STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Carbondale	120 North Tower Road Carbondale, IL 62901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure a resident was free from neglect when they failed to assess, treat, and implement interventions to prevent pressure ulcers, accurately assess for skin breakdown, discontinue psychotropic medications as ordered by the physician, and provide oral care for 1 of 5 (R12) residents reviewed for neglect in the sample of 19. This failure resulted in R12 being transferred to the local hospital on 12/01/24 for altered mental status and possible sepsis. Once at the hospital it was determined R12 had received Haldol and Clonazepam without a physician order from 11/23/24 until 12/01/24. R12 had developed 15 new wounds including a Stage 2 and Stage 3 to his buttocks, a Stage 2 to the left knee, and two deep tissue injuries to his bilateral heels. R12 also had a buildup of a hardened yellow/brown coating with cracking and fissures noted to be covering the tongue from lack of oral care. This failure resulted in an Immediate Jeopardy, which was identified to have begun on 11/23/24 when the facility failed to 1. Assess R12's skin upon return from the hospital on 11/23/24, 2. Put treatment orders in place for the pressure ulcer identified throughout R12's hospital stay 3. Identify, assess, treat, and notify the physician of the new pressure areas identified on R12's 11/30/24 shower sheet, 4. Discontinue psychotropic medications as ordered on the hospital discharge instructions on 11/23/24, and 4. Provide oral care per current standards of practice. V1 (Administrator) was notified of the Immediate Jeopardy on 12/11/24 at 1:30 PM. The surveyor confirmed by observations, interview, and record review, the Immediate Jeopardy was removed on 12/11/2024, but the noncompliance remains at Level Two due to additional time needed to evaluate implementation and effectiveness of training. Findings Include: R12's Admission Record with a print date of 12/5/24 documents R12 was admitted to the facility on [DATE] with diagnoses that include fracture of left femur, hypotension, diabetes, schizophrenia (diagnosis added on 11/07/24), bipolar disorder (added on 11/07/24) difficulty walking, and muscle weakness. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's MDS (Minimum Data Set) dated 10/17/2024 documents R12 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R12 is cognitively intact. This same MDS documents R12 required partial to moderate assist for transfers, was independent for bed mobility, and was at risk for developing pressure ulcers. R12's local hospital records dated 12/01/24 documents R12 is more confused upon arrival to the hospital. R12's current Care Plan documents a Focus area of (R12) uses psychotropic medications (Escitalopram) r/t (related to) dx (diagnosis) depression, anxiety. Schizophrenia 10/9/24 Clonazepam for agitation, 10/27/24 Clonazepam increased, 10/29/24 Escitalopram decreased, 11/8/24 Haldol, Date Initiated: 05/03/2024. Interventions for this Focus area include, Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 05/03/2024 . R12's facility Progress Notes document the following: 11/17/24 - At 0700 (7:00 AM) resident was observed to be unresponsive and weak. VS (vital signs): 97.1, 122, 32, sat (oxygen saturation) 70, bp (blood pressure) 139/75. No purposeful movement on the left side. Unable to assess pupils. Ambulance called and resident transferred to (local hospital) ER (emergency room). MD (physician) and POA (power of attorney) informed. 11/17/24 - Called for an update on the resident. Resident will be admitted IP (inpatient) for aspiration PNE (pneumonia). R12's local hospital record documents R12 was admitted to the local hospital on 11/17/24 and discharged back to the facility on [DATE]. R12's hospital record includes under Secondary Discharge Diagnosis, bed sore on buttock. This same hospital record documents under Hospital Course, .Patient advised to take Augmentin 875 for 3 days post discharge. He was also advised to stop taking Haldol and Clonazepam as the medications were held for the entirety of his admission and he had no psych issues . Under Active Issues Requiring Follow-up and Discharge Plan the hospital records document, .Please stop taking Haldol. Please stop taking Clonazepam . R12's facility Progress Note dated 11/23/24 documents, Resident's Haldol and Clonazepam discontinued by hospital at discharge. Antibiotic added Discharge medication list faxed to (name of pharmacy) and (V14/Physician) office. Provider notified of arrival. R12's facility Order Summary Report Active Orders as of 11/30/24 includes the following physician orders, Clonazepam 0.5 mg (milligrams) Give 0.5 mg by mouth three times a day for anxiety, with a start date of 10/27/24 and Haloperidol (Haldol) oral tablet 5 mg Give 5 mg by mouth three times a day related to schizophrenia, unspecified; bipolar disorder unspecified, with a start date of 11/08/24. There is no end or discontinue date documented for either physician order. R12's Progress Notes dated 11/24/24 at 2:57 PM signed by V18 (RN/Registered Nurse) documents, Clonazepam Tablet 0.5 MG, give 0.5 mg by mouth three times a day for anxiety Resident's medication was dc'd (discontinued) at the hospital. Reaching out for clarification on medication. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's Medication Administration Record (MAR) dated 11/01/24 to 11/30/24 documents an order for Clonazepam 0.5 mg to be administered at 9:00 AM, 2:00 PM, and 9:00 PM. This MAR documents initials indicating Clonazepam 0.5 mg was administered at 9:00 PM on 11/23, 11/24, 11/26-11/30, at 9:00 AM 11/24-11/30/24 and at 2:00 PM 11/26-11/30/24. This same MAR documents the Clonazepam was held at 2:00 PM on 11/24 and 11/25/24. This indicates upon R12's return to the facility the Clonazepam was administered 20 times and held three times. This same MAR documents an order for Haldol 5 mg to be administered at 9:00 AM, 2:00 PM, and 9:00 PM with initials documented indicating R12 was administered Haldol at each dose time from 11/23/24 to 11/30/24. On 12/16/24 at 12:37 PM, V18 (Registered Nurse/RN) stated she was responsible for readmitting R12 to the facility after his return from the hospital on 11/23/24. V18 stated she charted the Haldol and Clonazepam had been discontinued in the progress notes. V18 stated when she returned to work the next day, she noticed they were still active on R12's medication list so she held them waiting for clarification. V18 stated she spoke with the night shift nurse (V19/RN) who said she had taken care of it and the medications were reinstated so she assumed the physician had given an order to resume them. On 12/28/24 at 10:00 AM, V19 (RN) stated V18 was the day shift nurse when R12 returned from the hospital, and she (V19) was the oncoming night shift nurse. V19 stated V18 reported to her R12's medications were discontinued by the hospital. V19 stated R12 doesn't have any medications ordered on night shift other than Tylenol. V19 stated she did not call the physician to clarify the medication orders from the hospital discharge. V19 stated she wouldn't have had a reason to look at those medications and/or orders since R12 didn't take medications on her shift and V18 had reported to her they were discontinued. On 12/4/24 at 2:35 PM, V5 (CNA/Certified Nursing Assistant) stated mid-November, R12 stopped eating, started refusing care, and became a two person assist. V5 stated it was a change in R12's condition and it worsened when he came back from the hospital on 11/23/24. V5 stated R12 would get up for meals before he went to the hospital and when he came back, he would barely eat and/or drink and even stopped yelling down the halls. V5 stated she reported this to an unknown nurse, and she thought the nurse assessed R12 and documented it. On 12/9/24 at 12:50 PM, V2 (DON/Director of Nurses) stated the Haldol and Clonazepam were started because R12 had extreme behaviors. V2 stated after it was discontinued at the hospital, she assumed V15 (Psychiatric Nurse Practitioner/Psych NP) had resumed the order when he returned to the facility and that was why he was still getting the medications. On 12/9/24 at 1:02 PM, V15 (Psych NP) stated the facility did not notify her R12 had been to the hospital and/or that the medication had been discontinued by the hospital physicians. V15 stated she looked back at her communication with the facility, and she got a message R12 needed a refill on his Clonazepam but was never notified by the facility the medication had been discontinued. V15 stated she hadn't seen R12 since 10/24/24 and her expectations would be that if a medication were discontinued while the resident was at the hospital it would stay discontinued when they returned to the facility. R12's Braden Scale dated 11/10/24 documents a score of 14, which indicates R12 is at moderate risk of skin breakdown. R12's Braden Scale dated 11/24/24 documents a score of 12, which indicates R12 is at high risk of skin breakdown. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's current Care Plan documents a Focus area of (R12) is at risk for skin breakdown r/t (related to) requires assist with bed mobility, frequently incontinent of B & B (bowel and bladder). Has left side neglect. Date Initiated: 05/16/2024. This Focus area includes the following interventions, 10/30/24 cover spokes on left side of w/c (wheelchair) .8/27/24 Pad bed frame. This same focus area includes the following interventions initiated on 5/26/24, assist T & P (turn and position) at least every 2 hours and prn (as needed) Educate resident/family/caregivers of causative factors and measures to prevent skin injury Encourage good nutrition and hydration in order to promote healthier skin Follow facility protocols for treatment of injury .Keep skin clean and dry. Use lotion on dry skin . Monitor/document location, size and treatment of skin injury, if occurs. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (physician) Offer toileting/check every 2 hours and prn (as needed) provide peri-care as needed Pressure relief mattress on bed and cushion in w/c (wheelchair) as preventative . Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface . R12's Order Summary Report Active Orders as of 11/30/24 documents a physician order for weekly skin checks with no orders documented for treatments to specific areas of skin breakdown and/or orders for interventions to prevent skin breakdown from 11/23/24 to 12/01/24. R12's Progress notes document. 11/23/24 12:49, Report received from (name of local hospital). Resident will be arriving today by EMS (emergency medical services). Resident is a Mechanical soft diet with thin liquids by mouth. Family declined to have resident's code status changed to comfort measures and will remain full code with current plan of care with an addition of PO (oral) abx (antibiotic). 11/23/24 15:51, Resident arrives at this time via EMS. R12's Initial Skin Alteration Record signed by V18 (RN), dated 11/23/2024 documents under Site, Resident refusing skin assessment, yelling to leave him alone. Able to assess visible skin. Resident pushing away this nurse when trying to assess. Wound [NAME] found (sic) to BUE (bilateral upper extremities). Several bruises and skin tears present Comments- healing skin tears to left arm noted. no signs of infection observed. resident not in pain at this time. this nurse unable to complete a head to toe assessment as resident was screaming no and resisting with physical pushing away of this nurse. Treatment Plan .Monitor skin tears . There are no measurements, assessments, or physician notification documented on this assessment. R12's medical record did not document any Initial Skin Alteration Records after 11/23/24. On 12/5/24 at 11:16 AM, V18 (Registered Nurse) stated she was working on 11/23/24 when R12 returned from the hospital. V18 stated she attempted to do a skin assessment, but he was resisting, and she didn't want to cause him distress. V18 stated she did see the dressings that had been applied at the hospital and looked under them and didn't see any open areas. V18 stated she meant to put an order in to remove and replace them every three days and just forgot to do it. When asked what interventions were implemented to prevent skin breakdown, V18 stated he had a pressure reducing mattress on his bed and a cushion in his chair. V18 stated they floated his heels and would try to reposition him hourly. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's Weekly Skin Check dated 11/24/24 not signed until 12/04/24 by V18 (RN) documents under Site: Left antecubital- Resident refusing skin assessment, yelling to leave him alone. Able to assess visible skin. Resident pushing away this nurse when trying to assess. Wound found found (sic) to BUE. Several bruises and skin tears present Comments: healing skin tears to left arm noted, no signs of infection observed. resident no in pain at this time. This nurse unable to complete a head-to-toe assessment as resident was screaming no and resisting with physical pushing away of this nurse. will continue to monitor. This is the same narrative that was documented in R12's Initial Skin Alteration Record dated 11/23/24. On 12/9/24 at 9:59 PM, when asked if she completed the Weekly Skin Check dated 11/24/24, V19 (RN) stated R12 was sitting in his wheelchair, and she noticed the area on his arm was healed. V19 was asked if she assessed any other skin on R12 and she stated, No, I just looked at his arm. V19 stated they have another nurse who does all the treatments for south side. This surveyor reviewed with V19 that R12 wasn't located on that side and V19 stated she thought he was. This surveyor then asked V19 if she did a physical assessment of R12's skin from 11/23/24 until 12/01/24 and if she completed the 11/24/24 Weekly Skin Check and V19 stated, I don't remember. I usually just ask the CNA if the residents have any skin changes. On 12/9/24 at 12:50 PM, this surveyor reviewed the 11/23/24 initial skin assessment and the 11/24/24 weekly skin assessment with V2 (DON) and she stated the 11/24/24 assessment looks like it was copied and pasted from the 11/23/24 assessment. R12's Skin Monitoring: Comprehensive CNA Shower Review documents dark bruising to R12's left arm, heels as red, coccyx as dark red, a bandage to the inside of his inner right leg and a bandage on his left hip with V17's (CNA) signature dated 11/30/24. This Review documents V2 (DON's) signature with a date of 11/30/24 with no assessment of the new areas documented under Nurse Assessment. On 12/5/24 at 8:37 AM, V17 (CNA) stated R12's condition had declined when he returned from the hospital on 11/23/24. V17 stated R12 wasn't eating, drinking, and/or communicating as well. V17 stated she gave R12 a bed bath on 11/30/24 and found a bandage on his left hip that was looking a little rough. V17 did not remember if there was a date on the bandage that would indicate when it was placed. V17 stated when she rolled R12 over she noticed R12's coccyx was dark red, and his right hip was splotchy in color. V17 stated she was concerned R12 was mottling and then she removed his socks and noted that both of his heels were dark red as well. V17 stated there was a bandage on R12's inner thigh that didn't look as bad as the one on his left hip, but she again didn't know if there was a date on it. V17 stated she didn't remove the bandages, so she didn't know what his skin looked like under them. V17 stated she documented the areas on the shower sheet and told V2 (Director of Nurses) who was working as her nurse that night. V17 stated she told V2 she was worried R12 was dying and that his family needed to be notified. V17 stated she also reported the change in R12's condition to the oncoming shift and her supervisor (V21/CNA Supervisor). V17 stated R12 was sent out to the hospital two days later so she assumed someone heard her concerns. When asked what interventions were in place to prevent the pressure injuries from worsening, V17 stated there was a pillow under his left hip that was always there because of previous skin issues but that was the only intervention in place. V17 stated R12 was clean and dry when she changed him and that he was dependent on staff for all care. On 12/5/24 at 1:48 PM, V21 (CNA Supervisor) stated V17 told her R12's skin looked bad, but she didn't remember the date this occurred. V21 stated she asked V17 if she had reported it to the nurse and V17 told her she reported it to V2 (DON). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/5/24 at 12:04 PM, V2 (DON) stated she didn't remember signing off on the 11/30/24 shower sheet that documented the new areas of skin breakdown for R12. V2 stated she was working the floor that day and was told she had to get skin assessments on all the residents. V2 stated she attempted to get other nurses to assist her with it and was not able to get anyone to assist. V2 stated V17 (CNA) helped her by doing skin assessments and documenting them on the shower sheets. V2 stated she knew R12 was declining, not getting out of bed, not eating, and not drinking. V2 stated, I am really pi**ed off at myself and the building because I had zero help except for the CNA's who can't make calls or write orders. It can't be just me. I don't have any help at all. When asked if she ever assessed R12's skin, V2 stated, No. V2 stated the skin assessments were done on Sunday 11/30/24 but she didn't sign them until Monday, December 01, 2024. V2 stated she wished V17 had told her on Friday, how bad R12's skin was. When asked to clarify if R12's skin was assessed on Friday 11/29 or Saturday 11/30, V2 stated they were working midnight shift, and she wasn't sure if it was before or after midnight. V2 stated it was miscommunicated and they missed it. V2 stated if she had done R12's skin assessment she would have notified the physician and obtained orders for treatments. V2 stated they recognized there was an issue and have put things in place to make it better. V2 stated they are checking each morning during clinical rounds to make sure skin assessments are being done. V2 stated R12 should have had a head-to-toe assessment on 11/23/24 when he returned from the hospital and again before he went back to the hospital on 12/01/24. On 12/5/24 at 11:16 AM, V18 (Registered Nurse) stated she followed R12 closely even when she wasn't his nurse. V18 stated he wasn't eating well, and his oxygen dependence was increasing. V18 stated R12 didn't start showing skin breakdown until 11/30/24 and she was working on the other side that day. V18 stated she told his nurse she would be over there the next day and would look at him then. On 12/9/24 at 10:18 PM, V24 (CNA) stated she provided care to R12 between 11/23/24 and 12/01/24. V24 stated R12 was incontinent of bowel and bladder and was not able to turn and reposition himself. When asked what interventions were implemented to prevent pressure ulcers from developing, V24 stated they were turning and repositioning R12 and using pillows for support. V24 stated she was aware of the areas of skin breakdown on R12, and he had them for probably a couple of weeks. R12's facility Progress Notes document: 11/30/24 - 1907 (7:07 PM) Resident has a loss of appetite and motivation. Resident continues to take medication but not showing any improvement. This nurse will continue to monitor. Reported to nightshift nurse. If not showing improvement by mid shift tomorrow, will reach out to provider for further intervention. 12/01/24 - 14:06 (2:06 PM) Resident still not doing well and declining. Despite antibiotics, resident has not eaten in two days, has crackles throughout lung fields, febrile at 102.8 F (Fahrenheit), today extreme lethargy to the point where nursing judgement is that it is not safe to give PO (oral) medication. EMS (Emergency Medical Services) called for emergent send out for possible sepsis. Provider and POA (Power of Attorney) notified. Vital signs as follows: 154/64, pulse 138, respirations 28 and shallow with crackles and wheezes, Temp (temperature) 102.8, post Tylenol, O2 (oxygen) at 91 on 4 L (liters). 12/01/24 - 4:26 PM, (R12) admitted IP (in patient) for AMS (altered mental status) and sepsis r/t (related to) aspiration PNE (pneumonia). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R12's local hospital records dated 12/01/24 documents Patient presents from the nursing home for altered mental status. He is somnolent. This hospital record documents under ED (Emergency Department) Triage notes, Per EMS, pt (patient) was recently discharged with pneumonia. Pt had a temp of 103.6 F, Tylenol was given at nursing home. Heart rate 130's and more confused this morning. Pt localizing to pain and shaking head to questions. Labored breathing. skin warm, Dry. mouth is extremely dry The physical exam dated 12/01/24 documents R12 is ill appearing and lethargic. Under Clinical Impression it documents, Altered mental Status, unspecified altered mental status type. Sepsis without acute organ dysfunction, due to unspecified organism Under Physical Exam R12's hospital record includes, .Skin: General skin is warm and dry. Comments: Sacral decubitus, multiple wounds left buttocks, left hip, heels, left arm - see photos R12's hospital records document under Wound Nurse Note, Wound care: Wound consult completed w/(with) dressings applied to the following POA Pis (present on admission pressure injuries): right medial heel: DTPI (deep tissue pressure injury) & (and) left lateral heel.: DTPI & coccyx: Stage 3 PI and Left buttock: Stage 2 PI and left lateral knee: Stage 2 PI; and skin tear located on the left elbow previously dressed per assigned RN (Registered Nurse). R12's hospital records document the following assessments of the pressure areas all dated 12/01/24. 1. DTPI right heel- measured 4.5 cm (centimeters) x 3.8 cm described as purple, painful, dry, intact, non-blanchable. 2. Pressure injury of left lateral heel measured 2 cm x 1.5 cm and described as non-blanchable, purple, dry, intact. 3. Stage 2 pressure injury left buttocks measured 0.6 cm x 0.7 cm x 0.1 cm and described as partial thickness, red moist, painful, blanchable with scant serous drainage. 4. Stage 3 pressure injury to midline coccyx measured at 1.5 cm x 0.9 cm x 0.2 cm and described as full thickness, moist, painful, with scant amount of serosanguinous drainage, and 5. Stage 2 pressure injury to left lateral knee measured at 0.9 cm x 0.5 cm x 0.1 cm and described as red, moist, with scant amount of serous drainage. Under Adult Neglect Assessment and Plan, R12's hospital record document, Patient has over 15 new wounds since last admission, he received Haldol and benzos (benzodiazepine) in the nursing home which were discontinued by our team at the time of the discharge (11/23/24), patient became somnolent due to this and stopped eating and was readmitted this time. Patient's son does not want him to go back to (name of facility) and is looking at other nursing home options. On 12/4/24 at 8:55 AM, V16 (Registered Nurse-hospital) stated he was familiar with R12. V16 stated R12 was admitted to the hospital on 11/17/24 and discharged back to the facility on [DATE]. V16 stated R12 had three wounds when he left the hospital on 11/23/24 that had dressings on them. V16 stated when R12 returned to the hospital on 12/01/24, R12 had 15 wounds and still had the same dressings on the original three wounds that was on when he was discharged on [DATE]. On 12/5/24 at 2:08 PM, V14 (Physician) reviewed R12's hospital records and stated the pressure areas on R12's hip deteriorated from 11/23/24 to 12/01/24. V14 stated the area on R12's trochanter increased in size from 11/23 to 12/01/24. When asked if the pressure ulcers/injuries were avoidable, V14 stated the areas on R12's heels would have been preventable. On 12/09/24 at 1:29 PM, V14 (Physician) stated if R12 was immobile from somnolence then it could precipitate him developing pressure ulcers. According to the Medical Dictionary located at the website Somnolency | definition of somnolency by Medical dictionary the definition of somnolent is 1. Drowsy; sleepy; having an inclination to sleep. 2. In a condition of incomplete sleep; semi-comatose. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/4/24 at 4:00 PM, V1 (Administrator) stated R12 had new areas identified on his 11/30/24 shower sheet. V1 stated there were no assessments, treatment orders, physician notification, or physician orders documented in R12's record related to the new areas. V1 stated her expectation would be for any new area of skin breakdown to be assessed and the physician notified for treatment orders. R12's hospital records with an admitted [DATE] documents under Dehydration- Assessment & (and) Plan Note, Nursing staff reported pt (patient) has had decreased PO (oral) intake since last admission, especially for the last 2 days during (sic) pt has had only a few bites to eat. Pts oral mucus membrane appeared dry with yellow crusts on tongue and palate. R12's local hospital records with an admitted [DATE] documents a photograph of R12's mouth that shows R12's tongue that is covered in a dry scaly cracking with fissures, with a thick residue that is yellow/white/brown in color. On 12/11/24 at 10:04 AM, V23 (RN/Hospital Shift Supervisor) stated when R12 was admitted to the hospital on 12/01/24 his mouth looked like the bottom of the Sahara dessert. On 12/4/24 at 2:35 PM, V5 (CNA) stated they offer oral care, but residents have the right to refuse it and they don't offer it to someone who is alert and oriented since they can ask for it if they want it. When asked if she provided anyone with oral care today (12/4/24) while she was working, V5 stated she did not. V5 stated one of the nurse's was wanting to set up a cart for them so oral care would be offered when the residents got up. When asked if she ever provided oral care for R12, V5 stated she didn't. V5 stated it was hard to provide care for R12 because he would refuse. On 12/5/24 at 11:16 AM, when asked about oral care, V18 (RN) stated it was an issue. V18 stated for Christmas she bought rolling carts and was going to have them put their morning care supplies on the cart. V18 stated she had a concern oral care wasn't being provided but it had been identified as an issue and a plan was in place to attempt to improve it. On 12/5/24 at 11:47 AM, V20 (Family Member) stated he had concerns about the care R12 was provided at the facility. V20 stated he was told by the nurse at the hospital R12's bandages/treatments were not changed after he left the hospital on 11/23/24 and the areas were worse. V20 stated he also had concerns R12 wasn't getting good oral care because every time he would go to the facility his lips were always dry and chapped and R12 was always thirsty. On 12/5/24 at 12:48 PM, V1 (Administrator) stated she had access to the pictures of R12's mouth that were taken at the local hospital during his emergency room evaluation on 12/01/24. V1 stated she was very disappointed with the way his mouth looked. When asked what her expectations were for oral care, V1 stated, I mean that it is to be done routinely. On 12/5/24 at 2:08 PM, V14 (Physician) V14 stated oral care is pretty darn important. V14 stated the stuff on his tongue could be food or cancer but he wasn't able to tell from the pictures and did not elaborate further on why oral care was important. (continued on next page)

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	145757	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Carbondale	120 North Tower Road Carbondale, IL 62901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/18/24 at 3:00 PM, V39 (Physician) stated she provided care to R12 during his hospital stay beginning on 12/01/24. V39 stated R12 had been discharged from the hospital about a week (11/23/24) prior and when he returned to the hospital on 12/01/24, he had more pressure ulcers that had developed while at the facility. V39 stated when R12 was discharged from the hospital on 11/23/24 they had discontinued the Haldol and Clonazepam. V39 stated the facility continued to give R12 those medications. V39 stated those medications caused somnolence which in turn caused R12 to not eat and/or drink the way he should have. V39 stated this caused R12 to end up back in the hospital with dehydration. V39 stated R12 wasn't turned and repositioned while at the facility which led to R12 developing more pressure ulcers. V39 stated R12 was not provided oral care for probably 5-6 days leading to R12's tongue having the crusty build up on it that is evidenced in the photos that were taken at the hospital. V39 stated she considered these failures by the facility to be neglect. According to the National Library of Medicine found at A preventive care approach for oral health in nursing homes: a qualitative study of healthcare workers' experiences - PMC .Studies have reported that poor oral health affects older adults' wellbeing and is associated with issues pertaining to pain and problems with eating, swallowing and social interactions [3]. Impaired oral health can also have a negative impact on general health conditions such as cardiovascular disease and diabetes, and it can lead to malnutrition and aspiration pneumonia The facility Decubitus Care/Pressure Areas policy dated 9/2024 documents, The facility Decubitus Care/Pressure Areas policy dated September 2024 documents, Policy: To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified. Procedure: Upon identification of skin breakdown, the following will be completed; 1) The pressure area will be assessed and documented. 2) Complete all areas of a wound assessment following NPUAP (National Pressure Ulcer Advisory Panel) guidelines i) Document size, stage, site, depth, drainage, color, odor, and treatment (once obtained from the physician) 3. Notify the physician for treatment orders 4. Documentation of the pressure area must occur upon identification and at least once each week 8) Initiate problem area on care plan. The facility Change in a Resident's Condition or Status policy dated 2021 documents, Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) The facility Adverse Consequences and Medication Errors policy dated 2023 includes, .5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medications errors include: a. Omission .b. Unauthorized drug-a drug is administered without a physician's order . The facility Administering Medications policy dated January 2024 documents, Medications shall be administered in a safe and timely manner, and as prescribed 3. Medications must be administered in accordance with the orders, including any required time frame . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility Abuse Prevention Policy dated 2022 documents, residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Purpose: .The facility prohibits abuse, neglect, misappropriation of property, and exploitation of its residents, including verbal, mental, sexual or physical abuse; corporal punishment; and involuntary seclusion. The facility has a no tolerance philosophy; persons found to have engaged in such conduct will be terminated Neglect is a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident .Neglect is also the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The Immediate Jeopardy that began on 11/23/24 was remove[TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure oral care was provided for 2 of 5 residents (R2 and R12) reviewed for oral care in the sample of 19. This failure resulted in R12 having a buildup of a hardened yellow/brown coating with cracking and fissures noted to be covering the tongue from lack of oral care. This failure would cause a reasonable person to suffer humiliation with physical and emotional discomfort. Findings Include: 1. R12's Admission Record with a print date of 12/5/24 documents R12 was admitted to the facility on [DATE] with diagnoses that include fracture of left femur, hypotension, diabetes, schizophrenia (diagnosis added on 11/07/24), bipolar disorder (added on 11/07/24) difficulty walking, and muscle weakness. R12's MDS (Minimum Data Set) dated 10/17/2024 documents R12 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R12 is cognitively intact. This same MDS documents R12 requires set up or clean up assistance with oral care. R12's current Care Plan does not document a Focus area or interventions specific to oral care. R12's local hospital record with an admitted [DATE] documents under ED (Emergency Department) Triage Notes, Pt (patient) localizing to pain and shaking head to questions. Labored breathing. Skin warm, Dry, mouth is extremely dry. R12's hospital records with an admitted [DATE] documents under Dehydration- Assessment & (and) Plan Note, Nursing staff reported pt (patient) has had decreased PO (oral) intake since last admission, especially for the last 2 days during (sic) pt has had only a few bites to eat. Pts oral mucus membrane appeared dry with yellow crusts on tongue and palate. On 12/11/24 at 10:04 AM, V23 (RN/Hospital Shift Supervisor) stated when R12 was admitted to the hospital on 12/01/24 his mouth looked like the bottom of the Sahara dessert. R12's local hospital records with an admitted [DATE] documents a photograph of R12's mouth that shows R12's tongue was covered in a dry scaly cracking thick residue that was yellow/white/brown in color. On 12/4/24 at 2:35 PM, V5 (Certified Nursing Assistant/CNA) stated they offer oral care, but residents have the right to refuse it and they don't offer it to someone who is alert and oriented since they can ask for it if they want it. When asked if she provided anyone with oral care today (12/4/24) while she was working, V5 stated she did not. V5 stated one of the nurse's was wanting to set up a cart for them so oral care would be offered when the residents got up. When asked if she ever provided oral care for R12, V5 stated she didn't. V5 stated it was hard to provide care for R12 because he would refuse. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 12/5/24 at 11:16 AM, when asked about oral care, V18 (RN/Registered Nurse) stated it was an issue. V18 stated for Christmas she bought rolling carts and was going to have them put their morning care supplies on the cart. V18 stated she had a concern oral care wasn't being provided but it had been identified as an issue and a plan was in place to attempt to improve it. On 12/5/24 at 11:47 AM, V20 (Family Member) stated he had concerns about the care R12 was provided at the facility. V20 stated he also had concerns R12 wasn't getting good oral care because every time he would go to the facility his lips were always dry and chapped and R12 was always thirsty. On 12/5/24 at 12:48 PM, V1 (Administrator) stated she had access to the pictures of R12's mouth that were taken at the local hospital during his emergency room evaluation on 12/01/24. V1 stated she was very disappointed with the way his mouth looked. When asked what her expectations were for oral care, V1 stated, I mean that it is to be done routinely. On 12/05/24 at 2:08 PM, V14 (Physician) V14 stated oral care is pretty darn important. V14 stated the stuff on his tongue could be food or cancer but he wasn't able to tell from the pictures and did not elaborate further on why oral care was important. On 12/18/24 at 3:00 PM, V39 (Physician) stated she provided care to R12 during his hospital stay beginning on 12/01/24. V39 referenced the pictures of R12's tongue that was taken at the hospital and stated the build up on his tongue was caused by not getting oral care. When asked how long someone would go without oral care for their tongue to get that build up on it, V39 stated she couldn't say for sure but probably 5 to 6 days. 2. R2's Admission Record with a print date of 12/2/24 documents R2 was admitted to the facility with diagnoses that include atrial fibrillation, diabetes, peripheral neuropathy, morbid obesity, hemiplegia, hemiparesis, and hypertension. R2's MDS dated [DATE] documents a BIMS score of 14, which indicates R2 is cognitively intact. This same MDS documents R2 requires set up/clean up assistance with oral care and is dependent on staff for transfers. R2s's current Care Plan does not document a Focus area, or interventions related to oral care. On 12/2/24 at 3:02 PM, R2 stated she doesn't get out of bed and her teeth don't get brushed. R2 stated the staff never bring her any care items for her teeth. On 12/4/24 at 11:16 AM, V4 (Anonymous) stated R2 would require set up assistance for oral care since she doesn't ambulate or transfer independently. V4 stated she had never set up or assisted R2 with oral care. On 12/4/24 at 1:54 PM, V34 (CNA) stated she gets to work at 7:00 AM, checks on the residents and then goes to the dining room to assist residents with breakfast. V34 stated she wasn't sure if night shift provided oral care. V34 stated she hadn't ever seen oral care provided and wasn't even sure if she had seen a toothbrush at the facility. This surveyor went with V34 to R2's room and asked if we could look for oral care supplies. R2 stated she didn't have any supplies in her room, and no one ever offered to get her supplies and/or assist her with oral care. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On 12/4/24 at 2:48 PM, V33 (Anonymous) stated they had provided oral care to R12 in the past, but they had not provided any oral care to any resident today 12/4/24. When asked why V33 stated they had been running around like crazy and just hadn't done it yet. On 12/5/24 at 8:37 AM, when asked about oral care, V17 (CNA) stated they provide oral care on night shift, if the residents will let them. According to the National Library of Medicine the article titled A preventive care approach for oral health in nursing homes: a qualitative study of healthcare workers' experiences - PMC (PubMed Central) located at the website https://pmc.ncbi.nlm.nih.gov/articles /PMC11443800/ documents .Studies have reported that poor oral health affects older adults' wellbeing and is associated with issues pertaining to pain and problems with eating, swallowing and social interactions [3]. Impaired oral health can also have a negative impact on general health conditions such as cardiovascular disease and diabetes, and it can lead to malnutrition and aspiration pneumonia The facility Mouth Care/Oral Care policy dated December 2024 documents, Purpose: The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth Reporting: 1. Notify the supervisor if the resident refuses the mouth care. 2. Report other information in accordance with professional standards of practice.

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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** 32765 Based on observation, interview, and record review the facility failed to assess, treat, and implement interventions to prevent pressure ulcers, and failed to accurately assess for skin breakdown for 4 of 5 (R1, R2, R3, and R12) residents reviewed for pressure ulcers in the sample of 19. This failure resulted in R12 developing a Stage 2 and Stage 3 pressure ulcer to his buttocks, a Stage 2 pressure ulcer to his left knee, and two deep tissue injuries to bilateral heels. Findings Include: R12's Admission Record with a print date of 12/5/24 documents R12 was admitted to the facility on [DATE] with diagnoses that include fracture of left femur, hypotension, diabetes, schizophrenia (diagnosis added on 11/07/24), bipolar disorder (added on 11/07/24) difficulty walking, and muscle weakness. R12's MDS (Minimum Data Set) dated 10/17/2024 documents R12 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R12 is cognitively intact. This same MDS documents R12 required partial to moderate assist for transfers, was independent for bed mobility, and was at risk for developing pressure ulcers. R12's Braden Scale dated 11/10/24 documents a score of 14, which indicates R12 is at moderate risk of skin breakdown. R12's Braden Scale dated 11/24/24 documents a score of 12, which indicates R12 is at high risk of skin breakdown. R12's current Care Plan documents a Focus area of (R12) is at risk for skin breakdown r/t (related to) requires assist with bed mobility, frequently incontinent of B & B (bowel and bladder). Has left side neglect. Date Initiated: 05/16/2024. This Focus area includes the following interventions, 10/30/24 cover spokes on left side of w/c (wheelchair) .8/27/24 Pad bed frame. This same focus area includes the following interventions initiated on 5/26/24, assist T & P (turn and position) at least every 2 hours and prn (as needed) Educate resident/family/caregivers of causative factors and measures to prevent skin injury Encourage good nutrition and hydration in order to promote healthier skin Follow facility protocols for treatment of injury .Keep skin clean and dry. Use lotion on dry skin . Monitor/document location, size and treatment of skin injury, if occurs. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (physician) Offer toileting/check every 2 hours and prn (as needed) provide peri-care as needed Pressure relief mattress on bed and cushion in w/c (wheelchair) as preventative . Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface . R12's local hospital record documents R12 was admitted to the local hospital on 11/17/24 and discharged back to the facility on [DATE]. R12's hospital record includes under Secondary Discharge Diagnosis, bed sore on buttock. R12's Order Summary Report Active Orders as of 11/30/24 documents a physician order for weekly skin checks with no orders documented for treatments to specific areas of skin breakdown and/or orders for interventions to prevent skin breakdown from 11/23/24 to 12/01/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	R12's Initial Skin Alteration Record signed by V18 (Registered Nurse/RN), dated 11/23/2024 documents under Site, Resident refusing skin assessment, yelling to leave him alone. Able to assess visible skin. Resident pushing away this nurse when trying to assess. Wound [NAME] found (sic) to BUE (bilateral upper extremities). Several bruises and skin tears present Comments- healing skin tears to left arm noted. no signs of infection observed. resident not in pain at this time. this nurse unable to complete a head to toe assessment as resident was screaming no and resisting with physical pushing away of this nurse. Treatment Plan .Monitor skin tears . There are no measurements, assessments, or physician notification documented on this assessment. R12's medical record did not document any Initial Skin Alteration Records after 11/23/24. On 12/5/24 at 11:16 AM, V18 (Registered Nurse) stated she was working on 11/23/24 when R12 returned from the hospital. V18 stated she attempted to do a skin assessment, but he was resisting, and she didn't want to cause him distress. V18 stated she did see the dressings that had been applied at the hospital and looked under them and didn't see any open areas. V18 stated she meant to put an order in to remove and replace them every three days and just forgot to do it. When asked what interventions were implemented to prevent skin breakdown, V18 stated he had a pressure reducing mattress on his bed and a cushion in his chair. V18 stated they floated his heels and would try to reposition him hourly. R12's Weekly Skin Check dated 11/24/24 not signed until 12/04/24 by V18 (RN) documents under Site: Left antecubital- Resident refusing skin assessment, yelling to leave him alone. Able to assess visible skin. Resident pushing away this nurse when trying to assess. Wound found found (sic) to BUE. Several bruises and skin tears present Comments: healing skin tears to left arm noted, no signs of infection observed. resident no in pain at this time. This nurse unable to complete a head-to-toe assessment as resident was screaming no and resisting with physical pushing away of this nurse. will continue to monitor. This is the same narrative that was documented in R12's Initial Skin Alteration Record dated 11/23/24. On 12/09/24 at 9:59 PM, when asked if she completed the Weekly Skin Check dated 11/24/24, V19 (RN) stated R12 was sitting in his wheelchair, and she noticed the area on his arm was healed. V19 was asked if she assessed any other skin on R12 and she stated, No, I just looked at his arm. V19 stated they have another nurse who does all the treatments for south side. This surveyor reviewed with V19 that R12 wasn't located on that side and V19 stated she thought he was. This surveyor then asked V19 if she did a physical assessment of R12's skin from 11/23/24 until 12/01/24 and if she completed the 11/24/24 Weekly Skin Check and V19 stated, I don't remember. I usually just ask the CNA if the residents have any skin changes. On 12/9/24 at 12:50 PM, this surveyor reviewed the 11/23/24 initial skin assessment and the 11/24/24 weekly skin assessment with V2 (DON) and she stated the 11/24/24 assessment looks like it was copied and pasted from the 11/23/24 assessment. R12's Skin Monitoring: Comprehensive CNA Shower Review documents dark bruising to R12's left arm, heels as red, coccyx as dark red, a bandage to the inside of his inner right leg and a bandage on his left hip with V17's (CNA) signature dated 11/30/24. This Review documents V2 (DON's) signature with a date of 11/30/24 with no assessment of the new areas documented under Nurse Assessment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/5/24 at 8:37 AM, V17 (CNA) stated R12's condition had declined when he returned from the hospital on 11/23/24. V17 stated R12 wasn't eating, drinking, and/or communicating as well. V17 stated she gave R12 a bed bath on 11/30/24 and found a bandage on his left hip that was looking a little rough. V17 did not remember if there was a date on the bandage that would indicate when it was placed. V17 stated when she rolled R12 over she noticed R12's coccyx was dark red, and his right hip was splotchy in color. V17 stated she was concerned R12 was mottling and then she removed his socks and noted that both of his heels were dark red as well. V17 stated there was a bandage on R12's inner thigh that didn't look as bad as the one on his left hip, but she again didn't know if there was a date on it. V17 stated she didn't remove the bandages, so she didn't know what his skin looked like under them. V17 stated she documented the areas on the shower sheet and told V2 (Director of Nurses) who was working as her nurse that night. V17 stated she told V2 she was worried R12 was dying and that his family needed to be notified. V17 stated she also reported the change in R12's condition to the oncoming shift and her supervisor (V21/CNA Supervisor). V17 stated R12 was sent out to the hospital two days later so she assumed someone heard her concerns. When asked what interventions were in place to prevent the pressure injuries from worsening, V17 stated there was a pillow under his left hip that was always there because of previous skin issues but that was the only intervention in place. V17 stated R12 was clean and dry when she changed him and that he was dependent on staff for all care. On 12/5/24 at 1:48 PM, V21 (CNA Supervisor) stated V17 told her R12's skin looked bad, but she didn't remember the date this occurred. V21 stated she asked V17 if she had reported it to the nurse and V17 told her she reported it to V2 (DON). On 12/5/24 at 12:04 PM, V2 (DON) stated she didn't remember signing off on the 11/30/24 shower sheet that documented the new areas of skin breakdown for R12. V2 stated she was working the floor that day and was told she had to get skin assessments on all the residents. V2 stated she attempted to get other nurses to assist her with it and was not able to get anyone to assist. V2 stated V17 (CNA) helped her by doing skin assessments and documenting them on the shower sheets. V2 stated she knew R12 was declining, not getting out of bed, not eating, and not drinking. V2 stated, I am really pi**ed off at myself and the building because I had zero help except for the CNA's who can't make calls or write orders. It can't be just me. I don't have any help at all. When asked if she ever assessed R12's skin, V2 stated, No. V2 stated the skin assessments were done on Sunday 11/30/24 but she didn't sign them until Monday, December 01, 2024. V2 stated she wished V17 had told her on Friday, how bad R12's skin was. When asked to clarify if R12's skin was assessed on Friday 11/29 or Saturday 11/30, V2 stated they were working midnight shift, and she wasn't sure if it was before or after midnight. V2 stated it was miscommunicated and they missed it. V2 stated if she had done R12's skin assessment she would have notified the physician and obtained orders for treatments. V2 stated they recognized there was an issue and have put things in place to make it better. V2 stated they are checking each morning during clinical rounds to make sure skin assessments are being done. V2 stated R12 should have had a head-to-toe assessment on 11/23/24 when he returned from the hospital and again before he went back to the hospital on 12/01/24. On 12/5/24 at 11:16 AM, V18 (Registered Nurse) stated she followed R12 closely even when she wasn't his nurse. V18 stated he wasn't eating well, and his oxygen dependence was increasing. V18 stated R12 didn't start showing skin breakdown until 11/30/24 and she was working on the other side that day. V18 stated she told his nurse she would be over there the next day and would look at him then. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/09/24 at 10:18 PM, V24 (CNA) stated she provided care to R12 between 11/23/24 and 12/01/24. V24 stated R12 was incontinent of bowel and bladder and was not able to turn and reposition himself. When asked what interventions were implemented to prevent pressure ulcers from developing, V24 stated they were turning and repositioning R12 and using pillows for support. V24 stated she was aware of the areas of skin breakdown on R12, and he had them for probably a couple of weeks. R12's facility Progress Notes document: 11/30/24 - 1907 (7:07 PM) Resident has a loss of appetite and motivation. Resident continues to take medication but not showing any improvement. This nurse will continue to monitor. Reported to nightshift nurse. If not showing improvement by mid shift tomorrow, will reach out to provider for further intervention. 12/01/24 - 14:06 (2:06 PM) Resident still not doing well and declining. Despite antibiotics, resident has not eaten in two days, has crackles throughout lung fields, febrile at 102.8 F (Fahrenheit), today extreme lethargy to the point where nursing judgement is that it is not safe to give PO (oral) medication. EMS (Emergency Medical Services) called for emergent send out for possible sepsis. Provider and POA (Power of Attorney) notified. Vital signs as follows: 154/64, pulse 138, respirations 28 and shallow with crackles and wheezes, Temp (temperature) 102.8, post Tylenol, O2 (oxygen) at 91 on 4 L (liters). 