STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145897	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Lebanon	1201 North Alton Lebanon, IL 62254

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews, observations, and record reviews the facility failed to feed residents in a dignified manner for 4 out of 4 residents (R11, R14, R17, R34) reviewed for dignity in a sample of 39. Findings include: 1.R34 was admitted to the facility on [DATE] with diagnoses of, in part, dementia with behavioral disturbances, major depressive disorder, and chronic post-traumatic stress disorder. R34's Minimum Data Set (MDS) dated [DATE] documented he has severely impaired cognitive skills for daily decision making. R34's MDS further documented he is dependent on staff for eating assistance. R34's Care Plan last revised on 09/4/2024 documented R34 is dependent for Activities of Daily Living (ADLs) with interventions for staff to feed him his meals. On 12/16/2024 at 12:25 PM, V11 (Certified Nursing Assistant/CNA) fed R34 while standing over him. 50628 2. On 12/16/24, at 12:14 PM, R11, R14, and R17 were seated at a table together in the dining room. When questioned regarding needed level of assistance, V14 (CNA) and V15 (CNA) stated they are feeders. This was done within earshot of the R11, R14 and R17. R11's Minimum Data Set (MDS) documented that R11 is severely cognitively impaired and is dependent on staff for eating. R17's MDS documented that R17 is severely cognitively impaired. It documented that she requires partial/moderate assistance with eating. R14's MDS dated [DATE] documented R14 is severely cognitively impaired. It documented that she is dependent for eating. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/24 at 1:30 PM V19 (CNA) stated that when addressing residents who need assistance with their meals being fed to them, she would address the resident by their name and inform them that she would be feeding their lunch. V19 would then proceed to tell them what is on their plate and ask which food they would like to start with. On 12/18/24 at 3:15 PM V20 (CNA) stated that when addressing residents who need feeding assistance with their meals, she would address the resident by his name as Mr. or Mrs. and then inform them that it is time to eat and then she would tell them what is on the menu for that meal. The facility's Assistance with Meals Policy, with a revision date of 07/2017, documented residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: not standing over residents while assisting them with meals and avoiding use of labels when referring to residents such as feeders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44556 Based on observation, interview, and record review, the facility failed to implement progressive care plan interventions and ensure interventions were followed to prevent falls for 4 of 6 residents (R5, R10, R30, and R31) reviewed for falls in a sample of 39. Findings include: 1. R10's Face Sheet, admitted [DATE] documented R10 has diagnoses of but not limited to Dementia, malignant neoplasm of prostate, Chronic obstructive pulmonary disease (COPD), and hypertension (HTN). R10's Minimum Data Set (MDS) dated [DATE], documented R10 is moderately cognitively impaired with a brief interview for mental status (BIMS) of eight out of 15 and he requires supervision or touching assistance with transfers and walking. R10's Care Plan, with admitted [DATE], documented R10 has risk factors that require monitoring and intervention to reduce potential for self-injury. High risk for fall per risk assessment. Had a fall in previous six months when residing at home with son. Date initiated: 04/22/24. Interventions include but not limited to keep environment well-lit and clutter free. Observe for unsteady/unsafe transfer or ambulation and provide stand by or balance support as needed. Remind of safety precautions and limitations as necessary. It also documented R10 has had an actual fall with no apparent injury, minor injury, Root cause may be related to (r/t) assistive device not within reach, cognitive impairment- unaware of safety needs. 09/05/24 fall without injury, root cause: cognitive deficits-forgets to utilize walker even with signs to remind him to use the walker on walker in room. 10/03/24 fall without injury, root cause: cognitive deficits-poor judgement & and unaware of safety needs. Interventions include but not limited to new interventions for prevention of this type includes staff to ensure cane or walker is within R10's reach when in bed. emergency room (ER) for eval for change in condition. 09/06/24 15-minute checks. 10/03/2024 Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST) to eval & treat as indicated. R10's Assess/Intercommunicate/Manage (A.I.M.) for Wellness form, dated 09/05/24, was reviewed and documented R10 had a fall. R10 was in his room walking without his walker, fell backwards into door sliding to the floor. The nurse did his assessment while on the floor and seen he didn't have any injuries and he did not voice any complaints. R10 was assisted up out of the floor with a gait belt and walked to his bed with his walker. R10's Fall Risk Assessment, dated 09/05/24, documented he was a high risk for falls with a score of 17. R10's Interdisciplinary Team (IDT) progress notes, dated 09/06/24 at 9:00 AM, was reviewed and documented the root cause of R10's fall on 09/05/24 was due to deficits- forgets to use his walker for ambulation and the new intervention was to start R10 on 15-minute checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R10's A.I.M for Wellness form, dated 10/03/24, documented R10 had an unwitnessed fall in his room. Nurse was notified by staff R10 had fallen. Upon entering the room resident was in a sitting position and had his shoe in his hand and the comforter was under his feet. The nurse completed a skin assessment, and no redness, bruising, or other injury was noted. R10 complained of leg pain range of motion (ROM) was done and it was with in normal limits (WNL). The doctor was notified and said to monitor R10 and if he continues to complain to get an x-ray of his legs. R10's A.I.M for Wellness form, dated 10/15/24 documented R10 had an unwitnessed fall. R10 was lying face down. R10 was assessed while in the floor and was noted to have a skin tear to his left hand/fingers and steri-strips were applied. There were no other visible