STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145825	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Elgin Rehab & Hcc	746 West Spring Street South Elgin, IL 60177

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on interview and record review, the facility failed to give residents appropriate written notices that their Medicare Coverage was coming to an end. This applies to 2 of 2 residents (R36, R41) reviewed for Medicare coverage in a sample of 19. The finding include: On 5/28/24 at 9:45 AM, entrance conference was completed with V1 (Administrator). Surveyor gave V1 the form titled Beneficiary Notice-Residents discharged Within the Last Six Months. Surveyor asked V1 to fill out the sheet with the names of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. On 5/29/24 at 1:00 PM, V1 returned the form back to surveyor with only two resident's names (R36 and R41) on the form. V1 stated that V18 (Business Office Manager) completed the form. On 5/29/24 at 1:46 PM, V18 (Business Office Manager) stated, I started on 4/22/24. I'm new. I don't have a list of residents who were given a NOMNC (Notice of Medicare Non-Coverage) form and SNF-ABN (Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage) in the last 6 months. I just know of 2 residents (R36 and R41). I told them verbally that they had so many days remaining. I don't remember exactly how many days remaining they had. I was not aware that you need to give something in writing. I don't know what the NOMNC and SNF-ABN forms are. I don't have the names of the residents who had benefit days remaining. On 5/29/24 at 1:52 PM, surveyor submitted two forms titled SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review to V18. V18 filled out both forms for R36 and R41. On both forms, V18 wrote she did not give the NOMNC and SNF-ABN forms to both R36 and R41 because she was not aware of the forms. 1. On 5/29/24 at 2:35 PM, surveyor asked R36 if V18 ever told her that she had this many remaining days with Medicare or was given anything in writing. R36 stated, No! (V18) never told me anything and I never got anything in writing from her. R36's face sheet shows an admitted [DATE]. Payer information shows she has Medicaid Pending and Medicare B. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36's MDS (Minimum Data Set) dated 5/2/24 shows a BIMS (Brief Interview for Mental Status) score of 15 which means she is cognitively intact. Review of R36's medical record shows no NOMNC and SNF-ABN forms. 2. On 5/29/24 at 2:45 PM, surveyor asked R41 if V18 ever told him how many remaining days he had left with Medicare or was given anything in writing. R41 stated, She never told me anything and she never gave me anything in writing. R41's face sheet shows an admitted [DATE]. Payer information shows he is private pay and has Medicare B. R41's MDS (Minimum Data Set) dated 4/30/24 shows a BIMS score of 9, which means he is moderately impaired in cognition. Review of R41's medical record shows no NOMNC and SNF-ABN forms. Facility was unable to provide a policy.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 31327 Based on observation, interview, and record review, the facility failed to provide privacy during pressure ulcer dressing changes. This applies to 2 of 2 residents (R47, R50) reviewed for privacy in a sample of 19. The findings include: 1. R47's care plans show he has a gtube and stage 3 pressure ulcer to his right heel. V4's (Wound Doctor) note dated 5/22/24 shows that R47 has a stage 3 pressure wound to the right heel. Primary dressing: Alginate rope with silver. Apply once daily for 23 days. Secondary dressing: Foam silicone border. Apply once daily for 23 days. On 5/29/24 at 12:25 PM, V3 (RN-Registered Nurse) put on gloves and entered R47's room without wearing a gown. V3 removed R47's dressing on his right foot. V4 (Wound Doctor) put on gloves and came inside without wearing a gown. V4 measured (R41's) pressure sore wound on his foot. V3 then completed the dressing change on R47's foot as per the physician's orders. During the procedure, the door was left open and the curtain was only pulled halfway. R47's roommate was present in the room as well. 2. R50's face sheet shows a diagnosis of pressure ulcer of left heel, stage 3. R50's care plans show R50 has a pressure sore. V4's wound note dated 5/22/24 shows that he has a stage 4 pressure wound to the left heel. Primary dressing: Iodosorb get apply once daily for 30 days. Secondary dressing: Foam silicone border-apply once daily for 30 days. On 5/29/24 at 12:37 PM, V3 (RN) entered R50's room. V3 removed R50's heel boots, socks, and dressing on his left foot. V4 (Wound Doctor) came in wearing gloves, but no gown. He applied pain medicine (Benzocaine Aerosol Spray) and debrided the wound. V3 then applied the treatment which included wound cleanser Idosorb, and foam dressing. Throughout the procedure, R50's blinds were open. There was a house in view of the window. On 5/29/24 at 1:02 PM, V2 (DON-Director of Nursing) stated, When you give care like wound dressing changes, you need to close the door and blinds to maintain privacy. Facility's policy titled AM Care (3/20/23) shows: 3. Provide privacy. Pull window curtains and privacy curtains.

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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. 39182 Based on observation, interview, and record review the facility failed to provide the necessary services to maintain good personal hygiene for 1 of 11 residents (R11) reviewed for activities of daily living in the sample of 19. The findings include: On 5/28/24 at 9:39 AM, observed R11 lying in bed. R11's mouth was crusty and lips dry. R11 had very strong foul odor. On 5/28/24 at 2:30 PM, V5 (RN-Registered Nurse) stated, the foul odor on R11 is from his mouth and that it is because of some periodontal issue that R11 had. On 5/30/24 at 12:05 PM, V10 (CNA- Certified Nursing Assistant) stated, Mouth care is provided to prevent odor or to clear bad smell. Also to prevent any infection in the gums. V10 (CNA) stated, R11 had a strong mouth odor. V10 stated, sometimes, (R11) resists care and does not open his mouth and at other times he does. V10 stated, he had informed nurses multiple times in the past that R11's mouth smells bad. On 5/29/24 at 12:11 PM, V2 (DON-Director of Nursing) stated, she is not aware of any periodontal condition that R11 has. V2 stated, R11's mouth had very foul odor due to poor oral hygiene. On 5/29/24, at 2:00 PM, reviewed R11's medical records. R11's face-sheet did not show any diagnosis related to his mouth or teeth or gums.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48944 Based on interview and record review the facility failed to follow a physician's laboratory order for management of anticonvulsant medication. This applies to 1 of 3 residents (R10) reviewed for labs in a sample of 19. The findings include: R10's Medical Record (MR) showed multiple diagnoses including general convulsant epilepsy intractable seizure disorder, encephalomalacia, and encephalitis. R10's MR showed R10 was receiving phenobarbital (anticonvulsant) medication and an order dated 1/31/2024 for phenobarbital trough level laboratory (lab) draw. On 5/29/2024 at 12:54 PM, V3 (Registered Nurse/RN) said R10 was receiving phenobarbital for her seizure disorder and R10's medication blood levels should be monitored as ordered. Surveyor asked V3 to provide R10's last phenobarbital trough level lab draw, V3 said he reviewed R10's labs from present to 11/2023 and was unable to find the lab result. On 5/29/2024 at 3:57 PM, V2 (Director of Nursing/DON) said nurses are expected to follow physician lab orders to monitor blood levels. On 5/29/2024 R10's lab results for the past six months were provided and reviewed, and no phenobarbital trough level was found. R10's pharmacy consultation report dated 1/29/2024 said R10's MR did not have phenobarbital trough level within the previous six months. The report continued to show a recommendation to please monitor a Phenobarbital trough concentration on the next convenient lab day, 1 week after dosing changes, every 6 months, and as clinically indicated and the recommendation was accepted by R10's physician on 1/31/2024. R10's care plan reviewed on 5/30/2024 showed a neurological problem for seizure disorders with multiple interventions including labs as ordered, notify MD ASAP for abnormalities and monitor for adverse reactions and med toxicity, notify MD.