12/01/24 - 4:26 PM, (R12) admitted IP (in patient) for AMS (altered mental status) and sepsis r/t (related to) aspiration PNE (pneumonia). R12's local hospital records dated 12/01/24 documents Patient presents from the nursing home for altered mental status. He is somnolent. This hospital record documents under the physical exam dated 12/01/24 . Skin: General skin is warm and dry. Comments: Sacral decubitus, multiple wounds left buttocks, left hip, heels, left arm - see photos R12's hospital records document under Wound Nurse Note, Wound care: Wound consult completed w/(with) dressings applied to the following POA Pis (present on admission pressure injuries): right medial heel: DTPI (deep tissue pressure injury) & (and) left lateral heel.: DTPI & coccyx: Stage 3 PI and Left buttock: Stage 2 PI and left lateral knee: Stage 2 PI; and skin tear located on the left elbow previously dressed per assigned RN (Registered Nurse). R12's hospital records document the following assessments of the pressure areas all dated 12/01/24. 1. DTPI right heel- measured 4.5 cm (centimeters) x 3. 8 cm described as purple, painful, dry, intact, non-blanchable. 2. Pressure injury of left lateral heel measured 2 cm x 1.5 cm and described as non-blanchable, purple, dry, intact. 3. Stage 2 pressure injury left buttocks measured 0.6 cm x 0.7 cm x 0.1 cm and described as partial thickness, red moist, painful, blanchable with scant serous drainage. 4. Stage 3 pressure injury to midline coccyx measured at 1.5 cm x 0.9 cm x 0.2 cm and described as full thickness, moist, painful, with scant amount of serosanguinous drainage, and 5. Stage 2 pressure injury to left lateral knee measured at 0.9 cm x 0.5 cm x 0.1 cm and described as red, moist, with scant amount of serous drainage. On 12/4/24 at 8:55 AM, V16 (Registered Nurse-hospital) stated he was familiar with R12. V16 stated R12 was admitted to the hospital on 11/17/24 and discharged back to the facility on [DATE]. V16 stated R12 had three wounds when he left the hospital on 11/23/24 that had dressings on them. V16 stated when R12 returned to the hospital on 12/01/24, R12 still had the same dressings on the original three wounds that was on when he was discharged on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/18/24 at 3:00 PM, V39 (Physician) stated she provided care to R12 during his hospital stay beginning on 12/01/24. V39 stated R12 had been discharged from the hospital about a week (11/23/24) prior and when he returned to the hospital on 12/01/24, he had more pressure ulcers that had developed while at the facility. V39 stated R12 wasn't turned and repositioned while at the facility which led to R12 developing more pressure ulcers. On 12/05/24 at 2:08 PM, V14 (Physician) reviewed R12's hospital records and stated the pressure areas on R12's hip deteriorated from 11/23/24 to 12/01/24. V14 stated the area on R12's trochanter increased in size from 11/23 to 12/01/24. When asked if the pressure ulcers/injuries were avoidable, V14 stated the areas on R12's heels would have been preventable. On 12/09/24 at 1:29 PM, V14 (Physician) stated if R12 was immobile from somnolence then it could precipitate him developing pressure ulcers. According to the Medical Dictionary located at the website Somnolency | definition of somnolency by Medical dictionary the definition of somnolent is 1. Drowsy; sleepy; having an inclination to sleep. 2. In a condition of incomplete sleep; semi-comatose. On 12/4/24 at 4:00 PM, V1 (Administrator) stated R12 had new areas identified on his 11/30/24 shower sheet. V1 stated there were no assessments, treatment orders, physician notification, or physician orders documented in R12's record related to the new areas. V1 stated her expectation would be for any new area of skin breakdown to be assessed and the physician notified for treatment orders. 2. R1's Admission Record with a print date of 6/17/24 documents R1 was admitted to the facility on [DATE] with diagnoses that include osteomyelitis of vertebra, sacral and sacrococcygeal region, diabetes, peripheral neuropathy, hypertension, obesity, and malignant neoplasm of large intestine. R1's MDS dated [DATE] documents a BIMS score of 15, indicating R1 is cognitively intact. This same MDS documents R1 requires substantial maximal assistance to roll left and right and is dependent on staff for chair/bed to chair transfer. R1's current Care Plan documents a Focus area of (R1) was admitted with a Stage III pressure ulcer to coccyx. Is at risk for breakdown r/t requires assist with bed mobility, has Foley catheter and colostomy Date Initiated: 06/28/2024. This Focus area includes the following interventions.skin prep as ordered to right heel until wound MD (physician) can assess. d/c (discontinue) 8/14/24 Date Initiated: 09/22/2024 . R1's Braden Scale dated 11/19/2024 documents a score of 14, indicating R1 is at moderate risk of skin breakdown. On 11/26/24 at 3:09 PM, R1 stated she had a few little sores on her buttocks that burned when they got wet. On 11/27/24 at 2:23 PM, R1's skin was observed with V2 (DON) present. There was an open area observed on R1's right buttocks and R1's right heel was mushy per V2 (DON). R1's Order Summary Report dated 12/02/2024 includes the following physician orders, Apply skin prep to bilateral heels Q shift to preserve skin integrity, every day and night shift . Order date 12/01/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's progress notes do not document an assessment of the areas identified during the observation on 11/27/24. On 12/2/24 at 1:22 PM, V2 (DON) stated she forgot to get and implement orders for the area that was identified on R1's hip on 11/27/24. V2 stated she had no excuse it just got dropped. On 12/4/24 at 3:37 PM, V24 (Wound Specialist) stated R1's heels were a little mushy and he recommend heel protectors. V24 stated when he looked at R1's buttocks today, 12/4/24 it was not open, and it looked like old scar tissue. V24 stated they didn't notify him of an open area on her buttocks. 3. R2's Admission Record with a print date of 12/2/24 documents R2 was admitted to the facility with diagnoses that include atrial fibrillation, diabetes, peripheral neuropathy, morbid obesity, hemiplegia, hemiparesis, and hypertension. R2's MDS dated [DATE] documents a BIMS score of 14, which indicates R2 is cognitively intact. This same MDS documents R2 is requires substantial to maximal assistance for rolling left to right. R2's Braden Scale dated 11/28/2024 documents a score of 13, indicating R2 is at moderate risk of skin breakdown. R2's current Care Plan documents a Focus area of (R2) is at risk for skin breakdown r/t (related to) requires assist with bed mobility, occasionally incontinent of Bladder and is continent of bowel, dx (diagnosis) obesity. Date Initiated: 12/21/2022. The interventions documented for this Focus area include, .Heel protectors on when in bed. Date Initiated: 08/29/2023. On 11/26/24 at 8:51 AM, R2 was in bed with blankets covering most of her body. R2 stated she doesn't get out of bed often since she had her stroke. R2 stated she has a pressure ulcer on her foot they have been treating. R2 stated they usually put a pillow under her feet, but her knee locked up yesterday, so they don't have it there. On 11/26/24 at 11:10 AM, V3 (LPN/Licensed Practical Nurse) was observed providing treatment and doing a skin check for R2. V3 stated R3's right heel was red and a little soft. V3 stated this was a new area and she would have to do a skin assessment and it would be documented in the electronic record once she had completed it. The Initial Skin Alteration Record dated 11/26/24 does not document the red soft area to R3's heel. R2's Order Summary Report dated 12/02/24 documents a physician order with a start date of 12/01/24 to, Apply skin prep to bilateral heels Q (every) shift to preserve skin integrity. This same report documents a physician order with a start date of 7/22/24 for Heel protectors to be in place when in bed every shift for skin integrity. On 12/2/24 at 1:22 PM, V2 (DON) stated the physician was notified of the new areas to R2's heel and she refused to allow them to float her heels. On 12/2/24 at 3:02 PM, R2 was observed lying in bed with bilateral heel protectors in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/4/24 at 3:37 PM, V24 (Wound Specialist) stated R2's heels looked ok today (12/4/24). V24 stated he encouraged heel protectors, not skin prep. When asked if he would expect heel protectors to be in place prior to skin breakdown, V24 stated it isn't a standing order, but it would definitely cut down on wound problems. 4. R3's Admission Record with a print date of 12/02/24 documents R3 was admitted to the facility on [DATE] with diagnoses that included diabetes, peripheral vascular disease, cirrhosis of liver, hypertension, and solitary pulmonary nodule. R3's MDS dated [DATE] documents R3 has a BIMS score of 05, which indicates R3 has a severe cognitive deficit. R3's current Care Plan documents a Focus area of (R3) is at risk of skin impairment r/t (related to) dx (diagnosis) DM (diabetes mellitus) with polyneuropathy, PVD (peripheral vascular disease) frequently incontinent of B & B (bowel and bladder), requires assist with bed mobility. He was admitted with Chest tube to right lung. Date Initiated: 10/31/2024. The interventions documented for this Focus area include, .drain fluid from chest tube right lung as ordered. Date Initiated: 12/01/2024 . Provided with bilateral elbow pads for prevention. Date Initiated: 11/20/2024. The same Focus area includes the following interventions initiated on 10/31/24, Educate resident/family/caregivers of causative factors and measures to prevent skin injury . Encourage good nutrition and hydration in order to promote healthier skin .Follow facility protocols for treatment of injury .Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. (etcetera) to MD (physician) Pressure relief mattress on bed and cushion in w/c (wheelchair). R3's Braden Scale dated 11/07/2024 documents a score of 16, indicating R3 is at low risk of pressure ulcers. R3's Weekly Skin Check dated 11/23/2024 documents under Comments, .Heels and bony prominences intact with the exception of right elbow which is being treated There is no assessment or description of the area on R3's right elbow. R3's Weekly Skin Check dated 11/24/24 documents under Comments, On (sic) continues tx (treatment) to groin, buttocks with protective cream and T& P (turn and position). Exception of right elbow which is being treated . There is no assessment or description of the area documented on this assessment. R3's Wound Specialist progress note dated 11/27/24 does not document a wound to R3's right elbow. On 11/27/24 at 8:54 AM, R3 was in his room, sitting in his wheelchair with long sleeved shirt on and no elbow pads were observed. On 11/27/24 at 1:47 PM, R3's skin was observed with V6 (Registered Nurse) present. V6 removed the dressing to R3's right elbow and a pinpoint open area was observed with yellow/white slough appearing tissue observed surrounding the open area. V6 stated R3 doesn't normally wear anything on his elbows to protect them. V6 stated there is always a bandage in place and he usually wears long sleeves. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/27/24 at 1:57 PM, V8 (CNA/Certified Nursing Assistant) stated R3 doesn't wear elbow pads but the dressing is always on. On 11/27/24 at 2:01 PM, V7 (CNA) stated she wasn't aware R3 was supposed to be wearing elbow pads. V7 stated she hadn't seen any elbow pads in his room, and she had taken care of R3 twice this week and twice last week. On 12/4/24 at 3:37 PM, V24 (Wound Specialist) stated he at first thought the area on R3's elbow was a skin tear. V24 stated on his last visit the area was seeping with a lot of fluid and he thought it went all they way into the joint space. V24 stated he didn't know how beneficial elbow pads would be. When asked if there was an open area and the resident was continually applying pressure would cushion of some kind prevent it from worsening, V24 stated, Maybe. On 12/2/24 at 1:22 PM, V2 (Director of Nurses/DON), stated she had never seen R3's care plan intervention for elbow pads. V2 stated the area started as cellulitis and they started him on antibiotics and then she didn't like the way it looked so she had him seen by V24 (Wound Specialist). The facility Decubitus Care/Pressure Areas policy dated September 2024 documents, Policy: To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified. Procedure: Upon identification of skin breakdown, the following will be completed; 1) The pressure area will be assessed and documented. 2) Complete all areas of a wound assessment following NPUAP (National Pressure Ulcer Advisory Panel) guidelines i) Document size, stage, site, depth, drainage, color, odor, and treatment (once obtained from the physician) 3. Notify the physician for treatment orders 4. Documentation of the pressure area must occur upon identification and at least once each week 8) Initiate problem area on care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on observation, interview, and record review the facility failed to ensure medications were administered per current standards of practice for 5 of 7 (R9, R15, R16, R17, R18) residents reviewed for pharmacy services in the sample of 19. Findings Include: 1. R9's Admission Record with a print date of 12/02/24 documents R9 was admitted to the facility on [DATE] with diagnoses that include esophageal obstruction, dysphagia, fracture of sternum, gastrostomy, bipolar disorder, depression, and generalized anxiety disorder. R9's MDS dated [DATE] documents a BIMS score of 13, which indicates R9 is cognitively intact. R9's Order Summary Report with Active Orders as of 12/02/2024 includes the following physician orders, valproic acid oral solution 250 milligrams (mg)/5 milliliters (ml) give 10 ml via G-tube (gastrostomy tube) three times a day for anti-seizure, sucralfate oral suspension give 10 ml via G tube four times a day for GERD (gastroesophageal reflux disease), hydroxyzine 25 milligrams (mg) one tablet three times daily, tizanidine 4 mg give one table via G-tube three times a day for muscle relaxer, gabapentin 600 mg give one tablet via G-tube three times a day for neuropathy. This same Order Summary Report documents under Enteral-Feed, Enteral Feed Order three times a day for nutrition Jevity 1.5 237 ml TID (three times a day) 120 cc (cubic centimeter) flushes TID. There is no physician order documented on how to administer R9's medications. R9's current Care Plan documents a Focus area (R9) is at risk for nutritional deficit r/t (related to) dx (diagnosis) esophageal obstruction, dysphagia. Has g-tube, tube feeding, and flushes as ordered. May have clear liquids only by mouth. Is having dilatation of esophagus done as ordered. Is having dilatation of esophagus done as ordered. (R9) sometimes likes to participate in tube feeding administration. 2/22/22 is non-compliant with NPO (nothing by mouth) order. Stated I will eat and drink whatever I want. Educated on importance of compliance (risk vs (versus) benefits explained, voiced understanding) 11/15/23 Pleasure eating as tolerated per Hospice. Date Initiated: 11/11/2021. This Focus area includes interventions that includes an intervention of, Tube feeding as ordered with flushes as ordered. Date Initiated: 11/11/2021. On 11/26/24 at 1:22 PM, V3 (Licensed Practical Nurse/LPN) prepared R9's medications while standing outside of R9's room at the medication cart. V3 poured out the liquid valproic acid and the sucralfate into cups and then mixed them together. V3 poured the hydroxyzine 25 mg, tizanidine 4 mg, and gabapentin 600 mg onto the medication cart. V3 picked up the medications that were laying on the cart with her ungloved hand without performing hand hygiene. V3 crushed the medications and mixed the crushed pills in the cup with the liquid valproic acid and sucralfate. V3 took the medications into R9's room and handed her the cup containing the medications. V3 stated R9 normally self-administers her medications and V3 does not normally observe R9 self-administering her medications. This surveyor observed R9 flush her G-tube with tap water, push the medications V3 had provided her through the G-tube using a syringe, and then flush the tube with tap water. V3 exited the room without performing hand hygiene. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's medical record documents a Self Administration Review dated 12/2/24 that documents under Physician Review, Resident may proceed with the training program and self administer medications. R9's medical record did not document any Self Administration assessments prior to the assessment dated [DATE]. 2. R15's Admission Record with a print date of 12/2/2024 documents R15 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease, adult failure to thrive, anemia, hypertension, gastroesophageal reflux disease, and peripheral neuropathy. R15's MDS dated [DATE] documents a BIMS score of 11, indicating a moderate cognitive deficit. R15's Order Summary Report with Active Orders as of 12/02/24 includes the following physician orders, gabapentin 100 mg take one capsule by mouth three times daily and sucralfate one gram give one tablet by mouth four times daily. On 11/26/24 at 1:17 PM, V3 (LPN) poured R15's gabapentin onto the medication cart, picked it up with her hands without performing hand hygiene or donning gloves. V3 then entered R15's room administered his medication and exited the room without performing hand hygiene. 3. R16's Admission Record with a print date of 12/2/24 documents R16 was admitted to the facility on [DATE] with diagnoses that include spinal stenosis, anxiety disorder, chronic pain syndrome, hypertension, peripheral neuropathy, anemia, depressive episodes, osteomyelitis, and localized edema. R16's MDS dated [DATE] documents a BIMS score of 15, indicating R16 is cognitively intact. R16's Order Summary Report with Active Orders as of 12/02/24 includes the following physician orders. Dicyclomine 10 mg one capsule by mouth three times daily, hydralazine 50 mg one tablet three times daily, oxycodone 10 mg one tablet four times daily, Buspar 10 mg one tablet three times daily, and gabapentin 300 mg one capsule by mouth three times daily. R16's Order Summary Report does not document an order for R16 to self-administer medications. On 11/26/24 at 12:08 PM, V3 (LPN) placed R15's dicyclomine 10 mg, hydralazine 50 mg, oxycodone 10 mg, Buspar 10 mg, and gabapentin 300 mg in a cup to administer. V3 entered R15's room and left the medications sitting in the cup on the bedside table. V3 exited R15's room without observing R15 take the medications and without performing hand hygiene. 4. R17's Admission Record with a print date of 12/02/24 documents R17 was admitted to the facility with diagnoses that include hypertension and anxiety disorder. R17's MDS dated [DATE] documents a BIMS score of 15, which indicates R17 is cognitively intact. R17's Order Summary Report with Active Orders as of 12/02/2024 includes the following physician orders of Ativan 1 mg one tablet by mouth every 6 hours for anxiety, lactulose 10 mg/15ml give 30 ml by mouth three times daily, and oxycodone 20 mg every 8 hours for pain. On 11/26/24 at 12:11 PM, V3 entered R17's room after preparing his Ativan 1 mg and lactulose 30 ml for administration and left the medication cart sitting in the hallway unlocked while she entered the room and administered R17's medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/26/24 at 1:18 PM, V3 entered R17's room and administered oxycodone 20 mg. R16 dropped the medication cup on the floor, V3 leaned onto the floor, touching her left hand flat on the floor, to retrieve the medication cup. V3 threw the cup away exited the room without performing hand hygiene and continued to administer other resident's medications. 