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	02/10/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on observation, interview, and record review, the facility failed to ensure dignity was maintained during dining when staff remained standing to provide feeding assistance for 1 (R205) of 4 residents reviewed for resident rights in a sample of 42. Findings include: R205's Admission Record dated 01/30/25 documents an admitted [DATE] with diagnoses in part of unspecified dementia, altered mental status, Parkinson disease, and muscle weakness. R205's Baseline Care Plan with a date of 01/15/25 documented under functional ability and goals self-care of eating set-up. R205's Minimum Data Set (MDS) dated [DATE] documents in a Brief Interview for Mental Status (BIMS) score of 04, indicating R205 has severely impaired cognition. Under Functional Abilities, the MDS documented R55 required set-up and supervision with eating. On 01/27/25 at 12:35PM, V21 (Certified Nurse Assistant/CNA) walked over to assist R205 with eating. V21 stood up next to R205 and attempted to feed R205 her meal. V21 never sat down next to R205 while assisting with feeding. V21 stopped assisting R205 and took her out of the dining room. At this time, R205 had consumed approximately 25% of her meal. On 01/30/25 at 10:33AM, V15 (CNA) stated that when assisting residents with eating you are to sit down when assisting any resident. V15 said that you should be able to make eye contact when assisting a resident. On 01/30/25 at 10:43AM, V19 (CNA) stated that she usually always sits down when assisting residents with eating. V19 said that she always wants to make sure that she is eye level with the resident when they are eating to make sure they aren't choking or anything. On 01/30/25 at 10:45AM, V16 (CNA) stated that when she assists resident to eat that sometimes she sits down and sometimes she will stand up and assist them with eating. V16 said that usually she always tries to sit, but she also had to stand at times and just give some bites. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/25 at 1:30PM V1 was asked for policies on eating assistance and dignity. V1 brought in a paper stating that they did not have a policy on eating assistance or dignity.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on observation, interview, and record review, the facility failed to ensure resident's and/or resident representative's preferences for room accommodations and showers to ensure dignity were maintained for 2 (R55 and R51) of 4 residents reviewed for reasonable accommodations/preferences in a sample of 42. ' Findings include: 1. R55's Admission Record documents an admitted [DATE] and included the following diagnoses: vascular dementia, mild with psychotic disturbances, history of falling, depression, muscle weakness and difficulty walking, not elsewhere classified. R55's MDS (Minimum Data Set) dated 01/24/25, documents a BIMS (Brief Interview for Mental Status) of 11, indicating that R55 is moderately cognitively impaired. Under Functional Abilities, the MDS documents that R55 requires partial/moderate assistance with toileting hygiene and lower body dressing. In the section for indoor mobility R55 needs some help-Resident needed assistance from another person to complete any activities. Under Bowel and Bladder, the MDS documents R55 is occasionally incontinent of bladder and frequently incontinent of bowel. On 01/27/25 at 10:04 AM, 01/28/25 at 09:04 AM, 01/29/25 at 12:45 PM, and 01/30/25 at 09:14 AM, attempts were made to interview R55 and she appeared to be alert to person but unable to respond to this surveyor. R55 smiled when this surveyor said her name, but that was her only response. On 01/27/25 at 10:03 AM, V36 (Family Member) stated every time they come in R55's room, usually later in the morning, she is sitting in the dark, alone without her tv turned on. V36 stated that R55 has suffered from depression for years, is very confused most days, and sitting in the dark cannot be helping that. On 01/28/25 at 09:04 AM, R55 was observed sitting on the side of her bed with a breakfast tray in front of her. Neither the lights nor the television (tv) were on in her room. An interview was attempted, but R55 did not acknowledge this surveyor after several attempts. On 01/29/25 12:01 PM, V37 (Family member) stated every time they come to visit R55, she is sitting on the edge of the bed, in the dark and her tv is off. V37 stated that R55 has a history of falling but she is content when sitting in front of the tv. V37 stated because of this, he feels leaving R55 to sit in the dark alone with no tv on would not be a good idea. V37 stated he has brought this issue to multiple staff members' attention. V37 stated R55's tv remote was lost for the first three days she was here, and they continued to ask staff about it. On 01/29/25 at 12:45 PM, R55 was laying awake on the edge of her bed and staring at the window. R55's lights and television were off. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/25 at 09:14 AM, R55 was observed sitting on the side of her bed with her lights and television off. On 02/03/25 at 10:42 AM, V36 stated he came in this past Friday morning and R55 was again sitting on the edge of the bed in the dark with no tv on. V36 stated R55 wanted to put pants on, and he could not find her house shoes. He looked in both closets and stated he saw a dirty depends sitting on top of a pillow inside. V36 stated he felt like the room was in disarray. V36 stated he finally found R55's house shoes under the other bed in the room. V36 stated he went to the nurse's station and asked for the Administrator, he spoke with her about his concerns and felt like he was brushed off. On 2/4/25 at 4:14 PM, V1 (Administrator) stated she did have a grievance started on the concerns brought to her by R55's family. V1 stated she was in the room when they told her about their concerns and didn't think the room looked dirty. V1 stated staff told her there was an open (adult brief), but it wasn't dirty in the closet. V1 stated she didn't look in the closet to see for herself, but that they had given her a list of things she needed to fix, and she just left and started working on the list. 41610 2. R51's Admission Record documents an admitted [DATE] with diagnoses that included: cancer, diabetes mellitus, and chronic obstructive pulmonary disease. R51's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 09, indicating R51 has moderate cognitive impairment. R51's MDS also documented R51 requires substantial to maximum assistance for showering/bathing. On 01/28/25 at 7:30 AM, R51's hair appeared greasy and unwashed. On 01/29/25 at 2:52 PM, R51's hair again appeared unwashed. On 01/29/25 at 2:52 PM, R51 stated she received a shower right around when she arrived and hasn't had an actual shower since then. R51 stated they will wipe her off with the wipes in the important areas sometimes, but she just wants to be able to actually wash herself. R51 stated that she hasn't been given a bed bath with water in a basin. On 01/30/25 at 1:05 PM, R51 stated she would prefer a shower over them just quickly wiping her. R51 said she has never refused a shower and the staff do not tell her why she is getting wiped off instead of a shower. On 01/30/25 at 2:30 PM, V7 (Certified Nurse Aide/CNA) stated she has never given R51 a shower, she did wipe her off one time. V7 stated she did not shower R 51 at that time because R51 needed to leave for an appointment, and she just wanted to get her cleaned up a bit before she had to go to her appointment. V7 stated R51 does prefer to have a shower and has told V7 she wants a shower. On 01/30/25 at 2:38 PM, V18 (CNA) stated she has never showered R51. On 01/30/25 at 2:42 PM, V16 (CNA) stated she has never showered R51. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/25 at 3:10 PM, V27 (CNA) stated R51's showers are on Mondays and Thursdays. R51's medical records do not show any documentation of R51 receiving a shower on Monday 1/13/25 or Monday 01/27/25. R51's Skin Monitoring: Comprehensive CNA (Certified Nurse Aide) Shower Review sheets documented a shower on Saturday 01/11/25, a bed bath on Thursday 01/16/25, a bed bath on Monday 01/20/25, and a shower on Thursday 01/23/25. R51's Shower/Bathing Tasks documented: bathing occurred on: Thursday 01/16/25, Monday 01/20/25, and Thursday 01/23/25. Monday 01/27/25 documents not applicable. On 01/30/25 at 3:15 PM, V1 (Administrator) stated they do not have a policy for showers. R51's Care Plan dated 01/31/25 documents a focus area of: R51 has an ADL (Activities of Daily Living) self-care performance deficit relating to disease process (COPD, lung cancer with mets (metastases) to brain and bone and chronic pain), impaired balance and muscle weakness. R51 is frequently incontinent of bowel and has a catheter. She mobilizes in a WC (wheelchair) with staff assist at times with an intervention dated 01/31/25 of: bathing: she requires one staff participation with bathing/showering 2x wk (two times a week) and prn (as needed).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review, the facility failed to notify the physician of missing medications and a change in resident's condition for 1 of 5 residents (R55) reviewed for physician notification in the sample of 42. Findings include: R55's admission record documents an admitted [DATE] and list the following diagnoses in part; vascular dementia, mild with psychotic disturbances and type 2 diabetes mellitus. R55's MDS (Minimum Data Set) dated 01/24/25, documents a BIMS (Brief Interview for Mental Status) score of 11, indicating that R55 is moderately cognitively impaired. Section I-active diagnoses documents an active diagnosis of diabetes mellitus. R55's care plan documents an initiation date of 01/28/25 for a focus area that states R55 is at risk for complications r/t (related to) dm (diabetes mellitus). R55's Physician's Order Sheet (POS) documents an order with an order date and a start date of 01/17/25 for Toujeo Solostar Subcutaneous Solution pen-injector 300 Units/ML, (Insulin Glargine) (long-acting insulin), Inject 70 units at bedtime for diabetes mellitus. R55's Physician's Order Sheet (POS) documents an order with a start date of 01/18/25 for Blood glucose per fingerstick as needed for signs/symptoms of hyperglycemia/hypoglycemia. On 01/27/25 at 10:03am, V36 (Family member) stated that they continued to ask nurse about R55's meds the first couple of days being in the facility because she wasn't getting all of them or her insulin, they continued to be told they were still working on it. V36 stated staff reported they were still working on her admission through Sunday (1/19/25). On 01/29/25 12:01 PM, V37 (Family member) stated R55 was admitted on Friday 01/17/25 in the evening, and it was a struggle all weekend getting her medications. V37 said that they asked the nurses several times from Friday to approximately Sunday or Monday for R55's medications and insulin's and they kept saying that they were working on getting her admitted still. R55's progress notes document that on 01/17/25 and 01/19/25 Toujeo Solostar Subcutaneous Solution pen-injector (Insulin Glargine) (long-acting insulin) was not administered due to awaiting pharmacy delivery. R55's medication administration record (MAR) documents a blood glucose finger stick was started and administered by V42 (RN) on 01/18/25 and documents a blood sugar of 308. R55's MAR documents no signatures on 01/17/25 or 01/19/25 for Toujeo Solostar Subcutaneous Solution pen-injector (Insulin Glargine) (long-acting insulin), indicating it was not administered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R55's January 2025 Medication Administration Record (MAR) documents a signature on 01/18/25 for Toujeo Solostar Subcutaneous Solution pen-injector (Insulin Glargine) (long-acting insulin) indicating that it was administered by V46 (RN), and a blood sugar of 411. V46 was unavailable for interview to explain how she was able to administer a medication that was not available in the facility or why she did not contact the doctor over a blood sugar of 411. On 01/30/25 at 09:58am, V41 (Pharmacy medical records) reviewed medication orders for R55. V41 stated a new order was received from the facility for long-acting insulin on 1/17/25. V41 stated an emergency order was called to the backup pharmacy (a local pharmacy) on 1/17/25. V41 stated the order was never picked up by facility. V41 stated on 1/19/25 a nurse from the facility called to ask about it and the pharmacy informed them it was to be delivered later that evening or there was an emergency order called in to the backup pharmacy and