STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145666	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centralia Manor	1910 East McCord Rte 161 East Centralia, IL 62801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 48356 Based on interview, observation and record review the facility failed to answer calls lights in at timely manner and failed to provide grooming and feeding assistance to promote and maintain dignity for 5 (R13, R20, R38, R61, R179) of 5 residents in a sample of 34 reviewed for residents rights. Findings include: 1. R20's Face Sheet, dated 07/11/24, documents R20 was admitted to the facility on [DATE] with diagnoses in part of Chronic obstructive pulmonary disease, major depressive disorder, dysphagia, heartburn, dementia, cognitive communication deficit, dietary calcium deficiency, deficiency of other vitamins, pain, and hyperlipidemia. R20's Care Plan with a revised date of 05/16/24 documents under R20's Care information interventions of puree diet with super cereal at breakfast, fortified pudding at lunch/supper, and nutritional supplement at meals. No nutritional or weight loss information was included in the care plan. R20's Minimum Data Set (MDS), dated [DATE] documents in Section C a Brief interview for mental status (BIMS) score of 00 which indicates severely impaired cognition. Section GG document substantial/maximal assistance with eating. Section K documents no weight loss or gain of 5% or more in the last month or 10% or more in the last 6 months. On 07/08/24 at 11:57AM, R20 had her meal sitting in front of her. R20 was not eating, and no staff was assisting her with eating. R20's tray had pureed beef tips, green beans, mashed potatoes with gravy, bread, nutritional supplement ice cream. No fortified pudding was noted on tray. On 07/08/24 at 11:59AM, V27 (Certified Nurse Assistant/CNA) went over to R20 while standing she gave R20 a few bites of pureed beef tips. V27 then left and went back to assisting another resident with eating. After the few bites R20 was given, R20 just sat at the table with her food in front of her not eating. Another staff member, unknown name, walked up to the table while standing and gave R20 a couple more bites of food then left. On 07/08/24 at 12:01PM, V27 left another resident she was assisting again and while standing, gave R20 one bite of her food then left again. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/24 at 12:03PM, V27 left the table and then another staff member V30 (CNA) sat down at the table across from R20 and started to assist another resident with eating. R20 sat at the table during this time with no assistance. On 07/08/24 at 12:36PM, R20 was taken out of the dining room. On 07/08/24 at 12:38PM it was noted that R20's had consumed less than 25% of her tray. 2. R38's Face Sheet, dated 07/11/24, documents R38 was admitted to the facility on [DATE] with diagnosis in part of Myocardial infarction, Major depressive disorder, Chronic pulmonary edema, other abnormalities of the gait and mobility, abnormal posture, pain, Chronic atrial fibrillation, need for assistance with personal care, muscle weakness, acute cystitis, Type 2 diabetes mellitus, and legal blindness. R38's Care plan with a revised date of 05/23/24 documents under R38's care information continent/incontinent toileting assist x 1, incontinent products pull ups. Eyesight legally blind, and mobility dependent. R38's Minimum Data Set (MDS), dated [DATE] documents in Section C a Brief interview for mental status (BIMS) score of 14 which indicates R38 is cognitively intact. Section GG documents R38 requires partial/moderate assistance with toileting. R38 requires substantial/maximal assistance with toileting transfers and sit to stand transfers. On 07/08/24 at 2:30PM, R38 stated that the facility is short of staff all the time. R38 said she will hit her call light to go to the bathroom and it will take forever sometimes for them to answer the call light. R38 stated that she will already have an incontinent episode by the time they do answer her light. R38 said that it makes her feel embarrassed at times when she wets on herself. R38 said if they would answer the call light a little quicker, she might not have so many urine incontinent episodes. 3. R179's Face Sheet, dated 07/11/24, documents R179 was admitted to the facility on [DATE] with diagnoses of acute cystitis, heart failure, acute kidney failure, difficulty walking, weakness, urinary tract infection, stage 4 chronic kidney disease, and type 2 diabetes mellitus. R179's Care Plan with a revised date of 07/11/24 documents R179 has a UTI (urinary tract infection), R179 is at risk for falls related to decreased mobility, heart failure, osteoporosis, iron deficiency, atrial fibrillation, glaucoma, hypertension and diabetes. Interventions listed in part document bowel and bladder tracking and instruct R179 to call for assist before getting out of bed or transferring. R179's Minimum Data Set (MDS) had not yet been completed and was in progress. On 07/08/24 at 2:00PM, R179 who is alert and oriented to person, place and time stated that they don't have enough staff on all shifts to be able to help all the residents at the facility. R179 stated she will hit her call light to ask for assistance to get out of bed or for them to assist her to the bathroom and it takes them forever to answer the call lights. R179 said that she has had bowel incontinent episodes and urine incontinent episodes waiting on staff. R179 said that is does embarrass her when she has a bowel incontinent episode on herself. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/11/24 at 1:02PM, V8 (Certified Nurse Assistant) stated that when she is in the dining room sometimes there isn't enough people to assist all the residents who need help with eating. V8 said she may have to give several residents a bite here and there. V8 said that she does stand up and feed residents, because she may be there to give them a few bites and then have to go over to another resident to give them a few bites. V8 said that she has to do this often. V8 also stated she has had a lot of residents complain that they have had incontinent episode waiting on staff to answer their call lights. V8 said that it's especially bad in the mornings. V8 said what staff they have on midnight shift are in residents rooms trying to get them up for the day. V8 said they don't see the other call lights going off while they are in the rooms and it might take the staff a long time because it takes longer to get certain people up. V8 said day shift will come in and they will have a lot of call lights going off and residents saying they have been on their call lights for a long time waiting for assistance. V8 said day shift is usually the better staffed shift she said that second shift is horrible. V8 said that they hardly have any staff on second shift. V8 said that they are always short of staff on second shift and could really use some more help on that shift. On 07/11/24 at 1:19PM, V9 (CNA) stated they are short of staff on second shift. V8 said there may be only one person in the dining room to assisting all the residents that need help with eating. V9 said there may be 2 people most of the time trying to help all the residents that need assistance in the dining room. V9 said second shift doesn't have enough staff. V9 stated they have had resident complain that they have had incontinent episodes waiting for someone to answer their call lights and assist them. V9 said on second shift they don't have enough staff to take care of all the residents. On 07/11/24 at 1:29PM, V16 (CNA) stated that she has had resident complain to her that they had to wait forever for staff to answer their call light and that they had a incontinent episode while they waited on staff to answer their light. On 07/11/24 at 1:33PM, V12 (CNA Shift Coordinator) said somedays staff will have to assist several people with eating at the same time, other days they can help one person at a time it just depends on how much staff they have for the day. V12 said that she has had resident complain that they had a incontinent episode waiting on staff to answer the light. V12 said that's usually when they are complaining about having an incontinent episode waiting on staff it is in the morning time. V12 said that she isn't going to say that they are fully staffed at the facility. V12 said she knows that second shift has a lot of problems with staffing and don't have enough staff. On 07/11/24 at 1:55PM, V3 (Assistant Director of Nurses/ADON) stated every once in a while, they will have a resident complain that they had an incontinent episode waiting on staff to answer their call light. 49907 4. R61's face sheet documents an admitted [DATE], with diagnoses including Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, muscle weakness, need for assistance with personal care, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, generalized anxiety disorder. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R61's MDS dated [DATE], documents a BIMS of 4, which indicates R61's is severely cognitively impaired. Section GG documents R61 needs set up help with Personal hygiene: The ability to maintain personal hygiene, including shaving. R61 is also documented as set up assist with oral hygiene, upper and lower body dressing. Partial to moderate assistance with showers and bathing. R61's Care Plan dated 06/20/2024 documents in the problem section, Resident Care Information. Approach, Grooming: Stand by assist with cueing and set up. On 07/08/2024 at 10:55am, R61 was observed to have several dark hairs on her chin, approximately 1 inch in length. When asked what her preference was, she covered her chin with her hand and stated she did not want to talk about it. On 07/09/2024 at 11:01am, V14 (CNA) stated that she did not notice that R61 had facial hair on her chin that needed taken care of, but had she noticed, she would have assisted. V14 (CNA) stated R61 can be resistive to care at times. On 07/11/2024 at 1:48pm, V3 (ADON) stated it is her expectation that a female with noticeable facial hair be assisted with removing it, even if they are resistive to care due to cognitive impairment. V3 stated she would expect staff to continue to try and document if it had not been done. R61 was observed with dark, long facial hair on her chin on multiple occasions on 07/08/2024. R61 was observed in the sitting area, dining room and her room. R61 appeared calm and staff was never observed attempting to assist her to remove facial hair. 5. R13's face sheet documents an admitted [DATE], with diagnoses including Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, Contracture of muscle, unspecified site, Muscle weakness (generalized), Dysphagia, oropharyngeal phase, Cognitive communication deficit, Weakness, vitamin deficiency. R13's MDS dated [DATE], documents a BIMS of 3, which indicates R13 is severely cognitively impaired. Section GG documents R13 has an impairment of both upper extremities. R13 is dependent on staff for eating, oral hygiene, toilet hygiene, personal hygiene, showering and bathing. R13's care plan dated 06/27/2024 documents that the resident is independent and does not require assistance eating. On 07/08/2024 during the lunch meal R13 was sitting in the dining room. He was very lethargic through the meal and staff stood above him while assisting him to eat. Staff did not attempt to encourage him using verbal cues or get on resident's level to attempt to wake him. He ate less than 25% and did not drink any fluids. On 07/09/2024 during the lunch meal R13 was lethargic during the meal and staff stood above him while they assisted him. Staff did not attempt to encourage him using verbal cues or get on resident's level to attempt to wake him. He ate less than 25% and did not drink any fluids. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/11/2024 at 1:07pm, V8 (CNA) stated residents who are observed to have not eaten multiple meals in a short amount of time, regardless of their level of assistance, should be encouraged. V8 (CNA) stated they do move around the table a lot to feed multiple people and that she sanitizes her hands between residents. V8 (CNA) stated sometimes they will stand to feed a resident depending on the situation. On 07/11/2024 at 1:24pm, V9 (CNA) stated they encourage everyone to eat regardless of how much assistance they require. V9 (CNA) stated it is common for staff to stand while feeding, there may be one person trying to feed three people at one time. V9 (CNA) stated that she assists R13 meals. V9 (CNA) stated R13 just really won't wake up and eat for them most of the time. On 07/11/2024 at 1:31pm, V16 (CNA) stated they encourage residents to eat and even assist them if they are not eating regardless of how much assistance they normally require. V16 (CNA) stated they report these occurrences to the nurse also. V16 (CNA) stated they will even try other interventions such as offering alternatives, repositioning, etc. On 07/11/2024 at 1:48pm, V3 (ADON) stated it is her expectation that they assist anyone with feeding who may need it, regardless of the level of assistance they normally require. V3 (RN/ADON) stated that if she were feeding someone, she would sit down next to them and feed them. On 07/12/2024 at 11:38am, V1 (Administrator) stated the facility does not have any policy regarding feeding assistance. The facility policy titled, Personal Care of Residents with a revision date of December 2002 states the purpose of this document is to provide that residents of the facility receive adequate care. This policy further states that each resident shall have proper daily personal attention and or care.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on observation, interview and record review the facility failed to provide cueing and assistance with eating for one of four residents (R65) reviewed for Activates of Daily Living in a sample of 34. Findings include: 1. R65's face sheet documents an admitted [DATE], with diagnoses including cerebral infarction, unspecified(Primary, Admission), hyperosmolality and hypernatremia, major depressive disorder, recurrent, unspecified, dysphagia, oropharyngeal phase, myasthenia gravis without (acute) exacerbation, gastro-esophageal reflux disease without esophagitis, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R65's MDS (Minimum Data Set) dated 06/12/2024 documents that a (Brief Interview for Mental Status) was not completed because resident is rarely understood. Section GG documents R65 has an impairment of both upper extremities. R65 is coded as being independent for eating, partial to moderate assistance with oral hygiene and upper body dressing. R65's care plan dated 06/20/2024 documents R65 has a G tube related to CVA (cerebrovascular accident). Resident has decreased appetite. Dietary is to monitor and make changes. Care plan further documents R65 is independent with mouth care and feeds self. On 07/08/2024 at 11:52am, R65 received a mechanical soft meal of beef tips, green beans, mashed potatoes and gravy, and vanilla custard pie. Wife was assisting, he did not eat or drink anything. R65 seemed lethargic. Staff did not attempt to cue or offer alternatives. On 07/09/2024 at 11:35am, R65 received a mechanical soft meal of polish sausage, sauerkraut, noodles and biscuit. R65 was more alert today but did not eat or drink anything. R65's wife was present and would give verbal cues and assist him, but staff did not assist. Staff did not attempt to cue or offer alternatives. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/11/24 at 10:30 AM, V25 (Speech Language Pathologist) stated, she has been employed here since December of 2023 and has worked with R65 off and on throughout this year. She recalled around February she had spoken with the dietitian and had asked about stopping his Tube feeding earlier in the day so that he would have more interest in breakfast. She stated that it helped, and he had been doing much better, so she discontinued him from therapy at this time. She recalled that at that time he was eating at least 50%, which was considered normal for him. He drank really well with nectar thickened liquids. He would consume all of his liquids with no problems. She stated a few weeks later that the CNA's reported to her that he was having increased secretions, so she picked up him up again. The CNA's also reported that his wife was feeding him gelatin, and he eat it very well. She noted that when it melts it becomes a thin liquid, so they began putting thickener in his gelatin and that seemed to remedy the problem. She stated he had declined again, and she started seeing him again. She stated recently had discharged him again but had noticed the end of last week/beginning of this week that he was declining again. She stated he usually always drinks really well but has never been a big eater. She stated she thinks his most recent decline is due to depression. He seems like he has just given up. She stated that his ability to swallow has not decreased, she does not think it is from the tube feeding. She stated his initial goal was to have the tube feeding discontinued. It has been an up and down battle the whole time he has been here, and he typically requires some prompting. On 07/11/2024 at 1:07pm, V8 (Certified Nursing Assistant/CNA) stated residents who are observed to have not eaten multiple meals in a short amount of time, regardless of their level of assistance, should be encouraged. On 07/11/2024 at 1:24pm V9 (CNA) stated they encourage everyone to eat regardless of how much assistance they require. On 07/11/2024 at 1:31pm V16 (CNA) stated they encourage residents to eat and even assist them if they are not eating regardless of how much assistance they normally require. V16 (CNA) stated they report these occurrences to the nurse also. V16 (CNA) stated they will even try other interventions such as offering alternatives, repositioning, etc. On 07/11/2024 at 1:48pm V3 (Assistant Director of Nursing) stated it is her expectation that they assist anyone with feeding who may need it, regardless of the level of assistance they normally require.

