STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145720	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clara's Rehab & Senior Care	1450 Castle Manor Drive Lincoln, IL 62656

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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 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** 49187 Based on observation, interview, and record review, the facility failed to develop and implement specific pressure relieving interventions to prevent pressure ulcer development and worsening, conduct a pressure ulcer risk assessment once a week for four weeks after admission as directed by the facility's Wound and Ulcer Policy for one of four residents (R9) reviewed for facility acquired pressure ulcers in the sample of 33. These failures resulted in R9 developing a painful pressure ulcer to the right heel that deteriorated from a blister to a stage four pressure ulcer to R9's right heel, that required surgical debridement. Findings include: The Wound and Ulcer Policy and Procedure dated 3/28/24 documents It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. Procedure: All residents will be assessed to determine the degree of risk of developing a pressure ulcer using the Braden Scale- Ulcer Risk Assessment. The resident will be assessed upon admission, once a week for four weeks, quarterly, and any significant change in condition after admission. A skin assessment (skin check) will be documented at admission, once a week for four weeks, quarterly, and any significant change in condition after admission. A skin assessment (skin check) will be documented on the ETAR (electronic treatment administration record). A skin assessment (skin check) will be documented daily for residents assessed by the Braden Scale - Ulcer Risk Assessment to be moderate or high risk for development of pressure ulcer(s). Moderate Risk Protocol: Daily skin check-completed by direct care staff. The Skin Observation Report may be used to communicate skin observation(s) or changes to the nurse. Mattresses with documented pressure reduced/relieving properties may be placed on the resident's bed. Equipment, Prevention, and Treatment Resources: Equipment-Positioning aids; special mattress and/or chair cushion (low air loss, alternating pressure, etc. (example) with pressure reducing/relieving properties. Prevention: The following prevention measures may be initiated to address pressure, moisture, friction, and/or shearing. The facility may also implement additional measures. Pressure: Support heels on pillow or in splints. R9's Admission Record, dated 2/4/25, documents R9 was admitted to the facility on [DATE]. This same record documents R9 has the following, but not limited to diagnoses: Type Two Diabetes Mellitus, Nontraumatic Intracerebral Hemorrhage in Hemisphere, Personal History of Other Venous Thrombosis and Embolism, Weakness, Hypertension, Unsteadiness of Feet, Muscle Wasting and Atrophy. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R9's Admission MDS (Minimum Data Set) Assessment, dated 8/20/24, documents R9 was moderately cognitively impaired. This same assessment documents R9 had no pressure ulcers on admission, R9 was at risk for developing pressure ulcers, R9 required substantial to maximal assistance with transfers, lower body dressing, and taking off shoes, and required partial to moderate assistance with rolling left to right or right to left. R9's Admission Progress Note, dated 8/13/24, documents Skin: Skin warm and dry, skin color WNL (within normal limits) and turgor is normal. Skin Issue: New. Issue type: Lesion. Location: Right ear. New. Issue type: Lesion. Location: Mandible (lower jaw). Skin note: Has one area of skin cancer on left side of face and right ear. No other skin issues were documented. R9's Braden Scale for Predicting Pressure Sore Risk Assessment, dated 8/28/24, documents 2. Sensory Perception (ability to respond meaningfully to pressure-related discomfort)- slightly limited: responds to verbal commands but cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits ability to feel pain or discomfit in one or two extremities. 5. Mobility- very limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. 7. Friction and Shear: problem- requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent reposition and maximum assistance. Spasticity, contractures, or agitation leads to constant friction. R9's Assessment Outcomes for Braden Scale, dated 2/5/25, documents 8/14/24- Braden Score 15: At risk. 8/22/24- Braden Score 13: Moderate risk. 8/28/24- Braden Score 15: At risk. R9's Medical Record has no evidence of a Braden Scale for Predicting Pressure Sore Risk Assessment being completed the fourth week after R9's admission. R9's Plan of Care, dated 8/15/24, documents R9 is at risk for skin impairment/Deep Tissue Injury related to fragile aged skin, need for assistance with mobility and transfers, and use of an indwelling catheter. Interventions dated 8/15/24 document: Administer medications as ordered. Monitor/document side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Inform R9/R9's family/caregivers of any new area of skin breakdown. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Obtain and monitor lab/diagnostic work as ordered. Report results to MD (Medical Doctor) to follow up as indicated. Provide incontinence care after each episode according to facility protocol. R9 requires the bed as flat as possible to reduce shear. R9 requires the use of pressure relieving mattress for his bed to adequately relieve pressure. There are no individualized specific interventions documented to prevent pressure ulcers from developing to R9's heels after a risk for skin breakdown was noted from the Braden Scale on 8/14/24, 8/22/24, and 8/28/24. R9's Ulcer/Wound Documentation, dated 9/12/24, documents an in-house wound/ulcer was identified on 9/12/24. This same form documents Site: right heel. Type: Blister: Length 8.5cm (centimeters). Width 7cm. Peri-wound skin: Clear fluid-filled blister with 2.5cm x 2.5cm purple area in center. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R9's Wound Evaluation and Management Summary, dated 11/4/24 and signed by V17/Wound Physician, documents Stage three Pressure Wound of the Right Heel Full Thickness. Etiology: Pressure. Wound Size 7cm x 6cm x 0.1cm. Exudate: Light Serous (yellowish/clear fluid). Slough (non-viable tissue) 5% (percent). Wound Progress: Not at goal. Dressing Treatment Plan: Betadine apply once daily for 16 days. To eschar only, Leptospermum honey apply once daily for 16 days. Alginate with silver apply once daily for 16 days. Secondary Dressing: Abdominal pad once daily for 16 days. Gauze roll (stretch) 4 inches apply once daily for 16 days. Recommendations: Off-load wound; float heels in bed; no shoe on right foot for now; elevate leg(s) for one hour after meals three times a day; Cleanse with wound cleanser at time of dressing change; (pressure relieving boot) to use when out of bed. R9's Wound Evaluation and Management Summary, dated 1/14/25 and signed by V17/Wound Physician, documents Stage four Pressure Wound of the Right Heel Full Thickness. Etiology: Pressure. Wound Size: 5cm x 6cm x 0.2cm. Exudate: Moderate Sero-Sanguinous (pinkish-red fluid). Wound Progress: Not at goal. Primary Dressing: Santyl applies once daily for two days. Alginate Calcium is applied once daily for 23 days. Secondary Dressing(s): Abdominal pad applied once daily for 16 days. Gauze roll 4.5 inches apply once daily for 23 days. Recommendations: Off-load wound; float heels in bed; no shoe on the right foot for now; elevate leg(s) for one hour after meals three times a day; Cleanse with wound cleanser at time of dressing change; (pressure relieving boot) to use when out of bed; No (pressure relieving boot) while in bed. R9's Wound Evaluation and Management Summary, dated 2/4/25 and signed by V17/Wound Physician, documents Stage 4 Pressure Wound of the Right Heel Full Thickness. Etiology: Pressure. Wound Size: 6cm x 5.8cm x 0.2cm. Exudate: Moderate (pinkish-red fluid). Today Wound bed is mostly subcutaneous sloughy/necrotic tissue, although some granulation is visible. There is some new peri area erythema-marked for continued assessments. Area is not warm or tender suspect it may be from wound vac adhesive. Edges are macerated (softened). Necrosis and slough remain very adherent. Will take a break from vac and return to Santyl and alginate to assist with breaking down necrosis/slough. Wound bleeds easily with debridement. Cauterized to stop bleeding. Recommendations: Off-Load Wound: Please float heels on two pillows while in bed; Float heels in bed; Elevate Leg(s): For one hour after meals, three times a day; Cleanse with wound cleanser at time of dressing change; (pressure relieving boot) to use when out of bed; No (pressure relieving boot) while in bed. The wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade pick-ups were used to surgically excise 6.96 cm^2 of devitalized tissue and necrotic muscle level tissues along with slough and biofilm were removed at a depth of 0.21 cm and healthy bleeding tissue was observed. On 2/2/25 from 9:45 AM to 9:58 AM R9 was lying in bed in his room. R9's bilateral heels were lying directly on the mattress without offloading of pressure. On 2/2/25 from 1:45 PM to 2:00 PM R9 was sitting in his wheelchair in the dining room. Residents right heel was sitting directly on the floor with a sock on. No (pressure relieving boot) was observed to R9's right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 02/03/25 from 9:00 AM to 9:15 AM R9 was sitting in his wheelchair in his room. R9's right heel was sitting directly on the floor with a sock on. No (pressure relieving boot) was observed to R9's right heel. R9 stated I have a wound on my right heel. It is very painful. I kept telling staff my foot was hurting but they just thought it was the way my shoes were fitting. No one looked at my foot for a while when I was complaining about it. Finally, someone looked at it and said I had a spot on my right heel. The staff have not been putting my (pressure relieving boot) on my right heel or