS) dated [DATE], documented she is moderately cognitively impaired, is depended on staff for toileting hygiene, lower body dressing, rolling left and right, siting to standing and all types of transfers. R10's MDS further documented she required partial/moderate assistance from staff for personal hygiene and required substantial/maximal assistance from staff with showering/bathing. R10's Care Plan dated 11/19/24 documented R10 has a self-care deficit as evidenced by needing assistance with activities of daily living (ADLs), including bathing requiring two-person physical assistance. R10's Care Plan further document she is at risk for pain and for staff to utilize the following interventions: in part, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, observe/document for probable cause of each pain episode, remove/limit causes where possible, observe/record/report to nurse resident complaints of pain or requests for pain treatment. R10's Care Plan also documented she is at risk for impaired skin integrity (resident refuses turning and repositioning at times), observe skin integrity during AM/PM care, notify medical doctor (MD) of skin breakdown, provide peri-care. R10's Care Plan continued to document she is incontinent of Bowel/Bladder and for nursing staff to report to MD abnormal symptoms or conditions; skin break-down, excoriation, rash, bladder pain, dysuria, urinary pain, retro-peritoneal pain, excessive or inadequate urinary output, or abnormal urine characteristics; color, odor, clarity, hematuria, Et cetera (etc.). On 1/29/25 a copy of R10's Care Plan dated 11/6/24 was requested and the facility provided a copy with the care plan for risk of impaired skin integrity revised 1/29/25 adding that the resident refuses any other treatment for redness other than petroleum based ointment and resident prefers to use wipes for peri-care, there was also a new section added for R10 having actual impairment to skin integrity of her buttocks and bilateral gluteal folds related to Moisture Associated Skin Damage (MASD). R10's Re-Admission assessment dated [DATE] at 6:20 PM, completed by V13 (Nurse Manager) documented R10 had pressure sores to her right and left buttock. R10's orders dated 1/12/25 at 12:52 PM, documented R10 to have a skin inspection/nursing weekly assessment completed on Sundays in the evening shift. No skin and wound assessment, measurements, or an initial treatment plan for pressure ulcers was completed on 1/13/25 after V13 (Nurse Manager) documented finding two areas of pressure sores. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/25 at 10:05 AM R10 stated the staff could change me more often. I'll put my call light on to be cleaned, they'll come quickly to shut it off then tell me they will be back soon to clean me up but not return for hours. R10 stated she feels like an inconvenience to staff when they miss my bed baths. Some staff will be rude and ask what I need now. On 1/27/25 at 4:01 PM, V21 (Licensed Practical Nurse/LPN) stated she was not aware of any reddened skin marks on R10's peri-region and was not told in report of any by the previous nurse. V21 stated a nurse will have to look at them but she had not seen them today yet. On 1/27/25 at 10:30 PM, R10's Orders documented the following: barrier cream to bilateral buttock every shift; as needed every shift for prophylactic and barrier cream to groin every shift every shift for prophylactic and every 8 hours as needed for prophylactic. On 1/27/25 at 1:25 PM V19 (Certified Nursing Assistant/CNA) and V20 (CNA) entered R10's room to perform peri-care. R10's old brief was saturated with urine and stool upon removal. While performing peri-care, reddened areas with open wounds resembling skin tears/macerations were present on R10's right inner thigh, left butt cheek, and posterior left thigh as well as bright red skin to R10's labia. Any time one of those reddened areas was wiped R10 would state owe while grimacing. V20 stated these marks have been there since she came back from the hospital and the nurses have been applying barrier cream to it, while the CNA's apply A&D ointment. V20 stated V20 was aware of the red marks on R10. V20 applied A&D ointment to all the reddened skin marks before completing care. No barrier cream was applied or in R10's active orders at this time. On 1/28/25 at 10:04 AM, R10 stated she was not doing so good today after them wiping my butt so many times; it was very painful, I'm sore. On 1/28/25 at 10:09 AM, V19 and V20 entered R10's room to provide peri-care after an incontinence episode of urine and stool. R10 stated my butt hurts, people don't care and don't do anything about it. R10 told V20 not to wipe so rough. R10 stated her pain was as 22 out of 10 on a pain scale. V19 and V20 proceeded to provide peri-care. V20 wiped R10's buttock and posterior thighs using up an entire package of wipes while R10 repeatedly yelled in pain with each wipe. V20 told V19 we will need another thing of wipes. V19 left to go get more wipes. V13 (CNA) returned with more wipes and V25 (Registered Nurse/RN) with barrier cream. V20 completed peri-care on R10's front region using three wipes per section, each wipe having R10 yell out in pain. V20 told R10 she was sorry but needed to get her cleaned up. V13 and V20 stated if a resident needs more time to finished completing a bowel movement, like R10 had been doing while V20 proceeded to wipe, they can offer a bedpan or put a brief on them and give them more time to finish. V19, V20, and V13 did not offer R10 more time to finish or a break from wiping. On 1/28/25 at 1:55 PM, R10 stated she is still in pain from being wiped, she is doing horrible. R10 stated the staff never offer her breaks if it is too painful for her while receiving peri-care. R10 stated she tells the aides she is in pain from them wiping her, but they tell her they need to get her cleaned. R10 stated they just started putting on that white barrier cream yesterday, before that it was the petroleum-based ointment the aides can apply but I've been complaining of pain down there for at least two weeks now. On 1/28/25 at 10:42 AM, V25 (RN) stated the orders for barrier cream started yesterday. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 8:09 AM, V26 (Nurse Manager) stated she remembered R10 came back from the hospital with the pressure sores on 1/12/25 for the left and right buttock. V26 stated when we find sores on a resident after returning from the hospital, the next steps we take are to put in place a treatment plan, notify the wound nurse to go make an assessment and then the wound nurse tells the nurse practitioner for orders. On 1/29/25 at 9:15 AM, V14 (Wound Nurse) stated she was not aware of any wounds on R10 after her return from the hospital. V14 stated she was notified of skin concerns on R10 yesterday and R10 has Moisture Associated Skin Damage (MASD). On 1/29/25 at 11:44 AM, V14 (Wound Care Nurse) documented R10's Braden Scale for Predicting Pressure Sore Risk was High Risk. On 1/29/25 at 2:10 PM, R10 had Skin Inspection Assessments completed on the following dates 1/14/25 and 1/19/25 after her return from the hospital and being scored a High Risk by V14 (Wound Care Nurse). On 1/29/25 at 10:28 AM, V1 (Administrator) stated she expects the Certified Nursing Assistants (CNAs) to report pain to other staff. The facility's Incontinence Care Policy dated 5/16/22 documented all incontinent residents will receive incontinence care in order to keep skin clean, dry and free of irritation and/or order. The policy continued to document procedure included inspection of the skin and report all irritated areas to charge nurse. The facility's Activities of Daily Living (ADL) Support Policy dated 5/2/23 documented residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy continued to document that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care) and elimination (toileting). The policy further documented care and services to prevent and/or minimize functional decline will include appropriate pain management. The resident's response to interventions will be documented, monitored, evaluated, and revised as appropriate. The facility's Pressure Ulcer Policy dated 8/31/23 documented nurses are to complete skin assessments daily on residents deemed High Risk for skin breakdown. The policy further documented when a pressure ulcer is identified, whether in house or upon a resident's admission, the area will be assessed using the skins and wound assessment, a skin inspection assessment shall be completed, and initial treatment started per physician's orders. Daily skin checks shall be initiated on residents with a pressure wound to provide increased monitoring from nursing staff. The policy also documented it is the responsibility of the charge nurse/designee to measure and document on the pressure areas weekly. The facility's Non-pressure Skin Impairment Policy dated 1/3/23 documented it is the responsibility of the nursing department to ensure non-pressure skin impairments are identified and progress is tracked as required.

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Cedar Ridge Health & Rehab Ctr	One Perryman Street Lebanon, IL 62254

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on observation, interview, and record review the facility failed to supervise a resident with cigarettes, safely transfer residents using a mechanical lift, and implement fall interventions for 4 of 5 (R3, R41, R68, R94) residents reviewed for supervision. Findings include: 1. R41's Care Plan, dated 12/17/2024, documents that (R41) has Self-Care Deficit As Evidenced by: Needs assistance with ADLs Related to Parkinson's, chronic obstructive pulmonary disease (COPD), Chronic Respiratory Failure, Asthma, Interstitial Pulmonary Disease, Pulmonary Hypertension, Obstructive Sleep Apnea, Diabetes, end stage renal disease (ESRD), Hypertension, Congestive Heart Failure, Peripheral Vascular Disease, Hyperlipidemia, Anemia, Hypothyroidism, gastroesophageal reflux disease (GERD), Constipation, Convulsions, Morbid Obesity, Neuropathy, Gout, Arthritis, Left Above Knee Amputation, Right Below Knee Amputation, Low Back Pain, and incontinence. Transfer: Two-person physical assistance required Transfer: Mechanical Lift required, Transfer - uses adaptive devices mechanical Lift. R41's Minimum Data Set (MDS), dated [DATE], documents that R41 is cognitively intact and dependent on staff for transfers. On 1/27/2025 at approximately 10:20 AM observed V17 (Certified Nursing Assistant/CNA) and V18 (CNA) transfer R41 from the bed to the chair using a mechanical lift. V17 and V18 applied the lift pad and applied the hooks to the lift. V18 then started manually pumping the lift using the handle. V18 attempted to pull the lift from the bed and met resistance. V18 was not able to clear R41 from the bed. V17 then lowered the bed and wheels became stuck under the bed. V18 then pulled the lift with force from the bed causing R41 to swing freely in the lift. V18 at the control and V17 standing behind the wheelchair. V18 then attempted to move R41 in the lift and met resistance allowing R41 to swing freely in the lift. V17 then brought wheelchair to the lift and leaned it back with front wheels off the floor. V18 then lowered R41 into the wheelchair. On 1/29/2025 at approximately 9:30 AM R41 stated that she does not like being transferred with the lift that was used on her. R41 stated that she doesn't feel safe. R41 stated that she feels like she is going to fall. 2. R68's Care Plan, dated 11/25/2024, (R68) has Self-Care Deficit As Evidenced by: Needs assistance with Activities of Daily Living (ADLs) Related to Dementia, COPD, Peripheral Vascular Disease, Atherosclerotic Heart Disease, Bradycardia, Hypertension (HTN), Paroxysmal Atrial Fibrillation, Presence of Cardiac Pacemaker, Major Depressive Disorder, Anxiety, Hyperlipidemia, GERD, Anemia, Insomnia, Hypothyroidism, Constipation, R68's MDS, dated [DATE], documents that R41 is mildly cognitively impaired and requires substantial/maximal assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/2025 at 9:50 AM observed V17 (CNA) and V18 (CNA) perform incontinent care. Upon completion of incontinent care V17 and V18 transferred R68 from the bed to the chair using a mechanical lift. V17 and V18 applied the lift pad and applied the hooks to the lift. V18 then started manually pumping the lift using the handle. V18 standing at front of lift next to controls and V17 standing behind the chair. V18 pulled the lift from over the bed and to the middle of room. V18 then placed the wheelchair beneath the lift and V18 lowered R68 into the chair. During transfer staff was not in contact with R68 allowing her to swing freely in the sling. 