injuries noted. R10 complained of pain to his lower left abdomen when pressure applied with no rebound tenderness. He was assisted back to his wheelchair with gait belt and two assist. ROM WNL. Alert and able to make needs known. The Nurse Practitioner (NP) was notified, and new orders were given. R10's Fall Risk Assessment, dated 10/15/24, documented he was a high risk for falls with a score of 19. R10's 15-minute checks for the months of September 2024, October 2024, and November 2024, were reviewed and had multiple sections with no documentation R10 was checked every 15 minutes per his care plan intervention. On 12/18/24 at 12:47 PM V1 (Administrator) stated if someone was on 15-minute checks she would expect the 15-minute checks to be completed. V1 was given the October 2024 15-minute checks for R10 and informed they all appeared to be done in the same handwriting. V1 just shook her head. 44967 2. R5's Admission Record, dated 12/17/24, documents R5 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Hypertension, Arthritis, Major Depressive disorder, Generalized Anxiety disorder, Bipolar Disorder, Right and Left above knee amputations (AKA), and Dependence on supplemental oxygen. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Care Plan, updated 12/16/24, documents R5 is a High Risk for falls. Interventions: Use Mechanical Lift with two assist and gait belt for all transfers. Use additional assist as needed when R5 is not feeling well, fell ing weak or dizzy device used for transfer Mechanical Lift, Observe for and educate on proper technique and use of device. It continues R5 has had an actual fall with on apparent injury. Root cause may be related to A&O (alert and oriented) R5 chooses self-mobility despite known/understood risks. 8/30/24: fall from bed during self-mobility-mattress slick vinyl. Interventions (9/3/24): For no apparent acute injury, determine and address causative factors of the fall, OT (Occupational Therapy) consult for safety in executing ADL (Activities of Daily Living) tasks, PT (Physical Therapy) consult for strength and mobility, continue interventions on the at-risk plan, new mattress that covering is not slick vinyl, 11/28/24: fall during car transfer per family when returning from LOA (Leave of Absence). Interventions (11/29/24): Educate family on R5's safety with transfers and requesting staff assistance when returning from LOA. R5's Care Plan, continued, documents R5 is alert and oriented and usually makes decisions regarding cares, decision made to self-transfer despite consequences, has physical limitations that may place R5 at risk for falls during transfer. R5 understands risks of self-transfer and believes benefit of independence outweigh risks/consequences of fall. 10/17/24: Fall with self-transfer - Root cause: hypotension. 10/15/24: Fall with self-transfer - not receptive to education on the ill effects of self-transfer. 11/19/24: Fall wheelchair to floor due poor sitting balance, and another fall bed to floor due to self-transfer. Interventions (10/15/24): 15-minute checks, (8/27/24): Assist R5 to clean and place prescribed eyewear when awake, assure R5 that staff is plentiful and available for assist at any time, encourage to verbalize feeling regarding bothering staff. Encourage R5 to use call light and ask for help when feeling weak or lightheaded, fall risk assessment quarterly and as needed with change in condition or fall status, review quarterly and PRN (as needed) R5's ADL, mobility, cognitive, behavior, and overall medical status, Interdisciplinary team (IDT) review of changes and needs with R5 and/or responsible party during care plan. R5's MDS, dated [DATE], documents R5 has a Moderate Cognitive Impairment and is Dependent on staff for toileting, bathing, bed mobility, chair/bed-to-chair transfer, sit to lying and lying to sit on side of bed. R5 is frequently incontinent of urine and occasionally incontinent of bowel. The Facility's Fall Log, for the past six months, documents R5 has had falls on 8/29/24, 10/15/24, 10/17/24, 11/19/24 X 2, 11/28/24, and 12/13/24. R5's Fall Risk Assessment, dated 10/28/24 documents R5 is a high fall risk. R5's AIM (Assessment Intervention Management) for Wellness Assessment, dated 11/19/24, documents R5 had a fall: Resident found on floor lying by wheelchair in room. Resident states he slipped from his chair. Fall Risk Assessment, dated 11/19/24, documents R5 is a High Fall Risk. R5's AIM for Wellness Assessment, dated 11/19/24 (second fall), documents R5 had a fall: Resident found lying on floor on back. Resident fell from bed unwitnessed, no injury noted. Placed on neuro checks and ROM (range of motion) WNL (within normal limit). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's AIM for Wellness Assessment, dated 11/28/24, documents R5 had a fall: Notified by daughter in front parking lot as they had resident on slide board attempting to get him into wheelchair out of car. They had to lower him to the ground. By the time this nurse got down there they were wheeling him into the building. Assessed resident in room. VS WNL. Appeared somewhat out of sorts. Daughter said that he was high and had been smoking, did not say what he was smoking. Fall Risk Assessment, dated 11/29/24, documents R5 is a High Fall Risk. R5's AIM for Wellness Assessment, dated 12.13/24, documents R5 had a fall: Resident was in his room when attempting to transfer himself to his bed. Wheelchair rolled back and resident fell to floor on his buttock. ROM and Vitals WNL, Resident placed on neuro checks and fall precaution. Fall Risk Assessment, dated 12/13/24, documents R5 is a High Fall Risk. On 12/16/24 at 9:55 AM, R5 was seen lying in bed with bilateral AKAs. R5 stated that he has fallen several times while trying to get himself out of bed to his wheelchair, and usually lands on his butt. There are no fall precautions seen in the room. On 12/16/24 at 12:05 PM, V9 (Certified Nursing Assistant/CNA) was performing incontinence care on R5. After incontinence care, V9 told R5 that he can get himself up now and after three attempts just to sit up in bed, R5 got himself to sit up by using the wobbly side rail while pulling himself upright on the edge of the bed, then R5 scooted himself to the locked wheelchair next to his bed. R5 appeared to have difficulty getting himself up and over to the wheelchair with V9 not helping or standing by the bedside. V9 was picking up around the sink while R5 transferred himself. On 12/16/24 at 1:30 PM, R5 stated Some people will help me get in or out of my wheelchair, and others just walk away and leave me to do it myself. They don't do s*** around here, I have to do it myself. When asked if he refuses staff assistance, R5 stated No I don't refuse, but when they don't offer to help me, I just do it myself. On 12/17/24 at 9:45 AM, V9 (CNA) stated We try to stand by for (R5) but by the time we get there, he has already transferred on his own. We should be standing by him when he transfers to keep him safe. 3. R30's Admission Record, undated, documents R30 was admitted to the facility on [DATE] with diagnosis of Generalized Anxiety Disorder, Major Depressive Disorder, Osteoporosis, Chronic Kidney Disease, Heart Failure, Atrial Fibrillation, and Hypertension. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R30's Care Plan, dated 4/16/24, documents R30 has risk factors that require monitoring and intervention to reduce potential for falls. Interventions: Assess cognitive deficits and accommodate forgetfulness regarding safety devices and environmental risks, Encourage and assist placement of proper non-skid footwear, encourage rest periods during ambulation, place chair in hall for rest periods as needed. Encourage to use call light and ask for help when feeling weak or lightheaded. Encourage to wear brief during daytime hours to minimize risk of slipping on wet floor during toileting. Fall risk assessment quarterly and as needed with change in condition or fall status. IDT review of ADL status and fall potential with changes in condition or fall status. Ensure that adaptive devices-walker is within reach and in good repair, Keep call light within reach at all times. Answer promptly and notify R30 that help is coming. Keep environment well-lit and clutter free. Remind of safety precautions and limitations as necessary. Set up bathing supplies as needed and assist PRN to prevent spilling/slipping. It continues (11/7/24): R30 has had an actual fall with serious injury - fracture right foot. Root cause may be related to poor balance, loss of balance, unsteady gait. Interventions: Neuro-checks per facility protocol, OT consult for safety in executing ADL tasks, PT consult for strength and mobility, ST consult for cognitive evaluation. Continue interventions on the at-risk plan, New Intervention: (11/7/24) PT to eval and treat as indicated. It continues (4/16/24): R30 has increased risk for fractures/spontaneous fractures related to osteoporosis. it continues (11/7/24): R30 has a bone fracture related to ground level fall. Intervention: Support injured area with pillows and immobilize part as appropriate. R30's MDS, dated [DATE], documents R30 is cognitively intact and is dependent on staff for bathing and dressing, requires partial/moderate assistance for toileting and dressing, and requires substantial/maximal assistance from staff for all transfers. R30 is frequently incontinent of both bowel and bladder. R30's Nursing Summary Assessment, dated 8/9/24, documents R30 has not had any falls in last 30-days and is a Low Fall Risk. The Facility's Fall Log for the past six months, documents R30 has had one fall on 11/6/24. R30's AIM for Wellness Assessment, dated 11/6/24, documents R30 had a fall: Was notified by staff that resident fell upon entering TV Room. Resident is in sitting position, skin assessment done, has abrasion to side of right foot and unable to bear weight. C/O (complaint of) pain PRN (as needed) was given. Notified Dr. , received NO (new order) for STAT X-Ray to right foot, ankle, tibia, and fibula 3 views. Notified DON (Director of Nurses), POA (Power of Attorney), of unwitnessed fall with injury. (x-ray company) called and on the way. R30's Fall Risk Assessment, dated 11/6/24, documents R30 was a Low Fall Risk. R30's Radiology Report, dated 11/6/24, documents R30 has an Acute Comminuted fracture of the distal right fibular shaft and medial malleolus with soft tissue swelling. On 12/16/24 at 9:28 AM, R30 was seen sitting on side of her bed with her right ankle ace wrapped. R30 stated she fell at the facility and fractured her ankle. There were no fall precautions seen in the room. R30's Call Light was seen hanging down the wall and between the wall and her bed and was not in reach of R30. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24 at 11:50 AM, R30 was seen in her wheelchair with a large boot covering her left foot and ankle. R30 stated her physician's appointment went well, however, there is still an infection in her ankle. R30's Call Light is still hanging down the wall between her bed and the wall and not in reach. On 12/18/24 at 10:58 AM, R30 was seen asleep in her bed with her wheelchair next to side of her bed, with one wheel was locked and the other unlocked. R30's call light was still hanging down the wall and between her bed and the wall with the button on the floor. On 12/18/24 at 12:14 PM, V1 (Administrator) stated All residents who are on fall precautions should have fall interventions in place and their call lights within reach. The Facility's Fall Evaluation and Prevention Policy, undated, documents in part: To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. The goal is to prevent falls if possible and avoid any injury related to falls. The Care Plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed. Residents should be evaluated for their fall risk: On admission/re-admission to the home, following any change of status that may affect balance, mobility, or safety, Following a fall, and Quarterly. 4. R31's Admission Record, dated 12/18/24 documents R31 was admitted to the facility on [DATE] with diagnosis of Obesity, Osteoporosis, Anxiety Disorder, Chronic Obstructive Pulmonary Disease, Pulmonary Embolism, Venous Thrombosis/Embolism, and Gout. R31's Care Plan, dated 12/6/24, documents R31's review shows low risk for falls. 