STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aledo Rehab & Health Care Center	304 S.W. 12th Street Aledo, IL 61231

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32189 Based on interview and observation, the facility failed to ensure resident's clothing was labeled in a dignified manner. This failure has the potential to affect all 44 residents to reside at the facility. Findings include: During a tour of the Laundry Department on 6/3/24 at 1:30 PM, V18 (Housekeeping Supervisor) stated the facility no longer provides labels to the residents to identify their clothing. V18 demonstrated a black marker and stated We (housekeeping/laundry staff) have to write the residents name on the inside of their clothing (with the black marker). It's hard because you can't always read it on dark clothing and if there is not a tag (manufacturer tag) we (housekeeping/laundry staff) can write on, there is no way to identify it (clothing). Some of the residents have nicer articles of clothing and it just ruins the piece. V18 demonstrated multiple residents' pieces of clothing which had been washed and hanging on hangers that had the residents name or residents initials written on the collar of shirts. On 6/4/24 at 1:15 PM during the Resident Council Meeting, R147 demonstrated R147's initials written with a black marker on the collar of R147's t-shirt. On 6/4/24 at 1:15 PM during the Resident Council Meeting R147 and R37 stated they have white colored tops that the sharpie has bled through the material and smeared on the fabric. On 6/5/24 at 2:00 PM, R147 was observed in the Administrators office with a gray t-shirt on and black marks (appeared to be letters which had bled through the t-shirt material) were observed on the back collar of the shirt.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. 32189 Based on observation, record review and interview, the facility failed to ensure grievances or recommendations are considered, addressed and acted upon. This failure has the potential to affect all 44 residents who reside at the facility. Findings include: The Resident Grievances/Complaints policy, no date, documents 1. Resident Council meetings are to allow time for Residents to address complaints, grievances and other concerns which shall be reflected in minutes of the meeting. The facility liaison to the Resident Council shall direct complaints and grievances to the appropriate Department Head who will resolve the complaint and/or grievance. The Administrator shall also receive copies of the minutes so he/she can follow up to insure resolution. 6. Grievance and complaint investigations shall be completed within 15 days by the Investigator. 6. The Investigator shall notify the Resident and document the results of the investigation and notification on the grievance/complaint form. The Social Service Director is responsible to notify the family and resident representative of the resolution. The Resident Council Meeting Minutes documented the following complaints/grievances: on 7/3/23, four grievances were filed regarding missing clothes, call lights being turned off and staff not returning for cares, call light response time and maintenance requests not being fulfilled; on 9/11/23, missing laundry; on 10/9/23, missing laundry and the need to retrain housekeeping staff regarding missing laundry and transportation issues (missing appointments); on 11/6/23, missing laundry, need for staff name tags and transportation issues; on12/4/23, missing laundry, no heat in residents rooms and residents missing appointments/transportation issues; on 1/8/24, no heat in dining room, need for staff name tags and missing clothes; on 2/5/24, need for name tags documented as solved and no heat in dining room; undated, missing laundry; on 3/4/24, no heat in dining room documented as solved; on 4/15/24, missing laundry; on 5/13/24, missing laundry and staff name tags, on 6/3/24, ants in building. The following Grievance/Complaint Reports were filed and documented: On 7/5/23 the report documented Residents are reporting missing clothes and still not received after giving laundry a list and Residents reporting that maintenance requests are not being fulfilled; on 2/5/24 the report documented no heat in the dining room; on 5/13/24 the report documented a staff member was not passing medications and each report lacked documentation an investigation was initiated, a resolution was identified and the residents were informed of the resolution; on 4/15/24, the report documented the missing laundry plan of correction was to talk to the Department Director and request that new staff to be retrained on checking residents tags; on 5/13/24, the reports regarding the ants in the building and two report regarding lack of supplies documented the complaints were being taken care of. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/4/24 at 1:30 PM, R32 (Resident Council President) stated the residents don't receive verbal or a written report that a complaint/grievance investigation was initiated and/or feedback about a plan for resolution. R32 stated As the President, I feel our complaints are not heard because we complain about the same things over and over. If I do hear anything about it (complaint/grievance plan for correction), I hear it through the grape vine through the Activity Director.