44556 3. R94's Face Sheet, admitted [DATE], documented R94 had diagnoses of but not limited to malignant neoplasm of brain, COPD, and symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus. R94's MDS, dated [DATE], documented R94 is severely cognitively impaired with a Brief Interview for Mental Status (BIMS) of 06 out of 15 and requires substantial/maximal assistance with toileting hygiene, practical/minimal assistance with dressing, personal hygiene, supervision/touching assistance with walking 10 and 50 feet, and independent with bed mobility. He is occasionally incontinent of bladder and always continent of bowel. R94's Care Plan, admitted [DATE], documented R94 is at risk for falls and injuries related to (r/t) Medical Factors: Brain Cancer, Epilepsy, COPD, Emphysema, Interstitial Pulmonary Disease, Prediabetes, Chronic Kidney Disease Stage 3A, Hypertension, Hyperlipidemia, Low Back Pain, GERD, and incontinence. Interventions include but are not limited to Keep call light within reach. R94's Fall Risk Assessment, dated 01/07/25, documented R94 was a high fall risk. On 01/26/25 at 10:24 AM, R94 was lying in his bed resting. His call light was not within easy reach for him to be able to call and ask for assistance if needed. The call light was lying on the fall mat that was on the floor next to his bed. On 01/29/25 at 09:15 AM, V26 (Licensed Practical Nurse/LPN/Nurse Manager) stated most everyone on this hall can use their call light. She said R94 can use his light. On 01/29/25 02:20 PM, V1 (Administrator) was asked what her expectations of the staff when it comes to care plan interventions being in place? V1 stated We follow our policy. 44967 4. R3's Admission Record, dated 1/27/25, documents R3 was originally admitted to the facility on [DATE] with diagnosis of Cerebral Infarction with Hemiplegia/Hemiparesis affecting right dominant side, Aphasia, HTN, Heart Failure, Epilepsy, Anemia, Occlusion and Stenosis of left carotid artery, Osteoarthritis of knees, Intervertebral disc displacement lumbar, Contracture of right upper arm, Major Depressive disorder, and Right Above Knee Amputation (AKA). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Care Plan, dated 1/16/24: documents R3 has a history of smoking in his room. Interventions: R3 will be reminded of smoking times, R3 will be reminded appropriate smoking areas per smoking policy. 1/15/24: R3 is a smoker. At times is non-compliant with smoking policy. Resident refuses at times to wear coat when going outside to smoke on cold days. Interventions: Instruct resident about smoking risks and hazards and about smoking cessation aids that are available, instruct resident about the facility policy on smoking: locations, times, safety concerns, monitor oral hygiene, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, observe clothing and skin for signs of cigarette burns, the resident can smoke unsupervised. R3's MDS, dated [DATE], documents R3 has a moderate cognitive impairment and requires substantial/maximal assistance for chair to bed transfer, and is independent on transporting himself with his wheelchair. On 1/26/25 at 10:48 AM, R3 was seen sitting in his electric wheelchair with a cigarette package in his shirt pocket along with a lighter. R3 stated he goes out to smoke on the patio when it's time, and he carries his own cigarettes and lighter with him. R3 stated normally, there is not a staff member outside with him. On 1/26/25 at 1:05 PM, R3 seen going outside to smoke with cigarettes and lighter in his shirt pocket and obtained a cigarette from his shirt and lighted his own cigarette. On 1/27/25 at 9:20 AM, R3 went from the dining room to his room to obtain his cigarettes and lighter. R3 was then seen wheeling himself out to smoke and then lit his own cigarette. There were two staff members outside smoking by the door and was not near R3. On 1/27/25 at 9:25 AM, the other two staff members seen outside smoking came inside and left R3 outside by himself smoking. On 1/27/25 at 9:45 AM, R3 came back inside and to his room. On 1/29/25 at 10:35 AM, V27 (CNA) stated No resident should have their cigarettes or lighter with them. When they go out to smoke, the staff outside with them will give them one. On 1/29/25 at 10:40 AM, V28 (Activity Director) stated The residents are not allowed to have their own cigarettes or lighters. The staff member that goes outside with the residents will give them a cigarette and light it for them. We are constantly taking cigarettes and lighters from (R3) and I just took his away yesterday. His sister visits him and will bring him more. The Facility's Smoking Policy, dated 11/2019, documents This facility will comply with all state and local smoking regulations. Compliance will include recognition of a person's right to use nicotine materials and the facility taking responsibility to provide an area for smoking and providing everyone's safety. All residents who smoke will be assessed to determine safety risk. The facility has the right to establish smoking times and to control the distribution of all smoking materials. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Using a Mechanical Level II Policy, dated 11/1/23, documents in part The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. 1. At least two nursing assistants are needed to safely move a resident with a mechanical lift. Steps in the Procedure: 7. Make sure the lift is stable and locked. 9. Double check the sling and machine's weight limits against the resident's weight. 12.c. Before resident is lifted, double check the security of the sling attachment. e. Check the stability of the straps. 