9/6/24: High Fall Risk, 12/6/24: Fall Score 13 = High Risk. Interventions: 6/17/24: Be sure call light is within reach and encourage R31 to use it for assistance as needed. R31 needs prompt response to all requests for assistance. Follow facility fall protocol. It continues (6/19/24): R31 has had an actual fall with no apparent injury. Root cause may be related to attempted side to side bed mobility using mattress edge and rolled out of bed. Interventions: Restorative nursing bed mobility program review/initiation, continue interventions on the at-risk plan, New Intervention: half bilateral side rails to enable increased independence/safety with side-to-side bed mobility. It Continues (6/17/24): R31 is dependent for ADLs - unable to assist/assists only minimally. Interventions: Transfer R31 using mechanical device of (full body mechanical) lift and two staff members. Keep hand on R31 to reassure of safety if needed. R31's MDS, dated [DATE], documents R31 is cognitively intact and is dependent on staff for all ADLs. R31 is always incontinent of both bowel and bladder. The Facility's Fall Log for the past six months, documents R31 has only had one fall on 6/19/24. R31's Fall Risk Assessment, dated 6/19/24, documents R31 is not a High Fall Risk. R31's AIM for Wellness Assessment, dated 6/19/24, documents: Was notified by staff that resident was on the floor. Upon entering the room, resident was lying next to the bed. Skin assessment done; no injuries noted. Placed a call to doctor with no new orders received. Notified POA of unwitnessed fall with no injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/24 at 10:00 AM, R31 was seen lying in bed. R31 stated she fell out of bed once, but now she is bedridden and unable to walk, and doesn't get up on her own. On 12/16/24 at 11:50 AM, V9 (Certified Nursing Assistant/CNA), was about to get R31 out of bed and to her wheelchair using a full body mechanical lift device. Upon entrance, V9 already had the device sling under R31 and attached to the device, which was unlocked. V9 stated I have to go get some help. and waited for V10 (CNA) to come in and assist. V10 entered and both lifted R31 off the bed, having R31 hold onto the crossbar on the device, and pulled R31 to her wheelchair with neither CNA holding onto R31. V9 held the unlocked wheelchair and tilted it backwards, while V10 moved R31, swinging in the air, from her bed to her wheelchair, and then R31 was lowered and disconnected from the lift. On 12/18/24 at 11:02 AM, V9 (CNA) stated I have to use two people with the (full body mechanical lift) because I can't do it by myself. On 12/18/24 at 12:14 PM, V1 (Administrator) stated All residents who are on fall precautions should have fall interventions in place. I would expect any staff using the (full body mechanical lift device) to use two people and to hold onto the resident during the entire transfer. The Facility's Mechanical Lift Policy, dated 10/30/08, documents The mechanical lift may be used to lift and move a resident with limited ability during transfer while providing safety and security for residents and nursing personnel. Procedure: 8. Position lift at side of bed. Lock wheels on lift. 10. Have resident cross arms over chest. 11. Instruct the resident that they will be raised off the bed and start to raise the resident using a slow, steady movement. It may be necessary to support the resident's head. 12. Move resident to chair or wheelchair and lower resident. The guidance strap may be used to guide the resident into a proper position while resident is being lowered.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review the facility failed to provide incontinent care per standards of practice for 3 of 5 residents (R5, R11, R26) reviewed for incontinent care in a sample of 39. Findings include: 1. R11's Face Sheet, original admitted [DATE], documented she has diagnoses of but not limited to of Brain aneurysm, hypertension (HTN), Seizures, Cerebrovascular accident (CVA), Gastroesophageal reflux disease (GERD), Osteoarthritis, and Acute metabolic encephalopathy. R11's Minimum Data Set (MDS), dated [DATE], documented R11 is severely cognitively impaired with a brief interview for mental status (BIMS) of 07 out of 15 and is dependent on staff for her activities of daily living (ADLs). R11's Care Plan, admitted [DATE], documented R11 may be predisposed to develop skin impairment caused by pressure. Related to (R/T) Right hemiplegia, neuropathy, decreased mobility, incontinent bowel, and bladder (B&B). High risk per Braden. Goal: R11 will have intact skin, free of redness, blisters, or discoloration through review date. Interventions: Apply house stock incontinent barrier cream to peri area with every after incontinent episode and as needed. Toilet/change brief when wet and upon rising, at bedtime (HS) and after meals. R11 is at risk for skin impairment R/T incontinent of urine. Goal: Breakdown due to incontinence and brief use through the review date. Interventions: Incontinent: Check every 2 hrs (hours) and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Clean peri-area with each incontinence episode. On 12/17/24 at 09:30 AM, V14 (Certified Nursing Assistant/CNA) and V15 (CNA Coordinator) were observed doing incontinent care on R11. R11's wet incontinent brief was removed by V14 and V15. V14 then assisted R11 onto her back and separated R11's legs. V14 took a disposable wipe and cleansed the left crease between R11's thigh and pubic area then disposed of the wipe. She got another disposable wipe and wiped down the right crease between R11's thigh and pubic area then threw the wipe away. V14 then took another disposable wipe, opened the labia, and cleansed the inner area and failed to wash the outer labia. She disposed of the wipe in the trash then took a towel and dried all the areas. R11 was assisted onto her left side and V14 cleansed the right buttock and gluteal cleft. A new brief was placed and R11 was rolled onto her back, the new brief was fastened. CNAs failed to apply barrier cream per R11's care plan. V14 and V15 failed to cleanse R11's left buttock. V14 and V15 also failed to use a washcloth, wash basin, and soap per facility policy. 2. R26's Face Sheet, dated 08/22/2023, documented R26 has diagnoses of but not limited to dementia, chronic kidney disease, diabetes mellitus II, hypertension (HTN), and hepatitis C. R26's MDS, dated [DATE], documented R26 is severely cognitively impaired with a BIMS of 04 out of 15 and requires substantial assistance from staff with all her ADLs and transferring. (continued on next page)

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Evercare of Lebanon	1201 North Alton Lebanon, IL 62254