putting my feet on pillows while I am in bed. They were doing it sometimes but haven't been for a while. I just figured they didn't have to do it anymore. On 2/4/25 at 11:55 AM V5/Registered Nurse/Infection Preventionist stated, I monitor the wounds in the facility for the most part. (R9) has not had his (pressure relieving boot) on the past two days at least because no one could find it. We (the facility) just found it last night and put it on (R9) today. (R9) should not have any pressure to his right heel and should be always wearing the boot while out of bed to prevent (R9's) right heel wound from worsening. V5 also verified R9's left and right heels should be offloaded while in bed. On 2/4/25 at 2:40 PM, V17/Wound Physician stated, When I consulted with my company, they stated (R9's) right heel should be classified as pressure. V17 stated, I changed (R9's) wound documentation to classify (R9's) right heel area to pressure. If (R9) is not wearing his (pressure relieving boot) it can cause the wound to worsen. (R9) should always have his heels floated while in bed and should never wear his (pressure relieving boot) while in bed. On 2/4/25 at 2:45 PM V5/Registered Nurse/Infection Preventionist, V17/Wound Physician, and V18/CNA (Certified Nursing Assistant) were preparing treatment for R9's right heel. R9 was lying in bed with a (pressure relieving boot) on R9's right heel. V17 verified R9 had his (pressure relieving boot) on his right foot while in bed. V17 stated, I have told the facility (R9) is to not have his (pressure relieving boot) on while in bed. (R9) needs to have his left and right heel offloaded on a pillow while in bed to help with healing. V17 cleansed R9's right heel and measured the area. R9's right heel wound was 6cm x 5.8cm x 0.2. R9's right heel wound bed was 100 percent necrotic (dead tissue). V17 proceeded to surgically debride R9's right heel wound. Blood drainage was observed to R9's right heel. On 2/5/25 at 10:00 AM V5/Registered Nurse/Infection Preventionist verified specific interventions were not implemented to relieve pressure to R9's right and left heel after a Braden assessment was completed and indicated R9 was at risk for pressure ulcers. V5 also verified a Braden assessment should have been completed once a week for four weeks after R9's admission and was not. V5 stated (R9) should not have had his heel resting directly on the floor or had his boot on while in bed since (R9's) wound to his right heel was caused from pressure.

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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** 32875 Based on Observation, Interview and Record Review, the facility failed to complete hand hygiene and glove changes prior to providing urinary catheter care for one of two residents (R51) reviewed for indwelling urinary catheters in the sample of 33. Findings Include: The Catheter Care/Incontinent Care policy dated 8/1/05 documents Objective: To cleanse the urinary meatus and adjacent catheter. Procedure: 1. Obtain wash basin, washcloth, soap, water, and vinyl gloves. 4. Wash hands thoroughly. 6. Expose genitalia. 7. Put on vinyl gloves. The Infection Prevention and Control Standard and Transmission-Based Precautions for Communicable Diseases documents Standard Precautions: Gloves- gloves (clean, not sterile) should be worn whenever there is direct contact with blood, body fluids, mucous membranes, non-intact skin and other potentially infected material. Hand hygiene should be performed before and after removing gloves. Gloves are worn when handling or touching resident-care equipment that is visibly soiled or potentially contaminated with blood, body fluids, or infectious organisms. Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. Hand hygiene should be performed before and after removing gloves. After gloves are removed, clean hands immediately to avoid transfer of microorganisms to other residents or environments. R51's current computerized medical record, documents R51 was admitted to the facility on [DATE] with a diagnosis of Neuromuscular Dysfunction of Bladder. R51's current Physician Order Sheet, dated 2/4/25, document the following order, Catheter care every shift. This order has a start date of 10/21/2024. R51's current Care Plan documents (R51) uses a urinary catheter r/t (related to) BPH (Benign Prostatic Hyperplasia), Obstructive Uropathy, and Neurogenic Bladder. On 2/3/25 at 2:47 PM, V8/CNA (Certified Nursing Assistant) put on Personal Protective Equipment/PPE (gown and gloves) and entered R51's room carrying a washbasin, washcloths, towels, and a bottle of soap. V8 placed the items on R51's overbed table then took the washbasin to the bathroom to fill with water. V8 carried the washbasin back to the overbed table and placed the washcloths in the washbasin. V8 then removed R51's disposable brief and did urinary catheter care for R51, readjusted R51's catheter tubing, then reapplied R51's disposable brief. V8 did not wash her hands or change her gloves from the time she entered R51's room until V8 had emptied the washbasin in the bathroom before leaving the room. On 2/4/25 at 1:03 PM, V3/Director of Nursing verified that V8/Certified Nursing Assistant should have washed her hands and changed her gloves before providing urinary catheter care for R51.