STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145893	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Palos	11860 Southwest Highway Palos Heights, IL 60463

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on observation, interviews and record review, the facility failed to assess and evaluate a resident for self-administration of inhalers and eyedrops; and failed to obtain physician's order for eyedrops for one (R10) of one resident in the sample of 46 reviewed for medications. Findings include: R10 is an [AGE] year-old, male, admitted in the facility on 08/16/24 with diagnoses of Other Pulmonary Embolism Without Acute Cor Pulmonale; Chronic Obstructive Pulmonary Disease (COPD), Unspecified; Chronic Respiratory Failure with Hypoxia; and Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. MDS (Minimum Data Set) dated 08/19/24 Section C recorded R10 has BIMS (Brief Interview for Mental Status) score of 12 which means moderate impairment in cognition. On 11/18/24 at 10:09 AM, R10 was observed in room, in bed, watching television. A Combivent inhaler was observed placed on bedside table. R10 was asked if he is self-administering the Combivent inhaler. R10 stated, I use it when I feel like it. Two 10 ml (milliliters) bottles of eye drops were placed on nightstand. R10 was again asked if he is using the eyedrops. R10 stated, I use it twice a day. POS (Physician Order Sheet) dated 08/16/24 recorded: Combivent Respimat Inhalation Aerosol Solution 20-100mcg/act (microgram per actuation) 1 spray inhale orally every 4 hours for COPD when awake. There was no recorded physician order for eyedrops. R10's care plans documented: 08/17/24 - At risk for altered respiratory status/difficulty breathing related to COPD, Chronic Respiratory Failure with Hypoxia, OSA (Obstructive Sleep Apnea) Administer medication/puffers as ordered. Monitor for effectiveness and side effects. 08/16/24 - At risk for alteration in respiratory functioning related to COPD, Chronic Respiratory Failure with Hypoxia, OSA: Administer oxygen and other medications and respiratory treatments as ordered. On 11/19/24 at 11:17 AM, V2 (Director of Nursing) was asked regarding R10's self-medication administration. V2 replied, R10 is not supposed to be self-administering medications and no medications should be left at bedside. There is no order and there is no assessment. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled; Self-Administration of Medication dated 6/6/24 stated in part but not limited to the following: Policy It is the policy of the facility to ensure that resident's right to self-administer medications is observed. A resident who requests to self-administer medications will be assessed to determine if resident is able to safely self-medicate. Procedures: 1. The IDT (interdisciplinary team) will assign a staff to evaluate resident's ability to safely administer medication. A Self-Administration Evaluation will be filled out to determine capability. A return demonstration will be done to accurately evaluate resident's ability after the health teaching. 2. The resident may store the medication at bedside if there is a physician order to keep it at bedside. Facility's policy titled Physician Orders dated 8/16/24 documented in part but not limited to the following: Policy Statement It is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance with the licensed physician's orders. The facility shall ensure to follow physician orders as it is written in the POS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observation, interview, and record review the facility failed to follow their policy and procedures for comprehensive care planning by not ensuring care plans, and personalized care planning interventions were implemented as needed based on grievances, resident's past medical history, and comprehensive assessments. This failure applies to four of four residents (R7, R16, R45, and R56) reviewed for care planning. Findings include: R7 is an [AGE] year-old male with a diagnoses history of Metabolic Encephalopathy, Right and Left Side Pain from Back to Legs, and restless leg syndrome who was admitted to the facility 07/23/2024. R7's admission hospital records dated 02/21/2024 documents he had a history of frequent falls, he was admitted to the hospital after a fall at home, he had previous hospital admissions related to falls in the last few years, he has severe lumbar spine fusion and complains of pain, per family member he has been having more frequent falls as of late, and can be transferred to rehabilitation; The plan for recurrent falls included recommendation of subacute rehab; IDT (Interdisciplinary Team) recommendations also included Bed/Chair alarms, caregiver within arm's reach when out of bed, establish a toileting schedule and ADL (Activities of Daily Living) routine, non-skid socks, use of bedside commode, shades up during the day, lights off and shades down at night, and minimizing overnight disruptions. The facility's Fall Log reviewed 11/18/2024 documents R7 had falls on 10/22 at 11:40 AM and 10/26 at 9:25 PM R7's Current care plan initiated 07/23/2024 documents he is at risk for falls related to history of falls, potential medication side effects, poor safety awareness, disease process such as acute respiratory failure with hypoxia, sepsis, aspiration pneumonia, cognitive impairment, acute metabolic encephalopathy, Coronary Artery Disease, Benign Prostatic Hyperplasia, chronic Urinary Tract Infections, Hypertension, Diabetes Mellitus, Acute Kidney Injury, and A fibrillation. R7's care plan interventions did not include Bed/Chair alarms, caregiver within arm's reach when out of bed, establishing a toileting schedule and ADL (Activities of Daily Living) routine, non-skid socks, use of bedside commode, shades up during the day, lights off and shades down at night, or minimizing overnight disruptions. R7's Bed alarm intervention was not implemented until 10/22/2024 and the intervention of frequent rounding and asking if he needs assistance or toileting were not implemented until 10/26/2024. Resident #16 R16 is an [AGE] year-old female with a diagnoses history of Recurrent Severe Major Depressive Disorder, Overactive Bladder, who was admitted to the facility 12/12/2023. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/24 at 11:29 AM R16 stated sometimes they don't like to get her up with the mechanical lift and she must wait. R16 stated she was waiting for someone to get her out of bed, get her dressed, and place her in her chair. R16 stated she was supposed to be up in her chair by 11 AM. R16 stated sometimes they don't get her up until later. Observed R16 still in her bed wearing a gown. R16 stated she would prefer to be up and dressed. On 11/18/24 at 12:19 PM Observed staff getting R16 out of bed and dressed. R16's current care plan documents she has a self-care deficit in ADL's (Activities of Daily Living) and Impaired Mobility related to weakness, functional decline, and comorbidities such as Urinary Tract Infection, A Fibrillation, Hyperlipidemia, Hypothyroidism, and a personal history of venous thrombosis. R16's is on a dressing/grooming program. Interventions include requiring total dependence for transfers using a mechanical lift with two-person assistance and does not include a get up schedule. On 11/19/24 at 1:20 PM V24 (Family Member) stated, the aides tell R16 she's too heavy to put in a sling. V24 stated, months ago she reported this to V3 (Assistant Director of Nursing) and things would improve temporarily, then later she reported these issues to V2 (Director of Nursing). V24 stated, yesterday on 11/18/2024 she texted V25 (Assistant Administrator) about R16 not being out of bed yet at around 12:20 PM and he informed her they were finally getting her out of bed soon after. V24 stated, sometimes R16 calls her on the weekend and reports she's still in bed at 6PM. V24 stated, if R16 is changed at 9AM and needs to be changed again at 11 they tell her they just changed her. V24 stated R16 prefers to be gotten out of bed at 11 AM so she won't be in this situation. V24 stated, staff complain about getting R16 out of bed because she's heavy to put in the mechanical lift. V24 stated, R16 is told on the weekends we're short staffed, we'll be back, and they don't return, and she is left unchanged for hours. Grievance form dated 09/30/2024 documents V24 expressed concerns regarding R16 requesting to be placed on a get up schedule. Grievance form dated 11/19/2024 documents concerns were reported concerning R16 being gotten out of bed before lunch. On 11/20/24 at 1:36 PM V2 (Director of Nursing) stated, a get up schedule should be part of R16's care plan and the staff should have her up by 11 AM or 11:30 AM from what he can recall. Resident #45 R45 is a [AGE] year-old male with a diagnoses history of Partial Paralysis following a Stroke, Dementia, and History of Falling who was admitted to the facility 09/16/2024. On 11/18/24 11:00 AM Observed R45 left hand contracted. R45 stated, he cannot use his left hand. V33 (Family Member) stated, she was told the facility won't provide therapy services for R45 hand because his insurance won't cover it. V33 stated, R45 has multiple medical insurances, and she isn't sure why some form of therapy services isn't covered for him. R45's Admission Restorative assessment dated [DATE] documents he is experiencing functional decline, and he needs to be referred to Physical Therapy and Occupational Therapy for further evaluation. R45's Physician progress note dated 10/5/2024 documents he has a contracture of the hands. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R45's Current care plan documents he requires assistance with ADL's (Activities of Daily Living) such as bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting, co-morbidities such as hemiplegia/hemiparesis (partial paralysis), and dementia with interventions including Skilled Rehabilitation Therapy evaluation and treatment as indicated; he would like staff to refer him to Physical and/or Occupational Therapy as ordered by the physician to evaluate his current condition/status and recommend appropriate interventions to improve my functional ability. R45's current care plan does not include treatment for his left-hand contracture. R45's Current physician orders include an order effective 11/19/2024 for being seen 1 time by Occupational Therapy for evaluation only for left hand splinting needs and recommendations and an evaluation for a splint. On 11/20/24 at 1:29 PM V2 (Director of Nursing) stated, the MDS (Minimum Data Set) coordinator usually reviews care plans to ensure they are complete and agreed that R45's care plan should include care for his contracture. V2 stated, R45 should have been evaluated for a hand splint much sooner than 11/19/2024 based on his medical history and admission's restorative assessments. Resident #56 R56 is a [AGE] year-old male with a diagnoses history of Cirrhosis of Liver, Emphysema, Non-traumatic Brain Hemorrhage, Stage 4 Chronic Kidney Disease, Sarcoidosis, Epilepsy, Hepatic Encephalopathy, History of Falling, Multiple Fractures of Ribs, and Bone Disorder who was admitted to the facility 07/12/2024. On 11/18/24 01:29 PM V26 (Family Member) stated, R56 has been discouraged and depressed, has become withdrawn and believes a lot of it has to do with the injury he sustained when he fell at the facility on 07/12/2024. V26 stated, R56's condition and being in and out of the hospital a lot playa a role and they had not been providing him with any social services to address this. V26 stated, R56 has sarcoidosis, and this has affected his mood. R56's Admission Minimum Data Set, dated dated dated [DATE] documents his mood status included having little interest or pleasure in