STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145691	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare of Pekin	2501 Allentown Road Pekin, IL 61554

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview, and record review the facility failed to ensure the call light was in reach for one resident (R26) out of 15 residents reviewed for call lights in the sample 32. Findings include: R26's Current Medical Record documents that R26 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease/COPD, Chronic Respiratory Failure with Hypercapnia, Emphysema, Essential (Primary) Hypertension, Chronic Kidney Disease, and Type 2 Diabetes Mellitus with Hyperglycemia. R26's Minimum Data Set assessment dated [DATE] documents R26 has a BIMs (Brief Interview of Mental Status) of 14 (cognition intact). R26 requires partial assistance for activities of daily living, transfers and is dependent on staff for toileting. On 9/29/24 at 10:55 AM, R26 was sitting in her wheelchair in her room wearing oxygen. R26 did not have the call light in reach. R26 stated that she did not have the call light since staff got her out of bed. On 9/29/24 at 10:57 AM, V8/Certified Nursing Assistant/CNA came into R26's room and found R26's call light near the head of R26's bed on the floor. V8 verified that R26 should have had the call light in reach. On 10/1/24 at 1:28 PM, V2/Director of Nursing stated that the call light should always be in reach of the resident. The Call Light Guidance policy dated 8/20/24, documents 2. A call light activation device shall be kept within resident reach while in resident rooms and bathrooms.

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 35509 Based on interview and record review, the facility failed to educate residents on what a grievance is, have grievance forms readily available in a public area in the facility, and allow a resident to file a grievance anonymously if desired. This has the potential to affect all 59 residents living in the facility. Findings: On 9/30/24 at 10 AM, during the Group Meeting, Residents, R9, R10, R50, R211, all stated that they did not know what a grievance was, where forms were kept, how to file a grievance and it could be done anonymously. All four stated that they were interested in having this available to them for future use. R10 stated, it would be nice to let (the administration) know if something was going on without giving your name. On 10/01/24 at 10:15 AM, V1, Administrator, stated, Residents are welcome to tell staff if they have an issue. We don't actually call them grievances, more like concerns. V10, Social Services Director, will record the concern and look into the issue. We do not have grievance forms displayed anywhere for residents or family to fill out. I never thought about the possibility that they would want to do so anonymously. The document, Grievance Policy, and Procedure, dated 9/17/19, states, (The purpose of this policy) is to offer guidance to the facility in identifying, investigating, and resolving grievances reported by residents, visitors, family members or staff. In accordance with federal law, the facility shall post a sign or signs notifying individuals of the right to file a grievance or complaint, including the right to file this action anonymously. The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 9/29/24 and signed by V1, Administrator, documents 59 residents currently reside within the facility.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on record review and interview the facility failed to implement their Abuse Policy to report staff-to-resident abuse to the administrator immediately for one of one resident (R7) reviewed for abuse reporting in the sample of 32. Findings include: R7's MDS (Minimum Data Set) assessment dated [DATE] documents R7 is cognitively intact. On 9-29-24 at 9:20 AM V5 (Registered Nurse/RN) stated, (V6/CNA/Certified Nursing Assistant) reported to me on 9-28-24 around 12:30 PM that (R7) was saying that (V6) yanked on her arm (R7's arm) rough and hurt (R7's) shoulder. I have only worked here three weeks and was not trained on the abuse policy. I did not report (R7's) allegations to (V1/Administrator). I just thought it was a racist issue. On 9-29-24 at 9:30 AM V4 (CNA) stated on 9-28-24 around 12:15 PM R7 was refusing care from V6 (CNA). V4 stated R7 reported to her that V6 was rough during cares and was rude to R7. V4 stated she did not report R7's allegation to V1. On 9-29-24 at 9:18 AM V1 stated, (V5) should have reported to me immediately when (R7) reported her concerns about (V6) to (V5). (V5) has received abuse training on the facility's abuse policy on 9-3-24. The facility's Abuse Policy dated 1-9-24 documents, It is all staff responsibility to report any allegation or witnessed abuse immediately to the Administrator (Abuse Coordinator). The facility will report all allegations of abuse immediately to the Administrator.