STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145649	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Odin Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Green Street Odin, IL 62870	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview and record review the facility failed to respond in a timely manner to resident's requests and/or needs for assistance to promote dignity for 4 of 9 (R4, R8, R11, R12) residents reviewed for dignity in the sample of 17. This failure would result in a reasonable person experiencing feelings of embarrassment, shame, anger, and frustration. Findings Include: 1.R8's Admission Record with a print date of 3/25/24 documents R8 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, osteoarthritis, heart failure, hypertension, and bradycardia. R8's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 01, which indicates a severe cognitive impairment. This same MDS documents R8 requires partial/moderate assist of staff for toileting and is occasionally incontinent of bladder and always incontinent of bowel. R8's current Care Plan documents under the Focus Area initiated on 8/12/22 of Self-Care deficit as evidenced by: Needs assistance with ADL's (Activities of Daily Living), include the intervention of Toilet Use-one-person physical assist required. On 3/19/24 at 12:08 PM, R8 was sitting on a couch with a peer next to the nurse's station. R8's pants were wet with what appeared to be urine. Intermittent observation began at this time and continued through 12:44 PM. R8 remained on the couch and pants remained wet. At 12:46 PM, V24 (CNA) woke R8 up (who had fallen asleep on the couch) and walked with R8 to the dining room table. The back of R8's pants were saturated with what appeared to be urine. V24 assisted R8 to sit in the dining room chair while standing behind R8 and did not provide or offer to provide incontinence care. Intermittent observation continued of R8 until 2:25 PM, from 12:46 PM until 2:25 PM, R8 remained in the same dining room chair and in the same pants. This surveyor informed V38 (ADON) and she assisted R8 from the dining room for incontinence care. On 3/19/24 at 3:21 PM, when asked why she didn't assist R8 with incontinence care when she walked with him to the dining room, V24 (CNA) stated, He was wet? I didn't see it. I didn't see it at all. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145649	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R11's Admission Record with a print date of 3/25/24 documents R11 was admitted to the facility on [DATE] with diagnoses that include metabolic encephalopathy, COPD, diabetes, hypertension, and heart disease. R11's MDS dated [DATE] documents a BIMS score of 14, which indicates R11 is cognitively intact. This same MDS documents R11 is always incontinent of bladder and bowel incontinence is not rated on this assessment. R11's current Care Plan documents a Focus Area initiated on 9/13/22 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This focus area includes the intervention of, Toilet Use: One-person physical assist required, Date Initiated: 10/21/22. On 3/25/24 at 1:47 PM, R11 stated she gets assistance with toileting. R11 stated she has had to wait up to 30 minutes for assistance after she has had an incontinence episode. R11 stated she has talked with an unknown nurse about how long it takes. 3. R12's Admission Record with a print date of 3/25/24 documents R12 was admitted to the facility on [DATE] with diagnoses that include hemiplegia, hemiparesis, COPD, asthma, diabetes, morbid obesity, seizures, anxiety disorder, and sleep apnea. R12's MDS dated [DATE] documents a BIMS score of 12, which indicates a moderate cognitive impairment. This same MDS documents R12 is dependent on staff for toileting. R12's current Care Plan documents a Focus Area initiated on 8/2/23 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This focus area includes an intervention of Toilet Use: Two-person physical assistance required. R12's care plan does not have a Focus Area related to incontinence but does document under the Focus Area of Actual Pressure Ulcer . an intervention of Monitor incontinence and provide peri-care after each incontinent episode, Date Initiated: 3/25/24. On 3/21/24 at 11:40 AM, V42 (CNA) stated she had reported an incident related to R12 to administration and as far as she knows administration didn't follow up. V42 stated she walked past R12's room a few weeks ago and R12 yelled at her to come to her room. V42 stated R12 reported to her she had a bowel movement and an unknown staff member had told her twice they couldn't change her. V42 stated R12 was lying in bed, didn't have her call light, had the mechanical lift sling under her, and didn't have a blanket. On 3/25/24 at 1:43 PM, R12 stated she doesn't use the commode, she is incontinent, and wears incontinence briefs. R12 stated she has had to wait 30 minutes to an hour to get assistance with incontinence care and/or for staff to answer the call light. R12 stated she currently needs her incontinence brief changed and has been waiting for 20 minutes. 4. R4's Admission Record with a print date of 3/25/24 documents R4 was admitted to the facility on [DATE] with diagnoses that include COPD, heart failure, diabetes, chronic kidney disease (CKD), hypertension, weakness, and anemia. R4's MDS dated [DATE] documents R4 has moderate cognitive impairment, requires substantial/maximal assistance from staff for toileting, and is always incontinent of bladder with bowel incontinence not rated. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's current Care Plan documents a Focus Area of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This Focus Area includes the intervention of Toilet Use: Two-person physical assistance required. On 3/18/24 at 4:45 AM, V13 (LPN) stated when the CNAs were doing rounds (at the beginning of this shift on 3/17/24), they found residents who looked like they hadn't been changed all day. V13 stated she knew they were short staff on the previous shift and V2 (DON) had worked the floor. V13 stated she observed R4, and the bed pads she was on were brown with urine stains and it was someone who had laid in urine/feces for a period of time. V13 stated she was going to report it but since V2 had covered the hall R4 was on, she wasn't sure who to report it to. On 3/18/24 at 5:14 AM, V45 (CNA) stated when she came to work on 3/17/24 around 10:00 PM, R4 was covered in urine/feces, and it smelled like she had been that way for a long time. V45 stated it was brown and had dried circles. V45 stated R4 reported she hadn't been checked all day. On 3/18/24 at 5:28 AM, V8 (CNA) stated she came to work at 6:00 PM on 3/17/24 and there was only four CNAs working and V2 (DON) had come in to help. V8 stated she did a bed check when she got to the facility and R4 was saturated with urine and stool. V8 stated her entire bed was brown and saturated. On 3/18/24 at 6:15 AM, V19 (CNA) stated when he got to the facility on [DATE] around 6:00 PM, they had four CNA's working. V19 stated they told him in report R4 had refused care. V19 stated when he went to check on R4 she had urine and feces all around her. V19 stated R4 told him no one had checked on her since 7:00 AM. On 3/21/24 at 9:51 AM, R4 was in bed and provided incontinence care by V6 and V40 (CNA's). R4 stated there was one time, the first part of this month, she had an incontinence episode at night and had to lay in it until they checked her the next morning. R4 stated the facility staff didn't know she had a bowel movement until they came to wake her up. R4 stated after that incident they started checking her more frequently. On 3/21/24 at 11:28 AM, V6 (CNA) stated on multiple occasions she had come to work, and residents would be saturated with brown rings (indicating they had laid in urine for long periods of time). When asked if any of the residents she found like this were able to tell her what happened, V6 stated no it was usually the residents who are non-verbal. The facility Resident Rights policy dated 7/11/22 documents .Policy: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence, b. be treated with respect, kindness, and dignity .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to implement their Abuse policy when they failed to ensure an allegation of narcotics diversion was reported timely to the Administrator for 1 of 3 (R7) residents reviewed for abuse in the sample of 17. Findings Include: R7's Admission Record with a print date of 3/25/24 documents R7 was admitted to the facility on [DATE] with diagnoses that include pain due to internal orthopedic prosthetic devices, rotator cuff tear or rupture of left shoulder, paraplegia, colostomy, and stage 4 pressure ulcers. R7's MDS (Minimum Data Set) dated 3/12/24 documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R7 is cognitively intact. R7's current Care Plan initiated 3/21/24 documents a Focus Area of Pain/Opioid Therapy r/t (related to) chronic pain. This focus area has interventions initiated 3/21/24 that include observe for indications of pain every shift during routine interactions and administer pain medications as indicated/prescribed, observe effectiveness of pain management interventions. On 3/19/24 at 10:37 PM, V27 (RN/Registered Nurse) stated she reported to administration, on 12/24/23, there were resident narcotics missing and as far as she knows nothing was done. V27 stated she sent a message via WhatsApp to V5 (MDS Coordinator) on 12/24/23 and reported she witnessed R7 have two cards of Norco delivered. V27 stated when she came back to work a full card of Norco was gone and it shouldn't have been. V27 stated she sent all the information to V5. On 3/20/24 at 12:29 PM, V5 (MDS Coordinator) stated she remembered a narcotics diversion case but couldn't remember the details and/or the date it occurred. V5 stated it was reported a card of narcotics was missing and she and other administrative staff came to the facility and did a search and didn't find it. V5 stated two nurses were suspended and V1 (Administrator) was gone during the initial part of the investigation but came back at the end of the investigation and the allegation was not substantiated. On 3/20/24 at 12:37 PM, V1 (Administrator) stated they had not had a narcotics diversion allegation since June or July of 2023. At 12:40 PM, this surveyor reviewed V27's interview related to a report of a narcotics diversion on 12/24/23, V1 stated she was not aware of the report, and she would start looking into it. On 3/20/24 at 1:12 PM, V1 (Administrator) stated she had V5 (MDS Coordinator) look at WhatsApp and the message V27 sent isn't through the facility group message. V1 stated it was a personal message from V27. V1 stated she looked back and V5 wasn't on call on 12/24/23. V5 who was in the room at this time stated, It was 11:00 PM at night on Christmas Eve and I wasn't on call so my phone would have been off. V5 stated this was the first time she had heard about the allegation. The Facility Reported Incident dated 3/20/24 documents under Incident Description: Allegation of missing medication. Administrator notified 3/20/24 by surveyor related to complaint survey. Investigation initiated. Final Report to follow. This report documents the local police, physician, and ombudsman were notified of the allegation on 3/20/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse Policy dated 1/9/24 documents, Purpose: To provide guidance and Procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Under filing accurate and timely investigative reports the policy documents, .The Facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure an allegation of narcotics diversion was reported to the Administrator timely for 1 of 3 (R7) residents reviewed for abuse in the sample of 17. Findings Include: R7's Admission Record with a print date of 3/25/24 documents R7 was admitted to the facility on [DATE] with diagnoses that include pain due to internal orthopedic prosthetic devices, rotator cuff tear or rupture of left shoulder, paraplegia, colostomy, and stage 4 pressure ulcers. R7's MDS (Minimum Data Set) dated 3/12/24 documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R7 is cognitively intact. R7's current Care Plan initiated 3/21/24 documents a Focus Area of Pain/Opioid Therapy r/t (related to) chronic pain. This focus area has interventions initiated 3/21/24 that include observe for indications of pain every shift during routine interactions and administer pain medications as indicated/prescribed, observe effectiveness of pain management interventions. On 3/19/24 at 10:37 PM, V27 (RN/Registered Nurse) stated she reported to administration, on 12/24/23, there were resident narcotics missing and as far as she knows nothing was done. V27 stated she sent a message via WhatsApp to V5 (MDS Coordinator) on 12/24/23 and reported she witnessed R7 have two cards of Norco delivered. V27 stated when she came back to work a full card of Norco was gone, and it shouldn't have been. V27 stated she sent all the information to V5. On 3/20/24 at 12:29 PM, V5 (MDS Coordinator) stated she remembered a narcotics diversion case but couldn't remember the details and/or the date it occurred. V5 stated it was reported a card of narcotics was missing and she and other administrative staff came to the facility and did a search and didn't find it. V5 stated two nurses were suspended and V1 (Administrator) was gone during the initial part of the investigation but came back at the end of the investigation and the allegation was not substantiated. On 3/20/24 at 12:37 PM, V1 (Administrator) stated they had not had a narcotics diversion allegation since June or July of 2023. At 12:40 PM, this surveyor reviewed V27's interview related to a report of a narcotics diversion on 12/24/23. V1 stated she was not aware of the report, and she would start looking into it. On 3/20/24 at 1:12 PM, V1 (Administrator) stated she had V5 (MDS Coordinator) look at WhatsApp and the message V27 sent isn't through the facility group message. V1 stated it was a personal message from V27. V1 stated she looked back and V5 wasn't on call on 12/24/23. V5 who was in the room at this time stated, It was 11:00 PM at night on Christmas Eve and I wasn't on call so my phone would have been off. V5 stated this was the first time she had heard about the allegation. The Facility Reported Incident dated 3/20/24 documents under Incident Description: Allegation of missing medication. Administrator notified 3/20/24 by surveyor related to complaint survey. Investigation initiated. Final Report to follow. This report documents the local police, physician, and ombudsman were notified of the allegation on 3/20/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Abuse Policy dated 1/9/24 documents, Purpose: To provide guidance and Procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Under filing accurate and timely investigative reports the policy documents, .The Facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview and record review the facility failed to ensure activities of daily living were provided per current standards of practice for 7 of 9 (R1, R3, R4, R5, R8, R11, and R12) residents reviewed for activities of daily living in the sample of 17. Findings Include: 1. R1's Admission Record with a print date of 3/21/24 documents R1 was admitted to the facility on [DATE] with diagnoses that include sepsis, pulmonary disease, chronic kidney disease, atrial fibrillation, left hip osteoarthritis, and left artificial hip joint. R1's MDS (Minimum Data Set) dated 2/12/2024 documents a BIMS (Brief Interview for Mental Status) score of 12, which indicates R1 has a moderate cognitive impairment. This same assessment documents R1 is dependent on staff for bathing. R1's current Care Plan documents a Focus Area initiated on 9/28/23 of Self-Care deficits as Evidenced by: Needs assistance with ADL's (Activities of Daily Living). This Focus Area's interventions include, Transfer: Mechanical Lift required. There is no intervention related to bathing documented on this Care Plan. This same Care Plan documents a Focus Area initiated on 9/27/23 of Potential for impaired skin integrity related to impaired mobility this Focus area includes the intervention of Bath/shower per schedule. R1's electronic health record Task of Shower/Bathe self, documents R1 received a shower/bath on 2/22/24, 3/1/24 and 3/12/24 and refused a shower/bath on 3/5 and 3/8/24. This indicates R1 did not receive assistance with a shower/bath from 2/23/24 to 2/29/24 (7 days). On 3/14/24 at 11:40 AM, R1 stated the facility staff assist him with showers but they need a certain mechanical lift sling, and they don't have the one he needs. R1 stated he used to use a sling that would come up between his legs and it hurt him, so they stopped using it. R1 stated they found a different type of sling that was open and didn't hurt him. R1 stated they began using the open sling and then they didn't have it available again. R1 stated they tell him they don't have enough of them to go around. R1 stated sometimes they don't have enough staff for two people to assist him. R1 stated he did get a shower on Saturday because that was when the sling was available, and he believes the nurse pushed for him to be able to use it since he hadn't had a shower in a week. R1 stated he also didn't get a bed bath in that time frame. On 3/14/24 at 3:07 PM, V9 (LPN/Licensed Practical Nurse) stated R1 asked for a specific sling that wouldn't go between his legs. V9 stated they ordered one for him, but she didn't know what happened with it. When asked if she had concerns R1 wasn't getting showers the way he should V9 stated, Yes. V9 stated she made the CNAs (Certified Nursing Assistants) that were working on the floor on Saturday give him a shower since he hadn't gotten one. V9 stated R1 was supposed to have gotten one on Friday and didn't. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/14/24 at 3:33 PM, when asked if she was aware of residents not getting up because they didn't have slings to transfer them, V10 (CNA) stated, Absolutely. V10 stated when they give a resident a shower the sling must go to laundry. V10 stated when they don't have enough slings and they give them a shower then they can't get them up for supper. V10 stated they have shower aids at the facility, but they don't give bed baths for the residents who don't take a shower. V10 stated the shower aids work Monday, Tuesday, Thursday, and Friday. V10 stated there are two shower aids and they do approximately 45 showers a day. On 3/19/24 at 1:59 PM, V22 (CNA/Shower Aid) stated they do showers on the residents who reside on the left side of the halls on Monday and Thursday and the residents who reside on the right side of the halls on Tuesday and Friday. V22 stated she works between nine and eleven hours a day and does 40-50 showers per day. V22 stated for the most part they can get the showers done. V22 stated they have enough slings to do the showers, but they do have certain residents who won't use certain slings. V22 stated R1 doesn't like the split leg sling. V22 stated they have full body slings now and they have one labeled just for him. When asked when they got one labeled for R1, V22 stated on 3/15/24. V22 stated prior to that R1 had to use the split leg sling or not get up. V22 stated the split leg sling hurt R1's hips and legs. This surveyor asked if they were able to get bed baths done with 40-50 showers per day and V22 stated, Not really, no. V22 stated they talked with V5 (MDS Coordinator) on Friday and asked why the aids on the halls couldn't do the bed baths and V5 told her they should be the one's doing it. This surveyor reviewed R1's shower logs under the task in the electronic health record and asked if it was typical for R1 to not have a shower from 2/23/24 to 2/29/24 and V22 stated it was not. V22 stated that was before they had a full body sling for R1. On 3/19/24 at 3:21 PM, V24 (CNA/Shower Aid) stated she gives showers to about 45 residents a day. V24 stated she believes the two shower aids can complete the assigned showers. V24 stated it is when they have to stop and do bed baths that they are getting behind. V24 stated R1 will only use the straight sling and will not use the one that goes between his legs. V24 stated the sling that goes between the legs, pulls R1's legs apart and with the open areas on his bottom, it hurts him a lot. V24 stated if that sling is not available R1 doesn't get a shower. V24 stated on Friday they wrote R1's name on a sling so he has one. On 3/21/24 at 11:12 AM, V5 (MDS Coordinator) stated staff came to her and said R1 refuses showers because they don't have the specific sling he wants. V5 stated he wanted a sling they have and so she told them to take one of them and put his name on it so no one else can use it. When asked if she ever spoke with R1 about why he wanted a specific sling, V5 stated, No. When asked if anyone else other than the CNAs ever spoke with R1, V5 stated, I don't know. On 3/21/24 at 11:28 AM, V6 (CNA) stated she has had a couple of residents complain they aren't getting their showers. V6 stated R1 complains a lot about not getting them because they don't have the sling he likes. 2.R3's Admission Record with a print date of 3/21/24 documents R3 was admitted to the facility on [DATE] with diagnoses that include local infection, bacteremia, chronic obstructive pulmonary disease (COPD), asthma, malignant neoplasm, tracheostomy status, heart failure, hypertension, atrial fibrillation, and hypo/hypertension. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's current Care Plan has a Focus Area initiated on 3/16/24 of Potential for impaired skin integrity related to impaired mobility with interventions that include Bath/shower per schedule initiated 3/16/24. R3's Functional Abilities and Goals dated 3/16/24 documents R3 requires partial/moderate assistance for dressing, putting on/taking off footwear, personal hygiene, and mobility. R3's electronic health record documents a Task of shower/bathe self with no shower/bath documented as being offered or done from 3/15/24 to 3/20/24. On 3/21/24 and 3/25/24 the task documents R3 refused a shower/bath. On 3/19/24 at 1:59 PM, V22 (CNA/Shower Aid) stated R3 should have gotten a shower over the weekend. V22 stated new admits are supposed to get showers within 24 hours of admission but CNAs working the floor refuse to give showers. V22 stated then R3 should have had a shower on Monday. V22 stated she didn't work Monday so she didn't know why R3 didn't get one. On 3/18/24 at 6:15 AM, V19 (CNA) stated showers are usually done unless there is an emergency. V19 stated bed baths get neglected at times though. V19 stated he knows this because sometimes residents have foul odors and don't appear clean. V19 stated shower aids are responsible for bed baths during the week. On 3/21/24 at 11:40 AM, V42 (CNA) stated there are two shower aids that are supposed to get 48 showers done in a day. V42 stated she did showers one day, and she couldn't get 48 done. On 3/20/24 at 10:38 AM, V38 (ADON/Assistant Director of Nursing) stated she hadn't had any complaints or concerns brought to her related to residents not getting showers. On 3/20/24 at 10:05 AM, V2 (DON) stated she was not aware of any issues with mechanical lift slings. On 3/20/24 at 4:07 PM, V1 (Administrator) stated they have at least 27 slings in the facility, and she thinks there are more in a box in therapy. V1 stated she would have to look at R1's shower record to see if he missed showers. 3.R8's Admission Record with a print date of 3/25/24 documents R8 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, osteoarthritis, heart failure, hypertension, and bradycardia. R8's MDS dated [DATE] documents a BIMS score of 01, which indicates a severe cognitive impairment. This same MDS documents R8 requires partial/moderate assist of staff for toileting and is occasionally incontinent of bladder and always incontinent of bowel. R8's current Care Plan documents under the Focus Area initiated on 8/12/22 of Self-Care deficit as evidenced by: Needs assistance with ADL's, include the intervention of Toilet Use- one-person physical assist required. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/24 at 12:08 PM, R8 was sitting on a couch with a peer next to the nurse's station. R8's pants were wet with what appeared to be urine. Intermittent observation began at this time and continued through 12:44 PM. R8 remained on the couch and pants remained wet. At 12:46 PM, V24 (CNA) woke R8 up (who had fallen asleep on the couch) and walked with R8 to the dining room table. The back of R8's pants were saturated with what appeared to be urine. V24 assisted R8 to sit in the dining room chair while standing behind R8 and did not provide or offer to provide incontinence care. Intermittent observation continued of R8 until 2:25 PM, from 12:46 PM until 2:25 PM, R8 remained in the same dining room chair and in the same pants. This surveyor informed V38 (ADON) and she assisted R8 from the dining room for incontinence care. On 3/19/24 at 3:21 PM, when asked why she didn't assist R8 with incontinence care when she walked with him to the dining room, V24 (CNA) stated, He was wet? I didn't see it. I didn't see it at all. 4. R11's Admission Record with a print date of 3/25/24 documents R11 was admitted to the facility on [DATE] with diagnoses that include metabolic encephalopathy, COPD, diabetes, hypertension, and heart disease. R11's MDS dated [DATE] documents a BIMS score of 14, which indicates R11 is cognitively intact. This same MDS documents R11 is always incontinent of bladder and bowel incontinence is not rated on this assessment. R11's current Care Plan documents a Focus Area initiated on 9/13/22 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This focus area includes the intervention of, Toilet Use: One-person physical assist required, Date Initiated: 10/21/22. On 3/25/24 at 1:47 PM, R11 stated she gets assistance with toileting. R11 stated she has had to wait up to 30 minutes for assistance after she has had an incontinence episode. R11 stated she has talked with an unknown nurse about how long it takes. 5. R12's Admission Record with a print date of 3/25/24 documents R12 was admitted to the facility on [DATE] with diagnoses that include hemiplegia, hemiparesis, COPD, asthma, diabetes, morbid obesity, seizures, anxiety disorder, and sleep apnea. R12's MDS dated [DATE] documents a BIMS score of 12, which indicates a moderate cognitive impairment. This same MDS documents R12 is dependent on staff for toileting. R12's current Care Plan documents a Focus Area initiated on 8/2/23 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This focus area includes an intervention of Toilet Use: Two-person physical assistance required. R12's care plan does not have a Focus Area related to incontinence but does document under the Focus Area of Actual Pressure Ulcer . an intervention of Monitor incontinence and provide peri-care after each incontinent episode, Date Initiated: 3/25/24. On 3/21/24 at 11:40 AM, V42 (CNA) stated she had reported an incident related to R12 to administration and as far as she knows administration didn't follow up. V42 stated she walked past R12's room a few weeks ago and R12 yelled at her to come to her room. V42 stated R12 reported to her she had a bowel movement and an unknown staff member had told her twice they couldn't change her. V42 stated R12 was laying in bed, didn't have her call light, had the mechanical lift sling under her, and didn't have a blanket. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/24 at 1:43 PM, R12 stated she doesn't use the commode, she is incontinent, and wears incontinence briefs. R12 stated she has had to wait 30 minutes to an hour to get assistance with incontinence care and/or for staff to answer the call light. R12 stated she currently needs her incontinence brief changed and has been waiting for 20 minutes. 6. R4's Admission Record with a print date of 3/25/24 documents R4 was admitted to the facility on [DATE] with diagnoses that include COPD, heart failure, diabetes, chronic kidney disease (CKD), hypertension, weakness, and anemia. R4's MDS dated [DATE] documents R4 has moderate cognitive impairment, requires substantial/maximal assistance from staff for toileting, and is always incontinent of bladder with bowel incontinence not rated. R4's current Care Plan documents a Focus Area of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This Focus Area includes the intervention of Toilet Use: Two-person physical assistance required. On 3/18/24 at 4:45 AM, V13 (LPN) stated when the CNAs were doing rounds (at the beginning of this shift on 3/17/24), they found residents who looked like they hadn't been changed all day. V13 stated she knew they were short staff on the previous shift and V2 (DON) had worked the floor. V13 stated she observed R4, and the bed pads she was on were brown with urine stains and it was someone who had laid in urine/feces for a period of time. V13 stated she was going to report it but since V2 had covered the hall R4 was on, she wasn't sure who to report it to. On 3/18/24 at 5:14 AM, V45 (CNA) stated when she came to work on 3/1/724 around 10:00 PM, R4 was covered in urine/feces, and it smelled like she had been that way for a long time. V45 stated it was brown and had dried circles. V45 stated R4 reported she hadn't been checked all day. On 3/18/24 at 5:28 AM, V8 (CNA) stated she came to work at 6:00 PM on 3/17/24 and there was only four CNAs working and V2 (DON) had come in to help. V8 stated she did a bed check when she got to the facility and R4 was saturated with urine and stool. V8 stated her entire bed was brown and saturated. On 3/18/24 at 6:15 AM, V19 (CNA) stated when he got to the facility on [DATE] around 6:00 PM, they had four CNA's working. V19 stated they told him in report R4 had refused care. V19 stated when he went to check on R4 she had urine and feces all around her. V19 stated R4 told him no one had checked on her since 7:00 AM. On 3/21/24 at 9:51 AM, R4 was in bed and provided incontinence care by V6 and V40 (CNA's). R4 stated there was one time, the first part of this month, she had an incontinence episode at night and had to lay in it until they checked her the next morning. R4 stated the facility staff didn't know she had a bowel movement until they came to wake her up. R4 stated after that incident they started checking her more frequently. On 3/21/24 at 11:28 AM, V6 (CNA) stated on multiple occasions she had come to work, and residents would be saturated with brown rings (indicating they had laid in urine for long periods of time). When asked if any of the residents she found like this were able to tell her what happened, V6 stated no it was usually the residents who are non-verbal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. R5's Admission Record with a print date of 3/25/24 documents R5 was admitted to the facility on [DATE] with diagnoses that include sacrococcygeal disorders, aortic valve insufficiency, disc degeneration, hypertension, stress incontinence, anemia, and osteoarthritis. R5's MDS dated [DATE] documents R5 has a BIMS score of 03, which indicates R5 has a severe cognitive impairment. This same MDS documents R5 is dependent on staff for toileting and is frequently incontinent of bladder, always incontinent of bowel and R5 requires assist of staff to set up or clean up with eating. R5's current Care Plan documents a Focus Area initiated on 11/20/21 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This Focus Area includes interventions of .Eating- Setup help only/Cueing required. Date Initiated 3/4/24 .Toilet Use- One-person physical assist required. Date Initiated 11/20/21. On 3/18/24 at 4:45 AM, V13 (LPN) stated she observed R5 last night laying in urine. V13 stated the bed pads were brown with urine stains. On 3/18/24 at 5:28 AM, V8 (CNA) stated when she got to work at 6:00 PM, they only had four CNA's working and V2 (DON) had come in to help. V8 stated she did a bed check on R5 and she was saturated with urine. V8 stated R5's gown, blankets, incontinence brief, two bed pads, and sheets were soaked with urine and brown in color. On 3/19/24 at 12:21 PM, R5 was in bed sitting straight up with her feet out in front of her. The head of R5's bed was laying flat. There was an over the bed table sitting in front of R5 with a regular diet and an unopened health shake. R5 was continuously observed from 12:21 until 12:32 PM and then intermittent observations every couple of minutes continued until 12:40 PM when staff entered R5's room and asked her if she was finished and removed R5's meal tray. At no time throughout this observation did staff open or offer to open R5's health shake. On 3/20/24 at 12:15 PM, R5 was observed in bed with her meal tray sitting on front of her on a bedside table. R5's health shake was again unopened. At 12:27 PM, this surveyor went back to R5's room and her meal tray was gone. V42 (CNA) stated R5 had refused to eat her meal. On 3/21/24 at 12:25 PM, R5 was served the noon meal in the dining room. Unknown facility staff opened R5's health shake and R5 picked up the health shake and drank it independently. R5 fed herself independently but only took a few bites of her meal. No staff offered assistance or encouragement after her meal was set up. On 3/25/24 at 9:35 AM, this surveyor attempted to interview R5. R5 was unable to answer questions asked by this surveyor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Activities of Daily Living, Support for policy dated 1/1/22 documents Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Under Policy Interpretation and Implementation, the policy documents, .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); mobility (transfer and ambulation, including walking); c. Elimination (toileting); d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems) 8. While the frequency of care may be defined, times for care may vary based on resident preferences day to day, caregiver workload, other activities that may be taking place in or outside the center and the flexibility necessary for maximizing staff. Resident preference is honored wherever and whenever possible to promote choice and independence. The facility Incontinence Care Policy dated 5/16/22 documents under Purpose: to provide guidelines to all nursing staff for providing proper incontinence care in order to clean (sic) skin clean, dry, free of irritation and odor. Policy: All incontinent residents will receive incontinence care in order to keep skin clean, dry, and free of irritation and/or odor. Incontinence care will be provided as required.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review, the facility failed to ensure residents with psychiatric diagnoses, who were at risk of elopement, were accurately assessed and appropriately supervised for 1 of 3 (R2) residents reviewed for accidents and supervision in the sample of 17. This failure resulted in R2, who has a diagnosis of schizoaffective disorder and a history of suicidal ideation's exiting the facility without staff knowledge on [DATE] sometime between 4:45 AM and 5:30 AM. R2 was located slightly more than two tenths of a mile from the facility at approximately 6:30 AM, sitting outside an abandoned building on top of a truck camper shell, in the rain. R2 had to cross a busy highway to get to this location. This failure resulted in an Immediate Jeopardy, which was identified to have begun on [DATE] when R2 exited the facility with out staff knowledge. R2 walked approximately two tenths of a mile and was found by staff approximately one hour later. This past noncompliance occurred from [DATE] to [DATE]. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 10:26 AM. The surveyors confirmed by observations, interview, and record review that the Immediate Jeopardy was removed and the deficiency was corrected on [DATE]. Findings Include: R2's Elopement report dated [DATE] documents, Resident was not located in her room and had been having some odd behaviors up ambulating (sic). Resident was assessed ambulating in the hallways. Resident was observed at 4:54 AM in the dining room by our transport driver. At approx. (approximately) 5:00 AM resident was not able to be located and staff were attempting to do a visual check on resident. At this time Management notified and local authorities to do a search of the resident's location. Resident Description: Resident stated she had gotten her jacket and just needed to take a walk. Resident is baseline independent with care. Resident does sign self out for outings, and shopping with family. Resident stated it was just a hard morning and she had been thinking about her deceased husband and friends. Under Immediate Action Taken this same report documents, Immediately sent out team on foot and vehicle to locate resident. At this time resident was located at 6:30 AM walking in the alley of the post office in (name of town). She stated she was not in a good head space and attempting to clear her head. Resident was sent out to ER (emergency room) for evaluation due to increased depression No injuries observed at time of incident. Mental status, Predisposing Environmental Factors, and Predisposing Situation Factors are not assessed on this report. This report documents under Notes, ADHOC (as needed) QAPI (Quality Assurance and Performance Improvement) completed, timeline completed, wander guard placed, door alarms checked, door code changed, elopement assessment completed, elopement policy education, 15 min (minute) check policy education, door alarm education. R2's Admission Record with a print date of [DATE] documents R2 was admitted to the facility on [DATE] with diagnoses that include epilepsy, diabetes, hypertension, insomnia, chronic kidney disease, schizoaffective disorder, unspecified psychosis, macular degeneration, bipolar disorder, major depressive disorder, and cataracts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's MDS (Minimum Data Set) dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R2 is cognitively intact. This same MDS documents under Section C 1310 Delirium, R2 has inattention and disorganized thinking. R2's current Care Plan documents a Focus Area dated [DATE] of, (R2) has a history of self-harm ideations and/or behaviors. This appears related to recent loss of spouse/caregiver and son. She has a mental health dx(diagnosis)/Cancer dx and poor impulse control. These problems are manifest by voicing thoughts if (sic) self-harm. (R2) has been evaluated/is currently being evaluated in (name of local hospital) . The interventions for this care area dated [DATE] include Arrange for assessment by mental health professional, as warranted . As warranted conduct/carryout: daily monitoring, room safety checks, behavior tracking/monitoring looking for any changes, evaluate mental/mood status/thought content. As warranted conduct a room check and remove any sharp objects, alcohol/drugs (including over the counter medications), cleaning supplies (that could potentially be poisonous) and any other objects that in the health care professionals may pose a potential threat to safety. Engage resident in activities that she may enjoy to encourage resident spending time in a productive manner. This same care plan documents a Focus Area dated [DATE] of, Potential Risk of elopement exit seeking behavior (w/(with) purpose to leave). Interventions for this Focus Area, date initiated [DATE], date created [DATE], include, Place electronic sensor device to alert staff of exit attempt (or if unavailable, place on 1:1 observation: Routinely. Check Device Placement, Check Battery Function, Eval (evaluate) effectiveness . Identify any patterns of exacerbating factors . Maintain adequate I. D Provide re-direction and diversion as needed Respond to any alarm activation promptly .try to identify reasons when possible. Address physical needs such as hunger, thirst, pain, toileting, hot/cold, emotional needs, fear/distress, loneliness, worry . R2's Elopement Risk assessment dated [DATE] and [DATE] document a score of 02, which indicates R2 is not considered at risk of elopement. R2's Elopement Risk assessment dated [DATE] documents a score of 16, which indicates R2 is considered at high risk of elopement with IDT (Interdisciplinary Team) recommendations for a wander guard to be placed. R2's Elopement Risk assessment dated [DATE] documents a score of 02, which indicates R2 is not considered at risk of elopement. This assessment documents under IDT (Interdisciplinary) Notes: Unable to complete due to resident went out to the hospital. R2's Elopement Risk assessment dated [DATE] documents a score of 14, which indicates R2 is considered at high risk of elopement. R2's progress notes document on [DATE] at 8:15 AM, Resident (R2) sent to ER (emergency room) for Psych (psychiatric) evaluation, DR (doctor) and POA (power of attorney) notified of patient transfer to (name of local hospital) . There is no documentation in R2's progress notes related to R2 leaving the facility without staff knowledge. R2's emergency transport Patient Care Record dated [DATE] documents at 7:40 AM the ambulance service received a call from the facility for a patient who had eloped earlier that morning and was having homicidal and suicidal ideations. Patient made no statements to EMS (Emergency Medical Services) . Patient has a history of eloping .Patient (R2) answered questions for EMS with good cooperation (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's local hospital record dated [DATE] to [DATE] documents on [DATE], Precipitating Factor/event for this admission: (R2) .was admitted due to the fact she got aggressive with staff at (name of facility) and tried to elope. Patient (R2) has a history of schizoaffective disorder. Patient (R2) believes her family was killed because of a sexual act when she was young. Patient (R2) believes she is responsible for multiple deaths. It was reported patient made suicidal statements, but the patient (R2) denies this now. Presenting Problem: Patient (R2) is delusional believing she is the reason people are dying. Duration of Problem: gradually getting worse over the past month. Reason for Admission: Danger to self . Under Surrogate Decision Maker/Power of Attorney R2's medical records document R2 is not able to make informed decisions regarding his/her care and treatments. R2's electronic health record documents a Task of Behaviors with a check mark next to no behaviors observed from [DATE] to [DATE]. On [DATE] at 1:18 PM, R2 was sitting in a chair in her room and appeared clean and well-groomed with no obvious signs of distress. R2 stated she had been at the facility about a year and a half. R2 stated she had left the facility last night ([DATE]) because My mind said, just get out of here. R2 stated she didn't remember where she went. R2 stated she walked back into the facility, and she didn't remember any alarms sounding. R2 stated it was the last time she would do that and when asked why, R2 stated, because they will find you. R2 stated they found her down the road. R2 stated she wasn't hurt, and she was gone for about an hour. R2 stated it was raining and she couldn't recall if it was light outside. R2 stated she wasn't sure if it was last night (,d+[DATE]) or the night before. R2 then stated it was Tuesday ([DATE]) when she left. On [DATE] at 8:54 AM, R2 stated when she left, she used the front door and she put the code in, so it didn't alarm. When asked how she knew the code to the door, R2 stated someone at the facility had told her but she couldn't remember who it was. On [DATE] at 1:59 PM, V22 (CNA-Certified Nursing Assistant/Shower Aid) stated she was the one who realized R2 was missing on [DATE]. V22 stated around 5:30 AM (this time does not coincide with the time documented in the elopement report) she went to R2's room to get her for a shower. V22 stated R2 wasn't in her room so she asked the staff if they knew where R2 was. V22 stated she told them she couldn't find R2, and they started looking for her. V22 stated the nurses acted like they really didn't care that she was missing. V22 stated when they realized she wasn't in the building they got in their cars and started looking for R2. V22 stated around 6:00 AM she asked V11 (LPN/Licensed Practical Nurse) if she had called administration and the local authorities and V11 said she hadn't. V22 stated she wasn't sure who called administration but V3 (ADON/Assistant Director of Nurses) came to the facility shortly after that. V22 stated R2 had never attempted to elope before. V22 stated R2 didn't usually sign out to go out in the community alone and she didn't think R2 would be safe to be in the community by herself. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:45 PM, V13 (LPN) stated on the night of [DATE] there were four CNA's and two nurses working. V13 stated she had sent two other residents to the hospital and between 3:30 and 4:00 AM she was in R2's room checking on her roommate and R2 was in bed at that time. V13 stated she left R2's room and went back to her hall to notify V2 (DON/Director of Nurses) about R2's roommates' condition and to call the lab. V13 stated she was notified by staff at an unknown time that R2 was missing. V13 stated everyone started looking for R2 and when an unknown day shift nurse came in, she notified administration. V13 stated R2 didn't have an electronic monitoring device such as a bracelet and had not attempted to elope in the past. V13 stated R2 is alert and oriented but gets in moods sometimes. V13 stated the door alarm codes are to be changed monthly but it has been the same code since [DATE]. V13 stated no alarms sounded during the time frame R2 would have left the facility. V13 stated R2 has never signed out and left the facility when she was working. On [DATE] at 6:10 AM, V11 (LPN) stated she was working on the morning of [DATE]. V11 stated she saw R2 at 9:30 PM and then again at 4:00 AM, walking with coffee. V11 stated she didn't see her again after that. V11 stated at 4:30 AM (this time does not coincide with the elopement report and/or V22's interview), she was alerted R2 was missing. V11 stated she called V5 (MDS Coordinator) who was on call, and V5 notified everyone else. V11 was not able to explain the time discrepancy with her interview related to the time she was notified R2 was missing and/or the time she notified V5. V11's written facility statement does not document when she was notified R2 was missing. When asked where she documented this information V11 stated she didn't document it. V11 stated she assumed administration documented it all. V11 stated R2 was not an elopement risk and had never attempted to elope before [DATE]. V11 stated R2 didn't normally sign herself out and she thought R2 would be safe by herself in the community. V11 stated it was raining the day R2 eloped and when it started raining, she thought surely R2 will be back now. On [DATE] at 10:59 PM, V28 (CNA) stated she was working on [DATE] when R2 eloped. V28 stated there were four CNA's working and when that happens, they split the hall R2 is on. V28 stated two CNA's take (A) hall and the left side of (B) hall, and two CNA's take (C) hall and the right side of (B) hall. V28 stated she believed there were 34 residents on the full hall she had and 16 on her side of the hall they split. When asked if they had enough staff to meet the needs of the residents, V28 stated, My personal opinion, no. V28 stated they can't keep an eye on residents if the residents are up and wandering. V28 stated they have residents with multiple behaviors, and it is hard to monitor them and ensure their safety. V28 stated they did a bed check on R2's hall around 3:30 AM and R2 was in bed at that time. V28 stated they went to the next hall and were doing bed checks on those residents. V28 stated around 5:30 AM an unknown day shift CNA came to them and was looking for R2 for a shower. V28 stated they got worried, so they stopped what they were doing and started looking for R2. V28 stated R2 had never attempted to exit the facility before this. On [DATE] at 11:15 PM, V29 (CNA) stated she was in R2's room between 3:00 and 3:30 AM and R2 was in bed asleep. V29 stated she finished the bed checks on R2's hall then went with V28 (CNA) to the other hall to do bed checks. V29 stated V22 (CNA/Shower Aid) asked them if they knew where R2 was, and they told her R2 was in bed. V29 stated then another staff (unknown) again asked where R2 was. V29 stated at that time they stopped what they were doing, and it was all hands on deck with everyone checking the building for R2. V29 stated then it was chaos. V29 stated they never heard a door alarm go off. V29 stated she had never seen R2 up wandering at night. V29 stated as far as she knew R2 had not had exit seeking behaviors in the past. When asked if she knew how R2 had left without staff knowledge, V29 stated she heard R2 knew the code to the front door. When asked how R2 would know the code, V29 stated, I honestly don't have an answer for that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145649	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odin Health and Rehab Center	300 Green Street Odin, IL 62870

