STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145708	A. Building B. Wing	10/23/2024

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Country Health	2304 C R 3000 N Gifford, IL 61847

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32853 Based on observation, interview and record review the facility failed to maintain resident's furniture in a clean manner for two of 24 residents (R74, R61) reviewed for clean, comfortable, homelike environment in the sample list of 44. Findings include: On 10/20/24 at 9:36 AM, there is a light tan fabric chair in the sitting area of R74 and R61's room. This chair has dark brown stains and light brown stains on at least half of the seat of the chair. On 10/23/24 at 3:56 PM, V13 Housekeeping Supervisor stated that they clean resident's chairs in the resident's rooms every once in awhile. V13 stated that she just had most of them cleaned by an outside company a few months ago. V13 stated she was not aware that the chair in R74 and R61's sitting area was stained. On 10/23/24 at 9:05 AM, R74 and R61's chair had been removed from the sitting area in their room. On 10/23/24 at 9:07 AM, V28 Housekeeper stated that she does not know what happened to their chair. On 10/23/24 at 9:27 AM, V13 confirmed R74 and R61's sitting room chair was stained with what she thought was coffee. V13 stated she had the chair removed to be cleaned and stated it will be returned to their room after it is cleaned. The facility's Fabric Furniture Cleaning policy dated 11/1/12 documents, This procedure will be used as required whenever furniture fabric becomes soiled. Remove chair from normal area and take to cleaning area. When the entire surface has been scrubbed and vacuumed, allow the chair to dry. It is recommended that the chair dry at least 24 hours before being put back into service.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on observation, interview and record review the facility failed to ensure a resident was free from restraint by not having a Physician's Order, a signed consent form for a restraint and to complete restraint reduction attempts. This affects one of one resident(R74) reviewed for restraints in the sample list of 44. Findings include: On 10/20/24 at 10:14 AM and 12:51 PM, R74 was in his wheelchair and had a lap cushion across the front of his lap. On 10/21/24 at 9:35 AM and 10:43 AM, R74 was in his wheelchair and had a lap cushion on his lap. R74's diagnosis list documents diagnoses including Unspecified Dementia, Unspecified Severity with Mood Disturbance, Muscle Weakness, Polymyalgia Rheumatica and Muscle Wasting and Atrophy. R74's Physician's Orders dated 10/21/24 do not document an order for the use of a soft lap cushion as a restraint nor as a therapeutic intervention. R74's Care Plan dated 10/7/24 documents R74 utilizes a lap cushion as a comfort device. This Care Plan documents R74 is able to place and remove lap buddy on his own and he is not always able to remove it upon verbal command due to cognitive function. R74's Minimum Data Set, dated dated dated [DATE] documents under the section Physical Restraints that R74 uses other devices in a chair or out of bed daily. R74's Physical Device/Psychoactive Medication Initial and Quarterly Evaluation dated 1/2/24 documents the device used as a lap cushion while in wheelchair and to release every two hours. R74's medical record does not contain a signed consent form for the use of a lap cushion restraint. On 10/21/24 at 10:16 AM, V1 Administrator stated that they do not have a consent for R74's lap cushion because he can remove it himself. On 10/21/24 at 10:44 AM V29 Certified Nursing Assistant asked R74 to remove his lap cushion and R74 stated I don't know if I can or not. R74 was feeling around the outside of the lap cushion with his fingernails and mumbling to himself. R74 was not able to remove the lap cushion when asked to do so. On 10//21/24 at 10:50 AM, V6 Care Plan Coordinator stated that she was not aware that he could not remove it when asked. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21/24 at 2:12 PM V2 Director of Nursing stated that they went and asked him to remove it and he just tugged and pulled at it and could not remove it. V2 stated they called the V3 Nurse Practitioner and requested an order for the lap cushion restraint. and called the Power of Attorney and obtained verbal consent for the lap cushion restraint. V2 stated that they also completed a new restraint assessment on this day. The facility's Nonemergency Use of Physical Restraints Policy/Procedure dated 3/1/11 documents, Physical restraints shall be used when required to treat a resident's medical symptoms or as a therapeutic intervention, as ordered by a physician. A physical Restraint will be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. The plan of care will contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. The Restraint Program Policy and Procedure with a revised date of 11/10/15 documents, If a restraint is necessary, physician and POA (Power of Attorney) are notified and a Restraint Consent is completed. Reduction attempts are documented. Some examples of interventions may include, but are not limited to: a. Therapy consultation b. Environmental modifications c. Positioning d. Activity programming e. Toileting programming

