Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145636	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charleston Rehab & Health CC	716 Eighteenth Street Charleston, IL 61920

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 50993 Based on observation, interview, and record review the facility failed to ensure that call lights were in reach for four (R28, R32, R6, and R29) of 24 residents reviewed in a sample list of 39. Findings Include: The facility's Certified Nursing Assistant's Guidebook dated 2021 documents to ensure the call light is in reach before leaving the room. 1.) On 9/03/2024 at 9:52 AM, R28 was laying in the bed. R28's call light was not in R28's reach. The call light cord was laying on the floor at the foot of R28's bed. R28's care plan dated 3/13/2023, documents R28 is a high risk for falls. This care plan includes an intervention to ensure that the call light is within reach and to encourage R28 to use it as needed for assistance. 2.) On 9/03/2024 at 10:03 AM, R32 was laying in bed. R32's call light was not in R32's reach. A bedside table was positioned up against R32's head of the bed. R32's call light was laying on the floor on the side of the bedside table furthest from the bed. On 9/06/2024 at 8:55 AM, R32 was sitting up in a wheelchair in R32's room. R32's call light was not in R32's reach. The call light was tied to a stuffed animal sitting on the bedside table behind R32 and out of his reach. R32's care plan dated 6/12/2024 documents R32 is at high risk for falls. This care plan includes an intervention to ensure that R32's call light is within reach. 3.) On 9/03/24 at 10:21 AM, R6 was sitting up in a recliner in R6's room. The call light was not in R6's reach. The call light was laying on the floor. R6's care plan dated 3/16/2023 documents an intervention to ensure R6's call light is within reach and encourage R6 to use it for assistance as needed. 4.) On 9/03/24 at 10:08 AM, R29 was sitting up in R29's room in an adaptive wheelchair in the middle of the room. The call light was not in R29's reach. The call light string had a ping pong ball attached to it and was laying on the floor. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R29's care plan dated 5/31/2024 documents R29 is at risk for falls due to confusion, gait, and balance problems. This care plan includes an intervention to ensure R29's call light is within reach. On 9/05/24 at 10:51 AM, V3 Assistant Director of Nursing states all residents call lights should be in reach at all times.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to protect residents' right to be free from physical abuse by another resident. This failure affected two of two residents (R44, R58) reviewed for abuse on the sample list of 39. Findings include: R58's Resident to Resident Physical Aggression Initiated form dated 8/28/24 at 03:36 am documents the following: (R58) grabbed the other resident's (R44) arm. The other resident (R44) swung empty coffee cup at other resident (R58) without making contact. Second resident (R44) received a small laceration on his rt. (right) forearm. The same form documents: Predisposing Situation Factors (box checked) Wanderer. The same form documents: Resident (R58) has Schizophrenia, Dementia with Psychosis. R58's Minimum Data Set (MDS) dated [DATE] documents R58's Brief Interview of Mental Status score of 11 of a possible 15, indicating moderate cognitive impairment. R58's same MDS documents: Indicators of Psychosis: Yes (box checked) Delusions. The same MDS documents R58 has a behavior of wandering daily, during the seven day look back period of this assessment. On 9/4/24 at 1:25 pm R58 pleasantly confused seated at a table in resident common corridor alcove, alone. R58 is seated in a stationary chair across from V2, Director of Nursing Office. R58 stated he doesn't remember having an altercation with anyone recently. R58 talked about fighting in a war in [NAME] where he had to defend himself in combat. On 9/4/24 at 1:35 pm V1, Administrator/Abuse Prevention Coordinator stated, without a doubt, the allegation of physical abuse of (R44) by (R58) is substantiated. R44's Behavior Note dated 8/28/24 at 2:45 am documents the following: Note Text: Res (resident) was in confrontation between 2 res (resident) (R58 and R44). Res (resident) received abrasion (later identified as laceration) to right forearm, cleansed, approximated wound, steri-stripped (adhesive wound closure to hold both sides of a laceration together), no bleeding noted. Police (local), Adm (V1, Administrator), DON (V2, Director of Nursing), on call nurse (unidentified) notified. R44's MDS (minimum data set) dated 8/21/24 documents R44 has a BIMS (brief interview for mental status) score of 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R44 