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's Care Plan, dated 08/22/2024, documented R26 may be predisposed to develop skin impairment caused by pressure. R/T high risk per Braden scale- Risk factors noted as: decreased mobility and spends all of time in chair or bed, incontinent of B&B, diabetes, unaware of need to change position and unable to do so without staff assist, terminal care r/t heart failure. Intervention include but not limited to Apply house stock incontinent barrier cream to peri area after incontinent episode and as needed. Toilet/change brief when wet and upon rising, at HS and after meals. R26 is at risk for skin impairment r/t incontinent of urine and unable to retrain due to cognitive losses. R26 will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions include but not limited to clean peri-area with each incontinence episode, check every two hours and as needed for incontinence. Wash, rinse, and dry perineum. On 12/17/24 at 10:40 AM, V14 (CNA) and V10 (CNA) assisted R26 onto her back and the old incontinent brief was removed by V14. V14 took a disposable wipe and cleansed the crease on the right and left side between the pubic area and inner thigh of R26. V14 then disposed of the wipe and got a new wipe. She separated the labia and cleansed the inner labia but failed to cleanse the outer labia. V14 took a clean towel and dried all areas. R26 was assisted onto her right side and left buttocks cleansed and dried she was then assisted onto her left side and right buttocks cleaned and dried. V14 and V15 failed to apply lotion or barrier cream per R26's care plan and failed to use a washcloth, soap, and wash basin per facility policy. On 12/18/24 at 12:47 PM, V1 (Administrator) stated if the resident's care plan documented barrier cream was to be applied after each incontinent episode, she would expect them to be using barrier cream on the resident. 44967 3. R5's Admission Record, dated 12/17/24, documents R5 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Hypertension, Arthritis, Major Depressive disorder, Generalized Anxiety disorder, Bipolar Disorder, Right and Left above knee amputations (AKA), and Dependence on supplemental oxygen. R5's Care Plan, updated 8/27/24, documents R5 is rarely able to perform Activities of Daily Living (ADLs) without weight bearing/hands on assist of 1-2 caregivers related to Amputation Bilateral AKA. Interventions: Bed Mobility: R5 requires max assist of one staff to turn and reposition in bed, Side Rails: Bilateral half rails up as per doctor order for increased independence with bed mobility, Toilet Use: R5 requires partial to max assist by one staff for toileting, utilizes urinal and bed pan for toileting, not a candidate for toilet use due to sitting balance. Transfer: Assist to transfer R5 using full body mechanical lift device and two staff members, keep hand on R5 to reassure of safety. R5's Minimum Data Set (MDS), dated [DATE], documents R5 has a Moderate Cognitive Impairment and is Dependent on staff for toileting, bathing, bed mobility, chair/bed-to-chair transfer, sit to lying and lying to sit on side of bed. R5 is frequently incontinent of urine and occasionally incontinent of bowel. On 12/16/24 at 9:55 AM, R5 stated that he just voids in his incontinence brief and will let staff know to get cleaned up. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 12:05 PM, V9 (CNA) was seen performing incontinent care on R5 prior to getting him up for lunch. V9 came into room with gloves on and a clean brief in her hands. V9 started the water running in the sink, then left the room and returned to the room with one towel. V9 wet approximately a quarter of the towel in the sink and walked over to R5 and wiped R5's bilateral groins, and abdominal fold with the wet part of towel, then used the dry part of towel to dry the same areas. There was no wiping of R5's penis or scrotum. V9 had R5 roll to his left side by holding onto the bed rail, then used the same wet towel as previously used to wipe R5's buttocks and anal area. The soiled linen and brief were tucked under R5 as he rolled over to his right side for V9 to pull them out, then onto his back. V9 had R5 roll over to his left again while she reached inside his brief and wiped moisture barrier cream on his buttocks and then secured the brief. On 12/18/24 at 11:00 AM, V9 stated I always do hand hygiene when I start in the morning and then after I do something with the residents. On 12/18/24 at 12:10 PM, V1 (Administrator) stated I would expect the staff to perform timely and complete incontinent care, including proper equipment needed, proper hand hygiene and glove changes before care, during glove changes, and after care. All staff should be doing hand hygiene before and after resident contact and before leaving the resident's room. The Facility's Hand Hygiene Policy, dated 12/2018, documents in part: All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of the infection control and isolation precautions. The Facility's Perineal Cleansing Policy, dated 9/21/10, documents in part: To eliminate odor; to prevent irritation or infection and to enhance resident's self-esteem. Equipment: 1. Washcloth and towel. 2. Soap, other cleansing agent or (brand name cleaning agent). 3. Gloves. 4. Wash basin. 5. Plastic bag. Male without catheter: 4. Wet washcloth and apply cleansing agent chosen. 5. Wash pubic area, including upper inner aspect of both thighs as well as the penis and scrotum. b. Wash area under scrotum. 6. Rinse area in same sequence, if applicable. 7. Place soiled items in plastic bag. 8. Dry carefully and proceed with cleansing of the anal area. 10. Rinse cloth and proceed with the cleansing of the anal area. 11. Washing should alternate side to side, ending with the center anal area. 12. Rinse cloth and entire area in the same sequence, if applicable. 13. Place soiled items in plastic bag. 14. Dry area thoroughly. 15. Remove gloves and wash hands with soap and water, cleansing gel, or (brand name cleaning agent). 16. Apply clean incontinent product, clothes, or position resident comfortably. 17. Wash hands with soap and water, cleansing gel or (brand name cleaning agent). Note: The basic infection control concept for peri-care is to wash from the cleanest to the dirtiest area and remember to change or remove gloves and wash hands when going from working with contaminated items to clean items.