STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145758	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Glenwood	19330 South Cottage Grove Glenwood, IL 60425

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 49871 Based on observation, interview and record review, the facility failed to provide privacy during wound care treatment for 1 of 2 residents (R5, R40) observed for wound treatment in a sample of 26. Findings include: On 6/12/2024 at 09:50AM, V19 (Wound Nurse) observed for wound care treatment including dressing changed of R40's left heel. V19 prepared supplies needed and proceeded to R40's room. R40's door was not closed, and privacy curtain was not drawn the entire time treatment was performed. R40 is visibly seen in the hallway during treatment. On 6/12/2024 at 10:00AM, V19 stated she should have closed R40's door during treatment to provide privacy. On 6/12/2024 at 11:15AM, V2 (Director of Nursing/DON) stated staff is expected to close the door and curtain drawn when providing care to residents, including all treatment performed to maintain privacy. On 6/12/2024 and 6/13/2024, Privacy Policy related to treatment procedure was requested on multiple occasions to V1 (Administrator), V2 (DON), and V16 (Nurse Consultant) and facility was not able to provide. Admission Record: Diagnosis Information: Type 2 Diabetes Mellitus Without Complications, Peripheral Vascular Disease, Unspecified Order Summary Report: Left heel clean with wound cleanser, pat dry apply Santyl and Calcium alginate bordered gauze daily, everyday shift for wound care Care Plan: R40 has a pressure ulcer to left heel. Administer treatment as ordered.

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46560 Based on interview and record review, the facility failed to perform criminal history background checks within 24 hours of admission for three of five residents (R118, R322, R323) reviewed for criminal history background check in a sample of 26. Findings include: 1. On 06/12/2024 at 10:50AM during record review, R118 was noted with admitted [DATE] and Criminal History Information Response Process was initiated on 06/11/2024. On 06/11/2024 at 12:45PM during interview with V24 (Admissions Director), V24 stated that criminal background checks should be done within 24 hours of admission. On 06/13/2024 at 11:40AM during interview with V1 (Administrator), V1 stated that criminal background checks should be done within 24 hours of admission but because the facility staff did not have access to request Criminal History Information Response Process they were not able to do it within 24 hours for R118. Review of R118's order summary report printed 06/13/2024 indicated admitted [DATE]. Review of R118's Criminal History Information Response Process indicated dated of 06/11/2024. 2. On 06/12/2024 at 10:50AM during record review, R322 was noted with admitted [DATE], Criminal History Information Response Process was initiated on 06/11/2024. R322's electronic health records did not indicate the other background checks. On 06/11/2024 at 12:45PM during interview with V24 (Admissions Director), V24 stated that criminal background checks should be done within 24 hours of admission. On 06/13/2024 at 11:40AM during interview with V1 (Administrator), V1 stated that criminal background checks should be done within 24 hours of admission but because the facility staff did not have access to request Criminal History Information Response Process they were not able to do it within 24 hours for R322. On 06/14/2024 at 11:30AM during interview with V24, V24 stated that R322's name were not requested on Illinois Sex Offender website until today, 06/14/2024. Review of R322's order summary report printed 06/13/2024 indicated admitted [DATE]. Review of R322's Criminal History Information Response Process indicated date of 06/11/2024. Review of R322's Illinois Sex Offender Registration indicated date of 06/14/2024. 3. On 06/12/2024 at 10:50AM during record review, R323 was noted with admitted [DATE] and Criminal History Information Response Process was initiated on 06/11/2024. On 06/11/2024 at 12:45PM during interview with V24 (Admissions Director), V24 stated that criminal background checks should be done within 24 hours of admission. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/2024 at 11:40AM during interview with V1 (Administrator), V1 stated that criminal background checks should be done within 24 hours of admission but because the facility staff did not have access to request Criminal History Information Response Process they were not able to do it within 24 hours for R323. Review of R323's order summary report printed 06/13/2024 indicated admitted [DATE]. Review of R322's Criminal History Information Response Process indicated dated of 06/11/2024 and result of Hit. Review of facility's policy entitled Abuse Policy and Prevention Program dated 10-2022 indicated the following: II. Pre-Admission Screening of Potential Residents - ILLINOIS ONLY This facility shall check the criminal history background for any resident seeking admission to the facility in order to identify previous criminal convictions. This facility will - Request a Criminal History Background Check with 24 hours after admission of a new resident - Check for the resident's name on the Illinois Sex Offender Registration Web site: www.isp.state.il.us