they stated they will wait for the delivery. V41 confirmed the long-acting insulin was delivered on 01/19/25. On 01/30/25 at 02:19pm, V34 (Physician) stated on 01/17/25 he was notified late at night about R55 having a drug allergy and order clarification for a medication. V34 stated he was not contacted again until 1/21/25. V34 reviewed his communication with the facility and stated he had not been contacted at all about R55's insulin or blood sugar until 1/21/25. V34 stated he was contacted on 01/21/25 by V2 (DON) about orders for sliding scale insulin for R55. V34 stated yes to the sliding scale order, and he directed them to call his office if they were not familiar with his standard sliding scale. V34 stated he would be expected to be contacted about any resident, not just a new resident, with a blood sugar of 308 and 411, especially the 411. V34 stated his expectation would also be that they recheck R55's blood sugar after numbers like that. V34 said that he had not been notified of any of it. V34 stated his expectation would be for R55 to not miss any doses of insulin, especially if there was a script waiting at a pharmacy in town the same day. V34 stated his expectation would be to be notified in those instances. On 01/30/25 at 03:21pm, V2 (DON) stated there was no communication with V34 (Physician) from 1/17/25-1/21/24 regarding R55. On 02/03/25 at 11:41am, V39 (Licensed Practical Nurse/LPN) stated that the process with new admissions varies depending on the circumstance. V39 stated if for whatever reason, they cannot obtain the medications, they would notify the physician. V39 stated she was not R55's nurse on 01/17/25, she was just helping the V4 (LPN) admit her. On 02/03/25 at 12:03pm, V42 (RN) stated the process for admitting new residents with medications, is that the admitting nurse puts the orders in, and if they are not finished by the next shift, the oncoming nurse should finish them. V42 stated if she put an order in for an as needed (PRN) blood glucose fingerstick for R55, it was because it was either on her discharge sheet or ordered by the doctor. V42 stated that she did not notify the doctor of a blood sugar of 308 for R55 because they are not required to. V42 stated if they need medications, they call the pharmacy, if they cannot get them then they should notify the doctor. V42 stated on 01/19/25 when she was taking care of R55, her meds were still not available in the facility, and she did not notify the physician. On 02/03/25 at 12:19pm, V4 (LPN/License Practical Nurse) stated residents should not miss a dose of insulin and if that were to happen, the doctor should be notified. V4 stated she could not recall what the situation was with R55's admission. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/03/25 at 03:43pm, V2 (DON) stated she would have expected V34 (Physician) to be contacted with any missed doses of insulin or blood sugars above 300.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on observation, interview, and record review, the facility failed to provide privacy during wound care treatment or urinary catheter treatment for one (51) of 4 residents reviewed for personal privacy in the sample of 42. Findings include: 1. R51's Admission Record documents an admitted [DATE] and included the following diagnoses: muscle weakness, retention of urine and secondary malignant neoplasm of the brain. R51's Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 09, indicating R51 has moderate cognitive impairment. Under Functional Abilities, the MDS documents R51 is dependent for toileting hygiene, lower body dressing and bed mobility. R51's Care Plan documented a focus are of at risk for skin breakdown r/t frequently incontinent of bowel, has Foley catheter, requires assist with bed mobility. Has open area to left buttock and skin tear to right buttock. On 01/29/2025 at 02:26 PM, wound care was provided to R51 by V4 (Licensed Practical Nurse/LPN) with V2 (Director of Nursing/DON) assisting with supplies and positioning. The lower half of R51's body was exposed at this time. The window in R51's room has a sidewalk outside the window that leads to a side entrance of the building and looks out into a parking lot. Neither V4 or V2 pulled the curtain or blinds on R51's window prior to providing care. V2 assisted R51 to roll over onto her right side and held her in position with the front of her body exposed and facing the window. V4 completed wound care. On 01/29/2025 at 02:40pm, urinary catheter care was provided to R51 by V6 (Certified Nurse Assistant/CNA) with V2 assisting. The lower half of R51's body was exposed at this time. V6 did not pull the curtain or the blinds on R55's window which looks out into the parking lot and a sidewalk that leads into a side entrance of the building. On 01/29/25 at 02:52 PM, R51 stated that they never pull the privacy curtain in her room or the blinds on the window. R51 stated they just have her out here in all her [NAME] for everyone to see and they do not care. R51 stated that it really bothers her, it feels like they don't even look at her as a person with a brain.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review the facility failed to ensure residents were free from verbal abuse from staff for 1 of 3 residents (R55) reviewed for abuse and neglect in the sample of 42. Findings include: R55's admission record documents an admitted [DATE] and list the following diagnoses in part; vascular dementia, mild with psychotic disturbances and type 2 diabetes mellitus. R55's MDS (Minimum Data Set) dated 01/24/25, documents a BIMS (Brief Interview for Mental Status) of 11, indicating that R55 is moderately cognitively impaired. On 01/27/25 at 10:03am, V36 (Family member) stated on 01/17/25, the first day R55 was in the facility, there was a nurse who was being terribly mean to her for no reason, he stated they reported it to staff a couple times, but nothing was done until they had her care plan meeting. V36 stated that V1 (Administrator) told them that they were not going to do anything with the nurse that did it because she was moving back to the Philippines soon, but she wouldn't be caring for R55 anymore. On 01/27/25 at 10:04am, V35 (Family member) stated he and V37 had walked in on a nurse with her finger in R55's face, yelling at her to sit her ass down and stay down. But she no longer works here. V37 stated they reported it to someone over the weekend, but nothing was done until V1 called them about her care plan meeting. V35 stated most of the other staff has been kind to them. On 01/29/25 at 12:01pm, V37 (Family member) stated he and V35 walked in R55's room later in the evening on 01/17/25 to a nurse screaming at R55. V37 stated the nurse had her finger in R55's face and was telling her to sit her ass down and stay sitting. V37 stated R55 had spilled her food from earlier and was trying to clean it up. V37 stated they had told someone that weekend but didn't hear anything about. V37 stated when V1 (Administrator) called to set up a meeting, they told her about the incident. V37 stated they had a meeting with the facility the next day and the Ombudsman was present. V37 stated V1 told them at the meeting she was still looking into it. V37 stated she is very nice, but she is always making excuses or pushing stuff off on someone else. V37 stated that R55 has dementia and is really confused most of the time. On 01/27/25 at 01:04pm, V1 (Administrator) stated there was an investigation regarding an allegation of abuse between V46 (Registered Nurse) and R55. V1 stated it would be a minute before it could be reviewed, she had to put it together. V1 stated the allegation could not be substantiated due to no other evidence pointing to abuse through staff and resident interviews. On 01/27/25 at 10:04am, 01/28/25 at 09:04am, 01/29/25 at 12:45pm, and 01/30/25 at 09:14am attempts were made to interview R55, she appeared to be alert to person but unable to respond to this surveyor. R55 only smiled when this surveyor said her name. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility document titled Initial IDPH incident and/or abuse notification that was dated 01/21/25 at 2pm documents On 01/21/25 at 2pm .Ombudsman, notified administrator of an allegation of verbal inappropriate staff behavior from employee towards resident (R55). Employee was identified and suspended immediately pending investigation. Nursing assessed and resident demonstrates no signs of injuries or emotional distress. All parties have been notified. This is the initial report. Final to follow within 5 business days. A facility document titled, (R55) 1/21/25 Working Notes documents an untimed interview, conducted by V1 (Administrator) with V46 (Registered Nurse/RN) stated during the night that resident (R55) pulled her catheter out, she had noted her sitting EOB (edge of bed) or attempting to get up without any assistance on multiple occasions that evening. V46 stated that she educated resident on use of call light, risks of pulling out catheter if she gets up without assistance and fall risk. (V46) reported that it was around bedtime, so she did encourage resident to lay down and get some rest. V46 reported that she absolutely did not curse at the resident. V46 reported that there were no other employees around during her interactions with R55 and she did not have a roommate at this time. A facility document titled, (R55) 1/21/25 Working Notes documents an untimed interview conducted by V1 with R55. (R55) reported that she was waiting on (V37) and (V35) and they got lost on the road, so she was worried about them. She was getting out of bed since she was worried, but (V46) stopped her and told her that she needed to get back in bed. (R55) reported that she was not going to get back in bed because she was worried about (V37) and (V35). (R55) reports that (V46) told her that her husband and her son are not anything and pushed on her on her arms to get back into bed. Resident (R55) reported that she returned to sitting EOB and (V46) left. She reported that (V37) and (V35) arrived a couple hours later. Resident (R55) was asked multiple times throughout interview if (V46) ever cursed at her and she replied that she did not. A facility document titled, (R55) 1/21/25 Working Notes documents an untimed interview conducted by V1 with V37 and V35 stated, Asked (V37) and (V35) what happened the evening with the nurse. (V37) reported that he saw the nurse tell his mom to get her ass back in the bed. Educated family that this is absolutely not a standard that we set as a facility and to notify V1 (Administrator) if they are ever even the slightest bit concerned so we can do a full investigation. Educated resident and family on the process and all parties involved. They voiced thanks for the thorough investigation. Notified family that facility was a good way through the resident and staff interviews and there had not been any other findings noted at this time. Notified family that if allegation cannot be substantiated that employee would return to work, but we can have her work the other side of the building. Resident and family voiced that they understood and that the plan would be sufficient, and they appreciated the assistance. (continued on next page)