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to implement hearing devices and develop a care plan for hearing loss for one (R39) of one resident reviewed for communication in the sample list of 44. Findings include: R39's Minimum Data Set, dated dated dated [DATE] documents R39 has minimal difficulty hearing when using hearing aide/device and R39 has moderate cognitive impairment. R39's admission nursing assessment dated [DATE] documents R39 uses left and right hearing aides. R39's Care Plan dated 10/10/24 documents R39 is hard of hearing and only uses one hearing aide to the right ear. There is no documentation that R39's care plan addressed R39's hearing loss and hearing aide use prior to 10/10/24. R39's Concern Form dated 10/15/24 documents R39's family reported R39's left hearing aide has been missing since Sunday (10/13/24) and the right hearing aide was also missing. This form documents the right hearing aide was found on 1016/24, the facility will replace R39's hearing aide, and an appointment has been scheduled on 10/22/24. On 10/20/24 at 9:53 AM attempts were made to interview R39, but R39 had difficulty understanding/hearing questions. On 10/21/24 at 2:24 PM V5 administered R39's medications into R39's gastrostomy tube. V5 spoke to R39 during R39's cares, but R39 did not verbally respond. R39 was not wearing hearing aides. There was a sign on the wall near R39's sink that documented the hearing aide with red lettering goes in the right ear and the aide with blue lettering goes in the left ear. V5 was asked about R39's hearing aides. V5 instructed to check the hearing aide box on R39's sink, which only contained one hearing aide with red lettering. V5 applied R39's hearing aide. R39 was then able to answer questions, and appropriately responded when R39 was asked her name. R39 stated R39's left hearing aide has been missing for over a week and R39 was unsure if there had been any follow up. On 10/22/24 at 9:00 AM V8 Certified Nursing Assistant stated V8 has not been applying R39's hearing aide since she lost the other one last week. V8 stated R39 removes the hearing aides and V8 did not want R39 to lose her other hearing aide. On 10/22/24 at 11:50 AM V2 Director Of Nursing stated staff should be applying R39's hearing aide every day and especially when interacting with R39. V2 stated V2 thought R39 had two hearing aides for the same ear, but not one for each ear. V2 stated one of R39's hearing aides was broken and the family had it repaired. At 12:25 PM V2 stated the facility is going to replace R39's missing left hearing aide. V2 stated the hearing aide facility is not open, so staff will call tomorrow to schedule an appointment. At 12:43 PM V2 confirmed R39 did not have a care plan for R39's hearing loss and devices prior to 10/10/24 and should have.

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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** 42702 Based on observation, interview and record review the facility failed to provide targeted interventions to prevent skin breakdown, failed to assess, evaluate and document resident skin on a regular basis, and failed to obtain appropriate treatment orders for pressure ulcers for two (R20, R58) of five residents reviewed for pressure ulcers from a total sample list of 44 residents. These failures resulted in one resident (R20) developing a new, unstagable, deep tissue injury and a second resident (R58) developing seven, new stage two pressure wounds. Findings include: The facility Wound and Ulcer Policy and Procedure dated 3/28/24 documents that it is the policy of this facility to provide nursing standard for assessment, prevention, treatment and protocols to manage resident at any level of risk for skin breakdown and for wound management. A skin assessment will be documented daily for resident assessed to be at moderate or high risk for the development of pressure ulcers. When a resident is found to have a wound, the wound will be documented in the medical record, a treatment protocol will be initiated, the physician and family will be notified and orders implemented. 1.) The facility provided ulcer on-going summary report documents that R20 has an in-house acquired stage two wound on her sacrum and a bruise on her left wrist. R20's Minimum Data Set, dated dated dated [DATE] documents that R20 is cognitively intact. R20's facility skin assessment dated [DATE] documents R20 is as at moderate risk for skin breakdown. R20's October 2024 medical record does not document daily skin checks. On 10/20/24 at 10:57AM, R20 was laying in bed with her heels resting directly onto the mattress. No specialty mattress was observed. R20 stated, I have a wound on my backside and my foot hurts, pointing to her left foot. R20 was wearing non-slip footwear and said that she had no dressings on her feet. On 10/21/24 at 3:35PM, R20 was laying in bed with her heels pushing into the mattress. No specialty mattress was observed. R20 stated, My left foot hurts and it has for at least a week. I've told them that it hurts. On 10/21/24 at 3:38PM, V19 Certified Nursing Assistant (CNA) removed R20's left non-slip sock and exposed a quarter sized, black, deep tissue injury, unstagable. When V9 Licensed Practical Nurse (LPN) entered the room she stated that R20 only had a wound on her sacrum. V19 CNA showed V9 LPN, R20's left heel. R20 then stated that her left foot had been hurting for at least a week. V19 LPN said that she was unaware that R20 had a heel wound and had no idea how long it had been there. V19 confirmed that there was no treatment order for R20's heel wound because no one knew about it. On 10/21/24 at 3:55PM, V2 Director of Nursing stated