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50469 Based on observation, interview, and record review the facility failed to provide care and maintain hygiene for the resident's nails for 1 of 7 residents (R98) in a sample of 26. Findings include: On 6/11/24 at 10:30AM, Observed R98 with long dirty fingernails, R98 said he would like is fingernails to be cut down, R98 said that the staff does not cut them. On 6/11/24 at 10:32AM, Informed V12 (Licensed Practical Nurse) of above observation, V12 said that R98 sometimes refuses getting his fingernails cut. On 6/13/24 at 12:54PM, V2 (Director of Nursing) said that nail care should be provided to the residents, the nails should be cut and cleaned as needed by the CNA's (Certified Nursing Assistants). V2 said if the resident refuses, then the staff should notify the nurse so that a refusal care plan can be added. V2 said that the staff should follow the nail care facility policy. Review of R98 medical records. R98 admitted on [DATE] R98 is alert and verbal, with diagnosis listed in part but not limited to Primary osteoarthritis, right shoulder, Hemiplegia and Hemiparesis following cerebral, infarction affecting right dominant side, Muscle wasting and atrophy, other lack of coordination. Review of comprehensive care plan did not indicate R98 had any Refusal of care/nail care refusal care planed. Facility's policy on Nail Care Review Date 1/10/24 Policy Statement: To provide care and maintain hygiene for the resident's nails. Guideline: Nail care is offered and performed on the resident's shower day and as needed. Notify the nurse if the resident refuse nail care and when nail care is unable to be performed due to the resident's condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to accurately complete smoking assessment to a resident who smokes and formulate care plan for smoking safety. The facility also failed to initiate fall investigation and update fall care plan. This deficiency affects two (R46, R55) of five residents in the sample of 26 reviewed for Smoking Safety. Findings include: On 6/11/24 at 8:31AM, V11 said that R55 is a smoker. On 6/11/24 at 9:30AM, Observed R55 lying in his room. He said that he smokes daily. He said that he needs assistance when he goes to smoke. R55 is admitted on [DATE] with admitting diagnosis listed in part but not limited to Diabetes Mellitus type 2, Fractured of right toe, Osteoarthritis, Dependence of Renal dialysis. Smoking assessment dated [DATE] indicated that he is not smoking. No care plan formulated for safety smoking. Smokers list as of 6/11/24 given by V2 Director of Nursing (DON) indicated that R55 is included in the list of residents who smokes. On 6/12/24 at 10:53AM, V17 Social Service Director said that R55 is a smoker. He said that they are responsible for completing his smoking assessment and formulate smoking care plan. Informed V17 that R55 smoking assessment dated [DATE] indicated that he does not smoke, and no care plan is formulated for safety smoking interventions. On 6/13/24 at 10:23AM, V23 Activity Director said that R55 is a smoker and goes to smoking area when he is not on dialysis. Facility's policy on Smoking safety revised on 10/24/22 indicates: Purpose: To provide a safe and healthy living environment with respect for the health and well being needs of each resident, staff, member, and visitor. It is also the objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy. Safety measures: *A smoking safety assessment will be completed to determine the level of assistance and supervision needed during smoking, the ability to carry and store smoking materials and if as smoking apron is indicated. The plan of care shall reflect the results of this assessment. This assessment will be completed upon admission, quarterly and with significant change. 46560 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2024 at 1:30PM during record review, R46 was noted to have fall incidents on 1/20/2024, 2/12/2024, 5/28/2024 and 6/5/2024. On 06/13/2024 at 10:05AM during record review with V25 (Minimum Data Set [MDS]/Care Plan Coordinator), no documentation of fall investigation was noted on R46's electronic health records and R46's care plan did not indicate that the care plan was updated after the fall incidents on 2/12/2024 and 5/28/2024. On 06/13/2024 at 10:05AM during interview with V25, V25 stated that R46's care plan should have been updated after the interdisciplinary team (IDT) investigated the fall incidents on 2/12/2024 and 5/28/2024 were completed. V25 also stated that the IDT meets every morning to discuss any issues