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on interview, observation and record review the facility failed to ensure the resident's memory care unit had warm water and was clean and free of odors for 19 of 42 residents (R2, R3, R4, R7, R8, R10, R11, R16, R20, R21, R22, R25, R27, R31, R33, R41, R42, R43, and R247) reviewed for safe clean and homelike environment in the sample of 43. Findings include: The facility's Water Temperature monitor Policy-Resident Areas policy (undated) states, Policy: Ensure warm water temperatures are within the range of 100 degrees to 110 degrees for Resident areas and warm water is deliver to each faucet in timely manner. Water temps are to be taken at least once a week to ensure temperatures are within proper parameters. Any adjustments necessary will be immediately made to ensure comfortable and safe water temps. The facility's Housekeeper policy (undated) stated, Job Summary: Housekeepers are responsible for maintaining the facility in a clean, orderly, and sanitary manner. Responsibilities: 1. Duties a) Clean, organize, and sanitize each resident room, all hallways, congregate areas, nursing station, and offices at least once each day. e) All floor surfaces are continually monitored for wet, dirty spots debris and other safety hazards. Unsafe and unsanitary conditions are corrected immediately. k) Sweeps and wet mops every room in the facility every day (including weekends and holidays) using a cleaning/sanitizing solution. On 6/2/24 at 8:30 AM a tour of the facility was conducted. On the Memory Care Locked Unit, the hallway (between rooms 39 through 44) had a pungent urine odor. room [ROOM NUMBER] was observed and noted to have a malodorous smell of urine, a sticky floor, and debris noted around the cove board. room [ROOM NUMBER] was then observed and noted to have the cove board laying on the floor on the left side and back side of the room, had a sticky floor, debris all over the floor and around the cove boards, and had a bucket approximately four inches full of brownish/black liquid that had a putrid smell. The joint bathroom between room [ROOM NUMBER] and 43 was observed and noted to have the hot water knob turned off where no warm water could come out, and the cold-water knob was turned on with only cold-water coming out. On 6/3/24 at 1:00PM room [ROOM NUMBER] was observed. The cove boards were still laying on the left side and back side of the room on the floor, the floors remained sticky, and a bucket of brownish/black liquid with high odor around four inches full remained in the room next to the bathroom. On 6/3/24 at 1:05 PM room [ROOM NUMBER] was observed. room [ROOM NUMBER]'s floor remained sticky, the bed was unmade with filthy matter on the bed, debris noted around the cove board and had a malodorous smell of urine. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 12:42 PM room [ROOM NUMBER] was observed. The cove boards were still laying on the left side and back side of the room on the floor, the floors remained sticky, and a bucket of brownish/black liquid with high odor around four inches full remained in the room next to the bathroom. V14/Maintenance stated, the cove boards look like they have been laying on the floor for a while. No one has told me about them. They should have been fixed and put back on the wall right away. On 6/4/24 at 12:45 PM room [ROOM NUMBER] was observed. Feces was observed to be smeared all over the chair in room [ROOM NUMBER], the floor remained sticky with feces smeared on the floor, debris noted around the cove board, and had a malodorous smell of urine and feces. room [ROOM NUMBER]'s bathroom had feces smeared on the floor, around the toilet bowl, on the toilet bowl lid and inside the toilet bowl. No resident was in the room at that time. On 6/4/24 at 12:48PM V14/Maintenance was checking water temperatures. V14/Maintenance checked room [ROOM NUMBER] and 43's joint bathroom water temperature at 70 degrees, room [ROOM NUMBER]'s-bathroom water temperature at 72 degrees, room [ROOM NUMBER] and room [ROOM NUMBER]'s joint bathroom water temperature at 70 degrees, room [ROOM NUMBER]'s bathroom at 71 degrees, and room [ROOM NUMBER]'s bathroom at 71 degrees. On 6-2-24 at 9:15 AM V15 (CNA/Certified Nursing Assistant) stated, The resident's room and our main sink for washing hands has had no hot water for at least a year. The dietary staff is supposed to fill up the orange five-gallon jug of hot water and bring it back to us every day, but they don't. The orange jug was observed on a cart at the end of the Memory Care Locked Unit by the resident's sitting room. V15/CNA pushed the button on the five-gallon jug and cold water came out. V15/CNA stated, see, it never gets filled up with hot water. We use cold water to wash our hands and then use alcohol hand-based hand sanitizer afterwards. I don't even give my resident's a bed bath because I don't want them to have a cold bed bath. I do wash their perineum area with cold water though. On 6/2/24 at 10:48 AM V16/CNA stated, We (the staff) should be using the orange bucket for warm water to use the basin for bed baths. I did not give the resident's a bed bath this morning because the orange bucket was not filled up. We (the staff) don't torture the residents. I don't wash their backs or anything just their private area with cold