has had behaviors of verbal aggression towards others, one to three days during the seven day look back period of this assessment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 8:50 am V10, Certified Nursing Assistant (CNA) stated I worked the night shift (8/28/24) when (R44 and R58) got into it. I did not actually see anything. I heard (R58 and R44) yelling and walked from the hall I was working, to their hall. I did not report to the (V1, Administrator) someone else did. I think it was the nurse. I can't remember who it was. (V3, Assistant Director of Nursing /ADON) came in and dealt with it. (R44's) arm was bleeding when I got over here. The residents were already separated. No one asked me anything about the situation, I guess because I did not see it happen. (R58) has hallucinations and wanders all over the place. He may have thought (R44) was someone else. He probably can't tell you anything. He has Dementia. He was put on one on one (observations) then, and a couple of times before. I have never seen him aggressive with any other resident. He is sometimes with staff. (R44) is reliable in what he says, and likely remembers everything. On 9/5/24 at 11:20 am R44 was seated in his room, in a wheelchair. R44's right forearm had a two inch by two-inch bandage that covered a wound. R44 stated Last week, I had a situation with another resident (R58). That was the only problem I have had with another resident. There is a very confused guy (R58) who wanders the halls, constantly. I was coming down the hall in my wheelchair, he was behind me. He first threw a plastic coffee cup at me and hit me in the head. I turned and he was close enough to stab at me with a butter knife, he had in his hand. He cut my arm and it bled for a minute. It was not very bad, but it p*****(expletive) me off. I (R44) had a cup of coffee in my hand and threw it in his (R58) face. It was a natural reflex. The coffee was not hot, just warm. The cops came out and took a report. They (local police department) wanted to know if I wanted to press charges. There was no sense in that, the guy is totally confused and would never remember what happened anyway. The facility, Alleged Physical Abuse Final report of the incident occurring between R44 by R58 on 8/28/2024 documents the physical altercation occurred. Also documented staff assessed R44 and cleansed and steri-stripped his laceration. The facility policy ABUSE, PREVENTION AND PROHIBITION POLICY dated as revised January 2024, documents the following: STATEMENT OF INTENT Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The same policy documents the following: Definitions: Abuse -means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Willful as defined in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 31642 Based on interview and record review the facility failed to complete a thorough physical abuse investigation related to a resident-to-resident altercation. This failure affects two of two residents (R44, R58) reviewed for abuse on the sample list of 39. Findings include: The facility Alleged Physical Abuse Final report of R44 by R58 documents on 8/28/24 around 0200 the resident (R58) had an altercation with resident (R44). Per witness statements from staff and report from (R44), (R58) was unprovoked and went to (R44) who was in his wheelchair by the nurse's station heading to get coffee and (R58) grabbed (R44) (R44) right arm causing a laceration. R2 (R44) yelled and the CNA (unidentified) that was behind the nurse's station immediately got up and went to address the situation and yelled for another CNA (unidentified) to help separate the residents quickly. As CNA was approaching (R58) and (R44), (R44) began to swing his cup at (R58) in defense. There is no conclusion documented in the investigation that the facility acknowledged alleged abuse was or was not substantiated. On 9/4/24 at 1:20 pm V1, Administrator/Abuse Prevention Coordinator and V2, Director of Nursing provided a one page initial and one-page final report regarding R44's alleged physical abuse by R58. There were two witness statements signed by V12, and V13 Certified Nursing Assistants provided as the full investigation. There were no resident interviews and no other staff interviews. V1 confirmed there were no other staff or resident interviews conducted. On 9/5/24 at 8:50 am V10, Certified Nursing Assistant (CNA) stated V10 worked the night shift when R44 and R58 altercation occurred. V10 stated she heard R44 and R58 yelling. V10 stated V10 came over to R44 and R58's unit after they had been separated. V10 saw R44's arm was bleeding. V10 stated No one asked me anything about the situation, I guess because I did not see it happen. On 9/5/24 at 12:00 pm V20, Regional/Administrator stated the