that she was unaware of R20's wound on her left heel and that the staff should report any skin issues to the nurses who should then assess the issue, obtain orders from the physician, and that all residents with a stage two or greater should be on a specialized mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 9:20AM, V6 Wound Nurse said that the CNA's are supposed to fill out shower sheets every time that they give a shower and mark on the sheet if there are any changes to the skin. The nurses are then supposed to let the Infection Preventionist, the Physician and the Family know when there is a skin change and get orders for a treatment. None of these things happened. I usually do a skin sweep, but that didn't happen either. Based on its size and color I would guess it has been present for 3-4 weeks. I suggested when she broke her arm (July 2024) that she needed a (specialty) mattress, but it was not ordered. This unstageable wound will likely open and could cause an infection or other issues. 2.) The facility provided wound summary report dated 10/18/24 documents that R58 has wounds on her right upper inner thigh, left buttock and right buttock. All were documented as developed in house on 8/6/24. R58's Minimum Data Set, dated dated dated [DATE] documents R58 as cognitively intact. R58's facility skin assessment dated [DATE] documents R58 is a high risk for skin breakdown. R58's medical record does not contain daily wound assessments. R58's physician orders dated 8/31/24 document to cleanse the right buttock with soap and water, pat dry apply calcium alginate to wound bed and cover with silicone border dressing daily and as needed and to cleanse the left buttocks with soap and water, pat dry apply calcium alginate to wound bed and cover with silicone border dressing daily and as needed. On 10/21/24 at 11:46AM, V6 Wound Nurse removed R58's brief and no dressings were on R58's seven open areas on her buttocks and inner thighs. V6 stated that there are new wounds on R58's buttocks and thighs and that when a new wound is found, an assessment should be completed, the wound nurse and physician notified, treatments orders obtained and notifications made and that none of these things were done. R58 was sitting in a wet brief and stated that she was last changed at 8:00AM that morning. On 10/21/24 at 3:55PM, V2 Director of Nursing stated that she was unaware of R58's new wounds on her buttocks and thighs and that the staff should report any skin issues to the nurses who should then assess the issue, obtain orders from the physician, and that all residents with a stage two or greater should be on a specialized mattress. On 10/23/24 at 11:45AM, V6 Wound Nurse stated that R58 should have had a dressing on her wounds or a refusal if the resident would not allow the dressings to be completed, neither of which was done. On 10/23/24 at 11:20AM, V30 Nurse Practitioner stated that failing to do skin checks, failing to implement interventions such as alternating air mattresses or repositioning a resident every two hours, and failing to find and address wounds sooner could certainly cause harm to the resident and in the case of R20, did cause the wound to become an unstagable, deep tissue wound.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Failures at this level require more than one deficient practice statement. A. Based on interview and record review the facility failed to monitor a resident (R22), with Dysphagia (difficulty swallowing), after administering oral medication. This failure affects one resident (R22) of 7 residents reviewed for medication administration in the sample list of 44. R22 experienced a choking episode when staff had left R22's room after oral medication administration. Upon staff hearing R22's coughing, staff returned to R22's room and performed the Heimlich Maneuver to expel the tablet from R22. B. Based on interview and record review the facility failed to thoroughly investigate falls and document falls in the resident's medical record for one (R17) of nine residents reviewed for accidents in the sample list of 44. Findings include: a.) R22's Facility Census documents R22 was admitted to the facility on [DATE] and has the following medical diagnoses; Muscle Wasting and Atrophy, Muscle Weakness, Anxiety Disorders, Dysphagia Oropharyngeal Phase and Forms of Stomatitis. R22's Minimum Data Set (MDS) dated [DATE] documents R22's Brief Interview for Mental Status (BIMS) score 13, cognitively intact. R22's Physicians Order Sheet dated 10/3/24 documents Simethicone Tablet Chewable 80 milligrams, Give 1 tablet by mouth every 8 hours as needed for lower GI gas and bloating. R22's Care plan documents R22 has impaired Nutrition; Interventions-Assist with meals (Feed/Set-up) as needed, Encourage R22 to eat slowly, using pursed lip breathing between bites, Ensure R22 is in proper position for eating. R22's Health Status note dated 10/3/24 at 9:05 am documents administered as needed gas relief as ordered, educated R22 on chewing tablet very well, walked into hall by residents room, V8 Certified Nursing Assistant (CNA) walked past and saw R22 coughing, walked out room, V7 Licensed Practical Nurse heard R22 gasp and grab R22 throat, V7 yelled out for help, V8 and V11 Certified Nursing Assistant helped this V7 remove R22 from bed, R22 lips blue, still grabbing at R22's throat, one maneuver of Heimlich completed, R22 was able to clear R22's airway successfully. vital within normal limits, Medical Doctor aware Power of Attorney aware. Respiratory assessments ordered twice a day for 72 hours changed by mouth gas x to Mylanta liquid to prevent further choking hazards. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facilities Medication Administration Policy dated 1/11/10 documents: Objective; To provide accuracy during medication pass to assure quality care for residents. Policy: It is the policy of this facility to accurately administer medication following physician's orders. Procedure: 9. Administer meds with adequate fluids. Dilute medications, if needed, in juice or water according to pharmacy guidelines and the resident's restrictions. 13. Make sure the resident takes the medication. Generally-Do not leave meds at bedside. On 10/21/24 at 11:38am V8 Certified Nursing Assistant said, on 10/3/24 at 9:00am V8 and V11 Certified Nursing Assistant were pushing residents back to South Hall from breakfast. V8 said, V7 Agency Licensed Practical Nurse (LPN) was outside of R22's room by the medication cart. V8 said, walking back from South Hall, V8 heard R22 coughing. V8 said, V8 observed V7 go into R22's room and then heard V7 call out for help. V8 said, V8 and V11 entered R22's room and R22 was holding R22's throat. V8 said, V3 and V11 assisted R22 to the edge of the bed, and V8 got R22 out of bed and administered the Heimlich maneuver and R22 spit something out of R22's mouth and stopped choking. V8 said, V8 did not see what R22 spit out, only that R22 informed them that it's out. V8 said, V11 informed V8 that it was a pill that R22 spit out. On 10/21/24 at 1:18pm R22 said, a couple of weeks ago while R22 was in bed just after breakfast, R22 had a stomach ache a V7 Agency Licensed Practical Nurse gave me medication. R22 stated that after V7 gave R22 the medication, V7 left the room and R22 began to choke on the medication, and staff came back in and help R22 spit it out. On 10/21/24 at 1:38pm V11 Certified Nursing Assistant (CNA) said, on 10/3/24 R22 was in V11's group. V11 said, after breakfast V11 assisted R22 back to bed and was in a sitting up position. V8 said, at 9:00am V11 and V8 Certified Nursing Assistant were pushing residents back to the South Hall. V11 said, V11 observed V7 Licensed Practical Nurse outside R22's room. V11 said, after bringing the residents back to South Hall and walking back to the dining room, V11 heard V7 call out for help from R22's room. V11 said, V11 and V8 went into the room and observed R22 holding R22's throat. V11 said, V11, V3 and V8 got R22 up to the edge of the bed, and V8 administered the Heimlich Maneuver and R22 spit out a pill, and R22 stated, it came out'. On 10/22/24 at 9:34am V2 Director of Nursing said, V2 conducted the investigation regarding R22's choking incident. V2 said, on 10/3/24 V7 Agency Licensed Practical Nurse (LPN) administered R22 a chewable tablet per physicians orders. V2 said, V7 left the room prior to R22 thoroughly chewing and swallowing the tablet and began to choke. V2 said, V7 and V8 heard R22 coughing, and then V7 heard R22 gasping for air. V2 said, V7 entered the room and observed R22 grabbing R22's throat and V7 called out for help. V2 said, V7, V8 and V11 Certified Nursing Assistant got R22 to the edge of the bed and V8 administered the Heimlich maneuver and R22 was able to clear the medication. V2 said, V7 should have never exited the room until R22 chewed and swallowed the medication to ensure there were no issues with R22 swallowing the medication. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 at 8:39am V7 Agency Licensed Practical Nurse said, on 10/3/24 at 9:00am V7 administered R22's medication and R22 informed V7 that R22's stomach was upset. V7 said, V7 went and got R22 Simethicone for R22's upset stomach and put it in R22's mouth and told R22 to chew it. V7 said, V7 turned and walked out of the room and V8 Certified Nursing Assistant was walking by and R22 began to cough, V7 turned around and went back into R22's room and R22 was gasping for air and holding R22's throat. V7 said, R22's lips were blue, and V7 yelled for help, and V8 and V11 Certified Nursing Assistant came into R22's room. V7 said, V8 and V11 assisted in getting R22 up and V8 administered one stomach thrust and R22 spit the pill/medication out and was able to breath. V7 acknowledge that V7 should have stood at bedside and ensured that R22 had chewed and swallowed the medication, before turning and leaving the room. 40385 b.) On 10/20/24 at 12:17 PM R17 stated R17 had a prior fall in R17's bathroom and broke R17's back. R17's Minimum Data Set (MDS) dated [DATE] documents R17 is cognitively intact, R17 requires partial/moderate staff assistance for toileting hygiene and sitting to standing, and R17 requires substantial/maximum staff assistance for toilet transfers, chair/bed transfers, and walking. This MDS documents R17 is occasionally incontinent of urine and always incontinent of bowel R17's Nursing Note dated 6:42 PM documents R17 was observed lying on the floor on his right side, there was urine on the floor, and the bedpan was on the floor behind R17. R17 reported R17 was reaching for the bedpan that was on the floor and rolled out of bed. R17's Nursing Note dated 9/27/2024 at 8:40 AM documents R17 has continued to have hallucinations and multiple falls during the night which and was sent to the emergency room for evaluation. There is no documentation in R17's nursing notes, besides this note, regarding R17's falls on 9/26/24. R17's 8/30/24 fall investigation documents the