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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** 48944 Based on observation, interview, and record review the facility failed to safely transfer a resident (R10) and safely position a resident (R14) when assisting with feeding in bed. This applies to 2 of 2 residents (R10 and R14) reviewed for accidents in a sample of 19. The findings include: 1. R10's Medical Record (MR) showed multiple diagnoses including general convulsant epilepsy intractable seizure disorder, left hemiparesis secondary to encephalitis, left homonymous hemiopia, and degenerative joint disease with arthritis. R10's MDS (Minimum Data Set) dated 4/07/2024 showed R10 required substantial to maximal staff assistance with transfers. On 5/28/2024 at 9:53 AM, R10 was sitting on the edge of her bed leaning on her left side, and was barefoot. V11 (Certified Nurse Assistance/CNA) said R10 was scheduled for a shower, and V11 proceeded to transfer R10 from the bed to the shower chair. V11 pulled and lifted R10 from her armpits when transferring into the shower chair, V11 did not use a gait belt. On 5/29/2024 at 3:57 PM, V2 (Director of Nursing/DON) said staff should use a gait belt for residents that require one-person assistance and ensure residents have proper footwear when assisting with transfers for safety. R10's care plan was reviewed on 5/30/2024 and showed an activity daily living problem related to self-care deficit to assist to complete quality care. The care plan showed multiple interventions including Assist to Transfer using 1 staff assist. Use gait belt for all hands on transfers from one surface to another .Reassure of safety as needed. The facility's policy titled Transfer Belts/Gaitbelt Policy undated showed To promote safety in transferring and ambulating residents, a gait belt will be utilized by nursing or therapy staff .All Certified Nurses Aids (C.N.A. 's) and licensed nursing personnel engage in the lifting and transferring of residents will use gait belts .The use of gait belts and mechanical lifts is essential to reduce the risk of accident and injury to both residents and employees .Procedure: .1. Direct resident care personnel will routinely have a gait belt on their person . 3. Gait belt is placed around the resident's waist . 2. R14's MR showed multiple diagnoses including cerebral infarction, muscle weakness, and lack of coordination. R14's MDS dated [DATE] showed R14 required partial to moderate staff assistance with bed mobility. On 5/29/2024 at 8:06 AM, V14 (CNA) was feeding R14 in bed. R14 was in a slouched position, his buttock was lower than the bend of the bed. V12 (CNA) said sometimes R14 was able to feed himself if sitting up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/2024 at 2:36 PM, V2 (DON) said residents being fed in bed should be in a safe position not slouched. On 5/30/2024 the facility said they did not have a policy for feeding or positioning in bed. R14's care plan was reviewed on 5/30/2024 and showed a bed mobility problem with multiple interventions including Assess need for adaptive equipment or enablers to maintain safety and increase independence in bed mobility.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40054 Based on observation, interview, and record review, the facility failed to monitor and ensure that a resident with orders for a double protein diet received the diet as ordered by the physician. The facility failed to ensure weight interventions were followed per policy. This failure resulted in a -10.16 % weight loss from November 2023 to May 2024. This applies to 1 of 1 resident (R40) who was reviewed for double protein diet in a sample of 19 residents. The findings include: On 05/29/2024 at 12:24 PM, R40 was in the dining room, not interviewable, and appeared emaciated and weak. At 12:15 PM, staff served R40 a meal tray. R40's meal card showed diet pureed, honey thick, double protein. R40's meal tray was served with regular portions of pureed meat, green beans, and smashed potatoes. R40's face sheet showed R40 is a [AGE] year-old female with diagnoses including type 2 diabetes mellites, iron deficiency anemia, chronic kidney disease, cerebral vascular accident, and dysphagia. R40's medical records did not have weight recordings after March 2024. The weight document obtained from the weight log of residents from the Dietary Manager's folder showed the following weights: on 11/2023, 125.0 pounds; on 12/2023, 120.9 pounds; on 01/2024, 121.0 pounds; on 02/2024, 119.6 pounds; on 03/2024, 110.1 pounds; on 04/2023, 109.9 pounds; on 05/2023, 112.3 pounds; On 11/2023, the resident weighed 125 pounds; on 05/2024, the resident weighed 112.3 pounds, a -10.6 % loss from November 2023 to the current month. R40's physician order dated 03/12/2024 showed double protein with lunch and dinner. The dietician's quarterly assessment dated [DATE] showed weight loss for three months to add double protein at lunch and dinner and continue weight weekly. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/24 at 12:32 PM, V6 (Dietary Manager) saw R40's meal tray and said staff should have served double protein and it's ordered for her weight loss. V6 said the cook should set up meal trays per the meal card's directions. At 12:36 PM, V17, Cook said she set up R40's meal tray, forgot to set up double protein, and acknowledged that she should have done it correctly. V6 and V17 said they could give one now. On 05/30/2024 at 11:30 AM, V7 (Registered Dietician) recommended that R40 eat double protein for lunch and dinner to prevent weight loss. R40 should have received his double portion as ordered to prevent further weight loss. R40's care plan revision, dated 03/04/2024, was reviewed for the focus area of risk for weight loss. However, the care plan was not updated on significant weight loss and double protein meals for lunch and dinner, and the facility failed to have/provide evidence of weekly meetings and consistent monitoring of weekly weights from the recommended date of 03/04/2024 to current. The facility weight committee-food service responsibilities policy revised dated October 2016 in part showed the weight committee meets once a week to discuss weight changes of residents based on monthly/weekly weight. The facility policy resident weight monitoring revised dated March 2019 showed in part residents with increased risk for weight loss will be put on weekly weight for four weeks and after four weeks if a weight has stabilized monthly will be reestablished.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 31327 Based on observation, interview, and record review, the facility failed to ensure they had supply of gastrostomy tube feeding formula for residents per order, failed to label and date gastrostomy tube feedings and failed to follow physician's orders for feedings. This applies to 3 of 3 residents (R11, R12, R47) reviewed for gastrostomy tubes in a sample of 19. The findings include: 1. R12's face sheet shows diagnoses of quadriplegia, gastrostomy (g-tube) status, and dysphagia. R12's May POS (Physician Order Sheet) shows an order for Isosource HN (high nitrogen) at 80 ML/HR (milliliters/hour) per g-tube x 20 hours (may substitute with Jevity 1.5 if n/a): On at 9:00 AM and off at 5:00 PM. R12's care plan shows he receives enteral nutrition support. He has diagnosis of TBI (Traumatic Brain Injury) from motor vehicle accident. Current feeding Isosource 1.5 at 70 ML/HR x 20 hours with flushing water 325 ML every 6 hours (may substitute jevity 1.5 if Isosource is not available). On 5/28/24 at 10:41 AM, R12 was in bed. R12 is non-verbal. He was connected to a g-tube machine which was running at 70 ML/HR (Milliliters/Hour). There was a bag with therapeutic nutrition inside. The bag was not labeled or dated. 2. R47's face sheet shows diagnoses of cerebral infarction due to thrombosis of basilar and gastrostomy status. R47's May POS shows orders for Jevity 1.5 cal at 60 ML/HR continuous 10 to 6, 6 to 2, and 2-10. R47's care plan documents the resident to receive nutrition via tube feeding. Intervention: The resident is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders. On 5/28/24 at 10:45 AM, R47 was in bed. R47 is non-verbal. He was connected to a g-tube machine which was running at 55 ML/ HR. There was a bag with therapeutic nutrition inside. The bag was not labeled or dated. On 5/28/24 at 10:50 AM, V3 (RN-Registered Nurse) stated, (R12) and (R47) are both getting these cartons of Isosource. We ran out of the feedings last Thursday. In the meantime, I use these cartons of Isosource 1.5 and put in the Kangaroo bag. Then I flush it every 6 hours. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 9:38 AM, surveyor showed V3, R47's May POS which says an order for Jevity 1.5 cal at 60 ML/HR continuous. V3 stated, I don't know why that order is there. Whoever nurse transcribed it, did it wrong. That order should not be there. Jevity is the equivalent to Isosource. I don't know why R47 doesn't have an order for Isosource. We ran out of the Isosource feeding last Thursday. Now we are using the cartons and putting it in the Kangaroo bag. It's management's job to order more. Yes, we have to label and date the feeding tube bags. On 5/28/24 at 12:57 PM, V2 (DON-Director of Nursing) stated, We have to label and date the g-tube bag for validation and authenticity. I was not made aware that we ran out of feeding. The nurses should be following doctor's order. I'm new here. Facility's policy titled Enteral Feedings (2/2008) shows: Procedure: 1. The Dietician/Consultant will monitor all diet orders for tube feedings and will recommend as appropriate changes in product according to resident need. 2. Commercially prepared tube feedings are ordered by the attending physician and dispensed from the nursing department with preference given to closed systems. 6. Physician order will be obtained for all infusion orders prior to initiation of feeding. 13. If a closed system is not used, tubing, bag, and syringe will be replaced and labeled every 24 hours by the third shift. 39182 3. On 5/28/24 at 9:39 AM, observed R11 lying in bed. GTF (Gastrostomy feed) - Diabetisource 1.2, running at 80 ml/hr via pump. The bag had no label to show the date and time the feeding was started, who started the feeding and how much quantity to be given. On 5/28/24 at 2:30 PM, V5 (RN-Registered Nurse) stated, the bag of feed should have included a label showing date and time the feed started, signature of the person who started it and the quantity to be fed. On 5/29/24 at 12:11 PM, V2 (DON-Director of Nursing) stated, the GTF bag must be labeled with the resident's name, type of feed, rate, date, start time and nurse's initials.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review the facility failed to follow its policy on behavior monitoring for residents with known behaviors and receiving psychotropic medications. This applies to 5 of 5 residents (R1, R8, R14, R36, and R39) reviewed for behaviors in a sample of 19. Findings include: 1. R1's Medical Record (MR) showed multiple diagnoses including schizoaffective disorder, bipolar disorder, depression, and psychosis. R1's MDS (Minimum Data Sheet) dated 3/13/2024 showed R1 was cognitively impaired and did not show any behaviors such as screaming or public sexual acts. On 5/28/2024 at 10:03 AM, R1 was in bed. R1 was unable to engage in the interview, his speech was incohesive and disorganized. R1 was making inappropriate sexual gestures. On 5/29/2024 at 8:09 AM, R1 was in bed again making inappropriate sexual gestures. R1's care plan reviewed on 5/30/2034 showed psychotropic medication use related to behaviors of aggression, physically abusive, uncontrollable screaming, and auditory hallucinations. The care plan had multiple interventions including Perform Behavior Management Program and behavior monitoring tracking. Monitor behaviors and document on behavior flowsheet. On 5/30/2024 at 8:01 AM, V3 (Register Nurse/RN) said R1's behaviors were screaming, making inappropriate sexual comments, and hallucinations. V3 said the facility's social worker sometimes provided behavior-tracking documentation sheets, but he was not documenting behaviors for any of his assigned residents. 2. R8's MR showed multiple diagnoses including bipolar disorder, schizophrenia, dementia, psychosis, and anxiety. R8's MDS dated [DATE] showed R8 was cognitively intact and was showing psychotic behaviors such as hallucinations. R8's care plan reviewed on 5/30/3034 showed psychotropic medication use related to behaviors of paranoia, auditory hallucinations, refusing care, and getting out of bed. The care plan had multiple interventions including Perform Behavior Management Program and behavior monitoring tracking. Monitor behaviors and document on behavior flowsheet. On 5/30/2024 at 8:01 AM, V3 (Register Nurse/RN) said the facility's social worker sometimes provided behavior-tracking documentation sheets, but he was not documenting behaviors for any of his assigned residents. V3 continued to say R8 had behaviors related to her visual and auditory hallucinations. 3. R39's MR showed multiple diagnoses including autism, developmental delay, and anxiety. R39's MDS dated [DATE] showed R39 was cognitively impaired and did not show any behaviors such as screaming. (continued on next page)

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South Elgin Rehab & Hcc	746 West Spring Street South Elgin, IL 60177

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39's care plan reviewed on 5/30/2024 showed psychotropic medication use related to behaviors of anxiety, yelling, hitting hard objects, temper tantrums, and crying. The care plan had multiple interventions including Administer antidepressant medication as ordered by physician. Monitor/document side effects and effectiveness q-shift. On 5/30/2024 at 8:01 AM, V3 (Register Nurse/RN) said the facility's social worker sometimes provided behavior-tracking documentation sheets, but he was not documenting behaviors for any of his assigned residents. V3 continued to say R39's behavior was yelling frequently. 4. R14's MR showed multiple diagnoses including anxiety and adjustment disorder with depressed mood. R14's MDS dated [DATE] showed R14 was cognitively impaired and was having recurrent behavior of rejecting care. R14's care plan reviewed on 5/30/2024 showed psychotropic medication use related to behaviors of sadness, agitation, irritability, and refusing care. The care plan had multiple interventions including Administer psychotropic medication as ordered by physician. Monitor for side effects/effectiveness. On 5/30/2024 at 8:01 AM, V3 (Register Nurse/RN) said the facility's social worker sometimes provided behavior-tracking documentation sheets, but he was not documenting behaviors for any of his assigned residents. V3 continued to say R14's behaviors were resisting care and refusing to get out of bed. 5. R36's MR showed multiple diagnoses including major depression, anxiety, and insomnia. R36's MDS dated [DATE] showed R36 was cognitively impaired and did not show any mood symptoms such as feeling depressed. R36's care plan reviewed on 5/30/2024 showed psychotropic medication use related to behaviors of depression and agitation. The care plan had multiple interventions including refer to psychiatrist or neuro-psychologist for effective and safe behavior and med management. On 5/29/2024 at 3:56 PM, V2 (Director of Nursing/DON) said social services provides behavioral tracking sheets to the nurses. V2 said she expects nurses to assess and document resident behaviors for those receiving psychotropic medications or exhibiting behaviors daily in their behavioral tracking sheets. On 5/30/2024 at 8:01 AM, V3 (Register Nurse/RN) said the facility's social worker sometimes provided behavior-tracking documentation sheets, but he was not documenting behaviors for any of his assigned residents. V3 continued to say R36 was no longer exhibiting mood behaviors such as depression or anxiety. On 5/30/2024 at 9:43 AM, V14 (Psychiatric Nurse Practitioner/NP) said he was treating R1, R8, R14, R36, and R39 for psychiatric behavioral care services. V14 said he depends on facility staff to monitor and report resident behaviors to assist in managing their psychiatric services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled Reduction of Psychotropic Medications Protocol with the reviewed date of 8/22/2018 showed Policy: Residents who must receive psychotropic medications are to be maintained at the safest, lowest dosage necessary to control the resident's condition .Procedure: .2. The Behavioral Tracking sheet of the facility will be implemented at this time to ensure behaviors are being monitored.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46380 Based on observation, interview and record review, the facility failed to ensure medications were available for administration to residents with physician's orders. This applies to 5 out 5 (R5, R13, R23, R30 and R48) reviewed for medication administration. The findings include: 1. On 5/29/2024 at 8:05 AM, during medication pass, V5 (RN-Registered Nurse) said there was no available Ascorbic Acid (supplement) 500 MG (Milligrams) so she could not administer it to R13. V5 said Ascorbic Acid 250 mg and Ascorbic Acid 500 mg were both not available in her medication cart. V5 said there was also no Ascorbic Acid in the medication room and in the small closet they keep the extra house stock in. She said Ascorbic Acid medications were not available since Monday, May 27, 2024. V5 went into the closet where house stocks are stored but did not find any Ascorbic Acid. Review of R13's POS (Physician Order Sheet) showed an order for Ascorbic Acid 500 mg, 1 tablet due at 8:00 AM. 2. On 5/29/2024 at 8:20 AM, during medication pass, V5 was observed administering a total of six medications to R30 that did not include Ascorbic Acid 500 mg, 1 tablet due at 8:00 AM. Review of R30's May POS showed an order for Ascorbic Acid 500 mg, 1 tablet due at 8:00 AM. Review of MAR (Medication Administration Record) of the facility's back nursing station showed R5, R23 and R48 had orders for Ascorbic Acid. May 2024 MAR for R48 showed Ascorbic Acid 500 mg, 1 tablet was signed NA (Not Available) from 5/27/2024 to 5/29/2024. On 5/29/2024 at 10:38 AM, V2 (Acting DON - Director of Nursing) said V5 did not try to look for Ascorbic Acid. She said V5 did not inform her that she did not have Ascorbic Acid to administer since May 27, 2024. V2 said she expects the nurses to look in the medication room, the little closet space where house stocks are kept and in the DON office. V2 said she also expects nurses to inform her immediately if house stocks are depleted so she can order some more. On 5/30/2024 at 11:37 AM, V5 (RN) said if house stocks are not available, she informs a staff member who used to order house stocks. V5 said she informed V8 (ADON-Assistant Director of Nursing) that she did not have Ascorbic Acid to administer on May 27, 2024. She said she had no Ascorbic Acid to administer on May 27, 2024, to May 29,2024 to residents who needed it. She said she might have signed the MAR in mistake that it was given to some residents with order for Ascorbic Acid. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/2024 at 11:40 AM, V8 said V1 (Administrator) is responsible for ordering house stocks since she started to work in the facility on March 1. 2024. V8 said she does not work on Mondays so V5 did not inform her on the missing medication on Monday, May 27, 2024. She said she expects the nurses to inform her or V2 if house stocks are missing so they can let V1 know to order some more. Facility's Policy on Procurement and Storage of Medication dated 10/06 and revised on 11/6/18 does not address procurement of house stocks.

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F 0758 Level of Harm - Actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview and record review, the facility failed to follow physician's orders for psychotropic medication administration (R36). The facility failed to follow its psychotropic medication policy by failing to monitor residents (R1, R14, R36) for Extrapyramidal Symptoms due to antipsychotic medication use and failing to attempt/request a Gradual Dose Reduction of a Benzodiazepine medication for a resident (R14) no longer exhibiting anxiety behaviors. These failures resulted in the R36 receiving the wrong psychotropic medications and at excessive dosages. R36 experienced side effects of increased abnormal involuntary movements. This applies to 3 of 5 residents (R1, R14, and R36) reviewed for psychotropics in a sample of 19. The findings include: 1. R36's Medical Record (MR) showed R36 was receiving psychiatric care for major depression, anxiety, and insomnia. R36's MDS (Minimum Data Sheet) dated 5/02/2024 showed R36 was cognitively impaired and did not show any mood symptoms such as feeling depressed. On 5/28/2024 at 10:26 AM, R36 was sitting in her wheelchair in the dining room. R36 was observed displaying abnormal truck, facial, and oral movements such as rocking, lip-smacking, puckering, and her tongue moving in and out of her mouth repeatedly. On 5/30/2024 at 8:01 AM, V3 (Registered Nurse/RN) said R36 was receiving psychotropic medications including antipsychotics. V3 said R36 was no longer exhibiting mood behaviors such as depression or anxiety. V3 said he did not believe R36 was having any side effects related to her psychotropics such as abnormal involuntary movements. R36's care plan reviewed on 5/30/2024 showed psychotropic medication (med) use related to behaviors of depression and agitation. The care plan had multiple interventions including Administer anti-psychotic medication as ordered-See POS (Physician's order Sheets) for current med, dose and schedule. Observe for antipsychotic side effects: .parkinsonism .tardive dyskinesia .extrapyramidal reactions, dystonia . Refer to psychiatrist or neuro-psychologist for effective and safe behavior and med management. Assess/record/report drug related Tardive Dyskinesia symptoms. Perform AIMS (Abnormal Involuntary Movement Scale) assessment at least q (every) 6 months. Review quarterly w (with)/plan of care and prn (as needed) change in antipsychotic medication and changes in condition. Report changes in AIMS reported values to MD (Medical Doctor) for consideration and follow up. R36's Abnormal Involuntary Movement Scale (AIMS) assessment dated [DATE] showed a score of 0, for displaying any abnormal involuntary movements including facial, oral, and trunk movements. (continued on next page)

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F 0758 Level of Harm - Actual harm Residents Affected - Few	R36's pharmacy consultation report dated 4/23/2024 said there was a ***TIME SENSITIVE RECOMMENDATION: PRESCRIBER RESPONSE AND FACILITY ACTION REQUIRED BY 11:59 PM ON APRIL 24 2024 . The report said R36's MR was reviewed and multiple irregularities with her psychotropic medications were identified, **Per [V14's (Psychiatric Nurse Practitioner/NP)] progress notes from 2/19/24, Abilify was decreased twice from 20 mg to 5 mg at bedtime daily. Currently, the order is still for 20 mg***Per [V14's] progress notes from 12/23/23 Seroquel (Quetiapine) (Antipsychotic) was replaced with Trazodone (Antidepressant), however, there is an active order for Quetiapine 25 mg at bedtime and NO order for Trazodone. The report showed a notation that nursing staffing was made aware and per the nurse clarification from psychiatric NP would be obtained, but the report did not show acknowledgment or response to the recommendation. R36's POS (Physician Order Sheets) showed an order dated 5/02/2024 Decrease Aripiprazole (Atyplical Antipsychotic) to 10 mg PO (by mouth) daily QHS (every eveing) x 1 week and then decrease to 5 mg PO QHS x 1 week and then DC (discontinue) and an order dated 5/30/2024 (ordered during the survey) D/C Seroquel 25 mg at bedtime. R36's MAR (Medication Administration Record) from 5/01/2024-5/31/2024 showed R36 received Aripiprazole (Abilify) antipsychotic 20 mg (milligrams) at bedtime on 5/01/2024 through 5/13/2024, and additionally received 10 mg at bedtime on 5/02/2024 through 5/08/2024 and then continued to receive an additional dose of 5mg at bedtime on 5/09/2024 through 5/15/2024. The MAR showed R36 received Quetiapine (Seroquel) antipsychotic 25 mg at bedtime on 5/01/2024 through 5/29/2024. The MAR did not show any order for Trazodone. R36's psychiatric consultation report dated 2/19/2024 showed R36 was receiving ongoing psychiatric care services for behavior and mood management. The report said V14 (NP) had made psychotropic medication adjustments in 2022, During my prior visit with her on 9/5/2022, I replaced her Seroquel with Trazodone as she only uses Seroquel for sleep .I saw her again on 10/24/2022, I decreased her Aripiprazole from 20 mg to 10 mg QHS due to increased lethargy, sedation, falls, hand shaking and trunk rocking. During my prior visit with her on 11/16/2022, I Decreased her Aripiprazole from 10 mg to 5 mg QHS due to increased lethargy, sedation, falls, hand shaking and trunk rocking. The report continued to show R36 was to continue to receive Aripiprazole 5 mg at bedtime for major depression and anxiety, and Trazodone 50 mg at bedtime for insomnia. The facility was unable to provide R36's last psychiatric consultation report from 5/02/2024. (continued on next page)

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F 0758 Level of Harm - Actual harm Residents Affected - Few	On 5/30/2024 at 9:43 AM, V14 (Psychiatric Nurse Practitioner/NP) said he was managing R36's psychiatric behaviors and psychotropic medications. V14 said he expected staff to appropriately monitor residents and report psychotropic medication side effects to safely manage their psychiatric therapy. V14 continued to say he expected his orders to be followed, his consultation reports to be reviewed, and recommendations followed. V14 said he had ordered R36's Aripiprazole be tapered and discontinued because he noted R36 was displaying side effects including ESP (extrapyramidal symptoms), and her Seroquel be switched to Trazodone in 2022. V14 said R36 should have never been back on Aripiprazole. V14 said on his last visit on 5/02/2024 he was notified of R36's medication discrepancy for Aripiprazole, and he again ordered the medication to be safely tapered and discontinued. V14 said he was not notified of the medication discrepancy for Seroquel and Trazadone. V14 said he expected to be notified of medication discrepancies in a timely manner to prevent additional side effect complications. V14 said during his visit on 5/02/2024 he did not observe R36 displaying abnormal involuntary facial or oral movements such as lip smacking or repetitive tongue movements. V14 continued to say he was never notified of R36's new abnormal involuntary facial and oral movements nor R36's new medication error. V14 said he was never notified his order from 5/02/2024 was not carried out correctly which resulted in R36 receiving increased doses of Aripiprazole and an inappropriate tapering of the medication. The facility policy titled Reduction of Psychotropic Medications Protocol with the reviewed date of 8/22/2018 showed Policy: Residents who must receive medications are to be maintained at the safest, lowest dosage necessary to control the resident's condition .Procedure . 5. Each resident taking psychotropic medications shall have their psychotropic medications reviewed and documented as such by the physician. The consulting Registered Pharmacist will review psychotropic medications on a monthly basis. Any resident receiving psychotropic medications will be reviewed at a minimum of every quarter by the interdisciplinary team. Reduction shall be attempted at least twice in one year, unless the physician documents the need to maintain the resident regimen according to the Regulatory Guidelines for such. 6. These medications shall be used when deemed necessary by each resident attending physician and/or psychiatric consultant. Each resident will be maintained on as low dosage of these medications as possible. Dosage reductions may be attempted whenever the resident's behavior patterns indicate to the attending physician that a dosage reduction may be appropriate. 7. Nursing personnel will report any side effects observed to the appropriate charge nurse. Any side effects shall be charted in the resident's clinical record and the physician shall be notified .11. Individual resident response and/or progress will be documented at least monthly by a Licensed nurse in the clinical record. (continued on next page)

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F 0758 Level of Harm - Actual harm Residents Affected - Few	The facility policy titled Psychotropic Medication Policy with a revised date of 11/28/1017 showed Policy: It is the policy of this facility that residents shall not be given unnecessary drugs. Unnecessary drugs is any drug used: 1. In an excessive dosage, including in duplicative therapy 2. For excessive duration 3. Without adequate monitoring .5. In the presence of adverse consequences that indicate the drugs should be reduced or discontinued. That these medications be withheld if the resident is lethargic and/or exhibiting any sign of over sedation and the physician will be contacted if these conditions persist .Procedure .9. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue the drugs. Any resident receiving psychotropic medications will be reviewed at a minimum of every quarter by the interdisciplinary team .12. The consultant Pharmacist will request medication reductions as decided on a monthly basis. Recommendations will be printed and sent to the physician in a timely manner. 13. Licensed Nurses will transcribe any new recommendations from the Physician as received to the facility .16. The nurse will monitor for side effects such as drooling, shuffling gait, joint rigidity, mask like face, akathisia, significant weight changes, increased lethargy, decreased appetite, decrease in ADLs, decreased cognition, tardive dyskinesia and document by exception. 17. Any resident receiving psychotropic medications will have an AIMS assessment done at a minimum of every six (6) months .20. Quarterly documentation will be done on a progress note of any resident that currently receives psychotropic medications. This is to include, but is not limited to, individual resident response and/or progress, psychotropic medication assessment, behaviors exhibited, problems or issues which the resident may be having, current medications, recent medication changes, and tolerance of medication regimen . 2. R1's MR showed R1 was receiving psychiatric care for schizoaffective disorder, bipolar disorder, depression, and psychosis. R1's MDS dated [DATE] showed R1 was cognitively impaired. On 5/28/2024 at 10:03 AM, R1 was in bed. R1 was unable to engage in the interview, his speech was incohesive and disorganized. R1 was making inappropriate sexual gestures. R1 was observed displaying abnormal oral movements such as lip smacking with his mouth opening with his tongue moving in and out of his mouth repeatedly. On 5/30/2024 at 08:01 AM, V3 (RN) said R1's behaviors were screaming and making inappropriate sexual comments. V3 said R1 was receiving psychotropic medications including an antipsychotic. V3 said he did not believe R1 was having any side effects related to his psychotropics and R1's abnormal movement were not new. R1's Abnormal Involuntary Movement Scale (AIMS) assessment dated [DATE] showed a score of 1 for facial muscle expression not including abnormal movements of the lips, perioral area, jaw, or tongue. R1's care plan reviewed on 5/30/2034 showed psychotropic medication use related to behaviors of aggression, physically abusive, uncontrollable screaming, and auditory hallucinations. The care plan had multiple interventions including Assess/record report drug related Tardive Dyskinesia symptoms. Perform AIMS assessment at least q 6 mo. Review quarterly w/plan to care and prn with changes in antipsychotic medication and changes in condition. Report changes in AIMs reported values to MD for consideration and follow up .Observe for antipsychotic side effects: .parkinsonism .extrapyramidal reactions .Notify MD of noted side effects to determine if benefits of therapy outweigh side effects (continued on next page)

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F 0758 Level of Harm - Actual harm Residents Affected - Few	R1's psychiatric consultation report dated 5/22/2024 showed R1 was receiving ongoing psychiatric care services. The report showed R1 was receiving medication treatment for EPS (extrapyramidal symptoms). On 5/30/2024 at 9:43 AM, V14 (Psychiatric Nurse Practitioner/NP) said he was managing R1's psychiatric behaviors and for his ongoing EPS side effects. V14 said he expected staff to appropriately monitor residents and report psychotropic medication side effects to safely manage their psychiatric therapy. 3. R14's MR showed R14 was receiving psychiatric care for anxiety and adjustment disorder with depressed mood. R14's MDS dated [DATE] showed R14 was cognitively impaired. On 5/29/2024 at 10:00 AM and 5/30/2024 at 11:42 AM, R14 was observed in bed sleeping. R14 was unable to engage in the interview, R14 appeared fatigued and confused. On 5/29/2024 at 1:10 PM, V13 (Activity Aide) said she was familiar with R14, and R14 was always slepping a lot throughout the day. On 5/30/2024 at 8:01 AM, V3 (RN) said R14's behaviors were resisting care and refusing to get out of bed. V3 said R14 was receiving psychotropic medications including an anxiolytic. V3 also said R14 slept a lot throughout the day. R14's care plan reviewed on 5/30/2024 showed psychotropic medication use related to behaviors of sadness, agitation, irritability, and refusing care. The care plan's goal was Will respond cooperatively to behavior interventions resulting in maintenance on lowest therapeutic dose of medication and had multiple interventions including Administer anti-anxiety medication as ordered .Observe for antianxiety side effects: drowsiness, sedation, somnolence, difficulty speaking, impaired coordination, memory impairment, fatigue, depression, confusion . R14's pharmacy consultation report dated 2/21/2024 said R14 had been receiving Lorazepam/Ativan (Benzodiazepine) 0.5 mg (milligrams) twice daily since 7/06/2022. The report showed a recommendation to attempt a gradual dose reduction (GDR). The report did not show acknowledgment or response to the recommendation. R14's psychiatric consultation report dated 2/19/2024 showed R14 was receiving ongoing psychiatric care services for mood behavior. The report showed R14's Mirtazapine (antidepressant) was discontinued on 11/16/2022 due to sedation and drowsiness, especially during the day. The report continued to show R14 was to continue with Ativan for anxiety and Lexapro for depression. On 5/30/2024 at 9:43 AM, V14 (Psychiatric Nurse Practitioner/NP) said he was managing R14's psychotropic medications and behaviors. V14 said he could not remember if he received R14's pharmacy recommendation, but felt a GDR was not recommended because R14 had cycled episodes of being anxious and did not want to take the risk. V14 continued to say he had discontinued R14's Mirtazapine because he was sleepy in the past and R14's Ativan could be causing him to be sleepy currently. V14 said R14's sleepiness throughout the day was a concern.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 46380 Based on observation, interview and record review, the facility failed to administer medications as ordered by the physician. There were 37 opportunities with 4 medication administration errors resulting in a 10.81% medication error rate. This applies to 3 out of 4 residents (R13, R19 and R30) reviewed for medication administration in the sample of 19. Findings include: 1. On 5/29/2024 at 8:05 AM, V5 (RN-Registered Nurse) was administering medication to R13. V5 administered the following medications: Fish Oil (supplement) 1000 mg (milligrams), 1 capsule; Allopurinol (Uric Acid Inhibitor) 100 mg, 1 tablet; Daily-vite (supplement), 1 tablet; Divalproex (antiepileptic) Na (Sodium) ER (Extended Release) 250 mg, 1 tablet; Divalproex Na ER 500 mg, 2 tablets; Polyethylene Glycol (stool softener) 17 gm (gram); and Metoprolol (Antihypertensive) 25 mg, 1 tablet. V5 said there was no available Ascorbic Acid (supplement) 500 mg so she could not administer it to R13. V5 said Ascorbic Acid 250 mg and Ascorbic Acid 500 mg were both not available in her medication cart. V5 said there was also no Ascorbic Acid in the medication room and in the small closet they keep the extra house stock in. She said Ascorbic Acid medications were not available since Monday, May 27, 2024. V5 went into the closet where house stocks are stored but did not find any Ascorbic Acid. V5 counted and administered a total of seven pills and Polyethylene Glycol dissolved in water. Review of R13's POS (Physician Order Sheet) showed an order for Ascorbic Acid 500 mg, 1 tablet due at 8:00 AM. 2. On 5/29/2024 at 8:20 AM, V5 was administering medication to R30. V5 administered Vitamin B1 (supplement) 1000 mg , 1 tablet; Vitamin D3 (supplement) 50 mcg (micrograms), 1 tablet; Escitalopram (Antidepressant) 20 mg, 1 tablet; Famotidine (Acid Reducer) 20 mg, 1 tablet; Multivitamin with minerals (supplement), 1 tablet; and Polyethylene Glycol (stool softener) 17 gm. V5 counted the medication in the cup, there were 5 pills in the cup and the Polyethylene Glycol she dissolved in water. V5 gave a total of six medications. Review of R30's May POS showed an order for Calcium 600 mg/Vitamin D3 (supplement) 400 mg, 1 tablet and Ascorbic Acid 500 mg, 1 tablet due at 8:00 AM. Both medications were not administered at 8:00 AM as ordered. 3. On 5/29/2024 at 8:30 AM, V5 was administering medication to R19. V5 administered Diltiazem (Calcium Channel Blocker) 30 mg, 1 tablet; Valproic Acid (anticonvulsant) 250 mg, 2 capsules; Losartan (antihypertensive) 25 mg, 1 tablet; Vitamin D3 (supplement) 125 mcg, 1 capsule and Baclofen (muscle relaxant) 10 mg, 1 tablet. V5 counted and administered five medications to R19. Review of R19's POS showed that V5 did not administer Docusate Na (stool softener) 100 mg, 1 capsule due at 8:00 AM as ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Policy on Medication Administration dated 10/07 and revised on 7/3/13/ and 11/18/17 states the following: .Definition .The complete act of administration entails removing an individual dose form a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46380 Based on observation, interview and record review, the facility failed to store narcotic medications under double-lock and failed to properly store an inhaler. This applies to 2 out of 7 residents (R2 and R32) reviewed for medication storage in a sample of 19. The findings include: 1. On 5/29/2024 at 9:41 AM, facility's medication room was inspected with V5 (RN-Registered Nurse). It was observed that the medication refrigerator had no lock. Inspection of the refrigerator showed R2's opened Lorazepam Concentrate 2mg (milligrams)/ml (milliliter). The medication was opened on 3/19/2024. R2's May 2024 POS (Physician Order Sheet) shows order for Lorazepam Oral Solution 2 mg/ml, take 0.25 ml - 0.5 ml orally or sublingually every two hours as needed for agitation or restlessness. On 5/29/2024 at 9:41 AM, V5 said the refrigerator is never locked. On 5/30/2024 at 11:37 AM, V5 said all narcotics should be double locked to prevent theft and diversion of medication. She confirmed that R2's Lorazepam was in the unlocked refrigerator in the medication room. She again said that the refrigerator in the medication room is never locked. On 5/30/2024 at 11:40 AM, V8 (ADON-Assistant Director of Nursing) said all narcotics should be double locked to reduce the chances of theft or diversion. She said she was not aware that the refrigerator in the medication room had no lock. Facility's Policy on Procurement and Storage of Medication dated 10/06 and revised on 11/6/18 does not address storage of Lorazepam. 39182 2. On 05/28/24 at 10:50 AM, observed Albuterol inhaler on R32's bedside table. R32 stated, that is his rescue inhaler and that he uses it as needed when he cannot breathe. On 05/29/24 at 12:37 PM, DON (Director of Nursing) stated, a doctor's order is needed to keep medicines at the resident's bedside. DON stated, R32 does not have any orders to keep medications at his bedside. On 5/29/24 at 2:00 PM, reviewed R32's POS (Physician Order Sheet). R32's POS did not show any order for R32 to self medicate.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39182 Based on observation, interview, and record review, the facility failed to properly label, date, seal, and store food items in the kitchen. This applies to 53 residents that receive oral nutrition and foods prepared in the facility kitchen. Findings include: The facility's Longterm-Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671) dated [DATE] documents that the total census was 56 residents. On [DATE] at 10:14 AM, V2 (DON-Director of Nursing) stated, there are three NPO (Nothing by Mouth) residents that do not eat from the facility kitchen. On [DATE] starting at 9:35 AM, the facility kitchen was toured in the presence of V6 (Dietary Manager) and the following was found: 1. Macaroni Elbow pasta, 10 lbs opened bag - no date when it was received, no expiration date. 2. Spaghetti noodles pasta, 10 lbs opened bag - no date when it was received, no expiration date. 3. Macaroni Bow pasta, 10 lbs opened bag - no date when it was received, no expiration date. 4. Half loaf of bread and a bag of 4 buns - no date when it was received, no expiration date. 5. Can of [NAME] tomato soup, 50 oz, Expired on ,d+[DATE]. 6. [NAME] Cranberry Juice 33.8 Fl oz - 3 cans - no date when it was received, no expiration date. 7. Orange Juice 33.8 Fl oz - 4 tetra packs - no date when it was received, no expiration date. 8. Clear bag of steak 15 pieces - opened bag - no date when it was received, no expiration date. 9. Clear bag of sausage patties - opened bag - no date when it was received, no expiration date. 10. Clear bag of Breaded fish patties - opened bag - no date when it was received, no expiration date. 11. Unopened Can of Ministrone condensed soup - 4 lbs - no date when it was received, no expiration date. 12. Bread dough for 3 loves in clear plastic in freezer #2 - opened bag - no date when it was received, no expiration date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:00 AM, V6 (Dietary Manager) said all expired items should be discarded, so they are not accidentally given to the residents with the potential to make the residents sick. On [DATE] at 11:30 PM, V7 (Dietician) stated, If expired food is served to residents, they could get sick or get food poisoning The facility's policy for Food titled, Storage (Dry, Refrigerated and Frozen) last revised on ,d+[DATE] showed, Procedure: 1. All items will be dated upon receipt. Individual cans or bags shall each be dated . The facility's policy for Food titled, Refrigerator and Freezer Storage last revised on ,d+[DATE] showed, 2. [NAME] container with name of item. [NAME] the date that the original container is opened or date of preparation .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview, and record review, the facility failed to store resident food that requires refrigeration in the refrigerator, remove expired food, place a thermometer in the fridge, and complete temperature logs. This applies to 2 of 2 residents (R28, R51) reviewed for refrigerators in sample of 19. The findings include: 1. On [DATE] at 10:23 AM, during initial tour, surveyor went to R51's room. R51 was in the bathroom. On top of his dresser, he had the following opened items. Smooth ranch dip, two jars of 12 fluid oz (ounces) Miracle Whip, 1 bottle of 14 fluid oz of yellow mustard, 1 jar of 16 oz of extra hot giardiniera. On the items, it says refrigerate after opening. R51 did not have a refrigerator in his room. There was a package of ,d+[DATE] loaf of Brioche bread with a best by date of [DATE]. On [DATE] at 10:05 AM, surveyor went back to R51's room to talk to R51. However, R51 was sleeping and surveyor could not interview him. The items were still on top of his dresser. 2. On [DATE] at 11:14 AM, surveyor went to R28's room. R28 had a fridge in his room. Inside there was mayonnaise, peppers in jars, cola, butter, ranch dressing, mustard, hot sauce, creamer, a container of mustard potato salad with a sell by date of [DATE] and a container of American potato salad with a sell by date of [DATE]. There was no thermometer inside the refrigerator. There was no refrigerator temperature log. R28 stated, They (staff) never check my refrigerator. On [DATE] at 2:15 PM, V1 (Administrator) stated, Residents are supposed to have thermometers in their fridges and temperature logs for them. The logs should be kept close by. If there are expired items, they should be removed. Food that needs to be refrigerated should be refrigerated or it may cause possible contamination. On [DATE] at 9:57 AM, V8 (Licensed Practical Nurse/Assistant Director of Nursing) stated, I check the temperatures in the morning or if I'm not here, one of my nurses does it. There were some residents that didn't have thermometers inside, so I just completed the logs now. I use the red infrared thermometer to take the temperature of the refrigerators that don't have thermometers. Surveyor asked V8 to bring the infrared thermometer so the surveyor can see it. V8 never brought the thermometer to the surveyor during the course of the survey. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled Food From Outside Sources/Personal Food Storage (,d+[DATE]) shows the following: 6. Foods that do not require refrigeration may be stored in the resident's room in closed storage containers provided by residents and/or resident's responsible party. Other or beverages may be stored in facility refrigerators, freezers or resident's personal room refrigerators. 7. Food and beverages brought in from outside sources, that are to be stored in the facility refrigerators and freezers, will be checked by a dietary staff member. Any suspicious or obviously contaminated food or beverage will be discarded immediately. Food and beverages will be labeled with resident's name, food item and date. These foods and/or beverages will be placed on a designated tray/shelf. Facility storage procedures apply. 9. Each resident refrigerator shall have a temperature log. Housekeeping staff, or designee, will monitor and document refrigerator temperatures daily. All resident refrigerators will have an internal thermometer to monitor for his safe food storage temperatures. 12. All food stored in resident refrigerators will be monitored by resident and/or resident's responsible party. The facility has the right to discard any food or beverage items at any time should the item be deemed not suitable for resident consumption. Facility's policy titled Visitor Rules (Unknown Date) shows: 7. All items brought for the resident should be checked in the nurse's station prior to distributing to the resident. This is to insure proper storage and diet tolerance of foods

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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. 31327 Based on observation, interview, and record review, the facility failed to wear appropriate Personal Protective Equipment in enhanced barrier precaution rooms. The facility failed to provide proper catheter care and perform hand hygiene during gastrostomy tube care. This applies to 4 of 4 residents (R11, R30, R47, R50) reviewed for infection control in sample of 19. The findings include: 1. On 5/28/24 at 10:41 AM, during initial tour, surveyor went to R47's room. R47 had a G-Tube (Gastrostomy Tube) running and as per the floor nurse V3 (RN-Registered Nurse), R41 also has a pressure sore to his right heel. There was no sign on R47's door about enhanced barrier precautions. On 5/29/24 at 12:20 PM, there were signs posted on R47's door. One sign said, Stop and See Nurse. The other sign showed, Stop! Enhanced Barrier Precautions. Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities: Dressing, Bathing/Showering, Transferring, Changing linens, Providing hygiene, Changing briefs for assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing. On 5/29/24 at 12:25 PM, V3 (RN) stated, I don't know why those signs are there. (R47) is not on isolation. I don't know what enhanced barrier precautions are. Please ask the ADON (Assistant Director of Nursing. V3 put on gloves and entered R47's room without wearing a gown. V3 removed R47's dressing on his right foot. V4 (Wound Doctor) put on gloves and came inside without wearing a gown. V4 measured (R47's) pressure sore wound on his foot. V3 then completed the dressing change on R47's foot as per the physician's orders. R47's face sheet shows a diagnosis of gastrostomy status. R47's POS (Physician Order Sheet) has no orders for enhanced barrier precautions. R47's care plans show he has a gtube and stage 3 pressure ulcer to his right heel. R41 does not have a care plan for enhanced barrier precautions. V4's (Wound Doctor) note dated 5/22/24 shows that R47 has a stage 3 pressure wound to the right heel. Primary dressing: Alginate rope with silver. Apply once daily for 23 days. Secondary dressing: Foam silicone border. Apply once daily for 23 days. 2. On 5/28/24 at 10:14 AM, R50 stated he had a pressure sore to his left foot. There was no sign for enhanced barrier precautions on his door. On 5/29/24 at 12:30 PM, there was still no enhanced barrier precaution sign on R50's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/29/24 at 12:37 PM, V3 (RN) applied hand sanitizer to his hands and put on gloves. V3 did not put a gown on. V3 entered R50's room. V3 removed R50's heel boots, socks, and dressing on his left foot. V4 (Wound Doctor) came in wearing gloves, but no gown. He applied pain medicine (Benzocaine Aerosol Spray) and debrided the wound. V3 then applied the treatment which included wound cleanser Idosorb, and Optifoam dressing. Throughout the whole procedure, V3 and V4 did not wear a gown. R50's face sheet shows a diagnosis of pressure ulcer of left heel, stage 3. R50's POS shows no order for enhanced barrier precautions. R50's care plans show R50 has a pressure sore, but there is no care plan for enhanced barrier precautions. V4's wound note dated 5/22/24 shows that he has a stage 4 pressure wound to the left heel. Primary dressing: Iodosorb get apply once daily for 30 days. Secondary dressing: Foam silicone border-apply once daily for 30 days. Facility's policy titled Enhanced Barrier Precautions (7/13/23) shows: Enhanced Barrier Precautions (EBP) should be used when contact precautions do not apply, for residents with any of the following: open wounds that require a dressing change, indwelling medical devices, infection or colonized with a MDRO (Multi-Drug Resistant Organism). Enhanced Barrier Precautions require the use of a gown and gloves during high-contact resident care activities that provide opportunities for the transfer of MDRO's to staff hands and clothing. EBP is primarily intended to use for car that occurs within a resident's room, when high-contact resident care activities are bundled together. Procedure: 1. Educate staff on EBP. 3. Review contact precautions to ensure that enhanced barrier precautions are appropriate. 