that happened during the previous day, including falls, and discuss there if the interventions that has to be put in place to prevent further falls. V25 stated that the goal of putting new interventions and updating the care plan is to prevent further falls of residents as much as possible. At 1:30PM, V25 stated that she is unable to provide documentation of fall investigation/root-cause analysis for falls on 2/12/2024 and 5/28/2024 because she was not aware that she was the one who was supposed to do it. Review of R46's order summary report dated 6/13/2024 indicated admitted [DATE] and diagnosis of not limited to cerebral infarction affecting right dominant side. Review of R46's fall incident reports indicated that R46 had fall on 2/12/2024 and 5/28/2024. Review of R46's fall care plan did not indicate an update related to falls on 2/12/2024 and 5/28/2024. Review of R46's care plan initiated on 01/19/2024 indicated R46 is at risk for falls related to (r/t) hemiplegia, history of (H/O) falling prior to admission, weakness, deconditioning with interventions/tasks including to review information on past falls and attempt to determine cause of falls, record possible root causes, alter remove any potential causes if possible, and educate resident/family/caregivers/IDT as to causes. Review of facility's policy entitled Fall Prevention and Management reviewed on 1/2024 indicated the following: General: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and resident's existing plan of care shall be evaluated and modified as needed. Guidelines: Facility Guideline following a fall incident: 4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39781 Based on observation, interview, and record review the facility failed to account for the usage, disposition, and reconciliation of all controlled medications. This deficiency affects all 4 (four) medication carts reviewed for Controlled Substance reconciliation. Findings include: On 6/11/24 at 6:12AM, Checked A unit medication cart with V7 Registered Nurse. Observed shift change narcotic count form marked May unit C /D cart C wing. V7 verified that this is A unit narcotic medications binder. The shift changes narcotic count form listed count monitoring beginning June 9 and June 10, missing June 1 to 8, 2024. Noted missing shift nurses' signatures on 6/9 and 6/10/24. V7 said she does not know; this is how she received it. V7 and surveyor search the binder but unable to find the narcotic medication reconciliation for June 1 to June 8. V7 said she did not count the narcotic medications when she arrived to work at 11:30pm, the 3-11 shift nurse already left. V7 said that the off going and on coming nurses should count the narcotic medications. Count narcotic medications with V7. Observed R52's Tramadol HCl 50mg (milligram) tab medications card has correct number of remaining medications, but it was tampered. Observed R17's Lorazepam 0.5mg tab medications card has correct number of remaining medications but discrepancies on wasted medication dated 4/14/24 indicated wasted. V7 said that she does not know what happened. Observed R104's Oxycodone10mg tab medications card with remaining 2 tabs. The controlled drug administration record indicated remaining 2 tablets however discrepancy noted on record indicated on 6/10/24 at 1725 remaining tablet was 5. R104 took 1 tablet on 6/10/24 at 2000 but the remaining tablet documented was 3. V7 said she does not know; this is what she received. Then V7 picked up and showed to surveyor a small pink tablet at the bottom of the narcotic drawer. V7 said that the oxycodone medication must fall off from the medication card. V7 said that she should report to the Director of Nursing (DON) any discrepancy in the narcotic medications' reconciliation. On 6/11/24 at 6:31AM, Checked B unit medication cart with V6 RN. V6 corrected the marking on the Shift change narcotic count from C wing to B wing cart and from Unit C/D to A/B. The form was marked May. The shift changes narcotic count form listed count monitoring beginning June 5 to June 10, missing June 1 to June 4, 2024. Noted also missing shift nurses' signatures on 6/7 and 6/10/24. V6 said she does not know; this is how she received it. V6 and surveyor searched the binder but unable to find the narcotic medication reconciliation for June 1 to June 4. V6 said she did not count the narcotic medications when she arrived to work at 11:15pm, the 3-11 shift nurse already left. V6 said that the off going and on coming nurses should count the narcotic medications. Count the narcotic medications with V6. Observed R109's Oxycodone 5mg/5ml (milligram/milliliter) solution bottle remaining 40ml. Observed discrepancy on controlled drug administration record dated 4/14/24 9:30PM remaining amount of medication recorded at 95ml. The next entry dated 5/10/24 7AM received amount of 70ml. V6 said she does not know what happened, this is how she received it. V6 said that she should report to the Director of Nursing (DON) any discrepancy in the narcotic medications' reconciliation. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/11/24 at 7:16AM, Checked D unit medication cart with V9 RN. Observed shift change narcotic count form marked unit C/D, Cart C wing. Erased May marking. The shift changes narcotic count form listed count monitoring beginning June 4 to June 11, missing June 1 to 3 and duplicate entry of 6/4/24. V9 said she does not know; this is how she received it. V9 and surveyor searched the binder but unable to find the narcotic medication reconciliation for June 1 to June 3. Noted missing nurses shift signatures dated 6/4, 6/5, 6/6, 6/8, 6/9, 6/10 and 6/11/24. V9 said that off-going and on-coming nurses should count the narcotic medications and signed. On 6/11/24 at 7:26AM, Checked C unit medication cart with V8 RN. Observed shift change narcotic count form marked unit C/D, Cart C wing. Erased May marking and replaced June 24. The shift changes narcotic count form listed count monitoring beginning June 9 to June 10, missing June 1 to 8, 2024. V8 said she does not know; this is how she received it. V8 and surveyor searched the binder but unable to find the narcotic medication reconciliation for June 1 to June 8. V9 said that off-going and on-coming nurses should count the narcotic medications and signed. On 6/11/24 at 8:52AM, V2 DON said that they have 4 medication carts in the facility. V2 informed of above observations. V2 said that all controlled substances /narcotic medications should be counted each shift between off- going and on-coming licensed nurses. If the nurse has to leave early during the shift for emergency reason, she should count it with another nurse before she leaves the unit. Any discrepancies in the narcotic medications count shall be reported. Facility's policy on Controlled Substance review date 1/10/24 indicates: General: Medications classified by the FDA as controlled substances have high abuse potential and may be subject to special handling, storage and record keeping. Policy: 2. All controlled substances will be dispensed in tamper resistant containers designed for easy counting of contents. 10. Controlled Substance Count sheet: a. Date b. Time c. Signature (which includes minimum of first initials) of nurse who administered dose d. Number of doses remaining 11. All schedule II-controlled substances (and other schedules if facility policy so dictates) will be counted each shift or whenever there is an exchange of keys between off-going and on-coming licensed nurses. The two nurses will: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Inspect both drug package and the corresponding count sheet to verify the accuracy of the amount remaining. b. Both nurses will count the number of packages of controlled substances that are being reconciled during the shift/shift count and document on the Shift Controlled Substance Count Sheet. c. Both nurses will count the Controlled Substance count sheet and verify the accuracy of the number of remaining count sheets. d. Both nurses will sign the Shift/Shift Controlled Substance Count Sheet acknowledge that the actual count of controlled substance and count sheet matches the quantity documented. Discrepancies: a. Any discrepancy in the count of controlled substances shall be reported in writing to the responsible supervisor. b. The supervisor shall institute an investigation to determine the reason for discrepancy. The record shall then be updated.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to administer medication as ordered by physician. This deficiency affects two (R5 and R54) of three residents in the sample of 26 reviewed for Significant medication error. Findings include: On 6/11/24 at 8:07AM, V9 RN (Registered Nurse) prepared IVPB (Intravenous piggy bag) medication of Meropenem 50mg /100ml (milligrams/milliliter)0.9% NS (sodium chloride) infused for 1 hour every 8 hour for R5. Observed signage posted at the door indicating EBP (Enhanced barrier precaution). V9 donned gloves and entered the room with the medication. R5 has central intravenous line with double lumen on right chest. V9 primed the IVPB antibiotic. V9 cleansed the blue colored lumen from the central line, flushed the lumen with 10ml NSS (normal saline solution), attached the IVBP medication and set it at dial flow regulator at 200 rates. V9 said that the IVBP medication should infused for 1 hour. R5 is readmitted on [DATE] with diagnosis listed in part but not limited to Osteomyelitis of vertebra, sacral and sacrococcygeal region. Active physician order sheet indicated Meropenem-Sodium Chloride intravenous (IV) solution reconstituted 500mg /50ml (Meropenem and Sodium Chloride) use 500mg IV three times a day for infection until 7/1/24 start on 6/4/24. On 6/12/24 at 9:30AM, V2 Director of Nursing (DON) said that they should follow physician order in medication administration. On 6/12/24 at 10:10AM, V16 Nursing Consultant said that the nurse should set the rate at 