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated as well as provide humidified water per their policy for 3 of 3 residents (R5, R12, R31) reviewed for oxygen administration, in the sample 39. Findings include: 1. On 12/16/2024 at 10:46 AM, R12 was wearing an oxygen cannula connected to a humidifier bottle attached to an oxygen concentrator. There was no date observed on the bottle or the tubing. On 12/17/2024 at 1:05 PM, V7 (Licensed Practical Nurse/LPN) stated oxygen tubing and humidifier bottles are changed on night shift by the nurse and it should be dated. R12's Medication Administration Record (MAR) dated 12/1/2024-12/31/2024 documents R12 has a Physician's Order for oxygen at 2-5 Liters/minute as needed for shortness of breath. R12's Physician's Orders do not include an order to change the oxygen tubing. On 12/17/2024 at 1:50 PM, V1 (Administrator) and V2 (Director of Nursing) stated the oxygen tubing should be dated to ensure it is changed weekly. On 12/18/2024 at 2:10 PM, V3 (Assistant Director of Nursing/ADON) stated oxygen tubing should be dated and changed weekly. As of 12/19/2024 at 10:30 AM, R12's oxygen tubing remained undated and was in use. 44967 2. R5's Admission Record, dated 12/17/24, documents R5 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Hypertension, Arthritis, Major Depressive disorder, Generalized Anxiety disorder, Bipolar Disorder, Right and Left above knee amputations (AKA), Obstructive Sleep Apnea (OSA), and is Dependent on supplemental Oxygen (O2). R5's Care Plan, updated 8/27/24, documents R5 has oxygen therapy related to heart failure, COPD, chronic respiratory failure with hypoxia. Interventions: Give medications as ordered by physician, monitor for signs/symptoms of respiratory distress, Oxygen Settings: O2 at 3 Liters (L)/Nasal Cannula (NC) continuously, position R5 to facilitate ventilation/perfusion matching: Head of Bed (HOB) elevated or extra pillows behind back when in bed due to unable to lay flat. It continues R5 is at risk for complications from COPD, OSA, Chronic Respiratory Failure with Hypoxia. Interventions: Head of bed elevated and/or extra pillows behind his back when in bed due to unable to lay flat or out of bed upright in a chair during episodes of difficulty breathing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Minimum Data Set (MDS), dated [DATE], documents R5 has a Moderate Cognitive Impairment and is Dependent on staff for toileting, bathing, bed mobility, chair/bed-to-chair transfer, sit to lying and lying to sit on side of bed. R5 is frequently incontinent of urine and occasionally incontinent of bowel. R5's Physician Order, dated 11/30/24, documents Change O2 tubing and humidifier weekly on Sunday 10P-6A. R5's Treatment Administration Record (TAR), dated December 2024, documents Change O2 tubing and humidifier weekly on Sunday 10P-6A. On 12/16/24 at 9:55 AM, R5 was seen lying flat in bed on one pillow, and on O2 at 3 L/NC, no humidified bottle seen attached to concentrator. On 12/17/24 at 9:45 AM, R5 seen lying in bed flat with one small pillow under his head. R5 had both nasal cannulas on him, one from his portable oxygen tank on the back of his wheelchair, and the one attached to the concentrator next to his bed with both running at 3 L/NC with no humidified bottle of water attached. On 12/17/24 at 11:45 AM, R5's Oxygen concentrator was running at 3 L/NC to a nasal cannula lying on the bed and not on R5. There was no water bottle (humidified) attached to the concentrator. 3. R31's Admission Record, dated 12/18/24 documents R31 was admitted to the facility on [DATE] with diagnosis of Obesity, Osteoporosis, Anxiety Disorder, Chronic Obstructive Pulmonary Disease (COPD), Pulmonary Embolism, Venous Thrombosis/Embolism, and Gout. R31's Care Plan, dated 12/6/24, documents R31 is at risk for complications from COPD. Interventions: Give aerosol or bronchodilators as ordered, head of bed elevated. R31's MDS, dated [DATE], documents R31 is cognitively intact and is dependent on staff for all Activities of Daily Living (ADLs). R31's Physician Order, dated 3/1/23, documents Oxygen at 2 L (liters)/NC (nasal cannula) to keep sats >90% as needed. R31's Physician Order, dated 3/1/23, documents Change O2 tubing on Sundays 10-6. On 12/16/24 at 10:00 AM, R31 was seen lying in bed on O2 at 3 L/NC with a humidified water bottle not dated and empty while attached to the oxygen concentrator. On 12/17/24 at 11:42 AM, R31's Oxygen concentrator was running at 3 L/NC with cannula lying on the floor and a water bottle attached to the concentrator that was empty and not dated. On 12/18/24 at 11:40 AM, V8 (LPN), stated All of the nurses are responsible for setting up Oxygen for the residents who have orders for it. There should be a humidified water bottle attached to the concentrator and both the water bottle and the nasal cannula get replaced once a week. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 12:15 PM, V1 (Administrator) stated The nurses should be putting a new humidified water bottle on each Oxygen concentrator with a date of attachment, along with a clean nasal cannula for the resident once a week. The Facility's Liquid Oxygen Policy, dated 8/2003, documents in part: A method of supplying supplemental oxygen to a resident. A. Liter flow should be checked and documented every shift. Equipment Needed: D. Humidifier. Procedure: Attach humidification. The policy does not address dating of oxygen supplies.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 50908 Based on interviews and record reviews the facility failed to provide Register Nurse (RN) coverage for at least eight consecutive hours a day, seven days a week. This has the potential to affect all 54 residents residing in the facility reviewed for RN coverage in a sample of 39. Findings include: The facility's Nursing Master Schedule documented the following dates did not have an RN working: 11/10/24, 11/23/24, 11/24/24, 11/30/24, 12/1/24, 12/7/24, 12/8/24, 12/14/24 and 12/15/24. On 12/17/24 at 11:38 AM, V14 (Certified Nursing Assistant), stated during the weekends the facility will frequently not have an RN on duty. On 12/17/24 at 10:54 AM, V1 (Administrator) stated she is aware the facility is short on RN coverage over the weekends. V1 stated there are job postings for RNs on three different websites and one RN is having health concerns so has she not been able to pick up shifts lately. The facility's Nurse Staffing Policy, undated, documented it is the policy of the facility to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident.