facility is expected to complete a full abuse investigation that includes interviews of all staff working during the event, as well a resident interviews to determine if there had been any other incidents of abuse. The facility policy ABUSE, PREVENTION AND PROHIBITION POLICY dated as revised January 2024, documents Investigation: Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. While a facility investigation is under way, steps will be taken to prevent further abuse. If a person is identified in the allegation of abuse, that person will not be allowed access to the facility while the investigation is in progress, except to meet with the administrator as part of the investigation. The person identified in the allegation of abuse will have no contact with residents or other employees during the investigation process. Implement steps to prevent further potential abuse. (See section on Protection: Resident to Resident Altercation, Employee Allegations or Other Potential Perpetrators). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The same policy includes the following staff directive: * Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing statements if indicated. * Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift only will give a statement if indicated. * Interview the resident if they are cognitively able to answer questions in a private setting free from any intimidating factors. Request that a staff member who has a special rapport participate if possible. If the resident is not interviewable, question the roommate and any family or friends who visit frequently with completion of a questionnaire. On 9/06/24 at 11:20 am, V20, Regional/Administrator submitted the abuse investigation guidelines, then stated the facility is expected to ensure alleged abuse allegations are thoroughly investigated by following the ABUSE INVESTIGATIVE GUIDELINES which include: * Initiate Timeline and document all steps of investigation as they occur. * Team member and resident statements: > State exactly whom you spoke with and the date and time. > Any interviews conducted should be completed by 2 management level staff. > Statements should be typed, dated and signed. > Other residents should be interviewed to ensure they feel safe and don't have concerns with abuse/neglect.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50993 Based on interview and record review the facility failed to request a new Level 1 PASARR within 30 days of admission for one (R32) of one resident reviewed for PASARR in a sample list of 39. Findings include: R32's Level 1 PASARR (Preadmission Screening and Resident Review) dated [DATE] documents, Your Level 1 screen shows you have evidence of serious or intellectual disability (IDD). Further PASARR is not required because you meet the criteria for an exempted hospital discharge. This means you may stay up to thirty (30) days in a Medicaid certified nursing facility without further PASARR evaluation. If you or your care provider thinks you need to stay longer than thirty (30) days, a nursing facility staff member must submit a new level 1 screen to Maximus. This must be completed by or before the 30th day after your admission to the nursing facility. There were no other PASARR screenings in R32's medical record. On [DATE] at 12:20 PM, V1 Administrator states they had not requested a new PASARR (for R32)and the current PASARR is expired.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35347 Based on interview and record review, the facility failed to identify a residents' specific behaviors necessitating anti-psychotic medication use. The facility also failed to develop, implement, and care plan non-pharmacological interventions prior to use of anti-psychotic medication. These failures affect one resident (R20) of five reviewed for unnecessary medications in the sample list of 39. Findings include: R20's Physician Orders (printed 9/5/2024) document the following anti-psychotic medication order: Risperidone (anti-psychotic medication), give a 0.25 milligram tablet orally once daily for Major Depressive Disorder with a prescription start date of 3/4/2024. R20's Care Plan (printed 9/5/2024) does not document any specific targeted behaviors, expressions of psychic distress, or non-pharmacological interventions in lieu of anti-psychotic medication use for R20. R20's quarterly assessment (1/6/2024) documents R20 does not have indicators of psychosis and does not have behaviors. On 9/5/2024 at 10:55AM, V8 denied R20 has indicators of persistent psychic distress or persistent behaviors endangering R20 or other people. On 9/6/2024 at 10:33AM, V3 (Assistant Director of Nursing) reported the facility has not done behavior tracking for R20 and stated (R20) seldom comes out of (R20's) room.