13. Lift the resident two inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution. 16. Gently support the resident as he or she is moved, but do not support any weight. The Facility's Transfer Policy, dated 5/19/22, documents To promote safe transfer for the residents, as well as the staff. Gait belts, Mechanical lifts, and/or sit to stand lifts will be used, unless otherwise specified. Procedure: 3. A minimum of two staff members is recommended when transferring with a Mechanical lift. 4. When using a Mechanical lift, pay close attention to be sure that the Mechanical lift sling is properly positioned and that the straps are securely in the strap holders. The Facility's Fall Prevention Program/Protocol, revised date of 09/06/23, Purpose: To provide guidance to facility staff regarding the prevention/limitation of falls within the facility. Responsibility: It is the responsibility of the Director of Nursing and /or designee to ensure all staff are aware of the elements of the program. It further documents Early Prevention and Fall Risk detection. 4. Guardian Angel Rounds shall be completed at least daily to ensure fall interventions remain in place.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on observation, interview, and record review the facility failed to do timely and complete incontinent care for 4 of 5 residents (R39, R41, R68, R79) reviewed for incontinent care in a sample size of 44. The Findings Include: 1. R79's Admission Record, dated 1/27/25, documents R79 was originally admitted to the facility on [DATE] with diagnosis of Bipolar disorder, Depression, Hallucinations, Traumatic Brain Injury, Pancytopenia, Type 2 Diabetic Mellitus (DM), Thrombocytopenia, Urinary incontinence, Hydrocephalus, COVID, and Urinary Tract Infections (UTIs). R79's Care Plan, dated 1/30/24, documents R79 is incontinent of Bowel/Bladder. Interventions: Observe and record bowel and bladder pattern each shift, clean peri-area with each incontinence episode. It continues R79 has Self-Care Deficit as evidenced by: Needs assistance with Activities of Daily Living (ADLs) related to TBI, Obstructive Sleep Apnea, Diabetes, Tachycardia, Hallucinations, Bipolar Disorder, Depression, Pancytopenia, Thrombocytopenia, and Incontinence. Interventions: Care in pairs at all times, toilet Use - one-person physical assist required, transfer: One-person physical assistance required. R79's Minimum Data Set (MDS), dated [DATE], documents R79 has a moderate cognitive impairment and requires partial/moderate assistance from staff for Activities of Daily Living (ADLs). R79 is frequently incontinent of both bowel and bladder. On 1/26/25 at 8:55 AM, R79 was seen being assisted out of the restroom by V5 (Certified Nursing Assistant/CNA). R79's front of his pants were saturated in urine. V5 left R79 is his wet pants and pulled the bedside table over in front of his wheelchair and prepared his breakfast tray for him. V5 had a clean pair of pants she pulled out and laid on his bed but did not change R79's pants prior to breakfast. 2. R39's Admission Record, dated 1/27/25, documents R39 was originally admitted to the facility on [DATE] with diagnosis of Dementia, Cirrhosis of Liver, Type 2 DM, Spondylopathies, Chronic Kidney Disease, Hypertension (HTN), Polyneuropathy, Obstructive and reflux uropathy, Calculus of Ureter, Neuralgia/Neuritis, Polyosteoarthritis, Spinal stenosis lumbar, Major Depressive Disorder, COVID, and anxiety disorder. R39's Care Plan, dated 1/20/25, documents R39 has Self-Care Deficit. Interventions: Toilet Use: Two-person physical assistance required, Transfer: Two-person physical assistance required with Mechanical Lift required. It continues R39 is incontinent of Bowel. Interventions: Observe/document/report PRN (as needed) any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri-area with each incontinence episode. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39's MDS, dated [DATE], documents R39 has a severe cognitive impairment and is dependent on staff for toileting, dressing, and transfers. R39 is always incontinent of urine and occasionally incontinent of bowel. On 1/27/25 at 10:04 AM, V12 (CNA) and V13 (CNA) was seen in R39's room to provide peri-care. R39's brief was unfastened and tucked between her legs. V13 wiped R39's left groin once, her right groin once, and once down the middle of R39's vagina. R39 was rolled to her left side and the brief was tucked under her. V13 wiped R39's anal area. V13 put barrier cream on R39's buttock and anal area. R39 was rolled to her right and a clean brief was pulled up and between her legs. R39 was rolled to her back and the brief fastened. There was no wiping of R39's buttocks, esp. her left buttock and hip while R39 was turned on her right side. There was no wiping of R39's abdominal fold just above the pubic area, and no drying of R39. On 1/29/25 at 9:10 AM, V2 (Director of Nursing/DON), stated I would expect the staff to perform complete and timely incontinent care including cleaning all areas of the resident. 42108 3. R41's Care Plan, dated 6/5/24, (R41) is incontinent of Bowel/Bladder. Clean peri-area with each incontinence episode. R41's MDS, dated [DATE], documents that R41 is frequently incontinent of bowel. On 1/27/2025 at approximately 10:20 AM V17 (CNA) and V18 (CNA) performed incontinent care. R41 was incontinent of urine. V17 wet wash cloth with soap and washed beneath R41's arm and breast. V18 then opened R41's brief revealing soft stool. V18 then wiped R41's vaginal area with up and down motion V18 then cleansed buttocks using back and forth motion and then applied clean brief. V18 did not clean all soiled areas and apply skin protective skin lubricant. 