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	145757	A. Building B. Wing	02/10/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Facility Document titled Final IDPH incident and/or abuse notification with an incident date of 01/21/25 stated Through thorough investigation including interviews of residents and staff, the allegation of inappropriate staff behavior cannot be substantiated. IDT (Inner Disciplinary Team) concludes that this was a misunderstanding secondary to cultural differences with no intent. Employee is from the Philippines and (R55) had a hard time understanding her. Resident (R55) was upset due to her husband and son getting lost on their way to the facility and was worried about them. No residents or staff have ever witnessed any verbal or physical inappropriate behavior from employee. Employee has no prior resident complaints or concerns in regard to customer service. Resident (R55) reported that employee did not curse at her but thought she was too rough with her arms when assisting her with care. Skin assessment completed with no new skin areas. Resident continues to demonstrate no emotional distress and reports that she feels safe within the facility. Employee has returned to work, IDT met with resident and family, they agree with conclusion of investigation. All parties have been notified. This is the final report. On 01/30/25, an attempt was made to contact V46, and it was discovered her phone number had been disconnected and according to V1 (Administrator) she has moved back to the Philippines. Facility policy titled Abuse prevention policy with a revision date of 2022. This document states Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment . This document defines verbal abuse as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or families . This document defines mental abuse as including but not limited to, humiliation, harassment, threats of punishment or deprivation or offensive physical contact by a licensee or employee or agent. Mental Abuse is also the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. This includes, but is not limited to, harassing a resident; mocking, insulting, or ridiculing; yelling or hovering over a resident, with the intent to intimidate; threats of deprivation; and isolation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review the facility failed to ensure an allegation of staff to resident verbal/mental abuse resulted in an accurate conclusion and failed to ensure corrective action to prevent further potential abuse for 1 of 3 residents (R55) reviewed for abuse in the sample of 42. Findings include: R55's admission record documents an admitted [DATE] and list the following diagnoses in part; vascular dementia, mild with psychotic disturbances and type 2 diabetes mellitus. R55's MDS (Minimum Data Set) dated 01/24/25, documents a BIMS (Brief Interview for Mental Status) of 11, indicating that R55 is moderately cognitively impaired. On 01/27/25 at 10:03am, V36 (Family member) stated the first day R55 was here, there was a nurse who was being terribly mean to her for no reason, he stated they reported it to staff a couple times, but nothing was done until they had her care plan meeting. V36 stated that V1 (Administrator) told them that they were not going to do anything with the nurse that did it because she was moving back to the Philippines soon, but she wouldn't be caring for R55 anymore. On 01/27/25 at 10:04am, V35 (Family member) stated that he and V37 had walked into R55's room later in the evening of 01/17/25, to a nurse with her finger in R55's face, yelling at her to sit her ass down and stay down. But she no longer works here. V37 stated they reported it to someone over the weekend, but nothing was done until V1 called them about her care plan meeting. V35 stated most of the other staff has been kind to them. On 01/29/25 at 12:01pm, V37 (Family member) stated he and V35 walked in R55's room later in the evening on 01/17/25 to a nurse screaming at R55. V37 stated the nurse had her finger in R55's face and was telling her to sit her ass down and stay sitting. V37 stated R55 had spilled her food from earlier and was trying to clean it up. V37 stated they had told someone that weekend but didn't hear anything about. V37 stated when V1 (Administrator) called to set up a meeting, they told her. V37 stated they had a meeting with the facility next day and the ombudsman was present. V37 stated V1 told them at the meeting she was still looking into it. V37 stated she is very nice, but she is always making excuses or pushing stuff off on someone else. V37 stated that R55 has dementia and is really confused most of the time. On 01/27/25 at 01:04pm, V1 (Administrator) stated there was an investigation regarding an allegation of abuse between V46 (Registered Nurse) and R55. V1 stated it would be a minute before it could be reviewed, she had to put it together. V1 stated the allegation could not be substantiated due to no other evidence pointing to abuse through staff and resident interviews. On 01/27/25 at 10:04am, 01/28/25 at 09:04am, 01/29/25 at 12:45pm, and 01/30/25 at 09:14am attempts were made to interview R55, she appeared to be alert to person but unable to respond to this surveyor. R55 smiled when this surveyor said her name, but that was it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility document titled Initial (State Survey Agency) incident and/or abuse notification that was dated 01/21/25 at 2pm documents On 01/01/25 at 2pm .Ombudsman, notified administrator of an allegation of verbal inappropriate staff behavior from employee towards resident (R55). Employee was identified and suspended immediately pending investigation. Nursing assessed and resident demonstrates no signs of injuries or emotional distress. All parties have been notified. This is the initial report. Final to follow within 5 business days. A facility document titled, (R55) 1/21/25 Working Notes documented an untimed interview, conducted by V1 (Administrator) with V46 (Registered Nurse/RN) stated during the night that resident (R55) pulled her catheter out, she had noted her sitting EOB or attempting to get up without any assistance on multiple occasions that evening. (V46) stated that she educated resident on use of call light, risks of pulling out catheter if she gets up without assistance and fall risk. (V46) reported that it was around bedtime, so she did encourage resident to lay down and get some rest. (V46) reported that she absolutely did not curse at the resident. (V46) reported that there were no other employees around during her interactions with (R55) and she did not have a roommate at this time. (R55) reported that she was waiting on (V37) and (V35) and they got lost on the road, so she was worried about them. She was getting out of bed since she was worried, but (V46) stopped her and told her that she needed to get back in bed. (R55) reported that she was not going to get back in bed because she was worried about (V37) and (V35). (R55) reports that (V46) told her that her husband and her son are not anything and pushed on her on her arms to get back into bed. Resident (R55) reported that she returned to sitting EOB (edge of bed) and (V46) left. She reported that (V37) and (V35) arrived a couple hours later. Resident (R55) was asked multiple times throughout interview if (V46) ever cursed at her and she replied that she did not. A facility document titled, (R55) 1/21/25 Working Notes documented an untimed interview, conducted by V1 (Administrator) with V37 and V35 Asked (V37) and (V35) what happened the evening with the nurse. (V37) reported that he saw the Filipino nurse tell his mom to get her ass back in the bed. Educated family that this is absolutely not a standard that we set as a facility and to notify V1 (Administrator) if they are ever even the slightest bit concerned so we can do a full investigation. Educated resident and family on the process and all parties involved. They voiced thanks for the thorough investigation. Notified family that facility was a good way through the resident and staff interviews and there had not been any other findings noted at this time. Notified family that if allegation cannot be substantiated that employee would return to work, but we can have her work the other side of the building. Resident and family voiced that they understood and that the plan would be sufficient, and they appreciated the assistance. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Document titled Final (State Survey Agency) incident and/or abuse notification states Through thorough investigation including interviews of residents and staff, the allegation of inappropriate staff behavior cannot be substantiated. IDT (interdisciplinary team) concludes that this was a misunderstanding secondary to cultural differences with no intent. Employee is from the Philippines and (R55) had a hard time understanding her. Resident (R55) was upset due to her husband and son getting lost on their way to the facility and was worried about them. No residents or staff have ever witnessed any verbal or physical inappropriate behavior from employee. Employee has no prior resident complaints or concerns in regard to customer service. Resident (R55) reported to V1 (Administrator) that employee did not curse at her but thought she was too rough with her arms when assisting her with care . Skin assessment completed with no new skin areas. Resident continues to demonstrate no emotional distress and reports that she feels safe within the facility. Employee has returned to work, IDT met with resident and family, they agree with conclusion of investigation. All parties have been notified. This is the final report. Facility policy titled Abuse prevention policy with a revision date of 2022. This document states Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment . This document defines verbal abuse as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or families . This document defines mental abuse as including but not limited to, humiliation, harassment, threats of punishment or deprivation or offensive physical contact by a licensee or employee or agent. Mental Abuse is also the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. This includes, but is not limited to, harassing a resident; mocking, insulting, or ridiculing; yelling or hovering over a resident, with the intent to intimidate; threats of deprivation; and isolation. Facility policy titled Abuse prevention policy with a revision date of 2022. This document states The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. This will be accomplished by .Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51792 Based on interview and record review the facility failed to develop and implement a baseline care plan within 48 hours for 1 of 3 (R105) residents reviewed for care plans in the sample of 42. Findings include: R105's Admission Record with a print date of 1/28/2025 documents R105 was admitted to the facility on [DATE] with diagnoses that include fracture of femur, falls, epilepsy, and muscle weakness. R105's facility medical record does not document a baseline care plan. On 01/28/25 at 3:50 PM, V2 (Director of Nurses) stated the nurse who responsible for completing it upon R105's admission to the facility had forgotten to do it and it was being completed now.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Failures at this level require more than one deficienct practice statement. A. Based on observation, interview, and record review the facility failed to ensure a resident with dementia and a diffuse traumatic brain injury was adequately supervised to prevent elopements and failed to develop and implement new interventions to prevent elopements for 1 (R22) of 2 residents reviewed for supervision in a sample of 42. This failure resulted in R22 exiting the facility multiple times without staff knowledge, including on an unknown date in October or November of 2024 in which R22 walked approximately 0.8 miles from the facility down a busy street and across a busy highway in town, and was later located by facility staff walking around a business parking lot. This failure resulted in an Immediate Jeopardy. An Immediate Jeopardy situation identified to have begun on 06/15/2024, when R22 exited the facility without supervision and the facility failed to investigate the incident and failed to implement new interventions to prevent R22 from eloping. V1 (Administrator) was notified of the Immediate Jeopardy on 2/4/25 at 3:13 PM. The surveyor confirmed by observations, interview, and record review, the immediacy was removed on 02/4/2025, the facility remains out of compliance at a severity level two due to additional time needed to evaluate implementation and effectiveness of training. Findings Include: a) R22's Admission Record with a print date of 1/30/25 documents R22 was admitted to the facility on [DATE] with diagnoses that include unspecified dementia, diffuse traumatic brain injury, major depressive disorder, anxiety disorder, and insomnia. R22's MDS (Minimum Data Set) dated 11/7/24 documents R22 has a moderate cognitive impairment. This same MDS documents under Section E-Behavior, R22 has a behavior of wandering and the wandering placed R22 at significant risk of getting to a potentially dangerous place. R22's Elopement/Wandering risk assessments dated 2/9/24, 5/7/24, 8/8/24, and 11/6/24 document R22 is at risk for elopement. R22's Progress Notes document the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/10/24 8:43 AM, At approximately 0843 (8:43 AM) this writer was informed that resident was outside. Resident was escorted back inside facility. Resident came inside willingly. Full facility count was initiated, and it was confirmed that only this resident was outside. A head to toe assessment completed with no new skin issues noted or reported at this time, vital signs assessed, stable and recorded in EHR (Electronic Health Record). Resident was wearing Tie Dye shirt with grey sweat pants, non-skid footwear and a reflective vest, Administrator, DON (Director of Nursing), and MD (Physician) notified