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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. 31642 Based on observation, interview and record review, the facility failed to provide dependent residents timely assistance to eat. This failure affected seven out of seven residents (R1, R3, R29, R34, R37, R40, and R51) reviewed for dining assistance on the sample list of 39. Findings include: The facility Resident Council Meeting Minutes dated 5/03/24 documents: No CNA (Certified Nursing Assistance) at the (resident assistance) table at night (evening meal). Playing on their phones. R1, R3, R29, R34, R37, R40, and R51's current care plan document they each require physical staff assistance with dining. On 9/3/24 at 12:04 pm - 12:45 pm during dining observation, there was an approximately nine-foot, designated dining room table for resident's dependent on physical staff assistance to consume their meal. The designated table had seven residents (R1, R3, R29, R34, R37, R40, and R51) present and waiting to be assisted with dining. All seven resident meals had already been served by 12:04 pm. Each of the seven residents' food plate had the plate cover removed, and the food left open to air. There was one staff member (V6, CNA) present, who sat down to feed R29, while the remaining six residents sat waiting for assistance. At 12:25 am a second staff member (V7, CNA) sat down at the feeding assistance table and started to feed R37 to eat. (21 minutes after dining observation began). R1, R3, R34, R40 and R51 continued to wait for feeding assistance. On 9/03/24 at 12:35 pm V6, CNA stated Usually we have more people to help feed. Today, I could not make it down here soon enough to start helping. The resident food was already on the table. I was taking care of a resident (unidentified) on the hall. I did not get started until later then I usually do. On 9/03/24 at 12:38 pm V7, CNA stated Usually we do have more help. Several CNA's (unidentified) are down the hall helping other residents (unidentified). On 9/03/24 at 12:43 V2, Director of Nursing (DON) sat down to assist residents at the feeding assistance table. V2 confirmed there was only two staff present to provide feeding assistance to the seven residents. V2, DON stated the facility usually has more staff feeding residents. V2, DON also stated The resident should never have to wait 40 minutes for assistance. On 9/5/24, 1:30 pm- 2:00 pm the resident group meeting included the following five residents: R14, R35, R42, R47, and R57. All five residents stated the facility continues to feed residents at the feeding assistance table late, and without enough staff. The undated facility protocol Staff Interaction - Communal Dining documents: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guidelines: Staff members will strive to enhance the resident's quality of life while serving meals that meet nutritional needs, offers choice, is served with dignity and considers the person-centered care plan. Staff will offer personal attention to each resident and monitor the resident's satisfaction and food intake. The same protocol documents: Procedure: number 16. Staff will be available to assist residents in a timely manner with cueing, assisting, feeding, buttering bread, cutting, opening condiments, etc. The facility protocol Serving Meals dated 2021 documents: Assisting Residents with Eating directs staff as follows: No more than two residents at a time will be assisted by one CNA with eating.

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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. 50993 Based on observation, interview, and record review the facility failed to apply treatments as ordered by the physician and care plan interventions for two (R34 and R12) of two residents reviewed for skin condition in a sample list of 39. Findings include: 1.) On 09/03/2024 at 10:53 AM, R34 was sitting in a geriatric chair in the day room. There was a six inch long scabbed area to R34's face on the right cheek. R34 had multiple small scabbed areas to R34's arms, chest, and face. There was scattered red flaky patches on R34's skin. There was blood present under R34's fingernails. On 09/03/2024 at 12:16 PM, V21 (R34's family member) stated R34 has a history of Eczema and frequently itches and picks at R34's skin. R34's physician order dated 7/09/2024 document an order for Tacrolimus cream (topical ointment used for Eczema) twice a day for 14 days and then as needed after the 14 days. R34's medical record also includes a physician order dated 2/16/2024 to apply Calamine External lotion twice a day as needed for itching. R34's Medication and Treatment Administration Records dated July, August, September 2024 does not document an order for Tacrolimus after 7/23/2024. These records do not document that the Calamine lotion was applied for itching. R34's Weekly Skin Checks dated 7/13/2024, 7/21/2024, 7/28/2024, 8/04/2024, 8/24/2024, and 9/01/2024 documents self inflicted scratches to the right and left inner elbow, right and left lower legs, right and left upper arms, and back of head. R34's Care Plan updated on 1/29/2024 documents R34 had increased itching of body and scalp. This Care Plan was not revised with the new intervention of using creams for Eczema and itching. On 09/05/2024 at 10:37 AM, V8 (Wound Nurse) states R34 scratches are self inflicted due to excessive itching. V8 states the Tacrolimus cream was effective and should be a current order. V8 states that R34 also has an order for Calamine lotion to be used as ordered. On 9/06/2024 at 10:30 AM, V3 (Assistant Director of Nursing) states that V3 would expect that if the cream was given it would be documented on the Medication Administration Record and would assume the cream was not used if it was not signed off. 2.) On 9/04/24 at 1:10 PM, V22 (Registered Nurse) removed dressing from R12's left foot. The dressing was saturated with yellow and red drainage. Two quarter sized open wounds were present to the left foot. Slough and Eschar was present to the wound beds. V22 applied betadine to the wounds and covered with an adhesive border dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Care Plan updated 8/06/2024 documents an intervention to administer treatments as ordered and monitor for effectiveness. On 9/05/2024 at 10:37 AM, V8 (Wound Nurse) stated R12's wound to left foot is a diabetic ulcer. V8 stated the treatment order changed on 9/03/2024 due to the wound opening and draining. The new order was for Medihoney and Calcium Alginate daily. V8 stated R12 should have used Medihoney and Calcium Alginate as ordered by the physician. V8 stated the order was not put into the medical record, but should have been on 9/03/2024 when the order was received.