100 using the dial flow rate regulator for the 100ml IVPB to be infused for 1 hour. On 6/12/23 at 10:48AM, Informed V9 RN of observation made yesterday. V9 said that she did not realize it, it should be set at rate of 100 for 100ml for infused for an hour. V9 said that she just followed what the other nurses are doing and setting it at 200 flow rates. Facility's policy on Peripheral insertion and maintenance revision 1/11/18 indicates: Purpose: To establish guidelines to reduce the risk or to prevent infection during the insertion of peripheral IV, administration of IV fluids and or medications. Guidelines: 2. Physician's order for IV or saline lock start will be verified. Facility's policy in medication administration review date 1/2024 indicates: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	General: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 1. An order is required for administration of all medication. 13. Verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route. 16. Follow special instruction written on the label 40001 On 6/11/2024 at 12:20pm R54 said to surveyor I would like my blood sugar taken and my insulin given, the nurse gives it to me after I eat, and it should be before I eat. On 6/11/2024 at 12:22pm V8 (Registered Nurse-RN) was asked when does R54 receive her blood glucose and insulin. V8 said, I held it this morning because she did not eat well, and I was waiting for R54 to return to her room to obtain her blood glucose and give her insulin. V8 was asked what is the physician order and V8 said R54 should have her blood glucose before meals and insulin with meals. On 6/11/2024 at 12:30pm V8 obtained R54 blood glucose at (334) and administered 6 units of Insulin Lispro. On 6/12/2024 at 10:30am V2(Director of Nursing-DON) observed with V8 and surveyor R54 electronic medication administration log with V8 initials, on 6/1/24 at 8am blood glucose of 171, 6 units held no order from physician to hold, at 12 noon a blood glucose of 377. 6/4/2024 at 12 noon blood glucose of 138, 6 units held no physician order to hold at 5pm blood glucose of 211. On 6/10/24 blood glucose of 179 blood glucose held no physician order, at 5pm blood glucose of 184. On 6/11/2024 at 8am blood glucose of 124, 6 units of insulin held no physician order at 12 noon a blood glucose of 334. V2 said I expect for the nurses to administer insulin as ordered by the physician and report any abnormal elevations. V8 said I should have given the insulin. A order summary report indicate that R54 has a diagnosis of long term recurrent use of insulin , and type 2 diabetes mellitus without complications. A order for Insulin glargine subcutaneous solution 38 units one time daily, Insulin lispro 6 units with meals related to type 2 diabetes mellitus with out complications. A care plan focus of diabetes mellitus insulin dependent and receive antidiabetic meds, interventions blood glucose monitoring as ordered, diabetes medication as ordered by doctor, administer insulin as ordered following sliding scale, monitor glucometer checks as ordered and report results to medical doctor

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Aperion Care Glenwood	19330 South Cottage Grove Glenwood, IL 60425

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39781 Based on observation, interview, and record review the facility failed to ensure the medications are stored safely, securely, and properly following manufacturer/supplier recommendations. This deficiency affects all two (2) medication storage rooms reviewed for Medication Storage. Findings include: On 6/11/24 at 6:23AM, Checked medication storage room for Unit A and B with V7 Registered Nurse (RN). Observed Medication refrigerator unlocked. V7 said that medication refrigerator should be always locked. Observed 1 carton of thickened dairy. V7 said that she does not know who placed the carton of thickened milk inside the refrigerator. V7 said that no food should be placed inside the medication refrigerator. On 6/11/24 at 6:31AM, Checked medication cart and count controlled substance/narcotic medications. Observed R25's lorazepam 2mg /ml (milligram/milliliter) concentrate bottle inside the locked drawer inside the medication cart. The medication labeled keep refrigerated. On 6/11/24 at 7:21AM, Checked medication storage room for Unit C and D with V9 RN. Observed Medication refrigerator unlocked. V9 said that medication refrigerator should be always locked. Observed salad container in plastic bag inside the medication refrigerator. V9 said that V8 RN placed her food inside the medication refrigerator. V9 said that she does not know if employee is allowed to place their food inside the medication refrigerator. The medication refrigerator is filled with overflowing medications. On 6/11/24 at 7:26AM, V8 RN admitted that she placed her lunch food (salad) inside the medication refrigerator. V8 said that she should place her food in the employee's breakroom refrigerator instead of