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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145603	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Hc of Paxton on Pells	1001 East Pells Street Paxton, IL 60957

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to maintain privacy during wound care for one (R70) of 24 residents reviewed for privacy in the sample of 38. Findings include: R70's Minimum Data Set, dated dated dated [DATE] documents R70 has severe cognitive impairment. On 1/14/25 between 12:10 PM and 12:52 PM V9 Wound Nurse, V18 Wound Nurse Practitioner, and V40 Certified Nursing Assistant (CNA) performed R70's wound assessments and treatments. V9 and V40 entered and exited R70's room during R70's wound care. The privacy curtain wasn't pulled to block the view from R70's doorway and hallway while R70's buttocks/perineal area was exposed. On 1/15/25 at 9:05 AM V9 confirmed R70's privacy curtain should have been pulled during R70's wound care to block the view from the doorway and hallway. On 1/15/25 at 10:30 AM V2 Director of Nursing entered R70's room to observe R70's wounds. V2 did not pull the privacy curtain to block the view from the hallway and R70's doorway. V31 CNA entered and exited R70's room while R70's buttocks/perineal area was exposed. V2 stated the privacy curtain should be pulled during wound care. The facility's policy titled Resident Privacy and Dignity dated 8/2/24 documents Privacy will be maintained for all the residents receiving ADLS (Activities of Daily Living) such as bathing, dressing and pericare with the resident room/shower room door closed and curtain drawn.

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51951 Based on interview and record review, the facility failed to notify a resident and their representative in writing about a hospital transfer and failed to provide a bed hold notice for four of four residents (R39, R17, R25 and R52) reviewed for hospitalization s on the sample list of 38. Findings Include: 1. R39's ongoing Census documents R39 was hospitalized from 7/6/24 - 7/24/24 and 12/30/24 - 1/2/25. R39's medical record does not contain a copy of the facility Bed Hold Policy. On 01/14/25 at 8:40 AM, R39 stated R39 went to the hospital recently but unsure of the exact date. R39 stated the facility did not talk with him about a Bed Hold Policy. On 1/14/25 at 12:21 pm, V2 DON (Director of Nursing) stated Bed Holds are to be filled out by the nurses when a resident is sent to the hospital; a copy is sent with the resident, and we keep a copy. On 1/14/25 at 12:55 pm, V2 DON stated after talking with the nurses, they are no longer doing the Bed Holds at the time of hospitalization and also stated nothing is being sent to families. 2. R17's ongoing census documents R17 was hospitalized from 4/5/24-4/8/24 and 2/6-2/9/24. R17's medical record does not contain a copy of the facility Bed Hold Policy. On 1/14/25 at 12:21 pm, V2 DON (Director of Nursing) stated Bed Holds are to be filled out by the nurses when a resident is sent to the hospital; a copy is sent with the resident, and we keep a copy. On 1/14/25 at 12:55 pm, V2 DON stated after talking with the nurses, they are no longer doing the Bed Holds at the time of hospitalization and also stated nothing is being sent to families. The facility Discharge/Transfer Policy dated August 2023 documents before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the facilities bed to hold policy and the facilities policies regarding bed hold periods. The resident/resident responsible party will be given the Resident Rights Regarding Bed Holds. Give a copy of the jointly signed and dated Bed Hold form to the resident (or representative) and place a copy of it in the residents' medical record until the resident is readmitted . 41002 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 1/14/24 at 3:12pm V1 Administrator confirmed the facility does attach the Bed Hold Policy to the Resident's Transfer paperwork when the resident is sent to the emergency room however, they do not provide a written copy upon transfer to the resident's representative. On 1/14/24 at 12:15am V7 Licensed Practical Nurse stated that on 11/4/24 V7 sent R25 to the hospital due to shortness of breath. V7 stated that V7 did not provide R25's representative with a copy of the bed hold policy. On 1/14/25 at 12:55 pm V2 Director of Nursing (DON) stated after talking with the nurses, they are no longer doing the bed holds at the time of hospitalization . V2 also stated nothing is being send to families. R25's Orders-General Note dated 11/4/24 at 7:16am documents R25 leaving with Ambulance bed hold sent with R25, cell phone and charger. The facility could not provide documentation that R25's representative was provided a written copy of the Bed Hold Policy when R25 was transferred to the emergency roiagnom on [DATE]. 4. On 1/14/24 at 3:12pm V1 Administrator confirmed the facility does attach the Bed Hold Policy to the Resident's Transfer paperwork when the resident is sent to the emergency room however, they do not provide a written copy upon transfer to the resident's representative. On 1/14/25 at 12:55 pm V2 Director of Nursing (DON) stated after talking with the nurses, they are no longer doing the bed holds at the time of hospitalization . V2 also stated nothing is being send to families. R52's Communication with Family Note dated 11/20/24 at 8:53am documents spoke with R52's Power of Attorney concerning R52's change in condition and Nurse Practitioner order to send for further evaluation. R52's Power of Attorney agrees with plan of care and requests that R52 be sent to the hospital. R52's Nursing Note dated 9/19/24 at 1:45pm documents staff spoke to R52's Power of Attorney regarding change in condition and new order. R52's Power of Attorney agrees with plan of care to send to hospital. Ambulance here to transport R52 to hospital. R52 was transferred to stretcher with 3 assists. Left the facility at this time. R52's medical record does not contain documentation that a bed hold notice or a written notice of transfer was provided to R52's representative for R52's hospitalization s on 11/20/24 and 9/19/24. The facility could not provide documentation that R52's representative was provided a written copy of the Bed Hold Policy when R52 was transferred to the emergency roiagnom on [DATE] and 11/20/24.

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F 0686

Level of Harm - 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 40385

Based on observation, interview, and record review the facility failed to develop and implement pressure relieving interventions, complete pressure ulcer and skin assessments, and notify the physician of new pressure ulcers to obtain treatment orders for one of four residents (R70) reviewed for pressure ulcers in the sample list of 38. These failures resulted in R70 developing two stage two and one stage three pressure ulcers.

Findings include:

On 1/13/25 at 9:15AM, 12:38 PM, 1:46 PM and 2:05 PM R70 was sitting in a wheelchair in R70's room. R70 was in her wheelchair in the assisted dining room from 11:50 AM until 12:23PM. At 2:08 PM V12 and V13 Certified Nursing Assistants (CNA) entered R70's room with a full mechanical lift and transferred R70 into bed. R70 was wearing pressure relieving boots. V12 and V13 stated R70 was not laid down after breakfast today due to having a shower and being in activities, but R70 is supposed to lay down between meals. V13 stated we try to offload pressure when R70 is in the wheelchair by shifting her weight with a rolled bath blanket that was used today. V12 and V13 stated R70 did not start using pressure relieving boots until after R70's heel wound developed.