doing things; feeling down, depressed, or hopeless; sleep disturbances, feeling tired or having little energy, appetite disturbances, having negative feelings about himself, having trouble concentrating, and having communication disturbances for a period of several days. R56's current care plan does not include a plan or interventions for his mood. The facility's Care Planning Policy received 11/21/2024 states: It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations. Based in the State Operations Manual F656 regulation a comprehensive care plan must be developed after the comprehensive assessment of the resident. The baseline care plan at a minimum should include initial goals based on social services. After the comprehensive assessment (state/federal - required Minimum Data Set) is completed, the facility will put in place person-centered care plans outlining care for the resident within 7 days.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observation, interview, and record review the facility failed to follow their policies for restorative nursing program services by not ensuring a resident received the necessary treatment and services to prevent further decline in physical functioning for a resident with a contracture. This failure applies to one of one resident (R45) reviewed for rehab and therapy services. Findings include: Resident #45 R45 is a [AGE] year-old male with a diagnoses history of Partial Paralysis following a Stroke, Dementia, and History of Falling who was admitted to the facility 09/16/2024. On 11/18/24 at 11:00 AM Observed R45's left hand contracted. R45 stated, he cannot use his left hand. V33 (Family Member) stated, she was told the facility won't provide therapy services for R45 hand because his insurance won't cover it. V33 stated, R45 has multiple medical insurances, and she isn't sure why some form of therapy services isn't covered for him. R45's Admission Restorative assessment dated [DATE] documents he is experiencing functional decline, and he needs to be referred to Physical Therapy and Occupational Therapy for further evaluation. R45's Current care plan initiated 09/16/2024 documents he requires assistance with ADL's (Activities of Daily Living) such as bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting, co-morbidities such as hemiplegia/hemiparesis (partial paralysis), and dementia with interventions including Skilled Rehabilitation Therapy evaluation and treatment as indicated; he would like staff to refer him to Physical and/or Occupational Therapy as ordered by the physician to evaluate his current condition/status and recommend appropriate interventions to improve my functional ability. R45's current care plan does not include treatment for his left-hand contracture. R45's Physician progress note dated 10/5/2024 documents he has a contracture of his hand. R45's Current physician orders include an order effective 11/19/2024 for being seen 1 time by Occupational Therapy for evaluation only for left hand splinting needs and recommendations and an evaluation for a splint. Occupational Therapy Evaluation and Treatment Encounter Reports dated 11/19/2024 document R45 has a contracture of his left hand, he was referred by his primary physician in order to be evaluated for need of splint for his left hand and he could benefit from application of splint to prevent further limitations from occurring which could possibly cause skin break down and difficulty with proper hygiene of hand. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 1:33 PM V2 (Director of Nursing) stated, R45 should have been evaluated for a hand splint much sooner than 11/19/2024 based on his medical history and admission's restorative assessments. V2 stated, if not evaluated timely there could be further deterioration of the hand and worsening of contraction and disuse of the hand. The facility's Restorative Nursing Program Policy received 11/21/2024 states: It is the policy of this facility to assess for comprehensive nursing and restorative needs upon admission. Appropriate nursing and restorative services consistent to the resident's functional needs must be provided. If the assessment shows the resident needs therapy, then therapy should be provided. Nursing and Restorative Services may include the following: Contracture Management: Splint. Nursing and restorative services shall be reflected in the resident's individualized care plan consistent to the completion of the resident comprehensive assessment.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews the facility failed to follow their policy and procedures for care planning and fall prevention by not implementing previously established fall interventions based on all available information for a resident readmitted to the facility with a history of repeated falls and by not implementing personalized fall interventions or ensuring all available sources of information were utilized to identify and implement effective fall interventions for a resident who was admitted to the facility after being hospitalized from a fall that resulted in multiple significant injuries. This failure applies to two of four residents (R7 and R56) reviewed for falls and resulted in R56 experiencing a fall that resulted in a thigh bone fracture. Findings include: R7 is an [AGE] year-old male with a diagnoses history of Metabolic Encephalopathy, Right and Left Side Pain from Back to Legs, and restless leg syndrome who was admitted to the facility 07/23/2024. R7's admission hospital records dated 02/21/2024 documents he had a history of frequent falls, he was admitted to the hospital after a fall at home, he had previous hospital admissions related to falls in the last few years, he has severe lumbar spine fusion and complains of pain, per family member he has been having more frequent falls as of late, and can be transferred to rehabilitation; the