water when needed. On 6/2/24 at 10:08AM V2 (DON/Director of Nursing) stated, room [ROOM NUMBER] has a bucket in the room for (R33) to urinate in. I am not sure why the bucket has brownish/black liquid in it right now, but it is supposed to be emptied out and cleaned every two hours by the housekeepers. Housekeeping is supposed to go in and check room [ROOM NUMBER] and room [ROOM NUMBER]'s floors frequently because the residents urinate on the floor. On 6/3/24 at 1:30 PM V18/Housekeeping Supervisor stated, The CNAs are supposed to clean the bucket in room [ROOM NUMBER] every two hours and a towel or blanket should be placed under the bucket, but the CNAs don't do it. I am constantly going down the Dementia Unit hallway to find a CNA and yell at them to clean the bucket in room [ROOM NUMBER] because it is nasty. I do have newer employees, so I am not sure if they frequently check the floors in room [ROOM NUMBER] and 43 to ensure they are clean. The housekeepers should be keeping an eye on the resident's floors, especially rooms [ROOM NUMBERS]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 1:25 PM V14/Maintenance stated, We (the facility) have not had hot water on the Dementia Unit for a while. All of the hot water knobs have been turned off. The pipes in the ground have to be dug out and re-routed and I don't believe the company has set anyone up to come do it. 6/5/24 at 11:27 AM V1/Administrator stated, The Dementia Unit has not had hot water for approximately a year. The pipe is currently in the floor and needs to be re-routed in the ceiling. The cost is over 60,000 dollars and I am not sure if (the company) is planning on fixing it.

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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. 32061 Based on interview and record review the facility failed to notify the facility Ombudsman monthly of a resident transfer to the hospital and failed to provide the resident and resident representative with a written notice of transfer, for one of two residents (R26) reviewed for hospitalization s, in a sample of 43. Findings Include: R26's medical record documents that R26 was transferred to a local hospital on 2/12/24. No evidence of a facility notification to R26 of a transfer/discharge was present on R26's chart. On 6/4/24 at 1:30 P.M., V18/Social Services Director verified that the facility did not provide R26 or his representative with a written notice of transfer. At that time, V18/Social Services Director also confirmed that she had not sent notification to the local Ombudsman of monthly facility transfers/discharges.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on interview and record review the facility failed to provide a copy of the bed hold policy for residents discharging to the hospital, for one of two residents (R26), reviewed for bed holds, in the same of 43. Findings Include: R26's medical record documents that R26 was hospitalized on [DATE]. R26's medical record does not contain documentation of written notice to R26 or R26's resident representative, of the facility bed hold policy. On 6/4/24 at 1:30 P.M., V18/Social Services Director verified that the facility did not provide R26 or his representative with a a Bed Hold Policy or a written Notice of Transfer.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 32061 Based on interview and record review the facility failed to monitor a physician's order for self-catheterization and failed to update a resident's care plan to reflect self catherization needs for one of two residents (R18) reviewed for catheters, in a sample of 43. FINDINGS INCLUDE: The facility policy, Comprehensive Care Planning, dated (revised) 7/20/22 directs staff, It is the (facility) policy to comprehensively assess and periodically reassess each resident admitted to this facility. The results of this resident assessment shall serve as the basis for determining each resident's strengths, needs, goals, life history and preferences to develop a person centered comprehensive plan of care .The care plan shall be reviewed and revised as necessary to reflect the resident's current medical, nursing and mental and psychological needs as identified. R18's Cumulative Diagnosis Log documents R18's diagnoses as Hereditary Spastic Paraplegia, Neurogenic Bladder. R18's Physician Order, dated 11/20/2023 and signed by V13/Physician/Medical Director documents, Resident may continue self- catheterization PRN (as needed) for retention. Staff educate/monitor for retention/UTI weekly and as needed. A review of R18's current Physician Order Sheet, dated June 2024 does not include a physician's order for self-catheterization. R18's current Physician Order Sheet, dated 3/2/24 documents in Section C- Cognitive Patterns, BIMS (Brief Interview for Mental Status) Summary Score: 15:15 (Cognitively Intact). R18's current Care Plan, dated 11/18/2023 contains no documented Problem/Need Areas, Goals or Approaches/Interventions to address the required care of R18's self- catheterization needs. R18's Laboratory Test result Urinalysis with Culture, dated 5/27/24 documents, Urine positive for Escherichia Coli. On 06/04/24 at 2:10 P.M., V2/Director of Nurses (DON) verified the missing documentation for the monitoring of R18's self- catheterization and a care plan to address R18's self- catheterization.