with NNO (no new orders) at this time Outside temp (temperature) 42 degrees, clear and sunny, Resident is currently in his room resting. Signed by V44 (Former DON/Director of Nurses) 6/15/24 9:31 AM, (R22) found in the parking lot by staff on arrival to facility. (R22) brought in by said staff and informed this nurse. Resident is well appearing. No scratches, no bruises, no injuries observed. Resident seen by this nurse approximately 30 minutes prior. Residents nurse and administrator notified. Signed by V45 (RN/Registered Nurse) 6/24/24 3:46 PM, Resident elopes through north hall emergency exit door. 2 staff ran to door upon alarms. The resident had already gotten to church parking lot by the time staff reached the resident. Signed by V45 (RN) 7/13/24 11:58 AM, Resident exited facility and was returned safely by staff. Head to toe assessment performed. All body systems are at baseline. No trauma to skin. All vitals WNL (within normal limits). Resident given ice water and re-educated that he needs staff to accompany him when going outside. Resident currently in his room being assisted with breakfast meal. Call light within reach. Signed by V45 (RN) 10/27/24 9:04 AM, Resident exits the building today. His 101 (sic) sitter was right behind him when he exited. Resident was redirected into the building safely. Skin assessment performed. No skin integrity issues present. Signed by V45 (RN) 11/21/24 8:52 AM, Resident exited the building and was returned safely by staff. Skin assessed. No injuries and skin intact. Provider notified. Vitals WNL. Signed by V45 (RN) This surveyor attempted to contact V45 (RN) who no longer works at the facility on 1/29/25 at 1:20 PM and again on 2/3/25 at 9:31 AM, with no answer. This surveyor requested a return call with each attempt and no return call was received. On 1/28/25 at 8:23 AM, R22 walked into the beauty shop where the surveyors were working. There was no staff present with R22 at this time. R22 then left the beauty shop by himself and walked to the south hall where an unknown staff member saw R22 wandering around and took R22 to the front of the building by the reception desk. The unknown receptionist gave R22 a donut and then an unknown staff member walking in the door put on a mask and took R22 with her to his hall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R22's Progress Notes document on 1/29/25 at 7:14 AM, At approximately 0707 (7:07 AM) this writer was informed that resident was outside. Resident was escorted back inside facility by staff. Resident came inside willingly. Full facility count was initiated, and it was confirmed that only this resident was outside. A head to toe assessment completed with no new skin issues noted or reported at this time, vital signs assessed, stable and recorded in EHR. Resident wearing blue shirt with blue sweat pants, non-skid footwear and a reflective vest, Administrator, DON, and MD notified with NNO at this time. Outside temp 40 degrees, clear and sunny. Resident is currently in his room resting in his bed. Signed by V23 (RN/Registered Nurse) On 1/29/25 at 12:19 PM, when asked if she did investigations on elopements, V1 stated she did not think she had any official documentation. V1 stated the tracking and trending they do for R22's elopements include reviewing the care plan and discussing them in the daily QA (quality assurance) meetings. The facility Daily QA (Quality Assurance) Meeting Notes included multiple pages and handwritten dates with no year documented on some of them. The QA Meeting notes document the following under Resident Behaviors. 6/17/24 (R22) out of facility door alarm sounding, seen by staff member, returned without incident 6/25 (initials of R22): North R (right) staff to alarm. 7/15 (initials of R22) South left, staff responded to alarm running, staff caught. 10/28 (initials of R22) North R (right) with 1:1 . 11/22 Admin Add on Notes: (initials of R22): South, turned around with no difficulty. On 1/29/25 at 9:15 AM, V6 (Certified Nursing Assistant/CNA) stated she came to work at 7:00 AM on 1/29/25 and was told R22 had left the facility. V6 stated she didn't know details about what happened. V6 stated she had been told V21 (CNA) was outside and happened to notice R22 in the parking lot. V6 stated it is hard to keep up with R22 while providing care to the other residents. V6 stated R22 has a 1:1 staff member because he likes to get out and she thinks someone is always with R22. V6 stated R22 also wears a safety vest like construction workers wear (reflective) to make R22 more visible. On 1/29/25 at 10:19 AM, V21 (CNA) stated she got to the facility around 7:05 AM on 1/29/25 and saw R22 running around the parking lot. V21 stated R22 was wearing pants, shirts, socks, and had a blanket. V21 stated the doors were not alarming and they were trying to find out which door R22 went out. V21 stated R22 got out of the facility a month or two ago and was walking down the road toward the stop sign by a (2 lane highway). V21 stated she didn't have any other information about that time. According to the website Google.com/maps, (road referenced) is approximately 0.3 miles from the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/29/25 at 11:08 AM, V22 (CNA) stated she was responsible for R22 on night shift beginning on 1/28/25 and clocked out at 7:20 AM on 1/29/25. V22 stated she was giving report to the oncoming shift at 7:00 AM and R22 was doing laps around the facility. V22 stated R22 went into a room where they were covid testing staff around 7:10 AM. V22 stated R22 wasn't in his room when she did the walk through with the day shift staff relieving her, but she had just seen him walking around. V22 stated she wasn't aware he was found outside the facility, in the parking lot, until after she clocked out. V22 stated there were no door alarms sounding when she left. V22 stated if R22 had exited through any other hall exit door she wouldn't have heard the alarm. V22 stated she was not aware of R22 exiting the facility without staff supervision any other time. V22 stated R22 doesn't have a 1:1 staff on night shift because they don't have enough staff to provide it. V22 stated most of the time they have enough staff to keep R22 safe and meet the needs of the other residents. V22 stated R22 wears the safety vest at night in case he does elope. On 1/29/25 at 11:24 AM, V23 (RN) stated she works 12-hour night shift (7 PM to 7 AM). V23 stated on the morning of 1/29/25, she was giving report to day shift (V4 LPN/Licensed Practical Nurse) a little after 7:10 AM, when she was notified R22 had exited the facility and was in the driveway/parking lot. V23 stated she didn't hear a door alarm sound. V23 stated she looked at R22 to make sure he didn't have any injuries. V23 stated R22 had eloped before but it had been a while since he had. V23 stated R22 wears a reflective vest they take off when they put his pajamas on at night. V23 stated she had been told they couldn't use the wander guard system since it was considered a restraint. On 1/29/25 at 2:07 PM, V4 (LPN) stated she arrived at the facility around 6:30 AM on 1/29/25. V4 stated she was told R22 had eloped, and administration was checking to see which door he exited and checking the panels to see what alarms were going off. V4 did not have any other information related to this elopement. On 1/29/25 at 10:03 AM, V27 (CNA) stated he wasn't aware R22 eloped on the morning of 1/29/25. V27 stated R22 has a sitter with him, the doors are alarmed, and R22 won't leave the facility. V27 stated R22 has a tracker on his ankle, and they can track him if he would leave. V27 stated anyone who sees R22 should redirect him back to his area. V27 stated if R22 starts walking the sitter follows him but once he takes his medications, he is chill. On 1/29/25 at 11:36 AM, V12 (Maintenance Director) stated he was aware R22 had eloped on 1/29/25 and had already checked all the doors to make sure they were working correctly, and they were. V12 stated he makes daily rounds and hadn't had any door locks/alarms not working. At 11:41 AM on this same date, this surveyor walked with V12 to the exit door located near the beauty shop. V12 opened the door, and it alarmed as it should. This surveyor walked with V12 to see if the alarm could be heard on the halls the residents reside on and/or near the nurse's station. The alarm was no longer able to be heard after turning the corner and prior to reaching the nurse's station and/or resident room areas on the south hall. This surveyor and V12 walked toward the north hall and the alarm sound was no longer able to be heard near the entrance door of the dining room which is prior to the north hall nurse's station and resident room areas. V12 also confirmed he could not hear the alarms. When asked if they couldn't hear the alarms how would staff know someone had exited the facility, V12 stated, he knows they have a 1:1 staff sitting with R22, he wears a reflective vest, and V1 (Administrator) has something on her phone with R22's GPS (Global Positioning System) location. (continued on next page)

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	145757	A. Building B. Wing	02/10/2025

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/29/25 at 1:56 PM, V16 (CNA) stated she was not aware R22 had eloped on the morning of 1/29/25. V16 stated she wasn't sure what R22's interventions were to prevent elopement. V16 stated R22 has a consistent one to one staff from 8:00 AM to 3:00 PM but after 3:00 PM he pretty much does his own thing, especially if they are short staffed. On 1/29/25 at 9:28 PM, V24 (CNA) stated R22 doesn't have a 1:1 staff with him on night shift. V24 stated they watch him the best they can. V24 stated it is easy to watch him through the night it's in the morning when they are trying to get people up that is it harder. V24 stated R22 is very smart and has the concept of holding the door until it opens. V24 stated he wears the safety vest so people can see him if he gets out. V24 stated she was working when R22 eloped on 1/29/25 but he wasn't one of her assignments. V24 stated none of the alarms sounded. When asked if she could hear the alarms V24 stated, Not very well. V24 stated R22 is supposed to always have the safety vest on. On 1/29/25 at 9:38 PM, V18 (CNA) stated R22 has a staff member sitting with him throughout the day but not on nights. On 1/29/25 at 4:30 PM, V1 (Administrator) provided this surveyor with the facility undated Self-Identified Quality Assurance Plan of Correction documents, Problem Identified: Exit from facility. Resident did not leave grounds, resident not harmed or emotional upset. Returned to facility without difficulty. 1. Corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? (R22 initials) was immediately returned to the facility without complication and placed on 1:1 supervision .3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Facility immediately checked all exit doors for alarm function. All alarms functioning and require a key to shut them off. Facility immediately did a resident head count to assure all residents accounted for. All residents were accounted for. Facility interviewed all staff, and no one answered an alarm and shut it off. Facility has educated all staff on duty and will educate all staff who haven't previously been educated for the next three days about monitoring door closure behind them when they come in the facility or when they leave the facility to make sure door closes securely and properly. Facility placed (R22's initials) on 1:1 supervision and will continue until re-evaluate by the IDT (Interdisciplinary Team) to decide if is safe to remove the supervision. Facility contacted the sister and will send referrals to all TBI (Traumatic Brain Injury) facilities that can be located in the state of Illinois. Facility has ordered additional door exit alarms for the three doors that are the furthest from the nurse's station as added precaution. Facility has ordered Stop Sign door guards to be applied at each exit door with the exception of the front lobby door where visitors and staff enter and exit many times a day. Staff will be educated to not remove the door guards. 