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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** 48356 Based on interview, observation, and record review, the facility failed to provide dependent residents timely ADL (Activities of Daily Living) assistance with tolieting and feeding assistance for 4 of 5 residents (R13,R20, R38, R179) reviewed for ADL assistance in the sample of 34. Findings include: 1.R20's Face Sheet, dated 07/11/24, documents R20 was admitted to the facility on [DATE] with diagnoses in part of chronic obstructive pulmonary disease, major depressive disorder, dysphagia, heartburn, dementia, cognitive communication deficit, dietary calcium deficiency, deficiency of other vitamins, pain, and hyperlipidemia. R20's Care Plan with a revised date of 05/16/24 documents under R20's Care information interventions of puree diet with super cereal at breakfast, fortified pudding at lunch/supper, and nutritional supplement at meals. No nutritional or weight loss information was included in the care plan. R20's Minimum Data Set (MDS), dated [DATE] documents in Section C a Brief interview for mental status (BIMS) score of 00 which indicates severely impaired cognition. Section GG document substantial/maximal assistance with eating. Section K documents no weight loss or gain of 5% or more in the last month or 10% or more in the last 6 months. On 07/08/24 at 11:57AM, R20 had her meal sitting in front of her. R20 was not eating, and no staff was assisting her with eating. R20's tray had pureed beef tips, green beans, mashed potatoes with gravy, bread, nutritional supplement ice cream. No fortified pudding was noted on tray. On 07/08/24 at 11:59AM, V27 (Certified Nurse Assistant/CNA) went over to R20 while standing she gave R20 a few bites of pureed beef tips. V27 then left and went back to assisting another resident with eating. After the few bites R20 was given R20 just sat at the table with her food in front of her not eating. Another staff member unknown name did walk up to the table while standing and gave R20 a couple more bites of food then left. On 07/08/24 at 12:01PM, V27 left another resident she was assisting again and while standing gave R20 one bite of her food then left again. On 07/08/24 at 12:03PM, V27 left the table and then another staff member V30 (CNA) sat down at the table across from R20 and started to assist another resident with eating. R20 sat at the table during this time with no assistance. On 07/08/24 at 12:36PM, R20 was taken out of the dining room. On 07/08/24 at 12:38PM it was noted that R20 had only consumed less than 25% of her food from her tray. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/09/24 at 11:50AM, R20 was sitting in the dining room. R20 had pureed polish sausage, sauerkraut, biscuit, noodles, nutritional supplement ice cream, fortified pudding, and two glasses of cranberry juice on her tray. R20 was feeding herself a few bites of her meal. R20 was not assisted by staff with eating during this meal. Only food consumed was the few bites she gave herself. On 07/09/24 at 12:20PM it was noted that R20 she had consumed less than 25% of her meal off her tray and was and was not assisted by staff. 2. R38's Face Sheet, dated 07/11/24, documents R38 was admitted to the facility on [DATE] with diagnosis in part of myocardial infarction, major depressive disorder, chronic pulmonary edema, other abnormalities of the gait and mobility, abnormal posture, pain, chronic atrial fibrillation, need for assistance with personal care, muscle weakness, acute cystitis, Type 2 diabetes mellitus, and legal blindness. R38's Care plan with a revised date of 05/23/24 documents under R38's care information continent/incontinent toileting assist x 1, incontinent products pull ups. Eyesight legally blind, and mobility dependent. R38's MDS, dated [DATE] documents in Section C a Brief interview for mental status (BIMS) score of 14 which indicates R38 is cognitively intact. Section GG documents R38 requires partial/moderate assistance with toileting. R38 requires substantial/maximal assistance with toileting transfers and sit to stand transfers. On 07/08/24 at 2:30PM, R38 stated that the facility is short of staff all the time. R38 said she will hit her call light to go to the bathroom and it will take forever sometimes for them to answer the call light. R38 stated that she will already have an incontinent episode by the time they do answer her light. R38 said that it makes her feel embarrassed at times when she wets on herself. R38 said if they would answer the call light a little quicker, she might not have so many urine incontinent episodes. 3. R179's Face Sheet, dated 07/11/24, documents R179 was admitted to the facility on [DATE] with diagnoses of acute cystitis, heart failure, acute kidney failure, difficulty walking, weakness, urinary tract infection, stage 4 chronic kidney disease, and type 2 diabetes mellitus. R179's Care Plan with a revised date of 07/11/24 documents under R179 has a UTI (urinary tract infection), R179 is at risk for falls related to decreased mobility, heart failure, osteoporosis, iron deficiency, atrial fibrillation, glaucoma, hypertension and diabetes. Interventions listed in part document bowel and bladder tracking and instruct R179 to call for assist before getting out of bed or transferring. R179's Minimum Data Set (MDS) currently in progress. On 07/08/24 at 2:00PM R179 who was alert and oriented to person, place and time stated that they don't have enough staff on all shifts to be able to help all the residents at the facility. R179 stated she will hit her call light to ask for assistance to get out of bed or for them to assist her to the bathroom and it takes them forever to answer the call lights. R179 said that she has had bowel incontinent episodes and urine incontinent episodes waiting on staff. R179 said that is does embarrass her when she has a bowel incontinent episode on herself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49907 4. R13's face sheet documents an admitted [DATE], with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, contracture of muscle, unspecified site, muscle weakness (generalized), dysphagia, oropharyngeal phase, cognitive communication deficit, weakness, vitamin deficiency. R13's MDS (Minimum Data Set) dated 04/08/2024, documents a BIMS (Brief Interview for Mental Status) of 3, which indicates R13 is severely cognitively impaired. Section GG documents R13 has an impairment of both upper extremities. R13 is dependent on staff for eating, oral hygiene, toilet hygiene, personal hygiene, showering and bathing. R13's care plan dated 06/27/2024 documents that the resident is independent and does not require assistance eating. On 07/08/2024 during the lunch meal R13 was sitting in the dining room. He was very lethargic through the meal and staff stood above him while assisting him to eat. Staff did not attempt to encourage him using verbal cues or get on resident's level to attempt to wake him. He ate less than 25% and did not drink any fluids. On 07/09/2024 during the lunch meal R13 was lethargic during the meal and staff stood above him while they assisted him. Staff did not attempt to encourage him using verbal cues or get on resident's level to attempt to wake him. He ate less than 25% and did not drink any fluids. On 07/11/2024 at 1:07pm, V8 (CNA) stated residents who are observed to have not eaten multiple meals in a short amount of time, regardless of their level of assistance, should be encouraged. On 07/11/2024 at 1:24pm V9 (CNA) stated they encourage everyone to eat regardless of how much assistance they require. V9 (CNA) stated that she assists R13 meals. V9 (CNA) stated R13 just really won't wake up and eat for them most of the time. On 07/11/2024 at 1:31pm V16 (CNA) stated they encourage residents to eat and even assist them if they are not eating regardless of how much assistance they normally require. V16 (CNA) stated they report these occurrences to the nurse also. V16 (CNA) stated they will even try other interventions such as offering alternatives, repositioning, etc. On 07/11/2024 at 1:48pm V3 (RN/ADON) stated it is her expectation that they assist anyone with feeding who may need it, regardless of the level of assistance they normally require. On 07/11/2024 at 01:55pm, V2 (RN/DON) stated that he had only been here six weeks and was not sure how much information he could offer. V2(RN/DON) stated that he was not aware of which residents required assistance regularly at mealtime, but he would assist anyone who needed it. (continued on next page)

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Centralia Manor	1910 East McCord Rte 161 East Centralia, IL 62801