medication refrigerator. On 6/11/24 at 7:30AM, Observed V8 RN prepared medications for R22. After she prepared the medications, she left the medication cart unlocked with medications on top of the cart in the hallway across R22's room to administer medication to R22. V8 left the medications in plastic cup and water on R22's bedside table and instructed the resident to take it. V8 stood by the R22's door as she watched R22 taking his medication and the unlocked medication cart. On 6/11/24 at 7:58AM, Informed V8 RN of observation made during medication administration. V8 said that she should keep the medication cart always locked when out of site during medication administration. On 6/11/24 at 8:52AM, V2 Director of Nursing (DON) said that they have 2 medication storage rooms in the building. Informed with V2 of above observation made. V2 said that medication refrigerator should be always locked. V2 said that any kind of foods should not be placed in medication refrigerators. V2 said that medication cart should be locked at all times when out of site during medication administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility's policy on Medication storage in the facility review date 1/2024 indicates: General: Medications and biologicals are stored safety, securely and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. Procedure: 3. Medication rooms, carts and medication supplies are locked or attended by person with authorized access: a. Licensed Nurses 11. Medications requiring refrigeration or temperatures between 36 degrees Fahrenheit, and 46 degrees Fahrenheit are kept in a refrigerator. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. 13. Refrigerated medications are to be stored separate from fruit juices, applesauce and other foods used in administering medications. Other foods (e.g., employee lunches, activity department refreshments) should be not stored in this refrigerator. 15. Medication storage areas are kept clean, well lit, and free of clutter Facility's policy on Medication Administration review date 1/2024 indicates: General: All medications are administered safely and appropriate to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 28. Never leave the medication cart open and unattended.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to obtain physician order for resident on hospice care and failed to access hospice staff documentation of visit to ensure coordinated care and communication. This deficiency affects one (R71) of three residents in the sample of 26 reviewed for Hospice care management. Findings include: On 6/11/24 at 8:31AM, V11 said that R71 is on hospice care. On 6/11/24 at 9:20AM, Observed R71 sleeping in bed with bilateral floor mat on side on the bed. R71 is admitted on [DATE] with diagnosis listed in part but not limited to Dementia without behavioral disturbance, Benign neoplasm of pituitary gland. Active physician order indicates no order of hospice evaluation or hospice care. Review R71's hospice binder by the nursing station. Noted hospice nurse and CNA (certified Nurse Assistant) visit log from 5/1/24 to 6/11/24 but cannot find documentation/ notes in the binder. On 6/12 24 at 9:30AM, Informed V2 DON (Director of Nursing) that R71 is on hospice care but no order in chart. V2 said that there should be an order in chart for hospice service. Informed V2 that no hospice staff documentation of visit found in the hospice binder. V2 referred the surveyor to V17 Social Service Director (SSD). On 6/12/24 at 10:53AM, Informed V17 of above concerns. V17 said that there should be physician order from the hospice referral to admission to hospice care management. The hospice service provider has a binder for each resident. V17 unable to locate nurses and CNAs documentations of visits from the log dated 5/1/24 to 6/11/24. V17 said that hospice documentation should be accessible and available for coordinated care services. V17 said that he will call the hospice service to obtain their documentation's of visits as indicated in the log. Facility's policy on Hospice revision date 1/2024 indicates: General: To provide guidance on how services will be administered within the facility. A written agreement with the hospice that is signed by an authorized representative of the hospice provider and an authorized representative of the LTC (long term care) facility before hospice care is furnished to resident. Purpose: Ensure that hospice services meet the professional standards and principles that apply to individuals providing services in the facility and to the timeliness of the services. Protocol: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Communication process, including how the communication will be documented between the LTC facility and hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. Hospice communication: 3. Any hospice staff will communicate verbally and when necessary, in writing with the facility staff every visit outcome of the hospice visit.