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on record review and interview the facility failed to implement their Abuse Policy to remove an alleged perpetrator from direct care of residents once an allegation of abuse was made by R7. This failure has the potential to affect all 59 residents residing within the facility. Findings include: V6's (CNA's) Attendance Card dated 9-28-24 documents V6 worked on 9-28-24 from 6:09 AM through 2:17 PM. R7's MDS (Minimum Data Set) assessment dated [DATE] documents R7 is cognitively intact. On 9-29-24 at 9:20 AM V5 (Registered Nurse/RN) stated, (V6/CNA/Certified Nursing Assistant) reported to me on 9-28-24 around 12:30 PM that (R7) was saying that (V6) yanked on her arm (R7's arm) rough and hurt (R7's) shoulder. I did not remove (V6) from resident care or have (V6) leave the facility. I have only worked here three weeks and was not trained on the abuse policy. On 9-29-24 at 9:18 AM V1 stated, (V5) should have reported to me immediately when (R7) reported her concerns about (V6) to (V5). (V6) should have been suspended immediately once (R7) made an allegation. On 9-30-24 at 10:45 AM V6 (CNA) stated, On 9-28-24 around 12:00 PM (R7) started yelling at me to get out of her room and said I hurt her shoulder when moving her. I immediately let (V5) know that (R7) was upset and said I moved her too hard or too fast and I hurt her. I went back in her room around 1:00 PM and (R7) told me to get out of there again. I think I was moving (R7) too fast. (V5) did not suspend me when I informed (V5) around 12:00 PM that (R7) said I hurt her and (R7) was upset with me. I continued to work until a little after 2:00 PM and tried to take care of (R7) again around 1:00 PM. All the residents are on the same hallway at the facility, so I take care of all the residents whenever they need something. The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 9/29/24 and signed by V1/Administrator documents 59 residents currently reside within the facility. The facility's Abuse Policy dated 1-9-24 documents, The facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law: or have a disciplinary action against their license by a state licensing body as the result of a finding of abuse, neglect, exploitation, misappropriation of property, or mistreatment. Procedure: Any staff member or person suspected of abuse will be escorted by staff out of the facility and will be notified that they are not permitted back into the facility until the investigation has been complete.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 31682 Based on observation, interview, and record review the facility failed to implement physician ordered pressure relieving interventions for a resident identified as being a high risk for pressure ulcer development for one of three residents (R13) reviewed for pressure ulcers in the sample of 32. This failure resulted in R13 developing a painful, facility acquired stage four pressure ulcer to the left heel that became infected with MRSA (Methicillin Resistant Staphylococcus Aureus) and Proteus Mirabilis and required surgical debridement on multiple occasions. Findings include: R13's MDS (Minimum Data Set) Assessments dated 3-8-24 and 9-6-24 documents R13 is cognitively intact. R13's Braden Scale for Predicting Pressure Sore Risk dated 6-12-24 documents R13 is at high risk for developing pressure sores, is chairfast and her ability to walk is severely limited or non-existent, is completely immobile and does not make even slight changes in body or extremity position without assistance, has adequate nutrition, and requires moderate to maximum assistance in moving. R13's Current Care Plan documents R13 has a pressure injury to the left posterior heel with interventions to apply a heel floating device while R13 is in bed, provide off-loading of ulcer site, and reposition every two hours. This same Care Plan documents R13 has the potential for impaired skin integrity with interventions to ensure bilateral heel protectors are in place while in bed or chair as she will allow. R13's Wound Evaluation and Management Summary dated 4-9-24 and signed by V18 (Wound Physician) documents, Chief complaint: (R13) has wounds on her left posterior heel full thickness. Stage four pressure wound of the left posterior heel full thickness. Etiology: Pressure. Stage four. Duration less than one day. Wound size: 1.7 cm (centimeters) length by 1.5 cm width by 0.7 cm depth. Exudate moderate serosanguinous (pinkish-yellowish drainage). Slough (dead tissue) 40 percent. Recommendations: (pressure relieving heel boots). Reposition per facility protocol. Float heels in bed. Off-load wound. Management and prognosis presented; importance of wound off-load and wearing the boots while in wheelchair emphasized. Surgical excisional debridement procedure to remove necrotic tissue and establish the margins of viable tissue. R13's Wound Evaluation and Management Summary dated 9-3-24 and signed by V18 (Wound Physician) documents, Chief complaint: Stage four pressure wound of the left posterior heel full thickness. Etiology: Pressure. Stage four. Duration over 148 days. Wound size: 1.7 cm length by 0.6 cm width by 0.2 cm depth. Exudate light serosanguinous. Slough 20 percent. Recommendations: (pressure relieving boots). Reposition per facility protocol. Float heels in bed. Off-load wound. Surgical excisional debridement procedure to remove necrotic tissue and establish the margins of viable tissue. Dressing treatment plan: Silver Sulfadiazine apply once daily for 16 days. Gauze island with border apply once daily as needed. R13's Left Heel Wound Culture dated 7-9-24 documents, Heavy growth of Proteus Mirabilis. Heavy growth of (MRSA). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Physician's Order dated 7-9-24 documents, Tetracycline Hydrochloride 500 mg (milligrams) one tablet two times daily for MRSA of left heel wound for 14 days. On 9-30-24 from 9:10 AM through 12:05 PM R13 was lying in bed on her back with a four-inch raised mat under her knees. R13 had a four-by-four dressing to the left heel. R13's heels were lying directly on the mattress with no pressure relief or off-loading. R13 did not have pressure relieving boots on during this time. On 9-30-24 at 9:10 AM R13 stated, I was told I got the sores on my heels from rubbing my heels on the mattress. That sore is painful, especially when the doctor looks at it. They do not put heel boots on me. My heel boots are in the closet, and no one has been putting them on me. I need them because I have blisters on my heels, and I know I should wear them. On 9-30-24 at 12:08 PM V15 (CNA/Certified Nursing Assistant) entered R13's room and stated, I have not tried to turn (R13) since this morning around 7:00 AM. I do not know if (R13) has heel protector boots or not. I have worked here since August 1, 2024, and I have only seen (R13) wear heel boots one time. I know the boots were green. I have not tried to put heel boots on (R13) ever before. V15 also confirmed R13's heels were laying directly on the bed without pressure relief. V15 then exited R13's room and did not off-load R13's heels off the bed or apply heel pressure relieving boots before exiting the room. On 9-30-24 from 12:08 PM through 2:05 PM R13 was in lying bed on her back with a four-inch raised mat under her knees. R13 had a four-by-four dressing to the left heel. R13's heels were lying directly on the mattress with no pressure relief or off-loading. R13 did not have pressure relieving boots on during this time. On 10-1-24 from 9:30 AM through 10:35 AM R13 was in lying bed on her back with four inch raised mat under her knees. R13 had a four-by-four dressing to the left heel. R13's heels were lying directly on the mattress with no pressure relief or off-loading. R13 did not have on pressure relieving boots at these times. On 10-1-24 at 10:40 AM V14 (Assistant Director of Nursing) stated, I did not know (V18/Wound Physician) had ordered pressure relieving heel boots and off-loading. I thought we (the facility) were just supposed to off-load (R13's) heels. (R13's) heels are not off-loaded off the mattress. I will have to educate the staff on proper positioning of the off-loading device to ensure (R13's) heels are always off the bed. The staff did not have the off-loading device positioned correctly. On 10-1-24 at 10:50 AM V9 (LPN/Licensed Practical Nurse) stated, I did not see on (V18's) recommendations that (R13) needs heel boots on. I rounded with (V18). I know (R13) has pressure relieving boots in her closet and the staff have not put them on. On 10-1-24 at 11:00 AM V14 (Assistant Director of Nursing/ADON) removed R13's dressing to the left heel pressure ulcer. V21 (Wound Nurse Practitioner) cleansed the wound with normal saline and measured the wound at 1.7 cm by 0.9 cm by 0.2 cm with 10 percent slough covering the wound. The wound bed was dark red with a small amount of serosanguinous drainage. V21 applied honey alginate to the wound bed and covered with a four-by-four gauze and tape. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10-1-24 at 11:00 AM V21 (Wound Nurse Practitioner) stated, (R13's) heels should be always off-loaded. The wound on (R13's) left heel was caused by pressure and was facility acquired. I prefer (R13) to have pressure relieving boots on always. The facility's Pressure Ulcer Prevention, Identification and Treatment policy dated 4-1-2020 documents Purpose: To provide guidelines that will assist nursing staff in prevention, identification, and appropriate treatment of pressure ulcers. Policy: Prevention program including Turning and Positioning, will be utilized for all residents who have been identified of being at risk for developing pressure ulcers. The facility will initiate an aggressive treatment program for those residents who have pressure ulcers. Responsibility: A pressure ulcer is defined as any lesion caused by unrelieved pressure those results in damage to underlying tissue. Pressure ulcers usually occur over bony prominence and are graded or staged to classify the degree of tissue damage observed. The staging method is one method of describing the extent of the tissue damage in the pressure sore. Stage IV: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often