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NAME OF PROVIDER OR SUPPLIER: Charleston Rehab & Health CC		STREET ADDRESS, CITY, STATE, ZIP CODE: 716 Eighteenth Street Charleston, IL 61920	

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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 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. 50993 Based on observation, interview, and record review the facility failed to provide catheter care in a manner that prevented cross contamination, ensure urinary collection bags were placed up off the floor, secure a residents catheter tubing, and failed to develop a catheter care plan for residents. This failure affects three (R28, R6, R29) of three residents reviewed for catheters on the sample list of 39. Findings include: 1.) On 9/4/24 at 11:22 am Certified Nurse Assistants (CNA) V10 and V11 performed catheter care on R29. R29's Physician's Order Sheet (POS) dated September 2024 documents the following for R29: Obstructive and Reflux Uropathy, Unspecified and Retention of Urine, Unspecified. The same POS has an order for R29 to have an 18 French foley catheter with a 30cc balloon which is ordered to be changed every 30 days. R29 also has a meatal tear at the tip of his penis. V10, was the CNA performing catheter care and V10 used no rinse wipes on R29. V10 cleaned around the end of the penis with a wipe and did not change the area of the wipe and proceeded to wipe down R29's shaft of the penis. V10 then continue to provide care for R29 by having V11 assist her in turning R29 on his right side toward the window so V10 could clean the buttock's area. V10 took a clean wipe to R29's buttocks and went up the buttocks and then came down the buttocks with the same area of the washcloth. After completing the buttocks area and putting a new depends on R29 V10 and V11 rolled R29 back onto his back. V10 then started to clean the catheter and took a new wipe and wiped down the catheter tubing and did not anchor the tubing at the meatus, when V10 was cleaning the tubing, she was pulling on the catheter. V10 stated she was completed with R29's catheter care. On 9/4/24 at 11:30 AM V10 stated the catheter tubing was attached to the left thigh area by tape. V10 also stated I did not realize V10 was going in the wrong direction when cleaning R29's back side. The facility's policy titled Catheter Care, Urinary revised date 01/2017 documents under section titled Procedure Number 11 and 12 states For a resident male: Use a washcloth with warm water and soap to cleanse around the meatus. The policy also documents, Change the position of the cloth with each cleansing stroke. The policy also documents, use a clean washcloth with warm water and soap to cleanse and rinse the catheter from the insertion site outward. Secure the catheter. V2, Director of Nurses (DON) stated on 9/4/24 at 3:15 pm, Yes, I was told by V10 you said she did not do the catheter care correctly. Yes, V10 should of anchored the catheter at the opening of the penis when she was cleaning the catheter tubing. 2.) On 9/03/2024 at 10:21 AM, R6 sitting up in a recliner and was undressed from the waist down. R6's urinary catheter drainage bag was laying flat on the floor uncovered. The catheter tubing was not secured to R6's leg, and R6's hands were over R6's genitals touching and moving the catheter tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/04/2024 at 1:28 PM, V11 (Certified Nursing Assistant) provided catheter care to R6. When starting and finishing the catheter care the catheter tubing was not secured to the leg. V11 left the room without securing the catheter tubing to R6's leg. R6's care plan dated 3/13/2023 does not include interventions or goals for R6's catheter care and maintenance. On 9/05/24 at 10:51 AM, V3 (Assistant Director of Nursing) states catheter bag should never be laying on the floor. The facility's Catheter Care Policy dated 01/2017 documents the purpose of this policy is to prevent catheter associated Urinary Tract infections. This policy documents to be sure the catheter tubing and drainage bag are kept off the floor and to secure the catheter. 