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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. 39781 Based on observation, interview, and record review the facility failed to perform hand hygiene during medication administration in between residents, failed to disinfect medical equipment such as pulse oximeter and Blood pressure (BP) machine after each resident use, and failed to disinfect glucometer properly as manufacturer recommendation. The facility also failed to implement enhanced barrier precaution (EBP) during intravenous (IV) medication administration to resident with central line. The facility also failed to store the nebulizer mask in a plastic bag. This deficiency affects all 7 residents (R5, R16, R22, R31, R39, R68 and R77) in the sample of 26 reviewed for infection control during medication administration. Findings include: On 6/11/25 at 7:30AM, V8 Registered Nurse (RN) prepared medication for R22. V8 about to go to R22's room to administer his medication when she saw R31 propelling himself on wheelchair in the hallway, she asked R31 to stop as she placed the pulse oximeter to his left index finger and instructed him to wait for her. Then she went to R22 to administer his medication orally. After R22 took his medication, V8 went back to R31 and removed the pulse oximeter. V8 obtained reading of 95% oxygen saturation. Then she placed BP (blood pressure) cuff on R31's right wrist and obtained BP reading of 113/72mmhg. V8 did not disinfect both pulse oximeter and BP cuff/machine after using and placed it on tip of the medication cart. She did not perform hand hygiene between in contact with R22 and R31. On 6/11/24 at 7:40AM, V8 RN placed oximeter on R77's left index finger and BP cuff machine on left wrist without disinfecting it. V8 obtained oxygen saturation reading of 97% and BP reading of 124/69mmhg. She removed the pulse oximetry and BP apparatus without disinfecting it. V8 prepared his medications. On 6/11/24 at 7:46AM, V8 RN placed BP cuff machine to R39's right wrist. V8 obtained BP reading of 150/80mmhg. V8 did not disinfect the BP cuff machine and placed it on top of the med cart. Then she checked R39's blood sugar (BS) on his right thumb. V8 obtained BS reading of 114. She cleansed the glucometer using disinfectant wipes for few seconds only and placed it inside the medication cart. On 6/11/24 at 7:58AM, Informed V8 RN of observations made during medication administration. V8 that she should perform hand hygiene between R22 and R31 contact. V8 said that she should disinfect pulse oximeter and BP cuff machine in between resident use. V8 said that she should keep the disinfectant wipes in contact with the glucometer for 1-2 minutes. On 6/11/24 at 8:07AM, V9 RN prepared IVPB (Intravenous piggy bag) medication for R5. Observed signage posted at the door indicating EBP (Enhanced barrier precaution). V9 donned gloves and entered the room with the medication. R5 has central intravenous line with double lumen on right chest. Observed V9 touches her clothes to the side of the bed and bedside table of resident as she administered his IVPB medication. On 6/11/24 at 8:18AM, Informed V9 RN of observation made that she did not observe EBP precaution posted. V9 said that she should donned gown aside from gloves when administering IVBP medications to resident with central line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/24 at 8:52AM, V2 DON (Director of Nursing) informed of above observations. V2 said that nurses should perform hand hygiene in between residents' contact. V2 said that she nurses should disinfect pulse oximeter and BP cuff machine in between residents' usage. V2 said that nurses should clean the glucometer machine according to the manufacturer recommendation. V2 said that she will get back to the surveyor because she does not know what the manufacturer recommendation is in disinfecting the glucometer after using. V2 said that they should be implementing enhance barrier precaution as indicated in their policy. On 6/11/24 at 8:57AM, Informed V3 Infection Preventionist of above concerns. V3 said that nurses should perform hand hygiene in between residents' contact. V3 said that she nurses should disinfect pulse oximeter, BP cuff machine and glucometer after each resident use. V3 said that nursing staff should wear gloves and gown when providing IVPB medication to central line. On 6/12/24 at 9:30AM, Surveyor follow up with V2 DON regarding their policy in disinfecting glucometer or manufacturer recommendation in disinfection after using it. V2 said she does not know and she still looking for it. On 6/12/24 at 10:10AM, V16 Nursing Consultant said that the nurses should wipe down the glucometer with disinfecting wipes then allow 2-minute wet time. Informed V16 of above infection control concerns. Facility unable to provide policy on disinfection of medical equipment such as pulse oximeter and portable blood pressure machine after resident usage. Facility's policy on Hand hygiene review date 1/2024 indicates: General: Proper hand hygiene is necessary