STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Belleville	150 North 27th Street Belleville, IL 62226

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview and record review, the facility failed to ensure residents were free from abuse/neglect, failed to ensure residents felt safe, and failed to ensure residents needs were met in a dignified manner in the facility for 2 of 24 residents (R16, R99) in the sample of 44. This failure resulted in R16 feeling sexually assaulted and fearful to endure a similar situation from occurring again. Findings include: 1. On 5/14/2024 at 11:20 AM, V1, Administrator (ADM) stated, I am working on a reportable (incident) right now. I am going to term (terminate) her. It sounds like she was under the influence of something. Her set (assigned hall) was a mess. One resident made an allegation that is considered abuse. I also interviewed the other residents on the hall. Social Services took over. I had another resident (R99) with a complaint. She stated she did not feel abused but had an episode of incontinence, which she usually doesn't, and the CNA (Certified Nursing Assistant) slammed a diaper down and told her to clean herself up. She (R99) said she would just hate to see her do that to someone who couldn't speak for themselves. V1 continued to state, Another resident (R16) said she told the CNA she needed a pain pill. The CNA started rubbing on her all over and saying how she loved her. When I asked her (the resident) if she felt sexually harassed, she said, 'yes' and became tearful and stated she was uncomfortable. Her roommate (R16's) (R64) was in the bathroom, came out and told the CNA to leave. (R16) has had customer service complaints before but she is not someone who wouldn't be credible. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/14/24 at 12:05 PM, two police officers were observed in the building walking towards (R64's) room. At this time, (V1) told (R16) the officers were there to interview her about what had happened. This surveyor was present for the interview. R16 stated, I hit my button (call light) for pain med at 2:30 (AM)and nobody came. I did it again about a quarter til 3. The CNA said she thought it was my roommate who called (pressed the call light). I told her I was the one and she got all in my face. I told her if you get in my face, I'm gonna deck ya then, all the sudden she started rubbing all over my breasts. I'm sorry, I'm not like that. R16 then became visibly upset and anxious. R16 continued, I told her to stay away from me, don't touch me, stop! She just kept rubbing on me, my boobs. I am just a person, and I don't like that. (R64) got her off me and sent her down the hall. I finally got my medicine about 6 (AM). The nurse said no one had told her I needed it. I've been in 3 different places (facilities) and never had anything like this happen. At this time, (V21, Police Officer) asked R16 if it made her upset and uncomfortable and R64 stated, Yes, I'm going to always wonder if someone is going to do it to me again. If that's the case, I want out of here and to go somewhere else. V21 also asked R16, Was she rubbing with a flat hand or was she grabbing your breasts? R16 replied, I was protecting myself and had my hands over them (breasts). She was aiming to grab. She was saying, We're going to be the best of friends. R16 continued, I don't want to worry about when I need changed again if that will happen. You don't expect to be molested. On 5/14/2024 at 12:19 PM, R64, who was present in the room during R16's interview, R64 stated she concurs with everything R16 said about the incident and that R64 witnessed it. R16's Minimum Data Set, dated dated dated [DATE] documents R16 is cognitively intact. At 12:30, V21 stated the police report would take 5-7 days to be completed. On 5/14/2024 at 10:31 AM, V15, CNA stated, I witnessed the one (incident) with (R99). Nothing was done on the set (hall). The nurse said the CNA left at 6 (AM). (R16) told me she was soaking wet. I asked her why she didn't ask for help, and she told me she didn't want her (V24) touching her because she 'violated' her. She said (V24) started rubbing her across her chest and it made her uncomfortable. On 5/14/24 at 12:45 PM, R64 was heard asking an unknown staff member, Is that situation that happened in my room last night going to be taken care of? The Facility's Reported Incident Form dated 5/14/2024 documents the incident category is Resident Abuse, and the Resident/victim/perpetrators are R16 and V24. It further documents, (R16) reported that she put on her call light around 3:00 AM to ask for a pain pill. Staff member (V24, CNA) responded again and when she came in (V16) stated, 'You know there are two of us in this room and it was me who had the light on'. She said at that time (V24) was leaning over the bed rail and getting really close to her face asking her what she needed. She told her that she needed a pain pill. She also asked her to get out of her face, that she was getting too close to her. (V24) told her that it was too soon she couldn't have a pain pill. At that time, (V24) began to rub on her (R16's) chest on the outside of her gown and tell her that she would be ok, she was going to take care of her and loves her. (R16) felt uncomfortable and was telling (V24) to leave her alone. At that time, (R64), who is (R16)'s roommate, came out of the bathroom and got the aide out of the room. (R16) reported the incident to the nurse in the morning. It continues to document V24 was suspended. (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 0600 Level of Harm - Actual harm Residents Affected - Few	2. On 5/13/2024 at 10:45 AM, R99 stated, There are two bad staff. I reported it to the guy nurse (V17, Licensed Practical Nurse). They sent her home. I asked one of them to move me up in bed. I've had a stroke and can't move. It's very difficult. She told me to do it myself. On 5/14/2024 at 9:00 AM, R99 stated, The CNA last night told me to change myself., threw a diaper on the table and left. I did the best I could cleaning myself up. (V15) helped me the rest of the way this morning and there were still about 3 streaks of poop left. The Administrator was just in here talking to me and said the CNA will be fired and the police will be here later for a report. On 5/14/2024 at 10:31 AM, V15, Certified Nursing Assistant (CNA) stated, I witnessed the one (incident) with (R99). The lady (unknown CNA) came in (to work) mad about her set (hall assignment). She was slamming doors. She was yelling at (R99) 'You better get up!'. I was so shocked by it, my mouth dropped. I made eye contact with (R99), and she was in tears. She (R99) was so distressed. I told the nurse and he (V17, LPN) called (V1). (V17) sent her home. The next night (R99) said she had the same thing from another CNA. The CNA said, 'That lady (R99) don't want to do anything for herself!'. Some of these CNAs are 'nasty' (ill mannered). The Facility-Reported Incident Form dated 5/9/2024 documents, Interview of Alleged Victim documents, Resident (R99) reported that the CNA (Certified Nursing Assistant) (V16) 'threw' her shirt at her and then she only assisted her with putting her arms in sleeves and not in pulling it over her head. It further documents, Interview of Witness-(V15) CNA states that she witnessed CNA (V16) yelling and demanding resident in (room) to do things and to get up and get herself ready and that the yelling was really intense. She also stated the aide (V16) walked out of the room cussing and saying, 'It's a shame when you don't want to shower or do anything for yourself'. The Facility's Abuse Policy and Prevention Program 2022 documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility id doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of residents. It further documents this will be done by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment. This Policy defines Sexual Abuse as sexual harassment, sexual coercion, or sexual assault including non-consensual consent to sexual activity. This Policy defines Mental Abuse as humiliation, harassment, threats of punishment or deprivation.