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:26 PM, V30 (CNA) stated she was working on [DATE] when R2 eloped. V30 stated she was working with another CNA on one hall doing bed checks and the other two CNAs were on another hall doing bed checks. V30 stated she saw R2 in bed with her eyes closed around 3:10 AM. V30 stated after she finished her bed check, she took a break, took the linens out and around 4:15 AM, she started getting people up. V30 stated at approximately 5:30 AM, V22 (CNA/Shower Aid), asked if they knew where R2 was. V30 stated she asked V22 if she had checked the bathrooms and the other side of the bed to make sure R2 hadn't fallen on the floor and V22 stated she had checked. V30 stated they all started searching rooms and outside the facility. V30 stated around 6:15 or 6:20 AM, they were told R2 had been located. When asked if she had any concerns with how the facility handled the elopement, V30 stated she felt like the local police should have been notified she was missing immediately, and she didn't know if they had been. V30 stated she didn't believe they had enough staff to monitor the residents. V30 stated with four CNAs they have to pull the CNA off R2's hall to help with bed checks on the other halls. V30 stated that leaves R2's hall unattended. On [DATE] at 11:42 PM, V31 (CNA) stated on the night R2 eloped she was working on another hall and split R2's hall with the other CNA's. V31 stated there were residents with behaviors that night, call lights, bed checks were awful, and they had to do laundry. V31 stated she saw R2 around 2:47 AM and again around 3:40 AM. V31 stated R2 was in bed but did get up and go to the bathroom. V31 stated she didn't realize R2 was gone until V22 (CNA/Shower Aid) asked where R2 was. V31 stated she told V22 to check R2's room and she said she had. V31 stated she called V12 (Transportation Aid) to see if she had taken R2 somewhere. V31 stated V12 told her she had seen R2 at the front door with her jacket on and R2 was walking back towards her room. V31 stated she asked V12 why she didn't tell anyone and V12 told her because they were doing bed checks. V31 stated she knew this occurred after 5:00 AM because V12 was gone with a dialysis patient who had to be at dialysis at 5:30 AM. V31 stated they all started looking for R2. V31 stated the nursing staff called administration. When asked if she had any concerns with how it was handled, V31 stated she did. V31 stated they (administration) weren't really concerned, then they wanted to blame the CNA's. V31 stated they have 90 something residents at the facility and can't be on two halls at one time. V31 stated after they left the facility the administration posted on WhatsApp that they needed a statement from them. When asked how she thought R2 left without staff knowledge V31 stated R2 is with it sometimes, she could know the door code. V31 stated they don't ever change the codes and the side door where residents smoke doesn't lock. V31 stated residents can just open it up and walk out. V31 stated with so many residents with so many behaviors, we can't watch them all. V31 stated we can't check on them properly. On [DATE] at 11:08 AM, V12 (Transportation Aid/CNA) stated she clocked in on [DATE] and went down to get a resident who was going for dialysis. V12 stated about 4:45 AM, she noticed R2 with her coat on walking towards her room. V12 stated she left the facility around 5:12 AM to transport the other resident to dialysis. V12 stated she left the facility around 5:12 AM and drove straight across the highway. V12 stated after you cross the highway and go around the curve there are abandoned buildings and she saw someone sitting on a camper shell with a coat on and the hood of the coat pulled up. V12 stated it caught her attention because it was raining hard. V12 stated she took the other resident to dialysis and got a call at 5:45 AM asking her if she had R2. V12 stated she told them she didn't and that was when she knew the person on the camper shell was probably R2. V12 stated she went back and started searching for R2 where she had seen the person and then was notified, they had located R2. V12 stated she wasn't aware of R2 attempting to leave the facility prior to this incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:07 PM, V9 (LPN) stated she came to work around 5:45 AM on [DATE] to complete some charting before she started her shift. V9 stated she was at the time clock and V33 (Housekeeper) asked her if she had heard R2 was missing. V9 stated she went straight to the nurse's station and unknown staff were standing at the nurse's station. V9 stated she asked them if anyone had seen R2, and they said the last time they saw R2 was at the 4:30 AM bed check. V9 stated she did a sweep of the facility and didn't locate R2, so she sent staff out to look for her. V9 stated she called V2 (DON). V9 stated R2 doesn't leave the facility without family or staff. V9 stated if R2 wasn't in a manic state she would be capable of leaving the facility and returning by herself. V9 stated she spoke with R2 when she returned to the facility and R2 said she didn't know why she did it. V9 stated she wasn't sure what the facility staff did to locate R2 prior to her arriving to the facility at 5:45 AM. V9 stated she sent R2 to the hospital for evaluation and R2 was admitted . V9 stated R2 had suicidal and homicidal ideations. V9 stated R2 returned after 3 days and now has a wander guard on to alert staff if she attempts to leave. On [DATE] at 9:54 AM, V33 (Housekeeper) stated she came into to work on [DATE] and an unknown staff member asked if she had seen anyone walking on the highway as she drove to work. V33 stated they told her someone was missing. V33 stated, V36 (Housekeeping/Laundry Supervisor) told them all to start looking and to look until R2 was located. V33 stated this was at approximately 5:45 am. V33 stated she checked the barn, looked in rooms, cars, and then triple checked everywhere until R2 was located. On [DATE] at 10:10 AM, V36 (Housekeeping/Laundry Supervisor) stated she was working as a housekeeper on [DATE] and was cleaning the nurse's station when an unknown CNA stated they couldn't find R2. V36 stated she thought maybe she was in a bathroom or the pavilion. V36 stated this was between 5:30 and 6:00 AM. V36 stated she had them check those places and then when they couldn't find her, she got everyone to stop what they were doing and to start searching for R2. V36 stated she told the nurses to call V1 (Administrator) about a half hour later. On [DATE] at 3:45 PM, V5 (MDS Coordinator) stated she was notified of R2 eloping by V11 (LPN) at 5:59 AM. V5 stated she was the first one in administration who was notified of the incident. V5 stated V12 (Transportation Aid/CNA) saw R2 at approximately 4:45 AM walking towards her room. V5 stated then V12 took a different resident to dialysis and when she was coming back from dropping that resident off, she saw someone sitting outside the post office on a truck camper topper. V5 stated when V12 got back to the building and was told R2 was missing V12 went back to see if the person on the camper topper was R2. V5 stated, V12 had first seen this person at 5:12 AM when she left the facility. V5 stated R2 has never been an elopement risk and they changed the codes on the front door after this incident. (continued on next page)