root cause of the fall was R17 attempted to reach for an item on the floor and slid out of bed, and the post fall intervention was education to call for assistance and staff educated to leave items within reach. R17's 9/22/24 fall investigation documents R17 fell on [DATE] at 10:50 AM in R17's room while self-transferring in R17's room and sustained a nondisplaced fracture of the medial epicondyle (left arm) and a mild acute T10 (spine) superior endplate compression fracture post fall. R17's 9/26/24 3:20 PM fall investigation documents R17 was found on the floor of his room at 3:20 PM with his head resting on the foot of R17's bed. R17 pointed to his wheelchair and stated, I need to get all that stuff of mine situated for work and R17 thought he was working in a post office. This investigation only includes one staff statement dated 9/26/24 that documents R17 had been hallucinating all day and R17's bed was in low position when R17 was found on the floor. R17's 9/26/24 10:00 PM fall documents nurse walked past R17's room and found R17 lying on the floor parallel to the bed, bed was in low position and fall mats were in place. There is no documentation that staff were interviewed to determine when R17 was last toileted or checked on prior, or what R17 was doing when R17 was last observed prior to R17's falls on 8/30/24 and 9/26/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 12:25 PM V2 Director of Nursing stated V2 talks with staff regarding falls and documents staff statements, but V2 was unable to locate this documentation for R17's 8/30/24 and 9/26/24 falls. V2 confirmed this information would include interventions in place at the time of the fall, last time toileted or checked on prior to the fall, and activity when last observed. V2 stated resident falls should be documented in the resident's nursing notes, and the nurse has to check a box so that the note pulls from the incident report into the nursing notes. V2 confirmed this was not done for R17's 9/26/24 falls. The facility's Fall Assessment and Management policy dated June 2024 documents fall interventions will be based on fall risk assessments and circumstances regarding falls and risk for injury. This policy documents the nurse will assess the resident following a fall including a description of how the resident was observed, information regarding the fall, environmental factors, first aid treatment, physician and responsible party notification, and initiating an incident report. This policy documents to document post fall assessments for 72 hours after the incident.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 40385 Based on observation, interview, and record review the facility failed to check and record gastric residual volume to verify gastrostomy tube placement, and administer and record water flushes and enteral feeding amounts for one (R39) of one resident reviewed for gastrostomy tube in the sample of 44. Findings include: On 10/20/24 at 8:58 AM R39 was lying in bed asleep with Osmolite 1.5 Cal (calorie) infusing at 60 milliliters (ml) per hour via gastrostomy tube (g-tube). The mechanical pump also contained a bag of water and was set to infuse 200 ml of water every four hours. On 10/21/24 at 10:27 AM V5 Registered Nurse stated R39's feeding pump is set to administer a certain amount of feeding, and it stops infusing and beeps when it has reached the set amount. V5 stated if the pump is shut off early it is documented, but we don't record the total volume infused. On 10/21/24 at 2:24 PM V5 checked R39's g-tube placement by inserting 20 ml of air via syringe and listening with a stethoscope. V5 dissolved each medication (which were already crushed prior to observation) that was in three separate medication cups, in 5 ml of water and administered these medications into R39's g-tube. V5 did not check gastric residual volume prior to medication administration. V5 used a total of 50 ml of water to flush R39's g-tube before/after medication administration and between each separate medication administered, which was confirmed with V5. V5 stated V5 also used a total of 25 ml to dissolve R39's medications. V5 stated V5 flushes R39's g-tube with water when disconnecting R39's feeding. V5 stated gastric residual should be checked before administering R39's feeding, but V5 does not check residual prior to medication administration since V5 uses the air rush technique. V5 stated there is another resident whose residual checks are recorded on the Medication Administration Record and orders to hold feedings based on residual parameters, but V5 was unsure if this is done for R39. R39's Care Plan dated 1/11/24 documents R39 requires g-tube feeding and includes an intervention to check tube placement and gastric contents/residual volume per the facility's protocol, and record. R39's October 2024 Medication and Treatment Administration Records document to administer Osmolite 1.5 Cal at 60 ml per hour for a daily total of 750 ml and 200 ml water flushes every four hours, and does not document total feeding and water flush amounts administered each day. There are no orders prior to 10/22/24 to routinely check R39's gastric residual, gastric residual volumes, parameters to hold feeding based on gastric residual volumes, and water flushes needed for medication administration. R39's Nutrition Note dated 7/27/2024 at 12:44 PM recorded by V26 Registered Dietitian documents R39's weight as stable, R39 receives Osmolite 1.5 at 60 ml per hour for a daily total of 750 ml and 200 ml water flushes every four hours. This note documents a recommendation to give 100 ml of free water flushes while Osmolite infuses and adjust fluids based on physician recommendations. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 10:00 AM V2 Director of Nursing stated the total g-tube feeding volumes are not recorded since the volume is stated in the order. V2 stated the nurses should be checking g-tube placement by checking gastric residual volume, not air rush, prior to feeding administration and medication administration. V2 confirmed this should be documented on the Medication/Treatment Administration Records. On 10/22/24 at 12:25 PM V2 stated there should be water flush orders based on the dietitian's recommendations and V2 expects the nurses to follow the facility's policy for water flushes needed during g-tube medication administration. V2 confirmed the only water flush ordered for R39 is the 200 ml every four hours while R39's feeding infuses. The facility's Medication Administration Via A Feeding Tube policy dated 5/1/05 documents to check the tube for proper placement prior to medication administration, and to flush the feeding tube with 30 ml of water before and after medication administration, dilute medications separately in water, and flush the tube with 5 ml of water between each medication. This policy documents to record the water flush amount infused. The facility's Enteral/Tube Feeding Policy dated 2/26/15 documents the physician will prescribe the water flush amount and frequency which will be noted on the monthly physician's order sheet. This policy documents to document tube placement checks prior to feeding, medication, and water flush administrations. This policy documents to accurately record the amount of feeding and water flushes for each administration. This policy documents to use a syringe to withdraw gastric contents and evaluate the color of the contents, and a residual of 150 ml indicates the need for the feeding to be held unless otherwise ordered by the physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40385 Based on observation, interview, and record review the facility failed to label, store, and change oxygen and nebulizer tubing for three (R17, R39, R84) of three residents reviewed for respiratory care in the sample of 44. Findings include: 1.) On 10/20/24 at 9:55 AM R17 was asleep in his room. The undated and uncovered oxygen tubing was on top of R17's bed and connected to the oxygen concentrator. R17's Physician Order dated 9/30/24 documents titrate oxygen via nasal cannula to keep saturation above 90 %. There is no order to routinely change R17's oxygen tubing and there is no documentation in R17's medical record that R17's oxygen tubing is routinely changed. R17's ongoing oxygen saturation log documents R17 used oxygen on 13 days between 9/23/24 and 10/21/24. 2.) On 10/20/24 at 9:00 AM R39's undated and uncovered nebulizer mask and tubing was on R39's night stand and connected to a nebulizer machine which had splatters of a brown substance. R39's October 2024 Medication Administration Record (MAR) documents R39 receives Aformoterol Tartrate 15 micrograms per 2 milliliters (ml) and Budesonide 0.5 milligrams per 2 ml nebulizer inhalation twice daily, and to change nebulizer tubing and mask weekly on Wednesdays. This MAR does not document the nebulizer tubing/mask was changed on 10/16/24 as scheduled. 3.) On 10/20/24 at 9:03 AM R84 was in bed wearing oxygen via nasal cannula at 3 liters per minute. R84's oxygen tubing was dated 10/10/24. R84 stated R84 was unsure how often the oxygen tubing is changed. R84's Treatment Administration Record (TAR) documents to change oxygen tubing weekly on Thursdays and this is signed as being completed on 10/17/24. On 10/20/24 at 2:28 PM-2:40 PM V5 Registered Nurse stated oxygen and nebulizer mask/tubing should be labeled with dates and changed weekly by night shift staff. V5 stated after nebulizer use, the tubing and mask should be cleaned and stored in a plastic bag when not in use. V5 stated oxygen tubing should be stored in a plastic bag when not in use. V5 confirmed R39's nebulizer mask and tubing was unlabeled and uncovered, R17's oxygen tubing was undated and uncovered, and R84's oxygen tubing was dated 10/10/24. The facility's Oxygen Administration policy dated 1/15/24 documents to change nasal cannulas, tubing, and humidifiers weekly and label with the date, and store oxygen cannula or mask in a plastic bag when not in use. The facility's Aerosol Treatments dated August 2009 documents to change nebulizer equipment weekly and as needed, and disassemble the hand held unit, shake dry, and place in a plastic bag.