plan for recurrent falls included recommendation of subacute rehab; IDT (Interdisciplinary Team) recommendations also included Bed/Chair alarms, caregiver within arm's reach when out of bed, establish a toileting schedule and ADL (Activities of Daily Living) routine, non-skid socks, use of bedside commode, shades up during the day, lights off and shades down at night, and minimizing overnight disruptions. The facility's Fall Log reviewed 11/18/2024 documents R7 had falls on 10/22 at 11:40 AM and 10/26 at 9:25 PM R7's progress note dated 10/23/2024 documents a certified nursing assistant made writer aware that R7 was observed sitting on the floor. Writer and staff went into resident's room to assess resident. Resident stated he was trying to move to the other bed because his bed had a hole in it, and he slid down on the floor. R7's Fall Risk Management assessment dated [DATE] documents his bed alarm was going off in his room, staff immediately responded, and he was observed lying on the floor; R7 reported he didn't fall but slipped off the bed as he was trying to go to the other bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R7's Current care plan initiated 07/23/2024 documents he is at risk for falls related to a history of falls, potential medication side effects, poor safety awareness, disease process such as acute respiratory failure with hypoxia, sepsis, aspiration pneumonia, cognitive impairment, acute metabolic encephalopathy, Coronary Artery Disease, Benign Prostatic Hyperplasia, chronic Urinary Tract Infections, Hypertension, Diabetes Mellitus, Acute Kidney Injury, and A fibrillation. R7's care plan interventions did not include Bed/Chair alarms, caregiver within arm's reach when out of bed, establishing a toileting schedule and ADL (Activities of Daily Living) routine, non-skid socks, use of bedside commode, shades up during the day, lights off and shades down at night, or minimizing overnight disruptions. R7's Bed alarm intervention was not implemented until 10/22/2024 and the intervention of frequent rounding and asking if he needs assistance or toileting were not implemented until 10/26/2024. R56 is a [AGE] year-old male with a diagnoses history of Cirrhosis of Liver, Emphysema, Non-traumatic Brain Hemorrhage, Stage 4 Chronic Kidney Disease, Sarcoidosis, Epilepsy, Hepatic Encephalopathy, History of Falling, Multiple Fractures of Ribs, and Bone Disorder who was admitted to the facility 07/12/2024. The facility's Fall Log reviewed 11/18/2024 documents R56 had a fall with injury 07/12/2024 at 10:39 PM. R56's Admission Summary progress note dated 7/12/2024 documents patient has arrived at facility via stretcher around 2pm. Writer noted upon assessment patient has multiple bruises all over the body, left ear sutures, and bruising around left eye. Patient is currently in bed, with bed in the lowest position, call light within reach, ice water at bedside; at 11:03 PM it was documented that Writer was notified by certified nursing assistant of patient being on the floor. Upon assessment the writer observed the patient sitting upright at the bedside, as the writer asked the patient what happened his nose started to bleed. The patient had pain rating 10/10 with limited range of motion to the left leg, the patient was extremely confused. Facility Incident Report dated 07/18/2024 documents R56 had an unwitnessed fall 07/12/2024 at 10:10 PM and was admitted to the hospital with an acute right femoral shaft fracture; On 07/12/2024 at approximately 10:10 PM a certified nursing assistant observed patient sitting on the floor of his room, he was observed by nurse sitting upright on his buttocks on the floor by his bed, he was observe with minimal bleeding from nose and was unable to move his right leg, when asked what happened he reported he was trying to get up and use the bathroom, he did not activate the call light for assistance, he was last seen by the nurse before the incident at approximately 9:35 PM sleeping in bed with his call light in reach and bed in the lowest position. On 11/18/24 01:29 PM V26 (Family Member) stated, R56 fell when he first came to the facility, and she doesn't think they did the proper intake when he was admitted . V26 stated, the facility didn't get enough information about R56's needs. V26 stated, R56's other roommates had a better intake process and were better accommodated. V26 stated, she doesn't know how R56 fell but his bed was not equipped with sensors or railings, and his room was far back in the facility at the very end. V26 stated, after R56 fell they added railings to his bed, moved his room closer to nurses station, and added a motion sensor to his bed. V26 stated, when R56 fell he fractured his femur (thigh bone) and hasn't been able to receive therapy. V26 stated, R56 has been discouraged and depressed, has become withdrawn and believes a lot of it has to do with the injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R56's medical records did not include any information obtained from V26 (Family Member) on the day he was admitted regarding his needs based on his risk of falls and history of falls. R56's hospital report dated 07/24/2024 documents he was recently admitted to the hospital from 06/29/2024 - 07/12/2024 for traumatic subdural hematoma and sub arachnoid hemorrhage (bruising and bleeding near the brain), nasal bone fracture, abnormally low blood cells post bone marrow biopsy and having subsequent worsened confusion. R56's Minimum Data Set section for Functional Abilities dated 07/12/2024 marked as completed at 3:11 PM documents he required supervision and touching assistance with bed mobility and substantial/maximal assistance with transfers. The facility's census report documents when R56 was admitted on [DATE] his room was located in an area that was not close to the nurses station and when he was readmitted to the facility on [DATE] he