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/11/24 at 1:02pm V8 (Certified Nurse Assistant/CNA) stated that when she is in the dining room sometimes there isn't enough people to assist all the residents who need help with eating. V8 said she may have to give several residents a bite here and there. V8 said that she does stand up and feed residents, because she may be there to give them a few bites and then have to go over to another resident to give them a few bites. V8 said that she has to do this often. V8 also stated she has had a lot of residents complain that they have had incontinent episode waiting on staff to answer their call lights. V8 said that it's especially bad in the mornings. V8 said what staff they have on midnight shift are in residents rooms trying to get them up for the day. V8 said they don't see the other call lights going off while they are in the rooms and it might take the staff a long time because it takes longer to get certain people up. V8 said day shift will come in and they will have a lot of call lights going off and residents saying they have been on their call lights for a long time waiting for assistance. V8 said day shift is usually the better staffed shift she said that second shift is horrible. V8 said that they hardly have any staff on second shift. V8 said that they are always short of staff on second shift and could really use some more help on that shift. On 07/11/24 at 1:19PM, V9 (CNA) stated they are short of staff on second shift. V8 said there may be only one person in the dining room to assisting all the residents that need help with eating. V9 said there may be 2 people most of the time trying to help all the residents that need assistance in the dining room. V9 said second shift doesn't have enough staff. V9 stated they have had resident complain that they have had incontinent episodes waiting for someone to answer their call lights and assist them. V9 said on second shift they don't have enough staff to take care of all the residents. On 07/11/24 at 1:29PM, V16 (CNA) stated that she has had residents complain to her that they had to wait forever for staff to answer their call light and that they had a incontinent episode while they waited on staff to answer their light. On 07/11/24 at 1:33PM, V12 (CNA Shift Coordinator) said somedays staff will have to assist several people with eating at the same time, other days they can help one person at a times it just depends on how much staff they have for the day. V12 said that she has had resident complain that they had a incontinent episode waiting on staff to answer the light. V12 said that's usually when they are complaining about having an incontinent episode waiting on staff it is in the morning time. V12 said that she isn't going to say that they are fully staffed at the facility. V12 said she knows that second shift has a lot of problems with staffing and don't have enough staff. On 07/11/24 at 1:55PM, V3 (Assistant Director of Nurses/ADON) stated every once in a while, they will have a resident complain that they had an incontinent episode waiting on staff to answer their call light. The Facility policy titled Personal Care of a Resident revised 12/2002 documents under policy it is the policy of the facility to provide a plan of personal care for residents. The purpose documents to provide that residents of the facility receives adequate care.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on interview, observation, and record review the facility failed to provide prescribed nutritional supplements and provide assistance with meals, and monitor intake for one of one resident (R20) reviewed for weight loss in a sample of 34. These failures resulted in R20 experiencing a severe and continuing weight loss (8.48%) within 3 months. The findings include: R20's Face Sheet, dated 07/11/24, documents R20 was admitted to the facility on [DATE] with diagnoses in part of chronic obstructive pulmonary disease, major depressive disorder, dysphagia, heartburn, dementia, cognitive communication deficit, dietary calcium deficiency, deficiency of other vitamins, pain, and hyperlipidemia. R20's Care Plan with a revised date of 05/16/24 documents under R20's Care information interventions of puree diet with super cereal at breakfast, fortified pudding at lunch/supper, and nutritional supplement at meals. There were no care areas listed for areas pertaining to nutrition or weight loss in the care plan. R20's Physician orders dated 06/25/24 documents diet pureed add house supplement (nutritional supplement) with meals with start date of 6/25/24. Prior diet order dated 08/23/23 documents pureed diet with high calorie high protein supplement. R20's Minimum Data Set (MDS), dated [DATE] documents in Section C a Brief interview for mental status (BIMS) score of 00 which indicates severely impaired cognition. Section GG document substantial/maximal assistance with eating. Section K documents no weight loss or gain of 5% or more in the last month or 10% or more in the last 6 months. R20's meal intake documents found in R20's Electronic Medical Record document no recent meal percentages. Last meal percentage that was documented was on 12/07/23 at lunch which R20 consumed 51-75% of her meal. R20's Vitals Report from 1/1/24-7/1/24 documents monthly weights as 1/1/24- 95.8 lbs (pounds), 2/1/24- 98. 2 lbs, 3/1/24- 94.8 lbs, 4/1/24- 93.4 lbs, 5/1/24- 92 lbs, 6/1/24- 90 lbs, 7/1/24- 84.2 lbs. From 5/1/24 - 7/1/24 R20 experienced an 8.48% or severe weight loss within 3 months. (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 0692 Level of Harm - Actual harm Residents Affected - Few	R20's Dietitian assessment dated [DATE]: On a Pureed diet with House Supplement at meals. Fortified Pudding at lunch and supper. Super Cereal at breakfast. Intakes 25-75%. Weights: (7/5): 82.8, (7/4): 81.4, (6/28): 84, (6/21): 86.6, (6/14): 87, (6/5): 91, (4/6): 92, and (1/7): 93.4. Current weight is down 3# (pounds) (4.4%) x/14 day, down 4# (4.8%) x/21 days, down 8# (9.0%) x/1 month, down 9# (10.0%) x/3 months, and down 10#(11.3%) x/6 months. On daily weights. Below IBW (ideal body weight) Range 105-134. Body Mass Index: 14.67 (underweight). Had 3+ Left LE edema and 2+ Right LE edema, no reports of edema now, on Lasix. Potential risk for weight changes and dehydration. Fluids encouraged and dietary offers 15+ servings/day. Has skin tear right LE. No new labs to review. On Multivitamin Supplement. Estimated Needs: 1330 calories (35 kilo-calories per kg), 1330 cc fluids (1 cc per kilo-calories), and 38-46 gram protein (1.0-1.2 injury factor). Expect weight changes as edema changes and with diuretic therapy. Continue with diet Rx and monitor. R20's Dietitian assessment dated [DATE]: On a Pureed diet with High Calorie High Protein Supplement. Fortified Pudding at lunch and supper. Super Cereal at breakfast and House Supplement with ice cream at meals. Intakes 25-75%. Weights:(6/11): 87.7, (6/10): 84.8, (6/4): 91, (5/28): 92, (5/22): 91.1, (3/13): 88.4, and (12/13): 98.8. Current weight is up 2# (3.4%) x/1 day, down 3# (3.6%) x/7 days, down 4# (4.7%) x/14 days, down 5#(5.7%) x/1 month and down 11#(11.2%) x/6 months. On daily weights. Below IBW Range 105-134. Body Mass Index: 15.53 (underweight). Had 3+ Left LE edema and 2+ Right LE edema, no reports of edema now, on Lasix. Potential risk for weight changes and dehydration. Fluids encouraged and dietary offers 15+ servings/day. Has preventative treatment to Coccyx. No new labs to review. On Multivitamin Supplement. Estimated Needs: 1400 calories (35 kilo-calories per kg), 1400 cc fluids (1 cc per kilo-calories), and 40-48 gram protein (1.0-1.2 injury factor). Expect weight changes as edema changes and with diuretic therapy. PLAN: Clarify Supplements. 1). Discontinue High Calorie High Protein Supplement. 2). ADD: House Supplement at meals. R20's Dietitian Quarterly assessment dated [DATE]: On a Pureed diet with High Calorie High Protein Supplement. Fortified Pudding at lunch and supper. Super Cereal at breakfast and House Supplement with ice cream at meals. Intakes 25-75%. Weights: (5/8):92.5, (5/7): 95, (5/1): 92, (4/24): 93.8, (4/17): 90.5, (4/8): 93.1, (2/8): 101.8, and (11/10): 110.5. Current weight is down 9# (9.1%) x/3 months, and down 18#(16.3%) x/6 months. On daily weights. Below IBW Range 105-134. Body Mass Index: 16.38 (underweight). Had 3+ Left LE edema and 2+ Right LE edema, no reports of edema now, on Lasix. Potential risk for weight changes and dehydration. Fluids encouraged and dietary offers 15+ servings/day. Has preventative treatment to Coccyx. Skin tear below right knee. No new labs to review. On Multivitamin Supplement. Estimated Needs: 1470 calories (35 kilo-calories per kg), 1470 cc fluids (1 cc per kilo-calories), and 42-50 gram protein (1.0-1.2 injury factor). Expect weight changes as edema changes and with diuretic therapy. PLAN: Clarify Supplements. 1). Discontinue High Calorie High Protein Supplement. 