On 1/14/25 between 12:10 PM and 12:52 PM V9 Wound Nurse, V18 Wound Nurse Practitioner, and V40 CNA entered R70's room to assess R70's wounds and administer wound treatments. V18 removed an undated dressing from R70's right heel which contained a moderate amount of tan colored drainage. There was a circular open wound to R70's right heel. V18 stated the wound was a stage three pressure ulcer. As V18 cleansed the wound, R70 said oh and tried to pull her foot away. This wound measured 1.76 centimeters (cm) long by 2.31 cm wide by 0.2 cm deep. There was a superficial open area to R70's left buttock, which V18 stated was a stage two pressure ulcer. This wound measured 1.66 cm by 2.83 cm by 0.1 cm. V40 and V9 turned R70 in bed and there was an undated dressing that was partially dislodged on R70's right ischium. V40 stated V40 was unsure how long the wound had been there and V9 stated V9 was not aware of the wound. V18 stated the wound was a stage two pressure ulcer and to apply calcium alginate with a bordered dressing. This wound measured 1.66 cm by 2.83 cm by 0.1 cm. V9 cleansed each wound and administered the wound treatments as ordered but did not date any of the wound dressings. R70 yelled out oh, oh, ow and had facial grimacing as V9 cleansed and dressed R70's right heel wound. V9 and V40 told R70 I'm sorry when R70 cried out in pain. V9 stated the nurses are supposed to document weekly skin assessments under the assessments section of the resident's electronic medical record (EMR). V9 confirmed R70's dressings were not labeled with a date. V9 stated staff have been using a pillow to shift R70's weight in the wheelchair, but R70 should be laid down between meals to offload pressure and repositioned from side to side in bed, and R70 can't tolerate being up as much as R70 used to. V9 stated R70 has scheduled Tylenol but was unsure when the last dose was given. V9 confirmed V9 did not coordinate pain medication administration prior to R70's treatments.