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Odin Health and Rehab Center	300 Green Street Odin, IL 62870

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:07 AM, V5 (MDS Coordinator) stated at 5:59 AM on [DATE] she got a phone call from V11 (LPN) telling her they couldn't locate R2. V5 stated she asked if they had looked everywhere, and she told her she would message the administration team and be right there. V5 stated she texted V18 (Wound Nurse) and V2 (DON). V5 stated she got to the facility around 6:15 AM and saw CNA's walking around outside the facility. V5 stated some went to the local gas station to see if R2 was there and others got in their vehicles to look for R2. V5 stated she and V18 went to the post office to see if she was there since V12 had seen someone sitting there when she was taking a resident to dialysis. V5 stated R2 was there and was talking about killing everyone and how she wanted to die herself. V5 stated R2 agreed to walk back to the facility so they started walking. V5 stated once they got R2 back to the facility they had a staff member with her 1:1 until they sent her out to the local hospital for evaluation. V5 stated R2 was not assessed as being an elopement risk and had never attempted to elope prior to [DATE]. On [DATE] at 1:26 PM, V6 (CNA) stated she came to work on [DATE] around 5:52 AM and was sitting in her car. V6 stated there was a knock on her window and other unknown facility staff asked if she had seen R2. She told them she had not, and they left her vehicle and was looking around facility grounds. V6 stated they searched for about 45 minutes and then found R2 and brought her back to the facility. When asked if R2 had ever attempted to elope before, V6 stated R2 had tried but hadn't succeeded. V6 stated R2 does have behaviors like that. V6 stated R2 is usually alert and oriented but she thought R2 was having behaviors that day. V6 stated they monitor R2 more when she is having behaviors. On [DATE] at 2:47 PM, V7 (CNA) stated she was not aware of R2 attempting to elope before the incident on [DATE]. V7 stated R2 does have behaviors and she didn't think R2 would be safe in the community by herself. V7 stated R2 has a tendency of saying she doesn't want to be here anymore, and she wants to kill herself. On [DATE] at 2:53 PM, V8 (CNA) stated she wasn't aware R2 was an elopement risk and as far as she knew R2 had never attempted to elope before the incident on [DATE]. V8 stated she had never seen R2 leave the facility and she wasn't one to sign out and go out and about in the community independently. On [DATE] at 9:02 AM, V15 (Maintenance Director) stated he got to the facility after R2 had returned on [DATE]. V15 stated he reviewed the elopement binders. V15 stated he believed R2 observed someone putting the door codes in and that is how she left without alerting the staff. V15 stated he implemented a procedure to change the door alarm codes monthly. V15 stated R2 could have also left through the door the smokers use since it isn't coded but does have a wander guard alarm on it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Odin Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Green Street Odin, IL 62870	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:07 AM, V18 (LPN/Wound Nurse), stated on [DATE] she got a call from V9 (LPN) around 6:00 AM notifying her R2 was missing. V18 stated she went to the facility and when she drove past the post office, she saw V12 (Transportation Aid) walking around looking for R2. V18 stated she met V5 (MDS Coordinator) at the facility and they started driving around looking for R2. V18 stated they drove in front of the post office and R2 was there. V18 stated V5 got out of the car and attempted to get R2 to get in the car with her but she wouldn't. V18 stated they walked with R2 and when they got almost back to the facility R2 stated she wasn't going in. V18 stated they were able to get R2 back in the building by telling her a peer was waiting for her to eat breakfast. V18 stated once they got R2 back in the facility they placed her on 1:1 until they sent her to the hospital. V18 stated R2 had never attempted to leave the facility before other than when she went on outings with her family. On [DATE] at 2:28 PM, V4 (Family Member) stated the facility notified her R2 eloped. V4 stated R2 had never attempted to leave the facility before. V4 stated R2 said she just went nuts. V4 stated R2 never goes out of the facility independently and wouldn't be safe in the community. V4 stated R2 knew the door code and she thought R2 may have seen family enter the code when they left the facility. V4 stated after R2 eloped, she asked the facility to change the code, and they did. On [DATE] at 10:05 AM, V2 (DON) stated she had worked at the facility since [DATE] and had been DON since [DATE]. V2 stated she got a call at 5:59 AM from V9 (LPN) that R2 was missing. V2 stated staff had searched all the rooms and outside the facility. V2 stated R2 had been missing about an hour. V2 stated around 6:34 AM, she was almost to the facility and V18 (LPN) stated they were bringing R2 back to the facility. V2 stated R2 was assessed, placed 1:1, and because of the comments she was making they sent her out to the hospital for evaluation. When asked if an investigation was done on how R2 left the facility without staff being aware, V2 stated from her understanding R2 always signed out with family so they assumed she knew the code and changed it. When asked if anyone ever asked R2 how she left, V2 stated she didn't. V2 stated she wasn't aware of R2 attempting to elope in the past and wasn't able to answer if R2 would be safe in the community alone. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:07 PM, V1 (Administrator) stated she got a call from the facility, and they said V12 (Transportation Aid) had seen R1 in the dining room but didn't think anything of it since R2 gets up and goes out with family at times. V1 stated V12 didn't leave until after 5 and didn't see R2 leave while she was at the facility. V1 stated V12 took the other resident to dialysis and when V12 returned to the facility, other staff asked V12 if she had seen R2. (This does not coincide with the other interviews). V1 stated V12 told them she saw someone outside when she took the other resident to dialysis. V1 stated staff got in their cars and drove to where V12 saw this person. V1 stated they also called R2's family to see if she had gone with them. V1 stated when they asked R2 why she left R2 stated her head was full and she wanted to go for a walk. V1 stated R2 said she was thinking about her deceased husband and her roommate. When asked if the local police were notified, V1 stated she had but they didn't respond immediately. V1 stated if R2 had been missing more than an hour she would have called the county officials. V1 stated she notified all the managers, regionals, and all staff. When asked if she talked with all staff on midnight shift and day shift after R2 eloped, V1 stated she didn't remember but she would think they did speak with all of them. V1 stated R2 will sign herself out and goes with family and doesn't always tell someone when she is leaving. V1 stated R2 had never done anything like this before and was not an elopement risk. V1 stated R2 was assessed at risk of elopement after this incident. When asked if four CNA's and two nurses were enough staff to monitor the residents on night shift, V1 stated, it was, and they use the state required minimum staffing sheet to determine their staffing numbers. This surveyor reviewed staff interviews with V1 and noted it was ,d+[DATE] minutes after R2 was missing before administration was notified. V1 began looking through her phone and stated the earliest notification she could find was 5:58 AM. V1 stated she thought 30 minutes was an acceptable time frame because it gave staff time to look in other rooms. On [DATE] at 11:06 AM, V20 (SSD/Social Services Director) stated she reviewed the resident sign out logs and R2 had not signed out on the morning of [DATE]. On [DATE] at 9:29 AM, V20 stated after R2 eloped they went through the elopement binders and made sure copies of the policies were available for the staff. V20 stated they checked all the wander guards and changed the door codes. V20 stated she thought they changed the door codes quarterly prior to this. On [DATE] at 1:00 PM, when asked if she had been made aware R2 eloped, V32 (Physician), stated she knew R2 had been sent to the local emergency room for behaviors recently, but she didn't remember them notifying her she had eloped. When asked if she would consider R2 an elopement risk she stated, Yes, she has a diagnosis of schizophrenia so if she gets something in her mind that she wants to leave, I can see her doing that. Would you consider her safe in the community by herself? No. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Protecting Residents: Wandering/Elopement Risk policy dated [DATE] documents, All residents are assessed for risk of unsafe wandering and/or elopement and those who are identified as at risk will be assessed for utilizing the safety intervention of a Wander Guard bracelet to prevent unsafe exit from the center. In facility that do not have Wander Guard systems, an alternate method of protecting residents is used. Procedure: All residents are assessed using the Elopement Risk Assessment V-2 in (name of electronic health records) at the time of admission, quarterly, and with changes in condition, especially those affecting cognition, or with changes in behavior If a resident exhibits exit seeking behaviors or expresses the desire or determination to leave and if that resident is not cognitively able to support independent decision making, a new Elopement Risk Assessment and review by the interdisciplinary team will be conducted. Other safety interventions may be utilized pending the assessment. The facility shall not utilize Wander Guard or other similar interventions on a resident who is able to give consent based on cognitive level without further assessment to protect that resident's right to personal autonomy and decision making. This would include a BIMS assessment and CRSHC Safety Awareness Assessment, both in (name of electronic health record), consultation with a physician or psychiatrist and IDT review. A care plan problem, focus, and intervention are placed in the residents' clinical record that specifies the intervention to be used to protect a resident who is at risk for unsafe wandering or elopement . non-Wander guard Protections: any systems of locking door or units is monitored on an ongoing by staff to assure it is operating correctly The facility Missing Resident Procedure (Code Pink) dated ,d+[DATE] documents, The following procedure is utilized when a resident is determined to be missing. 1. Code Pink is announced/staff notified if no overhead system is used. 2. Note the time that the resid [TRUNCATED]

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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 - Actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32765

Based on observation, interview, and record review the facility failed to ensure staff were trained and the facility had the necessary equipment to meet the needs of a resident with a tracheostomy for 1 of 1 resident (R3) reviewed for tracheostomy care in the sample of 17. This failure resulted in R3 becoming short of breath shortly after admission with the facility unable to locate the necessary equipment to provide oxygen to R3 via the tracheostomy, causing R3 to be anxious and scared and then being transferred to the local hospital for oxygenation.