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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. 44967 Based on observation, interview, and record review, the facility failed to date medications containers that had been opened, and to ensure proper medication storage was maintained during medication administration for 4 of 4 residents (R6, R32, R49, R105) reviewed for medication labeling and storage in the sample of 39. Findings include: 1. On 12/16/24 at 9:48 AM, R49 was seen walking around her room. There was a cup of medications with eight pills in it sitting on the nightstand table. V8 (Licensed Practical Nurse/LPN) had already passed medications on R49's hall. R49's Medication Administration Record (MAR) dated 12/1/24 through 12/31/24, documents the following eight medications were given at 8:00 AM: Allopurinol 100 MG (milligram) Once Daily, Amlodipine 10 MG Once Daily, B Complex/C Folic Acid 1 MG Once Daily, Metoprolol 100 MG Once Daily, Sevelamer Carbonate 800 MG (2 tabs) TID (three times daily), Hydralazine 100 MG TID, and Vitamin D 4000units Once Daily. 2. On 12/16/24 at 10:07 AM, R32 was seen sitting on the side of her bed with Ellipta and Flonase Inhalers seen sitting on her nightstand table. V8 had already passed medications on R32's hall. R32's MAR, dated 12/1/24 through 12/31/24, documents the following medications was given at 8:00 AM: Anoro Ellipta Inhale one puff by mouth Once Daily. Fluticasone 50 MCG (microgram) one spray in each nostril Once Daily PRN (as needed) is listed on the MAR but was not documented as given. On 12/19/24 at 9:10 AM, V8 stated I never leave a cup of medications sitting in the resident room for them to take on their own. I make sure they take them when I give it to them. Inhalers are kept in the med cart. 40701 3. On 12/16/2024 at 10:03 AM, the 100-hall medication cart was inspected with V7 (Licensed Practical Nurse/LPN). At this time, there was a bottle labeled (R6) escitalopram 5 milligrams/milliliters. At this time, V7 confirmed the bottle was opened and there was no date to indicate when the bottle was opened. V7 stated he writes the date on the bottle if he breaks the seal of the bottle. R6's Physician's Orders dated 12/1/2024-12/31/2024 documents, escitalopram 10 ml per G-tube (Gastroenterol tube). 4. On 12/16/2024 at 10:17 AM, R105 was in her room. There were two medication cups on the nightstand. One cup had two colored circular tablets and the other cup had a circular white pill in it. At this time, R105 stated one of the cups contained Tums tablets (2) and the other cup contained one Tylenol tablet. R105 stated she did not bring the medications from home. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R105's Physician's Orders undated documents R105 can have two tablets of Tylenol 500 milligrams every 6 hours as needed for pain, as well as one Calcium Carbonate (tums) 500 mg daily at 8 AM. On 12/17/2024 at 11:14 AM, V7 (LPN) stated medications should not be kept at beside and he does not know of any residents who does keep them in their room. V7 stated he watches the residents to ensure they consume all their medications. On 12/17/2024 at 1:51 PM, V1 (Administrator) and V2 (Director of Nursing) stated medications at the bedside are not allowed. V1 added it is a big no. V1 and V2 stated liquid medications kept in bottles should be dated with the date the container was opened. On 12/18/2024 at 2:10 PM, V3 (Assistant Director of Nursing) stated medication bottles should be dated to reflect when the bottle was opened and medications should not be left at the bedside, unless there is a doctor's order, which R105 does not have. The Facility's Procurement and Storage of Medications Policy dated 11/6/2018 documents, All mediation containers shall be labeled with the date opened by the person breaking the container seal. The Facility's Medication Administration Policy dated 11/18/2017 documents, Drugs and biologicals are administered only by physicians and licensed nursing personnel. Definition: Drug administration shall be defined as an act in which a single dose of a prescribed drug or biologicals is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with physician's orders, giving the individual dose to the proper resident and promptly recording the time and dose given. It further documents, Observe the resident consume the medication to ensure resident swallows medication. Never leave prepared medications unattended. No medications should be left at bedside unless specifically ordered by the physicians and then only in limited amount as described by the physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on observation, interview, and record review, the facility failed to operationalize the facility's Legionella Policy and Procedure and perform hand hygiene to prevent the spread of infections (R5). This has the potential to affect all 54 residents. Findings include: 1. On 12/17/24 at 9:20 AM, V17 (Maintenance Director) stated that he runs the water and flushes toilets monthly in the empty rooms. V17 stated he also checks the temperatures of the hot water in each room and flushes the boilers monthly. A log was provided with documented these checks occurring monthly. V17 stated that the city performs the water sampling. On 12/17/24 at 3:15 PM the Legionella Policy and Procedure was reviewed with V17. The policy documented to run water through taps and showers no longer in use or used infrequently for a minimum of one minute weekly. In addition, to check hot and cold-water temperatures after water has been running for one minute randomly weekly. V17 stated that he only runs the taps and showers in infrequently used rooms monthly and checks water temperatures in all rooms monthly. V17 provided a logbook which documented each room checked monthly. The policy and procedure direct maintenance director to take shower heads apart every three months to clean and disinfect. V17 stated that he has never taken the shower heads apart. On 12/18/2024 at 8:05 AM, V17 stated that he does not have a water flow diagram in the facility. When asked what areas of the facility have been identified to have opportunistic waterborne pathogen growth, he stated that he knows the places where there may be stagnant water such as the unused rooms. On 12/18/24 at 1:05 PM, V17 stated that he has not been trained on legionella policies and procedures. On 12/18/2024 at 11:00 AM, V1 (Administrator) stated that there has been no training of any facility staff on legionella procedures or policies. Legionella Policy and Procedure dated 8/10/18, documented the two main reasons to monitor water temperatures and conditions is to prevent the risk of scalding and Legionnaires Disease. All premises where there are hot and cold-water outlets and air conditioning systems including portable humidifiers. This policy applies to all staff, residents, volunteers, and members of the community. Legionella Bacteria thrive and multiply in hot or cold-water systems and storage tanks and then spread through spray from showers and taps. The following measures may be initiated to minimize and control the risk by having the water system inspected maintained and cleaned annually, ensure water cannot stagnate anywhere in the system by removing redundant pipe work as needed, run through taps and showers no longer in use or infrequently used for a minimum of one minute once a week, check hot and cold water temperature after water has been running for 1 minute, take shower heads apart every 3 months to clean and disinfect quarterly, and annual servicing of boiler and thermostatic mixing valves annually. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Legionella Risk assessment dated [DATE] updated with the question answered yes that this is a healthcare facility with residents who have chronic and acute medical problems or weakened immune systems. 