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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 - 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** 40701 Based on observation, interview and record review, the facility failed follow their Abuse Policy and Prevention Program by ensuring residents were free from abuse/neglect as well as felt safe and needs were met in a dignified manner in the facility for 2 of 24 residents (R16, R99) in the sample of 44. This failure resulted in R16 feeling sexually assaulted and fearful to endure a similar situation occurring again. Findings include: The Facility's Abuse Policy and Prevention Program 2022 documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment of residents. It further documents this will be done by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment. This Policy defines Sexual Abuse as sexual harassment, sexual coercion, or sexual assault including non-consensual consent to sexual activity. This Policy defines Mental Abuse as humiliation, harassment, threats of punishment or deprivation. 1. On 5/14/2024 at 11:20 AM, V1, Administrator (ADM) stated, I am working on a reportable (incident) right now. I am going to term (terminate) her. It sounds like she was under the influence of something. Her set (assigned hall) was a mess. One resident made an allegation that is considered abuse. I also interviewed the other residents on the hall. Social Services took over. I had another resident (R99) with a complaint. She stated she did not feel abused but had an episode of incontinence, which she usually doesn't, and the CNA (Certified Nursing Assistant) slammed a diaper down and told her to clean herself up. She (R99) said she would just hate to see her do that to someone who couldn't speak for themselves. V1 continued to state, Another resident (R16) said she told the CNA she needed a pain pill. The CNA started rubbing on her all over and saying how she loved her. When I asked her (the resident) if she felt sexually harassed, she said, 'yes' and became tearful and stated she was uncomfortable. Her roommate (R16's) (R64) was in the bathroom, came out and told the CNA to leave. (R16) has had customer service complaints before but she is not someone who wouldn't be credible. (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 - Actual harm Residents Affected - Few	On 5/14/24 at 12:05 PM two police officers were observed in the building walking towards (R64's) room. At this time, V1 told R16 the officers were there to interview her about what had happened. This surveyor was present for the interview. R16 stated, I hit my button (call light) for pain med at 2:30 (AM)and nobody came. I did it again about a quarter til 3. The CNA said she thought it was my roommate who called (pressed the call light). I told her I was the one and she got all in my face. I told her if you get in my face, I'm gonna deck ya then, all the sudden she started rubbing all over my breasts. I'm sorry, I'm not like that. R16 then became visibly upset and anxious. R16 continued, I told her to stay away from me, don't touch me, stop! She just kept rubbing on me, my boobs. I am just a person, and I don't like that. (R64) got her off me and sent her down the hall. I finally got my medicine about 6 (AM). The nurse said no one had told her I needed it. I've been in 3 different places (facilities) and never had anything like this happen. At this time, (V21, Police Officer) asked R16 if it made her upset and uncomfortable and R16 stated, Yes, I'm going to always wonder if someone is going to do it to me again. If that's the case, I want out of here and to go somewhere else. V21 also asked R16, Was she rubbing with a flat hand or was she grabbing your breasts? R16 replied, I was protecting myself and had my hands over them (breasts). She was aiming to grab. She was saying, We're doing to be the best of friends. R16 continued, I don't want to worry about when I need changed again if that will happen. You don't expect to be molested. On 5/14/2024 at 12:19 PM, R64, who was present in the room during R16's interview, R64 stated she concurs with everything R16 said about the incident and that R64 witnessed it. R16's Minimum Data Set, dated dated dated [DATE] documents R16 is cognitively intact. At 12:30, V21 stated the police report would take 5-7 days to be completed. On 5/14/2024 at 10:31 AM, V15, CNA stated, I witnessed the one (incident) with (R99). Nothing was done on the set (hall). The nurse said the CNA left at 6 (AM). (R16) told me she was soaking wet. I asked her why she didn't ask for help, and she told me she didn't want her (V24) touching her because she 'violated' her. She said (V24) started rubbing her across her chest and it made her uncomfortable. On 5/14/24 at 12:45 PM, R64 was heard asking an unknown staff member, Is that situation that happened in my room last night going to be taken care of? The Facility's Reported Incident Form dated 5/14/2024 documents the incident category is Resident Abuse, and the Resident/victim/perpetrators are R16 and V24. It further documents, (R16) reported that she put on her call light around 3:00 AM to ask for a pain pill. Staff member (V24, CNA) responded again and when she came in (R16) stated, 'You know there are two of us in this room and it was me who had the light on'. She said at that time (V24) was leaning over the bed rail and getting really close to her face asking her what she needed. She told her that she needed a pain pill. She also asked her to get out of her face, that she was getting too close to her. (V24) told her that it was too soon she couldn't have a pain pill. At that time, (V24) began to rub on her (R16's) chest on the outside of her gown and tell her that she would be ok, she was going to take care of her and loves her. (R16) felt uncomfortable and was telling (V24) to leave her alone. At that time, (R64), who is (R16)'s roommate, came out of the bathroom and got the aide out of the room. (V16) reported the incident to the nurse in the morning. It continues to document V24 was suspended. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	2. On 5/13/2024 at 10:45 AM, R99 stated, There are two bad staff. I reported it to the guy nurse (V17, Licensed Practical Nurse). They sent her home. I asked one of them to move me up in bed. I've had a stroke and can't move. It's very difficult. She told me to do it myself. On 5/14/2024 at 9:00 AM, R99 stated, The CNA last night told me to change myself., threw a diaper on the table and left. I did the best I could cleaning myself up. (V15) helped me the rest of the way this morning and there were still about 3 streaks of poop left. The Administrator was just in here talking to me and said the CNA will be fired and the police will be here later for a report. On 5/14/2024 at 10:31 AM, V15, Certified Nursing Assistant (CNA) stated, I witnessed the one (incident) with (R99). The lady (unknown CNA) came in (to work) mad about her set (hall assignment). She was slamming doors. She was yelling at (R99) 'You better get up!'. I was so shocked by it, my mouth dropped. I made eye contact with (R99), and she was in tears. She (R99) was so distressed. I told the nurse and he (V17, LPN) called (V1). (V17) sent her home. The next night (R99) said she had the same thing from another CNA. The CNA said, 'That lady (R99) don't want to do anything for herself!'. Some of these CNAs are 'nasty' (ill mannered). The Facility-Reported Incident Form dated 5/9/2024 documents, Interview of Alleged Victim documents, Resident (R99) reported that the CNA (Certified Nursing Assistant) (V16) 'threw' her shirt at her and then she only assisted her with putting her arms in sleeves and not in pulling it over her head. It further documents, Interview of Witness-(V15) CNA states that she witnessed CNA (V16) yelling and demanding resident in (room) to do things and to get up and get herself ready and that the yelling was really intense. She also stated the aide (V16) walked out of the room cussing and saying, 'It's a shame when you don't want to shower or do anything for yourself'.

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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 - Few	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** 40701 Based on observation, interview and record review, the Facility failed to ensure 2 residents (R58, R99) reviewed for Activities of Daily Living (ADLs), were assisted with their needs, in the sample of 44. Findings include: 1. R58's Minimum Data Set (MDS) dated [DATE] documents R58 is severely cognitively impaired and is always incontinent of bowel and bladder. It further documents R58 requires total assistance with incontinent care. R58's Care Plan dated 7/10/2023 documents R58 requires assistance with all Activities of Daily Living (ADLs). It further documents, Keep clean and dry after incontinent episodes. On 5/14/24 at 9:00 AM, V15, Certified Nursing Assistant (CNA) was observed providing incontinent care for R58. At this time V15 stated, The other lady left at 6 (AM) I know she hasn't done changes since last night. I know this because (R99, R58's roommate) told me. At this time, R99 stated she know's R58 was last checked on/provided incontinent care at 11 PM the prior night (5/13/2024) by (V15). R99 stated (V15) checks on (R58) every half hour but when (V15) left, (R99) did not see/hear anyone check on (R58) the rest of the night. V15 removed (R58's) adult brief which was saturated with a large amount of urine and feces. V15 used multiple towels to clean (R58's) peri-area and buttocks. R58's bed linen pad had a large yellow/brown circular ring around R58's buttocks. This covered over half the pad. V15 was speaking to R58, stating, I know it hurts but you're dirty, I have to get you clean. V15 stated, She's (R58) been wet all night. She's sore. If they keep leaving her like this her skin will be open (develop a pressure ulcer/skin breakdown). See how soiled that (adult brief) is? It just don't make no sense. 2. R99's Care Plan provided on 5/15/2024 documents R99 requires assist with daily care needs, including turning and repositioning due to CVA (Stroke). On 5/13/2024 at 10:45 AM, R99 stated, I asked one of them (CNA) to move me up in bed. I've had a stroke and can't move. It's very difficult. She told me to do it myself. On 5/14/2024 at 9:00 AM, R99 stated, The CNA last night told me to change myself, threw a diaper on the table and left. I did the best I could cleaning myself up. (V15) helped me the rest of the way this morning and there were still about 3 streaks of poop left. On 5/14/2024 at 11:20 AM, V1, Administrator (ADM) stated, I had another resident (R99) with a complaint. She stated she did not feel abused but had an episode of incontinence, which she usually doesn't, and the CNA slammed a diaper down and told her to clean herself up. She (R99) said she would just hate to see her do that to someone who couldn't speak for themselves. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility-Reported Incident Form dated 5/9/2024 documents, Interview of Alleged Victim documents, Resident (R99) reported that the CNA (Certified Nursing Assistant) (V16) 'threw' her shirt at her and then she only assisted her with putting her arms in sleeves and not in pulling it over her head. It further documents, Interview of Witness-(V15) CNA states that she witnessed CNA (V16) yelling and demanding resident in (room) to do things and to get up and get herself ready and that the yelling was really intense. She also stated the aide (V16) walked out of the room cussing and saying, It's a shame when you don't want to shower or do anything for yourself.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview and record review, the Facility failed to ensure treatments prescribed daily by a physician were completed for four consecutive days for 1 of 24 residents (R9) reviewed for Quality of Care in the sample of 44. Findings include: R9's Face sheet dated 5/15/2024 documents R9 has diagnoses of Type Two Diabetes, Peripheral Vascular Disease, Acquired absence of the Right Great toe, and non-pressure chronic ulcer of the left ankle. R9's Minimum Data Set, dated dated dated [DATE] documents R9 is cognitively intact. R9's Care Plan dated 3/8/2024 documents, (R9) had reopened his DFU (Diabetic Foot Ulcer) to his right great toe as well as, Treatment as ordered to right great toe. R9's Care Plan further documents R9 is on an antibiotic for the wound infections in R9's right greater toe and left ankle. R9's Treatment Administration Record (TAR) dated 5/11/2024 documents, Apply betadine to left medial ankle then apply calcium alginate and cover with a dry dressing daily to promote wound healing. R9's TAR further documents, Start date-5/4/2024-Cleanse left [right] great toe with Dakin's solution and apply betadine. If actively bleeding may apply dry dressing daily to promote wound healing. On 5/14/2024 at 11:02 AM R9 stated R9 had sores on his foot/ankle but, They didn't get to it today. Yesterday they didn't either. I think it was last changed Thursday or Friday. I know it's Tuesday today. On 5/15/2024 at approximately 11:30 AM, V29, Licensed Practical Nurse/Wound Nurse (LPN) stated R9 began a new treatment order today due to culture results that showed an infection. At this time, R9 removed his socks and revealed an undated dressing to R9's right great toe and left medial ankle. V29 further stated the floor nurses were supposed to be applying betadine and a dry dressing to the wounds on (R9's) right great toe and left medial ankle over the weekend. V29 further stated, I can tell it wasn't done because I know my bandages and (R9) told me it wasn't done. The last time it was done would have been Friday. I was off the weekend and worked the floor on another hall Monday (5/13/2024) and left early yesterday (Tuesday 5/14/2024). At this time, both V29, Wound Nurse, and R9 confirmed R9's dressings/treatments to R9's foot and ankle had not been done on Saturday (5/11/2024), Sunday (5/12/2024), Monday (5/13/2024) or Tuesday (5/14/2024). At this time V29 stated there was an order for betadine and a dry dressing that should have been completed prior to beginning the antibiotic order. On 5/15/2024 at 12:54 PM, V1 Administrator, stated she was not aware R9's dressing had not been being completed. V1 also stated, I have been trying to get it approved to get another wound nurse hired to help (V29). We have 60 wounds in house. The agency nurses just assume we have a wound nurse on the weekends. (continued on next page)

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	145668	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Belleville	150 North 27th Street Belleville, IL 62226

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Physician's Orders policy dated 9/2023 does not address ensuring that Physician's Orders are completed as prescribed.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to provide proper wound care, and to turn and reposition a resident, for 1 of 1 resident (R270) reviewed for treatments and care to prevent pressure ulcers in the sample of 44. Findings include: R270's Face Sheet, undated, documents R270 was originally admitted to the facility on [DATE] with Diagnosis of Hypoxic Ischemic Encephalopathy, Type 2 Diabetes Mellitus (DM), Osteomyelitis, Dysphagia, Obesity, Dysarthria/Anarthria, Anemia, Major depressive disorder, Neuromuscular dysfunction of bladder, Gastrostomy, Dependence on renal dialysis, Gangrene, Pressure Ulcer of sacral region-stage 4, Sepsis, PVD, Metabolic Syndrome, Atherosclerotic Heart Disease (ASHD). R270's Care Plan states, R270 is at risk for skin complications related to Unspecified Severe Protein-Calorie Malnutrition. Interventions: Assist and encourage resident to turn and reposition every one to two hours and PRN (as needed), elevate HOB (head of bed) no more then 30-degrees, ensure proper body alignment, skin assessment weekly. It continues R270 was admitted with a DTPI (deep tissue pressure injury) to his left heel. Interventions: Assess and document of progress of areas weekly, Assist and encourage resident to turn and reposition every one to two hours and PRN, Elevate HOB (head of bed) no more then 30-degrees, ensure proper body alignment, maximal remobilization, monitor area for s/s (signs/symptoms) of infection: odor, drainage, color, size, observe and assess regularly, protect heels, treatment as ordered to left heel. It continues R270 was admitted with a DTPI to his left lateral malleolus. Interventions: Assess and document of progress of areas weekly, assist and encourage resident to turn and reposition every one to two hours and PRN, elevate HOB no more then 30-degrees, ensure proper body alignment, maximal remobilization, observe and assess regularly, protect heels, treatment as ordered to left malleolus. It continues R270 was admitted with a stage-III pressure wound to his left Ischium. Interventions: Assess and document of progress of areas weekly, assist and encourage resident to turn and reposition every one to two hours and PRN, elevate HOB no more then 30-degrees, ensure proper body alignment, maximal remobilization, observe and assess regularly, skin assessment weekly, treatment as ordered to left Ischium, wound-vac to aid in healing. It continues R270 was admitted with an unstageable wound to his right gluteus. Interventions: Assess and document of progress of areas weekly, assist and encourage resident to turn and reposition every one to two hours and PRN, elevate HOB no more then 30-degrees, ensure proper body alignment, maximal remobilization, monitor area for s/s of infection: odor, drainage, color, size, observe and assess regularly, skin assessment weekly, treatment as ordered to right gluteus, wound-vac to aid in healing. It continues R270 was admitted with a stage-IV pressure wound to his sacrum. Interventions: Assess and document of progress of areas weekly, assist and encourage resident to turn and reposition every one to two hours and PRN, elevate HOB no more then 30-degrees, ensure proper body alignment, maximal remobilization, monitor area for s/s of infection: odor, drainage, color, size, observe and assess regularly, skin assessment weekly, wound-vac to aid in healing. R270's Minimum Data Set (MDS), dated [DATE], documents R270 has severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs). R270 has anuria and has a colostomy. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/13/24 at 10:45 AM, R270, was seen sitting in his recliner chair around the nurse's desk, right below knee amputation (RBKA), soft boot on left foot. R270 was just back from Dialysis. On 5/14/24 at 10:35 AM, V6, Licensed Practical Nurse (LPN)/Wound Care, stated that R270 has three stage-4 pressure ulcers and two unstageable ulcers. V6 stated that R270 came back from the hospital without the wound-vac and had no orders to continue it. V6 stated that he changes dressings and does wound care every day. On 5/14/24 at 10:20 AM, R270's wound-vac was seen in his closet in a plastic bag, along with its supplies. On 5/15/24 at 8:25 AM, R270 was seen sitting on his buttocks in his recliner in Dialysis. On 5/16/24 at 8:15 AM, R270 sitting in recliner on his buttocks during Dialysis. On 5/16/24 at 11:20 AM, R270 is still sitting in his recliner on his buttocks in Dialysis. On 5/15/24 at 12:45 PM, V6, LPN/Wound Nurse, stated All of (R270's) wounds are from the hospital. He was hospitalized for amputation of his leg and then sent here. He had all of these wounds when he arrived here. When (R270) pulled out his G-Tube, he was sent back to the hospital and for some reason, they kept him for 10 days. When he came back, he did not have his wound-vac in place and had no orders for it. I did not call the physician and ask about it but will check with the NP tomorrow when she comes to see him. I think that (R270) could benefit from having the wound-vac back on. On 5/15/24 at 12:50 PM, V6 began providing wound care to R270, Santyl spread on Xeroform and applied to wounds, then covered with occlusive dressing. Upon assessing R270, there were three new areas seen on R270 that V6 was not aware of. These seem to be blisters and was covered up by a band aid on one, and a small dressing on the other. Right upper/proximal flank 4 CM (centimeter) X 6.5 CM, Right mid-flank 0.9 CM X 0.9 CM, and Right distal flank - 1.5 CM X 1.5 CM. The proximal flank was still in a blister form, while the other two had blisters that popped and was oozing. V6 stated he was going to wipe them with betadine to dry them up and apply a dry dressing. V6 stated he knows what the physician will order, so he is going ahead and doing it before he calls, if the order is different, he will change it. On 5/15/24 at 1:15 PM, V6, LPN/Wound Nurse, continuing to work on R270's wounds. R270 rolled to his left side to assess his wounds on his sacrum/coccyx. R270 has three large open wounds/holes to his right ischium/sacral area. V6 stated that R270 came from hospital with them, and they were tunneled together but they are getting better. Wounds cleansed with wound cleanser and 4X4's, then packed with Santyl and Xeroform, then covered with large occlusive dressing. V6 stated that he changes R270's dressings every day and the days he is not working, it is the responsibility of the floor nurse to do. V6 took off R270's soft boot from his left foot to reveal an old dressing on his heel. The dressing was dated 5/8/24. V6 stated he is not sure why this dressing has not been changed since 5/8/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/15/24 at 1:30 