Findings Include:

R3's Admission Record with a print date of 3/21/24 documents R3 was admitted to the facility on [DATE] with diagnoses that include local infection due to central venous catheter, bacteremia, asthma, malignant neoplasm base of tongue, malignant neoplasm of larynx, tracheostomy, heart failure, depression, anxiety, hypertension, and atrial fibrillation.

R3 is in the assessment period so her MDS (Minimum Data Set) did not document a Brief Interview for Mental Status score. However, upon interview R3 was alert and oriented to person, place, and time.

R3's current Care Plan documents a Focus area dated 3/16/24, Admission Baseline the interventions for this Focus area include, Resident is able to self-care for trach including suctioning, and The nurse will follow the MD (physician) orders for specialty care with oxygen, trach, suction. Both interventions are dated 3/16/24.

R3's Order Summary Report dated 3/21/24 includes the following physician orders dated 3/17/24, Change tracheostomy (trach) ties each day shift and as needed, clean or change inner cannula every day, oxygen at 2 liters per minute via tach mask as needed, trach site care with normal saline. May use trach kit every day shift and as needed for excessive drainage, trach: assess breath sounds every shift and as needed, change canister and tubing weekly and as needed, change trach tube every day shift every month and as needed, check oxygen saturation every shift and as needed, licensed nurse may reinsert trach tube as needed for dislodgment, may use trach dressing drain sponge to cover trach site or leave open to air, observe trach site/stoma for redness, bleeding, swelling, increased secretions, drainage, and skin breakdown every shift, and tracheostomy care every shift and as needed: clean or change inner cannula when needed. This same report includes the physician order dated 3/18/24 of tracheostomy site dressing change as needed if soiled as needed related to tracheostomy status.

R3's progress notes include the following:

3/15/24 at 4:33 PM, Resident (R3) arrived at facility with her uncle in a private car. Mouth pink and moist LCTA (lungs clear to auscultation) trach in place, BS (bowel sounds) present x (times) 4 ABD (abdomen) soft nontender. Bruising from needle sticks to both arms, no excoriation or open areas noted.

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few	3/15/24 at 11:20 PM, The patient (R3) is being transferred out to hospital r/t (related to) SOB (shortness of breath). Patient (R3) is requesting to be sent out because she is having trouble breathing and complaining of chest pains. The nurse attempted to call the doctor twice. No answer. Awaiting doctor to return call. The nurse reached out to DON (Director of Nursing) and made her aware of the situation. DON stated to send the patient (R3) out per patients request at this time. SPO2 is at 90%, T (temperature) 97.8, R (respirations) 20, B/P (blood pressure) 128/76. 3/16/24 at 5:19 PM, Client (R3) returned to facility with less than 23 hrs. (hours) stay at (name of local hospital) . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145649	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Odin Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Green Street Odin, IL 62870	

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F 0695 Level of Harm - Actual harm Residents Affected - Few	R3's emergency transport Patient Care Report dated 3/15/24 documents the following, .dispatched immediate response via private-line 911 to (name of facility) for report of a .female trach patient with shortness of breath. Nursing home is having difficulty with patient's oxygen/trach equipment. EMS (emergency medical services) arrives on scene and patient (R3) is found sitting alone in her wheelchair at the main nurse's station. Patient (R3) waves down EMS as they approach, and she tells them that they are here for her. ALS (Advanced Life Support) assessment. Female (R3) is alert and oriented x 4. She has a tracheostomy, but she can speak when she occludes it with her fingers. Patient (R3) presents with slightly increased work of breathing. She is able to speak relatively clearly with short sentences. She is not connected to any oxygen at this time. Skin is pink, warm, and dry. Pulse strong and regular. She tells EMS that the nursing home staff is having difficulty connecting her oxygen to the supplied devices from her discharge today. Patient (R3) has been at (name of regional hospital) receiving treatment for an infection of her port which had to be removed. She has been discharged to (name of facility) for rehabilitation and has been at the nursing home for 7 hours. Patient (R3) requests EMS assistance connecting her oxygen equipment. EMS wheels patient in her wheelchair to her room. Nurse meets EMS in the room. Various pieces of equipment are found lying on the bed and in bags. There is a simple mask, a Venturi/aerosol trach-mask, and other miscellaneous oxygen tubing's. Nurse explains that the provided equipment is from her discharge from (name of regional hospital) and provided by family and she is not familiar with use of this particular equipment. Lungs sounds reveal rhonchi in upper fields and clear lower fields. Patient (R3) has had a productive cough from time to time where she can clear her own airway by coughing. EMS asks if there's any suction equipment available if patient (R3) needs suctioning of her airway. Nurse claims there are no suctioning devices. Vitals are measured. Patient (R3) is maintaining adequate room air oxygen saturation. For several minutes, EMS examines the available equipment in an attempt to make something work. The preferred aerosol mask is attached to a 1-liter bottle of sterile water which, also has the necessary adapter to attach to the oxygen concentrator. Due to the large size of the bottle, it cannot fit on the concentrator. There are no smaller sterile water bottles available that will fit to the adaptor piece. The only other option is to use a simple mask which can also fit over the tracheostomy and provide supplemental oxygen. EMS explains to patient that supplemental oxygen, even if provided using improvised equipment might be what she needs to help ease of difficulty breathing and provide the comfort she seeks. Patient (R3) adamant (sic) refuses to let EMS try this and claims, it doesn't work, and she doesn't get enough air. EMS explains that if this is placed over her tracheostomy, it will work in providing oxygen as there is no reason it shouldn't work. Patient does not require supportive ventilation as she breathes with adequate rate and depth spontaneously. The simple mask would only increase the oxygen concentration entering her lungs as she breathes. EMS also adds that she is maintaining adequate oxygen saturation without any supplemental oxygen and current findings may be about her baseline with her history of COPD (chronic obstructive pulmonary disease). Despite these pleas, patient (R3) will not allow for use of the simple mask and demands that the aerosol mask be used. EMS explains that until the proper equipment can be provided, this demand cannot be met. Patient (R3) and family member who was in contact with the nursing home prior to EMS arrival request that patient (R3) be taken to (name of local hospital). Cot is prepared in hallway. Patient (R3) wheels self to hallway and she is able to stand and turn to cot, with minimal assistance Transport completed without incident. R3's local hospital records dated 3/16/24 documents under Chief Complaint, (R3) is a .female who present with no symptoms from (name of facility). Patient (R3) was sent to (name of hospital) due to the nurse at that facility not being comfortable with tracheostomy care The following is a note from (name of hospital nurse) who spoke with V34 (Marketing Director) who is the director at (name of facility). (continued on next page)

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F 0695

Level of Harm - Actual harm

Residents Affected - Few

Received call from (V34), Director at (name of facility). (V34's facility title is Marketing Director) He offered deepest apologies to staff of (name of hospital) for confusion at his facility that resulted in patient being sent to this hospital. He stated, the nurse on duty just wasn't comfortable with a trach patient. I don't know why. I have all the equipment here for patient. RN (Registered Nurse) that was uncomfortable is no longer an issue, and patient may return to (name of facility) at any time .This RN verified with V34 that he would like this information put into note in patients' chart, verbal agreement given.

On 3/19/24 at 10:00 AM, R3 was in her room, lying in bed, with no obvious signs of distress. R3 was receiving oxygen via her tracheostomy. R3 stated she didn't really want to talk but was willing to answer a question. This surveyor asked R3 about the night she went to the hospital and R3 stated the facility staff couldn't figure out how to hook her oxygen up, so they sent her out. R3 stated she wasn't in distress and wasn't sure if the facility had the right equipment.

On 3/18/24 at 4:45 PM, V13 (LPN) stated the facility recently accepted a resident (R3) who had a tracheostomy. V13 stated R3 came to the facility with no supplies, and they had to send her out because they couldn't get R3 oxygenated with the supplies the facility had. V13 stated there was another nurse V25 (LPN) who wasn't comfortable providing care for someone with a tracheostomy. V13 stated V25 told administration and they didn't get her any training. V13 stated the facility didn't even have trach kits.

On 3/19/24 at 3:39 PM, V25 (LPN) stated she provided care to R3 for 2-3 hours on the day she admitted to the facility (3/15/24). V25 stated R3 got to the facility and stayed in the dining room, since she arrived around dinner time. V25 stated an unknown staff member let V25 know R3 was having trouble breathing and wanted some oxygen. V25 stated she started searching the supply room to try to find everything they needed. V25 stated, It was kind of a fail. V25 stated she kept going into the dining room to ensure R3 was ok and because R3 was scared. V25 stated R3's oxygen saturations fell into the upper 80's. V25 stated she didn't feel like R3 was in any danger but at the same time R3 was scared and kept saying, I can't breathe. V25 stated the other nurses working that day assisted her and then R3 had her call V26 (Family Member). V25 stated V26 came to the facility and asked her what she wanted him to do since he didn't have the needed equipment at his house either. V25 stated V26 thought to call the hospital R3 had discharged from, and he drove to the hospital in a neighboring town and got supplies. V25 stated R3 did have a simple mask on over her trach with normal oxygen tubing. V25 stated R3 told her it wasn't going to work but that was what we had to work with. V25 stated R3 did calm down some after V26 arrived at the facility. V25 stated she was sent to the hospital after V25's shift ended. V25 stated she didn't have the supplies needed to apply oxygen when R3 arrived at the facility.