was placed in a room right outside the nurses station area. R56's physician order history documents 2 quarter side rails to aide with bed mobility and transfers were not ordered until 07/24/2024. R56's Current care plan initiated 07/12/2024 documents he is a high risk for falls due to traumatic subdural hemorrhage, calculus of kidney, stroke, acidosis, right ankle joints and right foot, stage 3 Chronic Kidney Disease stage, sarcoidosis, epilepsy, acute kidney failure, insomnia, and right hip fracture with interventions implemented 07/12/2024 including ensure that his frequent visitors are aware of the use of assistive and adaptive devices; he has periods of forgetfulness and would like staff to frequently reorient him to his surroundings; he would prefer to keep all needed items like water pitcher, tissue box, urinal, etc., within reach; he would prefer to keep the bed in the low position for safety; he would like Physical Therapy and Occupational Therapy to evaluate and treat him as ordered to increase his strength and mobility and prevent further falls; and he would like staff to provide him with a safe environment: even floors, free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; side rails as ordered, and handrails on walls. R56's care planned interventions of a bed alarm to alert staff when he attempts to get out of bed unassisted, or so staff can assist him and prevent falls and the two quarter side rails to aide with mobility and transfers were not implemented until 07/24/2024. R56's care planned interventions of reminding him to ask for assistance; reorienting him on how to use the call light, and if necessary, toileting him to prevent unassisted attempts to go to the toilet were not implemented until 11/09/2024. On 11/20/24 at 1:02 PM V2 (Director of Nursing) stated, initial fall assessments are done upon admission. V2 stated, if a resident has a known history of falls on admission based on information obtained from the resident, the resident's family, or the hospital this information would be including in the admission's assessment. V2 stated, any information obtained from those sources should be included on the admission or baseline care plans. V2 stated, any past medical history of fall interventions should have been incorporated in R56's care plan once he was readmitted to the facility in July 2024. V2 stated, he believes V26 (Family Member) was present and interviewed when he was admitted to the facility and possibly any available information regarding falls would have been obtained from her. (continued on next page)

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Harmony Palos	11860 Southwest Highway Palos Heights, IL 60463

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/21/24 at 10:33 AM V32 (Physician) replied, yes when asked by surveyor if fall interventions should be personalized to R56's needs. V32 stated, he saw R56 soon after his arrival prior to his fall and V26 (Family Member) was at bedside at this time. V32 stated, he believes there was some concern with R56's neurological status related to his sarcoidosis, and this may have led to him attempting to get out of bed. V32 stated, R56 suffers from a rare illness, and it may have been difficult to anticipate his particular needs and the appropriate precautions needed to be implemented prior to him coming to the facility for the first time. V32 stated, fall interventions are a personalized approach for each patient and should be tailored to the debilities that each patient comes with. On 11/21/24 at 11:32 AM V1 (Administrator) stated, the room R56 was located in on admission is not right near the nurses station and is towards the end of the hall. V1 stated, room R56 is currently located in is closer to the nurses station and is right outside of it. On 11/21/24 at 12:29 PM V2 (Director of Nursing) stated, R56's bed rails were not in place when he fell [DATE]. V2 stated, bed rails would not be added until an assessment is done, and consents were given. V2 stated, there was no reason rails could not be applied for R56 on admission, however there was no indications if bed railings were needed or not for R56 and no information was provided by V26 (Family Member) of him needing bed railings. V2 agreed it is not necessary for V26 to initiate the use of bed railings, and railings could be used for mobility or if the staff noticed that the patient was struggling with positioning however there was nothing indicating this during the brief amount of time R56 was admitted prior to his fall. The facility's Fall Occurrence Policy received 11/21/2024 states: It is the policy of the facility to ensure that residents are assessed for risk for falls and that interventions are put in place. A Fall Risk Assessment form will be completed by the nurse or the Falls Coordinator upon admission. Those identified as high risk for falls will be provided fall interventions. An interim Falls Care Plan may be started but a Falls Care Plan is necessary and required after the State required Minimum Data Set was done. If a resident had fallen, the resident is automatically considered as high risk for falls. Therefore, the nurse does not have to fill out the Fall Risk Assessment to determine if the resident is high risk for falls or not, after the resident had fallen. The Falls Coordinator will add the intervention in the resident's care plan. The interventions will be reevaluated and revised as necessary. The facility's Care Planning Policy received 11/21/2024 states: It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations. Based on the State Operations Manual F656 regulation a comprehensive care plan must be developed after the comprehensive assessment of the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The baseline care plan at a minimum should include initial goals based on admission orders, physician orders, and therapy services.

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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. 50036 Based on observation and interview the facility failed to follow their policy to ensure multidose vials of insulin were dated when vials were first accessed for two residents (R14 and R5) and failed to safely dispose of seven expired bottles of house stock medications. This failure has the potential to affect 38 residents residing on the second floor. Findings include: On 11/19/24, at 10:53 AM, Surveyor asked V8 Registered Nurse (RN) to review second floor low-end medication cart. Surveyor observed a previously accessed insulin pen of Toujeo Solostar (insulin) 300 unit/ml injection that showed an order date of 10/30/2024. Insulin pen was not dated when it was opened or dated for when to discard on the pen or the bag it was in. This insulin pen had an expiration date of 8/31/2026 and was for R5. V8 (RN) verified the pen had previously been accessed and that it did not have a date on the insulin pen of when it was accessed or when it should be discarded. Surveyor observed the following: 5 house stock medications bottles expired in the same medication cart: Oyster shell Calcium 500 mg stock bottle with expiration date of 10/2024 Niacin 100 mg stock bottle with expiration date of 08/2024 One daily multivitamin stock bottle with expiration date of 08/2024 Magnesium Oxide 400 mg stock bottle with expiration date of 06/2024 Stomach Relief 525 mg liquid stock bottle with expiration date of 10/2024 V8 (RN) was asked by surveyor to verify expiration dates on above 5 bottles. Dates were verified by V8 (RN). Surveyor observed V8 (RN) throw the 5 expired stock bottles dated prior to 11/2024 in trash bin on the low-end medication cart for second floor. On 11/19/24, at 11:20 AM, Surveyor asked V8 (RN) to review second floor middle medication cart. Surveyor observed a previously accessed insulin pen of Toujeo Solostar 300 unit/ml insulin glargine injection pen. Insulin pen was not dated when it was opened or dated for when to discard on the pen or on the bag it was in. This insulin pen had an expiration date of 8/31/2026 and was for R14. V8 (RN) verified the pen had previously been accessed and that it did not have a date on the insulin pen of when it was accessed or when it should be discarded or on the bag it was in. Surveyor observed the following: 2 house stock medications bottles that had already expired in the same medication cart: Niacin 500 mg stock bottle with open date of 3/6/24 that had an expiration date of 10/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Niacin 100 mg stock bottle that had expiration date of 08/2024. V8 (RN) verified the expiration dates and discarded the 2 expired bottles of stock medications dated prior to 11/2024 in trash bin on middle medication cart on second floor with surveyor present. On 11/19/2024, at 11:43 AM, V3 Assistant Director of Nursing (ADON) stated, insulin pens should be dated when opened. I am not sure how long they are good for once opened. I will get back to you. On 11/19/24, at 11:57 AM, Surveyor went back up to second floor and observed the discarded stock medication bottles were still in the trash bins in both medication carts on second floor. On 11/19/24, at 12:01 PM, V3 (ADON) stated, insulin pens/vials once opened are good for 28 days. Regarding discarding expired medications, we remove them from out of circulation and I will have to check with how we get rid of them. On 11/19/24, at 12:17 PM, V3 (ADON) stated, stock medications that are expired should be discarded in drug buster or sent back to pharmacy. It would be unacceptable to discard medication bottles of stock meds that are expired in the trash bin on the med carts. V3 (ADON) provided surveyor with census per medication cart for second floor residents. On 11/19/24, at 1:30 PM, Surveyor called V7 Pharmacist consultant. V7 stated, to dispose expired medications the facility should follow their policy for disposing of medications. Toujeo Solostar insulin pens should be dated when opened and are good for 56 days. They should also be labeled with the expiration date of the 56 days. On 11/19/24, at 03:39 PM, V2 (DON) stated, regarding insulin pens, they should be dated the first time they use them. All insulin pens are good for 28 days after first use. We do not put a discard date on the insulin pens. Regarding destruction of any expired medications, anything that is not able to go back to the pharmacy we use the drug buster to destroy in house. If a nurse throws medications/bottles of medications in the trash bin on the medication cart, that is not acceptable. Someone else could get them such as another resident and cause harm. We also do not want them to get into the garbage supply for contamination issues, etc. Medication Storage, Labeling, and Disposal Policy with revision date of 8/16/24 documents: Policy Statement: It is the facility's policy to comply with federal regulations in storage, labelling, and disposal of medications. Procedures 3. Medications will be stored safely under appropriate environmental controls. 4. Medications will be secured in locked storage areas. Medication Pass Policy with revision date of 08/16/24 documents: Medication Labeling: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. All opened medication vials in the refrigerator should be labeled with the date when it was opened and discarded within 28 days of opening except for Levemir insulin which can be discarded 42 days after opening and Xalatan eye drops which can be discarded 6 weeks after opening. 2. Follow pharmacy recommendation as to when the medication should be discarded after opening. 3. Insulin vials are to be discarded within 28 days after opening, except for Levemir insulin which are to be discarded 42 days after opening.

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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. 40718 Based on observation, interview, and record review, the facility failed to follow their policy and procedures for preparing food under sanitary conditions by not using hand hygiene, when necessary, not sanitizing surfaces after cleaning them, not ensuring appliances were adequately dried or free of surface contamination after cleaning and before use, and not ensuring hair restraints were worn properly. This failure applies to all 96 residents in the facility. Findings include: Kitchen On 11/19/24 from 10:30 AM - 11:30 AM Observed while taking temperature of seasoned rice observed V28 (Cook) doff and don gloves without performing hand hygiene then prepare pureed taco meat, observed V27 (Food Service Director) and doff and don gloves while performing tasks in the food prep area without performing hand hygiene. Observed V29 (Night Cook) doff and don gloves while performing hand hygiene while performing tasks in the food prep area then handle clean dishware. Observed V28 doff and don gloves multiple times without performing hand hygiene while preparing and temping food, handling containers with food in them, and handling clean dishware. Observed V28 with hair exposed from the back of her hairnet while preparing food and performing other kitchen tasks and V30 (Dietary Aide) with hair exposed from the sides of her hairnet while assisting with preparing meal trays. Observed V28 use a soapy towel to clean the food prep table where the food processor was located, the food prep table near the stove, and a beverage cart and not sanitize after cleaning. Observed V28 wash and clean the food processor equipment, then immediately puree vegetables in it with a noticeable amount of water remaining on the inside and outside of the food processor and the lid. 11/20/24 01:43 PM V27 (Food Service Director) stated, when staff remove gloves, they should wash their hands before donning new gloves. V27 stated, staff should sanitize a surface immediately after cleaning it with the soapy water. V27 stated, when the food processor can't be air dried during constant use because the temperature of the food will go down if air dried when in between use after being washed. V27 stated, the food processor should be left for a minute or two to allow some water to drain from it before reusing after cleaning it. V27 stated, any water left in the food processor after cleaning will change the consistency for the puree, and there could be contamination from the water. V27 stated, all hair should be covered when underneath a hairnet because hair can contaminate food. The facility's Kitchen Policy received 11/20/2024 states: The facility will comply with state and federal regulations in operating facility's kitchen. Hair restraint is required except for those who are bald. Staff will wash hands after handling soiled items. The facility's Hand Hygiene Policy received 11/20/2024 states: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hand hygiene is important in controlling infections. Hand hygiene consists of either hand washing or the use of alcohol gel. The facility will comply with the CDC (Centers for Disease Control and Prevention) Guidelines in regard to hand hygiene. Hand hygiene using alcohol-based hand rub is recommended during the following situations: After removing gloves.

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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** 34071 Based on observation, interviews and record reviews, the facility failed to implement the use of personal protective equipment during provision of care on residents in isolation rooms; failed to change soiled gloves during ADL (activities of daily living) care; and failed to prevent contamination of urinary catheter and bag by keeping it off the floor for four (R15, R71, R101 and R112) of four residents in the sample of 46 reviewed for infection control. Findings include: R15 is an [AGE] year-old, male admitted in the facility on 10/22/24 with diagnoses of Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; and Chronic Viral Hepatitis C. On 11/18/24 at 11:39 AM, V16 (Certified Nurse Assistant, CNA) was observed providing ADL care on R15. V16 was observed wearing the same pair of gloves when she started wiping R15's face, neck, upper back, lower back and when cleaning the genital area. She (V16) was also wearing the same pair of gloves when she put on his (R15) new gown, new incontinent brief, and clean bed linens. R71 is a [AGE] year-old, male, admitted in the facility on 09/23/24 with diagnoses of Obstructive and Reflux Uropathy, Unspecified; Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms and Personal History of Malignant Neoplasm of Prostate. POS (Physician Order Sheet) dated 09/24/24 recorded: Indwelling Catheter. On 11/18/24 at 10:45 AM, R71 was observed propelling his wheelchair in the hallway. R71 has an indwelling urinary catheter in placed. His urine bag was not inside privacy bag. The urine bag was observed being dragged to the floor as his wheelchair moves. On 11/19/24 at 12:41 PM, R71 was observed in his room; eating lunch while sitting in wheelchair. His indwelling urinary catheter bag was observed covered in front, not in a privacy bag, and was touching the floor. The catheter tubes were in between his legs, and on the floor. On 11/19/24 at 12:45 PM, V11 (Registered Nurse, RN) was asked regarding R71 and catheter care. V11 replied, His indwelling urinary