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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. 32061 F698 Based on observation, interview and record review the facility failed to obtain a physician's order for dialysis treatments, update a plan of care, for a resident receiving dialysis services and failed to assess a resident's dialysis fistula for hemorrhage post-dialysis for one of one residents (R26) reviewed for dialysis, in a sample of 43. FINDINGS INCLUDE: The facility policy, Comprehensive Care Planning, dated (revised) 7/20/22 directs staff, It is the (facility) policy to comprehensively assess and periodically reassess each resident admitted to this facility. The results of this resident assessment shall serve as the basis for determining each resident's strengths, needs, goals, life history and preferences to develop a person centered comprehensive plan of care .The care plan shall be reviewed and revised as necessary to reflect the resident's current medical, nursing and mental and psychological needs as identified. The facility policy, Dialysis, dated (revised) 01/02 directs staff, Dialysis is another name for artificial kidney treatment. It is a medical procedure, which is substituted for normal kidney function when the kidneys fail. For dialysis, two large needles are placed. One needle brings blood from the body into the dialysis machine. The other needle takes the cleansed blood back from the dialysis machine to the resident's body. After dialysis, the needles are removed and firm pressure must be maintained over the puncture site for approximately 15 to 20 minutes until all bleeding has stopped. A bandage is then applied. The bandage should be kept in place until the evening of dialysis or until bleeding from the needle sites has definitely stopped. Fistula: If a resident has a fistula, contact the physician and/or hemodialysis center for specific directions on care of the fistula. It is acceptable for a resident to bathe or shower with a fistula. Blood pressures and blood sampling are not to be taken in the fistula arm. Complications with a fistula are clotting and infection with the same principles applied as with a graft. R26's current Minimum Data Set Assessment, dated 3/6/24 documents in Section C- Cognitive Patterns, BIMS (Brief Interview for Mental Status) Summary Score: 15:15 (Cognitively Intact). R26's current Physician Order Sheet, dated June 2024 includes the following diagnosis: ESRD (End Stage Renal Disease). No current physician's order for R26's dialysis treatments is documented. R26's current Care Plan, dated 12/7/21 contains no documented Problem/Need Areas, Goals or Approaches/Interventions to address the required care of R26's dialysis needs. On 06/04/24 at 9:25 A.M., R26 stated, I have been receiving thrice weekly dialysis for many years. I return to the facility with a pressure bandage in place which I remove when I feel enough time has lapsed. The nurse never monitors the fistula after dialysis for signs of hemorrhage. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/04/24 at 2:05 P.M., V2/Director of Nurses (DON) verified the missing physician's order for R26's current dialysis treatment and a Care Plan to address R26's. At that time, V2/DON confirmed nursing staff should be monitoring R26's dialysis fistula for hemorrhage upon return to the facility from dialysis.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 49187 Based on observation, interview and record review, the facility failed to post the daily direct care staff hours and resident census. This has the potential to affect all 44 resident's residing in the facility. On 6/2/24 at 9:15 AM a tour was conducted of (the facility). No daily nursing hour data and census sheet was observed throughout the entire building. On 6/2/24 at 12:00 PM V2 (DON/Director of Nursing) stated, I was not aware that I was supposed to be filling out a sheet that includes the census for the day and the total number of staff and actual hours worked per shift for RN's (Registered Nurses), LPN's (Licensed Practical Nurses), and CNA's (Certified Nursing Assistants). V2/DON verified she has not posted the daily nursing staff data since she started as DON in March 2024. V2 stated, I would post the daily census for the day and the total number of staff and actual hours worked in the glass case outside of V1's/Administrator's office. On 6/3/24 at 10:00 AM there was no daily nursing staff data posted in the glass case on the wall or anywhere else within the building. On 6/4/24 at 10:15 AM there was no daily nursing staff data posted in the glass case on the wall or anywhere else within the building. On 6/5/24 at 10:00 AM there was no daily nursing staff data posted in the glass case on the wall or anywhere else within the building. A policy on staff posting was not provided by the time of Exit Conference on 6/5/24. The facility's CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Application for Medicare and Medicaid Form 671 dated 6/5/24 and signed by V1/Administrator documents 44 residents currently reside within the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49187 Based on observation, interview and record review, the facility failed to ensure medications were kept stored in their original packaging with labels until administered for four of forty-three residents reviewed (R7, R20, R27, and R43) for medication administration, storage, and labeling in the sample of 43. The facility policy, Medication Administration dated (revised 7/3/13) directs staff, Medications must be prepared and administered as ordered (by the physician). All medications must be labeled with the resident's name, the medication, the dosage and instructions for administration. On 6/2/24 at 8:25 AM V17 (Agency Licensed Practical Nurse) was standing at her medication cart next to the dining room on the Dementia locked unit. V17 opened the top left drawer of her medication cart where there were four medication cups labeled with a first name all full of medications. V17 stated, I pre-popped (R7), (R20), (R27), and (R43's) 8:00 AM medications. I did not administer the medications immediately and only labeled the medication cups with their first name. I know I am not supposed to pull medications ahead of time and store them in the cart, but I did. 6/2/24 at 10:58 AM V2 (Director of Nursing) verified the nurses should not be pre-pouring medications and storing them in the medication carts. V2 stated, When the nurses are preparing to administer medications to the residents, they should immediately administer the medications after they verify the medication, the label, and the date.

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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. 32061 Based on observation, interview and record review the facility failed to ensure equipment in the facility kitchen was clean and free of debris, failed to date cooked food items to ensure use before expiration, and failed to monitor and record the required refrigerator, freezer temperatures, food temperatures of served foods and the required dishwasher sanitation levels. These failures have the potential to affect all 44 residents currently residing in the facility. FINDINGS INCLUDE: The facility policy, Refrigerator and Freezer Storage, dated (revised) 10/14 directs staff, It is the policy of (facility) that any item to be placed in the refrigerators and freezers must be covered, labeled and dated with a date-marking system that tracks when to discard perishable food. The facility policy, Storage, dated (revised) 10/20 directs staff, Store leftovers in covered, labeled and dated containers under refrigeration or frozen. When using only part of a product, the remaining product shall be in the original package or air tight container and labeled and dated. The facility policy, Dish machine, dated (revised) 10/09 directs staff, It is the policy of (facility) that utensils and dishes washed by a mechanical dishwasher will be clean and sanitized. Check the cleanliness of the machine. For low-temperature dishwashers (temperature of the wash water shall not be less than 120 degrees), before washing anything, use a test strip to check the sanitation level, for Chlorine sanitizers, the level should be 50-100 PPM (Parts Per Million). Record the sanitizer level on the Dish machine Temperature/Sanitizer Log. On 06/02/23 at 8:36 A.M., upon entrance to the facility kitchen V3/Cook and V4/Dietary Assistant were washing dishes and preparing the facility noon meal. An observation of the facility refrigerator temperature show a 46 ounce bottle of thickener opened, but not dated. A stack of five slices of pepper cheese in a square, plastic container that was undated. An opened bottle of yellow mustard, 1/2 empty and undated. A cut apple pie with missing pieces, undated. A separate food storage room, down the hall from the kitchen contained a large white chest freezer with boxes of meat products and no thermometer present to record the temperature of the stored food. At that time, V3/Cook verified the undated food items and the missing thermometer. On 06/02/24 at 10:53 A.M., upon return to the facility kitchen, V3/Cook and V4/Dietary Assistant were present and preparing food for the noon meal. An exhaust fan currently running, above a metal food prep table had a thick build up of black dust. Multiple yellow plastic dishracks, on the floor in the dishwashing room, were smeared with a large build up of black grease. A green plastic dishrack with multiple metal steam table lids had a large build up of black greasy dirt, located under the facility steam table. An observation of the facility Refrigerator Temperature Log Chart, dated 4/1/24 through 4/30/2024 documents missing refrigerator temperature logs on 4/1/24, 4/26/24 and 4/29/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of the facility Freezer Temperature Log Chart, dated 4/1/24 through 4/30/2024 documents missing refrigerator temperature logs on 4/1/24, 4/10/24 and 4/25/24, 4/26/24 and 4/29/24. An observation of the facility Sanitizing Solution Log Chart, dated 4/1/24 through 4/30/2024 documents missing sanitizing solution checks on 4/25/24, 4/26/24 and 4/29/24. And for 5/1/24 through 5/31/24, missing sanitizing solution checks for 5/1/24, 5/2/24, 5/3/24, 5/6/24, 5/7/24, 5/8/24, 5/9/24, 5/16/24, 5/19/24, 5/22/24, 5/23/24, 5/28/24 and 5/29/24. An observation of the facility Dishwasher Temperature/Sanitizer Log, dated 4/1/24 through 4/30/2024 documents missing sanitizing solution checks on 4/1/24 through 4/5/24, 4/7/24, 4/8/24 and 4/11/24 through 4/30/24. An observation of the May 2024 logs document missing checks on 5/1/24, 5/2/24, 5/7/24 through 5/10/24 and 5/13/24 through 5/31/24. An observation of the facility Food Temperature Logs for May 2024 documents facility kitchen staff failed to obtain food temperature logs prior to serving meals on 5/26/24 through June 1, 2024. On 6/2/24 at 12:30 P.M., V3/Cook verified the missing food temperature logs, required refrigeration checks and sanitation solution and dishwasher checks. The facility Room Roster, dated 6/2/24 and verified by V1/Administrator documents 44 residents currently reside in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32189 Facility failures resulted in two deficient practices. A. Based on record review, and observation, the facility failed to place signage in a conspicuous location to clearly identify the category of transmission-based precautions, instructions for PPE (Personal Protective Equipment) and/or instruction to see the nurse prior to entering the resident's room for 1 of 1 (R32) residents that required transmission-based precautions in a sample of 43 residents. B. Based on interview and record review the facility failed to have interventions in place to mitigate the growth and spread of legionella and failed to maintain logs of interventions. This has the potential to affect all 44 residents that reside at the facility. Findings include: A. The Multidrug-Resistant Organisms in Non-Hospital Healthcare Settings, revised 11/30/09, documents 2. Multi-resistant drug organisms are bacteria and other microorganisms that have developed resistance to antimicrobial drugs. Common examples of these organisms include: MRSA- Methicillin/Oxacillin-resistant Staphylococcus aureus. The Transmission-Based Precautions, revised 12/14/09, documents Contact Precautions: Are designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. The Isolation Room Set Up policy, revised 5/30/14, documents It is the policy of this facility to set up isolation for communicable diseases. Procedure: 7. Place sign on door to resident's room for visitors to inquire at nurse's desk prior to entering room. On 5/18/24, R32 was readmitted to the facility with a diagnosis of MRSA in R32's leg wounds on 5/14/24 which required Intravenous Antibiotics and daily dressing changes. Between 6/2/24 at 10:30 AM and 6/5/24 at 1:00 PM, R32's room lacked signage to identify the category of transmission-based precautions, instructions for PPE (Personal Protective Equipment) and/or instruction to see the nurse prior to entering the residents room. B. On 6/5/24 at 1:30 PM, V2 (Director of Nursing/Infection Preventionist) stated V25 (Maintenance Supervisor) oversees Legionella management and this was all V25 has and then provided a log of water flushes every two weeks dated 10/3/20 through 5/24/24. The Infection Control Plan Index, no date, lacked inclusion of a Legionella prevention policy. The Quality Assurance Performance Improvement (QAPI) Agenda, updated 8/3/17, lacked inclusion of Legionella monitoring. The QAPI scope documents Maintenance We provide comprehensive building safety, repairs, and inspections to ensure all aspects of safety are enforced, assuring the safety and well being for each resident, visitor and staff who enter the building. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility lacked a flow diagram of the buildings water system, measures to prevent the growth of Legionella by implementing control measures such as disinfection, water temperatures and inspections and policies and procedures of ways to monitor measures and identify acceptable ranges.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 32189 Based on interview and record review the facility failed to: implement an antibiotic stewardship program that included assessing and monitoring residents for signs and symptoms of infections; ensure antibiotic usage was appropriate, and use of a nationally recognized surveillance criteria to define infections for 3 of 3 (R34, R57, R58) residents reviewed for the Antibiotic Stewardship Program in the sample of 43 residents. This failure has the potential to affect all 44 residents who reside at the facility. Findings include: The Infection Control Surveillance and Monitoring policy, dated 4/11/22, documents It is the policy of the facility to do routine surveillance and monitoring of the facility to determine if compliance with infection control practices is maintained. Monitoring of the day-to-day operations include: a. Investigation and implementation of controls to prevent infections