On 3/21/24 at 9:37 AM, V39 (CNA/Certified Nursing Assistant) stated when R3 got to the facility she wanted to sit in the dining room. V39 stated she walked past the dining room around 4:00 PM and R3 said she was having problems breathing. V39 stated R3 was really panicky and couldn't catch her breath. V39 stated she told the nurse, and they went to look for the equipment needed for the trach. V39 stated they didn't have the equipment so a family member of R3's went to the hospital and got what they needed. V39 stated she left around 6:00 PM or switched halls so she didn't have anymore contact with R3.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On 3/19/24 at 3:59 PM, V26 (Family Member) stated he got a call from the facility that they were going to send R3 to the hospital because they didn't have the equipment they needed. V26 stated he went to the facility and spoke with V25 who said they didn't have the equipment and probably wouldn't be able to get it since it was the weekend. V25 stated he called the hospital R3 discharged from and then drove to the neighboring town and got the equipment. V26 stated R3 was fine when he left the facility and then they sent her to the hospital later. On 3/19/24 at 10:20 PM, V13 (LPN) stated V25 was the nurse on shift when R3 arrived at the facility and then V13 came on shift and got report from V25. V13 stated she was the nurse who sent R3 to the hospital. V13 stated she called R3's physician but had to leave a voicemail and explained in the voicemail they didn't have the equipment they needed to provide oxygen for R3 and R3 had requested they send her to the hospital because she was having trouble breathing. V13 stated R3's oxygen saturation was at 90% when she checked it and at 93% when the EMS arrived. V13 stated all the equipment V26 brought to the facility worked but the bottle was too long to attach to the concentrator. V26 stated the bottle of sterile water wasn't fitting into the compartment on the concentrator so they couldn't attach it. V13 stated they had two other bottles that also didn't work. V13 stated EMS attempted to get it to work and another nurse attempted to get it to work but it wasn't fitting on the concentrator. V13 stated R3 had a non-rebreather mask over her trach but said that wasn't working for her. V13 stated she sent V2 (DON/Director of Nursing) a text message that R3 was requesting to be sent to the hospital and explained the sterile water didn't fit into the concentrator, that R3 had oxygen on, was getting a little air, but was saying she was having trouble breathing, and her oxygen saturation was at 90%. V13 stated V2 sent a message back to send R3 to the hospital. V13 stated the messages were not in the computer system but they were on WhatsApp, the communication app the facility staff were using. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On 3/21/24 at 10:37 AM, V37 (Paramedic) stated he transported R3 from the facility to the hospital on 3/15/24. V37 stated he got called to the facility for a resident who was short of breath, and they were having difficulty managing the resident with a tracheostomy. V37 stated when he arrived and got to the main nurse's station he was met by the resident (R3) flagging him down. V37 stated R3 stated she was having some shortness of breath, but the main problem was she was having issues with the concentrator. V37 stated R3 took them to her room and nurse (unknown) told them they were trying to get R3 hooked up to oxygen. V37 stated there were three main pieces. V37 stated there was a one-piece vent circuit that wasn't usable, just an extension and a Venturi or aerosol mask. V37 stated this mask was appropriate for R3 to get oxygen. V37 stated on the end of that where it would connect to the concentrator there was a bubbler on. V37 stated it was like a one-liter bottle and it was too long to fit with the way the connections were. V37 stated it physically would not fit on the machine. V37 stated the third piece was a simple mask. V37 stated this is a mask you would normally use on your nose/mouth. V37 stated the facility nurse was going to use it and put it over the trach so R3 could get oxygen since the aerosol mask was not an option. V37 stated they tried different bubblers, but they wouldn't fit on the aerosol mask. V37 stated R3 adamantly refused the simple mask. V37 stated as far as he knew they didn't have any other equipment options at the facility. V37 stated he had never seen a trach resident at the facility in the six years he has been a paramedic for that area. V37 stated the nurses were very uncomfortable with the trach and unfamiliar with the equipment. V37 stated the nursing staff had already tried everything he did but didn't seem very comfortable or knowledgeable with tracheostomy care. V37 stated there was also no suction equipment in the room. V37 stated R3 had some rhonchi. V37 stated he asked the nurse if R3 needed suctioning at all and the nurse said she didn't have any suctioning there. V37 stated as soon as they got to the hospital with R3 she coughed up a decent size mucus plug and needed suctioning. V37 stated if R3 hadn't been taken to the hospital it would have been an issue. On 3/19/24 at 10:37 AM, V27 (RN/Registered Nurse) stated she was not working the night R3 admitted to the facility. V27 stated she was working on the day R3 returned to the facility from the hospital and told V2 (DON/Director of Nursing) she wasn't comfortable with trach care. V27 stated V2 told her R3 was pretty independent with the trach and if she needed anything to call her. V27 stated another nurse who was familiar with trach's showed her how to suction because she had an order to suction and didn't know how to do it. V27 stated, We should have been trained before she (R3) got here, and we weren't at all. V27 stated this is the first trach patient she has ever provided care to. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On 3/20/24 at 9:38 AM, V34 (Marketing Director) stated when there is a potential resident he gets the referrals from the hospital, puts the information in the system and then they look at things such as payor source and background checks. V34 stated they will at times do a bedside evaluation and talk to the resident and/or family. V34 stated he was familiar with R3, and they had accepted her because V1 (Administrator) knows her well. V34 stated everyone else (other facilities) denied her. V34 stated he looked in the computer system around 5:00 PM (this time does not match the time of the other interviews) and saw they had sent R3 back to the hospital. V34 stated V5 (MDS Coordinator) told him R3 was in the dining room and her oxygen saturations were in the 90's, she was very anxious, so they sent her out. V34 stated he called the hospital to let them know they could accept her back. This surveyor reviewed the hospital record documenting V34's conversation with the hospital. V34 stated a nurse at the facility who was uncomfortable with the care was saying they didn't have supplies and because of that he said we would make sure we had the supplies at bedside. V34 stated they never had a problem caring for a resident with a tracheostomy before. V34 stated it had been a couple of years since they had a resident with a trach. When asked if he talked with staff prior to accepting R3 to see if they needed training prior to the admission, V34 stated he didn't. V34 stated he thought it would be clinical who would do that. When asked if he would know the equipment needed for a resident with a trach, V34 stated that would be a clinical question. On 3/20/24 at 9:54 AM, V5 (MDS Coordinator) stated she was a little bit familiar with R3. When asked what the admission process was, V5 stated V34 gets a referral and then lets the team know the referral is there then a member of the nursing team reviews it and says if the person is appropriate for the facility. V5 stated she didn't remember who reviewed R3's information. V5 stated they had residents with a trach before but wouldn't or couldn't say how long ago just said, It is not a very frequent thing. V5 stated they did have a training on trach care about a year ago. V5 stated if they have a resident with a unique need, they will do an in-service with staff prior to the admission. V5 stated she wasn't at the facility when R3 admitted but she knew they had supplies and she told V2 (DON) where to look for them. V5 stated she remembered R3's referral because the report had been called over from the hospital one day and then they held R3 at the hospital for an extra day. V5 stated when the hospital called report, they said R3 was independent with trach care, was mainly on room air, and only used oxygen as needed. V5 stated she knew V2 had set up another in-service for trach care. V5 stated if she had been working, she would have reached out to a manager and asked to be shown what to do and to my knowledge that didn't happen. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On 3/20/24 at 10:05 AM, V2 (DON) stated she started working at the facility on 1/29/24 and took the DON position on 2/2/24. V2 stated they were originally told by the hospital R3 was not on oxygen. V2 stated R3 got to the facility and was short of breath. V2 stated the nurse attempted to put a mask on R3 and she didn't like the mask the facility had. V2 stated R3 got very anxious and wanted to go to the hospital. V2 stated she said to send her if she wasn't comfortable. V2 stated she wasn't familiar with where everything was located at the facility. V2 stated they didn't tell her the type of mask R3 had on. V2 stated she spoke with other managers (V5 and V18), and they said they had everything at the facility. When asked if she had any conversation with the nursing staff about it, V2 stated when R3 came back to the facility, we made sure the hospital sent specifically what she wanted with her so, R3 could be comfortable coming back. V2 stated they spoke with the nurse working the night R3 was admitted and told her where the equipment was located, and they also have extra supplies in the shed outside. This surveyor confirmed with V2 they had all the equipment for oxygen including, sterile water, tubing, and mask on 3/15/24 when R3 admitted to the facility and V2 stated, Yes. When asked if there was ever any conversation with the nursing staff about needing training on trach care, V2 state, At the expense of sounding rude or heartless they are nurses in long term care, and trach's do come but after this incident I did reach out to get training set up again. On 3/20/24 at 4:07 PM, when asked about staff being trained on tracheostomy care, V1 (Administrator) stated, they are licensed nurses to do their capabilities within their work ethics and if they aren't comfortable, they can come get us to get training provided. We have it anytime they need from (name of online training program), it is a real person and any of us would be happy to go down and help them. V1 stated she was on the phone with nursing staff and verified all the equipment was there and was on the phone with the hospital. V1 stated she also had the manager on duty, V36 (Laundry/Housekeeping Manager) in R3's room going over all the items with her. V1 stated, No one was uncomfortable, everyone was fine, and everyone had the equipment. V1 stated they had a venturi mask and R3 refused to use it and that is why they went to the hospital to get her a different mask. V1 stated we had venturi masks at the facility. On 3/25/24 at 10:10 AM, when asked if she assisted nursing staff with finding supplies for R3's trach care, V36 (Laundry/Housekeeping Supervisor) stated when R3 came back from the hospital (3/16/24) she spoke with V1 (Administrator) on the phone to verify they had everything they needed to meet R3's needs. On 3/20/24 at 1:00 PM, V32 (Physician) stated she wasn't familiar with R3 since she had just admitted to the facility. V32 stated she was not R3's physician prior to her admission to the facility. This surveyor explained the scenario to V32 and asked if there was any potential negative outcome for R3, V32 stated there is a lot of potential negative outcome. V32 stated it could have devastating consequences if the facility doesn't have the necessary equipment for the trach. This surveyor then asked V32 if she had ever seen nurses who had not worked with trach's before and if so, would they need to be trained prior to caring for a resident with a trach, V32 stated it is very reasonable for a nurse who hasn't cared for a trach to need to be trained on how to do it. The facility Inservice Education Record dated 6/7/23 documents the subject of the training as trach orders and has a list of who attended. V13 (LPN), V25 (LPN), and V27 (RN) are not documented as attending the meeting. The training attached to this meeting documents staff was trained on how to set up tracheostomy orders in the electronic health record system. The facility annual training calendar does not include training on tracheostomies. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	The facility undated Tracheostomy Care procedures documents, The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas. The procedure documents under General Guidelines 7. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times. This procedure does not address the specific equipment needed to supply oxygen.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure pain and the effectiveness of pain medication was evaluated for 1 of 3 (R1) residents reviewed for pain in the sample of 17. Findings Include: R1's Admission Record with a print date of 3/21/24 documents R1 was admitted to the facility on [DATE] with diagnoses that include sepsis, chronic kidney disease, atrial fibrillation, depression, anemia, left artificial hip joint, gout, and osteoarthritis of left hip. R1's MDS (Minimum Data Set) dated 2/12/2024 documents a BIMS (Brief Interview for Mental Status) score of 12, which indicates R1 has a moderate cognitive impairment. R1's current Care Plan documents a Focus Area initiated on 11/24/23 of The resident is on pain medication therapy r/t (related to) chronic pain. This Focus Area documents the following interventions initiated on 11/24/23 Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness Q (every) shift .Ask physician to review medication if side effects persist . For respiratory depression: Monitor respiratory rate, depth, and effort after administration of pain medications .Monitor for increased falls .Monitor/document/report PRN (as needed) adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritis, respiratory distress/decreased respirations, sedation, urinary retention. This same Care Plan documents a Focus Area initiated on 9/27/23 of The resident has chronic pain. The interventions dated 9/27/23 documented for this Focus Area are as follows; Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician .Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. R1's Order Summary Report dated 3/18/24 includes the following physician order, Norco oral tablet 5-325 mg (milligrams) (Hydrocodone-Acetaminophen) give 1 tablet my mouth every 4 hours as needed for pain. On 3/14/24 at 11:40 AM, R1 stated on a Wednesday night towards the end of February (couldn't recall exact date) he requested pain medication because he was in a lot of pain, and he didn't get it. R1 stated he also requested it the next night and he didn't get it. R1 stated he was in a lot of pain and really needed his pain medication. R1 stated he spoke with V2 (DON/Director of Nursing), and she told him she would look into it, but she hadn't gotten back with him. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/24 at 10:37 AM, V27 (RN/Registered Nurse) stated she didn't take care of R1 on Wednesday, 2/21 or 2/28/24 but she knew why this surveyor was asking about R1's pain medication. V27 stated she came in to work one night (couldn't remember the exact date) and R1 made a complaint to her about not getting pain medications when he asked for them the night before. V27 stated she checked the books and they documented R1 had pain medication administered every four hours. When asked what books she was referring to, V27 stated she was talking about the narcotics book with the narcotics sign out log in them. V27 stated she didn't check R1's electronic record she checked the narcotics sign out log since the narcotics were not always signed out in the computer, but the log always has to be signed. On 3/20/24 at 10:05 AM, V2 (DON) stated she had not had residents complain to her they weren't getting their pain medications, including R1. When asked what the process was for narcotic reconciliation, V2 stated the narcotics are in cards and they are kept in the locked box in the locked medication cart. V2 stated when the nurse administers a narcotic, they sign them out in the electronic health record and then on the narcotics log sheet. On 3/20/24 at 12:40 PM, V1 (Administrator) stated R1 said he didn't get his pain medication and they had a care plan meeting and that was all resolved. V1 stated they talk to R1's family all the time. When asked how and when this occurred, V1 stated she didn't remember how she got the information, and she believed it was way before February. R1's MAR (Medication Administration Record) dated 2/1/24 to 2/29/24 includes an order for Norco 5-325 mg give one tablet by mouth every four hours as needed for pain. This is signed on the MAR, located in the electronic health record, as administered with effectiveness evaluated on the following dates and times 2/1/24- 9:40 PM, 2/2/24- 5:09 AM and 5:53 PM, 2/12/24 - 9:08 AM, 2/13/24 - 9:22 AM, 2/15/24- 2:22 PM, 2/16/24 - 9:18 AM, 2/17/24- 9:32 AM, 2/21/24- 4:31 PM, 2/22/24- 3:04 PM, 2/23/24- 9:51 AM and 5:53 PM- 2/24/24- 5:18 AM and 1:14 PM, 2/26/24- 6:25 AM, 2/28/24- 8:41 AM and 8:10 PM, and 2/29/24- 9:55 AM and 8:00 PM. There is no documentation on this MAR that R1 received pain medication through the night on 2/21/24. This same MAR dated 2/1/24 to 2/29/24 documents R1's pain level was assessed, and the highest level of pain was recorded each shift. This documents on Wednesday 2/21/24, R1's highest level of pain was assessed at a 0 on day shift and a 5 on night shift and on Wednesday 2/28/24 R1's highest level of pain was assessed as a 0 on both day and night shift. R1's Narcotic sign off log documents R1 received Norco 5-325 mg on the following dates and times 2/18/24- 7:00 PM and 11:00 PM, 2/19/24- 3:00 AM, 7:00 AM, 12:30 PM, 5:30 PM, and 11:00 PM, 2/20/24- 1:00 PM and 11:00 PM, 2/21/24- 6:00 AM, 4:30 PM, and 7:00 PM, 2/22/24- 3:00 AM, 7:00 AM, 2:00 PM, 7:00 PM, 11:00 PM, 2/23/24- 3:00 AM, 7:00 AM, 9:50 AM, and 6:00 PM, 2/24/24-5:18 AM, 5:00 PM, 8:00 PM, 2/25/24- 4:00 AM, 8:00 AM, and 5:00 PM, 2/26/24 6:30 AM, and another time that is not written legibly enough to read. This indicates R1's narcotics was signed out as administered on the narcotics log but not signed as administered on R1's MAR in the electronic health record. The narcotics log does not have a place to document R1's pain assessments prior to administration of the narcotic and/or a place to document if the narcotic was effective. R1's progress notes were reviewed from 2/1/24 to 2/29/24 and do not document evaluation of pain and/or effectiveness of the narcotic pain medication after it was administered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odin Health and Rehab Center	300 Green Street Odin, IL 62870

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 2:32 PM, V2 (DON) stated the narcotics sign out logs do not have a place to document pain scale or effectiveness of the pain medication. V2 stated that would be documented in the electronic health record. This indicates the facility was not able to provide reproducible evidence R1's pain was assessed prior to administration of the narcotics and/or the effectiveness was assessed after the administration of the narcotics that were signed out on the narcotics log but not signed as administered on R1's MAR in the electronic health record. The facility Management of Pain policy dated 5/16/22 documents, Policy: Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. We will achieve these goals through: Promptly and accurately assessing and diagnosing pain. Encouraging residents to self-report pain Monitoring treatment efficacy and side effects. This Policy documents under Procedure, .7. Pain Monitoring: document in (name of electronic health record) the effectiveness of pain medications should be measured 1-2 hours after administration of treatment using the pain scale chosen by the resident or the behavioral indicators. 8. Documentation: Document interventions and responses in the medical record as appropriate (i.e., medication administration record, treatment record, nursing progress notes, etc.) Communicate pain protocol and pain levels to the MDS Coordinator to ensure proper pain coding on the MDS. Update M.D. (physician) if pain was not relieved or if resident has break through pain