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on record review and interview the facility failed to ensure physician ordered daily weights were obtained and the physician notified of a significant weight increase for one of one resident (R347) reviewed for daily weights in the sample of 33. Findings include: The Weight Management Policy and Procedure revised 2023 documents Policy: Each resident will be weighed at least once a month on a predetermined schedule. All residents will be monitored for significant weight changes to assure maintenance of acceptable parameters of body weight. Weights may be obtained more frequently than monthly if warranted based on resident condition or physician order. A resident with a weight fluctuation of greater than five pounds (+ or -) will be re-weighed for accuracy. The new weight will be recorded in the medical record. The physician will be notified of any significant weight change and be made aware of any recommendations made by the dietitian. R347's current computerized medical record, documents R347 was admitted to the facility on [DATE] with diagnoses which included Essential (Primary) Hypertension, Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms, Atherosclerosis of Aorta, and Type 2 Diabetes Mellitus without Complications. R347's current Physician Order Sheet, dated 2/4/25, document the following order, Daily Weight: notify provider on greater than 3 (three) pound increase in 24 hours, or 5 (five) lbs. (pounds) in one week. This order has a start date of 1/21/2025. R347's current Care Plan Care Plan documents Daily Weight: notify provider on greater than 3 (three) pound increase in 24 hours, or 5 lbs. in 1 (one) week. R347's Weights and Vitals Summary Log dated 1/21/25 through 2/3/25 document R347 has not been weighed daily as ordered by the physician on five days within this timeframe. R347 was not weighed on 1/22, 1/24, 1/26, 1/27, and 1/28/2025. R347's weight on 1/31/25 was 233.7 pounds and 249.4 pounds on 2/1/25 (15.6 pound increase). On 2/4/25 at 12:35 PM, V3/Director of Nursing verified that there was a physician's order for daily weight and there were five days the weights were not done in a two-week period. V3 also verified that R347's weight on 1/31/25 was documented as 233.7 pounds and on 2/1/25 as 249.4 pounds (15.6 pound increase). V3 stated I did not see anywhere that the doctor was notified of the weight increase but should have been.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on observation, interview, and record review, the facility failed to place an oxygen sign on the door (R346) and failed to obtain a physician's order for oxygen use (R84) for two of two residents (R84 and R346) reviewed for oxygen in the sample of 33. Findings include: The Oxygen Administration policy dated 1/28/2025 documents Policy: To administer oxygen in conditions in which insufficient oxygen is carried by the blood to the tissues. Oxygen is administered by an LPN (Licensed Practical Nurse) or RN (Registererd Nurse) per physician's orders. (Other staff may not regulate, start, or discontinue oxygen.) Oxygen may not be dispensed without a physician's order. Each resident's room with oxygen shall be marked with an oxygen in use sign. Equipment: Oxygen sign Procedure: 2. Place sign OXYGEN IN USE outside the room of the resident. Smoking is prohibited. 12. Nasal cannulas, oxygen tubing, humidifiers and reservoirs will be tagged with date and initials of date changed. Date and initial the bag when placed and change weekly. 1. R346's current computerized medical record, documents R346 was admitted to the facility on [DATE] with diagnoses which included COPD (Chronic Obstructive Pulmonary Disease) and Acute Respiratory Failure with Hypoxia. R346's current Physician Order Sheet, dated 2/4/25, documents the following orders, Oxygen to keep SpO2 (Saturation of peripheral oxygen) above 92 percent. Order dated 1/27/25. Oxygen at 3 (three) liters per nasal cannula continuous. This order has a start date of 2/4/2024. R346's current Care Plan documents (R346) has COPD and history of respiratory failure r/t (related to) smoking. Initiated 1/28/2025. Intervention - O2 (Oxygen) to keep SpO2 (oxygen saturation) above 92 % (percent). On 2/2/25 at 9:23 AM, R346 was observed lying in bed wearing oxygen. There was no Oxygen sign on R346's door. On 2/3/25 at 10:52 AM, V3/Director of Nursing verified that R346 wears oxygen and there should be an Oxygen in use sign on R346's door. 49187 2. On 2/2/25 at 10:20 AM R84 was lying in bed with oxygen flowing at two liters per nasal cannula. R84's current Physician Order Sheet, dated 2/4/25, does not contain a physician order for the use of oxygen. On 2/4/25 at 10:35AM V3/Director of Nursing verified R84 did not have a current physician order for oxygen. V3 stated, We (the facility) should have got an order to administer oxygen to (R84) prior to (R84) wearing oxygen.