PM, V6, LPN/Wound Nurse, stated (R270's) got a colostomy to help his wound heal because of his incontinence. (R270) sits in a recliner for most of the day. He gets up to his recliner early in the morning, eats a small breakfast, then I see him go by my office around 6:15 AM on his way to Dialysis. He is there for 3-4 hours and brought back to the floor in time for lunch. After lunch, which is usually around 1:00 to 2:00 PM, (R270) will be put into his bed and then I do his dressings. (R270) spends a lot of time sitting in his recliner and is not repositioned, which is making his wounds worse and hard to heal. I expected (R270) to come back from the hospital with his wound-vac in place and I am not sure why I didn't call and ask about it because he would probably benefit from having it. I think the new blisters he has is from sitting a long time in his recliner and it is rubbing on him somewhere. On 5/16/24 at 8:10 AM, V31, Nurse Practitioner (NP), stated that she sees R270, but does not take care of his wounds, that is a different NP. V31 stated that R270 definitely needs to get off his backside in order for his wounds to heal. On 5/16/24 at 8:15 AM, V32, Certified Hemodialysis Technician (CCHT), stated that R270 is scheduled for Dialysis every day from 7:00 AM until 10:00 to 10:30 AM, no later than 11:00 AM. V32 stated that the staff in Dialysis cannot turn and position the residents because they do not work for the facility. V32 stated they have to call the facility transport staff member to transfer R270 from their recliner to his recliner and then back to the floor. V32 stated she does not recall seeing any blisters on R270. On 5/16/24 at 11:00 AM, V1, Administrator, stated (R270) should not be sitting for those long periods of time. The facility's transporter is not that busy and could go and reposition (R270) as needed. I will consult OT/PT, and the care plan team for recommendations, and possibly have (R270) eat meals in bed rather than keep him sitting in his recliner. On 5/16/24 at 11:55 PM, V19, Wound Nurse Practitioner, stated that she saw R270 last on 4/16/24. V19 stated that R270 came back from the hospital without his wound-vac. V19 stated that R270 needs to be turned side to side every one to two hours in order for his wounds to heal and R270 sitting on his butt all day long are detrimental to his wounds. On 5/16/24 at 12:10 PM, V5, LPN, stated that R270 just came back from Dialysis because he had an adverse reaction to Vancomycin infusion and will be going to the hospital shortly. R270's Physician Order (PO), dated 4/9/24, documents Cleanse left ischium wound with wound cleanser then apply ABX (compound) mixed with Santyl to wound bed cover with Xeroform lightly pack with calcium alginate and 4x4s and cover with silicone boarded dressing daily. Everyday shift for To Promote Wound Healing. R270's PO, dated 4/9/24, documents Cleanse right ischium wound with wound cleanser then apply ABX (compound) mixed with Santyl to wound bed cover with Xeroform lightly pack with calcium alginate and 4x4s and cover with silicone boarded dressing daily. everyday shift for To Promote Wound Healing. R270's PO, dated 4/9/24, documents Cleanse sacral wound with wound cleanser then apply ABX (compound) mixed with Santyl to wound bed cover with Xeroform lightly pack with calcium alginate and 4x4s and cover with silicone boarded dressing daily. everyday shift for To Promote Wound Healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R270's PO, dated 5/15/24, documents Apply betadine to right flank distal blister daily and cover with dry dressing daily. Everyday shift for To Promote Wound Healing. R270's PO, dated 5/15/24, documents Apply betadine to right flank medial blister and cover with dry dressing daily. everyday shift for To Promote Wound Healing. R270's PO, dated 5/15/24, documents Apply betadine to right flank proximal blister and cover with dry dressing daily. Everyday shift for To Promote Wound Healing. R270's PO, dated 5/14/24, documents Santyl External Ointment 250 UNIT/GM (Collagenase). Apply to Sacrum topically everyday shift for To Promote Wound Healing Cleanse sacrum with wound cleanser then apply Santyl to wound bed and cover with Xeroform and 4x4s and cover with silicone boarded dressing daily. R270's PO, dated 5/14/24, documents Santyl External Ointment 250 UNIT/GM (Collagenase). Apply to Left ischium topically everyday shift for To Promote Wound Healing Cleanse left ischium with wound cleanser then apply Santyl to wound bed and cover with Xeroform and 4x4s then apply silicone boarded dressing daily. R270's PO, dated 5/14/24, documents Apply betadine to left heel daily. Everyday shift for To Promote Wound Healing. R270's PO, dated 5/14/24, documents Apply betadine to left malleolus daily. Everyday shift for To Promote Wound Healing. R270's NP Note, dated 2/26/24, documents Patient being seen today for follow up care for pressure ulcer to sacral region, buttock and left gluteal fold, patient continues to be followed by wound care, patient examined while sitting in dialysis, patient expressed by nodding his head, continues to be followed by wound care, patient examined while sitting in dialysis, patient expressed by nodding his head his buttock is uncomfortable to sit on for long periods of time. R270's Skin Screen, dated 12/5/23, documents upon admission, Skin Evaluation: Sacrum: 5.1x5.4x3.0 with undermining from 11 to 4 o'clock. R270's Admission Observation, dated 12/31/23, documents R270's reason for admission was sepsis, wound-vac to coccyx. Skin Condition: Site - Coccyx, wound-vac in place. R270's last Skin and Wound Assessment located in the electronic medical record, is dated 3/12/24. V6, Wound Nurse, stated that he is doing them and has no idea why they are not showing up in the medical record. The facility's Pressure Injury Policy, dated 9/2022, documents To prevent or reduce the incidence of pressure injuries, standards of practice should be implemented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Skin Care Prevention Policy, dated 1/2023, documents All residents will receive appropriate care to decrease the risk of skin breakdown. 1. The Nursing Department will review all new admissions/readmissions to put a plan in place for prevention based on the resident's activity level, comorbidities, mental status, risk assessment and other pertinent information. 2. Dependent residents will be assessed during care for any changes in skin condition including redness (non-blanching erythema), and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider. 3. All residents will be evaluated for changes in their skin condition weekly. 5. All residents unable to reposition themselves will be repositioned as needed, based on a person-centered approach per the resident's plan of care. 6. Unless contraindicated, elevate heels off bed surface and avoid skin-to-skin contact.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44556 Based on observation, interview, and record review, the facility failed to make sure mechanical lift transfers were provided in a safe manner and care plan interventions were followed to prevent falls for 4 of 4 residents (R65, R78, R90, R91) reviewed for transfers and falls in a sample of 44. Findings include: 1. R78's Face Sheet, print date of 05/15/24, documented R78 has diagnoses of but not limited to amyotrophic lateral sclerosis, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and Hypertension (HTN). R78's Minimum Data Set (MDS), dated [DATE], documented R78 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and she is dependent on staff for bed mobility, dressing, and transferring. R78's Care Plan, with an admitted [DATE], documented R78 requires assistance with all ADLs (Activities of Daily Living) related to impaired mobility and Dx (diagnoses) of Amyotrophic lateral sclerosis (ALS). Interventions include but are not limited to staff to check in on R78 at least every 1-2 hours related to (r/t) inability to use call light at this time due to weakness and Hoyer lift with two assists for transfer. On 05/14/24 at 10:41 AM, V20, Certified Nurse's Assistant (CNA) and V18, CNA placed the mechanical lift sling under R78. V18 got R78's wheelchair in position. They connected the sling to the mechanical lift and checked to make sure the sling was secured. V20 then raised R78 up in the mechanical lift. While R78 was up in the mechanical lift and moving to her wheelchair neither V18 nor V20 were touching or giving hands on guidance to R78. When they got R78 almost to the chair V18 grabbed the sling and guided R78 into her wheelchair. 2. R90's Face Sheet, print date of 05/15/24, documented R90 has diagnoses of but not limited to metabolic encephalopathy, cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, Type II diabetes mellitus, flaccid hemiplegia affecting left nondominant side, and HTN. R90's MDS, dated [DATE], documented R78 is moderately cognitively impaired with a BIMS of 10 out of 15 and is dependent on staff for toileting hygiene, shower/bathe, dressing, personal hygiene, transfer, substantial/maximum assistance with lying to sitting on side of bed, and he is always incontinent of bowel and bladder. R90's Care Plan, with an admitted [DATE], documented R90 is at risk for falls related to (r/t) functional deficits, history of falls, Poor Balance, and use of psychotropic medication. Interventions included but are not limited to promote placement of call light within reach and assess residents' ability to use and provide proper, well-maintained footwear. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Fall List, print date of 05/13/24, documented R90, had falls on 04/21/24, 05/05/24, and 05/07/24. On 05/13/24 at 11:05 AM, R90 was observed sitting in a Geri chair close to the room door. His bed is observed to be in the low position, fall mat beside the bed, and the call light was observed to be lying on the floor by the bed. He is dressed in a clean white t-shirt and had on socks with no shoes. He is observed to be yelling out at times. On 05/14/24 at 09:30 AM, R90 was sitting in his Geri chair in his room. His bottom is observed to be in the bend of the footrest of the Geri chair with his feet dangling from the end of the chair. He was observed with only socks on his feet and no shoes at this time. His call light was observed to be lying on the floor beside his bed and out of his reach. On 05/15/24 at 10:02 AM, R90 is observed in his room in his Geri-chair leaned back. He is dressed in white t-shirt, blue pants, and only socks on and no shoes were observed on his feet. Call light was observed to be on his bed rail out of his reach. V18, CNA was observed sitting 1:1 with R90 at this time. 50628 3. R91's Face Sheet, dated 05/15/24, documents R91 has diagnoses of but not limited to metabolic encephalopathy, diabetes with diabetic neuropathy, marked severe obesity with alveolar hypoventilation, other abnormality of gait and mobility, weakness, unspecified cerebral infarction, altered mental status (AMS), chronic kidney disease (CKD), renal osteodystrophy, hyperlipidemia (HLD), general anxiety disorder, borderline personality disorder, restless leg syndrome (RLS), hypertensive heart and chronic kidney disease with heart failure, atherosclerotic heart disease, unspecified diastolic congestive heart failure, gout, end stage renal disease (ESRD), dependence on renal dialysis, vitamin D deficiency, secondary hyperparathyroidism, of renal origin, essential hypertension (HTN), chronic kidney disease stage 4, pressure ulcer of right and left buttocks stage 3. R91s MDS, dated [DATE], documents R91 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 13 out of 15 and she is dependent on staff for bed mobility, dressing, and transferring. R91's Care Plan, dated 05/15/24 documents assist resident with activities of daily living (ADLs), Hoyer lift with two-assist for transfers, and two-person assist for transfers. On 05/14/24 at 1:50 PM, V22, CNA and V23, CNA placed the sling under R91. V23 got R91's wheelchair in position. They connected the sling that was in the wheelchair to the Hoyer and checked to make sure the sling was secured. V23 then raised R91 up in the Hoyer. While moving R91 from the chair getting ready to place in the bed V22 or V23 did not give hands on guidance to R91. When R91 was about to be placed in the bed, V22 grabbed the sling and guided her into the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 at 1:35 PM, V22 CNA, and V30, CNA, placed the sling under R91. V30 (CNA) got R1's wheelchair and the Hoyer into position. They connected the sling that was in the wheelchair to the Hoyer and checked to make sure the sling was secured. V30 (CNA) then raised R91 up in the Hoyer. While moving R91 from the chair and getting the Hoyer maneuvered to place R91 in the bed, V22 or V30 did not give hands on guidance to R91. When R91 was about to be placed in the bed, V22 grabbed the sling and guided her into bed. 44967 4. R65's Face Sheet, undated, documents R65 was originally admitted to the facility on [DATE] and has diagnosis of Alzheimer's disease, Type 2 Diabetes Mellitus (DM), COVID-19, Schizoaffective disorder, Major depressive disorder, Psychosis, Anxiety disorder, Hypertension (HTN), Atrioventricular block (AV block), Osteoarthritis, and Falls. R65's Care Plan, dated 5/3/24, documents R65 is a High risk for falls related to poor safety awareness, incontinence, use of psychotropic medication and DX: Alzheimer's Disease, Hypertension, Osteoarthritis and DM II. Interventions: keep room free of obstacles/ clutter, 2/28/24 Redirect resident out of other residents rooms, 5/07/2024 Staff encouraged to keep resident in common areas where there's more staff to observe resident while she's up, 12/29/23 Provide proper, well maintained footwear, 12/6/23 Maintenance to evaluate dining room for potential safety hazards, 12/9/23 Staff to assist resident with walking when she is restless, 2/27/24 Dycem placed in wheelchair, 3/19/24 Floor mat placed on side of bed, 3/20/24 Keep bed in lowest position, 3/27/24 Staff to redirect resident when she is wandering in other peers bedrooms, 3/29/24 While in activities staff to sit resident next to them and close to the table, 4/17/24 Assist resident to bed when she is tired, 4/22/24 Staff to ensure when Dxxxxx (R65) is in wheelchair that the wheelchair brakes are on, 4/7/24 Redirect Dxxxxx (R65) attention to participation in some activity, 5/2/24 Staff to report to nurse when resident seems more restless, 5/22/23 Staff to ensure Dxxxxx (R65) is wearing grippy socks, 5/29/23 Frequent rounding, staff to monitor Dxxxxx (R65) closely, 5/7/24 Staff encouraged to keep resident in common areas where there's more staff to observe resident while she's up, 5/9/24 Bring Dxxxxx (R65) up to Nurse's station around people if she is trying to get up out of bed, 6/19/2023 Redirect resident from front lobby doors when wandering for safety, 7/7/23 Educate staff to encourage resident to use w/c, Evaluate multiple falls to determine commonalities or patterns, Fall risk assessment quarterly and as needed, Keep frequently used items within reach, Notify MD and family of any new fall, Promote placement of call light within reach and assess ability to use. R65's MDS, dated [DATE], documents R65 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs) and is always incontinent of bowel and bladder. On 5/13/24 11:29 AM, fall mat folded behind restroom door. On 5/13/24 at 11:29 AM, R65, not in room, fall mat folded and behind restroom door. On 5/15/24 at 8:36 AM, R65 lying in bed, no bedrails up, wheelchair at foot of bed, call light clipped to bed, fall mat folded and against the wall and not on floor. The Facility's Fall List, dated, documents R65, has had falls on 2/17/24, 2/27/24, 2/28/24, 3/19/24, 3/20/24, 3/27/24, 3/29/24, 4/7/24, 4/17/24, 4/22/24, 5/2/24, 5/7/24, and 5/9/24. (continued on next page)

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	145668	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Belleville	150 North 27th Street Belleville, IL 62226

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R65's Nurses Note, dated 2/27/24 at 10:39 PM, documents Notified Dr. (doctor) that resident had a fall in the dining room area. Received check ordered for 24 hours. R65's Nurses Note, dated 2/28/24 at 6:06 PM, documents Resident was found on the floor in room [ROOM NUMBER] at 4:40 PM. full range w/o (without) difficulty, vitals stable, resident still acting like normal self. Sent message to NP (Nurse Practitioner) exchange number. Still waiting for a response. updated POA (Power of Attorney) and sent message to ADON (Assistant Director of Nursing). R65's Nurses Note, dated 3/19/24 at 6:21 PM, documents Resident was found on the floor at 4:20 PM. Resident was laying on the side of the bed vitals was stable. The resident was grabbing at her right hip and moaning. Resident may have hit her head. NP was notified. The resident was sent to local hospital for CT (CAT) scan and x-ray of the right hip. POA was notified. R65's Nurses Note, dated 3/20/24 at 8:07 PM, documents Staff notified this nurse that resident fell getting out of bed at 6 PM. Resident fell on fall mat but did hit head on wall. contacted MD (Medical Doctor) via Telehealth N.O (new order) to continue neuro checks and if family wants resident to go out that's ok. contacted POA updated. Resident remains at facility with neuro checks. Notified DON (Director of Nursing). R65's Nurses Notes, dated 3/27/24 at 2:38 PM, documents Staff notified this nurse that resident fell in hallway on 400-hall at 9 AM. resident had arm stuck in trash can. No new open areas. no complaints or non-verbal indications of pain. Assisting nurse sent message to Dr. with no response. contacted NP N.O for x-ray to right arm. notified POA. R65's Nurses Note, dated 4/7/24 at 5:31 PM, documents Staff notified this nurse that resident tried to get out of chair and walk w/o (without) assistance. Resident then fell on left side at 1652 (4:52 PM). Resident would not stay still enough to get vitals. Full ROM (Range of Motion) w/o difficulty's. sent voice message to POA and contacted Dr. N.N.O. (no new order) sent message to DON. R65's Nurses Note, dated 4/22/24 at 5:11 PM, documents Resident tried to stand up from w/c (wheelchair) in dining room w/o w/c being locked. Resident fell on right side and hit head on a standing fan on the floor. Assessed resident no new injuries noted. Resident refused vitals. No nonverbal pain indicators. contacted (uxxxx) hospice and POA. R65's Nurses Note, dated 5/7/24 at 5:15 PM, documents This nurse was notified by aid that Resident was on the floor in dining room. Resident has a scrape on right forearm to the backside, and the fall was unwitnessed. Vitals WNL (within normal limits), DON notified, and NP. R65's Admission Fall Risk Assessment, dated 2/16/23, documents R65 was not a fall risk. R65's Admission Fall Risk Assessment, dated 3/29/24, documents R65 was a High fall risk. R65's Admission Fall Risk Assessment, dated 4/17/24, documents R65 was a Low fall risk. R65's Admission Fall Risk Assessment, dated 5/2/24, documents R65 was a High fall risk. R65's Admission Fall Risk Assessment, dated 5/7/24, documents R65 was a High fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R65's Admission Fall Risk Assessment, dated 5/9/24, documents R65 was a Low fall risk. On 05/16/24 at 08:42 AM, V1, Administrator stated she would expect the staff to know what the resident's care plan interventions are and to follow them. On 5/16/24 at 10:50 AM, an interview was performed with V2, Director of Nursing (DON) regarding her expectations of her staff for Hoyer use. She stated this always involves two staff members with one person always holding the resident and one maneuvering the Hoyer lift. She said training is provided upon hiring of staff and as needed. On 05/16/24 at 11:48 AM, V10, Licensed Practical Nurse (LPN) said when using a mechanical lift there should always be at least two staff. She said if the resident were a larger person, she would like for there to be three staff. V10 said they would place the mechanical lift pad under the resident, make sure the sling is on correctly, lower the bed, one person would guide the machine, and the other person would guide the resident into the chair or wherever they were moving them to. On 5/16/24 at 12:15 PM, V5, LPN, stated that R65 is a difficult resident, and they try to watch her the best they can, but she really needs to be a 1:1 because she always tries to get out of her wheelchair and will fall. On 5/16/24 at 12:25 PM, V2, DON, stated she would expect the staff to follow what is in the resident care plan to prevent falls. On 05/16/24 at 2:25 PM, Interview with V1, Administrator was conducted regarding her expectations of staff using a mechanical lift to transfer residents. She reports that the mechanical lift should only be used on residents that have orders for use in the care plan, should always be used by two people and to follow the policy and procedures of proper mechanical lift use. The facility's Mechanical lift policy, review date of 10/2023, documents GENERAL: To assist the lift and transfer of a resident from one surface to another using a hoyer lift when appropriate. RESPONSIBLE PARTY: Nursing, Restorative. 6. One caregiver is to focus on the resident's head and body positioning while the other is operating the lift. Tell the resident that he or she will be lifted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Prevention and management policy, review date of 09/22, documents General: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Responsible Party: RN, LPN, DON. Guidelines Upon admission: 1. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. 2. Residents at risk for falls will have fall risk identified on the interim plan of care and the ISP with the interventions implemented to minimize fall risk. It further documents Facility Guideline Following a fall incident: 3. A fall risk evaluation is completed by the Nurse. A score of 10 or greater indicates the resident is at high risk for falls; a score of less than 10 indicates at risk for fall. GENERAL: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. 4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence. The facility's Comprehensive Care plan policy, review date of 03/2023, documents General The facility must develop a comprehensive person-centered care plan for each resident. Responsible Party: all staff. Policy: 2. The care plan will include a focus, measurable goal, and interventions specific to the resident's medical, nursing, mental, and psychosocial needs. 3. The comprehensive care plan should drive the care and services provided for the resident and allow for the highest level of physical, mental, and psychosocial function based on the comprehensive MDS assessment. 4. The comprehensive care plan should be reviewed with the resident and/or resident representative and changes made as appropriate.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed to provide incontinent care in a timely manner and to do complete incontinent care for 3 of 5 residents (R58, R78, R91) reviewed for incontinent care in a sample of 44. 1. R78's Face Sheet, print date of 05/15/24, documented R78 has diagnoses of but not limited to amyotrophic lateral sclerosis, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and Hypertension (HTN). R78's Minimum Data Set (MDS), dated [DATE], documented R78 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and she is dependent on staff for bed mobility, dressing, transferring, and she is always incontinent of bowel and bladder. R78's Care Plan, with an admitted [DATE], documented R78 is incontinent of bowel and bladder, she will be kept clean, dry, and odor free through stay in the facility, check R78 frequently to see if she is clean and dry. It further documented R78 is at risk for skin complications related to (r/t) morbid obesity and incontinence. Interventions include but are not limited to assist and encourage resident to turn and reposition every one to two hours and as needed (PRN) and provide skin care after each incontinent episode. On 05/14/24 at 09:45 AM, R78 put her call light on. V18, Certified Nurse's Assistant (CNA) went right into the room to check on R78. On 05/14/24 at 09:47 AM, V18, CNA came out of R78's room and went into R90's room to check on him. On 05/14/24 at 09:56 AM, this surveyor spoke with R78 and R78 stated she told V18, CNA she needed to be changed and V18 said she was trying to find someone to help her. On 05/14/24 at 10:00 AM, R78 still had not been changed. On 05/14/24 at 10:01 AM, V18, CNA back on the hallway and walked past R78's room. On 05/14/24 at 10:15 AM, R78 still had not been changed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/24 at 10:28 AM, V18, CNA and V11, CNA came into R78's room to provide incontinent care. Neither V18 or V11 were observed doing hand hygiene prior to donning clean gloves. V18 wet several washcloths in the sink, she asked R78 if she was out of her soap and R78 said yes, the peri wash bottle that was sitting on the counter was observed to be empty. V18 took the wet washcloths over to R78's bed without putting any soap or peri wash on them. V20, CNA then came into the room and V11, CNA left the room. V20 donned clean gloves after using alcohol hand sanitizer. V20 then unfastened R78 incontinent brief and moved it down between R78's legs. V18, CNA proceeded to wipe R78's front pubic area with a wet washcloth and under R78's abdominal fold. She then got another wet washcloth and cleansed the outer labia of R78 but did not separate and clean the inner labia. V18 did not cleanse the left or right inner thigh area. No hand hygiene was performed, nor gloves changed during that time. V18 and V20 then assisted R78 onto her right side and R78's incontinent brief was observed to be wet with strong smelling urine. V18 then took a wet washcloth and wiped R78's buttocks but she did not dry the area off. R78's buttocks were observed to be pink in color. No open areas noted. V18 and V20 then assisted R78 onto her left side and V18 handed V20 a different towel and V20 then cleansed the other side of R78's buttocks she did not dry the area off. No hand hygiene or glove change was done after V18 and V20 completed the incontinent care. With the same dirty gloves V18 then got out the A&D ointment from the bedside table and put the ointment on R78's buttocks. After applying the ointment V18 placed the lid back on the ointment and put the jar back in the bedside table drawer still using the same pair of dirty gloves. A new incontinent brief was placed and secured on R78 at this time. No hand hygiene was performed during or after the incontinent care and all areas of incontinence were not cleaned properly. 40701 2. R58's MDS dated [DATE] documents R58 is severely cognitively impaired and is always incontinent of bowel and bladder. It further documents R58 requires total assistance with incontinent care. R58's Care Plan dated 7/10/2023 documents R58 requires assistance with all Activities of Daily Living (ADLs). It further documents, Keep clean and dry after incontinent episodes. On 5/14/24 at 9:00 AM, V15, CNA was observed providing incontinent care for R58. At this time V15 stated, The other lady left at 6 (AM) I know she hasn't been changed since last night. I know this because (R99, R58's roommate) told me. At this time, R99 stated she know's R58 was last checked on/provided incontinent care at 11 PM the prior night (5/13/2024) by V15. R99 stated V15 checks on R58 every half hour but when V15 left, R99 did not see/hear anyone check on R58 the rest of the night. V15 removed R58's adult brief which was saturated with a large amount of urine and feces. V15 used multiple towels to clean R58's peri-area and buttocks. R58's bed linen pad had a large yellow/brown circular ring around R58's buttocks. It covered over half the pad. V15 was speaking to R58, stating, I know it hurts but you're dirty, I have to get you clean. V15 stated, She's (R58) been wet all night. She's sore. If they keep leaving her like this her skin will be open (develop a pressure ulcer/skin breakdown). See how soiled that (adult brief) is? It just don't make no sense. 50628 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R91's Face Sheet, dated 05/15/24, documents R91 has diagnoses of but not limited to metabolic encephalopathy, diabetes with diabetic neuropathy, marked severe obesity with alveolar hypoventilation, other abnormality of gait and mobility, weakness, unspecified cerebral infarction, altered mental status (AMS), chronic kidney disease (CKD), renal osteodystrophy, hyperlipidemia (HLD), general anxiety disorder, borderline personality disorder, restless leg syndrome (RLS), hypertensive heart and chronic kidney disease with heart failure, atherosclerotic heart disease, unspecified diastolic congestive heart failure, gout, end stage renal disease (ESRD), dependence on renal dialysis, vitamin D deficiency, secondary hyperparathyroidism, of renal origin, essential hypertension (HTN), chronic kidney disease stage 4, pressure ulcer of right and left buttocks stage 3. R91's MDS, dated [DATE], documents R91 is cognitively intact with a BIMS of 13 out of 15 and she is dependent on staff for bed mobility, dressing, and transferring. R91's Care Plan, dated 05/15/24 documents R91 is incontinent of bowel and bladder, she will be kept clean, dry, and odor free through stay in the facility, check R91 frequently to see if she is clean and dry. It further documents R91 is at risk for skin complications related to (r/t) morbid obesity and incontinence. Interventions include but are not limited to assist and encourage resident to turn and reposition every one to two hours and as needed (PRN) and provide skin care after each incontinent episode. On 05/14/24 at 10:28 AM, V23, CNA and V22, CNA went into R91's room to perform incontinent care on R91. Neither V22 nor V23 were observed performing hand hygiene prior to donning clean gloves. V22 wet several wash clothes in the sink and then took them over to R91's bedside. No soap or no rinse peri wash was applied to the wet wash clothes prior to doing incontinent care. V22 then unfastened R91's incontinent brief. V23, CNA proceeded to wipe R92's front area with a wet washcloth. She then used the same washcloth and wiped her buttocks She then used a towel to dry the buttocks off. R91's buttocks were observed to be pink in color. Soiled silicone dressing was removed, and an open area was noted on the left and right buttocks A new incontinent brief was placed on R91at this time. No hand hygiene was performed during or after the incontinent care. The same gloves were used all during the care and after. All areas of incontinence were not cleaned appropriately. R91's buttocks' wound culture results dated 4/9/24 shows: 1) Klebsiella pneumoniae, 2) proteus mirabilis, 3) enterococcus faecalis. On 5/14/24 at 1:50 PM, V22 CNA and V23 CNA transfer R91 back to bed per mechanical lift. New gloves had been applied without hand hygiene. Privacy curtain was pulled as clothing/ diaper was changed. Peri care involved water and towel to buttocks only. No actual perineal care was performed. Buttocks dressing was removed. On 5/16/24 at 12:51 PM, V1 Administrator, stated, I expect incontinent care completed timely, at least every couple of hours. On 05/16/24 at 2:25 PM, When asked what your expectations of staff regarding incontinent care V1, Administrator stated she expects the care to be performed timely, residents checked every two hours, and toileting offered every two hours. She expects that the staff would use soap and water when providing incontinent care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/24 at 2:35 PM, V2, Director of Nursing (DON), stated she expects incontinent care to be offered every 2 hours and as needed during the day and at night. She states incontinent care should be performed as soon as the resident is noted to be incontinent. Soap and water should be used during the incontinent care. The facility Incontinence Care Policy, revision date of 04/24, documents General: Incontinence care is provided to keep residents as dry, comfortable and odor free as possible. It also helps in preventing skin breakdown. Level of Responsibility: All Nursing Staff. Guideline: 1. Incontinent residents are evaluated for a bowel and bladder program and placed on one if appropriate. 