3.) On 09/03/24 at 9:52 AM, R28's urinary catheter drainage bag was laying flat on the floor. laying in bed uncovered catheter bag laying in the floor with clear yellow urine present. R28's Care Plan dated 11/08/2023 documents R28 has an indwelling catheter. This care plan includes a goal to have no signs and symptoms of a Urinary Tract Infection. On 9/05/24 at 10:51 AM, V3 (Assistant Director of Nursing) states catheter bag should never be laying on the floor. The facility's Catheter Care Policy dated 01/2017 documents the purpose of this policy is to prevent catheter associated Urinary Tract infections. This policy documents to be sure the catheter tubing and drainage bag are kept off the floor and to secure the catheter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35347 Based on interview and record review, the facility failed to hold administration of a resident's blood pressure medication per medical provider's orders. This failure resulted in R14 receiving unordered medication for an additional 23 days. This failure affects one resident (R14) of five reviewed for unnecessary medications in the sample list of 39. Findings include: R14's diagnosis list (9/4/2024) documents the diagnosis of hypertension (high blood pressure). R14's Physician Orders (printed 9/4/2024) documents R14 was ordered the medication spironolactone, 50 milligrams by mouth, once daily, beginning on 6/10/2024. On 9/3/2024 at 12:00 PM, R14 reported taking the medication spironolactone (a diuretic primarily used to treat high blood pressure) and then having low blood pressure and feeling dizzy from the medication. R14 reported also taking other blood pressure medications and recently refusing additional doses of the spironolactone after experiencing the symptoms of low blood pressure and dizziness. V5 (R14's medical provider) documented (progress notes 8/6/2024) R14 complained of symptoms including nosebleed, dizziness, and weakness. V5 documented R14's nurse (unidentified) reported R14 had a low blood pressure measurement. The same notes document R14 was also taking additional blood pressure medications including losartan, furosemide, and clonidine for management of R14's hypertension and facility staff were ordered to hold R14's administration of spironolactone medication. R14's Physician Orders (printed 9/4/2024) document R14's spironolactone medication was on hold beginning on 8/6/2024 with an end date of indefinite. R14's August and September (2024) Medication Administration Records document facility staff held R14's spironolactone medication on August 7-9, 2024, and then resumed administration of the medication from August 10-September 1, 2024, inclusive. The same record documents R14 began refusing any further doses starting on September 2, 2024. On 9/5/2024 at 9:35AM, V5 reported holding R14's spironolactone on 8/6/2024 due to R14 having symptoms of a nosebleed, low blood pressure, and dizziness. V5 reviewed R14's electronic medical record and could not locate any order releasing V5's medication hold for facility staff to resume administering spironolactone to R14. R14's Physician Orders (printed 9/4/2024) documents V5 entered an order at 12:29PM on 9/5/2024 to discontinue R14's spironolactone.