including undermining and tunneling. Pressure Sore Prevention Guidelines and Suggested Interventions: Positioning device should be used to keep bony prominence from direct contact with each other. Residents who are completely immobile should have pressure reducing devices to totally relieve pressure on heels and raise the heels completely off bed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview and record review, the facility failed to ensure nebulizer masks and nebulizer tubing were dated and stored in a bag between uses for two resident (R41 and R161), failed to ensure a resident had a physician order for oxygen for one resident (R2) and failed to ensure nasal cannula tubing were dated for two of six residents (R26 and R161) reviewed for respiratory care in a sample of 32. Findings include: 1. On 9/29/24 at 10:55 AM R26 was sitting in her wheelchair in her room wearing oxygen. There was no date on the oxygen tubing. R26 stated I don't know how often they change the tubing, but I know it is not once a week. On 9/29/24 at 10:56 AM V8/CNA/Certified Nursing Assistant verified there was no date on the oxygen tubing. On 10/1/24 at 1:34 PM, V2/Director of Nursing stated that oxygen tubing should be changed at least once a week and labeled with the date. R26's Admission Record printed 9/29/24 at 10:32 AM documents that R26 was admitted to the facility 5/18/23 with diagnoses that include Chronic Obstructive Pulmonary Disease/COPD, Chronic Respiratory Failure with Hypercapnia, and Emphysema. R26's Minimum Data Set assessment dated [DATE], documents R26 has a BIMs (Brief Interview for Mental Status) of 14 (cognition intact). R26's Physician Order Summary dated 10/1/24 at 10:55 AM, documents Oxygen at 6 (six) liters via nasal cannula continuous every shift related to COPD. Change oxygen tubing weekly on Sunday night shift and as needed for infection control. R26's Care Plan documents that R26 has altered respiratory status and difficulty breathing related to diagnosis of COPD. Oxygen via nasal cannula as ordered. 2. On 9/29/24 11:00 AM R161 was lying in bed wearing oxygen. There was no date on the oxygen tubing. R161 also had a nebulizer machine in his room on the bedside table. The nebulizer mask was still attached to the tubing and machine. There was no date on the mask or tubing and no bag to store the mask in. R161 stated I don't know when the tubing was last changed. On 9/29/24 at 11:03 AM V8/CNA verified there was no date on the oxygen tubing or nebulizer tubing. On 10/1/24 at 1:34 PM, V2/Director of Nursing stated that oxygen tubing should be changed at least once a week and labeled with the date. V2 also stated that nebulizer tubing should also be labeled, and the mask should be stored in a plastic bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R161's Admission Record printed 10/1/24 at 10:40 AM documents that R161 was admitted to the facility on [DATE] with diagnoses that include Acute Respiratory Failure with Hypoxia, Centrilobular Emphysema, and Chronic Obstructive Pulmonary Disease. R161's Minimum Data Set assessment dated [DATE], documents R161 has a BIMs (Brief Interview for Mental Status) of 15 (cognition intact). R161's Physician Order Summary dated 10/1/24 at 10:42 AM, documents Oxygen at 5 (five) to 7 (seven) liters via nasal cannula continuous every shift. Change oxygen tubing every Sunday on night shift and place date on tubing. R161's Care Plan documents that R161 has altered respiratory status and difficulty breathing related to diagnosis of Respiratory Failure, Emphysema, and COPD. Oxygen via nasal cannula as ordered. The facility's Nebulizer Therapy policy, dated 4/1/20, documents Purpose: To provide guidelines to Licensed nursing staff for the proper administration of nebulizers per physician order. Nebulizer treatments are given to liquefy and moisten secretions or instill medications. Procedure: 8. Rinse all parts of nebulizer under warm water after each treatment. Wash all parts under warm soapy water daily. Store in plastic bag when not in use. Change mouthpiece, tubing and nebulizer monthly. The facility's Oxygen Administration policy, dated 3/17/22, documents Procedure: 16. Care and Use of Prefilled Disposable Humidifiers: I. Label humidifier with date opened. Tubing will be changed and dated weekly. 17. Care and Use of Reusable Humidifiers: G. Label humidifier with date opened. Tubing will be changed and dated weekly. 22. When Oxygen cannula/Mask is not in use it should be stored in a zip lock or like bag attached to the oxygen concentrator. 