STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145598	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seminary Manor	2345 North Seminary Street Galesburg, IL 61401

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 49187 Based on observation, interview and record review, the facility failed to ensure a nebulizer mask and nebulizer tubing was changed every seven days and stored in a bag between uses for two residents (R2 and R18) and failed to ensure Oxygen tubing was changed every seven days for two of four residents (R2, R34, and R62) reviewed for respiratory care in a sample of 30. Findings include: The facility's Nebulizer Treatment Administration, dated 01/2003, documents Purpose: 1. For delivery of liquid aerosol medication, as prescribed by a physician. 2. To aide in expectorations of secretions. Equipment: 1. Nebulizer unit. (Consists of (1) Medication container, (2) Nebulizer T-piece, and (3) Mouthpiece.) 2. O2 (Oxygen) tubing. Procedure: 15. O2 tubing used only for intermittent nebulizer therapy must be changed weekly. If used more often, such as for receiving O2, replace tubing every 48 hours. 16. Disposable nebulizers must be replaced every 15 days. The facility's Oxygen Therapy, dated 3/16/17, documents Objective: 1. To provide a source of oxygen to persons experiencing an insufficient supply of same. Procedure: 7. Oxygen set-up (cannula/mask, tubing) must be exchanged every seven days. Documentation: 1. Date, time, flow rate, frequency, and results of oxygen therapy in Medical Record. 1. R18's current POS (Physician Order Sheet) documents a Physician order for Albuterol Sulfate Solution 0. 62 milligram/3 milliliter one vial inhalation orally four times a day as needed. On 8/4/24 at 9:30 AM R18's nebulizer tubing and nebulizer mask was lying on R18's nightstand un-bagged and dated 6/20/2024. On 8/4/24 at 9:23 AM V4/Registered Nurse confirmed R18's nebulizer tubing and nebulizer dated 6/20/24 and un-bagged. V4 stated, Nebulizer masks and nebulizer tubing should be changed at least every seven days and bagged after use. 33970 2. 08/04/24 08:00AM R2's oxygen tubing was coiled up on bedside chair and attached to nebulizer machine dated 5/28. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 8/4/24 at 8:05 R34's Oxygen tubing and nasal cannula were on the floor in his room with no date on the oxygen tubing. R34 was not in his room at the time and the tubing was connected to an oxygen tank inside of his room and it was running. On 08/04/24 at 8:30 AM R34 was in the dining room with a small oxygen tank on the back of his wheelchair with oxygen tubing that had no dates on it. 4. On 08/04/24 R62's Oxygen tubing and nasal cannula were on the floor in her room with no date on the oxygen tubing. R62 was not in her room at the time and the tubing was connected to an oxygen tank inside of his room and it was running. On 08/04/24 at 8:30 AM R62 was in the dining room with a small oxygen tank on the back of her wheelchair with oxygen tubing that had no dates on it.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33970 Based on interview and record review, the facility failed to document justification for the use of duplicative antidepressant therapy for one of five residents (R18) and failed to document the justification for reinstating an antipsychotic for one resident (R60) reviewed for psychotropic medications in the sample of thirty. Findings Include: The facility's Psychopharmacologic Drug Usage Procedure, dated 10/18/17, documents Definition: A psychopharmacologic Drug is any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders. This includes the following types of drugs: antipsychotic, antidepressants, anti-anxiety medications, and sedatives/hypnotics. Procedure: Use of psychopharmacological medications requires assessment by the attending physician, and specific orders must be written by the attending physician with supporting diagnoses. 2. Psychopharmacological medication usage must be reassessed at least every 90 days and include rationale for continuing the medication. 7. Documentation of behaviors and conditions requiring the use of these mediations must be done on routine basis, as well as medication response and adverse consequences. 1.) R60's Admission Physician Order Sheet dated 5/10/2021 documents that R60 was admitted to the facility on the anitpsychotic medication Olanzapine 5 mg (milligrams) every night for Dementia with Delusions and Agitation. R60's Medication Regime Review from Pharmacy dated 8/3/23 documents a recommendation for the doctor to discontinue the use of the antipsychotic medication Olanzapine due to no documented behaviors to justify the use of it. The Physician accepted the recommendation so the medicine was discontinued. R60s nurse notes document that on 5/8/24 R60's daughter stated that when (R60) stayed the weekend with her that she was argumentative with her and accusatory. Daughter states that is what happens when they try to reduce their medication. R60's nurse's notes document that on 5/4/24 at 