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure sufficient staff was in place to meet the needs of the residents. This failure has the potential to affect all 93 residents currently residing at the facility. Findings Include: The facility Resident Listing Report dated 3/14/24 documents 93 residents currently reside at the facility. On 3/21/24 at 9:37 AM, V39 (CNA/Certified Nursing Assistant) stated he works on day shift and when he comes to work after night shift has been working with less staff, the residents tell him it took night shift a long time to answer their call lights. V39 stated he came to work on 3/16/24 at 4:00 PM and there were five CNA's working. V39 stated five CNA's are not enough to meet the needs of the residents because there are so many residents with behaviors. When asked what type of behaviors. V39 stated, residents falling, attempting to leave the facility, and one resident who tries to push other residents in their wheelchairs. On 3/14/24 at 2:53 PM, V8 (CNA) stated she works night shift on the weekends, and they had three CNA's a few weeks ago when she worked. V8 stated if they have five CNA's working, they work with one CNA on one hall and two on the other two halls. V8 stated they typically put one CNA on A hall when that happens. When asked how many residents required assist of two for transfer on A hall, V8 stated over half of them. On 3/18/24 at 4:45 AM, when asked if they had enough staff to meet the needs of the residents, V13 (LPN/Licensed Practical Nurse) stated Not CNA wise. V13 stated she started this night shift with five CNA's and one left at 4:00 AM. V13 then said two may have left and if so then there is only one CNA per hall. V13 stated she currently only has one CNA on her hall (A hall). V13 stated the evening shift on 3/17/24 was short staffed. V13 stated V2 (Director of Nursing/DON) came in to work because they only had three CNAs in the building. The facility untitled document dated 3/17/24 documents licensed and certified staff working on each shift. This form documents on the 10 PM to 6 AM shift, four CNA's (V8, V19, V45, and V47) working until 4:00 AM and then three CNA's (V8, V19, and V45) working until 6:00 AM. On 3/18/24 at 5:14 AM, V45 (CNA) stated she had another CNA working with her until between 3:30 and 4:00 AM, this morning. V45 stated then she was on A hall by herself. V45 stated they currently have three CNA's working in the facility. When asked if that was enough to meet the needs of the residents V45 stated they did the best they could. On 3/18/24 at 6:49 AM, V14 (LPN) stated she had more CNA's during the first part of her shift but only had one CNA on her hall after 4:00 AM. When asked if one CNA on her hall was enough to provide care for the residents, V14 stated Not in my opinion. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/18/24 at 6:15 AM, when asked if three CNA's were enough to meet the needs of the residents on night shift, V19 (CNA) stated, No. V19 stated when they have three CNA's there is no way to get everyone up, they are supposed to. V19 stated care is delayed because they don't have another person to help. V19 stated he works 2-10 PM, normally and they usually have 6-8 CNA's which is enough. V19 stated when he got to the facility on [DATE] at 6:00 PM, he believed there were only four CNA's working. V19 stated supper was delayed. V19 stated they normally served between 4:30 and 5:00 PM and they were still serving when he got to the facility at 6:00 PM. V19 stated they were still picking supper trays up at 7:00 PM. On 3/19/24 at 10:59 PM, V28 (CNA) stated she didn't think they could meet the needs of the residents with four CNA's on night shift. When asked what needs aren't met with four CNA's working, V28 stated, monitoring residents who are wandering, ensuring residents with behaviors are safe, and answering call lights timely. On 3/19/24 at 11:15 PM, V29 (CNA) stated at times they have four CNA's and two nurses working and she doesn't feel like it is enough to meet the needs of the residents. V29 stated, It can be chaotic, with behaviors, wanderers, and door alarms going off. On 3/19/24 at 11:26 PM, V30 (CNA) stated she didn't think there was enough staff for the number of residents with behaviors and who require assist of two staff. V30 stated it is hard when there is one CNA on a hall and they have to get pulled to help on another hall, which then leaves their hall unattended. On 3/25/24 at 3:30 PM, V16 (CNA Supervisor/Scheduler) stated staff had brought concerns to him related to staffing. V16 stated that is why he took the position. V16 stated four CNA's are generally enough to meet the needs of the residents on night shift but not three. V16 stated starting tonight there are supposed to be six CNA's on night shift. V16 stated staffing is a work in progress. 1. R1's Admission Record with a print date of 3/21/24 documents R1 was admitted to the facility on [DATE] with diagnoses that include sepsis, pulmonary disease, chronic kidney disease, atrial fibrillation, left hip osteoarthritis, and left artificial hip joint. R1's MDS (Minimum Data Set) dated 2/12/2024 documents a BIMS (Brief Interview for Mental Status) score of 12, which indicates R1 has a moderate cognitive impairment. This same assessment documents R1 is dependent on staff for bathing. R1's current Care Plan documents a Focus Area initiated on 9/28/23 of Self-Care deficits as Evidenced by: Needs assistance with ADL's (Activities of Daily Living). This Focus Area's interventions include, Transfer: Mechanical Lift required. There is no intervention related to bathing documented on this Care Plan. This same Care Plan documents a Focus Area initiated on 9/27/23 of Potential for impaired skin integrity related to impaired mobility this Focus area includes the intervention of Bath/shower per schedule. R1's electronic health record Task of Shower/Bathe self, documents R1 received a shower/bath on 2/22/24, 3/1/24 and 3/12/24 and refused a shower/bath on 3/5 and 3/8/24. This indicates R1 did not receive assistance with a shower/bath from 2/23/24 to 2/29/24 (7 days). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/14/24 at 11:40 AM, R1 stated the facility staff assist him with showers but they need a certain mechanical lift sling, and they don't have the one he needs. R1 stated he used to use a sling that would come up between his legs and it hurt him, so they stopped using it. R1 stated they found a different type of sling that was open and didn't hurt him. R1 stated they began using the open sling and then they didn't have it available again. R1 stated they tell him they don't have enough of them to go around. R1 stated sometimes they don't have enough staff for two people to assist him. On 3/14/24 at 3:07 PM, V9 (LPN) stated R1 asked for a specific sling that wouldn't go between his legs. V9 stated they ordered one for him, but she didn't know what happened with it. When asked if she had concerns R1 wasn't getting showers the way he should V9 stated, Yes. V9 stated she made the CNA's that were working on the floor on Saturday give him a shower since he hadn't gotten one. V9 stated R1 was supposed to have gotten one on Friday and didn't. On 3/14/24 at 3:33 PM, when asked if she was aware of residents not getting up because they didn't have slings to transfer them, V10 (CNA) stated, Absolutely. V10 stated when they give a resident a shower the sling must go to laundry. V10 stated when they don't have enough slings and they give them a shower then they can't get them up for supper. V10 stated they have shower aids at the facility, but they don't give bed baths for the residents who don't take a shower. V10 stated the shower aids work Monday, Tuesday, Thursday, and Friday. V10 stated there are two shower aids and they do approximately 45 showers a day. On 3/19/24 at 1:59 PM, V22 (CNA/Shower Aid) stated they do showers on the residents who reside on the left side of the halls on Monday and Thursday and the residents who reside on the right side of the halls on Tuesday and Friday. V22 stated she works between nine and eleven hours a day and does 40-50 showers per day. V22 stated for the most part they can get the showers done. This surveyor asked if they were able to get bed baths done with 40-50 showers per day and V22 stated, Not really, no. V22 stated they talked with V5 (MDS Coordinator) on Friday and asked why the aids on the halls couldn't do the bed baths and V5 told her they should be the one's doing it. This surveyor reviewed R1's shower logs under the task in the electronic health record and asked if it was typical for R1 to not have a shower from 2/23/24 to 2/29/24 and V22 stated it was not. V22 stated that was before they had a full body sling for R1. V22 stated they don't always have enough staff to meet the needs of the residents. When asked what care wasn't provided when they don't have enough staff, V22 stated, changing, repositioning and sometimes showers. On 3/19/24 at 3:21 PM, V24 (CNA/Shower Aid) stated she gives showers to about 45 residents a day. V24 stated she believes the two shower aids can complete the assigned showers. V24 stated it is when they have to stop and do bed baths that they are getting behind. V24 stated they don't always have enough staff and when they don't residents don't get changed as much as they should, and call lights don't get answered timely. 2. R3's Admission Record with a print date of 3/21/24 documents R3 was admitted to the facility on [DATE] with diagnoses that include local infection, bacteremia, chronic obstructive pulmonary disease (COPD), asthma, malignant neoplasm, tracheostomy status, heart failure, hypertension, atrial fibrillation, and hypo/hypertension. R3's current Care Plan has a Focus Area initiated on 3/16/24 of Potential for impaired skin integrity related to impaired mobility with interventions that include Bath/shower per schedule initiated 3/16/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R3's MDS dated [DATE] documents under Functional Abilities and Goals that R3 requires partial/moderate assistance for dressing, putting on/taking off footwear, personal hygiene, and mobility. R3's electronic health record documents a Task of shower/bathe self with no shower/bath documented as being offered or done from 3/15/24 to 3/20/24. On 3/21/24 and 3/25/24 the task documents R3 refused a shower/bath. On 3/19/24 at 1:59 PM, V22 (CNA/Shower Aid) stated R3 should have gotten a shower over the weekend. V22 stated new admits are supposed to get showers within 24 hours of admission but CNA's working the floor refuse to give showers. V22 stated then R3 should have had a shower on Monday. V22 stated she didn't work Monday so she didn't know why R3 didn't get one. On 3/21/24 at 11:40 AM, V42 (CNA) stated there are two shower aids that are supposed to get 48 showers done in a day. V42 stated she did showers one day, and she couldn't get 48 done. When asked if they had enough staff to meet the needs of the residents, V42 stated she would say, no. V42 stated care still gets provided it is just delayed. 3. R11's Admission Record with a print date of 3/25/24 documents R11 was admitted to the facility on [DATE] with diagnoses that include metabolic encephalopathy, COPD, diabetes, hypertension, and heart disease. R11's MDS dated [DATE] documents a BIMS score of 14, which indicates R11 is cognitively intact. This same MDS documents R11 is always incontinent of bladder and bowel incontinence is not rated on this assessment. R11's current Care Plan documents a Focus Area initiated on 9/13/22 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This focus area includes the intervention of, Toilet Use: One-person physical assist required, Date Initiated: 10/21/22. On 3/25/24 at 1:47 PM, R11 stated she gets assistance from staff with toileting. R11 stated she has had to wait up to 30 minutes for assistance after she has had an incontinence episode. R11 stated she has talked with an unknown nurse about how long it takes. 4. R12's Admission Record with a print date of 3/25/24 documents R12 was admitted to the facility on [DATE] with diagnoses that include hemiplegia, hemiparesis, COPD, asthma, diabetes, morbid obesity, seizures, anxiety disorder, and sleep apnea. R12's MDS dated [DATE] documents a BIMS score of 12, which indicates a moderate cognitive impairment. This same MDS documents R12 is dependent on staff for toileting. R12's current Care Plan documents a Focus Area initiated on 8/2/23 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This focus area includes an intervention of Toilet Use: Two-person physical assistance required. R12's care plan does not have a Focus Area related to incontinence but does document under the Focus Area of Actual Pressure Ulcer . an intervention of Monitor incontinence and provide peri-care after each incontinent episode, Date Initiated: 3/25/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/21/24 at 11:40 AM, V42 (CNA) stated she had reported an incident related to R12 to administration and as far as she knows administration didn't follow up. V42 stated she walked past R12's room a few weeks ago and R12 yelled at her to come to her room. V42 stated R12 reported to her she had a bowel movement and an unknown staff member had told her twice they couldn't change her. V42 stated R12 was lying in bed, didn't have her call light, had the mechanical lift sling under her, and didn't have a blanket. On 3/25/24 at 1:43 PM, R12 stated she doesn't use the commode, she is incontinent, and wears incontinence briefs. R12 stated she has had to wait 30 minutes to an hour to get assistance with incontinence care and/or for staff to answer the call light. R12 stated she currently needs her incontinence brief changed and has been waiting for 20 minutes. 5. R4's Admission Record with a print date of 3/25/24 documents R4 was admitted to the facility on [DATE] with diagnoses that include COPD, heart failure, diabetes, chronic kidney disease (CKD), hypertension, weakness, and anemia. R4's MDS dated [DATE] documents R4 has moderate cognitive impairment, requires substantial/maximal assistance from staff for toileting, and is always incontinent of bladder with bowel incontinence not rated. R4's current Care Plan documents a Focus Area initiated 12/30/23 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This Focus Area includes the intervention of Toilet Use: Two-person physical assistance required. On 3/18/24 at 4:45 AM, V13 (LPN) stated when the CNAs were doing rounds (at the beginning of this shift on 3/17/24), they found residents who looked like they hadn't been changed all day. V13 stated she knew they were short staff on the previous shift and V2 (DON) had worked the floor. V13 stated she observed R4, and the bed pads she was on were brown with urine stains and it was someone who had laid in urine/feces for a period of time. V13 stated she was going to report it but since V2 had covered the hall R4 was on, she wasn't sure who to report it to. On 3/18/24 at 5:14 AM, V45 (CNA) stated when she came to work on 3/17/24 around 10:00 PM, R4 was covered in urine/feces, and it smelled like she had been that way for a long time. V45 stated it was brown and had dried circles. V45 stated R4 reported she hadn't been checked all day. On 3/18/24 at 5:28 AM, V8 (CNA) stated she came to work at 6:00 PM on 3/17/24 and there was only four CNAs working and V2 (DON) had come in to help. V8 stated she did a bed check when she got to the facility and R4 was saturated with urine and stool. V8 stated her entire bed was brown and saturated. On 3/18/24 at 6:15 AM, V19 (CNA) stated when he got to the facility on [DATE] around 6:00 PM, they had four CNA's working. V19 stated they told him in report R4 had refused care. V19 stated when he went to check on R4 she had urine and feces all around her. V19 stated R4 told him no one had checked on her since 7:00 AM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/21/24 at 9:51 AM, R4 was in bed and was provided incontinence care by V6 and V40 (CNA's). R4 stated there was one time, the first part of this month, she had an incontinence episode at night and had to lay in it until they checked her the next morning. R4 stated the facility staff didn't know she had a bowel movement until they came to wake her up. R4 stated after that incident they started checking her more frequently. 