49187 3. R41's current POS (Physician Order Sheet) documents a Physician order for Ipratropium-Albuterol Solution 0.5-2.5 (3) mg(milligram)/3ml (milliliter) inhale orally two times a day and every 4 hours as needed. On 9/29/24 at 8:50 AM R41's nebulizer tubing and nebulizer mask were lying on R41's bedside table un-dated and unbagged. On 9/29/24 at 8:53AM V9/Licensed Practical Nurse verified R41's nebulizer tubing and nebulizer mask were undated and un-bagged. V9 stated, The nebulizer tubing and mask should be changed at least once a week and placed in a bag when not in use. 4 R2's POS, dated 9/29/24, does not document a physician order for the use of oxygen. On 9/29/24 at 8:45 AM R2 was sitting in her wheelchair in her room. R2 had oxygen flowing at 3.5 liters via nasal cannula. R2's nasal cannula was un-dated. V9/Licensed Practical Nurse verified that R2's nasal cannula tubing was undated. V9 stated, Oxygen tubing should be changed weekly and dated. On 9/30/24 at 2:00 PM V2/Director of Nursing verified R2 did not have a current order for oxygen. V2 stated, I am unsure why there is not an order for (R2) to wear oxygen, (R2) always has oxygen on.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49187 Based on observation, interview, and record review the facility failed to obtain physician ordered scheduled medication from the pharmacy for one of fifteen residents (R2) reviewed for pharmacy services in the sample of 32. Findings include: R2's Physician Orders, dated 9/29/24, documents Order date: 9/12/24: Cyclobenzaprine hydrochloride 10 mg (milligrams) one tablet by mouth three times a day for muscle spasms. On 9/29/24 at 8:23 AM V9/LPN (Licensed Practical Nurse) was administering R2's scheduled medications. R2's Cyclobenzaprine Hydrochloride 10 mg was not available in the medication cart. V9 stated, We (the facility) have been having trouble getting this medication in from pharmacy and I am not sure why. On 9/30/24 at 2:10 PM V9/LPN stated, R2 was still out of her Cyclobenzaprine 10 mg tab. V9 stated, I did not notify the (R2's) doctor yesterday or today that R2 was out of her Cyclobenzaprine. I did just call the pharmacy and it is something to do with insurance coverage for that medication. On 9/30/24 at 2:30 PM V2/DON verified R2's Cyclobenzaprine was not given yesterday or today. V2 stated, The nurses should notify the resident and the resident's doctor right away when a resident is out a medication. R2's Medication Administration Record, dated 9/2024, documents R2 missed six scheduled doses of Cyclobenzaprine on 9/29/24 and 9/30/24. The facility's Unavailable Medications policy, dated 8/2020, documents Policy: Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This may be due to pharmacy being temporarily out of stock of a particular product, a drug recall, or manufacturer's shortage of an ingredient, or may be a permanent situation due to the medication no longer being produced. The facility must make every effort to ensure that medications are available to meet the needs of each resident. Procedures: The pharmacy staff shall: 1. Notify nursing staff that the order (products) is/are unavailable. 2. Notify nursing staff of when it is anticipated that the drug(s) that is/are available. The nursing staff shall: 1. Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the Facility medical Director for orders and/or direction. 2. Obtain a new order and cancel/discontinue the order for the non-available medication. 3. Notify the pharmacy of the replacement order.

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	145691	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare of Pekin	2501 Allentown Road Pekin, IL 61554

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on observation, interview, and record review the facility failed to perform anti-psychotic drug assessments, failed to perform gradual dose reductions, and failed to document behaviors and diagnosis to justify the use of an anti-psychotic medication for one of five residents (R38) reviewed for the use of anti-psychotic medication with the diagnosis of Dementia in the sample of 32. Findings include: R38's current Physician's Order document R38 was admitted to the facility on [DATE]. R38's OBRA (Omnibus Budget Reconciliation Act) Initial Screen dated 1-16-22 documents R38 does not have a mental illness. R38's MDS (Minimum Data Set) Assessments dated 4-26-24 and 7-24-24 document R38 receives an anti-psychotic medication on a routine basis, has had no gradual dose reduction attempts, and has no physician documentation as to why a gradual dose reduction is clinically contraindicated. R38's Initial Psychiatric Evaluation dated 2-3-23 and signed by V22 (Psychiatric Nursing Practitioner) documents, Assessment: Dementia with psychotic disturbance, unspecified dementia severity, unspecified dementia type. Recommendations: Start Seroquel (anti-psychotic medication) 12.5 mg (milligrams) every night. R38's Order Summary Report dated 10-1-24 documents R38 has been receiving Seroquel 50 mg two times daily since 9-23-23. R38's current Care Plan documents R38 receives an anti-psychotic medication for the diagnosis of Dementia with agitation. R38's Medical Record does not include evidence or documentation of a gradual dose reduction attempt of R38's Seroquel since 9-23-23. R38's Medical Record does not include evidence or documentation of an anti-psychotic medication assessment since the start of R38's Seroquel on 2-3-23. R38's Behavior Tracking Report dated 4-1-24 through 9-30-24 documents R38 has had no