STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145759	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosiclare Rehab & Hcc	55 Ferrell Road Rosiclare, IL 62982

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32765 Based on observation, interview, and record review the facility failed to ensure residents rights were protected when they failed to ensure their privacy by not providing a curtain or door to cover the commode stall area in the women's common area bathroom. This failure has the potential to affect 33 female residents currently residing at the facility. Findings Include: The facility Nurses Midnight Census report provided to this surveyor by the facility on 6/3/24 documents 33 female residents currently reside at the facility. The facility resident rooms were observed to have no private/semi-private bathrooms. There was only one women's shower/bathroom located at the end of the women's hall for the women to use. On 6/3/24 at 11:31 AM, the women's shower room/bathroom was observed by this surveyor and had three stalls with commodes in them. There was a curtain covering the entrance to one commode area, and no curtain or covering over the entrance to the other two commode areas. On 6/3/24 at 11:33 AM, V7 (Certified Nursing Assistant/CNA) stated she thought the curtains that covered the entrance to the two commode stalls were in laundry since they were normally hanging up. On 6/3/24 at 11:46 AM, V5 (Laundry) stated she thought she saw one of the curtains in the clean utility room, but she didn't know about the other one. V5 stated there are normally three curtains hanging. V5 left the interview and returned a few minutes later with one curtain and stated she found one of the curtains but not the other one. On 6/3/24 at 2:07 PM, R6 was interviewed and was alert and oriented at the time of this interview. R6 stated she used the women's bathroom/shower room, and she wasn't sure why they didn't have curtains over the commode stall entrances. R6 stated, Maybe they are washing them. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	On 6/3/24 at 2:34 PM, the women's bathroom/shower room was observed by this surveyor. There was one curtain covering one commode stall and a second curtain that was hanging over a second commode stall. This second curtain was missing 6 hanging hooks. Five of the six missing hooks were not able to be placed due to the curtain holes that held the hooks were ripped. This made the curtain drape down in a fashion that only half of the entrance to the commode stall could be covered. The third commode stall did not have a curtain. On 6/3/24 at 2:40 PM, R1 was interviewed and was alert and oriented at the time of the interview. R1 stated she had lived at the facility 3-4 years and as long as she can remember they have been missing one of the curtains in the women's bathroom/shower room. On 6/4/24 at 10:22 AM, the women's bathroom/shower room was observed and was still missing a curtain for one commode stall entrance, the second commode stall entrance curtain was still hanging with half the hooks missing. On 6/4/24 at 11:18 AM, V2 (Anonymous) stated the curtains in the women's bathroom/shower room have been missing for more than a month or two. On 6/4/24 at 1:56 PM, V10 (CNA) stated she thinks the curtains in the women's bathroom/shower room have been missing since she started working at the facility in 2/2024. On 6/4/24 at 2:06 PM, V14 (CNA) stated she knew one of the curtains in the women's bathroom/shower room had been missing for a while. On 6/4/24 at 2:23 PM, V15 (CNA) stated she had worked at the facility since 2/2024 and the curtains were missing all the time. V15 stated they would get soiled and when she first started working, they were gone for a while, then V1 (Administrator) asked about them and they were back up, but now they have taken them down to clean again. On 6/5/24 at 9:35 AM, the women's bathroom/shower room commode stalls were still missing one curtain and a second curtain is only half hanging. On 6/5/24 at 1:32 PM, V1 (Administrator) stated she had the laundry/housekeeping supervisor price check curtains, and she is planning to replace them. When asked for the facility Resident Rights policy this surveyor was provided with an undated packet titled, Illinois Long Term Care Ombudsman Program Resident's Rights for People in Long-Term Care Facilities. Under Your rights to dignity and respect, it documents Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Under, Your rights to privacy and confidentiality it documents, You have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to ensure residents were able to choose what time they got up in the morning for 1 of 5 (R12) residents reviewed for resident's rights in the sample of 17. Findings include: R12's undated New Admission Information sheet documents R12 was admitted to the facility on [DATE]. R12's Physician's Order Sheet dated 6/1/24 to 6/30/24 documents R12 has diagnoses that include intractable seizures, debility, anxiety syndrome, and intermittent explosive disorder. R12's MDS (Minimum Data Set) dated 5/15/24 documents a BIMS (Brief Interview for Mental Status) score of 11 indicating R12 has a moderate cognitive deficit. This same MDS documents R12 is dependent on staff for chair/bed to chair transfers. R12's current Care Plan documents a Focus Category of Safety dated August 2019. This Focus Category includes the following interventions dated August 2024, Encourage resident to use call light and ask for help when feeling unsure of transfer/ambulation ability .Check every two hours when in bed for safety .Toilet per schedule and as needed when restless or agitated May use Hoyer lift for transfers prn (as needed) . R12's Care Plan does not address R12's preferences related to when she gets up and/or goes to bed. R12's Interview for Daily Preferences assessment dated [DATE] and 5/15/24 documents it is somewhat important for R12 to be able to choose her own bedtime. This assessment does not document information related to what time R12 prefers to get up in the morning. On 6/3/24 at 2:51 PM, when asked if staff had ever told a resident they had to get up early, R11 (R12's roommate) pointed to R12. R11 stated staff say they have to get R12 up before the morning shift arrives. R11's undated New Admission Information documents R11 was admitted to the facility on [DATE]. R11's MDS dated [DATE] documents a BIMS score of 15, which indicates R11 is cognitively intact. On 6/4/24 at 10:41 AM, V16 (Activities Director/Social Services Director) stated one wing of the facility is gotten up in the morning by midnight shift because it is too hard to get all of the residents up by 7:30 AM when breakfast is served. V16 stated V17 (Family Member) doesn't want R12 gotten up that early and he was told they do it to assist day shift. On 6/4/24 at 11:18 AM, V2 (Anonymous) stated V17 brought R1 getting up early in a care plan meeting and asked that R12 be allowed to sleep in the morning. V2 stated V1 (Administrator) told V17 it was better for staff to be able to get the residents up and ready for breakfast. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 11:58 AM, V17 (Family Member) stated R12 was having to get up really early and he told V1 (Administrator) he didn't want her to have to get up that early. V17 stated V1 told him she would see what they could do about it. On 6/4/24 at 1:56 PM, V10 (Certified Nursing Assistant/CNA) stated she gets to work at 6:00 AM and R12 is up when she gets to work. When asked why residents are up that early V10 stated midnight shift gets a few residents up for them to be helpful. V10 stated those residents like to get up that early. On 6/4/24 at 2:06 PM, V14 (CNA) stated she works day shift and gets to the facility at 6:00 AM. V14 stated there are residents up when she gets to the facility and R12 is one of them. V14 stated she wasn't sure why they were up before 6:00 AM. V14 stated none of the residents have said anything about getting up that early but sometimes R12 isn't up when she gets to the facility. On 6/4/24 at 2:15 PM, V18 (CNA) stated there is a list of residents that midnight shift gets up before day shift arrives. V18 stated R12 is on the list but will sometimes refuse to get up. On 6/5/24 at 10:20 AM, when asked what time she got up in the morning R12 stated, 5. When asked if she wanted to get up that early, she stated, No. when asked what happened if she told them she didn't want to get up that early R12 shrugged her shoulders. R12 was able to answer simple questions but was not able to have a full conversation. On 6/5/24 at 10:21 AM, R11 stated they get R12 up at 5:00 AM. When asked if R12 ever told staff she didn't want to get up and R11 stated R12 moans like she doesn't want to, and staff tell her she has to get up. On 6/5/24 at 1:32 PM, V1 (Administrator) stated R12 only gets up early when she wants to. V1 stated some days she gets up early and other days she doesn't. V1 then asked this surveyor if R12 had told this surveyor what time she wanted to get up. When asked for a resident rights policy this surveyor was provided with an undated packet titled Illinois Long Term Care Ombudsman Program Resident's Rights for people in Long-Term Care Facilities. This packet documents under, Your rights to participate in your own care You have the right to choose activities and schedules (including sleeping and waking times).

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765 Based on interview and record review the facility failed to report an allegation of staff to resident abuse to the State Survey Agency for 1 of 3 (R3) residents reviewed for abuse in the sample of 17. Findings Include: On 6/3/24 at 3:17 PM, V1 (Administrator) stated this surveyor had been provided with all of the facility abuse/neglect investigations. When asked if she had any reports of a resident being forced down the hall and yelling, V1 stated, No. At this time this surveyor reported an allegation of abuse to V1 of an unknown resident being pushed down the hall, dragging their feet, while an unknown staff member yelled at the resident. On 06/04/2024 the facility provided this surveyor with a document titled; Incident Investigation Form dated 5/24/24. This form included the following. Newly admitted resident (R4), had her husband (V21) in visiting. (V21) stated on 5/24/24 that during his visit to see his wife on 5/23/24 that he did not like how a nurse talked to a resident. (V21) stated nurse yelled at resident on shift 2-10 PM. Nurse over the phone: V22 (RN/Registered Nurse) stated resident (R3) is the only resident he could think of regarding (V21) comment. Nurse stated (R3) is hard of hearing and will not tolerate a hearing device and you have to speak loudly so resident can hear. Nurse stated (R3) was trying to grab on a med-cart and nurse began to redirect (R3) away from med-cart and in a different direction. CNAs (Certified Nursing Assistants) over the phone: (V15) worked until 10 PM and did not hear or see anything. V14 worked until 6 PM and stated she did not hear anything like this. V23 worked 2 pm until 10 PM, she is no longer an employee and will not answer phone. V24 worked 2 PM to 10 PM and does not recall anything happening regarding that complaint. In conclusion, this facility is unable to substantiate (V21's) claim. On 6/4/24 at 11:18 AM, V2 (Anonymous) stated on an unknown date, V21 (Family Member) reported he was visiting with R4 on an evening shift, when he saw one of the female residents being pushed down the hall and being yelled at. V2 stated V21 reported the resident was being physically pushed and was dragging her feet. V2 stated V21 reported if that is happening when people are witnessing it what is happening when no one is around. V2 stated, V21 was not able to identify the staff member or the resident. V2 stated since V1 (Administrator) was there at the time V21 reported it she assumed it was investigated. On 6/5/24 at 1:32 PM, V1 (Administrator) stated she didn't believe the allegation this surveyor reported to her on 6/3/24 was the same allegation that was documented in the incident investigation dated 5/24/24, but stated it was the only one she could recall. V1 stated she spoke to the nurse regarding the allegation on 5/24/24 and he said R3 was the only resident it could have been because she was hearing impaired and wouldn't tolerate a hearing device. When asked if she reported the allegation from 5/24/24 to the State Survey Agency, V1 stated she didn't because they didn't have a specific resident name so there was no resident to report on. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's undated New Admission Information sheet documents R3 was admitted to the facility on [DATE]. R3's Physician's Order Sheet dated 6/1/24 to 6/30/24 documents R3's diagnoses include left hip nailing, dementia, osteoarthritis, depression, and anemia. R3's MDS (Minimum Data Set) dated 5/22/24 documents a BIMS (Brief Interview for Mental Status) score of 01, which indicates R3 has a severe cognitive deficit. This same MDS documents under Section J, R3 has a history of falls with injuries. R3's current Care Plan documents a Focus Category of Communication dated 5/2024. The interventions included for this care plan dated 2/22/24 are as follows: Use questions that require yes/no answers or one to two word responses when resident is experiencing problems with communicating. Validate response thru repeating answers. Establish eye contact and face resident prior to communication. Assure resident you are listening by maintaining eye contact throughout conversation. Acknowledge resident at each greeting. Reduce environmental distractions. Take to quiet area as needed. The facility Abuse Prevention Program policy dated 3/5/2009 documents, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. Under External Reporting the facility policy documents, 1. Initial Reporting of Allegations. If, during the course of an incident investigation, the administrator or designee has determined that there is a reasonable cause to suspect mistreatment has occurred, the resident's representative and the (State Survey Agency) shall be informed with 24 hours. (State Survey Agency) shall be informed that an occurrence of potential mistreatment has been reported and is being investigated. A written report shall be sent to the (State Survey Agency) .2. Five-day Final Investigation Report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the (State Survey Agency) .