5. R18's Admission Record with a print date of 12/02/24 documents R18 was admitted on [DATE] with diagnoses that include chronic obstructive pulmonary disease, hypertension, anxiety disorder, and peripheral neuropathy. R18's MDS dated [DATE] documents a BIMS score of 15, which indicates R18 is cognitively intact. R18's Order Summary Report with Active Orders as of 12/02/2024 includes the following physician orders for Lasix 40 mg one tablet twice daily, nortriptyline 25 mg one every afternoon, senna 8.6 mg one in the afternoon, spironolactone 100 mg one every afternoon, venlafaxine 150 mg one twice daily, pioglitazone 30 mg one every afternoon. On 11/26/24 at 12:02 PM, V3 (LPN) V3 was observed opening the individual packages of R18's Lasix 40 mg, nortriptyline 25 mg, senna 8.6 mg, spironolactone 100 mg, venlafaxine 150 mg, and pioglitazone 30 mg and poured them onto the medication cart. V3 picked up the medications without performing hand hygiene or donning gloves and placed them in the medication cup. V3 entered R18's room and administered the medications. V3 exited R18's room without performing hand hygiene. On 12/2/24 at 1:22 PM, V2 (Director of Nurses) stated she would expect the licensed nurses to follow the policies and procedures when administering medication. V2 stated she hadn't checked R9's medical record to see if she was assessed to self-administer her medications. V2 stated there should be a physician order for how R9's medications should be administered. V2 reviewed R9's medical record and was not able to locate a physician's order and/or an assessment to self-administer medications. The facility Administering Medications policy dated January 2024 documents, Medications shall be administered in a safe and timely manner, as prescribed .16. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide 22. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable .24. Residents may self-administer medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure residents were free of unnecessary medications when they failed to discontinue psychotropic medications as ordered by the physician for 1 of 3 (R12) residents reviewed for unnecessary medications in the sample of 19. Findings Include: R12's Admission Record with a print date of 12/5/24 documents R12 was admitted to the facility on [DATE] with diagnoses that include fracture of left femur, hypotension, diabetes, schizophrenia (diagnosis added on 11/07/24), bipolar disorder (added on 11/07/24) difficulty walking, and muscle weakness. R12's MDS (Minimum Data Set) dated 10/17/2024 documents R12 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R12 is cognitively intact. R12's current Care Plan documents a Focus area of (R12) uses psychotropic medications (Escitalopram) r/t (related to) dx (diagnosis) depression, anxiety, schizophrenia. 10/9/24 Clonazepam for agitation. 10/27/24 Clonazepam increased. 10/29/24 Escitalopram decreased. 11/8/24 Haldol. Date Initiated: 05/03/2024. Interventions for this Focus area include, Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 05/03/2024 . R12's Care Plan/Behavior Tracking Record for November documents R12 has behavior tracking for verbal abuse and racial slurs, telling stories and untruths, and hitting himself in the head for attention. R12's behavior tracking documents R12 did not display the behavior of verbal abuse and racial slurs in 11/2024. R12's behavior tracking documents R12 displayed the behavior of telling stories and untruths on 11/2, 11/4-11/10, and 11/14-11/16/24. R12's behavior tracking documents R12 displayed the behavior of hitting himself in the head for attention on 11/1, 11/2, 11/3, 11/5, 11/6, 11/10, 11/12, 11/14-11/16, and 11/27/24. R12's local hospital record documents R12 was admitted to the local hospital on 11/17/24 and discharged back to the facility on [DATE]. This same hospital record documents under Hospital Course, .Patient advised to take Augmentin 875 for 3 days post discharge. He was also advised to stop taking Haldol and Clonazepam as the medications were held for the entirety of his admission and he had no psych issues . Under Active Issues Requiring Follow-up and Discharge Plan the hospital records document, .Please stop taking Haldol. Please stop taking Clonazepam . R12's facility Progress Note dated 11/23/24 documents, Resident's Haldol and Clonazepam discontinued by hospital at discharge. Antibiotic added Discharge medication list faxed to (name of pharmacy) and (V14/Physician) office. Provider notified of arrival. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Carbondale	120 North Tower Road Carbondale, IL 62901

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's facility Order Summary Report Active Orders as of 11/30/24 includes the following physician orders, Clonazepam 0.5 mg (milligrams) Give 0.5 mg by mouth three times a day for anxiety, with a start date of 10/27/24 and Haloperidol (Haldol) oral tablet 5 mg Give 5 mg by mouth three times a day related to schizophrenia, unspecified; bipolar disorder unspecified, with a start date of 11/08/24. There is no end or discontinue date documented for either physician order. R12's Progress Notes dated 11/24/24 at 2:57 PM signed by V18 (RN/Registered Nurse) documents, Clonazepam Tablet 0.5 MG, give 0.5 mg by mouth three times a day for anxiety Resident's medication was dc'd (discontinued) at the hospital. Reaching out for clarification on medication. R12's Medication Administration Record (MAR) dated 11/01/24 to 11/30/24 documents an order for Clonazepam 0.5 mg to be administered at 9:00 AM, 2:00 PM, and 9:00 PM. This MAR documents initials indicating Clonazepam 0.5 mg was administered at 9:00 PM on 11/23, 11/24, 11/26-11/30, at 9:00 AM 11/24-11/30/24 and at 2:00 PM 11/26-11/30/24. This same MAR documents the Clonazepam was held at 2:00 PM on 11/24 and 11/25/24. This indicates upon R12's return to the facility the Clonazepam was administered 20 times and held three times. This same MAR documents an order for Haldol 5 mg to be administered at 9:00 AM, 2:00 PM, and 9:00 PM with initials documented indicating R12 was administered Haldol at each dose time from 11/23/24 to 11/30/24. On 12/18/24 at 3:00 PM, V39 (Physician) stated she provided care to R12 during his hospital stay beginning on 12/01/24. V39 stated when R12 was discharged from the hospital on 11/23/24 they had discontinued the Haldol and Clonazepam. V39 stated the facility continued to give R12 those medications. On 12/16/24 at 12:37 PM, V18 (Registered Nurse/RN) stated she was responsible for readmitting R12 to the facility after his return from the hospital on 11/23/24. V18 stated she charted the Haldol and Clonazepam had been discontinued in the progress notes. V18 stated when she returned to work the next day, she noticed they were still active on R12's medication list so she held them waiting for clarification. V18 stated she spoke with the night shift nurse (V19/RN) who said she had taken care of it and the medications were reinstated so she assumed the physician had given an order to resume them. On 12/28/24 at 10:00 AM, V19 (RN) stated V18 was the day shift nurse when R12 returned from the hospital, and she (V19) was the oncoming night shift nurse. V19 stated V18 reported to her R12's medications were discontinued by the hospital. V19 stated R12 doesn't have any medications ordered on night shift other than Tylenol. V19 stated she did not call the physician to clarify the medication orders from the hospital discharge. V19 stated she wouldn't have had a reason to look at those medications and/or orders since R12 didn't take medications on her shift and V18 had reported to her they were discontinued. On 12/4/24 at 2:35 PM, V5 (CNA/Certified Nursing Assistant) stated mid-November, R12 stopped eating, started refusing care, and became a two person assist. V5 stated it was a change in R12's condition and it worsened when he came back from the hospital on 11/23/24. V5 stated R12 would get up for meals before he went to the hospital and when he came back, he would barely eat and/or drink and even stopped yelling down the halls. V5 stated she reported this to an unknown nurse, and she thought the nurse assessed R12 and documented it. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 12:50 PM, V2 (DON/Director of Nurses) stated the Haldol and Clonazepam were started because R12 had extreme behaviors. V2 stated after it was discontinued at the hospital, she assumed V15 (Psychiatric Nurse Practitioner/Psych NP) had resumed the order when he returned to the facility and that was why he was still getting the medications. On 12/9/24 at 1:02 PM, V15 (Psych NP) stated the facility did not notify her R12 had been to the hospital and/or that the medication had been discontinued by the hospital physicians. V15 stated she looked back at her communication with the facility, and she got a message R12 needed a refill on his Clonazepam but was never notified by the facility the medication had been discontinued. V15 stated she hadn't seen R12 since 10/24/24 and her expectations would be that if a medication were discontinued while the resident was at the hospital it would stay discontinued when they returned to the facility. On 12/11/24 at 8:14 AM, V15 (Psych NP) stated she did not have a diagnosis of schizophrenia documented in her records for R12. V15 stated she wasn't able to give him a diagnosis of schizophrenia since he wasn't able to give her a history documenting he had been diagnosed with it in his past. V15 stated her diagnoses for R12 were anxiety disorder, mild cognitive impairment, and unspecified psychosis. V15 stated R12 has a seventh-grade education which made it hard to diagnose an intellectual disability. V15 stated R12 was having behaviors of yelling out, hitting himself, and suicidal ideations. V15 stated the facility called her and asked for an order for Haldol and she told them she would order Clonazepam but not Haldol since he didn't have a diagnosis of schizophrenia. V15 stated the facility sent her a physician progress note from another physician dated 7/7/24 that documented a diagnosis of schizophrenia, so she ordered the Haldol for him. The facility Behavioral Assessment, Intervention and Monitoring policy dated 2023 documents, 1. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. 2. Residents who do not display symptoms of, or have not been diagnosed with, a mental, psychiatric psychosocial adjustment or post-traumatic stress disorder will not develop a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors that cannot be explained or attributed to a specific clinical condition that makes the pattern unavoidable. Residents will have minimal complications associated with the management of altered or impaired behavior. 3. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes.