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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145837	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsfield Manor	610 Lowry Street Pittsfield, IL 62363

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to prevent abuse for 1 of 1 residents (R63) reviewed for abuse in the sample of 33. Findings include: R63's Face Sheet, print date of 12/9/24, documents R63 was admitted on [DATE] and has a diagnosis of Dementia. R63's Minimum Data Set, dated dated [DATE], documents R63 is severely cognitievely impaired. R73s' Face Sheet, print date of 12/3/24, documents R73 was admitted on [DATE] and has diagnosis of Dementia with psychotic disturbance. R73's Minimum Data Set, dated dated [DATE], documents R73 is severely cognitively impaired. R73's Nurses Note, dated 11/03/2024 09:29 PM, documents, CNAs (Certified Nurses Aides) observed res. (resident) go into wife's (R63s') room, argue with her, and then hit her in face x 2. Staff intervened and assisted res. out of room. Res. very HOH (hard of hearing) and has difficulty understanding others. Appears to get frustrated with wife and staff d/t (due to) not understanding. Attempted to use communication board or writing things out on paper, but doesn't appear to understand that either. Res. taken to own room and assisted res to bed. Res up to br (bathroom) and back to bed at this time is resting well. Steristrips intact to old skin tear on rt elbow. On 12/9/24 at 9:40 AM, V29, Certified Nurse Aide, stated, After dinner, I was with another resident (R77) in the hall by the dining room because she was having an episode. I heard (R73) and (R63) having a commotion. They were having a disagreement. (R63) was getting aggravated with (R73). (R73) was standing in front of (R63) and he slapped her in the face. I left (R77) and went to separate them and redirect (R73). I went back to (R77). When I turned around, (R73) was back in-front of (R63) and he slapped her again. I am not sure who I told the nurse that was on duty that night or the morning nurse. I did not let (V1, Administrator) know. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Abuse Prohibition and Reporting, dated 11/28/19, documents, The facility actively prohibits resident abuse including neglect, corporal punishment, involuntary seclusion, misappropriation of property, injuries of unknown source, exploitation, and use of any physical or chemical restraining not required to treat resident symptoms.

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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** 33112 Based on interview and record review, the facility failed to report an allegation of abuse to the Illinois Department of Public Health for 1 of 1 resident (R63) reviewed for abuse in the sample of 33. Findings include: R63's Face Sheet, print date of 12/9/24, documents R63 was admitted on [DATE] and has a diagnosis of Dementia. R63's Minimum Data Set, dated dated [DATE], documents R63 is severely cognitievely impaired. R73's Face Sheet, print date of 12/3/24, documents R73 was admitted on [DATE] and has diagnosis of Dementia with psychotic disturbance. R73's Minimum Data Set, dated dated [DATE], documents R73 is severely cognitively impaired. R73's Nurses Note, dated 11/03/2024 09:29 PM, documents, CNAs (Certified Nurses Aides) observed res. (resident) go into wife's (R63s') room, argue with her, and then hit her in face x 2. Staff intervened and assisted res. out of room. Res. very HOH (hard of hearing) and has difficulty understanding others. Appears to get frustrated with wife and staff d/t (due to) not understanding. Attempted to use communication board or writing things out on paper, but doesn't appear to understand that either. Res. taken to own room and assisted res to bed. Res up to br (bathroom) and back to bed at this time is resting well. Steristrips intact to old skin tear on rt elbow. On 12/3/24 at 8:50 AM, V1, Administrator, stated she does not have an abuse investigation for R73. V1 stated there is a follow up note in his record because R73 did not slap his wife; he was trying to wake her up from her chair by shaking the chair. V1 stated she did not find out about this incident until they came across the note, also in his record. On 12/3/24 at 2:09 PM, V31, Director of Memory Care, stated, I was not here when the abuse allegation happened. I was notified later that evening by a CNA. She said they (R73 and wife) had gotten into it at the dining table and the nursing staff called (V1) and took care of it. The next day I came in and read the note about him hitting her. I went and asked (V1) if she was aware, and she said she wasn't. I left it at that, because it is (V1's) job to investigate abuse. On 12/3/24 at 2:34 PM, V30, Licensed Practical Nurse, stated, On 11/3/24, a Certified Nurses Aide (CNA) came and told me that he was getting excited and slapped his wife. I told (V2, Director of Nurses) called the family, and the Doctor. I did not let (V1) know. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 9:40 AM, V29, Certified Nurse Aide, stated, After dinner, I was with another resident (R77) in the hall by the dining room because she was having an episode. I heard (R73 and R63) having a commotion. They were having a disagreement. (R63) was getting aggravated with (R73). (R73) was standing in front of (R63), and he slapped her in the face. I left (R77) and went to separate them and redirect (R73). I went back to (R77). When I turned around, (R73) was back in-front of (R63), and he slapped her again. I am not sure who I told the nurse that was on duty that night or the morning nurse. I did not let (V1) know. The policy Abuse Prohibition and Reporting, dated 11/28/19, documents, The facility actively prohibits resident abuse including neglect, corporal punishment, involuntary seclusion, misappropriation of property, injuries of unknown source, exploitation, and use of any physical or chemical restraining not required to treat resident symptoms. It continues, B. Initial steps and reports of alleged abuse or neglect 1. Facility employee or agent who becomes aware of alleged abuse or neglect of resident should immediately report the matter to the facility Administrator or designee. If allegation involves the Administrator then the facility employee or agent should immediately report the matter to the facility DON (Director of Nurses) 2. If the matter involves alleged abuse or results in serious bodily injury, the administrator, or designee shall provide the Illinois Department of Public Health with initial notice of the alleged abuse or serious bodily injury as soon as possible, but not more that 2 hours after the matter becomes known or not later that 24 hours if the allegation does not involve abuse and does not result in serious bodily injury. It continues, 7. If the incident involves alleged abuse and substantiated evidence indicates that another resident of the facility is the perpetrator of the abuse, then the administrator shall take all steps necessary to protect all residents in the facility from abuse until the alleged perpetrator can be evaluated. It continues, Interviews with all involved parties or potential witnesses will be completed. If possible, at least two interviewers shall be present for each witness interview. At least one interviewer shall take notes. 2. Signed statements from those persons who saw or heard information pertinent to the incident shall be obtained. Statements shall be taken from the suspect, the person making the accusations, the resident abused or neglected, other staff or residents who may have witnessed the incident, and any other person who may have information related to incident. 3. The Administrator shall keep copies of all notes from the interviews conducted by the Administrator or other facility interviewed in the course of the investigation. 4. the Administrator shall be responsible for supervising the investigation and reporting the results of the investigation to the Illinois Department of Public Health.' It continues, 1. the shift nurse on duty who is first made aware of any allegations of abuse or neglect concerning any resident shall immediately examine the resident involved to determine whether the resident is an any distress or has suffered any injury. The nurse shall take all steps necessary to protect the resident from danger, and document as necessary. 2. If the incident involves suspected abuse, then the shift nurse shall assure that the suspected abuser has no further contact with the resident involved or withany other resident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to investagate an allegation of abuse for 1 of 1 resident (R63) reviewed for abuse in the sample of 33. Findings include: R63's Face Sheet, print date of 12/9/24, documents R63 was admitted on [DATE] and has a diagnosis of Dementia. R63's Minimum Data Set, dated dated [DATE], documents R63 is severely cognitievely impaired. R73's Face Sheet, print date of 12/3/24, documents R73 was admitted on [DATE] and has diagnosis of Dementia with psychotic disturbance. R73's Minimum Data Set, dated dated [DATE], documents R73 is severely cognitively impaired. R73's Nurses Note, dated 11/03/2024 09:29 PM, documents, CNAs (Certified Nurses Aides) observed res. (resident) go into wife's (R63s') room, argue with her, and then hit her in face x 2. Staff intervened and assisted res. out of room. Res. very HOH (hard of hearing) and has difficulty understanding others. Appears to get frustrated with wife and staff d/t (due to) not understanding. Attempted to use communication board or writing things out on paper, but doesn't appear to understand that either. Res. taken to own room and assisted res to bed. Res up to br (bathroom) and back to bed at this time is resting well. Steristrips intact to old skin tear on rt elbow. On 12/3/24 at 8:50 AM, V1, Administrator, stated she does not have an abuse investigation for R73. V1 stated there is a follow up note in his record because R73 did not slap his wife; he was trying to wake her up from her chair by shaking the chair. V1 stated she did not find out about this incident until they came across the note, also in his record. On 12/3/24 at 2:09 PM, V31, Director of Memory Care, stated, I was not here when the abuse allegation happened. I was notified later that evening by a CNA. She said they (R73 and wife) had gotten into it at the dining table and the nursing staff called (V1) and took care of it. The next day, I came in and read the note about him hitting her. I went and asked (V1) if she was aware, and she said she wasn't. I left it at that, because it is (V1's) job to investigate abuse. On 12/3/24 at 2:34 PM, V30, Licensed Practical Nurse, stated, On 11/3/24 a Certified Nurses Aide (CNA) came and told me that he was getting excited and slapped his wife. I told (V2, Director of Nurses), called the family, and the Doctor. I did not let (V1) know. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 9:40 AM, V29, Certified Nurse Aide, stated, I don't know anything about (R73) hitting his wife (R63) in her room. After dinner, I was with another resident (R77) in the hall by the dining room because she was having an episode. I heard (R73 and R63) having a commotion. They were having a disagreement. (R63) was getting aggravated with (R73). (R73) was standing in front of (R63), and he slapped her in the face. I left (R77) and went to separate them and redirect (R73). I went back to (R77). When I turned around, (R73) was back in front of (R63), and he slapped her again. I am not sure who I told the nurse that was on duty that night or the morning nurse. I did not let (V1) know. The policy Abuse Prohibition and Reporting, dated 11/28/19, documents, The facility actively prohibits resident abuse including neglect, corporal punishment, involuntary seclusion, misappropriation of property, injuries of unknown source, exploitation, and use of any physical or chemical restraining not required to treat resident symptoms. It continues, B. Initial steps and reports of alleged abuse or neglect 1. Facility employee or agent who becomes aware of alleged abuse or neglect of resident should immediately report the matter to the facility Administrator or designee. If allegation involves the Administrator then the facility employee or agent should immediately report the matter to the facility DON (Director of Nurses) 2. If the matter involves alleged abuse or results in serious bodily injury, the administrator, or designee shall provide the Illinois Department of Public health with initial notice of the alleged abuse or serious bodily injury as soon as possible, but not more that 2 hours after the matter becomes known or not later that 24 hours if the allegation does not involve abuse and does not result in serious bodily injury. It continues, 7. If the incident involves alleged abuse and substantiated evidence indicates that another resident of the facility is the perpetrator of the abuse, then the administrator shall take all steps necessary to protect all residents in the facility from abuse until the alleged perpetrator can be evaluated. It continues, Interviews with all involved parties or potential witnesses will be completed. If possible, at least two interviewers shall be present for each witness interview. At least one interviewer shall take notes. 2. Signed statements from those persons who saw or heard information pertinent to the incident shall be obtained. Statements shall be taken from the suspect, the person making the accusations, the resident abused or neglected, other staff or residents who may have witnessed the incident, and any other person who may have information related to incident. 3. The Administrator shall keep copies of all notes from the interviews conducted by the Administrator or other facility interviewed in the course of the investigation. 4. the Administrator shall be responsible for supervising the investigation and reporting the results of the investigation to the Illinois Department of Public Health.' It continues, 1. the shift nurse on duty who is first made aware of any allegations of abuse or neglect concerning any resident shall immediately examine the resident involved to determine whether the resident is an any distress or has suffered any injury. The nurse shall take all steps necessary to protect the resident from danger, and document as necessary. 2. If the incident involves suspected abuse, then the shift nurse shall assure that the suspected abuser has no further contact with the resident involved or withany other resident.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview record review, the facility failed to provide 2 of 5 residents (R46, R73) with written documentation as to why they were being sent to the hospital, for residents reviewed for transfer in the sample of 33. Findings include: 1. R73's Face Sheet, print date of 12/3/24, documents R73 was admitted on [DATE] and has diagnosis of Dementia with psychotic disturbance. R73's Minimum Data Set, dated dated [DATE], documents R73 is severely cognitively impaired. R73's Nurses Note, dated 11/06/2024 03:54 PM, documents, Resident returned from (local emergency room) with no new orders or changes in condition. Per the hospital record, no new findings were identified. The left pupil, which had been noted as dilated earlier, was documented in the hospital as a previous finding from an earlier event (likely related to an injury from a past fire-related incident). This was confirmed in the hospital record, and no acute concerns regarding the pupil were raised. The resident's blood and blood clots in the urine were evaluated during the ER (emergency room) visit; however, no additional issues were noted, and the urinary findings were not considered a new or urgent concern at this time. The attending physician at the hospital cleared the resident for return to the facility, and no further acute interventions were required. Resident's condition remains stable, and they will continue to be monitored closely for any changes. On 12/9/24 at 11:30 AM, V28, Licensed Practical Nurse, stated she does not remember if she gives anything to the resident in plain verbage as to why they are going out to the hospital. 32874 2. R46's face sheet, dated 11/18/2024, documents admitted [DATE]; latest return from hospital. R46's record does not document R46 was orientated or prepared for hospital transfer. On 12/3/2024 at 10:16AM, R46 stated she had been to the hospital several times this past year. On 12/5/2024 at 8:30AM, V16, Licensed Practical Nurse (LPN), stated the facility does not hand the resident anything in regards to reason for transfer. V16 stated there is no information handed specifically to the resident. V16 stated the information is given to the emergency medical staff. On 12/5/2024 at 8:50AM V2, Director of Nursing (DON), stated the facility does not provide the resident anything in writing in regards to reason for transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy transfer of a resident dated, revised 1/11/2023 documents, it is the policy of the facility to have established procedures for all types of resident transfers. The policy documents upon order by the physician to transfer a resident to the hospital , the family and /or representative and hospital shall be notified. The policy documents nurse will communicate information necessary to meet resident needs during resident transfer to the hospital.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 32874 Based on interview and record review, the facility failed to initiate a level 2 Preadmission Screening and Resident Review (PASARR) for one of 3 residents (R32) reviewed for PASAAR in the sample of 33. Findings include: 1. R32's face sheet, undated, documents diagnoses of Schizoaffective disorder, depressive type, and pervasive developmental disorder, unspecified. R32's PASARR level one report, dated 5/25/2023, documents, there is no evidence of a condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings , a new screen must be submitted. On 12/05/24 at 1:39 PM V27, Social Services, stated on admission R32 did not have a diagnosis of schizoaffective or pervasive personality disorder. V27 stated when the physician added a diagnosis of schizoaffective disorder and pervasive on 10/10/24, there was no Level 2 PASAAR done. V27, Social Services, stated a level 2 should be done with her change in diagnosis. On 12/9/2024 at 10:45AM, V1, Administrator, stated the facility does not have a policy on PASAAR. V1 stated she would expect the facility to follow the Illinois Department of Public Health (IDPH) guidelines on PASAAR requirements.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on observation, interview, and record review, the Facility failed to provide feeding assistance for 3 of 5 residents (R8, R41, and R52) reviewed for nutrition and feeding assistance in the sample of 33. The findings include: 1. R41's Face Sheet, undated, documents R41 was originally admitted to the facility on [DATE], with diagnoses of Generalized muscle weakness/wasting, falls, Lack of coordination, Hemiplegia/Hemiparesis affecting left side, Cerebral infarction, Trans Ischemic Attack (TIA), Anxiety disorder, Sacroiliitis, Right artificial shoulder joint, Hypertension (HTN), Anemia, Atrial Fibrillation, Chronic Kidney Disease (CKD) - stage 3, and prediabetes. R41's Care Plan, dated 11/15/24, documents R41 has had a 9% weight loss over 90 days. Interventions: Offer R41 house supplement with breakfast and lunch. It continues 9/18/24: Resident Care Information: Mobility: X1. Encourage ambulation to and from meals with staff assist. Regular diet/thin liquids Assistance for eating: set up; feeds self. R41's Minimum Data Set (MDS), dated [DATE], documents R41 is cognitively intact and is independent for eating. R41's Nutritional Assessment, dated 9/19/24, documents Feeding Capabilities: Independent/Supervised. R41's Physician Order (PO), dated 8/22/24, documents Weekly Weight. Once A Day on Fri. R41's PO, dated 5/29/24, documents Regular Diet. R41's PO, dated 11/15/24, documents House Supplement 4oz with breakfast and lunch. R41's Dietary Note, dated 10/22/24 at 1:26 PM, documents, RD (Registered Dietician) eval (evaluation) for Oct (October) wt (weight) loss. Ht (Height) 59 10/1 wt 130# (pounds) with wt loss of 10.3% x 90 days and 14. 1% x 180 days. 10/18 wt 130.2# BMI (Body Mass Index) 26.29. History of gradual wt loss, wts currently stable x 2months. Regular diet. Past intakes appear not to be meeting needs. Overall wt per BMI remains acceptable. Rec (recommend) adding house supplement with breakfast and lunch for additional support, goal is to prevent further wt loss. Monitor and f/u (follow up) as indicated. R41's Administrator Note, dated 11/8/24 at 9:45 AM, documents, Resident triggered for a weight loss @ (at) 90 days. Supplemental shakes requested TID (three times daily). MD (Medial Doctor) notified, will monitor weekly. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/24 at 1:00 PM, R41 was seen sitting in her room eating lunch (salisbury steak, mashed potatoes with gravy) on a normal plate and regular utensils. R41 was trying to use a fork to eat while her hands were shaking and her food was falling off the fork and all over. There was no supplemental shake seen on her lunch tray. V12 and V13, R8's Daughters, were visiting, and brought in pizza for R8 and R41, to eat and stated R8 and R41 should not use a fork to eat because they shake so much, the food just falls off and flies all over the room. V12 and V13 stated no one ever helps either R8 or R41 to eat. On 12/5/24 at 1:00 PM, R41 was seen in the dining room with regular plate and silver ware. R41 had a ham sandwich and was just eating the pieces of ham, R41 had a cup of juice and a cup of milk in front of her. There was no supplemental shake seen on her lunch tray. V24, CNA, stated, (R41) uses a sippy cup ([NAME] Cup) because she shakes so bad and can't use a regular cup. (R41) usually gets finger foods, such as sandwiches and such, so she can use her fingers to eat. (R41) is on a regular diet with regular texture. (R41) has a cup of juice and a cup of milk with her lunch today. V24 stated she is not aware of R41 getting any kind of supplement, and she doesn't see one with her lunch. On 12/9/24 at 12:20 PM, R41 was seen sitting at the dining room table eating spaghetti with a normal plate and normal utensils. R41 was seen shaking badly with spaghetti falling off her fork. R41 was picking up her piece of garlic bread and eating it, after trying to eat the spaghetti with a fork. On 12/9/24 at 12:22 PM, V28, was seen assisting other residents with feeding. When asked about R41 needing assistance, V28 stated, I don't normally work with (R41), but I can see she does shake badly. V28 asked V37, Licensed Practical Nurse/LPN, about R41 needing feeding assistance. V37 walked up to R41 and asked her if she needed help, and R41 stated No. R37 walked away without assisting R41. On 12/9/24 at 12:45 PM, R41 was seen leaving her dining room table with minimal amount of spaghetti eaten, and most of her piece of garlic bread. 2. R8's Face Sheet, undated, documents R8 was admitted to the facility on [DATE], with diagnoses of Cerebral infarction, Fracture of left humerus, Cellulitis, Morbid obesity, Urinary incontinence, Cardiomegaly, Malignant neoplasm of endometrium, Chronic Kidney Disease -stage 2, Hemiplegia, Aphasia, Urinary Tract Infection, and Type 2 Diabetes Mellitus. R8's Care Plan, dated 11/11/24, documents R8 Resident Care Information: Diet: Regular/thin liquids, Finger foods when available. Assistance for eating: set up for meals Adaptive Equipment: scoop plate/Kennedy cups. R8's MDS, dated [DATE], documents R8 is cognitively intact and requires set up/clean up assistance for meals, and substantial assistance to dependent on staff for all other ADLs. R8's Physician Order (PO), dated 3/15/24, documents, Pro-Stat AWC (amino acids-protein hydrolys) - 17-100 gram-kcal/30 mL, Twice A Day. R8's PO, dated 4/29/23, documents, Diet: Regular. R8's electronic medical record, under vitals: Weights: documents R8's weight on 1/19/24 was 161.3lbs, and with the most recent weight of 184lbs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145837	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Pittsfield Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 610 Lowry Street Pittsfield, IL 62363	

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

R8's Dietician Note, dated 6/23/24 at 5:07 PM, documents, RD eval May wt gain. Ht 62 5/7 wt 172# with wt gain of 11.7% over 180 days. 6/4 wt 176#. BMI 32.19-obese. Diet is regular, per meal card sent K cups and finger foods. Intake appears adequate to meet needs based on wt history. Prostat AWC 30ml TID continues with current wounds on right toe and shin, not identifed as pressure wounds. No changes at this time. Monitor and f/u as indicated.

On 12/2/24 at 12:25 PM, R8 seen with plate of food on bedside table. R8 was sitting in chair trying to eat with fork. R8 was very shaky and food falling all over. No staff seen attempting to help R8 with eating. No special utensils or plate was used.

On 12/2/24 at 1:00 PM, R8 was seen sitting in her room eating lunch. R8 was trying to use a fork to eat, with food falling all over. V12 and V13, R8's Daughters, were at R8's bedside assisting R8 to eat. V12 and V13 brought in pizza for R8 and her roommate (R41) to eat. V12 and V13 stated R8 cannot use a fork to eat and they have talked to the facility, including the kitchen staff, about giving R8 finger foods because she uses her fingers to eat most of the time. V12 and V13 stated R8's lunch had meat (salisbury steak), and mashed potatoes and gravy, which she cannot eat with her fingers, and it falls off the fork due to R8 shaking. V12 and V13 stated R8 is supposed to have a special plate with sides on it, and they are supposed to bring her finger foods, and they don't, so the family will bring in something R8 can eat with her hands. V12 and V13 stated R8's roommate, R41, is the same way, and no one every helps them eat, and they are so shaky that food falls all over.

On 12/5/24 at 12:55 PM, R8 was seen sitting in her room, R8 stated her grandson came in and brought her lunch and helped her. R8's plate for this meal had curved edges and regular silverware sitting on the table.

The Facility's Special Needs Policy, dated 11/28/17, documents, To address special needs, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Purpose: to properly provide routine and emergency care and treatment to residents with special needs pertaining to parenteral fluids, respiratory care, prostheses, and dialysis. Procedure: 1. Comprehensive care plans will be developed based on resident assessments, goals, and preferences in accordance with assessment and care plan procedures. 2. The facility will utilize a systematic approach for the management of special needs, including efforts to identify risk; stabilize, reduce, or remove underlying risk factors; monitor the impact of the interventions; and modify the interventions as appropriate, including emergency situations.

The Facility's Nursing Rehab Policy, dated 11/06, documents, It is the policy of the facility to provide a program to assist the resident to achieve and maintain the maximum level of function physically, mentally, and socially.

33112

3. R52's Face Sheet, print date of 12/5/24, documents R52 was admitted on [DATE] and has diagnoses of Parkinsonism and Neurocognitive disorder with Lewy Bodies.

R52's Minimum Data Set, dated dated [DATE], documents R52 has moderate cognitive impairment and requires set up clean-up assistance with dining.

(continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R52's Care Plan, dated 11/11/22, documents, Resident Care Information. Approach: Regular Diet, thin liquids. Assistance for eating; set up tray Adaptive Equipment; Kennedy cups; curved spoon takes meals in main dining room. On12/2/24 at 12:25 PM, R52 was served her lunch of Salisbury steak, corn, and mashed potatoes. No staff offered to open up her silverware or cut up her meat. R52 sat and stared at her plate, and holding her rolled up silverware. At 12:35 PM, R52 was trying to cut up her meat. R52 was unsuccessful. R52 was placing the knife on top of the Salisbury steak and trying to get the knife up to her mouth and lick the knife. R52 was unsuccessful. R52 was attempting to eat her mashed potatoes with her knife. R52 backed away from her table in her wheelchair. R52 pushed with her feet backwards to the middle of the dining room. No staff attempted to redirect her or encourage her to eat. At 12:57 PM, R52 asked staff to cut up her meat. V10, Certified Nurses Aide (CNA), stated she could do it for her, and did. V10 walked away. R52 was unable to get the food into her mouth. At 1:16 PM, V4, Registered Nurse (RN), asked R52 if she was done. R52 stated No, I can eat more. V4 asked R52 if she needed help, R52 stated Yes. V4 gave her 3 bites while standing up at her side. R52 then tried to feed herself again. V4 then pushed her wheelchair closer to the table and walked away. R52 tried to feed herself. V4, from across the room, said, Hold up you're really struggling today let me help you, and pulled up a chair and began to feed her. On 12/9/24 at 8:30 AM, V1, Administrator, stated the facility does not have a feeding policy, but she would expect staff to assist any resident with eating if they needed it.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32874 Based on observation, interview, and record review, the facility failed to provide timely treatment for 1 of 3 residents (R68) reviewed for change of condition in the sample of 33. This failure resulted in R68 delay in treatment and requiring hospital admission. Findings include: 1. R68's nursing notes, dated 12/01/2024 at 10:17 AM, documents attempted to contact radiology for x-ray results and left message on answering machine. R68's nursing notes, dated 12/1/2024 at 1:23 PM, documents, contacted Nurse Practitioner unable to obtain x-ray results and resident continues with decline in physical mobility, cough with yellow sputum, afebrile, wheezing bilateral upper lobes. and received NO (nurse order) for Ceftriaxome IM QD (daily) x 3 days. CBC (complete blood count) and CMP (comprehensive metabolic profile) on Monday 12-02-24. R68s' nursing notes, dated 12/01/2024 at 11:13 PM, documents, resident experiencing nasal congestion, denies dyspnea or shortness of breath. Resident afebrile at 98.4 F. Diffuse wheezing auscultated to bilateral lungs. Resident denies experiencing a productive cough. Resident has brisk capillary refill with no cyanosis present. HOB elevated pulse oximetry at 98% on room air. R68's final x-ray results, dated 12/2/2024 at 7:41AM, documents minimal bibasilar airspace disease, may represent atelectasis, aspiration or pneumonia. R68's nursing notes, dated 12/02/2024 at 09:02 AM, documents, resident noted to have increase in weakness requiring use of sit-stand. He continues to have cough, congestion, and wheezing heard in upper and bilateral lobes. Vitals were 145/77, 89% on RA (Room air), (initiated PRN oxygen at 2L) , T (Temperature):100, RR (Respiratory Rate) 20 (Pulse), P 77. He states during exertion he is SOB (Short of breath) but not at rest. Resident placed into isolation r/t (related to) s/s (signs and symptoms) and awaiting test at this time. On 12/2/2024 at 10:33AM, R68 stated, I am sick that is why I am in isolation R68's Hospital history and physica,l dated 12/2/2024 at 4:11PM, documents coarse lung sounds throughout with diffuse expiratory wheeze. Complaint community acquired pneumonia. R68's hospital admission history and physical documents R68 complains of body aches, weakness and non -productive cough. R68's history and physical documents assessment and plan ; community acquired pneumonia, supplemental oxygen via nasal cannula, titrate as able, vitals every 4 hours, respiratory failure. On 12/5/2024 at 12:50PM, V1, Administrator, stated she took R68 to the local hospital for an X-ray on Saturday 11/30/2024, as (x-ray company) could not be at facility until Monday. V1 stated when called hospital for x-ray results were told x-ray results not be read until Monday. V2 stated X-ray results came in sometime on Monday. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility policy Change in a resident's condition, revised 12/02, documents, the facility shall promptly notify the resident, and /or residents's representative, and his or her attending physician of changes in the resident's condition and/or status. The policy documents the nurse will notify the resident's attending physician when there is a significant change in the resident's physical , mental , or psychosocial status; deemed necessary or appropriate in the best interest of the resident. The facility policy diagnostic service dated revised 11/28/17 documents provision has been made for promptly and conveniently obtaining required clinical laboratory , x-ray and other diagnostic services from clinical laboratory or diagnostic service, physicians office or hospital.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44967 Based on interview, observation, and record review, the facility failed to provide timely and complete incontinence care, including proper hand hygiene and glove changes for 5 of 5 residents (R8, R34, R36, R46, R76) reviewed for incontinence care in the sample of 33. The findings include: 1. R8's Face Sheet, undated, documents R8 was admitted to the facility on [DATE], with diagnoses of Need for assistance with personal care, muscle weakness/wasting and atrophy, Lack of coordination, Generalized anxiety disorder, Depression, Vitamin deficiency, and Chronic obstructive pulmonary disease. R8's Care Plan, dated 11/11/24, documents R8's Resident Care Information: R8 is to be assessed for incontinence of bowel and bladder every 2 hours, Bowel and Bladder: Incontinent x2 assist, Incontinence Products Briefs: standard XL brief, Offer bed pan for toileting. R8's Minimum Data Set (MDS), dated [DATE], documents R8 is cognitively intact and is dependent on staff for other Activities of Daily Living (ADLs). R8 is always incontinent of both bowel and bladder. On 12/2/24 at 11:50 AM, V6, Certified Nursing Assistant (CNA), in to provide incontinent care to R8. V6 donned gloves and searched every drawer for wipes, and was unable to find any, so doffed her gloves and left the room, then came back with wash cloths and put them into the sink. V6 donned gloves again and unfastened R8's brief and tucked it between her legs, V10, CNA, came in to help, with no hand hygiene while she donned gloves, and began wiping R8's groins, folded the wash cloth, then wiped once down the middle of R8's vagina, then R8 was rolled to her left side, showing stool. V6 used a wet wash cloth and wiped R8's anal area, then realized they needed more wash cloths, so V10 left the room to obtain more, came back in the room with no hand hygiene seen done, V10 donned gloves, wet more cloths from the sink and handed them to V6 and V6 wiped R8's anal area and Right buttock, then rolled R8 to the right, and the soiled brief and linen removed from under R8. There was no wiping of R8's left buttock, which had small amount of feces seen. R8 was then rolled to her back and the brief secured. There was no drying of R8 at any time during incontinence care. Both CNAs doffed their gloves, with no hand hygiene after care and before leaving the room. 2. R34's Face Sheet, undated, documents R34 was admitted to the facility on [DATE], with diagnoses of Atherosclerotic heart disease (ASHD), Anemia, Malignant neoplasm of skin, Atrial fibrillation, Weakness, Hypertension, and Hyperlipidemia. R34's Care Plan, dated 11/26/24, documents R34's Resident Care Information: Bowel and Bladder: Continent Toileting: Assist of two, Incontinence Products: XL Incontinence brief. R34's MDS, dated [DATE], documents R34 is cognitively intact and is dependent on staff for ADLs, including toileting. R34 is always incontinent of both bowel and bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/2/24 at 12:26 PM, R34 was lying in bed with V10, CNA, and V6, CNA, getting ready to do incontinent care on R34. R34's brief was unfastened and tucked between his legs. V10 had a few washcloths and wet them from running water in the sink, then used the wet washcloths to wipe R34's peri-area, both groins, his testicles, and the shaft of R34's uncircumcised penis. At no time was R34's foreskin retracted and penis properly cleaned. R34 was turned to his right and the soiled brief was removed, then V10 wiped R34's anal area and buttocks, and applied a new brief to R34. Both CNAs doffed their gloves, then put R34's pants on him. There was no hand hygiene seen done before care, during glove changes, or after care, or before leaving the room. There were only wet washcloths with no cleansing product used during incontinent care. 32874 3. R36's Minimum data set (MDS), dated [DATE], documents R36 is dependant on staff for toileting. R36's MDS documents R36 is always incontinent of stool and urine. R36's care plan, dated 10/27/2021, documents R36 is at risk for skin injury related to poor nutritional intake, incontinence. R36's care plan documents document incontinent care after each incontinent episode. On 12/03/24 at 11:25AM, during incontinent care, R36 was turned to right side by V14, CNA. V14 washed V14's hands with soap and water, then donned gloves. R36 was incontinent a large amount of stool extending into vaginal area. V14, CN,A with folded wash cloth, wiped down R36's left groin, then folded wash cloth and cleaned right groin. V14, with clean wash cloth, then wiped down R36's peri area, and did not separate the labia to clean. 4. R46's cae plan, dated 9/17/2024, documents R46 has had multiple UTI's in the past 12 months. R46's care plan documents assist R46 with peri care after each use of restroom. On 12/03/24 at 9:58AM V8, CNA, entered room, placed gait belt on R46, assisted R46 to stand with walker, and walked to bathroom within room . V8 removed adult diaper which had stool in it, as verified by V8. V8 then took clean wipes standing behind R46 at back of stool and swiped from from to back twice, then got another wipe and cleansed rectal area. V8 then removed gloves and donned new gloves and swiped from front to back of R46's peri area. V8, CNA, then wiped buttock and pulled up adult brief. V8, CNA, did not separate the labia during care, or dry R46. 42108 5. R76's Care Plan, dated 9/11/2024, documents, Problem: Resident Care Information Approach: Bowel and Bladder: incontinent of both bowel and bladder, wears large (incontinence briefs). It also documents, 11/26/2024 Problem: (R76) has a UTI (Urinary Tract Infection). R76's MDS, dated [DATE], documents R76 is severely cognitively impaired, always incontinent of bowel and bladder, and dependent on staff for toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/5/2024 at approximately 12:45 PM, V25, Certified Nurse Assistant (CNA), and V26, CNA, performed toileting for R76. R76 was incontinent of urine. V26 and V25 assisted R76 into the standing position. V26 then pulled R76 pants and undergarment down. V26 then removed the urine soiled undergarment and placed in the trash. V26 then assisted R76 into the sitting position on toilet. V26 and V25 left the room. At 12:50 PM, V25 and V26 returned and assisted R76 with toileting. V26 applied incontinent brief. V25 and V26 assisted R76 into a standing position. Using a wet wipe, V26 wiped R76's buttocks 3 times, and pulled R76's incontinent brief and pants up. On 12/5/2024 at 12:51 PM, V26, stated she (V26) was not sure R76 used the toilet. On 12/5/2024 at 12:51 PM, V25 stated she (R76) usually voids during transfer to toilet. On 12/9/2024 at approximately 11:00 AM, V2, Director of Nursing, stated she expects staff to perform incontinent care on a resident if they are incontinent, even if they use the toilet afterwards. On 12/9/2024 at 12:15 PM, V16, Licensed Practical Nurse/LPN, stated she would expect the staff to cleanse all areas of incontinence and follow the policy. V16 stated she would expect them to cleanse the peri and groin area, labia, penis, buttocks, and all areas that urine would touch. V16 stated even if the resident voided after being incontinent, she would expect incontinent care to be performed. On 12/9/2024 at 12:27 PM, V11, CNA, stated when cleansing a resident, she cleanses all areas of incontinence. V11 stated if the resident is incontinent and voids on the toilet, she performs incontinent care including the labia, penis, peri area, inner thighs, both buttocks, any area that the urine would touch. The Facility's Perineal Care Policy, dated 11/2018, documents, Objective: 1. To cleanse the perineum. 2. To prevent infection and odors. Equipment: 1. Washbasin. 2. Disposable gloves. 3. Soap and water or perineal cleanser or disposable peri-care wipes. 4. Clean washcloths. 5. Bath towel. 6. Incontinent underpad. 7. Skin care product. Procedure: 1. Explain the procedure to the resident and bring equipment to the bedside, screen resident for privacy. 2. expose perineal area. 3. Wash hands and put on disposable gloves. 4. Wash perineal area with soap and water, perineal cleanser or wipes. Begin cleansing from cleanest area in front to the most soiled area in back. Be sure that a clean surface of the washcloth is used for each wipe. On a female resident, clean the labia and its folds first. On a circumcised male resident, was the skin folds at the top of the penis using a circular motion. begin at the urethra and work downward. On an uncircumcised male resident, pull back the foreskin and wash the tip of the penis. carefully return the foreskin to its natural position. Be sure to clean from front to back. 5. After cleansing is complete, rinse if necessary, and then dry the resident by patting skin gently with a clean bath towel if using perineal cleanser and or soap and water. No necessary to pat dry resident if using wipes. 6. Apply skin care product to skin. 7. Remove gloves and wash your hands. 8. Assist resident to a comfortable position. 9. Observe condition of resident's skin and report any significant findings to nurse. The Facility's Proper Hand Washing Procedure, undated, documents Proper handwashing is the most effective way to reduce microorganisms to prevent the spread of infection. Total [NAME] for effective hand washing should take 20 seconds. When to wash hands: Employees must wash their hands: After removing disposable gloves, after engaging in any activity that would contaminate hands, after touching anything that contaminates hands.

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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** 44967 Based on observation, interview, and record review, the Facility failed to provide supplemental shakes as ordered for 1 of 5 residents (R41) reviewed for nutrition and feeding assistance in the sample of 33. The findings include: 1. R41's Face Sheet, undated, documents R41 was originally admitted to the facility on [DATE], with diagnoses of Generalized muscle weakness/wasting, falls, Lack of coordination, Hemiplegia/Hemiparesis affecting left side, Cerebral infarction, Trans Ischemic Attack (TIA), Anxiety disorder, Sacroiliitis, Right artificial shoulder joint, HTN, Anemia, GERD, Atrial Fibrillation, Chronic Kidney Disease (CKD) - stage 3, and prediabetes. R41's Care Plan, dated 11/15/24, documents R41 has had a 9% weight loss over 90 days. Interventions: Offer R41 house supplement with breakfast and lunch. It continues 9/18/24: Resident Care Information: Mobility: X1. Encourage ambulation to and from meals with staff assist. Regular diet/thin liquids Assistance for eating: set up; feeds self. R41's Minimum Data Set (MDS), dated [DATE], documents R41 is cognitively intact and is independent for eating. R41's Nutritional Assessment, dated 9/19/24, documents Feeding Capabilities: Independent/Supervised. R41's Physician Order (PO), dated 8/22/24, documents, Weekly Weight. Once A Day on Fri. R41's PO, dated 5/29/24, documents, Regular Diet. R41's PO, dated 11/15/24, documents, House Supplement 4oz with breakfast and lunch. R41's Electronic Medical Record, under Vitals - Weights: 12/6/24 - 125lbs (pounds), 11/29/24 - 125lbs, 11/15/24 - 128.6lbs, 11/8/24 - 127.6lbs, 11/4/24 - 131lbs, 11/1/24 - 130.8lbs, 10/25/24 - 130.1lbs, 10/18/24 - 130.2lbs, 10/11/24 - 131.8lbs, 10/9/24 - 131lbs, 10/1/24 - 130lbs, 9/27/24 - 130lbs, 9/20/24 - 133lbs, 9/15/24 - 133lbs, 9/11/24 - 129.6lbs, 9/10/24 - 129.6lbs, 8/23/24 - 134lbs, 8/7/24 - 144lbs, 6/26/24 - 145lbs, 6/4/24 - 146lbs, 5/22/24 - 141lbs, 5/15/24 - 144.8lbs, 5/8/24 - 142.8, 5/7/24 - 146lbs, 5/1/24 - 143.2lbs, 4/24/24 - 144.8lbs, 4/17/24 - 144.8lbs, 4/4/24 - 151.4lbs, 4/3/24 - 153.8lbs, 4/1/24 - 160lbs, Admission Weight 3/27/24 161.2lbs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145837	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's Dietary Note, dated 4/23/24 at 3:37 PM, documents, RD (Registered Dietitian) eval (evaluation) for new admit and wt (weight) loss. Nutrition related medical history includes recent pneumonia, CKD (chronic kidney disease) and prediabetes. Nutrition related med (medication) use includes Vit (vitamin) D3, psychotropics, MVI (multivitamin). Edema none found documented as present: Lab review, abnormal results: Per 4/17 lab report-glucose high, sodium, albumin an H/H (hemoglobin/hematocrit) low. Ht (height) 59 (inches) 3/27 admit wt 161.2# (pounds), 4/17 wt 144.8# BMI (body mass index) 29.24. Wt loss of 10.2% notes since 3/25 admit. 4/7 wt entry for 227.6# is not correct, request nursing to remove and/or correct wt entry to prevent future wt triggers. Diet is regular with Ensure 120ml (milliliters) BID (twice a day). Feeding ability: self. Nutrition needs calculated using AdjBW (adjusted body weight) of 158#- 1848 calories (28), 79 grams protein (1.2) and 1650 ml fluid (25 CKD). Skin: no pressure wounds reported/documented as present. No changes at this time as overall wt per BMI remains acceptable. Monitor and f/u (follow up) as indicated. R41's Dietary Note, dated 6/29/24 at 11:51 AM, documents, RD eval for new admit. Resident previously d/c (dis charged) home, admitted after recent hospitalization . Nutrition related medical history includes CKD and prediabetes. Nutrition related med use includes psychotropics, MVI. Lab review, abnormal results: no new for review. Ht 59 5/29 admit, 6/4 wt 146#, 6/26 wt 145# BMI 29.28. Wts stable since admit. Diet is regular. Feeding ability: self. Nutrition needs calculated using CBW- 1848 calories (28), 66 grams protein (1) and 1650 ml fluid (25 CKD). Skin: no pressure wounds reported/documented as present. No changes at this time, Monitor and f/u as indicated. R41's Dietary Note, dated 8/20/24 at 1:32 PM, documents, RD eval for wt loss as referred by facility. Ht 59 8/7 wt 144# BMI 29.08-overwt (overweight). Some wt loss 10.7% noted since original admit in March 2024. Wts have been stable since last admit 5/29. Diet is regular. No supplements in use. No changes at this time as overall wt per BMI remains acceptable. Monitor and f/u as indicated. R41's Dietary Note, dated 10/22/24 at 1:26 PM, documents, RD eval for Oct wt loss. Ht 59 10/1 wt 130# with wt loss of 10.3% x 90 days and 14.1% x 180 days. 10/18 wt 130.2# BMI 26.29. History of gradual wt loss, wts currently stable x 2months. Regular diet. Past intakes appear not to be meeting needs. Overall wt per BMI remains acceptable. Rec (recently) adding house supplement with breakfast and lunch for additional support, goal is to prevent further wt loss. Monitor and f/u as indicated. R41's Administrator Note, dated 11/8/24 at 9:45 AM, documents, Resident triggered for a weight loss @ (at) 90 days. Supplemental shakes requested TID (three times daily). MD notified, will monitor weekly. R41's Nursing Note, dated 12/6/24 at 10:17 PM, documents, Resident was awake propelling herself throughout the halls in her wheelchair until dinner time. She then returned to bed. She did not eat dinner because she never eat dinner per her statement. Fluids encouraged. On 12/2/24 at 1:00 PM, R41 was seen sitting in her room eating lunch (salisbury steak, mashed potatoes with gravy) on a normal plate and regular utensils. R41 was trying to use a fork to eat while her hands were shaking and her food was falling off the fork and all over. There was no supplemental shake seen on her lunch tray. V12 and V13, R8's Daughters, were visiting, and brought in pizza for R8 and R41 to eat, and stated R8 and R41 should not use a fork to eat because they shake so much, the food just falls off and flies all over the room. V12 and V13 stated no one ever helps either R8 or R41 to eat. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 1:00 PM, R41 was seen in the dining room with regular plate and silver ware. R41 had a ham sandwich and was just eating the pieces of ham. R41 had a cup of juice and a cup of milk in front of her. There was no supplemental shake seen on her lunch tray. V24, CNA, stated, (R41) uses a sippy cup ([NAME] Cup) because she shakes so bad and can't use a regular cup. (R41) usually gets finger foods, such as sandwiches and such, so she can use her fingers to eat. (R41) is on a regular diet with regular texture. (R41) has a cup of juice and a cup of milk with her lunch today. V24 stated she is not aware of R41 getting any kind of supplement, and she doesn't see one with her lunch. On 12/9/24 at 12:20 PM, R41 was seen sitting at the dining room table eating spaghetti with a normal plate and normal utensils. R41 was seen shaking badly with spaghetti falling off her fork. R41 was picking up her piece of garlic bread and eating it, after trying to eat the spaghetti with a fork. On 12/9/24 at 12:22 PM, V28, Licensed Practical Nurse (LPN), was seen assisting other residents with feeding. When asked about R41 needing assistance, V28 stated, I don't normally work with (R41), but I can see she does shake badly. V28 asked V37, LPN, about R41 needing feeding assistance. V37 walked up to R41 and asked her if she needed help and R41 stated, No. R37 walked away without assisting R41. On 12/9/24 at 12:45 PM, R41 was seen leaving her dining room table with minimal amount of spaghetti eaten, and most of her piece of garlic bread. The Facility's Special Needs Policy, dated 11/28/17, documents, To address special needs, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Purpose: to properly provide routine and emergency care and treatment to residents with special needs pertaining to parenteral fluids, respiratory care, prostheses, and dialysis. Procedure: 1. Comprehensive care plans will be developed based on resident assessments, goals, and preferences in accordance with assessment and care plan procedures. 2. The facility will utilize a systematic approach for the management of special needs, including efforts to identify risk; stabilize, reduce, or remove underlying risk factors; monitor the impact of the interventions; and modify the interventions as appropriate, including emergency situations. The Facility's Nursing Rehab Policy, dated 11/06, documents, It is the policy of the facility to provide a program to assist the resident to achieve and maintain the maximum level of function physically, mentally, and socially.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to maintain communication with dialysis center and check patency of a dialysis shunt for 1 of 2 residents (R55) reviewed for dialysis in the sample of 33. Finidngs include: R55's Face Sheet, print date of 12/5/24, documents R55 was admitted on [DATE] and has a dependence on renal dialysis. R55's Minimum Data Set, dated dated [DATE], documents R55 is cognitively intact. R55's Care Plan, dated 9/9/24, documents, Problem (R55) has end stage renal disease that requires HD (hemodialysis). Approach: Monitor dialysis port / shunt for bleeding. If profuse or quick bleeding, apply direct pressure and contact EMS (Emergency Medical Services). On 12/2/24 at 1:11 PM, R55 stated the Dialysis Center does not use his right arm shunt. He stated it hurts too bad and they use his chest access. R55 stated the staff do not check his shunt. On 12/3/24 at 1:57 PM V28, Licensed Practical Nurse (LPN), stated, There is no written communication between the facility and the dialysis center. (R55) does not take any paperwork with him and he doesn't bring any back. If I need to know a weight, I have to call them. He does not let the Dialysis Center use his right arm shunt. He says that it hurts to much. It is a new shunt that works just fine. He says it hurts to much so they are using the one in his chest. On 12/5/24 at 1:35 PM, R55 stated he never takes paperwork to dialysis or brings any back unless a medication has been changed. On 12/5/24 at 1:50 PM, V2, Director of Nursing, stated, I am not sure if the nurses chart on dialysis fistulas. The dialysis fistula should be checked for a bruit and thrill. There is a paper for communication between us and the Dialysis Center but getting the Dialysis Center to cooperate is difficult. On 12/9/24 at 8:14 AM, V28 stated, I usually do check (R55's) fistula. I am not sure what the other nurses do. V26 was questioned where she charts on the fistula, V26 stated, There isn't a place to chart it but you bring up a good point. I will get that added to the TAR (treatment administration record). R55's Electronic Medical Record fails to document the condition R55's right arm dialysis shunt. The policy Special Needs, dated 11/28/2027, documents, Purpose 1. to properly provide routine and emergency care and treatment to residents with special needs pertaining to parental fluids, respiratory care, prostheses, and dialysis. It continues, The facility will communicate relevant information with outside providers to ensure safe, continuous care of the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32874 Based on observation, interview, and record review, the facility failed to administer correct dose of medication . There were 28 opportunities with 2 errors resulting in 7.14% medication error rate. The errors involved R41 in the sample of 3 observed during medication administration. Findings include: 1. On 12/3/2024 at 8:35AM, during medication administration, V4, Registered Nurse (RN), handed R4 nasal spray, and R4 was unable to administer. V4, RN, then sprayed one spray of fluticasone propionate nasal spray in each nostril. V4 then removed container of psyllium husk from medication cart. V4 then poured medication in medication cup measuring 30 Milliliters (ML). V4 then asked surveyor if correct dose. V4 then poured psyllium husk back in container and administered one teaspoon (tsp) in glass of water to R41. On 12/05/24 at 10:39 AM, V20, Licensed Practical Nurse (LPN), stated R41's nasal spray fluticasone proprionate is to be administered 2 sprays each nostril. V20, LPN, stated when administering Psyllium husks R41 is to receive 30 cc in med cup. R41's Physician Order (PO), with start date 5/29/2024, documents fluticasone propionate 50mcg; 2 sprays each nostril. R41's physician order, dated 9/19/2024, documents psyllium husk powder 3.4 grams/5.4grams amount : 30 grams total oral once a day R41's face sheet, dated 12/5/2024, documents in part a diagnosis of constipation. The facility policy medication administration, dated 2/04, documents all medications must be administered to the resident in the manner ad method as prescribed by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42108 Based on observation, interview, and record review, the facility failed to properly store medication, label tuberculin vial, and maintain medication carts locked. This has the potential to affect all 80 residents living in the facility. Findings include: 1. On 12/2/2024 at 10:30 AM, Memory Lane medication Cart was observed unlocked and out of sight of nurses. 2 nurses observed sitting at the nurse's station with back to medication cart. On 12/9/2024 at approximately 11:00 AM V2, Director of Nursing, stated she expects the medication carts to be locked when not in use. 44967 2. On 12/2/24 at 11:45 AM, V4, Registered Nurse (RN), was seen walking away from her med cart, which was unlocked, and computer screen open to resident, sitting next to nurses desk and by dining room. V4 opened the med room and attempted to open fridge, but could not find a key that would open the fridge.V4 contacted Director of Nursing (DON), attempted keys from other floor, and still not able to open. On 12/2/24 at 12:22 PM, Maintenance was called to cut lock off when the DON came with keys that she had in her office and opened the fridge. Upon opening, there was a vial of Tuberculin (TB) in the fridge with a label on the vial indicating it was for the facility stock with a delivered date of 9/27/24. The vial and the box was opened and not dated, the vial appeared half full. On 12/2/24 at 1:05 PM, V4, RN, stated, The TB vial in the fridge is used for both staff and residents. If I would find it undated to when it was opened, I would discard it. When told it does not have a date opened, V4 stated, I will go throw it away now and let the Infection Prevention nurse know to replace it. On 12/9/2024 at 12:15 PM, V16, Licensed Practical Nurse/LPN, stated the medication carts are to be locked when not in use. V16 stated when the TB is opened, an open date is applied. V16 stated TB is good for 30 days after opening, and the open date is important because it tells when that discontinue date is. V16 stated the mult dose TB vial is used for all residents and is a stock medication The Tuberculin Purified Protein Derivative (Mantoux) Tubersol package insert, dated April 2016, documents, A vial of TUBERSOL which has been entered and in use for 30 days should be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Pharmaceutical Procedures policy, dated 1/5/23, documents, IV. Procurement and Labeling of Drugs: Drug Labeling: E. Each floor stock container shall bear the name and strength of the medication, lot and control number, expiration date (when applicable), and any other appropriate accessory or cautionary information. V. Care and Storage of Medications A. Drug supplies for the facility shall be stored under proper conditions of sanitation, temperature, light, refrigeration, and moisture. B. Residents' medications shall be properly labeled and stored at or near the nurses' station in: 1. a locked cabinet, or 2. a locked medication room, or 3. one or more locked mobile medication carts. All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored safely and securely - either in a locked room or otherwise made immobile.

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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. 33112 Based on interview, observatoin, and record review, the facility failed to store food products and wash hands to prevent food borne illness. This failure has the potential to affect all 80 residents living in the facility. Findings include: On 12/02/24 at 8:56 AM, the kitchen was entered for initial tour. A large plastic storage container of flour did not have a lid on it. A large plastic storage container of roll oats and thickener both had a measuring cup in them with the handles in the product. A bag of brown sugar has a measuring spoon in it laying on top of the brown sugar. In the walk in refrigerator on the bottom shelf there is a box of beef on top of a box of pork which is on top of box of pork. These 3 boxes are not separated by drip tray. On 12/5/24 at 11:37 AM, V22, Dietary Aide, donned gloves with no hand hygiene, made a grilled cheese sandwich, removed gloves, put bread away, went to the walk-in refrigerator and put cheese away, came out of the walk-in and removed gloves, and washed hands. On 12/5/24 at 11:53 AM, V22 grabbed a glove and entered the walk-in refrigerator. V22 came out of the walk-in refrigerator with a large bag of chopped lettuce and a large bag of cheese. V22 put on one glove, reached into the lettuce and got a handful and placed it in bowl, then reached into the bag of cheese and got a handful and placed it in the bag. V22 removed her glove, got a new glove, went to the walk in refrigerator, and came out holding 2 frozen chicken patties, placed them in the air fryer, and removed her gloves. On 12/5/24 at 12:00, V23, Dietary Aide, with his bare hand, rubbed the end of his nose, took a food tray, put the food tray back on the service line, removed the plate of food, place it on a new food tray, got a soda can, and fruit salad, and served it to the dining room. On 12/2/24 at 9:10 AM, V3, Kitchen Manager, stated the storage bins should not have measuring cups or spoons stored in them. She stated she will fix the meat in the walk in refrigerator. On 12/9/24 at 8:14 AM, V1, Administrator, stated the facility does not have a policy on how to defrost meat in the the refrigerator, kitchen staff hand hygiene, or glove use. V1 stated she expects staff to not stack boxes of different meats on top of each other while in the refrigerator, and staff should wash their hands before donning gloves and after removing gloves. The Application of Medicare and Medicaid, dated 12/5/24, documents the facility has 80 residents living in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to perform hand hygiene, change gloves, and properly store soiled lines for 7 of 8 (R8, R34, R36, R46, R64, R73, R76) reviewed for infection control in the sample of 33. Findings include: 1. R64's Face Sheet, print date of 12/5/24, documents R64 was admitted on [DATE] and has a diagnosis of Dementia. On 12/03/24 10:27 AM, V9, Certified Nurses Aide (CNA), and V10, CNA, entered R64's room to provide incontinent care for R64. R64's incontinent brief was removed. It had a small amount of feces. V9 cleansed the rectal area, buttocks, changed gloves with no hand hygiene in between, cleansed the peri area, changed gloves with no hand hygiene in between, and placed a new incontinent brief on R64. 2. R73's Face Sheet, print date of 12/3/24, documents R73 was admitted on [DATE] and has diagnosis of Dementia with psychotic disturbance. On 12/2/24 at 11:30 AM, V32, CNA, and V33, CNA, entered R73's room to provide incontinent care and to turn and reposition R73. R73's soiled adult incontinent brief was removed. It was soiled with feces. V32 cleansed R72's penis with pre moistened peri-wash cloths, rolled R73 over on to his right side, and with pre-moistened prewash cloths, R73's rectal area and buttocks were cleansed. V32 removed her gloves, got a wash cloth wet and put liquid soap on it, donned new gloves, cleansed the scrotum of feces, then dried the rectal area, buttocks, and scrotum. V32 placed a new incontinent brief. V32 and V33 both changed gloves without hand hygiene, positioned R73 for comfort. During the care, V33 threw the soiled sheet and bed pad on the floor. V33 placed the soiled items in a bag removed her gloves, failed to perform hand hygiene, and then left the room. On 12/9/24 at 10:47 AM, V2, Director of Nursing, stated staff should preform hand hygiene before donning gloves, between glove changes, and after removing gloves. V2 stated that soiled linens should not be thrown on the floor. 32874 3. On 12/03/24 at 11:25AM, during incontinent care on R36, V8, CNA, with gloved hands, wet wash cloths. V8 wiped front to back, and with visible stool on gloves of right hand, V8 used left hand to remove glove from right hand . No hand sanitizing done prior to donning new right glove. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 12/03/24 at 9:58AM, V8, CNA, entered room and placed a gait belt on R46, assisted R46 to stand with walker, and walked R46 to bathroom within room. V8, CNA, donned gloves V8 did not sanitize hands prior to donning gloves. V8 placed adult diaper and wipes on back of stool; adult diaper fell on floor. V8, CNA, doffed gloves and got another diaper from drawer. V8, CNA, did not sanitize hands prior to removal or donning new gloves. V8 removed adult diaper, which had stool in it, as verified by V8, CNA. V8 removed gloves; did not sanitize hands prior to donning gloves. V8 then took clean wipes standing behind resident at back of stool and swiped from from to back twice then got another wipe and cleansed rectal area. V8 then removed gloves and donned new gloves without sanitizing hands. 42108 5. R76's Care Plan, dated 9/11/2024, documents Problem: Resident Care Information Approach: Bowel and Bladder: incontinent of both bowel and bladder, wears large pull ups. It also documents 11/26/2024 Problem: (R76) has a UTI (Urinary Tract Infection). R76's MDS, dated [DATE], documents R76 is severely cognitively impaired, always incontinent of bowel and bladder and dependent on staff for toileting. On 12/5/2024 at 12:45 PM, V25, Certified Nurse Assistant (CNA), and V26, CNA, performed toileting for R76. R76 was incontinent of urine. V26 and V25 applied gloves and assisted R76 into the standing position. R76 was incontinent of urine. V26 then removed the urine soiled undergarment and placed in the trash. V26 then assisted R76 into the sitting position on toilet. V26 and V25 removed gloves and left the room. At 12:50 PM, V25 and V26 returned and assisted washed hands, applied gloves and R76 with toileting. V26 applied incontinent brief. V25 and V26 assisted R76 into a standing position. Using a wet wipe, V26 wiped R76's buttocks 3 times. Using the same soiled gloves, V26 pulled R76's clean incontinent brief and pants up. On 12/9/2024 at 12:15 PM, V16, Licensed Practical Nurse/LPN, stated she expects the staff to use good hand hygiene and change gloves as appropriate. On 12/9/2024 at 12:27 PM, V11, CNA, stated when cleaning a resident the gloves are changed after touching soiled and before touching clean undergarments and clothing. 44967 6. R8's Face Sheet, undated, documents R8 was admitted to the facility on [DATE], with diagnoses of Cerebral infarction, Fracture of left humerus, Cellulitis, Morbid obesity, Urinary incontinence, Cardiomegaly, Malignant neoplasm of endometrium, Chronic Kidney Disease -stage 2, Hemiplegia, Aphasia, Urinary Tract Infection, and Type 2 Diabetes Mellitus. R8's Care Plan, dated 11/11/24, documents R8 Resident Care Information: R8 is to be assessed for incontinence of bowel and bladder every 2 hours, Bowel and Bladder: Incontinent x2 assist, Incontinence Products Briefs: standard Xl brief, Offer bed pan for toileting. R8's MDS, dated [DATE], documents R8 is cognitively intact and is dependent on staff for other ADLs. R8 is always incontinent of both bowel and bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/2/24 at 11:50 AM, V6, CNA, provided incontinent care to R8. V6 donned gloves and searched every drawer for wipes and was unable to find any, so V6 doffed her gloves and left the room, then came back with wash cloths and put them into the sink. V6 donned gloves again and unfastened R8's brief and tucked it between her legs. V10, CNA, came in to help. No hand hygiene was done while she donned gloves. V10 began wiping R8's groins, folded the wash cloth, then wiped once down the middle of R8's vagina, then R8 was rolled to her left side, showing stool. V6 used a wet wash cloth and wiped R8's anal area, then realized they needed more wash cloths, so V10 left the room to obtain more, came back in the room with no hand hygiene done. V10 donned gloves, wet more cloths from the sink and handed them to V6, and V6 wiped R8's anal area and right buttock, then rolled R8 to the right, and the soiled brief and linen removed from under R8. There was no wiping of R8's left buttock, which had small amount of feces. R8 was then rolled to her back and the brief secured. There was no drying of R8 at any time during incontinence care. Both CNAs doffed their gloves with no hand hygiene done after care and before leaving the room. 7. R34's Face Sheet, undated, documents R34 was admitted to the facility on [DATE], with diagnoses of Atherosclerotic heart disease (ASHD), Anemia, Malignant neoplasm of skin, Atrial fibrillation, Weakness, Hypertension, and Hyperlipidemia. R34's Care Plan, dated 11/26/24, documents R34's Resident Care Information: Bowel and Bladder: Continent Toileting: Assist of 2, Incontinence Products: XL Pullups. R34's MDS, dated [DATE], documents R34 is cognitively intact and is dependent on staff for ADLs, including toileting. R34 is always incontinent of both bowel and bladder. On 12/2/24 at 12:26 PM, R34, was lying in bed with V10, CNA, and V6, CNA, getting ready to do incontinent care on R34. R34's brief was unfastened and tucked between his legs. V10 had a few wash cloths and wet them from running water in the sink, then used the wet wash cloths to wipe R34's peri-area, both groins, his testicles, and the shaft of R34's uncircumcised penis. At no time was R34's foreskin retracted and penis properly cleaned. R34 was turned to his right and the soiled brief was removed, then V10 wiped R34's anal area and buttocks, and applied a new brief to R34. Both CNAs doffed their gloves, then put R34's pants on him. There was no hand hygiene done before care, during glove changes, after care, or before leaving the room. There were only wet wash cloths with no cleansing product used during incontinent care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145837	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER: Pittsfield Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 610 Lowry Street Pittsfield, IL 62363	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Perineal Care Policy, dated 11/2018, documents Objective: 1. To cleanse the perineum. 2. To prevent infection and odors. Equipment: 1. Washbasin. 2. Disposable gloves. 3. Soap and water or perineal cleanser or disposable peri-care wipes. 4. Clean washcloths. 5. Bath towel. 6. Incontinent underpad. 7. Skin care product. Procedure: 1. Explain the procedure to the resident and bring equipment to the bedside, screen resident for privacy. 2. expose perineal area. 3. Wash hands and put on disposable gloves. 4. Wash perineal area with soap and water, perineal cleanser or wipes. Begin cleansing from cleanest area in front to the most soiled area in back. Be sure that a clean surface of the washcloth is used for each wipe. On a female resident, clean the labia and its folds first. On a circumcised male resident, was the skin folds at the top of the penis using a circular motion. begin at the urethra and work downward. On an uncircumcised male resident, pull back the foreskin and wash the tip of the penis. carefully return the foreskin to its natural position. Be sure to clean from front to back. 5. After cleansing is complete, rinse if necessary, and then dry the resident by patting skin gently with a clean bath towel if using perineal cleanser and or soap and water. No necessary to pat dry resident if using wipes. 6. Apply skin care product to skin. 7. Remove gloves and wash your hands. 8. Assist resident to a comfortable position. 9. Observe condition of resident's skin and report any significant findings to nurse. The Facility's Proper Hand Washing Procedure, undated, documents Proper handwashing is the most effective way to reduce microorganisms to prevent the spread of infection. Total [NAME] for effective hand washing should take 20 seconds. When to wash hands: Employees must wash their hands: After removing disposable gloves, after engaging in any activity that would contaminate hands, after touching anything that contaminates hands.