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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 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** 32765 Based on interview and record review the facility failed to thoroughly investigate an allegation of staff to resident abuse for 1 of 3 (R3) residents reviewed for abuse in the sample of 17. Findings Include: On 6/3/24 at 3:17 PM, V1 (Administrator) stated this surveyor had been provided with all of the facility abuse/neglect investigations. When asked if she had any reports of a resident being forced down the hall and yelling, V1 stated, No. At this time this surveyor reported an allegation of abuse to V1 of an unknown resident being pushed down the hall, dragging their feet, while an unknown staff member yelled at the resident. On 06/04/2024 the facility provided this surveyor with a document titled; Incident Investigation Form dated 5/24/24. This form includes the following. Newly admitted resident (R4), had her husband (V21) in visiting. (V21) stated on 5/24/24 that during his visit to see his wife on 5/23/24 that he did not like how a nurse talked to a resident. (V21) stated nurse yelled at resident on shift 2-10 PM. Nurse over the phone: V22 (RN/Registered Nurse) stated resident (R3) is the only resident he could think of regarding (V21) comment. Nurse stated (R3) is hard of hearing and will not tolerate a hearing device and you have to speak loudly so resident can hear. Nurse stated (R3) was trying to grab on a med-cart and nurse began to redirect (R3) away from med-cart and in a different direction. CNAs (Certified Nursing Assistants) over the phone: (V15) worked until 10 PM and did not hear or see anything. V14 worked until 6 PM and stated she did not hear anything like this. V23 worked 2 pm until 10 PM, she is no longer an employee and will not answer phone. V24 worked 2 PM to 10 PM and does not recall anything happening regarding that complaint. In conclusion, this facility is unable to substantiate (V21's) claim. On 6/4/24 at 11:18 AM, V2 (Anonymous) stated on an unknown date, V21 (Family Member) reported he was visiting with R4 on an evening shift, when he saw one of the female residents being pushed down the hall and being yelled at. V2 stated V21 reported the resident was being physically pushed and was dragging her feet. V2 stated V21 reported if that is happening when people are witnessing it what is happening when no one is around. V2 stated, V21 was not able to identify the staff member or the resident. V2 stated since V1 (Administrator) was there at the time V21 reported it she assumed it was investigated. On 6/5/24 at 1:32 PM, V1 (Administrator) stated she didn't believe the allegation this surveyor reported to her on 6/3/24 was the same allegation that was documented in the incident investigation dated 5/24/24, but stated it was the only one she could recall. V1 stated she spoke to the nurse regarding the allegation on 5/24/24 and he said R3 was the only resident it could have been because she was hearing impaired and wouldn't tolerate a hearing device. When asked if she had interviewed any other staff or residents, V1 stated she had not. When asked if she had started an investigation on the allegation this surveyor reported on 6/3/24, V1 stated, I didn't do an investigation because I thought it was the same allegation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's undated New Admission Information sheet documents R3 was admitted to the facility on [DATE]. R3's Physician's Order Sheet dated 6/1/24 to 6/30/24 documents R3's diagnoses include left hip nailing, dementia, osteoarthritis, depression, and anemia. R3's MDS (Minimum Data Set) dated 5/22/24 documents a BIMS (Brief Interview for Mental Status) score of 01, which indicates R3 has a severe cognitive deficit. This same MDS documents under Section J, R3 has a history of falls with injuries. R3's current Care Plan documents a Focus Category of Communication dated 5/2024. The interventions included for this care plan dated 2/22/24 are as follows: Use questions that require yes/no answers or one-to-two-word responses when resident is experiencing problems with communicating. Validate response thru repeating answers. Establish eye contact and face resident prior to communication. Assure resident you are listening by maintaining eye contact throughout conversation. Acknowledge resident at each greeting. Reduce environmental distractions. Take to quiet area as needed. The facility Abuse Prevention Program policy dated 3/5/2009 documents, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. Under Investigation Procedures the policy documents, Regardless of the specific nature of the allegation .the investigation shall consist of: a review of the initial written reports. Completion of a written report on the status of the investigation of the occurrence; An interview with the person (s) reporting the incident; Interviews with any witness to the incident; an interview with the resident; Where appropriate, an interview with the resident's attending physician or psychiatrist; A review of the medical records of any residents involved in the occurrence; If the accused individual is an employee, review the personnel file to check for references, background check, and documentation of orientation and training; An interview with staff members having contact with the resident and accused individual during the period of the alleged incident; Where appropriate, interviews with the resident's roommate, family members, visitors, or others who were in the vicinity of the incident; Interviews with other residents to which the accused individual has regular contact; Interview other employees to determine if they have ever witnessed other incidents of mistreatment involving the accused individual; Obtain address, phone number, and social security number of the accused individual; an interview with the accused individual or individuals (with a witness present); and a review of all circumstances surrounding the incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - 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** 32765 Based on observation, interview, and record review the facility failed to provide timely incontinence care per current standards of practice for 2 of 3 (R12 and R16) residents reviewed for incontinence care in the sample of 17. Findings Include: 1. R12's undated New Admission Information sheet documents R12 was admitted to the facility on [DATE]. R12's Physician's Order Sheet dated 6/1/24 to 6/30/24 documents R12's diagnoses include intractable seizures, debility, depression, and anxiety. R12's current Care Plan documents a Focus Category dated 8/2019 of Continence. This Focus area includes the following interventions dated 8/2024, Allow brief when up. Assist to change PRN (as needed) . Consider scheduled toileting if pattern is evident. Set schedule per pattern. Include resident in decision making R12's MDS (Minimum Data Set) dated 5/15/24 documents a BIMS (Brief Interview for Mental Status) score of 11, which indicates R12 has a moderate cognitive impairment. This same MDS documents R12 is dependent on staff for toileting. On 6/5/24 at 10:21 AM, R11 stated R12 had been up since around 5:00 AM, had been taken to breakfast, brought back to the room and hadn't been checked or changed since she was gotten up. Intermittent observation of R12 began at this time. No staff were observed entering R12's room or providing care to R12. R11's undated New Admission Information documents R11 was admitted to the facility on [DATE]. R11's MDS dated [DATE] documents a BIMS score of 15, which indicates R11 is cognitively intact. On 6/5/24 continuous observations of R12 began at 11:15 AM. R12 was sitting next to her bed, in a reclined chair with footstool. Continuous observation continued until 11:51 AM with no staff entering R12's room and/or providing care. At 11:51 AM, V25 (CNA/Certified Nursing Assistant) entered R12's room and stood at the foot of her bed until V14 (CNA) entered the room. Neither V25 nor V14 took incontinence care supplies into R12's room with them. They shut the door to R12's room. This surveyor knocked on the door and asked R12 if care could be observed. At this time, V14 exited the room and returned with incontinence care supplies and V10 (CNA). R12 was transferred to bed by V10 and V25 using a gait belt. R12's pants were saturated with urine and the bed pad under R12 was saturated with urine. R12 was placed in bed and her pants were removed. V25 removed the incontinence brief that was saturated from front to back and was dark yellow/brown. R12 was dressed in a new incontinence brief and clean pants, then transferred to her chair. V10, V14, and V25 all stated they had checked and changed R12 when she was brought back from breakfast at approximately 8:45 AM. This indicates a discrepancy in the time frames as told to this surveyor by R11. Based on the interviews of R11, V10, V14, and V25, R12 had either not been changed since she was gotten up at approximately 5:00 AM or had not been changed since her return from breakfast at approximately 8:45 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R16's undated New Admission Information sheet documents R16 was admitted to the facility on [DATE]. R16's Physician's Order sheet dated 6/1/24 to 6/30/24 documents R16's diagnoses include hypertension, dementia, and depressive disorder. R16's MDS dated [DATE] documents a BIMS score of 08, which indicates R16 has a moderate cognitive impairment. R16's bowel and bladder assessment dated [DATE] documents R16 requires supervision to find the bathroom, is continent of bladder with occasional incontinence. R16's current Care Plan documents a Focus Category of ADL (Activities of Daily Living) dated 5/2024. This Focus area includes the following interventions, .Assist Resident to toilet upon rising and hs (hour of sleep) and after all meals as tolerated. Place brief on when up. Pad on bed, change q (every) 2 hrs (hours) and prn (as needed) when repositioning. Cleanse peri-area after each incontinent episodes (sic). Barrier cream as needed upon cleansing. On 6/5/24 at 11:30 AM, R16 was walking down the hallway towards this surveyor. R16 was redirected back to the other hallway by V10 (CNA). When R16 turned around to walk the other way, the back of her pants was noted to be wet. R16 walked to the common area and started down the other hallway when V20 (RN/Registered Nurse) redirected R16 to the dining room. At 11:35 AM, R16 was observed in the dining room area, pants were soaked. At 12:04 PM, R16 walked to the bathroom by herself, exited the bathroom at 12:07 PM, R16's pants remained soaked. At 12:10 PM, R16 was assisted to the bathroom. On 6/5/24 at 12:15 PM, R16's room was observed by this surveyor. The rocking chair next to R16's bed had a cushion in it that was wet. This surveyor then saw R16 exiting the bathroom with V14 (CNA). V14 stated R16 takes herself to the bathroom all the time. When asked about the wet cushion in R16's rocking chair, V14 stated R16 probably went to her room and urinated in the rocking chair, then took herself to the bathroom. On 6/5/24 at 1:32 PM, V1 (Administrator) stated she would expect residents to be changed as needed and shouldn't be made to wait for care. V1 stated she would expect residents to get care timely to prevent skin breakdown and infections. V1 stated if the care plan says they should be assisted to toilet, then they should be assisted.