6. R5's Admission Record with a print date of 3/25/24 documents R5 was admitted to the facility on [DATE] with diagnoses that include sacrococcygeal disorders, aortic valve insufficiency, disc degeneration, hypertension, stress incontinence, anemia, and osteoarthritis. R5's MDS dated [DATE] documents R5 has a BIMS score of 03, which indicates R5 has a severe cognitive impairment. This same MDS documents R5 is dependent on staff for toileting and is frequently incontinent of bladder, always incontinent of bowel and R5 requires assist of staff to set up or clean up with eating. R5's current Care Plan documents a Focus Area initiated on 11/20/21 of Self-Care Deficit as Evidenced by: Needs assistance with ADL's. This Focus Area includes interventions of .Eating- Setup help only/Cueing required. Date Initiated 3/4/24 .Toilet Use- One-person physical assist required. Date Initiated 11/20/21. On 3/18/24 at 4:45 AM, V13 (LPN) stated she observed R5 last night laying in urine. V13 stated the bed pads were brown with urine stains. On 3/18/24 at 5:28 AM, V8 (CNA) stated when she got to work at 6:00 PM, they only had four CNA's working and V2 (DON) had come in to help. V8 stated she did a bed check on R5 and she was saturated with urine. V8 stated R5's gown, blankets, incontinence brief, two bed pads, and sheets were soaked with urine and brown in color. On 3/25/24 at 9:35 AM, this surveyor attempted to interview R5. R5 was unable to answer questions asked by this surveyor. On 3/18/24 at 10:10 AM, V16 (CNA supervisor/Scheduling Coordinator) stated it is not typical to have three CNA's working on night shift. V16 stated they try to have five but at least four. V16 stated they only had three CNA's for a short time. V16 stated they normally have at least six CNA's on evening shift, and he tries to have three per hall (9) on day shift. When asked if three CNA's could meet the needs of the residents on night shift, V16 stated, If they work together, yes. On 3/20/24 at 10:05 AM, V2 (DON) stated she started working at the facility on 1/29/24 as the Assistant Director of Nurses and then took the DON position on 2/2/24. V2 stated they have had staff call ins recently. V2 stated she came into work this weekend to cover shifts. When asked about the day she came in V2 stated she got to the facility around 2:30 PM and stayed for two hours. V2 stated from 2-2:40 PM, there were four CNA's and then she came in and made the fifth CNA. V2 stated at 4:00 PM and 6:00 PM another CNA came in, and this made six CNA's. When asked if they were able to meet the needs of the residents with the number of CNA's they had, V2 stated she was asking them what they needed and they told her to answer call lights. V2 stated she thought three to four CNA's were enough to meet the needs of the residents on night shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/20/24 at 4:07 PM, V1 (Administrator) stated four CNA's and two nurses were enough to provide care for the residents on night shift. V1 stated they use the required minimum staffing sheet to determine their staffing numbers and fill one out daily. The facility Minimum Daily Staffing Calculations documents with a census of 90 residents the facility should have 11.12 (8-hour full time employees) on day shift, 8.65 on evening shift, and 4.94 on night shift. The facility Staffing Policy dated 6/13/23 documents, Purpose: To offer guidance to the facility on employee staffing. Policy: The facility has developed and assigned duty hours for the Nursing Services department, based on state/federal requirements, and utilizing the staffing calculator.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review, the facility failed to ensure pharmacy services were provided per current standards of practice for 2 of 3 (R1 and R7) residents reviewed for pharmacy services in the sample of 17. Findings Include: 1. R1's Admission Record with a print date of 3/21/24 documents R1 was admitted to the facility on [DATE] with diagnoses that include sepsis, chronic kidney disease, atrial fibrillation, depression, anemia, left artificial hip joint, gout, and osteoarthritis of left hip. R1's MDS (Minimum Data Set) dated 2/12/2024 documents a BIMS (Brief Interview for Mental Status) score of 12, which indicates R1 has a moderate cognitive impairment. R1's current Care Plan documents a Focus Area initiated on 11/24/23 of The resident is on pain medication therapy r/t (related to) chronic pain. This Focus Area documents the following interventions initiated on 11/24/23 Administer ANALGESIC medications as ordered by physician. Monitor/document side effects and effectiveness. Q (every) shift .Ask physician to review medication if side effects persist . For respiratory depression: Monitor respiratory rate, depth, and effort after administration of pain medications .Monitor for increased falls .Monitor/document/report PRN (as needed) adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritis, respiratory distress/decreased respirations, sedation, urinary retention. This same Care Plan documents a Focus Area initiated on 9/27/23 of The resident has chronic pain. The interventions dated 9/27/23 documented for this Focus Area are as follows; Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician .Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. R1's Order Summary Report dated 3/18/24 includes the following physician order, Norco oral tablet 5-325 mg (milligrams) (Hydrocodone-Acetaminophen) give 1 tablet my mouth every 4 hours as needed for pain. On 3/14/24 at 11:40 AM, R1 stated on a Wednesday night towards the end of February (couldn't recall exact date) he requested pain medication because he was in a lot of pain, and he didn't get it. R1 stated he also requested it the next night and he didn't get it. R1 stated he was in a lot of pain and really needed his pain medication. R1 stated he spoke with V2 (DON/Director of Nursing), and she told him she would look into it, but she hadn't gotten back with him. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/24 at 10:37 AM, V27 (RN/Registered Nurse) stated she didn't take care of R1 on Wednesday, 2/21 or 2/28/24 but she knew why this surveyor was asking about R1's pain medication. V27 stated she came in to work one night (couldn't remember the exact date) and R1 made a complaint to her about not getting pain medications when he asked for them the night before. V27 stated she checked the books and they documented R1 had pain medication administered every four hours. When asked what books she was referring to, V27 stated she was talking about the narcotics book with the narcotics sign out log in them. V27 stated she didn't check R1's electronic record, she checked the narcotics sign out log since the narcotics were not always signed out in the computer, but the log always has to be signed. On 3/20/24 at 12:40 PM, V1 (Administrator) stated R1 said he didn't get his pain medication and they had a care plan meeting and that was all resolved. V1 stated they talk to R1's family all the time. When asked how and when this occurred, V1 stated she didn't remember how she got the information, and she believed it was way before February. On 4/2/24 at 9:09 AM, V1 stated she checked the care plan meetings and it was related to R1 refusing therapy not an issue with R1 not getting his pain medications. R1's MAR (Medication Administration Record), located in the electronic health record, dated 2/1/24 to 2/29/24 includes an order for Norco 5-325 mg give one tablet by mouth every four hours as needed for pain. This medication is signed on the MAR, as administered with effectiveness evaluated on the following dates and times: 2/1/24- 9:40 PM, 2/2/24- 5:09 AM and 5:53 PM, 2/12/24 - 9:08 AM, 2/13/24 - 9:22 AM, 2/15/24- 2:22 PM, 2/16/24 - 9:18 AM, 2/17/24- 9:32 AM, 2/21/24- 4:31 PM, 2/22/24- 3:04 PM, 2/23/24- 9:51 AM and 5:53 PM- 2/24/24- 5:18 AM and 1:14 PM, 2/26/24- 6:25 AM, 2/28/24- 8:41 AM and 8:10 PM, and 2/29/24- 9:55 AM and 8:00 PM. There is no documentation on this MAR to show that R1 received pain medication through the night on (Wednesday) 2/21/24. This same MAR dated 2/1/24 to 2/29/24 documents R1's pain level was assessed, and the highest level of pain was recorded each shift. On Wednesday 2/21/24, R1's MAR documents the highest level of pain was assessed at a 0 on day shift and a 5 on night shift. On Wednesday 2/28/24, R1's MAR documents the highest level of pain was assessed as a 0 on both day and night shift. R1's Narcotic sign off log (a paper document to count down/reconcile narcotics dispensed to the resident) documents R1 received Norco 5-325 mg on the following dates and times 2/18/24- 7:00 PM and 11:00 PM, 2/19/24- 3:00 AM, 7:00 AM, 12:30 PM, 5:30 PM, and 11:00 PM, 2/20/24- 1:00 PM and 11:00 PM, 2/21/24- 6:00 AM, 4:30 PM, and 7:00 PM, 2/22/24- 3:00 AM, 7:00 AM, 2:00 PM, 7:00 PM, 11:00 PM, 2/23/24- 3:00 AM, 7:00 AM, 9:50 AM, and 6:00 PM, 2/24/24-5:18 AM, 5:00 PM, 8:00 PM, 2/25/24- 4:00 AM, 8:00 AM, and 5:00 PM, 2/26/24 6:30 AM, and another time that is not written legibly enough to read. This indicates 28 doses of Norco were signed out as administered on R1's paper narcotic log and 19 doses of Norco were signed out as administered on R1's MAR in the electronic health record. 2. R7's Admission Record with a print date of 3/25/24 documents R7 was admitted to the facility on [DATE] with diagnoses that include pain due to orthopedic prosthetic devices, rotator cuff tear, left artificial shoulder joint, stage 4 pressure ulcers, colostomy, major depressive disorder, and history of healed traumatic fracture. R7's MDS dated [DATE] documents R7 has a BIMS score of 15 and is assessed on this same MDS as having pain occasionally. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's current Care Plan documents a Focus Area of (R7) has (acute/chronic) pain r/t (related to) Chronic Physical Disability, Disease process, Wound. Date Initiated 12/06/2022. The interventions for this Focus Area include Monitor/document for side effects of pain medication .Monitor/record pain characteristics Q (every) shift and PRN (as needed) .Monitor/record/report to Nurse any s/sx (signs/symptoms of non-verbal pain .Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment .Notify physician if interventions are unsuccessful . This same Care Plan documents another Focus Area initiated on 3/21/24 of Pain/Opioid therapy r/t (related to) chronic pain. This Focus Area includes interventions initiated on 3/21/24 of, Observe for indications of pain every shift during routine interactions .Administer pain medications as indicated/prescribed .Observe effectiveness of pain management interventions .Recognize common side effects of Opioid use: dry mouth, constipation, sedations, drowsiness, dizziness, dysuria, confusion or weakness . Report immediately any signs of adverse drug reactions: throat swelling, significant drop in B/P (blood pressure), bradycardia, hypoventilation, dyspnea, seizures, tremors, hallucinations, respiratory distress .Consult with MD (physician) when pain regimen changes are indicated. Inadequate pain relief or unpleasant side effects .If serious adverse drug reaction develops, such as RR (respiratory rate less than) 12 BPM (beats per minute) remove patch and contact MD immediately. R7's Order Summary Report dated 3/28/24 documents a physician order for oxycodone 5 mg (milligrams) one tablet my mouth every four hours as needed for moderate to severe pain due to left shoulder surgery. R7's MAR in the electronic record dated 3/1/24 to 3/31/24 documents an order for oxycodone 5 mg every four hours as needed for moderate to severe pain. R7's MAR shows the following were signed as administered: 3/1/24 at 6:17 PM, 3/4/24 at 8:48 PM, 3/5 at 12:00 PM, 3/6 at 9:09 AM, 3/7 at 7:50 AM, 3/10 at 11:06 AM, 3/18 at 9:38 PM, 3/19 at 9:26 PM, 3/20 at 7:00 PM and 11:00 PM, 3/21 at 7:07 AM, 3/23 at 8:41 PM, 3/24 at 4:33 PM, and 3/25/24 at 7:00 AM and 3:02 PM. This indicates a total of fifteen doses (pills) were documented as administered from 3/1/24 to 3/25/24. R7's narcotics sign out log (the paper document to count down/reconcile narcotics dispensed to the resident) dated 3/6/24 documents a total of 30 doses of oxycodone 5 milligrams were signed out as administered from 3/7/24 to 3/17/24. R7's narcotic sign out log dated 3/12/24 documents a total of 24 oxycodone 5 mg were signed out as administered from 3/17/24 to 3/28/24. This indicates a total of 54 doses of oxycodone were signed out as administered on R7's narcotics log during March 2024. With the total amount of 15 doses documented in the electronic MAR and 54 doses signed out on the paper narcotic sign out log, this accounted for a total of 69 doses of oxycodone signed as administered in March 2024. On 3/26/24 at 9:03 AM, V46 (Quality Assurance Pharmacist) stated R7 had 122 oxycodone 5 milligrams dispensed from 3/1/24 to 3/12/24, further stating there were 30 pills dispensed on 3/1, 3/5, and 3/7/24; 8 pills dispensed on 3/3/24, and 24 pills dispensed on 3/12/24. V46 stated the facility requested a refill on 3/21/24 and pulled one from the emergency supply on 3/25/24, indicating R7 did not have any oxycodone available to administer on 3/25/24. V46 stated the facility is responsible for reconciliation after they receive the narcotics, and the facility policy would determine how they reconcile. This indicates that while 122 oxycodone were dispensed between the dates of 3/1/24 to 3/12/24, only 69 oxycodone were documented as signed out/administered on R7's narcotics log and MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 10:05 AM, V2 (DON) stated she hadn't had any complaints residents weren't getting their pain medications as ordered. When asked what the process was for narcotics reconciliation, V2 stated the narcotics are delivered in a card system, it is kept in the locked box on the locked cart, the nurses sign the narcotics out in the electronic health record on the MAR (to document it was administered to the resident) and on the narcotics log (to reconcile the narcotics count). V2 stated once the card of narcotics is empty it goes to her office with the narcotics sign out log documenting when each dose was given, and the number of doses left each time a dose was administered. V2 stated she keeps the empty card and log in her office to be able to go back and look at them if needed. On 3/26/24 at 9:23 AM, when asked if she had any other narcotic sign out logs for R7, V2 stated she had one dated 3/12/24 and one dated 3/6/24. This indicates V2 did not have the narcotics sign out logs for the narcotics dispensed on 3/1, 3/3, and 3/7. On 3/26/24 at 3:18 PM, V2 stated when the medications in the cards have all been administered, the nurses put the card and the final narcotics log in her mailbox. V2 stated she compares the narcotics sign out log to the pharmacy delivery packing slip to reconcile that all of the narcotics delivered were administered to the resident. V2 then stated she destroyed the narcotics sign out logs and cards for those packing slips (This does not coincide with V2's previous interview on 3/20/24 at 10:05 AM, when V2 stated she kept the narcotic sign out logs). When asked why she destroyed the sign out logs, V2 stated she was new to the facility and didn't know to keep them. This surveyor reviewed with V2 that the pharmacy documented they dispensed 122 oxycodone 5 mg to the facility for R7 in March 2024 and the narcotics sign out logs only documented 54 oxycodone 5 mg were administered to R7. This surveyor again asked V2 if she had anymore sign out logs or packing slips. V2 stated, What I have, I sent you. After speaking with V2 regarding other issues, this surveyor asked if they were still looking for more narcotic log/packing sheets for R7 and V2 stated she reviewed the electronic pharmacy record where they can see all the narcotics delivered to the facility and verified every amount dispensed for R7. This surveyor reviewed with V2 there were more narcotics dispensed by the pharmacy that she had not provided narcotics logs or packing slips for. V2 asked for the dates the oxycodone was dispensed and stated she had packing slips for those dates at the facility. On 4/2/24 at 8:42 AM, when asked about the discrepancy in her interviews related to the narcotics logs, V2 stated there was a big stack of the narcotics logs on her desk and she didn't know what she was supposed to do with them, so she destroyed them. V2 stated then she realized she was supposed to keep them, so she now has a binder that she is keeping them in. V2 supplied this surveyor with packing slips with a check mark and V2's initials next to R7's name and the amount of oxycodone delivered to the facility. The packing slips document 30 oxycodone were delivered to the facility for R7 on 3/2, 3/6, and 3/7/24: 8 oxycodone on 3/4/24 and 24 oxycodone on 3/12/24. Per V2's interview, after she reviewed the completed narcotics sign out logs, she initialed the packing slips to indicate the narcotics delivered to the facility were administered to the resident. By destroying the narcotic sign out logs and not having each dose signed out as administered on R7's MAR, V2 was unable to provide this surveyor with reproducible evidence that 53 of the 122 oxycodone delivered to the facility for R7 were administered to R7. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Controlled Substances Policy dated 5/11/20 documents, Purpose: To provide guidance to nursing staff at the facility on the control of controlled substances. Policy: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications The nurse administering the medication is responsible for verifying/recording: 1. name, strength, and dose of medication, 2. Time of administration, 3. Method of administration, 4. Quantity of the medication remaining, 5. Signature of nurse administering medication.