for the prevention and the transmission of infectious disease. Guideline: 1. Hand hygiene is done before and after resident contact. Facility's policy on Enhanced barrier precaution (EBP) review date 1/2024 indicates: Policy: EBP requires the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Use if eye protection may be necessary when splash or spray may occur but is not necessary in another situation. High contact resident care activities requiring gown and gloves use among residents that trigger EBP use include: *Device care or use of central line, Facility's policy on Glucometer cleaning revision date 11/17/17 indicates: Purpose: To prevent the growth and spread of microorganism and bloodborne pathogens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guidelines: The blood glucose monitor should be cleaned and disinfected between each resident test. Procedure: 3. To clean and disinfect the meter, use pre-moistened wipe/towel of 1ml or 5-6% sodium hydrochloride solution (household bleach) and 9ml water to achieve a 1:10 dilution final concentration of 0.5-0.6% sodium hydrochloride. 4. Wipe meter with 1:10 solution bleach wipe/towel until all surfaces of the glucometer are visibly wet. Do not wipe inside battery compartment, code ship port or test strip port. 5. Discard bleach wipe/towel. 6. Place glucometer on a clean surface such as paper towel and allow to air dry for no less than 3 minutes or according to manufacturer instructions. Glucometer manufacturer's instructional instruction manual indicates: Page 47 Cleaning and disinfecting guidelines: Option 1: *Cleaning and disinfecting can be completed by using a commercially available EPA registered disinfectant detergent or germicide wipe. *To use a wipe, remove from container and follow product label instructions to disinfect the meter. Take extreme care not to get liquid in the test strip and key code ports of the meter. *Many wipes acts as both cleaner and disinfectant, though if blood is visible present on the meter, two wipes must be used; use one wipe to clean and a second wipe to disinfect. 50469 On 6/11/24 at 10:20AM, Observed R16 with nebulizer treatment mask on top of dresser with no covering or dated tubing. On 6/11/24 at 10:26AM, Informed V12 (Licensed Practical Nurse) of above observation, V12 said that R16 nebulizer mask should be placed in a bag after use, and it gets changed weekly. On 6/12/24 at 10:58AM, V2 (Director of Nursing) said that she expects the staff to follow the facility policy for usage of Nebulizer treatment and care procedures. On 6/11/24 at 10:02AM, Observed R68 with nebulizer treatment mask on top of dresser with no covering or dated tubing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/24 at 10:25AM, Informed V12 (Licensed Practical Nurse) of above observation, V12 said that R68 nebulizer mask is to be placed inside a plastic bag after use for infection control purposes and it gets changed weekly. On 6/12/24 at 10:58AM, V2 (Director of Nursing) said that she expects the staff to follow the facility policy for usage of Nebulizer treatment and care procedures. Facility's policy on Oxygen & Respiratory Equipment- Changing/ Cleaning Revision date: 1-7-19. Purpose: 1. To provide guidelines to employees for changing all disposable respiratory supplies. 2. To ensure the safety of residents by providing maintenance of all disposable respiratory supplies. 3. To minimize the risk of infection transmission. Procedure: 1. Hand Held Nebulizer (HHN) and Mask, if applicable. a. The hand held nebulizer should be changed weekly and PRN (as needed). b. A clean plastic bag with a zip loc or draw string, etc. will be provided with each new set up, and will be marked with the date the set up was changed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49871 Based on record review and interview the facility failed to ensure immunization documentation for 5 of 5 residents (R13, R17, R40, R55, R71) reviewed for immunization administration. Findings include: On 6/13/2024 at 11:00AM, V3 (Infectious Preventionist) provided immunization record of R13, R17, R40, R55, and R71. Record revealed (R13, R17, R40, R55, R71) did not received pneumonia vaccine as evidenced by lack of documentation in the immunization record. On 6/13/2024 at 01:00PM, V3 stated vaccine should be offered on admission. When vaccine is given, documentation on resident immunization record should be completed. Facility Policy: Guideline: Infection Control Program - General Manual: Nursing Review Date: 2/2024 General: The facility is committed to ensuring that all appropriate infection and control measures are in place as determined by State and Federal Regulations as well as CDC (Centers for Disease Control) recommendations and guidance. Policy: c. Ensure that all residents and staff are offered and encouraged to receive immunizations as recommended by CDC and State and Federal Regulations. All immunizations should have appropriate documentation including but not limited to, consents, refusals, historical, and administration of immunizations.