behaviors. On 9-29-24 at 10:00 AM R38 was in bed. R38 was well-groomed and pleasant. R38 was alert and orientated and had no behaviors. R38 stated I do not want all my medications. The medications make me tired. On 9-30-24 at 12:08 PM V15 (CNA/Certified Nursing Assistant) stated, I have not noticed (R38) to have any behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10-1-24 at 11:00 AM V2 (Director of Nursing) stated, (R38) has not had any behaviors in the last six months for the use of Seroquel and has never had a gradual dose reduction of the Seroquel. We (the facility) have not done any anti-psychotic medication assessments for (R38's) Seroquel use. The Psychotropic Medication Protocol (not dated) documents Purpose: To provide guidance to facility staff in the implementation, monitoring and gradual dose reductions of psychotropic medications. Initiating a Psychotropic Medication: Appropriate diagnosis/justification must be obtained. Initial Psychotropic Assessment shall be completed. Behavior tracking shall be initiated, specific to the medication and the targeted behaviors in POC (Plan of Care). Quarterly - Initiate potential GDR/Gradual Dose Reduction.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 32875 Based on interview and record review, the facility failed to explain the arbitration agreement to the resident, or their representative in a form or manner they could understand and explain that the agreement must be rescinded within 30 days of signing the agreement. This has the potential to affect all 59 residents residing in the facility. Findings include: On 9/29/24 at 11:57 AM, V12 Social Services stated that she does the admission packet with the resident or their representative when a resident is admitted . V12 tells the resident/representative that if there is a conflict between the facility and the resident there will be an arbitrator and they will work it out. V12 also tells the resident/representative that they have 60 days to rescind the agreement. V12 does not tell them (resident/representative) they are giving up there right to sue the facility if they sign the arbitration agreement. V12 tells them to read the agreement and decide what they want to choose. On 9/30/24 at 10:00 AM, at the Resident Council Meeting there were four residents in attendance R9, R10, R50, and R211. All four stated that they did not know what the arbitration agreement was, and it was not explained to them. None of the residents knew if they or their representative had signed the agreement. On 9/30/24 at 12:08 PM V16/R162's Power of Attorney stated that he did not understand that he was giving up R162's right to sue the facility by signing the Arbitration Agreement. V16 also stated that he wanted to change his mind and was going to talk to V12 and tell V12 he wanted to change the agreement. On 9/30/24 at 1:05 PM, R50 stated that the Arbitration Agreement was not explained to him that he was giving up his rights. R50 did not know if he had signed the contract but would not have signed it if R50 knew what it meant. On 10/1/24 at 10:24 AM, V20/R50's Power of Attorney for Finance stated that she signed the admission papers for R50. It was not explained to V20 that signing the arbitration agreement meant she was giving up any rights for R50. V20 also stated that she would have talked it over with R50 and let him decide since R50 is cognitively intact. On 10/1/24 at 1:10 PM, V1/Administer stated that there is no policy about the Arbitration Agreement. It is important that the resident/resident representative understand what the Arbitration Agreement means. V1 also stated that V16 did get with V12 and chose to not sign the Arbitration Agreement. R50's Arbitration and Limitation of Liability Agreement Between Resident and Facility signed 2/28/24 by V20/R50's Power of Attorney documents that V20 accepted the arbitration agreement. R162's Arbitration and Limitation of Liability Agreement Between Resident and Facility signed 9/27/24 by V16/R162's Power of Attorney documents that V16 accepted the arbitration agreement. (continued on next page)

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 9/29/24 and signed by V1/Administrator documents 59 residents currently reside within the facility.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 35509 Based on record review and interview the facility failed to ensure direct care staff received annual QAPI (Quality Assurance and Performance Improvement) in-service training. This failure has the potential to affect all 59 residents residing within the facility. Findings include: The facility's Annual Training Logs were reviewed and do not include evidence of the facility providing employees with QAPI training. On 10-01-24 at 10:27 AM V1 (Administrator) stated, We (the facility) do not do QAPI training with any of the staff. The facility does not have a policy on providing QAPI training. The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 9/29/24 and signed by V1, Administrator, documents 59 residents currently reside within the facility.