4. R68's Care Plan, dated 08/08/2024, documents that (R68) is incontinent of Bowel/Bladder. It continues, clean peri-area with each incontinence episode. R68's MDS, dated [DATE], documents that R68 is always mildly cognitively impaired, always incontinent of urine and frequently incontinent of bowel, and dependent on staff for toileting. On 1/27/2025 at 9:50 AM observed V18 (CNA) perform incontinent care. R68 was incontinent of urine and bowel. V18 applied soap to a wet towel. V18 then opened R68's incontinent brief that was soiled with urine and stool. V18 then washed R68's neck and breast. With same towel washed R68's vaginal area with one wipe. V18 then turned R68 on her side. Using the same towel V18 wiped R68's buttocks with a back-and-forth motion. V18 did not cleanse R68's inner or back thighs. V18 then applied R68's clean brief. V18 did not clean all soiled areas and apply skin protective skin lubricant. The facility's Incontinence Care Policy, dated 5/16/2022, documents All incontinent residents will receive incontinence care in order to keep skin clean, dry, and free of irritation and/or odor. Incontinence care will be provide as required. Procedure: Wash all soiled skin areas and dry very well, especially between skin folds. Apply skin protective skin lubricant and rub well into skin.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interview, observation, and record review the facility failed to provide effective pain management for 1 (R10) out of 1 resident reviewed for pain in the sample of 44. This failure resulted in R10 experiencing ongoing pain during peri-care as evidence by visual and audible reports of pain expressed. Findings include: R10 was readmitted to the facility on [DATE] from the hospital with diagnosis of, in part, surgical aftercare on the digestive system, calculus of bile duct with cholecystitis, biliary acute pancreatitis, acute and chronic respiratory failure, and transient cerebral ischemic attack. R10's Minimum Data Set (MDS) dated [DATE], documented she is moderately cognitively impaired, is depended on staff for toileting hygiene, lower body dressing, rolling left and right, siting to standing and all types of transfers. R10's MDS further documented she required partial/moderate assistance from staff for personal hygiene and required substantial/maximal assistance from staff with showering/bathing. R10's Care Plan dated 11/19/24 documented R10 has a self-care deficit as evidenced by needing assistance with activities of daily living (ADLs), including bathing requiring two-person physical assistance. R10's Care Plan further document she is at risk for pain and for staff to utilize the following interventions: in part, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, observe/document for probable cause of each pain episode, remove/limit causes where possible, observe/record/report to nurse resident complaints of pain or requests for pain treatment. R10's Care Plan continued to document she is incontinent of Bowel/Bladder and for nursing staff to report to MD abnormal symptoms or conditions; skin break-down, excoriation, rash, bladder pain, dysuria, urinary pain, retro-peritoneal pain, excessive or inadequate urinary output, or abnormal urine characteristics; color, odor, clarity, hematuria, Et cetera (etc.). On 1/27/25 at 4:01 PM, V21 (Licensed Practical Nurse/LPN) stated she was not aware of any reddened skin marks on R10's peri-region and was not told in report of any by the previous nurse. V21 stated a nurse will have to look at them but she had not seen them today yet. No pain score was documented for R10 on 1/27/25. On 1/27/25 at 1:25 PM V19 (Certified Nursing Assistant/CNA) and V20 (CNA) entered R10's room to perform peri-care. R10's old brief was saturated with urine and stool upon removal. While performing peri-care, reddened areas with open wounds resembling skin tears/macerations were present on R10's right inner thigh, left butt cheek, and posterior left thigh as well as bright red skin to R10's labia. Any time one of those reddened areas was wiped R10 would cry owe while grimacing. V20 stated these marks have been there since she came back from the hospital and the nurses have been applying barrier cream to it, while the CNA's apply petroleum-based ointment. V20 stated V21 was aware of the red marks on R10. V20 applied petroleum-based ointment to all the reddened skin marks before completing care. No barrier cream was applied or in R10's active orders at this time. V19 and V20 completed peri-care at 2:10 PM on R10 on 1/27/25. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R10's Pain Scores did not have a score completed on 1/27/25. R10 had stated during peri-care on 1/27/25 while V19 and V20 were present, it was hurting her, and she yelled owe with each wipe while grimacing. On 1/28/25 at 10:09 AM, V19 and V20 entered R10's room to provide peri-care after an incontinence episode. R10 stated my butt hurts, people don't care and don't do anything about it. R10 told V20 not to wipe so rough. R10 stated her pain was as 22 out of 10 on a pain scale. V19 and V20 proceeded to provide peri-care. V20 wiped R10's buttock and posterior thighs using up an entire package of wipes while R10 repeatedly yelled in pain with each wipe. V20 told V19 we will need another thing of wipes. V19 left to go get more wipes. V13 (CNA) returned with more wipes and V25 (Registered Nurse) with barrier cream. V20 completed peri-care on R10's front region using three wipes per section, each wipe having R10 yell out in pain. R10 stated it hurts, it hurts so much. V20 told R10 she was sorry but needed to get her cleaned up. V13 and V20 stated if a resident needs more time to finished completing a bowel movement, like R10 had been doing while V20 proceeded to wipe, they can offer a bedpan or put a brief on them and give them more time to finish. V19, V20, and V13 did not offer R10 more time to finish or a break from wiping nor any other pain-relieving alternative throughout peri-care. On 1/28/25 at 10:04 AM, R10 stated she was not doing so good today after them wiping my butt so many times; it was very painful, I'm sore. On 1/28/25 at 1:55 PM, R10 stated she is still in pain from being wiped, she is doing horrible. R10 stated the staff never offer her breaks if it is too painful for her while receiving peri-care. R10 stated she tells the aides she is in pain from them wiping her, but they tell her they need to get her cleaned. R10 stated they just started putting on that white barrier cream yesterday, before that it was the petroleum-based ointment the