On 1/15/25 at 10:30 AM V2 Director of Nursing (DON) entered R70's room to observe R70's buttock wounds. V2 confirmed the left buttock wound observed on 1/14/25 was the left buttock wound that was previously healed as of 1/7/25, and not the gluteal cleft wound.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Wound Report dated 7/13/24-1/13/25 documents R70 had a stage two pressure ulcer of right buttock on 10/27/24 that healed on 11/12/24, a stage two pressure ulcer of the coccyx on 11/12/24 that healed on 11/22/24, a stage two pressure ulcer to the left buttock on 12/21/24 that healed on 1/7/25 and a stage three pressure ulcer to the right heel as of 1/7/25. R70's Wound Report dated 11/1/24-1/14/25 documents an abrasion/trauma wound of the gluteal cleft as of 1/7/25. R70's Minimum Data Set (MDS) dated [DATE] documents R70 has severe cognitive impairment, is dependent on staff assistance for toileting, hygiene, transfers, and bed mobility, and has no pressure ulcers. R70's Braden Assessments dated 10/28/24 and 12/22/24 document R70 is at moderate risk for developing pressure ulcers. R70's current Care Plan documents R70 is at risk for skin impairment and has not been updated to include R70's pressure ulcers or any new pressure relieving interventions since 2022. There are no pressure relieving interventions documented on R70's EMR profile or in the section for CNA charting. R70's ongoing weight log documents R70's weight (pounds) as follows: 120 on 4/4/24, 107.5 on 8/6/24, 102. 5 on 9/4/24, 103 on 10/6/24 (14.17% loss in six months), 97.5 on 11/12/24 (5.34% in one month), 98 on 12/1/24, and 95 on 1/5/25 (15.93% loss in six months). R70's Skin Assessments dated 12/6/24 and 1/10/25 document no new wounds but does not identify if there were any existing wounds found on the head-to-toe assessment as instructed. R70's Skin assessment dated [DATE] documents R70's stage two pressure ulcer to the left buttock measured 1.0 centimeter (cm) x 0.5 cm x less than 0.1 cm deep. These skin assessments document a turn schedule as the only pressure relieving interventions, the sections for specialized mattress, heels floated, and heel protectors are not marked. There are no other documented skin assessments in R70's EMR between 12/1/24 and 1/14/25. R70's Nursing Note dated 1/6/2025 at 12:51 PM documents V9 Wound Nurse was notified that R70 had an open area to the right heel that was previously scabbed over, and a treatment order was implemented. R70's Nursing Note dated 1/10/2025 at 12:52 PM documents an air mattress was applied to R70's bed and R70's wheelchair cushion was changed. There is no documentation that R70's right ischium wound was reported to a physician and treatment orders were implemented prior to 1/14/25. R70's December 2024 Treatment Administration Record (TAR) documents a treatment order to cleanse left buttock wound, apply skin protectant to the periwound, apply calcium alginate, and cover with a hydrocolloid dressing three times per week initiated on 12/21/24. R70's January 2025 TAR documents R70's left buttock wound treatment was discontinued on 1/7/25 when this wound resolved and there are no treatments for this wound after. There are no documented treatments for R70's right heel wound prior to 1/7/25. These TARs document R70's skin assessments were completed on 12/13/24, 12/20/24, 12/27/24 and 1/3/25, but there are no corresponding skin assessments documented to indicate if R70's skin was intact or impaired. There are no documented assessments in R70's EMR of R70's left buttock wound until 12/22/24, R70's right heel wound prior to 1/7/25, R70's left buttock wound between 1/8/25 and 1/13/25, or R70's right ischium wound prior to 1/14/25. R70's Multi Wound Chart Details documents on 1/7/25 R70's right heel stage three pressure ulcer measured 1.8 cm by 1.8 cm by 0.3 cm and this wound was debrided (removal of dead tissue), and R70's gluteal cleft wound measured 1.9 cm by 0.2 cm by no measurable depth. This report documents to elevate R70's heels off bed at all times, turn/reposition frequently per facility protocol and avoid direct pressure to wound site. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R70's January 2025 Medication Administration Record documents Tylenol Extra Strength Tablet 500 milligrams three times daily as of 8/28/23 and the noon dose was not administered as of 12:46 PM on 1/14/25. There are no other pain medication orders. On 1/14/25 at 12:53 PM V18 Wound Nurse Practitioner stated R70 should be repositioned side to side in bed every two hours using cushions to relieve pressure and R70 should not be up in the wheelchair for more than two hours. V18 stated V18's office was not aware of R70's right ischium wound prior to today. On 1/14/25 at 1:37 PM V18 stated R70 should have pressure relieving boots or heels floated with a pillow when in bed. V18 confirmed weight loss is a risk factor that can contribute to the development of pressure ulcers and pressure relieving interventions should be implemented to prevent skin breakdown. V18 stated R70's skin is thin and wounds can develop overnight. On 1/14/25 at 12:57 PM V12 CNA stated R70 has had a dressing to the right buttock for at least three or four days. On 1/14/25 at 1:00 PM V10 Licensed Practical Nurse stated V10 had not yet given R70's scheduled noon dose of Tylenol today. V10 stated V10 reported R70's right ischium wound to V9 yesterday, but V9 thought V10 was referring to R70's left buttock wound. V10 stated yesterday V10 covered the wound with a dressing but did not do anything else besides notify V9. V10 stated the wound was not there on Friday (1/10/25) when V10 last cared for R70. On 1/14/25 at 1:28 PM V40 CNA stated pressure relieving interventions are listed as part of the CNA charting or on the resident's dashboard profile in the EMR. On 1/14/25 at 1:30 PM V12 CNA stated prior to the pressure relieving boots, V12 used pillows to float R70's heels in bed. V12 stated depending on who works night shift depends on if R70's pressure relieving interventions are implemented as V12 has come on duty and found that R70's heels weren't floated or boots weren't in place. On 1/14/25 at 1:35 PM V9 stated R70's pressure relieving boots weren't implemented until last week. V9 stated pressure relieving interventions should be listed on the bottom of the skin assessments and was unsure where this information is documented for the CNAs to see. On 1/14/25 between 4:15PM and 4:28PM V2 DON stated skin assessments should be done weekly and documented in the assessment section of the resident's EMR and confirmed R70's missing skin assessments in December 2024 and January 2025. V2 stated that is something V2 was going to work on, V9 was recently hired within the last two weeks and V2 planned to have V9 follow up on skin assessments to ensure they were being completed and follow up to ensure pressure relieving interventions are implemented. V2 stated pressure relieving boots and an air mattress were initiated last week for R70. V2 stated V2 is working on having the pressure relieving interventions on the resident's profile and on the kardex, which is pulled from the resident's care plan. V2 confirmed R70's profile does not document pressure relieving interventions. V2 stated V2 has been having a hard time keeping up with wounds and updating the care plans. V2 stated V2 was not aware that R70's left buttock wound had reopened and that it had healed on 1/7/25. V2 stated V20 was not aware of R70's right ischium wound, and the nurse should have notified V9. V2 confirmed there were no documented assessments for this wound prior to today. V2 confirmed staff should coordinate pain medication prior to wound treatments and stated it is hard since the facility doesn't always know what time V18 will be rounding. On 1/15/25 at 8:50 AM V2 stated wound dressings are not dated, per facility policy, and the TAR is used as the documentation for when dressings are changed. At 12:35 PM V2 confirmed all of R70's December 2024 and January 2025 wound assessments were provided. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/15/25 at 10:50 AM V28 Nurse Practitioner stated V28 was not consulted regarding R70's pain during wound treatments and the nurses should be coordinating pain medication to be given prior to wound treatments. On 1/15/25 at 11:30 AM V15 MDS Coordinator confirmed R70's care plan had not been updated with R70's pressure ulcers and pressure relieving interventions. The facility's Wound Treatments policy dated April 2023 documents to implement prevention protocol according to resident needs, turn at least every two hours, reposition in chair, and provide appropriate redistribution and pressure reducing devices. The facility's Treatment Administration policy dated April 2023 documents treatment orders are documented on the Treatment Administration Record, ensure pain medication is offered and given as needed prior to treatments, and document all significant observations in the resident's electronic medical record. The facility's Skin and Wound Management Guidelines dated April 2023 documents to notify the wound care nurse of new alterations in skin, if the wound nurse is not in the facility, then the staff nurse must notify the physician and obtain a treatment order. This guide documents to ensure immediate pressure relieving interventions are implemented. This guide documents the wound care nurse will assess, measure, photograph, and document; and update the resident's plan of care with identified site and new interventions. This guide documents the nurse management or wound care nurse will review shower documentation and weekly skin checks to ensure compliance and identify new wounds at an early stage and will round to ensure residents are positioned correctly and heels are off loaded.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to offer services to maintain or increase range of motion for one of three residents (R34) reviewed for range of motion in the sample list of 38. Findings include: On 1/13/25 at 9:04 AM R34 was sitting in a wheelchair in R34's room and there was a brace on R34's right leg. R34 stated R34 is unable to walk and unable to move R34's right arm and leg, and R34 has not received any therapy services or exercise programs since R34 admitted to the facility. On 1/13/25 at 3:41 PM V15 MDS (Minimum Data Set) Coordinator stated the facility doesn't have restorative nursing services where participation is recorded, but they have walk to dine programs. At 3:48 PM V15 stated R34 has not yet been evaluated by therapy since R34 transferred from another facility where therapy had just been completed. On 1/14/25 at 3:47 PM V2 Director of Nursing stated V2 just became aware yesterday that skilled nursing facilities (SNF) are supposed to offer restorative nursing services and confirmed this had not been implemented for R34. On 1/14/25 at 3:53 PM V2 stated we don't really have restorative services, but we have therapy evaluate and treat periodically. V1 Administrator stated R34 had transferred from another SNF where R34 received therapy, R34 was on the list to be screened by therapy but then R34 got pneumonia. V1 stated therapy is supposed to screen R34 tomorrow. R34's Admission Minimum Data Set (MDS) dated [DATE] documents R34 has moderate cognitive impairment and has impaired range of motion to one upper and one lower extremity. This MDS documents R34 did not receive therapy or restorative nursing services. R34's current care plan documents R34 admitted on [DATE] and has diagnoses of hemiplegia of the right dominant side and Cerebral Infarction. This care plan does not document a problem, goals, and interventions to address R34's impaired range of motion. There is no documentation in R34's medical record that therapy or restorative nursing services were provided for R34's impaired range of motion. R34's January 2025 Medication Administration Record documents R34 received antibiotics for respiratory infection/pneumonia from 1/3/25-1/14/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Functional Maintenance Program dated September 2022 documents: A resident may be started on a functional maintenance program when he or she is admitted to the facility with functional needs, but is not a candidate for formalized rehabilitation therapy, or when functional needs arise during a long-term stay, or in conjunction with formalized rehabilitation therapy. Generally, functional maintenance programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. The facility will complete a Contracture Risk Evaluation upon admission, with a significant change in condition, and quarterly to assess risks. Residents at risk will have custom interventions