in the facility. b. Determine and direct the correct procedures necessary for the prevention of infections. c. Follows up on documentation of, and reporting of infection to physicians, through direct, random inspection of the clinical record with respect to: 1. Isolation techniques instituted and followed; 2. Evaluation of parameters involved in assessment of physical condition are evaluated and reported as appropriate; 3. Periodic observation of infection sensitive techniques, including soaks, irrigations, catheter procedures, intravenous infusions, tracheostomy procedures, and inhalation techniques. f. Updates the infection Control Log on a daily basis in order to analyze data and identify trends that would indicate need for additional controls to prevent any further spread of an infection. g. Prepares quarterly Infection Control report for quarterly presentation to Quality Assurance committee. 3. Documentation of noncompliance of practices and corrective actions taken to ensure improvement will be conducted. 4. Responsibility of maintaining records of surveillance and monitoring will be the DON/ICP (Director of Nursing/Infection Control Preventionist) and/or Administrator. On 6/3/24 at 11:00 AM, V2 stated I don't formally track and write down observations (of infection control practices). I look around as I'm in the halls but don't have a formal audit process. There haven't been any reports done since I started in March. I haven't had a chance yet. V2 stated V2 is notified of residents treated for infections but they are not tracked and/or trended according to caregivers, locations or any other sources that could be controlled and antibiotics have not been reviewed for use.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 32189 Based on record review and interview, the facility failed to designate a qualified infection preventionist who is responsible for the facility's Infection Prevention and Control Plan. This failure has the potential to affect all 44 residents who reside at the facility. Findings include: The Infection Control Surveillance and Monitoring policy, dated 4/11/22, documents The facility shall employee, at a minimum, a part time Infection Control Preventionist. These duties maybe performed by the Director of Nursing with an approved Infection Control Certification. The Infection Preventionist Job Description, dated 3/3/23, documents Qualifications: 2. Must have completed Specialty Training in Infection Prevention and Control through accredited continuing education. On 6/3/24 at 11:00 AM, V2 (Director of Nursing/Infection Preventionist) stated V2 was the designated Infection Preventionist although no specialty training in Infection Prevention and Control had been completed at this time. On 6/5/24 at 2:00 PM, V1 (Administrator) stated V2 was hired on 3/19/24 and has not had the time to complete the training for Infection Prevention and Control due to other responsibilities.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on record review and interview, the facility failed to offer immunizations and vaccinations in 5 of 5 residents (R12, R14, R39, R40, R96) per policy. This failure has the potential to affect all 44 residents who reside at the facility. Findings include: The Immunization of Residents policy, dated 5/19/23, documents Verify the date of last vaccination. Obtain proof of previous Pneumococcal and Influenza vaccination for residents when able. Assess all newly admitted resident's pneumococcal and Influenza vaccination status upon admission and record last known immunization on the resident's Immunization Record. Offer the (Pneumonia Vaccination) unless contraindicated. Offer the Influenza annually from September 1st thru March 31st. Offer the current recommended COVID-19 Vaccine upon admission for those identified as not being up to date with recommended vaccination. Document immunization on the resident's Medication Administration Record and on the Resident's Immunization Record. R12 was admitted on [DATE]. R12's Immunization Record lacked documentation the influenza vaccination was offered, given or refused. R14's was admitted on [DATE]. R14's Immunization Record lacked documentation the influenza vaccination was offered, given or refused. R39 was admitted on [DATE]. R39's Immunization Record lacked documentation the influenza and/or pneumococcal vaccination was offered, given or refused. R40 was admitted on [DATE]. R40's Immunization Record lacked documentation the influenza and/or pneumococcal vaccination was offered, given or refused. R96 was admitted [DATE]. R96's Immunization Record lacked documentation the pneumococcal vaccination was offered, given or refused. On 6/3/24 at 1:30 PM, V2 (Infection Preventionist/Director of Nursing) stated all resident immunizations and vaccinations are documented on the residents Immunization Record and kept in the residents' chart. V2 stated R39 and R40 refused the Influenza Vaccination, although did not sign a declination nor was verbal refusal documented and stated, Do they have to sign a refusal?