2). ADD: House Supplement at meals. On 07/08/24 at 11:57AM, R20 had her meal sitting in front of her. R20 appeared frail and thin in stature. R20 was not eating, and no staff was assisting her with eating. R20's tray had pureed beef tips, green beans, mashed potatoes with gravy, bread, nutritional supplement ice cream. No fortified pudding was noted on tray. R20's meal ticket listed fortified pudding, ice cream and nutritional supplement on her meal ticket. (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 0692 Level of Harm - Actual harm Residents Affected - Few	On 07/08/24 at 11:59AM, V27 (Certified Nurse Assistant/CNA) went over to R20 while standing she gave R20 a few bites of pureed beef tips. V27 then left and went back to assisting another resident with eating. After the few bites R20 was given R20 just sat at the table with her food in front of her not eating. Another staff member unknown name did walk up to the table while standing and gave R20 a couple more bites of food then left. On 07/08/24 at 12:01PM, V27 left another resident she was assisting again and while standing gave R20 one bite of her food then left again. On 07/08/24 at 12:03PM, V27 left the table and then another staff member V28 (CNA) sat down at the table across from R20 and started to assist another resident with eating. R20 sat at the table during this time with no assistance. On 07/08/24 at 12:36PM, R20 was taken out of the dining room. On 07/08/24 at 12:38PM it was noted that R20 had consumed less than 25% of the food on her tray. R20 mainly consumed her nutritional supplement ice cream. On 07/09/24 at 11:50AM, R20 was noted in the dining room. R20 had pureed polish sausage, sauerkraut, biscuit, noodles, nutritional supplement ice cream, fortified pudding, and two glasses of cranberry juice on her tray. R20 was feeding herself a few bites of her meal. R20 was not assisted by staff with eating during this meal. Only food consumed was the few bites she gave herself. On 07/09/24 at 12:20PM it was noted R20 had consumed less than 25% of the meal on her tray and was not assisted by staff. R20 had a few bites of her pureed polish sausage, sauerkraut, nutritional supplement ice cream, and a few bites of fortified pudding. On 07/11/24 at 11:04AM, R20 was in the dining room she was served pureed ham, mashed potatoes with gravy, mixed vegetables, cake, fortified pudding, nutritional supplement ice cream, and bread. R20 was being assisted by staff with her meal. On 07/11/24 at 11:45AM observed R20's tray she consumed around 50% of her tray. R20 consumed half of her nutritional supplement ice cream and half of her fortified pudding On 07/11/24 at 1:02PM, V8 (CNA) stated that R20 can feed herself at times, but if she doesn't eat on her own that staff must assist her with eating. V8 said they don't monitor the intake of all residents at the facility they only monitor residents who are at risk for weight loss. V8 said she doesn't know where the paper goes after they fill it out with the intakes of the resident they do monitor. V8 said she thought R20 was on the monitor intake list for weight loss and supplements. V8 stated that when she is in the dining room sometimes there isn't enough people to assist all the residents who need help with eating. V8 said she may have to give several residents a bite here and there to be able to assist all of them with eating. V8 said she does stand up and feed residents, because she is feeding several people at a times and will give a few bites and then go over to another resident and give them a few bites of their food. V8 said she has to do this often. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 07/11/24 at 1:19PM, V9 (CNA) stated that they don't monitor every resident's intake only people who have lost weight or on nutritional supplements. V9 said that she thought R20 is on the meal intake sheet for weight loss and nutritional supplement. V9 stated that R20 will mainly eat her nutritional supplement ice cream and her fortified pudding, she doesn't touch a lot of the main meal. V9 said that she does assist R20 at times with eating. V9 said R20 will feed herself at times, but they have to assist her at times. V9 said that if they notice someone isn't eating good, they let the nurse know. V9 said that she doesn't know who is responsible for putting people on the intake monitoring sheet or where the intake monitoring sheet goes after she fills it out. V9 stated that they are short of staff on second shift she said that there may be only one person in the dining room assisting all the residents that need help. V9 said there may be 2 people most of the time trying to help all the residents that need assistance with eating in the dining room. V9 said second shift doesn't have enough staff. On 07/11/24 at 1:55PM, V3 (Assistant Director of Nursing/ADON) stated that the only intakes they monitor are the ones that are ordered by a doctor. V3 said if a resident isn't eating well that the certified nurse assistant will usually let the nurse know. V3 said that they notify the doctor of any weight losses, and they will give an order to monitor the resident food intake. V3 said she didn't know who all they had orders to monitor intake for. V3 said that R20 can assist herself with eating, but if she doesn't eat then staff should be assisting her. V3 was unaware if R20 had a weight loss or not. V3 said that she has never seen the meal intake sheets that the certified nurse assistants had to write down the intake of certain people with weight loss. She thought R20 was on the list to be monitored. V3 said that R20's intakes should have been in the electronic medical record if they are monitoring it. V3 didn't know why R20 didn't have no intakes in her chart since 12/07/23. On 07/11/24 2:00PM, V4 (Dietary Supervisor) said that they monitor intakes of new admission times four weeks, and anyone that has a significant weight change. V4 said that she prints out a meal intake sheets daily for staff to write down intakes, but she doesn't know who gets it afterwards. V4 said that she thinks the nurses get it and then input the information into the electronic medical record. V4 said when they need to add someone to the intake sheet she usually gets an email. V4 said that she has no clue who gets the meal intakes sheets. V4 said that R20 was on the meal intake sheet for her nutritional supplement and weight loss. On 07/11/24 at 2:10PM, V10 (Licensed Practical Nurse/LPN) stated she hasn't seen a meal intake sheet in a while. V10 said that she does not receive the meal intake sheets and she has no clue where they go. V10 said it's been a while since she saw one. V10 was not sure if R20 was on the meal intake sheet or not. On 07/11/24 at 2:15PM, V11 (Registered Nurse/RN) stated that she hasn't seen a meal intake sheet in a long time for the other halls. V11 said they monitor all the resident on the memory care unit's meal intake, but she doesn't think they monitor the intake of the other residents. On 07/11/24 at 2:22PM, V26 (RN) stated that she doesn't get the meal intake sheets and she does not put any meal intakes in for any resident in the electronic medical record. V26 said the only monitoring they do is input fluid intake. V26 said that she has never seen the meal intake sheet. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 07/11/24 at 2:29PM, V2 (Director of Nursing/DON) stated that he has never seen the meal intake sheet that documents percentages of what food residents took in. V2 said that he is newer to the facility and is still trying to learn everything. V2 was unsure if R20 was on the meal intake sheet or if R20 has had a weight loss. V2 was unsure of R20's meal assistance needs. V2 did state that if a resident is not eating and needs assistance staff should be assisting any resident that needs help or not eating on their own. On 07/12/24 at 11:39AM, V28 (Registered Dietitian) stated that she believes that the facility does not monitor meal intakes because it is their policy. V28 said that meal intake recording is so subjective. V28 said that they pick and choose whose meal intakes to monitor. V8 said that she thinks it works out well. V8 said that she doesn't feel like she misses anyone even though she can't see what amount of food intake they have consumed. V28 said the certified nurse assistants are very good about letting them know if someone isn't eating well. V28 stated that even with the same staff not assisting the same resident daily they still monitor it well. V28 said that on her note on 07/05/24 that she wrote in R20's chart she obtained her meal intake percentages from some of the certified nurses assistants and the progress notes. V28 said there wasn't much about meal intakes in the notes. V28 stated that she didn't know if R20 required assistance with meals, but if R20 is supposed to get assistance with meal she expects staff to assist her. V28 said that she recommends supplements like ice cream, nutritional shake and would expect the staff to offer and make sure that the resident receive these supplements. V28 said that she usually is at the facility every other week and looks at the weights or looks at them remotely. V28 said that if R20 had a large weight loss she would have noticed it and put a new intervention in place. V28 was unsure if R20 required any assistance with meals. V28 said if they notified the doctor recently about R20 having a weight loss she will look at her weights and diet when she comes in next time or do it from home. R20's Progress Note dated 07/10/24 at 1:17PM Weight loss report received. R20 (resident) had a weight loss of 10.6% (96lbs-85lbs) over the last 180 days. R20 (resident) currently a daily weight. Puree diet with house supplement. Notified primary doctor, awaiting orders. The facility policy titled Weight Monitoring objective states to consistently assess residents for significant weight loss or gain. The Facility Policy Food Service with a revised date of 09/2010 documents in part under procedure the nursing staff shall be responsible for observing the resident's food acceptance and record the intake on the provided meal intake or documentation into POC (Point of Care for meal intake) only for those residents that are identified to be at risk.