added to their plan of care to prevent decline or to maintain current functional status. Therapy will provide recommendations for maintenance programming based on therapy outcomes or screenings. Individual custom tasks will be documented in (electronic charting system) of the EHR (electronic health record). Measurable objectives, goals and interventions will be documented in the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51951 Based on interview and record review the facility failed to investigate and record a fall incident and failed to complete fall risk assessments for one of one resident (R39) reviewed for falls on the sample list of 38. Findings include: On 01/14/25 at 08:40 AM R39 reported slipping out of his wheelchair when R39 was in transport van because the full mechanical lift sling was under R39 and caused R39 to slip down in R39's wheelchair. R39 explained that R39 did not completely hit the van floor but rather slipped to the edge of the chair and R39's legs were holding R39 up because R39's legs were pinned against the seat in front of R39. R39 stated R39 did not hit the floor. On 01/16/25 at 09:09 AM V2 (DON) provided an electronic mail from V29, transporter, dated Tuesday, December 31, 2024, at 6:42 AM. V29's email to V2 explained that on December 30th, 2024, V29 was transporting R39. V29 stated that within blocks of the destination, R39 stated that he was sliding out of R39's chair a bit. V29 explained that on arrival at the location, R39 was now midway between R39's wheelchair and the floor, with R39's jacket hooked on the handle, helping R39 stay upright. V29 called 911 for fire department with help getting R39 into R39's wheelchair. V29 reported that R39 was a bit slower than usual to answer V29's questions, stated R39 did not have the same energy that R39 displayed prior to leaving the facility. V29 stated that was cause for concern so V29 asked for a nurse to come for a quick evaluation of R39. V29 stated the unidentified nurse decided to call an ambulance and the ambulance transported R39 to the hospital. On 1/14/25 at 12:55 PM, V2, DON, stated R39 did not have a fall on 1/3/25, instead that is when V2 put in the documentation and explained R39 slid down in R39's chair while on the van on 12/30/24. V2 stated V2 didn't consider it a fall and did not do an investigation or even talk to R39 about it yet and confirmed no new interventions were put into place at that time. V2 stated the fall on 1/9/25 was due to poor positioning and R39 had to be lowered to the ground. R39's Falls Progress Notes document a fall on 1/3/25 and 1/9/25. There are no fall risk assessments in R39's medical record since 2023 until 1/2/25 = low risk, and 1/9/25 = low risk (not accurate as it doesn't score previous fall). R39's Care Plan dated 12/20/24 was not updated after the fall on 1/3 with a new intervention. This care plan was updated after the fall on 1/9/25 with new intervention of staff education on appropriate positioning when transferring. On 1/14/25 at 1:04 PM, V2 (DON) confirmed no fall risk assessments were completed in 2024 and stated they should be done quarterly and as needed with a fall or change in condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Accolade Hc of Paxton on Pells		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 East Pells Street Paxton, IL 60957	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facilities Accidents & Incidents Policy dated November 2023 states all accidents/incidents involving a resident will be investigated, and then recorded in Risk Management of the electronic medical record software. It is the responsibility of the Charge Nurse to complete the Accident and Incident Risk Management report and notify attending physician and responsible parties and document information accordingly. It is the responsibility of the DON (Director of Nursing)/Designee to investigate and ensure appropriate completion, notification, and follow-up on all Accidents and Incidents. The Charge Nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate interventions to affected parties. The Interdisciplinary Team will be notified of the accident/incident so that appropriate changes may be made to the care plan as needed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 51951 Based on observation, interview and record review, the facility failed to perform hand hygiene before and after catheter care to prevent potential contamination and failed to ensure a urinary drainage bag was covered with a dignity bag for one of one resident (R39) reviewed for catheters on the sample list of 38. Findings Include: On 1/13/25 at 8:40 am and 3:12 PM, R39 was lying in bed and had an uncovered urinary catheter drainage bag hanging on the bed frame, which was visible from the hallway. On 1/14/25 at 8:40 am, R39 was lying in bed and had an uncovered urinary catheter drainage bag hanging on the bed frame, which was visible from the hallway. On 1/15/25 at 11:25 AM, R39 was lying in bed and the urinary catheter drainage bag was hanging on the bed frame, covered in a dignity bag. At this time, V33 and V34 CNAs (Certified Nursing Assistants) both stated that catheter drainage bags should be in a dignity bag at all times. V33 and V34 donned gloves to provide catheter care using disposable wash rags but did not wash their hands before donning gloves. After catheter care was completed, with the same gloved hands, V33 and V34 proceeded to place an incontinence brief onto R39, adjust R39's sheets and blankets, and reposition R39's call light. V33 and V34 then removed their gloves and exited the room without performing hand hygiene. V33 and V34 both confirmed they did not perform hand hygiene before or after catheter care. The facility Catheter Care and Maintenance Policy dated March 2024 documents a resident's catheter drainage bag will be concealed with a privacy covering. The facility Hand Washing Policy dated March 2024 documents the facility considers hand hygiene the primary means to prevent the spread of infections. All staff will properly wash hands after direct contact with any contaminated substances, after direct resident care, and as instructed. Employees must wash their hands for 15 to 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with residents, when hands are visibly dirty or soiled with blood or other bodily fluids, after contact with blood, body fluids, secretions, mucous membranes, and after removing gloves.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to obtain a re-admission weight, notify the physician and resident representative of significant weight loss, and develop a plan of care to address significant weight loss for one of three residents (R77) reviewed for weight loss on the sample list of 38. Findings Include: The facility's Weight Management policy dated August 2017 documents all residents will be weighed on admission, re-admission, and weekly for the first four weeks, then monthly thereafter. Weekly weights will also be done with a significant change of condition. Any significant weight loss will be reviewed with the physician to obtain an order for a nutritional supplement until the resident's condition is discussed during weekly risk meetings. The resident's care plan will be updated to include interventions promoting weight gain or loss. The family or Power of Attorney will be notified of significant weight changes and plan of care which will be documented in the resident's medical record. R77's Medical Diagnoses List dated January 2025 documents R77 is diagnosed with Severe Protein Calorie Malnutrition, Muscle Wasting and Atrophy, Dysphagia, and Adult Body Mass Index of 19.9 or less. R77's Clinical Census list dated January 2025 documents R77 was discharged to the hospital on 8/18/24 and was readmitted to the facility on [DATE]. R77's Progress Note dated 8/15/24 documents R77 was positive for Covid-19 and R77's Progress Note dated 8/18/24 documents R77 had a change of condition was sent to the emergency room for evaluations. R77's progress note dated 8/28/24 documents R77 returned to the facility on [DATE] and had been diagnosed with Pneumonia. R77's Weight Log documents on 8/6/24 R77's weight was 131 pounds. The same Weight Log documents on 9/4/24 R77's weight was 112 pounds. This is a 14.5% weight loss in one month. R77's Electronic Medical Record does not have documentation of a re-admission weight within 24 hours of admission, physician notification or family notification regarding R77's significant weight loss, or a weight specific care plan addressing R77's risk for or actual weight loss with related interventions. On 1/15/25 at 1:23 PM V2 Director of Nurses confirmed a re-admission weight should be taken within 24 hours. V2 also confirmed if a resident has lost a significant amount of weight, the resident's physician and family should be notified of the weight loss. V2 also confirmed residents at risk for weight loss or with actual unplanned weight loss should have a documented plan of care with interventions in place to prevent further weight loss. V2 confirmed there was no documentation that any of these things were done for R77.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40385 Based on observation, interview, and record review the facility failed to maintain hygienic care and storage of continuous positive airway pressure (CPAP) masks and oxygen nasal cannulas, and failed to develop a care plan for respiratory care and diagnosis for two of three residents (R57, R34) reviewed for oxygen in the sample list of 38. Findings include: 1.) On 1/13/25 at 9:17 AM R57's CPAP mask was uncovered and on top of the CPAP machine on R57's night stand. On 1/13/25 at 3:31 PM V14 Licensed Practical Nurse (LPN) stated CPAP masks are cleaned daily and confirmed the masks should be stored in a bag when not in use. V14 entered R57's room and confirmed R57's CPAP mask was uncovered and on top of the CPAP machine on R57's night stand. V14 stated V14 will need to get a bag to store the CPAP mask in. V14 stated R57 uses the CPAP at night, but sometimes removes it himself during the night. On 1/15/25 at 8:50 AM V2 Director of Nursing stated CPAP masks are cleaned daily per manufacturer's guidelines, placed on a towel in the bathroom to dry, and then should be stored in a plastic bag when not in use during the day. R57's January 2024 Treatment Administration Record documents R57 uses a CPAP nightly and to remove the CPAP every morning at 5:00 AM, wash with warm soapy water, air dry, and place in a plastic bag when fully dry. The CPAP cleaning guidelines dated 2025, provided by the facility, documents to disassemble, wash and rinse the CPAP mask, and place on a towel to dry. 2.) On 1/13/25 at 9:05 AM R34 was in R34's room. R34's oxygen concentrator was off and R34's oxygen tubing was draped over top of the concentrator with the nasal cannula on the floor. There was no bag to store R34's oxygen tubing. R34 stated R34 uses oxygen when needed and the tubing was just changed last night. At 12:23 PM R34's oxygen concentrator remained off and R34's oxygen nasal cannula remained on the floor. There was no bag to store R34's oxygen tubing when not in use. R34's January 2024 Medication Administration Record documents R34 was on antibiotics from 1/3/25 thru 1/14/25 for respiratory infection/pneumonia and R34 receives scheduled nebulizer treatments as of 11/27/24. R34's Physician Order dated 11/27/24 documents may use oxygen to maintain oxygen saturation of greater than 91% as needed for Chronic Obstructive Pulmonary Disease (COPD). R34's current care plan does not address R34's COPD or oxygen and nebulizer use. On 1/13/25 at 3:31 PM V14 LPN stated oxygen tubing should be stored in a bag when not in use. V14 entered R34's room and R34 was wearing oxygen at 2 liters per minute per nasal cannula. V14 confirmed there was no bag for oxygen tubing storage and confirmed there should be. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/14/25 9:00 AM V10 LPN stated V10 had not changed R34's oxygen tubing yesterday and V10 was unaware that R34's nasal cannula was on the floor. V10 stated R34 had not used oxygen during V10's shift on 1/13/25, and there should be a bag on the oxygen concentrator to store the tubing when not in use. On 1/15/25 at 8:50AM V2 Director of Nursing stated if oxygen is not in use, then the tubing should be placed in a plastic bag that is attached to the oxygen concentrator. V2 stated R34 does remove her oxygen tubing at times, but if she wasn't using the oxygen then the nurse should have placed it in a bag. On 1/15/25 at 11:30 AM V15 Minimum Data Set/Care Plan Coordinator confirmed R34's care plan did not include COPD or oxygen and nebulizer use.