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49664 Based on observation, interview, and record review the facility failed to implement interventions to prevent the development of new pressure ulcers for a resident at high risk and failed to timely identify a new pressure ulcer for 1 of 3 (R13) residents reviewed for pressure ulcers in the sample of 17. This failure resulted in R13 developing an unstageable pressure ulcer to her right heel. Findings Include: R13's New Admission Record undated, documented R13's initial admitted to the facility as 11/05/2014. R13's POS (Physician Order Sheet) dated 6/1/2024, documents diagnosis to include Dementia, Hypertension, Diabetes Mellitus, Hyperlipidemia, Degenerative Joint Disease, Cyclic Neutropenia, and Depression. R13's POS includes orders for Skin Prep to Left Heel twice a day with order date of 4/25/2024, and float heels while in bed as tolerated with order date of 3/13/2024. R13's MDS (Minimum Data Set) dated 1/2/2024 includes a BIMS (Brief Interview for Mental Status) score of 00 indicating Severely Cognitively Impaired. The same MDS documented in section GG, R13 requires total dependence of staff for Activities of Daily Living. R13's Braden Scale for Predicting Pressure Ulcer Risk assessments dated 4/13/24 and 5/9/24 both document a total score of 14 indicating R13 is at a high-risk level for developing pressure ulcers. The section of Wound Review indicates R13 currently has an unresolved pressure ulcer. Under the section of Skin Treatment Review indicates mattress type is Foam, and heel protectors. R13's current Plan of Care documented a date of April 2024. Focus category of Skin Integrity with Focus Information of Potential for impaired skin integrity r/t (related to) dx (diagnoses): Diabetes Mellitus and decreased mobility. The section for Goal documents resident will be free of skin breakdown thru the next 90 days, goal start date is documented a 1/12/2015 with goal date documented as 7/24. Section of Plan of Care for Intervention/Task documents all interventions with start date of 1/12/2015. There were no interventions listed to float heels while in bed as tolerated. On 6/4/2024 at 10:05am, V13 (Licensed Practical Nurse/LPN) administered treatment to R13's Left Heel. V13's heels were both flat on the bed and were not floated off the bed at time of entering the room. R13's mattress was noted to be a standard mattress. V13 removed the sock to R13's left heel and applied skin prep, then placed the sock back on her left foot. V13 then stated, I always apply it to the right heel as well. V13 then removed the sock off R13's right foot and started applying skin prep to right heel and V13 stated, Oh wow look at this heel, it is really red, looks worse than the left heel. V13 then stated, I am not saying anymore. V13 then replaced the sock to the right foot, covered R13's feet back up, left R13's heels flat on the bed without floating the heels off the bed and left the room. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/4/2024 at 2:10pm, this surveyor observed V3 (MDS Coordinator/Infection Preventionist) assess R13's heels. Upon entering room R13's heels were not floated off the bed. V3 assessed R13's right heel and stated, this heel injury area is bigger than the one on the left heel. V3 stated this heel is very red and mushy. V3 stated these heels should be floated or have boots on them. V3 stated I will get treatment orders for the right heel and add the right heel to the weekly/monthly logs. On 6/5/2024 at 9:10am, observation was made of R13 in bed resting on her back with a pillow wedged under her thighs and both heels flat on the bed. On 6/5/2024 at 11:06am observation was made of R13 in bed resting on her back without the pillow under her thighs with both heels flat on the bed. On 6/5/2024 at 2:00pm R13 was resting in bed positioned on right side with pillow between knees and heels flat on the bed. R13's Monthly Wound Tracking Report dated 5/2024 documents R13 has a wound to left heel. This document includes a description of R13's wound to Left Heel as: Stage is Unstageable, Measurements are 0. 2cm (centimeters) length, 0.2 cm width and 0 cm depth, no drainage, acquired in facility, and no odor. This same document does not include date of onset of wounds. R13's Monthly Wound Tracking Report does document a pressure ulcer to R13's right heel that is being assessed and tracked. On 6/4/2024 at 9:55am, V13 (LPN/Licensed Practical Nurse) provided R13's Facility Weekly Wound Tracking log which documents on Mondays for the month of May 2024, weekly descriptions of left heel wounds for R13. This record documents assessments of left heel on 5/6/2024 measuring 0.3cm length, 0.3 cm width, 0 cm depth, no odor, no drainage, pink in color, on 5/13/2024 measuring 0.2cm length, 0.2 cm width, 0 cm depth, no odor, no drainage, pink in color, on 5/20/2024 measuring 0.1cm length, 0.1cm width, 0 cm depth, no odor, no drainage, pink in color, on 5/27/2024 measuring 0.1cm length, 0.1cm width, 0 cm depth, no odor, no drainage, and pink in color. At that time V13 stated wound assessments were not done as of this time for this week, and they should have been done yesterday. There was no documentation on the log that R13 had a pressure ulcer to the right heel. On 6/4/2024 at 3:45pm, V3 (MDS Coordinator/Infection Preventionist) presented a copy of the Facility Weekly Wound Tracking log. The log documents R13 has Area #1 Left Heel with no documentation of assessment and Area # 2 Right Heel includes documentation of Date of Assess: 6/4/2024, Type: P (Pressure), Stage: U (Unstageable) Measurements: 3.3cm Long, 2cm Width, 0cm depth, Drainage: none, Odor: none, Wound color: red, Date of Onset: 6/4/2024, MD/Family notified marked Yes. On 6/5/2024 at 1:05pm, V12 (Certified Nurse Assistant/CNA) stated she takes care of R13. V12 stated we are supposed to keep her heels floating while in bed, she also has a boot to wear sometimes too. V12 stated I try to keep her on her side most of the time. V12 stated R13 is total care and is incontinent of bowel and bladder. V12 stated R13 doesn't communicate normally, and she must have assistance in turning and repositioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/5/2024 at 1:10pm, V10 (CNA) stated she provides care to R13. V10 stated R13 is totally dependent on staff for all needs. V10 stated