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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. 35347 Based on interview and record review, the facility failed to prevent unnecessary use of anti-psychotic medication (Risperidone) by failing to identify and document an approved diagnosis for anti-psychotic use and failing to identify and track targeted behaviors or persistent psychiatric distress necessitating the use of anti-psychotic medication. These failures affect one resident (R20) of five reviewed for unnecessary medications in the sample list of 39. Findings include: R20's Order Summary Report (printed 9/5/2024) documents R20's diagnosis list including diagnoses of Major Depressive Disorder and Anxiety Disorder. No other psychiatric diagnoses are present on the Report. The same record does not document any diagnosis approved for use of anti-psychotic medication. R20's Physician Orders (printed 9/5/2024) document the following anti-psychotic medication order: Risperidone (anti-psychotic medication), give a 0.25 milligram tablet orally once daily for Major Depressive Disorder with a prescription start date of 3/4/2024. On 9/5/2024 at 10:55AM, V3 (Assistant Director of Nursing) and V8 (Registered Nurses) could not locate any psychotropic medication assessment in R20's electronic medical record (undated) for R20's anti-psychotic medication use. On 9/5/2024 at 10:55AM, V8 denied R20 has indicators of persistent psychiatric distress or persistent behaviors endangering R20 or other people. On 9/5/2024, R20's electronic medical record (undated) does not document any specific targeted behaviors or indicators of persistent psychiatric distress necessitating R20's use of anti-psychotic medication. R20's quarterly assessment (1/6/2024) documents R20 does not have indicators of psychosis and does not have behaviors. On 9/6/2024 at 10:33AM, V3 (Assistant Director of Nursing) reported the facility has not done behavior tracking for R20 and stated (R20) seldom comes out of (R20's) room. The facility Psychotropic Medication Use policy (9/2022) documents residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective, staff will complete a Psychoactive Medication Review assessment upon admission and quarterly when any psychotropic medication is ordered, and antipsychotic medications will generally only be used for the diagnoses of Schizophrenia, Tourette's Disorder, and Huntington Disease.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to honor food preferences for one of seven residents (R34) reviewed for food preferences on the sample list of 39. Findings include: R34's Minimum Data Set, dated dated dated [DATE] documents R34's Brief Interview of Mental Status score as three out of a possible 15, indicating severe cognitive impairment. R34's current Physician Order Summary Sheet documents R34's diet order as Regular diet, Mechanical Soft texture, Honey/Moderately Thick consistency (liquids). R34's undated Lunch Meal Ticket undated, documents R34 dislikes all vegetables. On 9/5/24 at 12:20 pm, V7, Certified Nursing Assistant (CNA) was feeding several residents (unidentified) at the resident assisted dining room table. R34's plate of mechanical soft meat, mashed potatoes and whole cooked cauliflower was untouched. V7 stated R34 did not like what was served, and V7, CNA had ordered R34 a grilled cheese. V7, CNA confirmed R34's diet card documents R34 does not like any vegetables. V7, CNA confirmed R34's plate of food included cauliflower. The facility protocol Serving Meals dated 2021 directs staff to honor Make sure resident's food preferences are honored before the plate is served.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 31642 Based on interview and record review the facility failed to ensure required personnel attended the quarterly Quality Assessment and Assurance (QAA) committee meetings and failed to hold (QAA) committee meetings quarterly. This failure has the potential to affect all 60 residents residing in the facility. Findings Include: The facility QA (Quality Assessment & Assurance) Meeting Members list documents the required facility leadership and staff except there is no required Infection Preventionist on the QA member list. The facility QAPI (Quality Assurance Performance Improvement) Policy plan updated January 2024 documents the following: The QAPI Program takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality while involving all caregivers in practical and creative problem solving. The community QAPI Program achieves the following: monitor quality/performance, find opportunities for improvement, improve performance, achieve resident/family desired outcomes, meet regulatory requirements, understand the CMS survey process and regulations, provide a QAPI path to correcting issues. The QAPI Program consists of monthly/quarterly meetings, daily quality assurance activities, 'QAPI tasks' and Performance Improvement Plan. On 9/4/24 at 9:33 am V2, Director of Nursing provided QAPI Plan, QA Meeting Members list, and QA attendance sign- in sheets. V2 confirmed the documents V2 provided. V2 stated Yes, that is all. Short and sweet. The QA Members list does not include an Infection Control Preventionist. The QA quarterly attendance sheets dated January 15, 2024, document the fourth quarter of 2023 meeting and do not have an Infection Control Preventionist signature. There is no documentation that a first quarterly QA Meeting 2024 took place. The QA quarterly attendance sheets dated June 19, 2024, document the second quarter of 2024 meeting and do not have an Infection Control Preventionist signature. On 9/6/24 at 11:20 am V1, Administrator confirmed the facility did not have an Infection Control Preventionist at the QA meetings. V1 stated those meetings were prior to V14, Infection Control Preventionist hire date of August 1, 2024. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 09/03/24 documents 60 residents currently reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024

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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. 50993 Based on interview and record review the facility failed to have an operational Legionella water management plan. This failure has the potential to affect all 60 residents residing in the facility. Findings include: The facility's Legionella Management Procedure documents that this procedure policy was last reviewed on 8/10/2018. This policy did not contain an assessment to identify areas where Legionella and other pathogens could grow and spread, or measures to prevent and monitor the growth of water borne pathogens. On 9/05/24 at 12:05 PM, V24 (Maintenance Director) stated he has been the facility's Maintenance Director for about four years. V24 stated V24 has not done anything with the Legionella water management plan since he started. V24 stated, Corporate has never talked to me about that. V24 stated he has never assessed the building for areas where Legionella or other pathogens could grow. V24 stated he does not have a routine to flush water lines that are not in use. On 9/05/24 at 12:08 PM, V14 (Regional Infection Preventionist) states V24 is responsible for implementing and following the facility's Legionella water management plan. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 9/3/24 documents there is 60 residents residing in the facility.