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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. 51951 Based on interview and record review the facility failed to ensure that as needed psychotropic medication was limited to 14 days for one of five residents (R49) reviewed for unnecessary medications on the sample list of 38. Findings include: R49's November 2024 - January 2025 MAR (Medication Administration Record) documents R49 was started on Lorazepam {Antianxiety} 2 mg (milligrams) per 1 ml (milliliter) - give 0.25 ml every 4 hours as needed for agitation/restlessness which was ordered on 11/14/2024 {greater than 14 days ago}. These MAR's also document that R49 has not used this PRN (as needed) medication since 11/18/2024. On 1/15/25 at 1:39 PM, V2, Director of Nursing (DON) stated that PRN (as needed) orders which are for psychotropic medications are limited to 14 days. The facilities Psychotropic Medications Protocol dated January of 2024 documents when a PRN psychotropic mediation is ordered, it will have a 14 day stop date and the resident will be reassessed by the physician for further use. The protocol lists psychotropic medications as any medication that is used for or listed as used for antipsychotic, antidepressant, antimanic, or ant-anxiety behavior modification or behavior management purposes.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 50322 Based on interview and record review the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition services. This failure has the potential to affect all 92 residents within the facility. Findings include: The Long-Term Care Facility Application for Medicare and Medicaid Services dated 1/13/25 documents 92 residents reside in the facility. On 1/13/25 at 9:00 AM V3, dietary manager, stated V3 is not a certified dietary manager and has no certifications. On 1/14/25 at 11:00 AM V2, Director of Nursing (DON), stated that V7, Registered Dietician (RD), visits once a week on Tuesdays and is not in the facility full time. On 1/14/25 at 2:13 PM, V7 stated while she does consult at facility for weight loss and dietary recommendation for residents, she does not write the menus and has been told by facility administration that they have an outside company that deals with menus, food ordering, education, and kitchen. V7 stated she has offered educational services as well as menu writing. V7 stated she had concerns with nutritional values of the menus. V7 stated she has attempted to get in touch with this company and filed a formal complaint on 12/11/24 with V1 administrator and contracted dietary company. V7 stated she has had no response from company but has informed both that she will not approve the next menu cycle. On 1/14/25 at 2:23 PM, V24 Registered Dietician (RD) from consulting dietary services company stated the registered dietician, who wrote the menus for facility is no longer employed with the company. V24 stated she believes the local RD inspects the kitchen at the facility and ensures menus are followed, but she does not have accurate name or contact information for the local RD and no collaboration has been attempted. V24 stated they are a software company and have not been onsite recently at this facility. V24 stated the facility is responsible for alternative menus and ensuring compliance. On 1/14/25 at 3:50 PM, V3 provided a binder containing dietary staff certifications. This binder contained food handling certifications for 11 dietary staff, including aides and cooks. V3's food safety certification was not included. V3 stated she is having trouble printing her certification off of the computer but is working on it. On 1/15/24 V3 was not in the facility. V1 stated at 10:05 AM on 1/16/25 that V3 does not have any certifications for dietary at this time. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility policy titled Director of Food and Nutrition Services, undated, documents the director of food and nutrition services will be responsible for all aspects of the food and nutrition services department including but not limited to food safety, staff safety, cost management, and meeting nutritional needs of patients/residents served. The policy also documents that the requirements for dietary manager include holding an active certified dietary manager or food service manager certification.