1:40 PM R60 was standing in the front entry telling staff she was going on a walk she was reminded that she needs staff to assist her that she became agitated with staff. She offers statements of missing clothing items. R60's Nurse Notes on 5/4/24-5/29/24 document several episodes of R60 yelling at staff regarding missing clothing, becoming angry and agitated with staff. There is no documentation of R60 having delusions or halluciantions. R60's Physican Order Sheet for June 2024 documents that R60 was put back on antipsychotic medication Olanzapine 2.5 mg (milligrams) every 12 hours as needed for agitation and delusions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60's Physican Order Sheet for June 2024 documents that R60 was put back on antipsychotic medication Olanzapine at 5 mg every night for failed gradual dose reduction with return of agitation and delusions. On 8/6/24 at 10:00 AM V3 (Licensed Practical Nurse/ Care Plan Coordinator) confirmed that R60 was upset about laundry that indeed was missing and some were ruined by the laundry dpartment and replaced by facility. V3 stated that R60 was obsessed about her missing clothes and was very angry and upset. V3 stated The daughter also wanted her back on her regular dose of medicine. On 8/6/24 at 10:15 AM V2 (DON) also confirmed that R60's clothes that she accused people of stealing were missing, that they were at the daughters house after a home visit. V2 also confirmed that the facility had ruined some of R60's clothes and she became very upset and was yelling at staff. V2 confirmed that the things that R60 was upset about were actually happening, therefore would not be considered delusions or hallucination. 49187 2. R18's POS (Physician Order Sheet) documents the following: Mirtazapine (antidepressant) 30mg (milligrams) by mouth daily, Bupropion HCL (hydrochloride) (antidepressant) 300mg by mouth daily, and Sertraline (antidepressant) 150mg by mouth daily. On 8/7/24 at 10:00AM V2/Director of Nursing stated she is the individual responsible for managing psychotropic medications for the residents in the facility. V2 stated R18 is not a harm not herself or others. V2 stated she is not sure why R18 is taking three antidepressants, and verified that this information was not documented in R18's medical record.

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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. 33970 Based on interview observation and record review the facility failed to ensure that wound care supplies were disinfected after each resident's wound cares. This failure has the potential to affect residents (R34, R57, R62, R67, R80, R199) that receive wound cares in the facility. Findings include: The facility's Standard Precautions policy facility's Wound Care policy, dated 08/2009, documents Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infectious agents. On 08/06/24 at approximately 1:00pm, V2 DON (Directed of Nurses), provided a Wound Summary Report, dated 08/05/2024, listing residents receiving wound care in the facility. The facility's Wound Care policy, dated 03/2004, documents, **Standard Precautions Must Be Followed During Care of Wounds. ** R80's medical record documents diagnoses including Insulin Dependent Diabetes and Chronic Kidney Disease Stage three. R80's Treatment Administration Record documents. Wound Care to Upper Gluteal Region: 1) Clean and dry area well. 2) Apply thin layer of zinc paste over open areas. 3.) Place bordered foam dressing. 4) Change daily and as needed. R80s Physicians Progress Note by resident's physician (V9), dated 8/5/24, documents under Chief Complaints: Pressure Ulcer and Assessment includes: Pressure Ulcer Left Buttock. V9 Dr. Wagner's Plan documents, I would put a moisture barrier this wound followed by a (bordered foam dressing). On 8/5/24 at approximately. 10:05am, R80 was laying on their left side and R80's waterproof, bordered dressing, dated 8/4/24, was intact to R80's coccyx and left buttock area. On 8/5/24 at 10:25am V3, Wound Nurse and ADON, Assisted Director of Nurses, gathered wound supplies and completed R80's daily wound care as ordered, to include cleansing R80's wound with an eight-ounce spray bottle of wound cleanser, using spray at close proximity to R80's open wound. After completion of R80's wound care, V3, ADON, returned wound cleanser spray bottle to the top treatment cart in the Medication Room without disinfecting the wound cleanser bottle. V3 stated that the multi-use spray wound cleanser is used for multiple residents' wound cared treatments and returned to the treatment cart. On 8/6/24 at 10:45am V6, LPN (Licensed Practical Nurse), verified that spray wound cleanser bottles are used for multiple residents' wound care and stored in the Medication Room or on the top of the treatment cart. On 8/7/24 at approximately 8:30am, V2, DON (Director of Nurses), stated that the wound cleanser bottles used for wound care throughout the facility, are considered community property and used for multiple residents' wound cares.