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50962 Based on interview, observation, and record review the facility failed to provide an appropriate indication for use of antipsychotic medications for four of five residents (R2, R5, R54, R82) with a diagnosis of dementia and failed to do a gradual dose reduction for one of five residents (R54) reviewed for antipsychotics in a sample of 33. Findings include: The facility's policy titled Psychotropic Medication revised 11/28/17 documents, Intent: Residents are free from unnecessary psychotropic medication use. Psychotropic medication is any drug that affects brain activity associated with mental processes and behavior. These medications include but not limited to 1) Antianxiety, 2) Antidepressant, 3) Antipsychotic, 4) Hypnotic. These medications are to be given to treat a specific condition/medical symptom that is diagnosed and documented in the clinical record. Specific condition/medical symptoms alone are not enough to justify pharmacological use. An evaluation must be done to determine other possible physical, mental, behavioral, psychosocial needs. A) Indications for Use for psychotropic medication may include but not limited to 1) Expressions or indications of distress, 2) Symptoms are clinically significant that is causing a functional decline, 3) Non-pharmacological approaches were implemented and not effective or were clinically contraindicated. Additionally, Antipsychotic medication may be indicated for use if 1) Behavioral symptoms present a danger to the resident or others; 2) Expressions or indications of distress that are significant distress to the resident; 3) If not clinically indicated, multiple non-pharmacological approaches have been attempted but did not relieve the symptoms which are presenting a danger or significant distress; and/or 4) GDR (Gradual Dose Reduction) was attempted, but clinical symptoms returned. B) Dose, Duration, Monitoring: 1) Evaluation of pharmacological ongoing effectiveness towards therapeutic goal. 2) Evaluation of the effectiveness of the non-pharmacological approaches prior to medication administration. 3) Quarterly evaluation or more frequent if needed to determine if a reduction is warranted. C) Gradual Dose reduction: 1) Resident's should receive the lowest effective dose of psychotropic medication for the resident's physical, mental, and psychosocial well-being. 2) GDR is to be attempted within the first year in two separate quarters, (with at least one month between attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. 3) If treating expressions or indications of distress related to dementia, the GDR may be contraindicated for the following reasons: a) target symptoms returned or worsened after a recent attempt of GDR, and b) Physician has documented rationale why a reduction would impair residents' function or increase distressed behavior. 4) Treating disorder other than dementia, the GDR may be contraindicated for the following reasons: a) Physician has documented rationale why a reduction would impair residents' function or exacerbate the disorder, or b) Target symptoms returned or worsened after recent attempt of GDR, and physician has documented why a reduction would impair function or exacerbate disorder. 1. R2's Admission Record documents that R2's date of admission to the facility was 3/22/22 and her diagnoses on admission include Dementia, Severe, with Other Behavioral Disturbance, Major Depressive Disorder, and Insomnia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's Minimum Data Set (MDS) assessment dated [DATE], documents in Section C a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment, and Section N indicating R2 takes antipsychotic medication. R2's Physician Orders dated 10/15/24, documents R2 has an order for Seroquel/Quetiapine (Antipsychotic medication) 200 mg (Milligrams) by mouth twice a day related to Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. R2's current Care Plan documents R2 uses an antipsychotic medication related to behaviors secondary to dementia. On 2/02/25 at 10:25 AM, R2 was lying in bed with eyes closed, calm, and in no distress. On 2/03/25 at 8:48 AM, R2 was lying in bed asleep but aroused when spoken to. R2 kept closing eyes as she spoke but appeared calm and smiled during conversation. 