4. How will you monitor the corrective action (s) to ensure the deficient practice will not recur .Admin (administrator), DON, and/or designees will do random observations of at least one staff member entering and exiting the facility a minimum of 5 times per week for 4 weeks. Admin, DON, and/or designees will do random observations of Stop Sign door guards properly applied to each exit door a minimum of 5 times per week for 4 weeks. Results of the observations will be discussed in the Quarterly QA (Quality Assurance) Meeting times 2 with educational needs discussed as need by the Facility Administrator, DON, and or designee. Completion Date: 1/29/25. The untitled document dated 1/29/25 attached to this plan of correction documents 1/29/25 After investigation, IDT concluded that resident (R22) followed an employee out of a door. During investigation all door alarms were checked and functioning properly on 1/29/25. In addition, door alarms are checked daily by maintenance or designee. IDT identified QAPI (Quality Assurance and Performance Improvement) and implemented staff in-servicing immediately. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/30/25 at 12:02 PM, V28 (Family Member) stated the facility hadn't communicated with her at all recently. When asked how long it had been since the facility had called her with an update, V28 stated it had been a couple of months since she heard anything from them. V28 stated she was R22's surrogate mom and she was the only one they would contact regarding R22's condition and care. V28 stated she was told awhile back (date unknown) R22 had attempted to escape the facility. V28 stated that is the only elopement she was made aware of. V28 stated she hadn't been contacted by the facility at all the past few days. V28 stated she is concerned with the care R22 is getting because she is the one who always looks after him and she hadn't been getting any communication from the facility. On 1/30/25 at 1:15 PM, V1 (Administrator) stated they have a tracking tag on R22 so if he exits the facility, they call her or the Director of Nursing and they track where R22 is located. V1 stated they don't have a wander guard system because it would be expensive to implement in the building. V1 stated V31 (Social Services Director) was the staff member who contacted V28 (Family Member) after R22's elopement on 1/29/25. On 1/30/25 at 2:00 PM, V31 (Social Services Director) stated R22 eloped once while she was at the facility. V31 stated he made it to the facility parking lot. V31 stated he just gets out and the facility staff get him and bring him back in. V31 stated he doesn't make it very far. When asked if she called V28 (Family Member) to discuss possible placement in a TBI (Traumatic Brain Injury) facility after he eloped on 1/29/25, V31 stated she had not spoken with her and hadn't sent out any referrals. V31 stated she tries to call everyone's power of attorneys who are on her advocate list and V28 had never returned her calls. V31 stated, she (V28) is [NAME] (missing in action). V31 stated she had worked at the facility since 12/2023 and had never had contact with V28. V31 stated she had left a number for V28 to return calls and she had never called her back. When asked if she had attempted to contact V28 after R22 eloped on 1/29/25, V31 stated, No, I haven't tried to call her yet. On 1/30/25 at 10:04 AM, V7 (CNA) stated she had provided care for R22, and he elopes at times. V7 stated they can't hear the door alarms when they go off and R22 moves fast. V7 stated R22 got close to the next town one time and that is when they implemented the reflective vest. V7 stated they also put an air tag on his ankle. V7 stated R22 usually walks to the church located next to the facility. On 1/30/25 at 10:41 AM, R46, who is alert to person, place, and time, stated sometimes R22 will run out of the door. R46 stated R22 looks for food all the time, will take whatever he finds, and eat it. R46 stated R22 has made it out the door, run across the street, and made it into people's houses. R46 stated this occurred about a month and a half ago. R46 stated he also went towards the stop sign located at the corner of Old Murphysboro Road and Tower Road. On 1/30/25 at 1:32 PM, V29 (Medical Records/CNA) stated she had been working when R22 had eloped in the past. V29 stated R22 wanders and has a staff member who sits with him. V29 stated they try to have one 24 hours a day, but it doesn't always work that way. V29 stated R22 isn't afraid to just walk out the door. V29 stated she wasn't working when R22 made it to the next town or into neighboring houses but had heard about it and believes it was more than a year ago that it occurred. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/30/25 at 3:07 PM, V32 (CNA) stated R22 usually had a staff member sitting with him from 8 AM to 1 PM or 3 PM. V32 stated when R22 doesn't have a sitter the other aids can't always keep an eye on him. V32 stated most of the time R22 stays in his room. V32 stated the farthest R22 got was down Tower Road toward Old Murphysboro Road. V32 stated one time (date unknown) he did make it to the gym located close to the intersection of Old Murphysboro Road and New Route 13 (4 lane highway). V32 stated she was busy providing care to another resident that day and she thought V33 (CNA Supervisor) was the one who picked R22 up. V32 stated R22 didn't have a staff member sitting with him that day. V32 stated the front door was alarming and they were able to hear it. V32 stated R22 wasn't injured or upset when he returned to the facility. V32 stated she had heard R22 had gotten into the houses across the street from the facility but that was before she started working at the facility in 2023. On 1/30/25 at 3:16 PM, V33 (CNA Supervisor) stated she was working when R22 had eloped in the past. V33 stated R22 usually elopes at shift change when they are getting the residents up in the morning. V33 stated R22 made it to the gym located at the corner of Old Murphysboro Road and New Route 13. V33 stated it occurred around 7:00 AM. V33 was unable to recall the exact date but stated it was in October or November of 2024. V33 stated on that day, she saw R22 make a lap around the unit and when R22 starts wandering, they redirect him back to his room. V33 stated she happened to hear the alarm go off and she knew she needed to look for him. V33 stated she got in her car, and she went one way and other staff went another way. V33 stated she found him wandering around the gym parking lot (located at the intersection of Old Murphysboro Road and New Route 13), with a cup in his hand. V33 stated she got R22 in the car and took him back to the facility. V33 stated another time R22 left, he made it onto Old Murphysboro Road and was found near the funeral home (located 2 miles from the facility). V33 stated R22 had the reflective vest on and that happened a long time ago (unable to provide a date). V33 stated if it's quiet enough they can hear the alarms on the doors. According to the website Google.com/maps, the gym is located 0.8 miles from the facility and would take the average person 16 minutes to walk from the facility to the gym. On 2/3/25 at 10:02 AM, V43 (CNA) stated he remembered R22 exiting the facility without staff. V43 stated R22 likes to go through his bathroom into the adjoining room and out that room's door. V43 stated they immediately mobilized a search party and found him about 15 minutes later. V43 stated he believed it was V33 (CNA Supervisor) who located him that time. V43 was not able to remember the date it occurred but believed it was 2-3 months ago. V43 stated he knew R22 had eloped two other times and was trying to get into someone's residence and someone's car but that was probably two years ago. V43 wasn't sure if R22 had a 1:1 present with those elopements. V43 stated it is very hard to do 1:1 with him if no one is assigned to him. V43 stated it is very hard to keep track of him. On 2/6/25 at 10:22 AM, V51 (CNA) stated she was working when R22 eloped once. V51 stated she believed it was in December of 2024 but couldn't remember the exact date. V51 stated staff heard the alarm on the laundry room door, and all went to see why it was alarming. V51 stated R22 was found in a neighbor's yard by V45 (RN). V51 stated R22 didn't have staff with him and when they located him, he was trying to wrap himself in a blanket. V51 stated she didn't think he was gone long because the neighbors called the facility and believed it happened around 8:00 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/6/25 at 9:40 AM, V50 (CNA) stated she was working when R22 eloped in the past. V50 stated she couldn't remember the exact date, but she knows the elopements occurred in 2024. V50 stated it happened twice. V50 stated one of the times (date unknown) she was in or near the dining room when a resident told her the door alarm was sounding on R22's unit. V50 stated as she went around the corner onto the unit, she could hear the alarm and see the door was cracked. V50 stated she spotted R22 across the main busy street, walking on the sidewalk, towards the stop sign located at the intersection of Tower Road and Old Murphysboro Road. V50 stated R22 was alone with no staff with him. V50 stated she yelled his name, and he kept walking. V50 stated she caught up to him close to the intersection, turned him around, brought him back to the facility, and notified nursing. V50 stated the other time she walked to the nurse's station on the north hall and heard the door alarm sounding. V50 stated she quickly walked to the door and when she looked out, she saw R22 outside without staff, walking toward the stop sign. V50 stated she caught up to him close to the intersection. V50 stated she didn't remember the date of these occurrences, but they were both in 2024. On 1/30/25 at 3:51 PM, V44 (Former Director of Nurses) stated she worked at the facility from 2/24/23 to 1/10/25. V44 stated R22 did leave the facility when she was working and he either went out the front door or out the door at the end of his hall and staff were with him. V44 stated when R22 doesn't have a sitter everyone keeps an eye on him. V44 stated they try to keep him away from the beauty shop hall since that door is the farthest away and hardest to hear. V44 stated she doesn't recall R22 ever making it to the gym located on Murphysboro Road and New Route 13. R22's current Care Plan documents a Focus area of (R22) is an elopement risk/wanderer AEB (as evidenced by) Disoriented to place, History of attempts to leave facility unattended, Impaired safety awareness, Resident wanders aimlessly, significantly intrudes on the privacy or activities of others. Date Initiated: 05/24/2022. The interventions documented for this Focus Area are, 1:1 sitter x (times) 72 hours. Medication review and adjustments made as ordered. Date Initiated: 06/01/2022 .Hydroxyzine as ordered for anxiety and restless behaviors. Date Initiated: 08/18/2023 .Allow him to sleep longer in the morning and offer snack upon waking up. Date Initiated: 08/21/2022 . Medications times changed, no meds to be given before 9 a.m. Date Initiated: 8/21/2022 .offer a more substantial snack such as peanut butter and jelly or appropriate substitute at bedtime. Date Initiated: 08/21/2022 Offer snack upon waking, Date Initiated: 08/21/2022 .Safety device monitor to right ankle-check for placement every shift and notify management (DON/Director of Nurses, ADON/Assistant Director of Nurses, Administrator) if it is not in place. Date Initiated: 8/11/2023 . Assess for fall risk. Date Initiated: 5/24/2022 Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Likes to listen to music. Date Initiated: 05/24/2022. Documents wandering behavior and attempted diversional interventions in behavior log. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist: Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Date Initiated: 05/24/2022. Monitor for fatigue and weight loss. Date Initiated: 05/24/2022. Safety vest on at night. Date Initiated: 12/11/2024. (continued on next page)