I know we are to float her heels while she is in bed. V10 stated she had not noticed the area to her right heel before. V10 stated it has been a while since she gave R13 a shower. V10 stated if she would have noticed the area, she would have reported it to the nurse immediately. V10 stated R13 depends on the staff for proper turning and repositioning. V10 stated we are not assigned specific residents we work together. On 6/4/2024 at 10:55am, V1 (Administrator) stated the floor nurses do the monitoring of the wounds in the facility and the treatments. The floor nurses make sure the interventions are in place too. V1 then stated V3 is our MDS Coordinator and Infection Preventionist, she also keeps up with all the wounds and makes wound logs since we don't have a Director of Nurses. V1 stated she is the one that orders the specialized mattresses and the only specialized mattresses they use are the air loss mattresses. V1 stated the delivery time is very quickly and she has not had any issues with ordering. On 6/4/2024 at 1:50am, V3 stated my duties are MDS, Infection Preventionist and I make the wound logs but that is all I do with wounds, and I get the information from the floor nurses for the wound log. V3 stated the Director of Nurses (DON) always kept up with the wounds like assessing the wounds weekly, assuring the interventions are in place including prevention, assuring the treatments are getting done and the wounds are healing. V3 stated I am not doing all that a DON would do, I am only here on Mondays, Tuesdays, and Wednesday from 2pm to 10pm and I don't have time to do the wound stuff with doing MDS and Infection Preventionist. V3 stated the IDT (Interdisciplinary Team) decides the interventions. V3 explained she was aware that R13 was on a standard mattress and should be on a specialized air loss mattress. On 6/6/2024 at 10:03 am, V19 (Physician), stated he expected the facility to follow his orders for wound care and prevention such as floating the heels. V19 also stated he expects the facility to follow their policy and procedure for Wound Care and Prevention. V19 stated he was aware of the issues with R13's left heel. V19 was asked if he was aware of the unstageable right heel pressure and V19 stated I am going to call the facility and discuss treatments and the need for pressure relief for R13. V19 said there is a need for an air loss mattress for R13. R13's POS (Physician Order Sheet) dated 6/1/2024 documents on 6/4/24 there is a handwritten order to apply skin prep to right outer heel each shift and PRN (as needed). The facility document titled (Company name) Preventative Skin Care. Policy statement reads It is the facility's policy to provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers. The section of this document with subtitle of Equipment reads 1. Lotion, 2. Barrier Cream, 3. Special Mattresses (i.e., gel, foam, water, air, etc.), 4. Special chair cushion (i.e., gel, foam, air, etc.), 5. Pillows or positioning devices. The section of this document with subtitle of Procedure reads #6 Special mattresses and or chair cushions will be used on any resident identified as being high risk for potential skin breakdown.

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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** 32765 Based on observation, interview, and record review the facility failed to ensure interventions to prevent falls were implemented and followed for 1 of 3 (R3) residents reviewed for falls in the sample of 17. Findings Include: R3's undated New Admission Information sheet documents R3 was admitted to the facility on [DATE]. R3's Physician's Order Sheet dated 6/1/24 to 6/30/24 documents R3's diagnoses include left hip nailing, dementia, osteoarthritis, depression, and anemia. R3's MDS (Minimum Data Set) dated 5/22/24 documents a BIMS (Brief Interview for Mental Status) score of 01, which indicates R3 has a severe cognitive deficit. This same MDS documents under Section J, R3 has a history of falls with injuries. R3's current Care Plan documents a Focus Category of Safety dated 5/2024. This focus area includes the following interventions. 4/24/24 rolled out of bed- unwitnessed, body pillow for comfort and positioning when in bed as tol (tolerated). R3's Fall Risk assessment dated [DATE] documents a score of 24, which indicates R3 is at high risk of falls. The facility Quality Improvement Review dated 4/24/24 documents, R3 rolled out of bed. Yelled for help. Staff noted her on floor. Bruise to (Rt-right) forehead and (Rt) elbow. Care plan status Comfort Care. Staff In-serviced: Using body pillow to help prevent rolling out of bed. Intervention: Body pillow to go along res (resident/R3) on bed for comfort/positioning as resident allows. On 6/4/24 at 1:20 PM and 3:36 PM, R3 was in bed sleeping, the foot board was padded, there was no body pillow observed on the bed. On 6/5/24 at 9:32 AM, R3 was in bed sleeping, covered with blanket, no body pillow observed. On 6/5/24 at 9:37 AM, V10 (CNA/Certified Nursing Assistant) walked with this surveyor to R3's room. There was no body pillow in R3's bed. V10 checked the closet and stated her body pillow may be in laundry. V10 placed a regular size pillow next to R3. On 6/5/24 at 1:32 PM, V1 (Administrator) stated she had been told R3 didn't have the body pillow in place after this surveyor observations. V1 stated staff told her it was in laundry, and she told them they needed to get another pillow and make sure R3 has a pillow where it is supposed to be. V1 stated she preferred the body pillow over a regular size pillow, and they should have at least one back up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Fall Prevention Policy dated 11/10/18 documents, Policy: to provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Under Procedure the policy documents.5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurse's notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan.