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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** 41610 48356 Based on interview and record review the facility failed to ensure sufficient staff were available to provide timely and needed care. This failure has the potential to affect all 75 residents residing in the facility. Findings include: 1. R20's Face Sheet, dated 07/11/24, documents R20 was admitted to the facility on [DATE] with diagnoses in part of Chronic obstructive pulmonary disease, Major depressive disorder, Dysphagia, Heartburn, Dementia, cognitive communication deficit, dietary calcium deficiency, deficiency of other vitamins, pain, and hyperlipidemia. R20's Care Plan with a revised date of 05/16/24 documents under R20's Care information interventions of puree diet on super cereal at breakfast, fortified pudding at lunch/supper, and nutritional supplement at meals. No nutritional or weight loss care plan. R20's Minimum Data Set (MDS), dated [DATE] documents in Section C a Brief interview for mental status (BIMS) score of 00 which indicates severely impaired cognition. Section GG document substantial/maximal assistance with eating. On 07/08/24 at 11:57AM, R20 had her meal sitting in front of her. R20 was not eating, and no staff was assisting her with eating. R20's tray had pureed beef tips, green beans, mashed potatoes with gravy, bread, nutritional supplement ice cream. No fortified pudding was noted on tray. On 07/08/24 at 11:59AM, V27 (Certified Nurse Assistant/CNA) went over to R20 while standing she gave R20 a few bites of pureed beef tips. V27 then left and went back to assisting another resident with eating. After the few bites R20 was given R20 just sat at the table with her food in front of her not eating. Another staff member unknown name did walk up to the table while standing and gave R20 a couple more bites of food then left. On 07/08/24 at 12:01PM, V27 (CNA) left another resident she was assisting again and while standing gave R20 one bite of her food then left again. On 07/08/24 at 12:03PM, V27 (CNA) left the table and then another staff member V28 (CNA) sat down at the table across from R20 and started to assist another resident with eating. R20 sat at the table during this time with no assistance. On 07/08/24 at 12:36PM, R20 was taken out of the dining room. On 07/08/24 at 12:38PM, observed R20's tray less than 25% of her tray was consumed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/09/24 at 11:50AM observed R20 in the dining room. R20 had pureed polish sausage, sauerkraut, biscuit, noodles, nutritional supplement ice cream, fortified pudding, and two glasses of cranberry juice. R20 was feeding herself a few bites of her meal. R20 was not assisted by staff with eating during this meal. Only food consumed was the few bites she gave herself. On 07/09/24 at 12:20PM, observed R20's tray she had consumed less than 25% of her meal and was not assisted by staff. 2. R22's Face Sheet, dated 07/11/24, documents R22 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, need for personal assistance with personal care, muscle weakness, unspecified fracture of lower end of left tibia, pain, age related osteoporosis, anxiety, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. R22's Care Plan with a revised date of 07/11/24 documents under R22's Care information continent of bladder toileting use of a bed pan or full mechanical lift. R22 is at risk for falls interventions include encourage R22 to call for assist before getting out of bed or transferring. R22's Minimum Date Set (MDS), dated [DATE] documents in Section C a Brief interview for mental status score of 15 which indicates R22 is cognitively intact. Section GG documents R22 is dependent for toileting and transfers. On 07/08/24 at 10:20AM R22 stated that they don't have a lot of staff at the facility. R22 feels like they are short on all shifts. R22 said that she has to wait forever just to be able to get anyone to answer her call light. R22 said that she has even went as far as to start yelling thinking her call light might not be working. R22 said that yelling doesn't help either it still takes forever for them to answer her light. R22 said that she hears other resident yelling to get staffs attention as well. 3. R38's Face Sheet, dated 07/11/24, documents R38 was admitted to the facility on [DATE] with diagnoses in part of Myocardial infarction, Major depressive disorder, Chronic pulmonary edema, other abnormalities of the gait and mobility, abnormal posture, pain, Chronic atrial fibrillation, need for assistance with personal care, muscle weakness, acute cystitis, Type 2 diabetes mellitus, and legal blindness. R38's Care plan with a revised date of 05/23/24 documents under R38's care information continent/incontinent toileting assist x 1, incontinent products pull ups. Eyesight legally blind, and mobility dependent. R38's Minimum Data Set (MDS), dated [DATE] documents in Section C a Brief interview for mental status (BIMS) score of 14 which indicates R38 is cognitively intact. Section GG documents R38 requires partial/moderate assistance with toileting. R38 requires substantial/maximal assistance with toileting transfers and sit to stand transfers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/08/24 at 2:30PM R38 stated that the facility is short of staff all the time. R38 said that she will hit her call light to go to the bathroom and it will take forever sometimes for them to answer the call light. R38 stated that she will already have a incontinent episode by the time they do answer her light. R38 said that it makes her feel embarrassed at times when she wets on herself. R38 said if they would answer the call light a little quicker, she might not have so many urine incontinent episodes. 4. R73's Face Sheet, dated 07/11/24, documents R73 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, muscle weakness, weakness, lack of coordination, urinary tract infection, hemiplegia affecting right side, and need for assistance with personal care. R73's Care Plan revised 06/05/24 documents R73's care information with interventions of toileting, dressing assist x 1, grooming assist x 1, transfers sit to stand aide with assist x 2, R73 is at risk for falling with interventions of encourage R73 to call for assist before getting out of bed or transferring. On 07/09/24 at 10:09 AM R73 stated that they don't have enough staff at the facility. R73 said everyone has to wait for help. R73 said it may take up to 30 minutes to an hour that's if they even answer the call light. R73 said the staff is really nice at the facility they just don't have enough of it. 5. R179's Face Sheet, dated 07/11/24, documents R179 was admitted to the facility on [DATE] with diagnoses of acute cystitis, heart failure, acute kidney failure, difficulty walking, weakness, urinary tract infection, stage 4 chronic kidney disease, and type 2 diabetes mellitus. R179's Care Plan with a revised date of 07/11/24 documents under R179 has a UTI (urinary tract infection), R179 is at risk for falls related to decreased mobility, heart failure, osteoporosis, iron deficiency, atrial fibrillation, glaucoma, hypertension and diabetes. Interventions listed in part document bowel and bladder tracking and instruct R179 to call for assist before getting out of bed or transferring. On 07/08/24 at 2:00PM, R179 who was alert and oriented to person, place and time stated that they don't have enough staff on all shifts to be able to help all the residents at the facility. R179 stated she will hit her call light to ask for assistance to get out of bed or for them to assist her to the bathroom and it takes them forever to answer the call lights. R179 said that she has had bowel incontinent episodes and urine incontinent episodes waiting on staff. R179 said that is does embarrass her when she has a bowel incontinent episode on herself. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/11/24 at 1:02pm V8 (Certified Nurse Assistant/CNA) stated that when she is in the dining room sometimes there isn't enough people to assist all the residents who need help with eating. V8 said she may have to give several residents a bite here and there to be able to assist all of them with eating. V8 said she does stand up and feed residents, because she is feeding several people at a times and will give a few bites and then go over to another resident and give them a few bites of their food. V8 said she has to do this often. V8 also stated she has had a lot of residents complain that they have had an incontinent episode waiting on staff to answer their call lights. V8 said that it's especially bad in the mornings. V8 said what staff they have on midnight shift are in residents rooms trying to get them up for the day. V8 said they don't see the other call lights going off while they are in the rooms. V8 said it might take the staff a long time because it takes longer to get certain people up. V8 said that day shift will come in and they will have a lot of call lights going off and residents saying they have been on their call lights for a long time waiting for assistance. V8 said day shift is usually the better staffed shift. V8 said that second shift is horrible. V8 said they hardly have any staff on second shift. V8 said they are always short of staff on second shift and could really use some more help on that shift. On 07/11/24 at 1:19PM, V9 (CNA) stated that they are short of staff on second shift she said that there may be only one person in the dining room assisting all the residents that need help. V9 said there may be 2 people most of the time trying to help all the residents that need assistance with eating in the dining room. V9 said second shift doesn't have enough staff. V9 stated they have had resident complain that they have had incontinent episodes waiting for someone to answer their call lights and assist them. V9 said on second shift they don't have enough staff to take care of all the residents. On 07/11/24 at 1:29PM, V16 (CNA) stated that she has had resident complain to her that they had to wait forever for staff to answer their call light and that they had a incontinent episode while they waited on staff to answer their light. On 07/11/24 at 1:33PM, V12 (CNA Shift Coordinator) said someday's staff will have to assist several people at one time, other days they can help one person at a times it just depends on how much staff they have for the day. V12 said that she has had resident complain that they had a incontinent episode waiting on staff to answer the light. V12 said that's usually when they are complaining about having an incontinent episode waiting on staff it is in the morning time. V12 said that she isn't going to say that they are fully staffed at the facility. V12 said she knows that second shift has a lot of problems with staffing and don't have enough staff. On 07/11/24 at 1:55PM, V3 (Assistant Director of Nurses/ADON) stated every once in a while, they will have a resident complain that they had a incontinent episode waiting on staff to answer their call light. The facility document titled, Resident Bed List Report dated 07/08/24 documents 75 residents residing at the facility. The Facility policy titled Staffing revised 09/2018 documents under purpose to provide adequate staffing for proper resident care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on observation, record review and interview, the facility failed to properly date an opened insulin pen and make sure the resident's name was properly labeled on the insulin pen for one of one (R54) resident reviewed for proper labeling in a sample of 34. The findings include: R54's Face Sheet, dated 07/11/24, documents R54 was admitted to the facility on [DATE] with diagnosis of Type 2 diabetes mellitus without complications. R54's Care Plan revised 06/27/24 documents R54 has diabetes. R54's goal is blood sugar will be maintained within normal limits during this quarter. Interventions include accuchecks as ordered, administer insulin as ordered. Monitor for side effects, administer oral hypoglycemic medication as ordered. Monitor for side effects., assist resident in making dietary choices related to diabetes, Educate R54 on dietary needs/choices related to diabetes, monitor for symptoms of hyperglycemia, such as polyuria, polydipsia, weight loss, fatigue, blurred vision, monitor for symptoms of hypoglycemia, such as sweating, tremor, pallor, tachycardia, palpations, nervousness, headache, confusion, slurred speech, lack of coordination. R54's Minimum Data Set (MDS), dated [DATE] documents in Section C a Brief interview for mental status (BIMS) score of 14 which indicates that R54 is cognitively intact. R54's Physician orders documents an order on 05/01/24 Novolog Flexpen units 100 per sliding scale if blood sugar is less than 60 call MD(Medical Doctor), if blood sugar is 100 to 130 give 6 units, if blood sugar is 131 to 170 give 8 units, if blood sugar is 171 to 220 give 10 units. If blood sugar is 221 to 300 give 12 units, if blood sugar is greater than 300 give 14 units. Route subcutaneous administer three times a day. Order date 05/30/24 Novolog flexpen units 100 give 10 units subcutaneously two times a day. Order date 07/01/24 Lantus insulin pen 100units/ml give 60 units subcutaneously one time a day. On 07/10/24 at 12:33PM observed V15 (Registered Nurse/RN) opening the 400 hall medication cart. Three insulin pens were in the top drawer of the cart 2 pens with Lantus and one with Novolog. One Lantus pen and the Novolog pen had no opened dates listed on them. The Novolog pen had no residents name listed on it. Both Lantus insulin pens had R54's name on them. Both Lantus pens had expiration dates of 09/24 and Novolog insulin pen had 10/24 expiration date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/10/24 at 12:25PM, V15 (RN) stated that both of the Lantus insulin pens were R54's along with the Novolog insulin pen. V15 stated that she didn't know why they had two Lantus insulin pens in the cart for R54. V15 said they should only get one pen out of the refrigerator as they use it. V15 also stated that the Novolog insulin pen that was in the top drawer undated was also R54's. V15 stated that she is the only resident on that hall that takes insulin. V15 said that all insulin pens when taken out of the refrigerator should be labeled with a date after it is opened so that why they can keep track of how long the insulin pens have been out for use. V15 said they have to dispose of them after 28 days. On 07/11/24 Observed 400 hall medication cart. Both Lantus insulin pens and Novolog Pens were dated for 07/01/24 all three pens had R54's name on them. On 07/11/24 at 9:55AM, V26 (Registered Nurse/RN) stated that all insulin pens should be labeled with the date it was open and taken out of the refrigerator to be used. V26 said all of the insulin pens have an open date sticker on them so you can mark the date on them. V26 doesn't know why the insulin pens for R54 wasn't marked or why the pens in the cart for R54 are now marked with the date of 07/01/24. On 07/11/24 at 1:55PM, V3 (Assistant Director of Nursing) stated that all insulin pens when they are taken out of the refrigerator to be used should be labeled with the date that they were opened for use. V3 said she doesn't know why R54's Novolog and Lantus insulin pens were not dated. V3 didn't know why the insulin pens were dated for 07/01/24 now. V3 said that the insulin pens that was undated should have been discarded unless they knew when they were opened for use. V3 said that the only reason she can figure out why they were dated for 07/01/24 is that maybe the nurse who opened them remember the date she opened them. V3 also stated that all the insulin pens should have the residents name on them. V3 said that insulin pens are used for only that specific resident. V3 said they recently had a in-service with the nurses about making sure they date the insulin pens when they open them and make sure that the residents name is listed on the pen. The Center for Disease Control article titled Preventing unsafe injection practices dated 03/26/24 documents in part once a multi-dose vial is opened (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer states another date for the opened vial.