2. Perform hand hygiene and don gloves. It further documents 5. Clean peri area with appropriate cleanser and dry. Appropriate cleanser can mean soap and water, periwash, etc. Cleansing should always be from front to back. It also states, Apply barrier cream if appropriate.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 44967 Based on observation, interview and record review, the facility failed to administer medications according to the physician order for 1 of 4 residents (R54) reviewed for medication administration in the sample of 44. Findings include: On 5/14/24 at 8:45 AM, V5, Licensed Practical Nurse (LPN), was seen giving the following medications to R54: Fish Oil 1200 MG (milligram) ordered, only had 1000 MG in the cart and V5 gave that 1000 MG dose. V5 stated He's going to get 1000 MG because that's what I have. V5 was to give R54 Folic Acid 800 MG, V5 placed two 1000 MCG (microgram) pills in a medicine cup, when questioned on the proper dose, V5 stated That's microgram and not milligram. We usually have 400 MG tablets, but we don't have it in the cart. V5 went to the medication room and obtained the 400 MG tablets, went back to R54 and took out the previous two Folic Acid pills from the medication cup and replaced them with the 400 MG tablets. When questioned if she was going to give R54 the two 1000 MCG pills to R54, V5 stated Yes Sir, I was. V5 was giving R54 his Symbicort Inhaler 2 puffs as ordered. V5 took the inhaler to R54, put the inhaler in front of his mouth, and without any instructions, R54 took a puff and blew it out his mouth, took another puff, and R54 blew it out his mouth, with a visible puff exiting his mouth both times. R54's Physician Order (PO), dated 12/10/23, documents Fish Oil Oral Capsule 1200 MG (Omega-3 Fatty Acids). Give 1 capsule by mouth one time a day for supplement. This order was discontinued on 5/15/24 after med error occurred. R54's PO, dated 5/15/24, documents Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids). Give 1 capsule by mouth one time a day for prophylaxis. R54's PO, dated 4/3/23, documents Folic Acid Tablet 1 MG. Give 800 mg by mouth one time a day for Supplement. On 5/15/24 at 8:20 AM, V5, LPN, seen passing medications on the 300-hall with the medication cart sitting in the hall, unlocked, and with computer monitor open. On 5/16/24 at 12:25 PM, V2, Director of Nursing (DON) stated she would expect the nurses to follow physician orders for medication administration, to perform hand hygiene when appropriate, and to wipe down medical equipment as needed prior to resident use. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Medication Administration Policy, dated 4/2024, documents All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. 1. An order is required for administration of all medication. 2. Medications are administered by licensed personnel only. 6. Check medication administration record prior to administering medication for the right medication, dose, route, patient/resident and time. 7. Read each order entirely. 8. Remove medication from drawer and read label three times; when removing from drawer, before pouring and after pouring. 9. If there is a discrepancy between the MAR and label, check orders before administering medications. 13. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. 20. Explain procedure to resident and give the medication. 27. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation), and a note should reflect the situation in the resident's medical record. 28. Never leave the medication cart open and unattended.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Belleville	150 North 27th Street Belleville, IL 62226

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49494 Based on observation, interview, and record review the facility failed to remove expired stock medications from the front hall medication room and from 2 medication carts. This failure has the potential to affect 54 residents. Findings include: On 5/13/24 at 1:20 PM, the 200 hall medication cart was inspected and the cart contained the following expired bottles of medications: 1 bottle of Bisacodyl stool softener tablets with an expiration date of 1/24, 1 bottle of Geri Dryl allergy relief tablets with an expiration date of 2/24, 1 bottle of Acidophilus probiotic capsules with an expiration date of 3/23, 1 bottle of lutein 20mg capsules with an expiration date of 3/24, 1 bottle of sodium bicarbonate tablets with an expiration date of 11/23, 1 bottle of sodium chloride tablets with an expiration date of 1/24, 1 bottle of Coenzyme Q-10 100 mg tablets with an expiration date of 3/24, 1 bottle of Optimum iron 65 mg tablets with an expiration date of 1/24, and 1 bottle of multivitamins with an expiration date 3/24. On 5/13/24 at 1:35 PM, the 100-hall medication cart was inspected, and the cart contained the following expired bottles of medications: 1 bottle of vitamin E 400 mg capsules with an expiration date of 11/23, 1 bottle of sodium chloride 1 gm tablets with an expiration date of 1/24, 1 bottle of Acidophilus probiotic 100 mg capsules with an expiration date of 5/23, and 1 bottle of Optimum iron 65 mg tablets with an expiration date of 1/24. On 5/13/24 at 1:50 PM, the front hall medication room was inspected, and 4 sodium chloride .9% pre-filled flush syringes with expiration dates of 4/1/23 were observed in the stock medication supply area. On 5/13/24 at 2:03 PM, V10 LPN (Licensed Practical Nurse) stated that the bottles of expired medications are stock medications that are used for all residents if they have an order for it and that she does not know who is responsible for ensuring the expired medications are disposed of. On 5/15/24 at 1:15 PM, V1 Administrator stated she would expect the floor nurses to be checking the stock medications expiration dates and that the nurse management team is also supposed to be checking the medication carts and the medication rooms for expired medications. On 5/16/24 at 9:20 AM, V2, Director of Nursing (DON) stated that she would expect the floor nurses to check the expiration dates on the stock medications daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Medication Storage In The Facility Policy, dated April 2018, documented Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure: 1. UnitedRx dispenses medications in containers that meet legal requirements for stability. 2. Medications are not to be transferred medications in containers in which they were received. 3. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access: a. Licensed Nurses b. Consultant Pharmacist c. Pharmacist Technician d. Individual lawfully authorized to administer drugs e. Consultant Nurses. It continues, 14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40701 Based on interview and record review the facility failed to provide appetizing/palliative meals for 2 of 24 residents (R57, R99) reviewed for Dietary Services in the sample of 44. Findings include: 1. R99's Face Sheet dated 5/15/2024 documents R99 has a diagnosis of Moderate Protein-Calorie Malnutrition. On 5/13/24 at 12:57 PM R99 stated, I had my daughter bring in food. It's (facility food) so disgusting. I wouldn't feed it to my dogs. It's so nasty. 2. R57's Face Sheet dated 5/15/2024 documents R57 has a diagnosis of Moderate Protein-Calorie Malnutrition. R57's Care Plan dated 2/15/2024 documents R57 is at risk for altered nutrition/hydration status and weight fluctuation. It further documents a goal of maintaining adequate food intake to prevent weight changes. R57's Progress Note dated 2/29/2024 documents, Patient refused to take morning and noon dose of Keflex (antibiotic) because he didn't eat breakfast and lunch here because it's not appetizing. R57's Monthly Weight Report dated 5/15/2024 documents R57 was 137 pounds in January 2024 and was 128 pounds in February 2024. R57's Monthly Weight Report does not document any weights for March or April of 2024. On 5/14/2024 at 9:40 AM, R57 stated, The (food) quality is way down. The burgers got a smell to them. By the time the food gets to the rooms, its cold. The fries are half cooked. The hashbrowns don't even have any 'brown' to them. It's gross. Food isn't supposed to stink. The Facility's Resident Council Meeting Minutes dated 2/29/2024 documents, found hair in meatloaf, don't get what they requested, don't get coffee, always comes out late. The Facility's Resident Council Meeting Minutes dated 3/28/2024 documents, No consistency in food. Not enough. Menu is wrong. The Facility's Resident Council Meeting Minutes dated 4/29/2024 documents, Dietary- better food. [we] want meat with breakfast. Bread is sometimes stale. Milk is bad.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49494 Based on observation, interviews, and record review the facility failed to serve meals at regular times in a manner that meets the resident's needs and per posted scheduled mealtimes. This has the potential to affect all 117 residents living in the facility. Findings include: The Facility's posted mealtimes are breakfast at 7:30 AM, lunch at 12:00 PM and dinner at 5:30 PM. On 5/14/24 at 10:15 AM facility staff were observed passing breakfast trays on the 400-hall. On 5/14/24 at 1:18 PM facility staff were observed passing lunch trays on the 400-hall. On 5/15/24 at 10:03 AM facility staff were observed passing breakfast trays on the 200-hall. On 5/15/24 at 1:20 PM facility staff were observed passing lunch trays on the 200-hall. On 5/14/24 at 9:55 AM R19 stated Breakfast has been late every morning for the past couple of weeks. Supper sometimes comes after 7 PM. On 5/14/24 at 10:22 AM V13, Certified Nurse Assistant, CNA, stated breakfast has been late every morning for a while now. On 5/14/24 at 10:24 AM V14, CNA/Restorative Aide stated that the residents have been complaining the last couple of weeks about the breakfast coming out so late. On 5/14/24 at 01:54 PM during resident council R62 stated the mealtimes are not consistent, lunch is sometimes served as late as 2:30 PM - 3 PM. R83 stated mealtimes have been very inconsistent and that the last couple of weeks it has been really bad. R83 stated that they get to the dining room between 4:00 PM and 5:00 PM and the dinner meal might not be served until 7:00 PM. The Resident Council minutes dated 2/29/24 documented don't get coffee, always come out late, meals served late on weekends. On 5/15/24 at V4, Infection Prevention Nurse stated that breakfast has been coming late because there are issues with kitchen staffing. On 5/15/24 at 1:15 PM V1, Administrator, stated meals should be served at 8:30 AM, 12:30 PM and 5:30 PM. V1 stated that it is unacceptable for residents to be receiving breakfast so late. V1 further stated the Dietary Manager walked out on 5/13/24 and they are working out some issues. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Meal Distribution Policy, dated 9/2017, documented Policy Statement; Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, are delivered in a timely and accurate manner. Procedures 1. All meals will be assembled in accordance with the individualized diet order, plan of care, and preferences. 2. All food items will be transported promptly for appropriate temperature maintenance. 3. All foods that are transported to dining areas that are not adjacent to the kitchen will be covered. 4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients. 5. For point-of service dining, the Dining Services department staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the individual meal card and present it to the resident/patient or care staff for delivery to the resident/patient. 6. Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining. The facility's Long-Term Care Application for Medicare and Medicaid, CMS 671, dated 5/13/24, documented there are 117 residents in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed to perform hand hygiene and cleanse multi-use resident equipment to prevent the spread of infection for 4 of 6 residents (R32, R49, R78 and R91) reviewed for infection control in the sample of 44. Findings include: 1. R78's Face Sheet, print date 05/15/24, documented R78 has diagnoses of but not limited to amyotrophic lateral sclerosis, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and Hypertension (HTN). R78's Minimum Data Set (MDS), dated [DATE], documented R78 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and she is dependent on staff for bed mobility, dressing, transferring, and she is always incontinent of bowel and bladder. R78's Care Plan, admitted [DATE], documented R78 is incontinent of bowel and bladder, she will be kept clean, dry, and odor free through stay in the facility, check R78 frequently to see if she is clean and dry. It further documented R78 is at risk for skin complications related to (r/t) morbid obesity and incontinence. Interventions include but are not limited to assist and encourage resident to turn and reposition every one to two hours and as needed (PRN) and provide skin care after each incontinent episode. On 05/14/24 at 10:28 AM, V18, Certified Nurse's Assistant (CNA) and V11, CNA came into R78's room to perform incontinent care. Neither V18 or V11 were observed doing hand hygiene prior to donning clean gloves. V18 wet several washcloths in the sink, she asked R78 if she was out of her soap and R78 said yes, the peri wash bottle that was sitting on the counter was observed to be empty. V18 took the wet washcloths over to R78's bed without putting any soap or peri wash on them. V20, CNA then came into the room and V11, CNA left the room. V20 donned clean gloves after using alcohol hand sanitizer. V20 and V18 provided R78 with incontinent care. No hand hygiene or glove change was done after V18 and V20 completed the incontinent care. With the same dirty gloves V18 then got out the A&D ointment from the bedside table and put the ointment on R78's buttocks. After applying the ointment V18 placed the lid back on the ointment and put the jar back in the bedside table drawer still using the same pair of dirty gloves. A new incontinent brief was placed and secured on R78 at this time. No hand hygiene was performed during or after the incontinent care. 50628 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R91's Face Sheet, dated 05/15/24, documents R91 has diagnoses of but not limited to metabolic encephalopathy, diabetes with diabetic neuropathy, marked severe obesity with alveolar hypoventilation, other abnormality of gait and mobility, weakness, unspecified cerebral infarction, altered mental status (AMS), chronic kidney disease (CKD), renal osteodystrophy, hyperlipidemia (HLD), general anxiety disorder, borderline personality disorder, restless leg syndrome (RLS), hypertensive heart and chronic kidney disease with heart failure, atherosclerotic heart disease, unspecified diastolic congestive heart failure, gout, end stage renal disease (ESRD), dependence on renal dialysis, vitamin D deficiency, secondary hyperparathyroidism, of renal origin, essential hypertension (HTN), chronic kidney disease stage 4, pressure ulcer of right and left buttocks stage 3. R91's MDS, dated [DATE], documents R91 is cognitively intact with a BIMS of 13 out of 15 and she is dependent on staff for bed mobility, dressing, and transferring. R91's Care Plan, dated 05/15/24 documents R91 is incontinent of bowel and bladder, she will be kept clean, dry, and odor free through stay in the facility, check R91 frequently to see if she is clean and dry. It further documents R91 is at risk for skin complications related to (r/t) morbid obesity and incontinence. Interventions include but are not limited to assist and encourage resident to turn and reposition every one to two hours and as needed (PRN) and provide skin care after each incontinent episode. On 05/14/24 at 10:28 AM, V23, CNA and V22, CNA went into R91's room to perform incontinent care on R91. Neither V22 nor V23 performed hand hygiene prior to donning clean gloves. V22 and V23 wet several wash clothes in the sink and then took them over to R91's bedside. No soap or no rinse peri wash was applied to the wet clothes prior to doing incontinent care. After R22 and R23 assisted R91 with incontinent care, they did not perform hand hygiene. The same gloves were used all during the care and after. 44967 3. On 5/14/24 at 8:25 AM, R49, was seen sitting in her wheelchair in room, stating she was stuck and needed help. V5, Licensed Practical Nurse (LPN), came in to assist R49 and then proceeded to pass medications to residents. No hand hygiene was done before or after assisting R49. 4. On 5/14/24 at 8:30 AM, V5, LPN, was seen passing medications on the 300-hall. V5 was giving R32 medications and did not perform hand hygiene before or after giving R32 his medications. On 5/14/24 at 8:35 AM, V5, LPN, was seen taking R32's vital signs with no cleaning or wiping of the Blood Pressure cuff after use and it was then given to another nurse to use elsewhere. On 5/16/24 at 10:50 AM, V2, Director of Nursing (DON) was interviewed regarding her expectations of staff regarding hand hygiene. She expects hand hygiene to be used before care, during care, after care and during medication pass. She said staff should use hand sanitizer three times and then soap and water for the next time. When asked if staff should use hand hygiene before glove application she replied definitely. On 05/16/24 at 11:48 AM, V10, Licensed Practical Nurse (LPN) stated hand hygiene should be done before and after providing resident care and when your hands are visibly soiled. It should also be done before and after giving incontinent care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hand Hygiene policy, review date of 1/23, documents General: Proper hand hygiene is necessary for the prevention and transmission of infectious disease. Responsible Party: All facility staff. Guideline: 1. Hand hygiene is done before and after resident contact, before and after any procedure, after using a Kleenex or the rest room, before eating or handling food, when hands are obviously soiled and regardless of glove use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview, and record review, the facility failed to ensure residents are offered and receive if wanted the pneumococcal vaccination in accordance with Center for Disease Control and Prevention (CDC) recommendation for 5 of 6 residents (R6, R9, R48, R82 and R91) reviewed for pneumonia vaccinations in the sample of 44. Findings include: 1.R6's Face Sheet, dated 5/15/24, documented R6 was admitted to the facility on [DATE] with diagnoses of amyotrophic lateral sclerosis and chronic obstructive pulmonary disease. R6's electronic medical record (EMR) does not document any pneumonia vaccination administration nor a history of any pneumonia vaccinations. 2.R9's Face Sheet, dated 5/15/24, documented R9 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, type two diabetes, chronic kidney disease with dialysis, peripheral vascular disease, and atherosclerotic heart disease. R9's EMR does not document any pneumonia vaccination administration nor a history of any pneumonia vaccinations. 3.R48's Face Sheet, dated 5/15/24, documented R48 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, hemiplegia, chronic kidney disease and diabetes. R48's EMR does not document any pneumonia vaccination administration nor a history of any pneumonia vaccinations. 4.R82's Face Sheet, dated 5/15/24, documented R82 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease and cognitive communication deficit. R82's EMR does not document any pneumonia vaccination administration nor a history of any pneumonia vaccination administration. 5.R91's Face Sheet, dated 5/15/24, documented R91 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, diabetes, and chronic kidney disease. R91's EMR does not document any pneumonia vaccination administration nor a history of any pneumonia vaccinations. On 5/15/24 at 10:50 AM V4, Infection Preventionist (IP) nurse stated that she has worked at the facility for a little over a year and she has not had the vaccine clinic that they contract with come in and administer pneumonia vaccines nor has she offered any residents any pneumonia vaccines since she has worked at the facility. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 at 1:15 PM V1, Administrator stated she would expect the IP nurse to be offering and administering pneumonia vaccines. The Facility's Pneumococcal Vaccinations Policy, dated 6/2015 with a review date of 9/2022, documented 1. All current residents or the resident's responsible party will be screened and offered the pneumonia vaccine within the 1st week of admission and annually if eligible per CDC guidelines. 2. A consent will be obtained and serves as the education tool for the vaccine. If the resident has previously received any of the pneumonia vaccines previously, the date and location will be entered into the Immunization Tab of the EHR (Electronic Health Record). 3. If the resident or responsible party signs the consent, an order will be obtained. If the resident or responsible party refuses the specific reason for the refusal of either or both vaccines will be documented in the Immunization Tab of the EHR. 4. When the order for the vaccine is received, the order will be entered into the EHR. 5. The vaccine will be obtained from stock received from the pharmacy, given, and signed on the eMAR (Electronic Medication Administration Record) and in the immunization tab of the EHR.