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 40385 Based on observation, interview, and record review the facility failed to administer medications timely and according to physician's orders and manufacturer's instructions for four (R17, R61, R42, R4) of seven residents reviewed for medication administration in the sample list of 44. These failures resulted in eight medication errors out of 25 opportunities, a 32% medication error rate. Findings include: 1.) On 10/21/24 at 10:36 AM V5 Registered Nurse (RN) stated V5 is behind on the morning medication pass, and there are still morning medications that need to be given. On 10/21/24 at 10:59 AM V5 stated V5 still has scheduled morning medications that need to be administered. On 10/21/24 at 10:51 AM V5 administered R17's medications which included Lantus insulin 15 units, Macrobid (antibiotic) 100 milligrams (mg), Tylenol 650 mg, and Metoprolol Tartrate (cardiac medication) 25 mg. V5 did not prime the Lantus insulin pen prior to administration. R17's October 2024 Medication Administration Record (MAR) documents to administer Lantus 18 units daily at 8:00 AM starting on 10/9/24, Macrobid 100 mg by mouth twice daily at 8:00 AM and 4:00 PM from 10/20/24-10/23/24, Metoprolol Tartrate 25 mg by mouth twice daily at 8:00 AM and 4:00 PM, and Tylenol 650 mg three times daily at 8:00 AM, 12:00 PM and 4:00 PM. This MAR documents R17's noon dose of Tylenol was not administered on 10/20/24 and 10/21/24. R17's Electronic Medication Administration Detail Reports dated 10/22/24 document on 10/21/24 R17's scheduled 4:00 PM doses of Metoprolol Tartrate and Macrobid were given at 5:20 PM. There is no documentation in R17's nursing notes that R17's physician was notified of the late administration and missed doses of R17's medications. On 10/22/24 at 10:48 AM V2 Director of Nursing stated medication administration has an hour window before and after the scheduled administration time. V2 stated if the medication is given late, the nurse should notify the physician and document in the nursing notes. The Lantus manufacturer's instructions dated August 2022 documents to take this medication at the same time every day and to prime (remove air from the needle) the pen prior to each administration. 2.) On 10/21/24 at 10:59 AM V5 stated there were scheduled morning medications that still needed to be administered. On 10/21/24 at 11:36 AM V5 obtained R61's blood glucose result of 108. V5 administered R61's medications including Humulin N insulin 14 units and Persantine (prevents blood clots) 25 mg. V5 did not prime the insulin pen prior to administration. R61's October 2024 MAR documents to administer Humulin N 14 units twice daily at 8:00 AM and 12 units at 8:00 PM and Persantine 15 mg by mouth twice daily at 8:00 AM and 4:00 PM. R61's Electronic Medication Administration Detail Report dated 10/22/24 documents on 10/21/24 R61's scheduled evening dose of Persantine was given at 5:51 PM. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There is no documentation in R61's nursing notes that R61's physician was notified that R61's medications were administered late on 10/21/24. On 10/21/24 at 12:42 PM V5 confirmed V5 did not prime insulin pens prior to administration. V5 stated V5 was unaware that insulin pens needed to be primed prior before each administration. On 10/22/24 at 11:15 AM V2 reviewed R61's MAR and confirmed R61's missed dose of Tylenol on 10/21/24. The Humulin N Kwikpen Instructions for Use dated June 2022 to use 2 units to prime the insulin pen prior to each administration. 3.) On 10/21/24 at 11:30 AM V24 Licensed Practical Nurse obtained R42's blood glucose result of 202 and administered Admelog insulin 18 units. R42 was in bed and there was no food at R42's bedside. On 10/21/24 at 12:07 PM V8 Certified Nursing Assistant delivered R42's meal tray to R42's room and began feeding R42. R42's October 2024 MAR documents R42 receives Admelog 14 units scheduled three times daily and additional units based on sliding scale three times daily. The Admelog Instructions for Use dated August 2023 documents to administer this medication within 15 minutes prior to a meal or immediately after a meal. 4.) On 10/22/24 at 10:34 AM V25 RN administered Brimonidine Tartrate 0.2% on drop into R4's right eye. R4's October 2024 MAR documents to administer Brimonidine Tartrate 0.2% solution one drop to right eye twice daily at 8:00 AM and 5:00 PM. On 10/22/24 at 10:42 AM V25 confirmed R4's Brimonidine administration was the dose scheduled at 8:00 AM. V25 stated V25 was behind in her medication pass and this is a heavy hall. The facility's Medication Administration dated 1/11/10 documents to notify the physician of medication errors and missed doses of medications.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 42702 Based on interview and record review the facility failed to develop, implement, measure, act on or analyze a performance improvement program project in the last twelve months. This failure has the potential to affect all 85 residents who reside in the facility. Findings include: The facility provided long term care facility application for Medicare and Medicaid dated 10/20/24 documents 85 residents reside in the facility. The facility provided Quality Assessment Performance Improvement Policy dated 12/8/23 documents that the facility quality program will enable a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in the facility while involving all caregivers in practical and creative problem solving. Additionally, the policy documents that a systematic approach to determine underlying causes of problems, and development of corrective actions that will be designed to effect changes at the facility level to prevent quality of care, quality of life or safety problems and to facilitate and monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. On 10/22/24 at 11:00AM, V1 Administrator stated that the facility did not have a performance improvement project in place for the last four quarters that included the front line staff or with measures to monitor effectiveness. V1 said that she was still learning and that performance improvement projects would become a part of the quality process for the next year.