44967 2. R5's Admission Record, dated 12/17/24, documents R5 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Hypertension, Arthritis, Major Depressive disorder, Generalized Anxiety disorder, Bipolar Disorder, Right and Left above knee amputations (AKA), and Dependence on supplemental oxygen. R5's Care Plan, updated 8/27/24, documents R5 is rarely able to perform Activities of Daily Living (ADLs) without weight bearing/hands on assist of 1-2 caregivers related to Amputation Bilateral AKA. Toilet Use: R5 requires partial to max assist by one staff for toileting, utilizes urinal and bed pan for toileting, not a candidate for toilet use due to sitting balance. R5's Minimum Data Set (MDS), dated [DATE], documents R5 has a Moderate Cognitive Impairment and is Dependent on staff for toileting, R5 is frequently incontinent of urine and occasionally incontinent of bowel. On 12/16/24 at 12:05 PM, V9 (Certified Nursing Assistant/CNA), was seen performing incontinent care on R5 prior to getting him up for lunch. V9 came into room with gloves on and a clean brief in her hands. V9 started the water running in the sink, then left the room and returned to the room with one towel. V9 wet approximately a quarter of the towel in the sink and walked over to R5 and performed incontinent care on him. After incontinent care, V9 then used the same soiled gloves to put R5's shorts on him. There were no glove changes done during this care and no hand hygiene seen done before, during glove changes, or after care and before leaving the room. On 12/18/24 at 11:00 AM, V9 stated I always do hand hygiene when I start in the morning and then after I do something with the residents. On 12/18/24 at 12:10 PM, V1 (Administrator) stated I would expect the staff to perform timely and complete incontinent care, including proper equipment needed, proper hand hygiene and glove changes before care, during glove changes, and after care. All staff should be doing hand hygiene before and after resident contact and before leaving the resident's room. The Facility's Hand Hygiene Policy, dated 12/2018, documents in part: All staff will wash hands, as washing hands as promptly and thoroughly as possible after resident contact and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them is an important component of the infection control and isolation precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145897	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Lebanon	1201 North Alton Lebanon, IL 62254

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Perineal Cleansing Policy, dated 9/21/10, documents in part: To eliminate odor; to prevent irritation or infection and to enhance resident's self-esteem. Equipment: 1. Washcloth and towel. 2. Soap, other cleansing agent or (brand name cleansing agent). 3. Gloves. 4. Wash basin. 5. Plastic bag. Male without catheter: 4. Wet washcloth and apply cleansing agent chosen. 5. Wash pubic area, including upper inner aspect of both thighs as well as the penis and scrotum. b. Wash area under scrotum. 6. Rinse area in same sequence, if applicable. 7. Place soiled items in plastic bag. 8. Dry carefully and proceed with cleansing of the anal area. 10. Rinse cloth and proceed with the cleansing of the anal area. 11. Washing should alternate side to side, ending with the center anal area. 12. Rinse cloth and entire area in the same sequence, if applicable. 13. Place soiled items in plastic bag. 14. Dry area thoroughly. 15. Remove gloves and wash hands with soap and water, cleansing gel, or (brand name cleansing agent). 16. Apply clean incontinent product, clothes, or position resident comfortably. 17. Wash hands with soap and water, cleansing gel or (brand name cleansing agent). Note: The basic infection control concept for peri-care is to wash from the cleanest to the dirtiest area and remember to change or remove gloves and wash hands when going from working with contaminated items to clean items. The Facility's Centers for Medicare and Medicaid Services Form 671 dated 12/16/2024 documents there are 54 residents residing at the Facility.

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep all essential equipment working safely. 50628 Based observation, interview, and record review, the facility failed to maintain equipment in safe condition regarding lint buildup and failed to follow the Facility Policy. This has the potential to affect all 54 residents in the facility. Findings include: On 12/27/24 at 9:15 AM, V16 (Laundry/ Housekeeping) stated that she has never cleaned the lint traps and doesn't know when they were last cleaned. The two lint traps each measuring 36 inches x 23 inches located at the bottom of each dryer showed an accumulation of a moderate amount of lint. A horizontal red sign on the door handles states Urgent: Lint compartment must be cleaned daily. On 12/17/24 at 9:20 AM, V17 (Maintenance Director) stated that he cleans the lint traps monthly and provided a checklist that showed the monthly cleaning log that documented when the lint traps were cleaned V17 stated that he thinks that it would be better if this was done at the end of each shift. V17 checked with V18 (Regional Maintenance Director) who stated that the lint traps should be changed after every dryer cycle. On 12/17/24 at 1:15 PM V17 stated that lint traps not being cleaned poses a fire hazard. On 12/18/24 at 9:40 AM, V1 (Administrator) stated that her expectation is that the dryer lint trap should be cleaned daily. The Facility Policy titled, Servicing the Dryer/Preventive Maintenance Instructions. (Lint related) documents, Daily- 1) Clean lint screen. Use soft brush if necessary. 2. Check lint screen for tears. Replace if necessary. 3) Clean lint from lint screen compartment. Monthly- 1) Remove lint accumulation from end bells of motor. 2) Remove lint from front control compartment. 3) Remove lint and dirt accumulation from top of the dryer and all around the burners and burner housing. Failure to keep this port leads to build-up of lint creating a fire hazard. Quarterly- 1) Remove lint accumulation from primary airports in burners. Semi-Annually - 1) Remove and clean main burners. 2. Remove all lint accumulation. Remove from panel, lint screen and check for accumulation. Annually Check and remove any lint accumulation from exhaust system. The Facility policy titled Dryer Lint Cleaning Policy and Log, documents, All dryer lint traps must be cleaned by laundry staff every (dryer) cycle. Staff must ensure this gets completed to ensure proper and safe functioning of the dryer. Be aware of the sensors and wiring when cleaning out lint areas so as to not damage the equipment. Dryer lint trap, burner box and all other areas of the dryer must be thoroughly cleaned/vacuumed and inspected monthly by maintenance staff. Track date of each dryer cleaning/inspection under each dryer unit. Include any issues or repairs made in notes. (continued on next page)

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Many	An article written by retired fire chief titled McKnight's Long-Term Care dated 4/2/22 state that the laundry room is an area of your healthcare facility requires vigilance and a strong operational commitment to prevent fires. Policies, procedures, and safety protocols should be developed in accordance with manufacturer's guidelines to help ensure proper operation of laundry equipment. Staff should be continuously trained on these procedures to help reduce the potential for fires. Lint traps should be regularly emptied, and all interior and exterior surfaces should be maintained in a condition that is free of combustible materials like lint. Again, follow the information contained in the equipment's' operating manuals and safety guidelines to help ensure proper operations and a reduced risk of fire. Some nursing homes have developed a log to document the frequency of lint trap cleaning daily. Maintenance and cleaning of other elements of commercial laundry equipment, including the clothes dryers, should be on your facility's preventative maintenance schedule. This type of equipment is typically inspected and comprehensively cleaned at least monthly or more frequently depending on use. The more active the equipment is, the more frequently it should be cleaned. The Long-Term Care Facility Application for Medicare and Medicaid, CMS 672, dated 12/16/2024 documents there are 54 residents residing at the Facility.