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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** 48356 Based on observation and interview the facility failed to provide indwelling urinary catheter care in accordance with facility policy and standard of practice for 1 (R47) of 2 residents reviewed for catheter care in the sample of 42. Findings include: R47's Admission Record printed on 01/30/25 documented an admitted [DATE] with diagnoses in part of dysphagia, muscle weakness, gastrostomy status, hyponatremia, colostomy, pressure ulcer sacral region stage 4, infection, and inflammatory reaction due to internal left hip prothesis. R47's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5, which indicates severely impaired cognition. Section GG of the MDS documented R47 is dependent with toileting and turning and repositioning. Section H documented indwelling catheter. R47's Care Plan documents a focus area of R47 is at risk for UTI (Urinary Tract Infection) r/t (related to) use of (Urinary) Catheter (Indwelling Catheter) with date initiated of 01/29/25. On 01/29/25 at 3:38PM, V20 (Licensed Practical Nurse/LPN) went into R47's room to perform catheter care. V20 cleansed her hands and put on gloves and gown. V20 stated that she had a basin filled with warm soapy water and wash cloths that she was going use to perform catheter care. V20 cleaned the area to right side and then flipped her washcloth and cleaned the area to the left side of R47's groin. V20 placed that washcloth in clear trash bag. V20 got a new soapy washcloth and cleansed the area to the top of R47's groin and placed that washcloth in the clear trash bag. V20 got another soapy washcloth and cleaned R47's penis then placed that washcloth in the clear trash bag. V20 grabbed another soapy washcloth and started at the tip of the penis and washed R47's catheter outwards toward the tubing. At this time, V20 then stated that she was done with catheter care. V20 began to clean everything up and put items away. On 01/29/25 at 3:45PM, V20 was asked by this surveyor if she was done with catheter care, and she stated yes. V20 was asked if she should have rinsed off the groin and catheter area with clean water after using soapy water to cleanse the groin and catheter area. V20 stated that she should have cleansed the area with plain water after she used soapy water, and she also should have patted the area dry since it was wet. The facility policy titled Catheter Care with a review date of 06/2014 documents under policy that Catheter care is provided daily and as needed to all residents who have an indwelling catheter to reduce the incidence of infection. Procedure for male documents 1. Wash your hands. 2. Apply clean gloves. 3. Retract the foreskin if the resident is uncircumcised. 4. Wash around the urinary meatus with warm soap and water. 5. Gently remove any secretions and encrustation around the urethral opening. 6. Remove any crustations that are on the catheter. 7. Rinse and dry the area well. 8. Return foreskin to its normal position. 9. Remove your gloves. 10. Reposition the resident to a comfortable position. 11. Wash your hands.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on record review, observation, and interview, the facility failed to follow facility policy and procedure by failing to check the placement of a gastrostomy tube prior to administering medication and flusing with water and feeding for 1 of 1 resident (R47) reviewed for gastrostomy tube use in the sample of 42. Findings include: R47's Admission Record printed on 01/30/25 documents an admitted [DATE] with diagnoses that included dysphagia, muscle weakness, gastrostomy status and hyponatremia. R47's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 5, which indicates severely impaired cognition. Under Functional Abilities and Goals, the MDS documents R47 is dependent with eating. Under Swallowing/Nutritional Status, the MDS documents R47 has a feeding tube. R47's Care Plan dated 12/23/24 documents a focus area of R47 is at risk for nutritional deficit r/t (related to) dx (diagnosis) dysphagia, COPD (Chronic Obstructive Pulmonary Disease). Has a gastrostomy tube (G-Tube,) multiple pressure ulcers, colostomy. R47 is on a regular pureed diet with nectar thick liquids and TF (tube feeding) of Nutren (Supplement) 1.0. R47's Physician Order Detail documents an order date of 01/17/25 with a order summary of change diet to: Nutren 2.0 1 carton (250ml) (milliliter) with 165ml flush before and after each feeding (4x (times) daily). On 01/29/25 at 10:53AM, V20 (Licensed Practical Nurse/LPN) flushed R47's g-tube with 30ml of water prior to administering medications to g-tube. V20 did not check placement of g-tube prior to administering medications. On 01/29/25 at 11:20AM, V20 (LPN) administered a flush of 165ml of water to R47's g-tube and then administered 1 carton of Nutren 2.0 and then another flush of 165ml of water. V20 did not check placement of R47's g-tube prior to flush and feeding. On 01/30/25 at 1:16PM, V10 (Registered Nurse/RN) said that placement to g-tubes are checked prior to administering a flush, feedings, or medications. V10 said that she checks placement to a g-tube by aspirating back the contents in the g-tube. V10 said that is when she aspirates back the stomach contents, if there is more than 100ml of content in the syringe she will hold the feeding, flush, or medication and notify the doctor. V10 said that she will see if the doctor would like for her to continue to give the flush, medication, or feeding or hold it. On 01/30/25 at 2:00PM, V20 (LPN) stated that she did not check placement before administering the medications, flush, or feeding. V20 said that the last time placement had been checked on R47 was around 6:30AM when the shift before had checked placement. V20 said that she checks placement by taking 30-40ml of air in a syringe and puts her stethoscope on R47's belly and listen for a whoosh sound. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/25 at 2:45PM, V2 (Director of Nursing/DON) stated that all g-tubes should have placement checked before administering any medication, flush, or feeding. V2 said that placement should be checked by aspirating back the stomach contents with a syringe and if the content is greater then a 100ml they should contact the doctor. V2 stated that they don't check placement with pushing air into the stomach and listening for the whoosh sound anymore. V2 said that no nurse should check placement with pushing air in the stomach anymore. On 01/30/25 at 2:50PM, V3 (Regional Nurse) stated that the facility does not check placement with air bubbles and listen for a whoosh anymore. V3 said that all g-tubes should be checked (for placement) prior to flushes, medication administration, and feedings. V3 said that all g-tubes should be checked for placement by pulling the syringe and checking for stomach content. The facility policy titled Confirming Placement of Feeding Tubes revised on 03/2025 documents The purpose of this procedure is to ensure proper placement of feeding tube to prevent aspiration during feedings. The policy further documents To confirm placement of tube .#3. Observe for changes in residual volume: a. a sharp increase in residual volume may indicate that a small bowel tube has moved into the stomach; b. little to no residual volume may suggest that the tube has migrated from the stomach to the esophagus. #4. If the above suggests improper tube positioning, do not administer feeding or medications. Notify the Charge Nurse or Physician.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review, the facility failed to ensure physician's orders were followed, for 1 of 5 residents (R55) reviewed for significant medication errors in the sample of 30. This failure resulted in R55 missing three doses of long- acting insulin from 1/17/25 to 1/19/25, causing R55's blood sugars to be extremely elevated. This has the potential to lead to ketoacidosis which could result in coma and possible death. This failure resulted in an Immediate Jeopardy. An Immediate Jeopardy was identified to have begun on 01/17/25 at approximately 9:00 PM when the facility was unable to provide R55's scheduled long-acting insulin and did not notify the physician. The facility also failed to administer R55's long-acting insulin as ordered on 01/18/25 and 01/19/25. V1 (Administrator) and V2 (Director of Nursing), were notified of the Immediate Jeopardy on 02/04/25 at 3:13 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on 02/04/25, but the noncompliance remains at Level Two due to additional time needed to evaluate implementation and effectiveness of training. Findings include: R55's admission record documents an admitted [DATE] and list the following diagnoses in part; vascular dementia, mild with psychotic disturbances and type 2 diabetes mellitus. R55's MDS (Minimum Data Set) dated 01/24/25, documents a BIMS (Brief Interview for Mental Status) of 11, indicating that R55 is moderately cognitively impaired. Section I-active diagnoses documents an active diagnosis of diabetes mellitus. R55's care plan documents an initiation date of 01/28/25 for a focus area that states R55 is at risk for complications r/t (related to) dm (diabetes mellitus). R55's Physician's Order Sheet (POS) documents an order with an order date and a start date of 01/17/25 for Toujeo Solostar Subcutaneous Solution pen-injector 300 Units/ML, (Insulin Glargine) (long-acting insulin), Inject 70 units at bedtime for diabetes mellitus. R55's Physician's Order Sheet (POS) documents an order with a start date of 01/18/25 for Blood glucose per fingerstick as needed for signs/symptoms of hyperglycemia/hypoglycemia. On 01/27/25 at 10:03am, V36 (Family member) stated that they continued to ask the nurse about R55's meds the first couple of days of being in the facility because she wasn't getting all of them or her insulin, they continued to be told they were still working on it. V36 stated staff reported they were still working on her admission through Sunday. V36 stated R55 was not getting her blood sugar checked at meals either. V36 stated that R55 had her blood sugar checked four times a day at the hospital and she had continuous monitoring at home. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/29/25 at 12:01pm, V37 (Family member) stated R55 was admitted on Friday 01/17/25 in the evening, and it was a struggle all weekend getting her medications. V37 said that they asked the nurses several times from Friday to approximately Sunday or Monday for R55's medications and insulin's and they kept saying that they were working on getting her admitted still. V37 stated they asked staff several times to check R55's blood sugar around mealtime, which is what she did at home and at the hospital, but no one did. R55's progress notes document that on 01/17/25 and 01/19/25 Toujeo Solostar Subcutaneous Solution pen-injector (Insulin Glargine) (long-acting insulin) was not administered due to awaiting pharmacy delivery. R55's January 2025 Medication Administration Record (MAR) documents a blood glucose finger stick was started and administered by V42 (Registered Nurse/RN) on 01/18/25 and documents a blood sugar of 308. R55's January 2025 MAR documents no signatures on 01/17/25 or 01/19/25 for Toujeo Solostar Subcutaneous Solution pen-injector (Insulin Glargine) (long-acting insulin), indicating it was not administered. R55's January 2025 MAR documents a signature on 01/18/25 for Toujeo Solostar Subcutaneous Solution pen-injector (Insulin Glargine) (long-acting insulin) indicating that it was administered by V46 (Registered Nurse/RN), and a blood sugar of 411. V46 was unavailable for interview to explain how she was able to administer a medication that was not available in the facility or why she documented in the MAR a blood sugar of 411 and did not contact the physician. On 01/30/25 at 09:58am, V41 (Pharmacy medical records) reviewed medication orders for R55. V41 stated a new order was received from the facility for long-acting insulin on 1/17/25. V41 stated an emergency order was called to the backup pharmacy (a local pharmacy) on 1/17/25. V41 stated the order was never picked up by facility. V41 stated on 1/19/25, a nurse from the facility called to ask about it and the pharmacy informed them it was to be delivered later that evening or there was an emergency order called in to the backup pharmacy and they stated they will wait for the delivery. V41 confirmed the long-acting insulin was delivered on 01/19/25. V41 stated the facility would not be able to access their supply without contacting the pharmacy for a code to open the bin the medication was in. On 02/03/25 at 03:43pm, V2 (DON) stated that discharge orders from residents admitted from the hospital are to be put into the computer system as soon as possible, copied and then faxed to the pharmacy. V2 stated if they are not faxed by 8pm, they will not be received that day. V2 stated some medications, including insulin's are kept in the emergency kit in the medication room. V2 stated if they are not in there, they should contact the pharmacy and see if they can bring them on an emergency run or from the backup pharmacy (local pharmacy). V2 stated if it comes from the backup pharmacy, she believes they deliver it. V2 stated she was not aware that R55 missed multiple doses of long-acting insulin before she reviewed her admission packet on 1/20/25 or 1/21/25. V2 stated at that time she contacted V34 (Physician) to see if he wanted R55 to have sliding scale insulin. V2 stated that her process for new admission orders is that two nurses independently review the orders and then she will review the admission packet also. V2 stated she would have expected V34 be contacted with any missed doses of insulin or blood sugars above 300. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/03/25 at 12:03pm, V42 (RN) stated the process for admitting new residents with medications, is that the admitting nurse puts the orders in, and if they are not finished by the next shift, the oncoming nurse should finish them. V42 stated if she put an order in for an as needed (PRN) blood glucose fingerstick for R55, it was because it was either on her discharge sheet or ordered by the doctor. V42 stated that she did not notify the doctor of a blood sugar of 308 for R55 because they are not required to. V42 stated if they need medications, they call the pharmacy, if they cannot get them then they should notify the doctor. V42 stated on 01/19/25 when she was taking care of R55, her meds were still not available in the facility and she did not notify the physician. On 02/03/25 at 12:19pm, V4 (License Practical Nurse/LPN) stated when a new admit comes, they get discharge orders and the nurse that receives the resident is to put them in. V4 stated they are then checked by a second nurse and then by V2 (DON). V4 stated this is a new process that was put in place by V2 since she started a few weeks ago. V4 stated the process for obtaining medications is to call the pharmacy and order the medication, see if it is in the emergency supply and then the backup pharmacy. V4 stated she was not sure who's responsibility it was to get meds from the backup pharmacy, but she has seen them come via door dash from a local pharmacy before. V4 stated residents should not miss a dose of insulin and if that were to happen, the doctor should be notified. V2 stated she did R55's admission but could not recall what the situation was with R55's medications when she was admitted . On 01/30/25 at 02:19pm, V34 (Physician) stated on 01/17/25 he was notified late at night about R55 having a drug allergy and order clarification for a medication. V34 stated he was not contacted again until 1/21/25. V34 reviewed his communication with the facility and stated he had not been contacted at all about R55's insulin not being available or blood sugar until 1/21/25. V34 stated he was contacted on 01/21/25 by V2 (Director of Nursing/DON) about orders for sliding scale insulin for R55. V34 stated yes and he directed them to call his office if they were not familiar with his standard sliding scale. V34 stated he would expect to be contacted about any resident, not just a new resident, with a blood sugar of 308 and 411, especially the 411. V34 stated his expectation would also be that they recheck R55's blood sugar after numbers like that. V34 could not say for sure what would have happened or the level of harm that could have happened because everyone responds differently, but that he had not been notified of any of it. V34 stated his expectation would be for R55 to not miss any doses of insulin, especially if there was a script waiting at a pharmacy in town the same day. V34 stated his expectation would be to be notified in those instances. On 02/03/25 at 02:45pm, V26 (LPN) stated she was working on 01/17/25. V26 stated she did not recall the situation with R55 and not receiving insulin. After a review of R55's medication administration record (MAR), V26 verified she did not administer R55's insulin and she recalled being told in report from the day shift nurse that the medication was on its way. V26 stated she could not recall if she notified the doctor or not but should have. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/10/25 at 07:51am, V50 (Pharmacy medical records) stated it is the responsibility of the pharmacy couriers to pick up medications filled at the backup pharmacy. V50 stated she had no documentation as to why R55's insulin was not picked up from the backup pharmacy or that anyone from the facility contacted them about R55 until 01/19/25. V50 stated the facility did not attempt to obtain the medication from the Emergency kit for R55. V50 stated when the facility calls in the order to the pharmacy, if it is the emergency kit (E-kit), the pharmacy technician would advise them to pull from E-kit if it were available there. V50 stated the pharmacy technician would then walk them through the process and grant them access to the medication. V50 stated judging by the fact that an order was sent to the backup pharmacy immediately, the medication may not have been available in the E-kit. V50 confirmed there was not R55's type of insulin available in the facility emergency kit from 01/17/25-01/20/25. V50 confirmed there was no correspondence between the facility and the pharmacy from 01/17/25 and 01/19/25 regarding R55's insulin. According to the Mayo Clinic website (https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551), Diabetic ketoacidosis is a serious complication of diabetes. Under When to See a Doctor it documents Seek emergency care if: Your blood sugar level is higher than 300 milligrams per deciliter (mg/dL), or 16.7 millimoles per liter (mmol/L) for more than one test .untreated diabetic ketoacidosis can lead to death. According to the Center for Disease Control (CDC) website (https://www.cdc.gov/diabetes/about/diabetic-ketoacidosis.html), Diabetic ketoacidosis (DKA) is serious and can be life-threatening. Under Causes it documents Very high blood sugar and low insulin levels lead to DKA. The two most common causes are: .2. Missing insulin shots, a clogged insulin pump, or the wrong insulin dose. Under Testing it documents Go to the emergency room or call 911 right away if you can't get in touch with your doctor and if you're having any of these signs: Your blood sugar stays at 300 mg/dL or above . A facility document titled Administering Medications with a revision date of December 2012 documents under policy statement, Medications shall be administered in a safe and timely manner, and as prescribed. The Immediate Jeopardy began on 01/17/25 and was removed on 02/04/25 when the facility took the following actions to remove the immediacy and correct the deficient practice as confirmed through observation, interview, and record review. 1. 2/4/25 Facility has reviewed the following policies for education and implementation. -Medication Order Policy-Revision made to assure IDT review and reconcile all new admission medication orders within 24 hours of admission. 2. 2/4/25 at 5:30 PM DON educated by the Regional Clinical Director, on the following policies and procedures; Medication Order Policy. IDT to review all new admission medication orders within 24 hours. 3. 2/4/25 at 5:30 PM Staff education on the following policies and procedures by DON and Regional Clinical Director and/or IDT who received train the trainer training listed above. -Medication Order Policy -IDT to review all medication within 24 hours. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Alleged Completion date 2/4/2025 and ongoing prior to working next scheduled shift until 100% of employees are educated. -Clinical department new hires will be educated prior to starting any shifts by a member of the IDT that have been trained to provide the training. 4. 2/4/25 at 3:55 PM Nurses in serviced on Medication Order Policy including but not limited to medication reconciliation with hospital orders upon admission done by V2 (DON) and V39 (LPN). 5. 2/4/25 at 5:00PM IDT team in-serviced on revised Medication Order Policy with emphasis on all new admission orders should be reviewed within 24 hours completed by V8 (LPN, MDS/CP Coordinator) and V2 (DON) V39 (LPN) or clinical designee. 6. 2/4/25 at 5:35 PM. All resident medication order to medications on hand match back began by V3(Regional Director of Clinical Services), V2 (DON), V39 (LPN).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview, observation, and record review, the facility failed to serve food at palatable/preferred, appetizing temperatures for 5 (R27, R28, R35, R51, R105) of 22 residents reviewed for appetizing food temperatures in a sample of 42. Findings include: R51's Admission Record documents an admitted [DATE]. R51's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) of 09, indicating moderately impaired cognition. On 01/27/25 at 10:17 AM, R51 stated the food is not good and is typically cold. On 01/28/25 at 7:30 AM, a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit. On 01/28/25 at 7:45 AM, the dietary hall cart was starting to be filled. On 01/28/25 at 8:26 AM, V21 (Certified Nurse Aide/CNA) had two hall trays left to deliver. R35's tray was delivered and R35 refused her tray. V21 immediately returned the tray to the dietary cart, stating R35 refused her tray. At this time, the temperature of the food on R35's tray was taken. The waffles were 76.5 degrees Fahrenheit, and the bacon was 77.2 degrees Fahrenheit. Both items were cool to the touch. R27's Admission Record documents an admitted [DATE]. R27's minimum data set (MDS) dated [DATE] documents a brief interview of mental status (BIMS) of 14 indicating her cognition is intact. On 01/29/25 at 11:44 AM R27 stated, she eats in her room and a lot of the hot food items are typically cold when they get to her. R28's Admission Record documents an admitted [DATE]. R28's MDS dated [DATE] documents a BIMS score of 12, indicating moderately impaired cognition. On 01/29/25 at 11:49 AM, R28 stated he typically eats in his room and at times, the food is cold. R28 stated breakfast is cold more often, but any meal can be. R105's Admission Record documents an admitted [DATE]. R105 was alert and oriented to person, place, time, and event. On 01/29/25 at 11:57 AM, R105 stated he typically eats in his room. R105 stated the food can be cold. R105 stated items like oatmeal and chili are usually warm, but any item that does not hold heat well such as eggs, waffles, bacon, or if it is a thinner meat, is typically cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/30/25 at 3:18 PM, V14 (Dietary Director) stated she thought it was taking too long to load and deliver the large hall cart to the residents that eat in their rooms. Since the tall hall cart is not enclosed or insulated, they are going to start using only the regular carts to deliver hall trays so the food will hopefully be warmer. Food sitting on the cart for over 30 minutes is not going to keep it all hot.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41610 Based on observation, interview, and record review the facility failed to provide safe and sanitary food and dietary services. This failure has the potential to affect all 54 residents that reside at the facility. Findings include: 1. On 01/27/25 at 9:30 AM, a container of sugar was observed on the counter between the kitchen and dining room. The container of sugar was sitting by the coffee and tea on the dining service counter within residents' reach. There was a small plastic portion cup in the sugar container that was utilized by both staff and residents to get sugar for the drinks. On 01/27/25 at 11:30 AM, R12 was observed getting sugar from the container with the small plastic portion cup. On 01/27/25 at 11:53 AM, V21 (Certified Nurse Aide/CNA) used the portion cup in the sugar container to get sugar for a resident's drink. After touching the counter and the lid to the sugar container, V21 placed the portion cup back into the sugar container. On 01/29/25 at 10:15 AM, during Resident Council meeting, residents were asked if the container of sugar that sits on the counter by the coffee canister is what they use to sweeten their beverages, and R2, R6, R12, R37, R46, and R45, all confirmed it was. All agreed that they use the small plastic portion cup to get the sugar out, then it is placed back in the container. On 01/29/25 at 3:17 PM, R46 removed the lid from the sugar container, used the portion cup to get sugar for his drink, returned cup to the sugar container, and placed the lid back on the sugar container. 2. On 01/27/25 at 2:20 PM, on the south hall, a scoop was observed on the side of a cooler by the nurse's station. R51 used the scoop to get ice for her cup. R51 grabbed the handle of the scoop but then shifted it in her hand where she was touching the lower portion, or body of the scoop. After touching her wheelchair handles, her pants, her cup and the beverage cart handle, R51 placed the scoop back in the cooler full of ice. On 01/27/25 at 3:07 PM, on the south hall, R46 used the scoop placed on the side of the cooler to get ice for his cup. On 01/27/25 at 3:20 PM, on the south hall, V7 (CNA) used the scoop to place ice in a cup and delivered it to R16. On 01/27/25 at 3:40 PM, on the south hall, V11 (Registered Nurse/RN) stated the cooler of ice by the nurse's station is the ice that is used for the drinks for the residents. (continued on next page)