aides can apply but I've been complaining of pain down there for at least two weeks now. On 1/29/25 at 10:28 AM, V1 (Administrator) stated she expects the Certified Nursing Assistants to report pain to other staff. The facility's Activities of Daily Living (ADL) Support Policy dated 5/2/23 documented care and services to prevent and/or minimize functional decline will include appropriate pain management. The resident's response to interventions will be documented, monitored, evaluated, and revised as appropriate. The facility's Management of Pain Policy dated 5/16/22 documented our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. The policy further documented they will achieve these goals through providing, in part, promptly and accurately assessing and diagnosing pain, encouraging residents to self-report pain, monitoring treatment efficacy and side effects, preventing and minimizing anticipated pain when possible, using non-pharmacological and complementary and alternative medicine when appropriate, and using pain medication judiciously to balance the resident's desired level of pain relief with the avoidance of unacceptable adverse consequences.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Health & Rehab Ctr	One Perryman Street Lebanon, IL 62254

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 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** 44556 Based on interview and record review the facility failed to ensure a resident is free from significant medication errors for 1 or 5 residents (R89) reviewed for medications in a sample of 44. Findings Include: R89's Face Sheet, original admitted [DATE], documented R89 has diagnoses of but not limited to infection following a procedure, deep incisional surgical site, subsequent encounter, and local infection to the skin and subcutaneous tissue. R89's Minimum Data Set (MDS), dated [DATE], documented R89 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 14 out of 15 and is dependent on staff for transferring from bed to chair, chair to bed, and toileting transfer. R89's Care Plan, admitted [DATE], documented R89 is at risk for complications related to (r/t) a wound infection and requires antibiotics. Interventions include but not limited to Administer antibiotic as per medical doctor (MD) orders. Follow facility policy and procedures for line listing, summarizing, and reporting infections. R89's Wound culture, dated 12/17/2024 from the hospital documented R89's wound had the following organisms 1. Esherichia Coli, 2. Enterococcus Faecalis, 3. Proteus Mirabilis. R89's Physician's Orders, dated 12/26/24, documented R89 was ordered Ceftriaxone Sodium injection reconstituted 2 grams (GM), use 2000 milligrams (mg) intravenously one time a day for wound infection. R89's Physician's Orders, dated 12//27/24, documented Vancomycin HCl Intravenous Solution 1000 milligrams (MG)/200 milliliters (M)L (Vancomycin HCl) Use 1000 mg intravenously every 12 hours for infection, and a weekly vancomycin trough on Tuesday. R89's Medication Administration Record (MAR) for the month of December 2024 was reviewed and had no documentation on 12/29/24 that R89 had her Ceftriaxone IV antibiotic. There was no documentation on 12/28/24 and 12/29/24 that R89 received her Vancomycin IV antibiotic. R89's MAR for the month of January 2025 was reviewed and had no documentation R89 received her Ceftriaxone IV antibiotic on 01/09/25, 01/11, 01/12, 01/17, 01/18, 01/19, 01/21, 01/25, and 01/26/25. There was also no documentation R89 received her Vancomycin IV antibiotic on day shift on 01/09/25, 01/11, 01/12, 01/17, 01/18, 01/19, and 01/26/25. On 01/29/25 at 09:02 AM, V2 (Director of Nursing) brought in documents for this surveyor to review regarding R89's missed doses of IV antibiotics. She said she did education with nurses, and they are filling them now. The documents were reviewed and documented R89 received the evening dose of her IV antibiotics but there was no documentation R89 received the morning doses. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at 01:25 PM, V29 (Pharmacist) said she would consider seven missed does of 9 doses of Ceftriaxone and 7 doses of Vancomycin is a significant medication error. She said that is a lot of missed doses. V29 said it could affect R89 by causing the infection to take longer to get rid of and it could cause the infection to even get worse depending how bad the infection was. The Facility's Medication Administration Policy/Procedure, revised date of 09/27/22, documented Policy Medications will be administered safely to residents within the facility by licensed nurses at the specified time/time frame, following the recommended administration method and will be documented as required. It further documented 12. Chart the medication administered on the electronic medication administration record.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews, observations, and record reviews the facility failed to serve food with an appetizing appearance and taste for 7 out of 7 residents, (R61, R10, R15, R2, R87, R53), reviewed for Nutritive Value/Appearance, Palatable/Preferred Temperature in a sample of 44. Findings include: 1.R61's Minimum Data Set (MDS) dated [DATE] documented she is cognitively intact. 1/26/25 at 9:35 AM R61 stated the food here is nasty, so I buy my own food to eat and have a refrigerator to keep it in. 2.R10's MDS dated [DATE] documented she is moderately cognitively impaired. 1/26/25 at 10:05 AM R10 stated the food is not good. 3.R15's MDS dated [DATE] documented she is cognitively intact. 1/26/25 at 10:11 AM R15 stated the food is not good and doesn't taste good, so I buy my own food and keep it in my personal refrigerator. 4.R2's MDS dated [DATE] documented he is cognitively intact. 1/26/25 at 9:30 AM R2 stated the food is grubby and doesn't look appetizing. 5.R87's MDS dated [DATE] documented he is cognitively intact. 