2. R5's Admission Record documents that R5's date of admission to the facility was 4/6/21 and her diagnoses on admission include Unspecified dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Major Depressive Disorder, Anxiety Disorder, and Insomnia. R5's Minimum Data Set (MDS) assessment dated [DATE], documents in Section C that R5 is rarely/never understood, Section E indicated no behaviors, and Section N indicated that R5 is on an antipsychotic medication. R5's Physician Orders dated 12/19/24, documents R5 has an order for Seroquel/Quetiapine (Antipsychotic medication) 25 mg by mouth two times a day related to Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. R5's current Care Plan documents R5 uses an antipsychotic medication related to agitation secondary to dementia. On 2/03/25 at 9:04 AM, R5 was sitting up in her high back, reclining wheelchair by the nurse's station. R5 stated I have been tearful, but they help me (pointing to the nurse). R5 also denied discomfort and was easily redirected with conversation. On 2/03/25 at 12:19 PM, R5 was sitting in high back, reclining wheelchair at nurses' station, she appeared calm and in no distress. On 2/04/25 at 9:10am, R5 was sitting at nurses' station in high back, reclining wheelchair, calm and smiling as people walked by. 3. R54's Admission Record documents that 54's date of admission to the facility was 8/1/23 and his diagnoses on admission include Parkinson's Disease Without Dyskinesia, without Mention of Fluctuations, Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, With Psychotic Disturbance, Major depressive Disorder, Insomnia, and Cognitive Communication Deficit. (continued on next page)

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	145720	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clara's Rehab & Senior Care	1450 Castle Manor Drive Lincoln, IL 62656

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R54's Minimum Data Set (MDS) assessment dated [DATE], documents in Section C a Brief Interview for Mental Status (BIMS) score of 14, indicating cognition intact, Section E indicated no behaviors, and Section N indicated R54 is on an antipsychotic medication. R54's Physician Orders dated 1/12/24, documents R54 has an order for Seroquel/Quetiapine (Antipsychotic medication) 25 mg give two tablets by mouth at bedtime related to Unspecified Mood (Affective) Disorder. R54's current Care Plan documents R54 uses an antipsychotic related to unspecified mood affective disorder. On 2/02/25 at 12:18 PM, R54 was lying in bed asleep in no discomfort. Arouses when spoken to but closes eyes and will not speak. On 2/03/25 at 8:50 AM, R54 was sitting up in his wheelchair in the TV (Television) lounge, calm, watching television. R54's Behavior Tracking Task documents no behaviors the last 30 days. R54's Monthly Medication Review (MMR) dated 7/5/24, documents request for Gradual Dose reduction (GDR) on Seroquel/Quetiapine (Antipsychotic medication) rejected by physician with no clinical rationale or evidenced symptoms documented. 4. R82's Admission Record documents that R82's date of admission to the facility was 3/29/24 and her diagnoses on admission include Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Hallucinations, Anxiety Disorder, and Major Depressive Disorder, Recurrent. R82's Minimum Data Set (MDS) assessment dated [DATE], documents in Section C Brief Interview or Mental Status (BIMS) score of 4, indicating severe cognitive impairment and Section N indicated R82 is on an antipsychotic medication. R82's Physician Orders dated 4/10/24, documents R82 has an order for Seroquel/Quetiapine (Antipsychotic medication) 12.5 mg by mouth two times a day related to Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Hallucinations, Unspecified. R82's current Care Plan documents R82 uses an antipsychotic medication related to agitation secondary to dementia. On 2/02/25 at 10:48 AM, R82 was standing in room dressed in clean clothes, well groomed, talking to herself and conversation was nonsensical. R82 smiled and giggled when spoken to. On 2/03/25 at 10:11 AM, R82 was walking around in room in no distress, pleasant and friendly when spoken to. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/05/25 at 9:31 AM, V3/DON (Director of Nursing) verified that R2, R5, R54, and R82 did not have appropriate diagnoses for the use of their Seroquel/Quetiapine (Antipsychotic medication) per CMS (Central Management Services) guidelines. V3 also verified that R54 has not had a GDR and stated R54 has not had any documented behaviors that would justify a declination of a GDR attempt.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38396 Based on observation, interview and record review, the facility failed to use temperature testing strips that reflect the required dish surface temperature and check the surface temperature daily, to ensure dishes reach the required temperature during the rinse cycle of a high temperature sanitation dish machine, and complete and record cool down temperatures for meals containing meat that were prepared ahead and stored in the facility's freezer for future use. These failures have the potential to affect all 96 residents residing in the facility. Findings include: The facility's Dishwasher Technical Manual (undated), documents the required incoming water temperature for hot water sanitation is a minimum of 180 degrees Fahrenheit. On 2/2/25 at 12:10 PM, V4 (Dietary Manager) stated the facility uses a high temperature dishwashing machine. At this time V4 placed a sticker temperature testing strip on a plate and ran the dishwasher cycle. V4 verified that the sign on the front of the dish machine documents the rinse cycle should reach a minimum of 180 degrees Fahrenheit. V4 also verified the sticker strip that was