catheter is the one that has an attached front cover. This doesn't cover the whole urine bag. The indwelling catheter should not be touching the floor as he moves the wheelchair. The tube should not be on the floor as well to prevent contamination and for infection control. R101 is a [AGE] year-old-male, admitted in the facility on 10/31/24 with diagnoses of Unspecified Dementia, Unspecified Severity, Without Behavioral disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; and Gastrostomy Status. On 11/18/24 at 12:23 PM, V21 (Podiatry Assistant) and V22 (Podiatrist) were observed inside R101's room, putting aside a blue pad with trimmed toenails. V21 stated they just finished cutting his (R101) toenails. V21 and V22 were observed not wearing gowns. R101 is on EBP (enhanced barrier protection) due to presence of gastrostomy tube. V21 and V22 were also not observed wash their hands before leaving his (R101) room. V21 and V22 went directly to R112's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R112 is an [AGE] year-old, male, admitted in the facility on 11/15/24 with diagnoses of COVID 19 (Coronavirus 19). R112's care plan dated 11/15/24 recorded: Requires (droplet/contact) precautions related to COVID infection - Interventions: Initiate proper precaution; Observe isolation precautions as clinically indicated; Use appropriate protective equipment; Utilize proper handwashing technique. POS dated 11/18/24 documented: Maintain at all times. Strict contact/droplet isolation precautions due to an active infection. On 11/18/24 at 12:25 PM, V21 and V22 were observed going into R112's room without wearing gown, N95 mask, eye wear or face shield; and started cutting his (R112) toenails. No handwashing was observed on V21 and V22 prior to contact with R112. On 11/20/24 at 11:31 AM, V23 (Infection Preventionist) was asked regarding infection control. V23 replied, For residents on enhanced barrier precautions, gowns and gloves are worn prior to entering room and while providing care such as assistance with ADLs (activities of daily living) and trimming nails. Hand hygiene/handwashing should be done before and after contact. During provision of morning/care incontinence care, staff wears gloves and change when soiled making sure not contaminating clean items with soiled items. Gloves are changed when visibly soiled; when putting on clean gowns; in between residents. Droplet precautions - mask and goggles/face shields/eye wear are to be used when providing care. For COVID, staff must wear gown, gloves, N95 and eye wear/face shields. Facility's policy titled Infection Prevention and Control dated 6/6/24 recorded in part but not limited to the following: Policy Statement The facility has established a policy to Identify, Record, Investigate, Control, Test, and Prevent Infections in the facility. The facility will also maintain a record of incidents and corrective actions implemented for the identified infection. Procedures: 17. Hand hygiene will be performed by staff before and after direct patient contact and after each situation that necessitates hand hygiene. Alcohol-based hand-rubs or hand washing for 20 seconds will be used. Precautions to Prevent Transmission of Infectious Agents and Transmission Based Precaution: 1. Standard Precaution - based on principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membrane may contain transmissible infectious agents. Infection prevention practices include hand hygiene, use of gloves, gown, or mask depending on anticipated exposure, and safe injection practices. PPE is used depending on anticipated exposure to blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated environmental surfaces or equipment. 2. Contact Precaution - intended to prevent transmission of infectious agents spread by direct or indirect contact with patient or the environment. b. Use of gown and gloves is necessary prior to room entry. Face protection may be necessary if performing activity with risk of splashing or spraying (Standard Precaution). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Droplet Precaution - intended to prevent transmission through close respiratory or mucous membrane contact with respiratory secretions. b. Eye protection, and mask should be worn for close contact with the resident. If there are infectious material that can be transmitted through contact, then gloves and gown should also be used. 5. Enhanced Barrier Precaution (EBP) a. Involves the use of gloves and gowns during high contact resident care activities for residents infected or colonized with MDROs as well as residents with wounds and/ or indwelling medical devices. Facility's signage posted by the door (resident room) documented in part but not limited to the following: Droplet Precautions Everyone must: Clean their hands, including entering and when leaving room. Make sure their eyes, nose and mouth are fully covered before room entry or remove face protection before room exit. Enhanced Barrier Precautions Providers and staff must also: Wear gloves and gown for the following high-contact resident care activities: providing hygiene. Facility's policy tiled Urinary Catheter Care dated 8/19/24 stated in part but not limited to the following: Purpose The purpose of this procedure is to prevent catheter-associated urinary tract infections. Infection Control 2. b. Be sure the catheter tubing and drainage bag are kept off the floor. Facility was requested to present policies related to infection control during ADL care but unable to provide one.