1/26/25 at 9:32 AM R87 stated the food is bad and not appealing. Resident Council Meeting Minutes dated 10/16/24 documented under dietary that the meat cooked the other day was tough. Resident Council Meeting Minutes for the month of September 2024 documented under dietary that the dinner was not fresh. On 1/28/25 at 11:30 AM, the menu for lunch 1/28/25 was Stuffed bell pepper, buttered corn, sherbet, and beverage. On 1/28/25 at 12:22, a sample tray was tested by this surveyor with the following concerns, the stuffed pepper was broken up (not intact) with the meat separated from the pepper and the sauce spread over both, the buttered corn was bland. On 1/29/25 at 10:28 AM, V1 (Administrator) stated she expects her dietary department to follow recipes according to the menu. The facility's Food and Nutrition Services Manual dated 9/1/21 documented food will be prepared by methods that conserve nutritive value, flavor, and appearance; food will be palatable, attractive, and served at a safe and appetizing temperature; food and liquids are prepared and served in a manner, form, and texture to meet resident's needs. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42108 6. R53's MDS, dated [DATE], documents that R53 is cognitively intact. On 1/27/2025 at 9:05 AM observed R53 lying in bed with plate in front of R53. A partially eaten black circular meat observed on plate. R53 hit sausage against plate an audible taping was heard. On 1/27/2025 at 9:05 AM R53 stated that the breakfast does not taste well. R53 stated that the meat is tough and hard to chew. R53 stated that he could not eat it because of how hard it was. R53 stated see and held sausage in the air. R53 stated Watch this and hit sausage on plate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on observation, interview, and record review, the facility failed to perform hand hygiene and glove changes for 6 of 7 residents (R9, R27, R41, R65, R68, R93) reviewed for hand hygiene in the sample of 44. The Findings Include: 1. On 1/26/25 11:45 AM, V6 (Restorative Certified Nursing Assistant/CNA) was seen standing between R65 and R93 at a dining room table. V6 stood and used her right hand to feed R93, then used her left hand to feed R65. There was no hand hygiene seen done prior to or between assisting the residents. R65's Care Plan, dated 1/23/25, documents R65 has a Self-Care Deficit with Interventions: Take to dining room for meals, Eating - Setup help/Cueing required. R65's Minimum Data Set (MDS), dated [DATE], documents R65 is cognitively intact and is dependent on staff for eating. 2. R93's Care Plan, dated 11/4/24, documents R93 has Self-Care Deficit with Interventions: Eating - Independent required. R93's MDS, dated [DATE], documents R93 has a severe cognitive impairment and required partial/moderate staff assistance for eating. 3. On 1/26/25 at 9:15 AM, V7 (Registered Nurse/RN) was seen passing meds to residents on C-hall. Hand Hygiene was not seen performed between residents. V7 was seen popping out pills from a medication card for R27, with a pill falling onto the medication cart, V7 picked up the pill with her bare hands, put it in a medicine cup, then gave them to R27. There was no hand hygiene seen done. 4. On 1/26/25 at 9:25 AM, V7 was also seen putting medications into a medicine cup, and while picking up the medicine cup to take to R9, there was a random pill lying on the medication cart next to the medicine cup. V7 went through the cup to find out which pill was missing, noted it was a Multivitamin (MVI), and got another MVI pill from the bottle and put into the medication cup with her bare hands, then walked the medications into R9's room to administer them. There was no hand hygiene seen done. 42108 5. R68's Care Plan, dated 08/08/2024, documents that (R68) is incontinent of Bowel/Bladder. It continues, clean peri-area with each incontinence episode. R68's MDS, dated [DATE], documents that R68 is always mildly cognitively impaired, incontinent of urine and frequently incontinent of bowel, dependent on staff for toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/2025 at 9:50 AM observed V17(Certified Nursing Assistant/CNA) and V18 (CNA) perform incontinent care. R68 was incontinent of urine and bowel. V18 applied gloves and applied soap to a wet towel. V18 then opened R68's incontinent brief that was soiled with urine and stool. V18 then washed R68's neck and breast. With same towel washed R68's vaginal area with one wipe. V18 then turned R68 on her side. Using the same towel. Using the same soiled gloves V18 applied R68's then applied R68's clean brief, pants, bra, and shirt. V18 then removed the soiled gloves. The facility's Incontinent Care Policy, dated 5/16/2022, documents Procedure 5. perform hand hygiene, apply gloves. 8. Wash all soiled skin areas and dry very well, especially between skin folds; changing gloves and performing hand hygiene as required to prevent cross-contamination. 12 perform hand hygiene. 15. hand hygiene. The facility's Medication Administration Policy/Procedure, dated 9/27/2022, documents Oral Medications: 7. Do not touch the medication with your hands.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108 Based on interview and record review the facility failed to confirm the need for an antibiotic and failed to ensure a resident received all doses of the antibiotic(s) as ordered for 5 of 5 (R34, R39, R85, R89, R95) residents reviewed for the antibiotic stewardship program in the sample of 44. Findings include: 1. On 1/26/2025 the facility provided a document, not labeled, and not dated, listing Resident Name, DOB (date of Birth), Onset Date, Infection, and organism. On 1/28/2025 at approximately 2:00 PM V24 (Infection Preventionist) stated that this was the tracking tool used for infections and antibiotic usage. V24 stated that she was not sure what infection R39 had. The Facility's Infection Control Log, not dated, documents that R39 had an unknown infection starting 12/13/2024. The infection control log does not document if R39 received antibiotics, the residents medical record number, unit and room number, adverse effects, and outcomes. A review of R39's medical record was performed. No documentation of culture results in medical record. R39's Physician Order Sheet POS, dated December 2024, documents 12/13/2024 Linezolid Tablet 600 MG Give 1 tablet by mouth every 12 hours for Infection for 8 Administrations. R39's Medication Administration Record (MAR) dated December 2024 documents R39 received this antibiotic. 