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42702 Based on interview and record review the facility failed to store, handle, and launder linens that were potentially exposed to scabies. This failure has the potential to affect all 85 residents who reside in the facility. The facility also failed to follow enhanced barrier precautions for two (R4, R39) of six residents reviewed for enhanced barrier precautions from a total sample list of 44 residents. Findings include: 1.) The facility provided undated Scabies/Crusted Norwegian Scabies infection control policy documents that scabies are infectious diseases of the skin. Transmission occurs from brief skin to skin contact with items such as bedding, clothing, furniture, rugs carpeting, floors and other items that can become contaminated with skin scale and crusts shed by a person with Scabies. To avoid reinfestation, bedding and clothing used by residents with scabies would be collected and transported in plastic bag an emptied directly into the washer to avoid contaminating other surfaces and items. Machine wash and dry using the hot water and high heat cycle temps in excess of 122 degrees Fahrenheit for 10 minutes. Laundry staff should use appropriate person protective equipment when handling contaminated items. The facility provided Scabies/Crusted Norwegian Scabies surveillance log dated 9/19/24 documents eight residents (R20, R75, R10, R45, R63, R4, R57 and R2) with a positive case, a suspected case or was a roommate of one of the two. R20 was diagnosed with a positive case on 9/19/24. R10's rash began on 9/19/24. R63's rash began on 9/25/24 and R57's rash began on 9/30/24. No one was tested after R20 was diagnosed positive. All with symptoms and their roommates were treated for Scabies. All eight residents use items from the common laundry. On 10/21/24 at 2:18PM, V4 Infection Preventionist (IP) stated that when R20 came down with scabies in September of 2024, this was the second time that she had done so in two years. V4 IP stated that R20's family member brings clothing and other soft items for R20 and they believe based on investigation that R20's family member is bringing them into the facility. V4 IP stated that because of this, the facility had implemented a process where when V R20's family member brings in any soft items, the items are bagged at the front desk and then taken to laundry where V13 Housekeeping/Laundry Supervisor knows to put them in the isolation laundry, so that they don't go in with other people's clothing. On 10/21/24 at 3:15PM, V13 Housekeeping/Laundry Supervisor stated that she is aware that R20's family member brings items in to the facility for R20, but that she was not aware that R20's items from home are to be bagged, kept separate or washed in the isolation cycle. (R20's) things just go in to the sorting piles and then laundry with everyone else's things. None of my staff know about this. On 10/22/24 at 8:30AM, V4 IP stated that mixing the clothes could cause further infestation and infection. The facility provided Long Term Care Facility Application for Medicare and Medicaid dated 10/20/24 documents 85 residents reside in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	40385 2.) R4's Care Plan dated 1/2/24 documents R4 is on Enhanced Barrier Precautions (EBP) due to wounds and urinary catheter, and includes an intervention to follow the guidelines on the signage posted at R4's doorway. On 10/21/24 at 1:48 PM - 2:03 PM there was a sign posted on the outside of R4's doorway that indicated R4 was on EBP and to wear a gown and gloves for high contact resident care. There were isolation gowns and gloves in a container outside of R4's room. R4 was lying in bed. V16 and V17 Certified Nursing Assistants turned R4 while V5 Registered Nurse administered R4's pressure ulcer treatments. V16 and V17 dressed R4 and transferred R4 from the bed into her wheelchair with a full mechanical lift. V16, V17, and V5 were not wearing gowns during R4's cares. On 10/21/24 at 2:20 PM V16 and V17 confirmed gowns were not worn during R4's observed wound care, dressing and transfers V16 and V17 stated they are aware of EBP and confirmed a gown should have been worn during R4's cares. On 10/21/24 at 3:34 PM V4 Infection Preventionist stated V4 was aware that staff did not follow EBP during R4's cares. V4 confirmed gowns should be worn during high contact care as part of EBP. 3.) On 10/20/24 at 8:58 AM R39 was in bed with Osmolite 1.5 infusing at 60 milliliters per hour via enteral feeding tube. There was an EBP sign posted on R39's doorway and there was a cart containing personal protective equipment outside R39's room. On 10/21/24 at 2:24 PM V5 administered R39's medications into R39's gastrostomy tube. V5 was only wearing gloves and was not wearing a gown during R39's medication administration. R39's Care Plan dated 1/11/24 documents R39 is on EBP due to gastrostomy tube and includes an intervention to follow the barrier precaution guidelines on the signage that is posted at R39's doorway. The facility's Enhanced Barrier Precautions Protocol dated 4/8/24 documents refers to using gown and gloves during high contact resident care activities that provide the opportunity to transfer Multi-Drug Resistant Organisms to staff's hands and clothing. This policy documents dressing, bathing/showering, transferring, hygiene assistance, changing linens, incontinence cares/toileting assistance, feeding tube care, urinary catheter care, and wound care are considered high contact resident care activities that require gown and gloves to be worn.