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation and record review the facility failed to provide a diet that provides the recommended amount of protein required for one (R15) of 10 residents reviewed for nutrition in a sample of 34. Findings include: R15's Face Sheet documents R15 has an admitted [DATE] and diagnoses including: atrial fibrillation, nontraumatic hematoma of soft tissue, epistaxis, presence of cardiac pacemaker, cystic disease of liver, glaucoma, essential (primary) hypertension, hypothyroidism, vitamin deficiency, major depressive disorder, disorder of the skin and subcutaneous tissue, idiopathic gout, hypertensive crisis, and chronic kidney disease, stage 3. R15's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 05, indicating cognitively severely impaired. R15's Physician Order Sheet documents a diet order dated 06/08/24 of Regular diet. R15's Care plan with a problem area dated 01/10/23 documents: resident care information: with an approach start date of 07/05/23 documents: Liquids: regular, Assistance for eating: feeds self, Snacks between meals: as required, Diet: regular, butter ball, supper cereal at breakfast, double portions at breakfast, and ice cream at lunch and supper. R15's care plan does not document any other nutrition category. On 07/08/24 at approximately 11:45 AM it was observed R15 was in the Dining Room and received of mashed potatoes, green beans, ice cream for lunch. On 07/09/24 at approximately 11:40 AM it was observed R15 was in the Dining Room and received salad made with iceberg lettuce shredded cheese, mashed potatoes, white cake and ice cream. On 07/10/24 at approximately 11:35 AM it was observed R15 was in the Dining Room and received sweet potatoes, salad made with iceberg lettuce with shredded cheese, ice cream and a chocolate chip cookie for lunch. On 07/11/24 at approximately 11:40 AM it was observed R15 was in the Dining Room and received mashed potatoes, vegetable medley, pineapple cake and ice cream. On 07/11/24 at 1:05 PM, R15 stated she usually has cold cereal or toast and coffee for breakfast. She does not eat meat or eggs. She just eats what they give her, that's just how it is. On 07/11/24 at 2:10 PM, V4 (Dietary Manager) stated, R15 does not eat meat or eggs. Typically for breakfast she will have toast and coffee. They do not have a menu to follow for her diet choices. She is not for sure how they are supposed to assure that she receives the 48 - 58 grams of protein that is recommended by V28 (Registered dietician). She usually receives what is on the menu without the meat or eggs. She will have to make a plan with V28 (Registered dietician) to consider adding a supplement or protein powder for her to increase the amount of protein she receives. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's dietitian assessment by V28 (Registered dietician) dated: 06/12/2024 at 7:12 PM documents: on a regular diet. Butter ball, super cereal, and double portions at breakfast. Ice Cream at lunch and supper. Dislikes meat, eggs, and cooked tomatoes. Likes: Grilled Cheese and Cottage Cheese. Intakes 50-75%. Weights: (6/7): 106 pounds, (5/7): 107 pounds, (3/7) 111 pounds, and (12/7): 116 pounds. Current weight is down 10 pounds (8.6%) x/6 months. WNL (within normal limit) of IBW (ideal body weight) range 96-125. Body Mass Index: 20.70 % (Normal/Healthy Weight). R15 has no edema she is on Lasix. There is a potential risk for weight changes and dehydration. Fluids are encouraged and dietary offers 15+ servings/day. R15's labs for: (4/22/24): Hemoglobin 13.3, and Hematocrit 39.6. (1/11/24): Glucose 83, Sodium 141, Potassium 3. 8, Blood Urea Nitrogen 19, and Creatinine 0.9. R15's estimated Needs are: 1440 calories (30 kilo-calories per kg), 1440 cc (cubic centimeters) fluids (1 cc per kilo-calories), and 48-58 gram protein (1.0-1.2 injury factor). R15's dietitian assessment by V28 dated: 05/22/2024 at 8:51 PM documents: on a Regular diet. Butter Ball, super cereal, and double portions at breakfast, High Calorie High Protein Supplement. Ice Cream at lunch and supper. Dislikes meat, eggs, and cooked tomatoes. Likes: Grilled Cheese and Cottage Cheese. Intakes 50-75%. Weights: (5/7): 107, (4/8): 108, (2/7) 111, and (11/7): 113. WNL of IBW Range 96-125. Body Mass Index: 20.89 (Normal/Healthy Weight). R15 has no edema, she is on Lasix. R15 has a potential risk for weight changes and dehydration. Fluids are encouraged and dietary offers 15+ servings/day. R15's Labs document: (4/22/24): Hemoglobin 13.3, and Hematocrit 39.6. (1/11/24): Glucose 83, Sodium 141, Potassium 3.8, Blood Urea Nitrogen 19, and Creatinine 0.9. R15's estimated needs are: 1470 calories (30 kilo-calories per kg), 1470 cc fluids (1 cc per kilo-calories), and 49-59 gram protein (1.0-1.2 injury factor). PLAN: Discontinue High Calorie High Protein Supplement. On 07/11/24 at 10:14 AM V28 (Registered dietician) stated, she does not have a specific menu documented for R15. R15 does not meat or eggs. V28 stated, she believes that is correct that she documented that R15 should receive 48-58 grams of protein per day. She believes that is correct that she does not currently have a supplement ordered for her but she does have ice cream listed for lunch and supper. R15 has had weight loss but it is not at a significant level. V28 stated, she would be getting more protein with the addition of cottage cheese or a grilled cheese. She stated she believes that is correct that she only has that as likes and not as an additional item to receive. If she received toast for breakfast, that would be a couple grams of protein. If she received sweet potatoes, cabbage, ice cream, and a cookie would probably approximately 5 grams or protein. V28 stated that if R15 received the appropriate amount of protein it would be on the low end. V28 stated, she need to talk with V4 about getting R15 a supplement or add some items like a grilled cheese or cottage cheese to her diet and do some reeducation. The document titled, Diet Spreadsheet dated day 9 Monday documents: #8 dip (0.5 cup) beef tips in gravy, #8 dip mashed potatoes, 4 oz (ounces) garlic green beans, 1/8 pie creamy custard pie, and bread/margarine. Day 10 Tuesday documents: 3 oz polish sausage, 4 oz German potato salad, 4 oz sauerkraut, and oatmeal cake. Day 11 Wednesday documents: 3 oz honey glazed pork loin, 4 oz roasted sweet potatoes, #8 dip crunchy cabbage bake, salted caramel chocolate chip cookies, bread/margarine. Day 12 Thursday documents: 2 oz/1 bun hot turkey sandwich, #8 dip mashed potatoes, 4 oz vegetable medley, and #8 dip pineapple cake.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review the facility failed to offer pneumococcal vaccinations for 3 of 5 residents (R13, R15, R58) reviewed for immunizations in a sample of 34. Findings include: 1. R15's Face Sheet documents an admitted [DATE] and a date of birth (DOB) of 03/23/1933 indicating R15 is [AGE] years of age. R15's Face Sheet documents diagnoses including: atrial fibrillation, epistaxis, cardiac pacemaker, cystic disease of liver, hypertension, hypothyroidism, major depressive disorder, and chronic kidney disease. R15's Immunization Record in the electronic health record (EHR) only documents administration of Prevnar -13 (Pneumococcal Conjugate Vaccine) on 12/06/2016. R15's Preventive Health Care Report dated 01/01/2001 - 07/09/2024 only documents the administration of Prevnar-13 on 12/06/2016. There is no documentation in R15's medical record any pneumococcal vaccination was offered or administered to R15. 2. R58's Face Sheet documents an admitted [DATE] and a DOB of 02/20/1928 indicating R58 is [AGE] years of age. R58's face sheet document diagnoses including: dementia, eating disorder, fracture of sacrum, fracture of left pubis, urinary tract infection, chronic kidney disease, stage 3, hypothyroidism, and hyperlipidemia. R58's electronic health record does not document any pneumococcal vaccination were offered or administered to R58. On 07/10/24 at 1:10 PM, V2 (Director of Nursing /DON) stated, they do not have any information for R58 for pneumococcal vaccination status or any consents or declinations. 3. R13's face sheet documents and admitted [DATE] and a DOB of 06/19/35 indicating R13 is [AGE] years of age. R13's face sheet document diagnoses including: dementia, diastolic (congestive) heart failure, bacterial pneumonia, depression, hyperlipidemia, presence of cardiac pacemaker, presence of prosthetic heart valve, and obesity. R13's Immunization Record in the electronic health record (EHR) documents administration of Prevnar -13 (Pneumococcal Conjugate Vaccine) on 06/22/2017 and PPV23 (Pneumococcal Polysaccharide Vaccine) on 09/13/2018. R13's Preventive Health Care Report dated 01/01/2001 - 07/09/2024 only documents the administration of Prevnar-13 on 06/22/2017 and PPV23 on 09/13/2018. On 07/11/24 at 11:05 AM, V2 (DON) and V3 (Assistant Director of Nursing) stated, they do not have any consents or declinations forms for the pneumococcal vaccine PVC 20 for R15 or R13. V3 stated R15, R13 and R58 should have been offered the PVC 20. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Disease Control (CDC) Immunization Schedule https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#note-pneumo) documents for adults age 65 or older who have: Previously received both PCV13 and PPSV23, AND PPSV23 was received at age [AGE] years or older: Based on shared clinical decision-making, 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine dose. The facility policy dated 08/11/22 titled, Pneumococcal Vaccination documents in part: all residents aged [AGE] years or more and those residents that are determined to be at high risk (those with chronic illness such as lung, heart, or kidney disease, sickle cell anemia, diabetes, recovering from acute illness, those in congregate living environments, with a weakened immune system, etc.) will be offered the pneumococcal vaccine as recommended by the CDC.