2. On 1/26/2025 the facility provided a document listing Resident Name, DOB, Onset Date, Infection, and organism. On 1/28/2025 at approximately 2:00 PM V24 (Infection Preventionist) stated that this was the tracking tool used for infections and antibiotic usage. V24 stated that she was not sure what infection R85 had and why she was on antibiotics. V24 stated that she thinks it was COVID. The Unlabeled, not dated, list provided by the facility, documents that R85 had an unknown infection starting 12/17/2024. No organism listed. The infection control log does not document if R85 received antibiotics. A review of R85's medical record was performed. No documentation of culture results in medical record. R85's POS, dated December 2024, documents 12/17/2024 Cefdinir Capsule 300 MG Give 1 capsule by mouth two times a day for infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R85's Medication Administration Record (MAR) dated December 2024 documents R85 received this antibiotic. 3. On 1/26/2025 the facility provided a document listing Resident Name, DOB, Onset Date, Infection, and organism. The document is untitled and not dated. On 1/28/2025 at approximately 2:00 PM V24 (Infection Preventionist) stated that this was the tracking tool used for infections and antibiotic usage. The Unlabeled, not dated, list provided by the facility, documents that R95 had a Urinary Tract Infection starting 12/10/2024. No organism listed. The infection control log does not document R95's antibiotics. A review of R95's medical record was performed. No documentation of culture results in medical record. R95's POS, dated December 2024, documents 12/10/2024 Amoxicillin Oral Tablet 500 MG (Amoxicillin) Give 1 tablet by mouth two times a day for UTI for 2 Days R95's Medication Administration Record (MAR), dated December 2024, documents R95 received this antibiotic. 4. On 1/26/2025 the facility provided an unlabeled and not dated, document listing Resident Name, DOB, Onset Date, Infection, and organism. On 1/28/2025 at approximately 2:00 PM V24 (Infection Preventionist) stated that this was the tracking tool used for infections and antibiotic usage. The Unlabeled, not dated, list provided by the facility, documents that R34 had an unknown infection starting 12/25/2024. No organism listed. The infection control log does not document if R34 received antibiotics. R34's Physician's Order Sheet (POS), dated December 2024, documents 12/25/2024 Azithromycin Tablet 250 MG Give 500 mg by mouth in the morning for INFECTION for 1 Day. 12/27/2024 Azithromycin Tablet 250 MG Give 1 tablet by mouth one time a day for bacterial infection for 4 Days. R34's Medication Administration Record (MAR) dated December 2024 documents R34 received this antibiotic. 44556 5. R89's Face Sheet, original admitted [DATE], documented R89 has diagnoses of but not limited to infection following a procedure, deep incisional surgical site, subsequent encounter, and local infection to the skin and subcutaneous tissue. R89's MDS, dated [DATE], documented R89 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 14 out of 15 and is dependent on staff for transferring from bed to chair, chair to bed, and toileting transfer. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R89's Care Plan, admitted [DATE], documented R89 is at risk for complications related to (r/t) a wound infection and requires antibiotics. Interventions include but not limited to Administer antibiotic as per medical doctor (MD) orders. Follow facility policy and procedures for line listing, summarizing, and reporting infections. R89's Wound culture, dated 12/17/2024 from the hospital documented R89's wound had the following organisms 1. Esherichia Coli, 2. Enterococcus Faecalis, 3. Proteus Mirabilis. R89's Physician's Orders, dated 12/26/24, documented R89 was ordered Ceftriaxone Sodium injection reconstituted 2 grams (GM), use 2000 milligrams (mg) intravenously one time a day for wound infection. R89's Physician's Orders, dated 12//27/24, documented Vancomycin HCl Intravenous Solution 1000 milligrams (MG)/200 milliliters (M)L (Vancomycin HCl) Use 1000 mg intravenously every 12 hours for infection, and a weekly vancomycin trough on Tuesday. R89's MAR for the month of December 2024 was reviewed and had no documentation on 12/29/24 that R89 had her Ceftriaxone IV antibiotic. There was no documentation on 12/28/24 and 12/29/24 that R89 received her Vancomycin IV antibiotic. R89's MAR for the month of January 2025 was reviewed and had no documentation R89 received her Ceftriaxone IV antibiotic on 01/09/25, 01/11, 01/12, 01/17, 01/18, 01/19, 01/21, 01/25, and 01/26/25. There was also no documentation R89 received her Vancomycin IV antibiotic on day shift on 01/09/25, 01/11, 01/12, 01/17, 01/18, 01/19, and 01/26/25. On 1/26/2025 the facility provided an unlabeled and not dated, document listing Resident Name, DOB, Onset Date, Infection, and organism. R89's name, DOB, Onset Date, Infection, or organism was on this list. On 01/29/25 at 09:02 AM, V2 (Director of Nursing) brought in documents for this surveyor to review regarding R89's missed doses of IV antibiotics. She said she did education with nurses, and they are filling them now. The documents were reviewed and documented R89 received the evening dose of her IV antibiotics but there was no documentation R89 received the morning doses. On 01/29/25 at 01:25 PM, V29 (Pharmacist) said she would consider seven missed does of 9 doses of Ceftriaxone and 7 doses of Vancomycin is a significant medication error. She said that is a lot of missed doses. V29 said it could affect R89 by causing the infection to take longer to get rid of and it could cause the infection to even get worse depending how bad the infection was. The facility's Antibiotic Stewardship Policy/Procedure, dated 12/13/23, documents Policy: It is the policy to maintain an Antibiotic Stewardship Program (ASP) with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use.