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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 50322

Based on observation, interview and record review, the facility failed to assure that menus and menu substitutions are developed, prepared, and followed to meet residents' therapeutic diets and nutritional needs while using established national guidelines. This failure affects one of four residents (R70) reviewed for nutrition and has the potential to affect all 92 residents residing in the facility.

Findings include:

1.) The Long-Term Care Facility Application for Medicare and Medicaid Services dated 1/13/25 documents 92 residents reside in the facility.

Continuous observations of the lunch meal service were conducted on 1/14/25 from 11:28AM-12:35PM as follows:

The steam table set up at the kitchen service window included a large pan of barbecue pork (regular texture), small pan of mechanical soft pork, and small pan of puree pork. The mid-steam table contained two containers of hot vegetables one for mechanical soft texture and one for puree. Directly to the left of the hot vegetables was a large pan of regular cold coleslaw. Individual scoops for each item were placed in the food. All scoops were the same size a half cup scoop. There were no other items on the steam table. The rolling cart contained trays of dessert bars that were all one portion size.

Individual dining tickets were handed to V20, cook, for plate service. Tickets indicated resident name and diet including allergies and preferences. V20 proceeded to plate food for each ticket based upon mechanical texture of diet. Mechanical soft diet received ground meat and hot vegetable, piece of cornbread and dessert bar. Puree received puree meat, pureed hot vegetable, and cup of pureed dessert bar. Regular texture received whole pieces of meat, scoop of coleslaw, cornbread, and dessert bar. There were no variations of items served based upon therapeutic diets and no smaller or larger portions were served. There were no fruit items served during this meal.

During this lunch service on 1/14/25 individual tickets were observed as follows:

At 12:00 PM, R44's meal ticket dated 1/14/25 titled Week 2 Tuesday Lunch documents for Low Concentrated Sweets (LCS)/ No Added Salt (NAS) diet: BBQ Pork Shoulder (#12 scoop = 2oz pro); Coleslaw (diet) (#8 scoop = 1/2 cup); spiced pear bar (1/2 piece); cornbread (1 Piece); margarine (1tsp); coffee/tea (6 oz); sugar substitute, pepper (1 ea.). R44's plate served contained 1 scoop (1/2 cup) barbecue pork, 1/2 cup regular coleslaw, and 2 slices of white bread.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:05 PM, R42's meal ticket dated 1/14/25 titled Week 2 Tuesday Lunch documents for Low Concentrated Sweets (LCS)/ No Added Salt (NAS) diet: BBQ Pork Shoulder (#12 scoop = 2oz pro); Coleslaw (diet) (#8 scoop = 1/2 cup); spiced pear bar (1/2 piece); cornbread (1 Piece); margarine (1tsp); coffee/tea (6 oz); sugar substitute, pepper (1 ea.). R42's plate served contained 1 scoop (1/2cup) barbecue pork, 1/2 cup regular coleslaw, 1 piece of cornbread, 1 full dessert bar, and a chocolate shake (8 ounces). The document titled (Facility) Menu F/W 24/25 Week at a Glance for Regular/Regular week 2, documents Tuesday Lunch meal as BBQ Pork shoulder (PP, double protein), coleslaw (V, vegetable), spiced pear bar (G, grain), cornbread (G) with option of salad in small bowl. There was no fruit or salad observed or offered at this meal. Document titled Daily Spreadsheet Week 2 Tuesday documents variations of daily menu based upon therapeutic diet ordered. The Spreadsheet documents Low concentrated sweets (LCS) diet is to receive diet coleslaw instead of regular and one half of dessert bar instead of whole. On 1/14/25 at 1:30 PM, V2 Director of Nursing (DON), provided the recipe book that dietary staff use when preparing the menu. The recipe book contains recipes for regular diet and additives for making puree. There are no recipes for low salt or low concentrated sugars. On 1/14/25 at 1:40 PM, V20 confirmed the book that V2 provided is the book used to prepare food on the menu. V20 denied knowledge of any variations and showed the binders utilized in the kitchen. Two binders were labeled Menu Handbook were noted and V20 stated V20 has no idea what those are for and stated they never use them. The Menu Handbook dated last revision of September 2021, contains information from the contracted dietary service company which includes current the menu and menu spreadsheets. The Handbook contains policy and procedures for therapeutic diet guidelines and appropriate nutritional substitutions, calorie count breakdown of each item, and how each item is counted towards national nutritional guidelines. Page 3 of the menu handbook documents the general diet is planned following guidance from the Dietary Guidelines for Americans 2020-2025 and the Food exchange list provided by the Academy of Nutrition and Dietetics. Documents general diet follows guidelines for 2000 calorie level which includes 6 ounces of protein, 5 fruit and vegetable servings including one source of vitamin C with breakfast daily and 3 sources of Vitamin A per week, 6 servings of grains and 2 servings of dairy. Documents general diet is then altered for resident needs. At 2:13 PM on 1/14/25, V19, facility Registered Dietician, stated she has serious concerns with the facility's current menu not meeting state requirements of five plus servings of fruits and vegetables with Vitamin A and Vitamin C. V19 stated the menu does not meet the required minimum national dietary standards. V19 stated she has attempted to explain to V1, administrator, but is told an outside company makes menu choices. V19 stated she has reached out to the consulting dietary company to discuss her concerns several times with no response and on 12/11/24 she filed a formal complaint and informed the facility she will not be approving the next quarter menus. (continued on next page)

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

At 2:23 PM on 1/14/25, V24, contracted Registered Dietician Supervisor, stated the dietician assigned to the facility no longer works for the company. V24 stated facility menus are written based upon the facilities needs and the dietary manager can make changes through the software. V24 stated they use a combination method when counting fruits and vegetable daily servings. V24 stated there is a sample list of appropriate menu substitutions provided but ultimately the facility makes that list according to their budget. V24 stated that she is unclear why the facility would not be following dietary changes for low concentrated sweets or no added salt diet.

At 2:00 PM on 1/15/25 V28, facility Nurse Practitioner, stated she was unaware that residents were not receiving appropriate diets. V28 stated this could negatively affect resident health and treatment especially if they aren't receiving minimum nutritional needs.

The document titled Menu Nutritional Analysis documents breakdown of all the foods on the menu for week. The Analysis documents that by receiving a regular diet, residents that require a no added salt diet are receiving an extra 871 mg of sodium in four weeks, and residents that require a LCS diet are receiving an extra 25 grams of carbohydrates.

The facility order listing report dated 1/15/25 documents 49 of the current 92 residents' dietary orders are for low concentrated sweets (LCS), no added salt (NAS) or both LCS and NAS.

On 1/16/25 at 9:37AM, V19, Registered Dietician, stated she has reviewed the upcoming quarter menus, and while these do have more fruit and vegetables than the last menu, these still don't meet dietary needs in V19's opinion. V24 stated that garnishes are being counted such as taco toppings, fruit gelatin, etcetera as servings. V19 stated she is hesitant to count some of the casseroles in the vegetable servings as it is unlikely you are truly getting a serving in each slice of casserole and the same with the tomato salad which is a tomato slice on top of some lettuce. V19 stated many residents don't receive the garnishes or are offered fruit due to allergies and no substitutions with equal nutritive value are being offered.

The Facility assessment dated [DATE] documents in Part 2: Services and Care offered based upon resident needs documents that individual dietary requirements, therapeutic diets, nutrition, hydration, cultural or ethical dietary needs including any fluid and dietary restrictions are provided.

40385

2.) The facility's Daily Spread Sheet Week 2 Monday documents puree chicken, puree penne pasta, puree Italian vegetables, and puree pears for the puree noon meal.

The noon meal in the assisted dining room of the 100 and 200 halls was observed on 1/13/25 from 11:50 AM until 12:25 PM. Small dishes of pears or applesauce were distributed to the residents. R70's meal was served in a three-compartment plate and R70 was not served or offered fruit. V13 CNAs fed R70's lunch, V13 stated R70's lunch was pureed vegetables, pureed chicken and pasta, and pureed mashed potatoes. Dishes of ice cream were brought around and offered to all residents in this dining room and was served to R70. R70's meal ticket documented pureed pears as part of the noon meal. V13 confirmed R70 was not served fruit for lunch as her meal ticket indicates. V13 stated R70 was given ice cream instead since R70 wanted the ice cream. R70 ate a few bites of R70's meal, was finished eating at 12:23 PM and transported out of the dining room.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Accolade Hc of Paxton on Pells		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 East Pells Street Paxton, IL 60957	