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	145757	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/29/25 at 2:44 PM, R51 used the scoop placed on the side of the cooler to get ice for her cup. R51 again grabbed the handle of the scoop, but then shifted it in her hand, touching the body of the scoop. After touching her cigarette, the door leading to the inside, her wheelchair handles, her pants, her cup, and the cooler lid, R51 placed the scoop back in the bin full of ice. 3. On 01/27/25 at 10:18 AM, on the north hall, a scoop was observed on the side of the ice cooler. R3 used the scoop to get ice for his cup touching the body of the scoop to his cup that he had already been drinking out of and handling after touching his wheelchair, his coat, his jeans, and his cup. On 01/27/25 at 10:24 AM, on the north hall, R45 used the scoop to get ice for his cup. On 01/27/25 at 10:30 AM, on the north hall, V21 (CNA) used the scoop to get ice for R11. On 01/29/25 at 10:15 AM during Resident Council meeting, residents were asked if the scoops and ice coolers on the halls are what they use to obtain ice for their drinks, and R2, R12, R6, R37, R45, and R46 all confirmed it was. All agreed the residents can get the ice themselves or the staff will get ice for those residents that cannot or do not come out of their room. On 01/30/25 at 3:18 PM, V14 (Dietary Director) stated the facility does not have sugar packets because they are too expensive, but they should not have a portion cup in the sugar container, especially that everyone touches and puts back into the container. V14 stated she will have to find a new method to have sugar for distribution. V14 stated the ice coolers on the north and south halls should be used by staff only in a sanitary manner. The lower portion (body) of the scoop should not be touched, and if the scoop touched any item that was not a clean surface it should be washed and sanitized before putting it back in the ice. The Long-Term Care facility application for Medicare and Medicaid dated 01/27/25 documents 54 residents residing at 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** 48356 Based on observation, interview, and record review, the facility failed to implement infection control practices for Enhanced Barrier Precautions and for Covid-19 infections as recommended by the CDC (Centers for Disease Control and Prevention) to prevent the development and transmission of communicable diseases and infections for 6 of 9 residents (R5, R24, R36, R47, R49, and R51) observed for infection control in the sample of 42. Findings include: 1. R47's Admission Record printed on 01/30/25 documents an admitted [DATE] and included diagnoses of dysphagia, muscle weakness, gastrostomy status, hyponatremia, colostomy, pressure ulcer sacral region stage 4, infection, and inflammatory reaction due to internal left hip prothesis. R47's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5, indicating R47 has severe cognitive impairment. Under Functional Abilities and Goals, the MDS documents R47 is dependent with turning and repositioning, eating, personal hygiene, and showers. Under Swallowing/Nutritional Status, the MDS documents R47 has a feeding tube. Under Skin Conditions, the MDS documents R47 has two stage 4 pressure ulcers. R47's Care Plan included a focus area initiated 1/29/25 that documents R47 is at risk for UTI (Urinary Tract Infection) r/t (related to) use of urinary catheter (Indwelling Catheter). Another focus area with a date initiated of 12/23/24 documents R47 is at risk for nutritional deficit r/t dx (diagnosis) dysphagia, COPD (Chronic Obstructive Pulmonary Disease). Has G-Tube, multiple pressure ulcers, colostomy. R47 is on a regular pureed diet with nectar thick liquids and TF (tube feeding) of Nutren (Supplement) 1.0. The Care Plan also documents a focus area initiated 12/15/24 which documents R47 was admitted with multiple pressure ulcers. Unstageable to left heel, Stage 4 to coccyx, Stage 4 to left medial shin, Stage 4 to left lateral shin, Stage 4 to right medial ankle, arterial wound to right lateral ankle, ST (Skin tear) to right lateral knee and ST to right buttock. R47 has a surgical wound to right hip. R47 is at further risk for breakdown r/t requires assist with bed mobility, had colostomy, foley catheter and g-tube. R47's intervention does not document any area related to Enhanced Barrier Precautions. On 01/29/25 at 10:53AM, V20 (Licensed Practical Nurse/LPN) entered R47's room which had Enhanced Barrier Precaution signage outside the door. V20 washed her hands and put on gloves, then accessed R47's G-tube to administer a flush and medications. V20 never donned a gown before administering the flush or medications to g-tube. On 01/29/25 at 11:20AM, V20 (LPN) again entered R47's room. V20 washed her hands and put on gloves before accessing R47's g-tube and administering a flush and supplemental feeding. V20 never donned a gown before accessing g-tube for flushes and feeding. On 01/30/25 at 10:33AM, V15 (Certified Nurse Assistant/CNA) stated that anytime she does direct care on a resident on Enhanced Barrier Precautions she washes her hands, puts on gloves and a gown before providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/30/25 at 10:45AM, V16 (CNA) stated that anytime she does direct care on a resident who is on enhanced barrier she washes her hands, puts on gloves and puts on a gown. V16 said that they do this to protect the residents. V16 stated that R47 is one of the residents on Enhanced Barrier Precautions. On 01/30/25 at 1:16PM, V10 (Registered Nurse/RN) stated that any resident with a wound, g-tube or catheter is on Enhanced Barrier Precautions. V10 stated any time you are providing direct care to a resident on Enhanced Barrier Precautions you should wash your hands, put on gloves, and don a gown. V10 said this is to protect the resident. V10 said that if she is administering medications or doing flushes and feeding to a g-tube, she would make sure to wash hands, put on gloves, and don a gown. V10 said that is considered direct care. On 01/30/25 at 2:00PM, V20 (LPN) stated that R47 is on Enhanced Barrier Precautions. V20 stated that she should have washed her hands, put on gloves and a gown before accessing R47's g-tube for medication administration and his flush and feeding. V20 stated that she did not wear a gown during his feeding or during his medication administration via g-tube. On 01/30/25 at 2:45PM, V2 (Director of Nursing/DON) stated that any time a staff member provides direct care to a resident on Enhanced Barrier Precautions they should wash their hands, put on gloves and a gown. V2 said that administering medication via g-tube and flushes and feeding via g-tube is direct care. 49907 2. R51's Admission Record documents an admitted [DATE] and included the following diagnoses: muscle weakness, retention of urine and secondary malignant neoplasm of the brain. R51's MDS dated [DATE], documented a BIMS score of 09, indicating R51 is moderately cognitively impaired. Under Functional Abilities, R51's MDS documented that R51 is dependent for toileting hygiene, lower body dressing and bed mobility. R51's Care Plan documented a focus are of at risk for skin breakdown r/t frequently incontinent of bowel, has a urinay catheter, requires assist with bed mobility. Has open area to left buttock and skin tear to right buttock. R51's Physician's Order Sheet dated 02/05/25, documents the following wound care orders. Wound to left buttock: Clean with cleanser. Pat dry. Santyl apply to wound bed. Apply calcium alginate. Cover with bordered foam dressing. Daily and PRN (as needed). Alginate calcium; Collagen powder; Silver sulfadiazine apply once daily for 30 days to Skin tear wound of the right buttock Gauze Island w/ bdr (with border) apply once daily for 30 days. On 01/29/2025 at 02:26PM, R51 had an Enhanced Barrier Precautions sign posted on the door. At this time, wound care was provided to R51 by V4 (LPN) with V2 (DON) assisting with supplies and positioning. Neither staff member put on a gown. V4 washed her hands and donned gloves. V2 helped R51 roll over onto her right side and held her in position while V4 began cleaning the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/29/25 at 02:39PM, V6 (CNA) stated R51 is on Enhanced Barrier Precautions. V6 stated Enhanced Barrier Precautions should be in place on anyone who has a urinary catheter, g-tube, or open wounds. V6 stated that if a resident is on Enhanced Barrier Precautions, staff should wash their hands, don gown and gloves anytime they are providing or assisting with direct patient care. On 01:29/25 at 02:58 PM, V4 (LPN) stated that R51 is on Enhanced Barrier Precautions, and she should have put a gown on before providing wound care or any direct patient care. On 01/30/25 at 2:45PM V2 (Director of Nursing/DON) stated that any time a staff member provides direct care to a resident on Enhanced Barrier Precautions they should wash their hands, put on gloves and a gown. The facility Policy titled Isolation-Categories of Transmission-Based Precautions revised January 2012, reviewed and updated 2023 documents under Enhanced Barrier Precautions in addition to standard precautions, implement enhanced barrier precaution for all residents with any of the following: b. wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tubes, tracheostomy/ventilator) regardless of MDRO (Multidrug-resistant Organism) 7. Signs- The facility will implement a system to alert staff and visitors to the type of precautions the resident requires. According to the CDC website https://www.cdc.gov/long-term-care-facilities/media/pdfs/PPE-Nursing-Homes-508.pdf, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), CDC recommendations for Enhanced Barrier Precautions applies to: All residents with any of the following: Infection or colonization with an MDRO when Contact Precautions do not otherwise apply, Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. PPE used for these situations during high-contact resident care activities 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. Required PPE includes gloves and gown prior to the high-contact care activity (Change PPE before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray). 41610 3. A facility document titled, Midnight Census Report 01/26/25 dated 01/27/25 documents R36 and R5 reside together in the same room and R24 and R49 reside together in the same room. A facility document titled, Residents documents on 01/24/25: R36 tested positive for Covid-19 and R5 tested negative; R49 tested positive for Covid-19 and R24 tested negative. R36's Admission Record documents an admitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease, major depressive disorder, and anxiety disorder. R5's Admission Record documents an admitted [DATE] with diagnoses that included: senile degeneration of brain, anxiety disorder, anemia, hypertension, epileptic seizure disorder, major depressive disorder, and schizophrenia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R49's Admission Record documents an admitted [DATE] with diagnoses that included: aphasia following cerebral infarction, hypertension, peripheral vascular disease, diabetes mellitus type II, chronic obstructive pulmonary disease, and atrial fibrillation. R24's Admission Record documents an admitted [DATE] with diagnoses that included: dementia, contracture of muscle, and anxiety disorder. On 01/27/25 at 9:30 AM, R36 and R5 were observed to reside in the same room together. On 01/27/25 at 9:30 AM, R49 and R24 were observed to reside in the same room together. On 01/27/25 at 10:15 AM, V30 (Activities Director) stated R24 was positive for Covid-19 and R49 was not and verified they are in the same room together. V30 stated R36 was also positive for Covid 19 and R5 was negative and verified they are in the same room together. During subsequent observations on 01/28/25 at 8:30 AM, 1/29/25 at 7:30 AM and 1/30 at 7:20 AM, R36 and R5 were still observed to be residing in the same room, as were R24 and R49. On 01/30/25 at 3:50 PM, V3 (Regional DON) stated he was unaware of the current guidelines for Covid-19 infection control, but after reading the guidance he can see the residents should have been separated. The CDC website (https://www.cdc.gov/covid/hcp/infection-control) documents the following: Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection: The IPC recommendations described below (e.g., patient placement, recommended PPE) also apply to patients with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection. However, these patients should NOT be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.