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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. 50993 Based on interview and record review the facility failed to ensure the Infection Preventionist completed specialized training in infection prevention. This failure has the potential to affect all 60 residents in the facility. Findings Include: The facility's Infection Control Manual dated 2019 documents, the facility will designate an Infection Preventionist, the Infection Preventionist will have completed specialized training in infection prevention and control. On 9/04/24 at 11:06 AM, V2 (Director of Nursing) states V14 (Regional Infection Preventionist) is acting as the facility Infection Preventionist until a facility nurse is trained to take over the role and is educated. On 9/04/24 at 2:16 PM, V14 stated she is the facility's Infection Preventionist, and she does not currently have a copy of her training certificate and she will try and bring it tomorrow. On 9/06/24 at 8:30 AM, V8 (Wound Nurse) stated V14 couldn't find her certificate but would be in the facility later today. On 9/06/24 at 11:00 AM, V3 (Assistant Director of Nursing) states that V14 would not be in the facility today. V3 stated V14 could not find her training certificate. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 9/3/24 documents there is 60 residents residing in the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 50993 Based on interview and record review the facility failed to offer influenza vaccinations for one (R6) of five residents reviewed for immunizations on a sample list of 39. Findings include: The facility's Infection Prevention and Control Manual dated 09/2022 documents it is the policy of this facility that all residents will be offered influenza vaccinations. R6's immunization report documents R6 routinely received the influenza vaccination. This report documents that R6 received the influenza vaccine in 2010, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, and 2021. This report does not document that R6 received the influenza in 2022 or 2023. R6's medical record does not document that R6 was offered the influenza vaccination in 2022 or 2023. On 9/06/24 at 8:26 AM, V8 (Registered Nurse) states that they have no records for R6's influenza vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 50993 Based on interview and record review the facility failed to offer a vaccination booster for Covid-19 for one (R36) of five residents reviewed for immunizations in a sample list of 39. Findings Include: On 9/03/24 at 10:40 AM R36 states he has not been offered any vaccinations since admitted to the facility. R36 states he would like to receive the Covid-19 booster immunization. R36's immunization record documents R36 has not received a Covid-19 vaccination since 4/01/21. On 9/06/24 at 8:26 AM, V8 (Registered Nurse) stated the facility had a Covid-19 vaccination clinic from an outside organization in June of 2024. V8 stated R36 should have been offered a Covid-19 vaccine during the vaccination clinic, but his name was not placed on the list for the clinic. V8 stated R36 should have been on this list to receive the Covid-19 vaccination.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 31642 Based on record review and interview, the facility failed to ensure staff were provided the required abuse prevention education. This has the potential to affect all 60 residents in the facility. Findings include: On 9/6/24 at 11:24 V1, Administrator /Abuse Prevention Coordinator confirmed the facility has no facility-wide documentation of staff education on abuse training to provide this surveyor. V1 stated the current new company providing management of the facility does not have access to the previous owner of the facilities education documents. The facility policy ABUSE, PREVENTION AND PROHIBITION POLICY dated as revised January 2024, documents the following: The facility's abuse prohibition program includes the following seven components: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response: The facility Administrator will be designated as the facility Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation. If the Administrator is not available to address this role, the Administrator will designate a person in charge in their absence to fulfill the role. This person would normally be the Director of Nursing. The same policy documents: Training: Facility staff shall be trained on the Abuse Prohibition Program during orientation, annually and ongoing during educational sessions, and per state regulations. The facility may utilize speakers, training videos or other mechanisms to help staff understand the importance of Abuse Prohibition and Prevention. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 09/03/24 documents 60 residents reside in the facility.