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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** 32765 Based on observation, interview, and record review the facility failed to provide incontinence care per current standards of practice for 1 of 3 (R12) residents reviewed for incontinence care in the sample of 17. Findings Include: 1. R12's undated New Admission Information sheet documents R12 was admitted to the facility on [DATE]. R12's Physician's Order Sheet dated 6/1/24 to 6/30/24 documents R12's diagnoses include intractable seizures, debility, depression, and anxiety. R12's current Care Plan documents a Focus Category dated 8/2019 of Continence. This Focus area includes the following interventions dated 8/2024, Allow brief when up. Assist to change PRN (as needed) . Consider scheduled toileting if pattern is evident. Set schedule per pattern. Include resident in decision making R12's MDS (Minimum Data Set) dated 5/15/24 documents a BIMS (Brief Interview for Mental Status) score of 11, which indicates R12 has a moderate cognitive impairment. This same MDS documents R12 is dependent on staff for toileting. On 6/5/24 at 11:51 AM, V10, V14, and V19 (Certified Nursing Assistants/CNAs) provided incontinence care to R12. V19 took a washcloth out of the basin that was sitting at the foot of the bed and put no rinse peri wash on the cloth. V19 then washed R12's pubic area in circular and up and down motion. V19 got a second wash cloth, applied more no rinse peri wash, and washed down R12's inner legs near her groin area. V19 then took a dry washcloth and wiped the suds from the no rinse peri wash off. V19 did not wash near R12's labia. R12 was assisted to turn to her side and V19 wiped R12's buttocks using current standards of practice. V19 doffed his gloves and donned a new pair without performing hand hygiene. On 6/5/24 at 1:32 PM, V1 (Administrator) stated she would expect incontinence care would be provided per current standards of practice. The facility Perineal Cleansing policy dated 12/17 documents, Policy: To eliminate odor; to prevent irritation or infection and to enhance resident's self-esteem .Procedure .5. Wash pubic area including upper inner aspect of both thighs and frontal portion of the perineum. a. Use long strokes from the most anterior down to the base of the labia. b. After each stroke refold the cloth to allow use of another area Remove gloves and wash hands with soap & (and) water, cleansing gel, or (Brand name solution) .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32765 Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety and maintain floors, walls, and equipment in a safe and sanitary condition. This failure has the potential to affect all 40 residents residing in the facility. Findings Include: The facility Nurses Midnight Census provided to this surveyor on 6/3/24 documents 40 residents currently reside at the facility. On 6/3/24 at 11:16 AM, this surveyor opened the refrigerator door in the kitchen and observed fruit in individual bowls sitting on the shelf, uncovered and undated. On 6/3/24 at 11:20 AM, this surveyor showed V8 (Dietary Manager) the uncovered, undated fruit in the refrigerator and V8 told V6 (Cook) that all food should be covered and dated. On 6/3/24 at 11:20 AM, a roach crawled out from underneath the freezer and crawled towards this surveyor's feet. At that time V8 (Dietary Manager) stated they have been without pest control services. V8 stated she was aware of the roaches and there had been an uptick and them since they hadn't had pest control services. On 6/4/24 at 10:22 AM, this surveyor walked into the kitchen and observed a trash bag with what appeared to be dirty linens sitting on the floor by the door. The ice machine was sitting to the left and had scaly white and rust colored residue on the side, down the side, and on the front around the rim of the lid and on the inside of the lid. A soiled wet blanket was spread out in the middle of the floor between the ice machine and the dishwasher. V6 (Cook) stated the blanket was on the floor because the drain kept backing up and they had to order a new tool to snake the drain. The trays sitting on the dishwasher drain with clean silverware in it was covered with a black and scaly appearing residue. The kitchen floors were dirty, the walls behind and under the three-compartment sink and the stove was dirty with a greasy appearing residue. There was a black residue on the wall behind the dishwasher and garbage disposal that ran the length of the wall and was near the caulk above the sink. V8 (Dietary Manager) stated the black residue behind the sink/disposal area was a buildup of grease and stuff. V8 stated the residue on the food trays is calcium from the local water. V8 took her fingernail and scraped a layer of the residue off. V8 stated they run the trays through the dishwasher with bleach. V8 stated the ice machine has calcium build up on it also, from years of leaking and maintenance is responsible for cleaning it monthly. On 6/5/24 at 11:07 AM, V4 (Maintenance Director) stated he hadn't worked at the facility long so he hadn't cleaned the ice machine yet but will be cleaning it this month. V4 stated he was aware of the black substance behind the dishwasher/disposal. V4 stated he wasn't sure what it was, but he was planning to take the caulk out, clean it, and apply new caulk. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/5/24 at 11:08 AM, V18 (Laundry/Housekeeping/Dietary Aid) stated the black substance behind the dishwasher/disposal was gone. V18 stated he cleaned the area with bleach and a wire brush, and it took the substance off. V18 stated he cleaned under everything but hadn't had the opportunity to deep clean. V18 stated they hadn't done anything with the dish crates and thought they may have to power wash them to get the scaly substance off. On 6/3/24 at 3:17 PM, V1 (Administrator) stated they had not had pest control services since 12/2023. V1 stated at one point the company told them to purchase something at a local store, but she told them she didn't think that would work and she was concerned about using the chemicals. V1 stated the facility had not put anything in place to mitigate pests. On 6/5/24 at 1:32 PM, V1 (Administrator) stated pest control had been called and was supposed to be at the facility on 6/1/24 and 6/4/24 and hadn't come. V1 stated the pest control company was supposed to come again on 6/5/24. On 6/5/24 at 1:32 PM, V1 (Administrator) stated food in the refrigerator should be covered and dated. V1 stated daily cleaning may prevent some of the calcium build up. V1 stated pest control has been called and was supposed to be at the facility on 6/1/24 and didn't come. The facility policy Kitchen Sanitation dated 10/20 documents, Policy: It is the policy of (name of company) to comply with public health standards and local and state sanitation regulations. Procedure: 1. The Food Service Manager will monitor sanitation of the Dietary Department on a daily basis. 2. The Dietary Sanitation QA (Quality Assurance) Review (see attached form) shall be used as a tool to monitor compliance with sanitation standards and identify which areas need corrective action. 3. The Food Service Manager will develop a cleaning schedule for the department and ensure that dietary employees complete cleaning tasks as scheduled. 4. The Food Service Manager shall provide cleaning instructions for each area and piece of equipment in the kitchen and specify which chemical and personal protective equipment should be used for each task. 5. In-service training should be scheduled periodically to review sanitation standards. The facility policy Refrigerator and Freezer Storage dated 10/14 documents, It is the policy of (name of company that any item placed in the refrigerators and freezers must be covered, labeled and dated with a date-marking system that tracks when to discard perishable food

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 32765 Based on observation, interview, and record review the facility failed to maintain an effective pest control program. This has the potential to affect all 40 residents residing at the facility. Findings Include: The facility Nurses Midnight Census provided to this surveyor on 6/3/24 documents 40 residents currently reside at the facility. On 6/3/24 at 11:20 AM, a roach crawled out from underneath the freezer and crawled towards this surveyor's feet. V8 (Dietary Manager) stated they have been without pest control services. V8 stated she was aware of the roaches and there had been an uptick in them since they hadn't had pest control services. On 6/3/24 at 11:46 AM, V4 (Maintenance Director) gave this surveyor a pest control summary dated 12/27/23. V4 stated that was the last report he had from a pest control company. V4 stated he was told the pest control company had been at the facility once since 12/2023 but he could not find any report documenting that. V4 stated he had worked at the facility about two weeks and had not had any reports of roaches in the kitchen. V4 stated he had been told he could call the pest control company and he called but they hadn't gotten back to him with a date of service. On 6/3/24 at 1:01 PM, V4 provided this surveyor with a pest control contract dated 10/2019. When asked why they hadn't had the pest control company in the facility since they had a contract, V4 stated he wasn't sure, but he thought it may be because of the company bankruptcy. V4 stated he was just given the ok to call the pest control company on 5/31/24. When asked if they were doing anything internally to mitigate the pests, V4 stated, I don't know. On 6/3/24 at 2:36 PM, R9 who was alert to person, place and time stated she had seen roaches and spiders in the facility. On 6/3/24 at 2:40 PM, R1 who was alert to person, place and time stated she had seen roaches, water bugs, and ants in the facility. On 6/4/24 at 11:58 AM, V17 (Family Member) was sitting at the dining room table with R12. This surveyor observed V17 swiping flies off R12's food. V17 stated there are a lot of flies. V17 stated they come in every time someone opens the door. V17 stated they need fly strips in the facility, but he doesn't think those are legal. On 6/4/24 at 1:56 PM, V10 (Certified Nursing Assistant/CNA) stated they have flies and roaches. V10 stated they use a fly swatter for the flies, and they have a roach man who comes in every so often and sprays. On 6/4/24 at 2:15 PM, V7 (CNA) stated they have flies and a few cock roaches here and there, but not like an infestation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145759	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosiclare Rehab & Hcc	55 Ferrell Road Rosiclare, IL 62982

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/4/24 at 2:23 PM, V15 (CNA) stated they have flies and a few roaches. On 6/3/24 at 3:17 PM, V1 (Administrator) stated they had not had pest control services since 12/2023. V1 stated at one point the company told them to purchase something at a local store, but she told them she didn't think that would work and she was concerned about using the chemicals. V1 stated the facility had not put anything in place to mitigate pests. On 6/5/24 at 1:32 PM, V1 (Administrator) stated pest control had been called and was supposed to be at the facility on 6/1/24 and 6/4/24 and hadn't come. V1 stated the pest control company was supposed to come again on 6/5/24. The facility undated Insect and Pest Control Policy documents, It is the policy of (name of company) to contract with a duly licensed exterminating service to protect and/or control against infestations of insects and rodents. A preventative treatment, both interior and exterior, shall be applied at least monthly. Treatments will be applied more often if required. Chemicals, materials and equipment used to control insects and rodents will be provided by the Vendor, and will be in accordance with current Federal and State specifications for use in nursing homes. Methods of applications shall be in accordance with current Federal and State regulations and manufacturer's recommendations.