3. Post approved EBP signage that indicates high-contact activities. On 5/29/24 at 1:02 PM, V2 (DON) stated, Enhanced barrier precautions means standard precautions. Any resident that has enhanced barrier precautions means they have an opening on the skin. Those residents are residents with wounds, gtubes and catheters. I started putting up the signs yesterday. I'm working on it. I did some today. It's a project I'm working on. Staff is supposed to wear gown and gloves when they give care to those residents. (V3-RN) should know that. I just in-serviced him on that yesterday and today. (V3) should have known what enhanced barrier precautions when he took the NCLEX-RN (National Council Licensure Exam-Registered Nurse). 46380 3. R30 has a suprapubic catheter for diagnoses of neuromuscular dysfunction of bladder and urinary retention. On May 28, 2024, at 1:44 PM, R30's suprapubic catheter care observed done by V5 (RN-Registered Nurse). V5 performed hand hygiene and applied gloves. V5 said suprapubic catheter care is done every shift. V5 unfastened the incontinent brief. She squeezed NSS (Normal Saline Solution) onto a gauze and proceeded to clean the catheter. V5 observed to be cleaning the catheter towards the base of the catheter more than ten times with the same gauze. There was minimal bleeding noted at the base of the catheter and V5 said R30's skin gets irritated at times but always dries up. Using the same glove, V5 took a gauze from the treatment cart, opened the package, and cut the gauze with scissors. V5 then took gloves off, applied hand sanitizer and applied new gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On May 30, 2024, at 11:37 AM, V5 said when cleaning catheters, the motion should be away from the base to prevent urinary tract infections. On May 30, 2024, at 11:40 AM, V8 (ADON-Assistant Director of Nursing) said she expects the nurse to perform suprapubic care every shift. She said the nurse should wipe the catheter clean and should clean away from the base. She said if the catheter is cleaned towards the base, the dirt and germs are being brought back to the site and might cause infections. Facility's Policy on Suprapubic Catheter Care dated 1/2002 and reviewed on 2/2028 and 3/15/2023 does not address how catheter tubing should be cleaned. 39182 4. On 5/28/24 at 2:30 PM, observed V5 (RN-Registered Nurse) change GT (gastrostomy) dressing for R11. V5 (RN) did not wear PPE (Personal Protective Equipment) as required for a resident on EBP (Enhanced Barrier Precaution). V5 wore gloves and removed the soiled dressing. Did not do any hand hygiene before or after removing the soiled dressing. With the same gloves, V5 (RN) took clean gauze and cleaned the site with normal saline. With the same gloves and no hand hygiene, V5 (RN) took a split gauze and placed it around the gastrostomy tube. V5 (RN) did not secure the split gauze with a tape nor label the dressing with date, time and signature of the nurse. With the same used gloves and no hand hygiene, V5 (RN) patted R11 on his arms to reassure him. V5 removed gloves and discarded into the trash bag. Did not wash hands or use hand sanitizer. Replaced all the remaining clean items back in the drawers. Then used hand sanitizer on her hands and wheeled the cart out of the room. On 5/29/24 at 12:11 PM, V2 (DON-Director of Nursing) stated, R11 was on GT feeding and hence on EBP. V2 stated, the nurse should have washed her hands before starting the procedure of GT care. V2 (DON) stated, after cleaning the site, V5 should have washed her hands or done hand sanitization. V2 stated, touching clean items and clean surfaces with soiled gloves is a potential for contamination of the clean items and possible infection. Facility policy on 'Hand Hygiene' updated 8/14/2023 showed, . Indications for Hand-Washing . 2. Before and after direct resident care .Indications for ABHR (Alcohol Based Hand Rub) - When hands are not visibly soiled, . 3. After contact with resident's intact skin, 4. After contact with inanimate objects, 5. After removing gloves. Facility policy on 'Dressing Change' reviewed on 3/16/23 showed, ' . Procedure 7. Set up clean area for supplies. 8. Wash your hands. 9. Put on non-sterile gloves 23. Discard all equipment appropriately. 24. Wash your hands .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 40054 Based on the interview and record review, the facility failed to utilize a standardized tool to determine the necessity of antibiotic therapy prescribed to residents. This applies to 5 of 5 residents (R10, R12, R22, R50, and R206) reviewed for antibiotics therapy in sample of 19. The findings include: 1.R10 (Physician Order Sheet) showed Bactrim DS (antibiotic) 800-160 milligrams daily in the evening by mouth for ten days. No reason for antibiotic therapy (ABT) was entered either in the Physician Order sheet or in the medication administration log. R10 did not have a McGeer's criteria form in the infection control binder or his medical record for April . Further, the infection control and antimicrobial log did not have the reason for the medication administration. 2. R12's Physician Order Sheet dated 4/20/2024 showed Bacitracin (antibiotic) 2 percent ointment to apply to Gastrostomy tube redness and drainage two times daily until healed. The sheet dated 04/29/2024 showed Keflex 500 milligram four times tablet by mouth for ten days left lower extremity cellulitis. The April monthly infection log showed that R12 did not have a McGeer's criteria form in the infection control binder or his medical record. Further, the onset date for bacitracin in the log did not match the date on the physician's order sheet. 3. R22's Physician Order Sheet dated 05/02/2024 showed Erythromycin (antibiotic) ophthalmic (eye) ointment to apply to the right eye three times a day for five days for blepharitis (infection of the eyelid) and Doxycycline (antibiotic) 100 milligram capsule two times by mouth for seven days. The May 2024 antibiotic Stewardship log shows a start date of 05/02/2024 and an end date of 05/07/2024 for Erythromycin and no start or end date for Doxycycline. R22 did not have a' McGeer's criteria form in the infection control binder or medical records. 4. R50's Physician Order Sheet dated 05/06/2024 showed Cefadroxil (antibiotic)500 milligram tablet two times a day by mouth for seven days for left foot cellulitis. The May 2024 antibiotic Stewardship log shows a start date of 05/06/2024 and an end date of 05/13/2024. R50 did not have a McGeer' sMcGeer's criteria form in the infection control binder or his medical records. 5. R206's Physician Order Sheet showed Augmentin (antibiotic) 250 milligrams by mouth for seven days for an ear infection. The May 2024 antibiotic Stewardship log did not have R206's name or a McGeer's criteria form in the infection control binder or medical records. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145825	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Elgin Rehab & Hcc	746 West Spring Street South Elgin, IL 60177

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/30/2024 at 10:30 AM, V2 (Director of Nursing/Infection Preventionist) stated that she is at the facility for a few weeks only and that the facility should follow McGeer's criteria to ensure residents are not getting antibiotics unnecessarily. Labs are to be done before administering medications, with some exceptions, and she was not sure why it was not done. At 11:30 AM, V16 (Physician) said he didn't follow McGeer's criteria and did not want to discuss them further. At 11:46 AM, V3 (Registered Nurse) said when the nurses observe any signs of infection in residents, they call the physician and follow the orders, if any. V3 said he had never heard of McGeer's criteria. The facility's policy, Infection Control Surveillance and Monitoring, revised date 04/11/2022, stated, Update infection control log on a daily basis to analyze data and identify trends. The facility could not provide an Antibiotic/Antimicrobial Stewardship Program-Mission Statement and Guidelines.