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R7's Minimum Data Set, dated dated dated [DATE] documents R70 has severe cognitive impairment and has had a significant weight loss in one or six months. On 01/14/25 at 3:24 PM V19 Registered Dietitian stated the staff should serve R70 the food that is listed on R70's meal ticket and ice cream would not be considered an appropriate substitute for pears. V19 stated V19 had asked the dietary staff today if they have had any substitutes because they haven't been logging that information, and V19 was told there hasn't been any substitutes. V19 stated applesauce would be a substitute for pears and should be logged, and has told dietary staff this previously. The facility's (contracted dietary based company) Menu Substitutions policy dated 2014 documents substitutes should be available, planned with the dietitian, and of similar nutritive value from the same food group as the menu item.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50322 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This failure has the potential to affect all 92 residents in facility. Findings include: The Long-Term Care Facility Application for Medicare and Medicaid Services dated 1/13/25 documents 92 residents reside in the facility. On 01/13/25 at 8:30 AM V3 Dietary Manager gave a tour of the kitchen and storage area. There was food debris noted inside the toaster, on the countertop in front of the toaster and on the floor directly inside the kitchen door. There were boxes of food from a delivery that were stacked in the food prep area in front of both coolers and the dry storage. There were clear bulk bin containers on a rolling cart behind the kitchen door next to the sink and cooler in a heavy traffic area. The label on the bin documents dry cereal. Inside the walk-in freezer, the top right shelf contained clear bins dated 3/13/24 labeled Meatballs. The substance inside was unidentifiable and contained a block of solid substance with freezer burn crystals noted throughout. The standing cooler next to the stove contained sliced ham in a clear bag that was not labeled with a date. Directly under the sliced ham, the shelf contained sliced cheese wrapped in clear plastic and a bag of shredded cheese. In the dietary aide cooler, there were four trays containing clear small serving bowls with a white gelatin substance, all uncovered, and none were dated. V3, dietary manager, stated the bowls contained pudding. In the dry storage, there were four large bins sitting on the floor against the wall in the back. The bins were labeled as follows: Oatmeal with date of 7/15/24, no expiration date noted; brown sugar dated 9/9/24 no expiration date, one uncovered scoop noted on top of the brown sugar bin with one half of a scoop covered in the dry oatmeal. The flour bins were dated 9/9/24 and sugar bin dated 10/29/24 and had no expiration or discard dates. At 11:25 AM on 1/14/25, the clear, bulk bins containing the dry cereal remained as noted above. On 1/14/25 between 11:28AM-12:35PM continuous observation of lunch meal service were completed and included: The steam table set up at the kitchen service window included large pan of barbecue pork (regular texture), a small pan of mechanical soft pork, and puree pork. The mid-steam table contained two containers of hot vegetable one for mechanical soft texture and one puree. Directly to left of hot vegetables was large pan of cold coleslaw. The rolling cart with trays of dessert bars was next to the steam table. Individual dining tickets were handed to V20, cook, for plate service. The tickets indicated resident name and diet including allergies and preferences. V20 did not temp the food prior to serving. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 11:45 PM on 1/14/25 V21 Dietary Aide was requested to obtain the temperature of all food on the steam table with temperatures as follows regular meat 156 degrees Fahrenheit (F), mechanical meat 173 degrees F, puree meat 171 degrees F, mechanical hot vegetable 173 degrees F. pureed hot vegetable 172 degrees F, and cold coleslaw 54 degrees F. Food service continued at current temperatures. There were no other temperature checks observed. V21 stated there are no issues with temperatures of food currently. There was no hand hygiene performed during the meal service and no glove changes made after touching surfaces. V20 used gloved hand to place cornbread on each individual plate served to resident. At 12:10 PM, V3 Dietary Manager, stated they usually don't check the temperature food during service. V20, cook, provided a binder where temperatures and menus are kept at 1:15 PM on 1/14/25. V20 demonstrated binders are used for temperature logs and current weeks recipe for menu. The Document titled Production Sheet - 1/14/2025 - Facility Menu F/W 24/25 Week 2 Tuesday documents food serving temperatures at service time start. Ground BBQ Pork Shoulder 130. Coleslaw 36. On 1/14/25 at 2:13 PM V19, Registered Dietician, stated she has serious concerns with the dietary services. V19 stated that while she is the in-house dietician, the facility uses an outside consulting group for menus, food ordering, and kitchen services. V19 stated that V1, administrator, has told her that this consulting company manages food services and inspection. V19 stated that a start food temperature of 130 degrees F is below the 140 benchmark for hot foods and that especially with pork, her concern is that the meat was not cooked to temperature and therefore could cause residents to become very ill. V19 also stated that coleslaw at a temperature of 54 degrees F should have been immediately pulled off service. At 2:34 PM on 1/14/25, V24, contracted Registered Dietician Supervisor, stated the person assigned to the facility no longer works for the company. V24 stated she is not aware of the last time that someone from their company had been into the facility but stated she will contact the administrator. On 1/14/25 at 3:45 PM V3, Dietary Manager prepared the dinner meal. On 1/15/25 at 10:00 AM, the food service temperature log does not document the temperature of the food served prior, during or after meal service. On 1/15/25 at 11:50 AM, the walk-in freezer still contained the clear bin on the top shelf of the cooler dated 3/13/24 Meatballs. The substance inside was unidentifiable and contained a block of solid substance with freezer burn crystals throughout. The cooler labeled dietary aides, contained two trays of a yogurt like substance. The tray on the top shelf has pink colored yogurt dished into individual souffle cups with another serving tray placed upside down on top of cups. There was no covering on each individual cup, no identifying label, and no dates. The next tray contained an opened yogurt container with no date. The second shelf directly under contained a white yogurt substance dished into individual portion cups that were uncovered and undated with a serving tray placed upside down on top of the cups. The yogurt container next to this tray was also opened and undated. The left side of dietary aides cooler contained a shelf with a tray containing employee drinks, some unopened, and others with lids with straws. There were two containers of thickened lemon water that were not labeled with dates. In the cold storage next to the stove, there were two large slabs of red meat on trays, uncovered, both had dark red substance pooling on the tray underneath around the raw meat. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 2:00 PM on 1/15/25 V28, facility Nurse Practitioner, stated that any food not handled, stored, or cooked appropriately could cause residents to have adverse effects such as gastrointestinal upset, nausea, vomiting, diarrhea, and dehydration. The Undated facility policy, titled Chapter 3: Food production and food safety 3-22;3-23 Food Storage, documents scoops must be provided for bulk foods, the scoops are not to be stored in food and must be kept covered in protected area near the containers. Scoops are to be washed and sanitized on a regular basis. The same policy documents all foods must be covered, labeled, and dated with use by date. All leftover food must be used within 7 days or discarded per 2017 Federal Food Code. All meats, fish and poultry are to be stored below fruits, vegetables, and dairy products in coolers. The Undated facility policy, titled Chapter 3: Food production and food safety 3-26; General food preparation and handling documents, all thawing meat must be kept in a drip pan in a manner to avoid cross contamination, all meat must be cooked to temperature and internal temperature must be checked at interval times. The Dietary document titled (Name) food safety and sanitation dated 2014 documents food should not be kept in the danger zone of 41 degrees F to 135 degrees F; hot foods should be served at 135 degrees F and above and all cold foods should be served at 41 degrees F and below.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 40385 Based on observation, interview, and record review the facility failed to track culture results and organisms as part of the resident infection control logs. This failure has the potential to affect all 92 residents in the facility. The facility also failed to implement enhanced barrier precautions (EBP), provide hygienic wound care, and identify and report changes in urine for four of 24 residents (R24, R70, R45, R39) reviewed for infection control in the sample list of 38. Findings include: 1.) The facility's August 2024 - January 2025 resident infection control logs do not document culture results for wound or urinary tract infections or tracking of bacterial organisms as part of the surveillance monitoring used to identify any trends. On 1/16/25 at 9:24 AM V1 Administrator confirmed the facility's infection control logs do not document if cultures were completed or tracking of organisms. V1 stated that is something we are doing, but it just isn't logged. The facility's Long Term Care Facility Application for Medicare and Medicaid Services dated 1/13/25 documents a census of 92 residents. The facility's Surveillance and Baseline Calculations for Nosocomial Infections policy dated April 2024 documents the Infection Control Nurse or Designee is responsible for monitoring infections to determine incidences of infections, outbreaks, probably cause, and prevention. This policy documents an infection incidence report will be completed monthly, quarterly, and annually and information will be obtained including laboratory records and infection control rounds. 2.) On 1/13/25 at 2:08 PM V12 and V13 CNAs entered R70's room with a full mechanical lift and transferred R70 into bed. V12 and V13 did not apply a gown prior to entering R70's room. There was a sign on R70's door indicating EBP and to wear a gown and gloves during high contact care including transfers. V13 stated the EBP sign on R70's door was for R70's roommate. V12 and V13 stated EBP is followed only for when they are providing urinary catheter or wound care. On 1/14/25 between 12:10 PM and 12:52 PM V9 Wound Nurse, V18 Wound Nurse Practitioner, and V40 CNA entered R70's room to assess R70's wounds and administer wound treatments. These staff were not wearing gowns during R70's wound care. V9 brought the treatment cart into R70's room and placed supplies on top of the cart including R70's wound supplies and the cellular phone used to photograph wounds. V9 cleansed and applied R70's wound treatments to the left buttock wound, right ischium wound, and right heel wound. During R70's wound treatments V9 did not consistently perform hand hygiene and glove changes prior to and during each wound treatment, after handling the cellular phone, after removal of soiled dressings, after cleansing wounds, and after applying the treatment. V9 tore a piece of calcium alginate that was applied to R70's right heel and right ischium wounds while wearing the same gloves used when handling the cellular phone. V9 did not disinfect the cellular phone or treatment cart prior to or after R70's wound care. V9 left R70's room and continued rounding with V18 down the hallway with the treatment cart and cellular phone. The EBP sign remained posted on R70's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/14/25 between 4:15 PM and 4:28 PM V2 Director of Nursing stated V9 should not have taken the treatment cart into R70's room since R70 is on EBP. V2 confirmed EBP is implemented for residents with pressure ulcers and urinary catheters and gowns/gloves should be worn for all high contact cares. V2 stated V2 will need to do more education with staff on EBP. On 1/15/25 at 9:05 AM V9 stated V9 was not aware that a treatment cart should not be brought into a resident's room during wound treatments. V9 stated V9 uses a bleach wipe to disinfect scissors after use and the cellular phone used to photograph wounds. V9 confirmed V9 did not disinfect the cellular phone and treatment cart after R70's wound treatments on 1/14/25. V9 stated hand hygiene should be performed during wound care when moving from soiled to clean and when changing gloves. V9 stated V9 changes gloves and performs hand hygiene after removing soiled dressings and then V9 cleans the wound and applies the clean dressing. V9 confirmed V9 was inconsistent with glove changes and hand hygiene during R70's wound care. V9 stated V9 was not aware of EBP until after V2 spoke with V9 yesterday. V9 confirmed gowns were not worn during R70's wound care. The facility's Infection Control Enhanced Barrier Precautions policy dated 10/21/22 documents EBP expands the use of gown and gloves to be worn during high contact resident care activities that provide opportunities to transfer multidrug resistant organisms (MDROs) to staff hands and clothing that may be indirectly transferred to other residents. This policy documents that residents with indwelling medical devices and wounds are at high risk of acquiring MDROs. The facility's Hand Washing policy dated March 2024 documents hand hygiene is used to prevent the spread of infections and staff should wash their hands before/after direct contact with residents; after contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; after removing gloves; and after handling items potentially contaminated with blood, body fluids or intact skin. This policy documents to use hand sanitizer if hands are not visibly soiled before/after direct resident contact; before performing non-surgical invasive procedures; before handling clean or soiled dressings; before moving from contaminated body site to a clean site during cares; after contact with a resident's skin; after handling soiled dressings and contaminated equipment; and after removing gloves. The facility's Treatment Administration policy dated April 2023 documents to place all necessary supplies in the treatment cart, complete the treatment as ordered using stringent infection prevention and control measures and discard disposable dressings and return reusable items to the proper location. 3.) On 1/14/25 at 1:35 PM V12 Certified Nursing Assistant (CNA) was in R24's room using a sit to stand mechanical lift to transfer R24. R24 was not wearing a gown or gloves during R24's transfer. There was a sign on R24's door indicating EBP and to wear gown and gloves for high contact care including transfers. There was no personal protective equipment cart in or near R24's room. R24's Physician Order dated 2/21/24 documents R24 uses a urinary catheter. R24's Physician Order dated 3/12/24 documents R24 is on EBP. 50322 4.) R45's current care plan documents R45 has an ostomy and buttock wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/14/25 at 3:15 PM Wound care observed for R45 with wound nurse practitioner V18 and wound nurse V9. There was an EBP sign on the door and there was no personal protective equipment available outside R45's room or visualized in R45's room. No gowns or masks were worn by either V18 or V9 while assessing R45's wounds and hand hygiene was not performed before or after R45's treatment. V18 donned one glove only while touching R45 and assessing the wound. V9 brought in the treatment cart with wound care into R45's room and placed next to R45's bed. V9 did not change gloves or perform disinfection at any time prior, during, and after R45's treatment. V9 placed used instruments on top of the treatment cart, then opened drawers and grabbed items with the same dirty gloves on. On 1/14/25 between 4:15 PM and 4:28 PM V2 Director of Nursing confirmed EBP is implemented for residents with pressure ulcers and urinary catheters and gowns/gloves should be worn for all high contact cares. V2 stated V2 will need to do more education with staff on EBP. 51951 5. On 01/13/25 at 09:20 AM, R39 had an EBP (Enhanced Barrier Precautions) sign posted outside of R39's room but there was no PPE (Personal Protective Equipment) cart at R39's door. At this time, R39 stated staff wear gloves but not gowns when providing cares to R39. On 1/14/25 at 08:40 AM, R39 was lying in bed with a urinary catheter in place. The EBP sign remained posted outside of R39's room. At this time, R39 stated R39 had been told by V30 LPN (Licensed Practical Nurse) that his urine was cloudy but then a couple weeks later, R39 ended up being hospitalized with a UTI (Urinary Tract Infection). On 1/15/25 at 9:08 AM, V30 LPN stated R39 has a history of UTI's and confirmed that V30 had noticed R39's urine was cloudy, prior to R39 being hospitalized with a UTI. V30 stated V30 had written that update on a communication sheet for V28 NP (Nurse Practitioner) but that V28 never responded or replied to the update. V30 stated V28 is in the facility two days one week and three days the next. V30 provided a copy of the undated/untitled communication form that documents on 12/15/24, R39's urine is starting to get cloudy-do you want a UA (Urinalysis)? This communication form did not have a response from V28. R39's Hospital Discharge Note dated 1/2/25 documents R39 was hospitalized from 12/30/24 - 1/2/25 for a UTI. On 1/15/25 at 9:30 AM, V2 DON (Director of Nursing) stated that nursing staff are to notify the provider on call when a change of condition is observed. On 01/15/25 at 11:25 AM, an EBP sign remained posted at R39's door but there was no PPE cart in sight. V33 and V34 CNAs entered R39's room to provide catheter care and donned gloves but did not don a gown. V33 and V34 completed catheter care and exited R39's room. At this time, both V33 and V34 stated they have received EBP training but normally do not wear gowns when performing catheter cares for R39. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Catheter Care and Maintenance Policy dated March 2024 documents, residents with indwelling catheters will receive the appropriate care and monitoring as indicated in the procedures. The facility will monitor the resident's urine for unusual appearance (i.e., blood, color, consistency, odor, etc.) and will report any changes in condition such as pain or the resident experiencing fullness in the bladder, to the health care provider. The facility will monitor the resident for signs and symptoms of urinary tract infection and urinary retention which can include abdominal distention and pain, changes in volume and appearance of urinary output, fever, altered mental status or increased confusion, nausea, or vomiting, etc. Negative findings will be reported to the health care provider. The facilities Physician Notification of Resident Change of Condition Policy dated August 2023 documents, the resident's attending physician will be notified of changes that occur in the resident's condition by Licensed Personnel as warranted.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to have a qualified Infection Preventionist with the required training in infection prevention and control. This failure has the potential to affect all 92 residents in the facility. Findings include: The facility's Facility assessment dated [DATE] documents the facility will have an Infection Control Preventionist as part of its staffing plan. On 1/14/25 at 10:48 AM V1 Administrator stated V9 Wound Nurse/Infection Preventionist was recently hired as the Infection Preventionist for the facility with the intention of V9 completing the Infection Prevention training course. V1 stated nurse managers and V1 have collectively been overseeing the Infection Preventionist role prior to V9 being hired. On 1/15/25 at 1:33 PM V1 confirmed V1 does not have completed infection prevention training to provide for any of the nurse managers who are involved in the infection control program. On 1/15/25 at 9:05 AM V9 stated V9 has not officially taken over as the facility's Infection Preventionist and V1 has been handling the infection prevention and control. V9 stated V9 has not completed the infection prevention and control training course. The facility's Long Term Care Facility Application for Medicare and Medicaid Services dated 1/13/25 documents a census of 92 residents.