used will turn the expected color (black) when it reaches 160 degrees Fahrenheit (F). V4 stated the dietary staff check the dish machine temperature three times daily by recording the number on the machine's outer digital thermometer. V4 stated I only do a strip through the machine about once every week when I de-lime the machine. We do not run a thermometer strip through everyday. The facility's (supplier) parts description (undated), provided by V4, documents the facility uses testing strips to check dishwasher temperature of 160 degrees (F) and documents Description: Test strip 160 degrees (F). Same sticker as what (state agency) uses. Directions attach to a dry metal surface. Then place in dish machine. Label will change color to verify proper sanitizing temperature is reached. The facility's Cooling Hot Foods policy, dated 2/2022, documents Food will be properly cooled to reduce the potential for food borne illness. Check the temperature of the food item after cooking is completed. Cool food from 135 degrees to 70 degrees F in two hours. Check the temperature of the food after two hours and record the temperature on the temperature log. If the food does not reach a temperature of less than or equal to 70 degrees in two hours, you must reheat item to 165 degrees F and start cool down process again. Cool down from 70 degrees to 41 degrees F in four additional hours (this is a total of six hours). Check the temperature of food after the additional 4 hours and record the temperature on the temperature log. If the food has not cooled to the appropriate temperatures in the time allotted, discard the food. The facility's Cooling Hot Foods logs for January 2025 and February 2025 document the only hot foods that were cooled down for both months was pork loin. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/2/25 at 12:00 PM, the facility's walk-in freezer contained two large metal pans. One pan was labeled Goulash, 2/2/25 and the other pan was labeled Lasagna, 1/29/25. At this time V4 (Dietary Manager) confirmed both the goulash and the lasagna contain cooked meat and she does not have cool down logs to show they were monitored for hazardous temperatures during the cooling process. V4 stated The only cool down items I have logs for are pork loin. The Lasagna and the Goulash were cooked ahead, and both contain hamburger and they will need thrown out because I do not have cool down logs for them. The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 2/2/25 and signed by V2/Administrator in Training documents 96 residents currently reside within the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38396 Based on Observation, Interview and Record Review, the facility failed to complete hand hygiene and glove changes prior to administering invasive medications and failed to ensure the facility implemented and followed Enhanced Barrier Precautions for four of 27 residents (R59, R63, R77, R347) reviewed for Infection Control in the sample of 33. Findings include: The Infection Prevention and Control Standard and Transmission-Based Precautions for Communicable Diseases documents Standard Precautions: Gloves- gloves (clean, not sterile) should be worn whenever there is direct contact with blood, body fluids, mucous membranes, non-intact skin and other potentially infected material. Hand hygiene should be performed before and after removing gloves. Gloves are worn when handling or touching resident-care equipment that is visibly soiled or potentially contaminated with blood, body fluids, or infectious organisms. Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. Hand hygiene should be performed before and after removing gloves. After gloves are removed, clean hands immediately to avoid transfer of microorganisms to other residents or environments. ebp (Enhanced Barrier Precautions)- Used in addition to Standard Precautions to prevent transmission of novel or targeted MDROs (Multi-Drug Resistant Organisms). Expands the use of PPE (Personal Protective Equipment) beyond situations which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multi-Drug Resistant Organisms (MDROs) to staff hands and clothing. Examples of high-contract resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing, Gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities. Regardless of the type of precautions, the following guidelines should be adhered to: Post clear signage on the door or wall outside resident's room indicating type of precautions & (and) PPE required. Make sure all PPE is readily available. Position a trash can inside resident room and near exit, if possible, for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. EBP All residents with any of the following: Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. Infection or colonization with a novel or targeted MDRO when Contact Precautions do not apply. 1. On 2/3/25 at 1:33 PM, V9 (Licensed Practical Nurse/LPN) applied gloves to both hands then retrieved medication cart keys from her pocket. V9 opened a medication drawer and removed a box of eye drops. V9 then wearing the same gloves entered R77's room, touched the door and bedside table. Without completing hand hygiene or changing gloves, V9 instilled antibiotic eye drops (Ciprofloxacin) into each eye for R77. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/3/25 at 1:38 PM, V9/LPN applied gloves to both hands and entered the facility's medications room. V9 then touched the door handle, the medication fridge, and shelves where needles and syringes are located. With the same gloves, V9 opened syringe and needle packaging and withdrew Hepatitis B vaccine into a syringe for injection. V9 took the syringe of vaccine into R347's room and gave R347 an intramuscular injection while continuing to wear the same gloves. On 2/3/25 at 1:43 PM V9/LPN applied gloves to both hands then retrieved medication cart keys from her pocket. V9 opened the medication cart and pulled out a box of lubricating eye drops. Wearing the same gloves, V9 went back into R77's room, touched R77's face and instilled one eye drop into each eye. On 2/3/25 at 1:47 PM, V9 confirmed that once she applied gloves during her medication administration for R77 and R347, she did not remove them or apply new ones before giving the medication. V9 stated she usually changes her gloves a lot because she doesn't like germs. V9 then confirmed that she would be potentially giving R77 and R347 germs when she touches surfaces and does not change those gloves before administering eye drop or injections. On 2/4/25 at 11:25 AM, V5 (Registered Nurse/Infection Control Preventionist) confirmed that nurses can wear gloves when passing medications if they choose. V5 stated When passing invasive medications, washing hands and donning gloves is expected just prior to the administration. If a nurse touches items on the medication cart or environmental surfaces, those gloves should be removed and clean gloves applied before administering eye drops or injections. 49187 2. R63's current Physician Order Sheet, dated 2/5/25, documents Cleanse areas to bilateral buttocks with wound wash or normal saline, pat dry, then apply hydrocolloid every night shift every three days. Start Date: 12/26/2024. R63's Ulcer/Wound Documentation Assessment, dated 1/30/2025 documents R63 has a facility acquired stage two pressure wound to R63's left buttock that was identified on 12/18/2024. This same assessment documents R63's left buttock wound is open and has sanguineous drainage. On 2/3/25 at 11:55 AM no EBP sign or PPE was observed inside or outside of R63's room. On 2/4/25 at 10:00 AM no EBP sign or PPE was observed inside or outside of R63's room. 50962 3. R59's Admission Record documents that R59's date of admission to the facility was 12/17/24 and his diagnosis on admission include Cerebral Infarction, Hemiplegia Affecting Right Dominant Side, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and Atherosclerotic Heart Disease of Native Coronary Artery. R59's Minimum Data Set (MDS) assessment dated [DATE], documents in Section H, R59 has an indwelling urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R59's Physician Orders dated 12/17/24, documents #(Number)16/10ml (Milliliter) foley for urinary retention/bladder outlet obstruction every shift, Catheter care every shift and irrigate foley catheter with 60 ml piston syringe twice daily and as needed for bloody urine output, foley obstruction or urine output with blood clots. R59's current Care Plan documents R59 has an indwelling urinary catheter in place. On 02/02/25 at 11:50 AM, R59 was lying in bed, dressed in clean clothes, well-groomed with indwelling catheter hanging on bed with cover over it. No EBP sign was noted on door and no PPE available. On 02/03/25 at 9:01 AM, R59 sitting up in bed with indwelling urinary catheter hanging on the side of the bed. R59's room continues to have no EBP sign on door or PPE available. On 2/03/25 at 1:00 PM, V7 (CNA) observed doing indwelling urinary catheter care on R59. V7 placed a clean towel over a bedside table then placed clean wash cloths and towels with a fresh tub of warm soapy water on the table. V7 performed hand hygiene and donned gloves but no gown and proceeded to complete catheter care on R59. R59's room remains without EBP sign on door or PPE available. V7 stated she has not heard of Enhanced Barrier Precautions. On 2/4/25 at 11:20 AM, V5 (Registered Nurse/Infection Control Preventionist) confirmed R59 has an indwelling urinary catheter and R63 has a wound requiring dressing changes. V5 stated EBPs are for anyone with a catheter, feeding tube, tracheostomy or any wounds with dressings. Those resident rooms should have a PPE cart outside of their room, a sign (indicating the type of precautions) on the door and receptacles inside the rooms for linen and trash collection. (R63) has a wound on his buttocks and he is not in EBP. I just must have missed him and need to implement that today. (R59) did not have a sign or equipment outside of his room on Sunday or Monday. I realized this yesterday after it was pointed it out. He should have been in EBP due to his indwelling urinary catheter.