STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vandalia Rehab & Health Care C	1500 West St Louis Avenue Vandalia, IL 62471

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34201 Based on interview and record review, the facility failed to promote resident independence and dignity while providing care by neglecting to explain a task prior to beginning and allowing the resident time to perform the task independently for one (R31) of six residents reviewed for resident rights in the sample of 27. Findings Include: R31's MDS (Minimum Data Set), dated 6/28/24, documents R31 has moderate cognitive impairments. On 7/29/24 at 10:48 AM, R31 stated, Yesterday {7/28/24} around 2:00 PM, a bigger girl was very rough with me during cares. R31 explained R31 is normally able to turn over in bed by herself with just a little help but this bigger girl was in a hurry to get her job done and just pushed me over hard and fast. R31 stated this action caused R31 to yell out What are you doing? R31 stated a man across the hall must have heard R31 yell because the man yelled back, What are you doing to her? R31 explained there was also a supervisor present. R31 thought the girl might have gotten fired, but then was back today {7/29/24}. R31 also stated the big girl made it known that she was big, strong and in charge. On 7/31/24 at 10:57 AM, V8, CNA (Certified Nursing Assistant/CNA), stated on 7/26/24, V8 was working 6:00 PM - 12:00 AM, and V12 (CNA) came in to relieve V8 at 12:00 AM. Upon V12 entering the facility, V12 entered R31's room and started providing cares. V8 stated V8 was at the nurses station, which is down the hall from R31's room, with V9 (CNA) when V8 and V9 overheard V12 and R31 yelling at each other. V8 explained V8 could not make out what exactly was being said, but explained R31 is hard of hearing so V12 was probably talking loud to R31 so R31 could hear V12. However, V12 was not pausing to give R31 the opportunity to voice R31's concern without talking over R31. V8 stated V8 and V9 walked down to R31's room and stood in the doorway and observed R31 lying in bed facing the door, with V12 standing over R31 and reaching around R31 to change R31's brief and said, I have to change you. V8 explained at this time, R31 said something to the affect of, If you just give me time, I can do it myself or I can help you, but V12 kept changing R31. V8 stated R31 felt like R31 was being rushed and man-handled. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 11:06 AM, V1 (Administrator) stated V12 (CNA) is currently suspended due to the incident with R31 during cares. V1 stated that during V1's investigation, V12 admitted R31 became vocal during cares because R31 felt V12 was rough in handling R31 and didn't explain what was happening. V1 explained the facility does not feel like the incident was abuse, however, it was poor customer service, and stated V12 should have given R31 more time to assist in rolling over in bed, and V12 should have explained to R31 what cares were going to be completed before doing them.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to honor resident choices regarding preferences for sleeping/waking schedules for one (R16) of one resident reviewed for Self-determination in a sample of 27. Findings include: R16's face sheet documents an admitted [DATE], with diagnoses that include depression and insomnia. R16's Minimum Data Set (MDS), dated [DATE], documents chair/bed-to-chair transfer: the ability to transfer to and from a bed to a chair (or wheelchair) as Dependent designating: helper does all of the effort, resident does none of the effort to complete the activity .or, the assistance of two or more helpers is required for the resident to complete the activity. On 07/29/24 at 1:53 PM, R16 was alert to person, place, and time and stated the one thing he just does not agree with at the facility is they get him up too early, then he will just sit in his room. R16 stated sometimes they will take him to the dining room at 5:00 AM, and he will sit down there with nothing to do until breakfast is delivered around 8:00 AM. R16 again stated he doesn't agree with having to get up that early to go to the dining room and sit in his chair longer, as he would prefer to sleep longer. On 07/30/24 at 11:40 AM, R16 stated this morning they got him up before 5:00 AM, it was probably close to 4:30 AM, and he just does not understand why he has to get up so early; he does not like it. On 08/01/24 at 9:37 AM, V17 (Licensed Practical Nurse/LPN) stated R16 is already in the dining room prior to him arriving for work at 6:00 AM. On 08/01/24 at 9:39 AM, V25 (Dietary) stated R16 and R11 are typically in the dining room when she comes in to work at 6:00 AM. On 08/01/24 at 10:31 AM, R11 stated he independently propels himself in his wheelchair and goes to the dining room early in the morning around 6:00 AM or before, and R16 is usually down there. R11's MDS, dated [DATE], documents a Brief Interview for Mental Status score of 13, indicating R11 is cognitively intact. On 08/01/24 at 10:42 AM, V15 (Certified Nurse Aide/CNA) stated R11 and R16 are usually in the dining room upon her arrival to work at 6:00 AM. On 08/01/24 at 10:59 AM, V29 (CNA) stated she gets to work at 6:00 AM, and R16 is usually in the dining room when she arrives. V29 stated the night shift usually gets R16 up between 5:00 AM and 5:30 AM. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/24 at 3:05 PM, V1 (Administrator) stated residents should be able to get up when they would like. V1stated she does not know if they have a policy for that, it would just be a resident's right.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Based on record review and interview, the facility failed to accurately code a Minimum Data Set (MDS) Assessment for one (R4) of 12 residents reviewed for accuracy of assessments in the sample of 27. Findings Include: R4's ongoing weight log documents the following weights: 12/21/23 - 132 pounds and 6/1/24 - 111.4 pounds. This change in weight calculates as a 15.61% weight loss in six months. R4's Minimum Data Set (MDS), dated [DATE], does not document a significant weight loss. On 7/31/24 at 12:52 PM, V13 (MDS/Care Plan Coordinator) stated significant weight losses should be coded on the MDS. The facility Comprehensive Assessment/MDS Policy, dated 11/1/17, documents the facility shall make every effort to ensure the MDS is accurate. Should an inaccuracy in coding be found, the facility shall follow the instructions for amending the assessment found in the RAI (Resident Assessment Instrument) Manual.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34201 Based on observation, interview, and record review, the facility failed to follow physician orders for skin protection for one (R6) of two residents reviewed for standards of practice in the sample of 27. Findings Include: R6's July 2024 Physician Orders document an order for R6 to wear protective skin sleeves at all times related to being prone to skin tears. On 7/29/24 at 11:25 AM and 7/30/24 at 12:07 PM, R6 was sitting up in a reclining wheeled chair without the ordered protective skin sleeves in place. On 7/30/24 at 12:28 PM, V15 (Certified Nursing Assistants/CNA's) and V16 (CNA) both stated R6 is to wear protective skin sleeves at all times, and explained R6 isn't wearing them because they don't know know where they are. R6's Care Plan, last updated 7/24/24, documents R6 is supposed to have arm sleeve protectors in place at all times. On 7/30/24 at 1:39 PM, V13 (Minimum Data Set/Care Plan Coordinator) confirmed R6 is supposed to wear arm sleeve protectors at all times.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Deficiencies at this level require more than 1 Deficient Practice Statement. A. Based on observation, interview, and record review, the facility failed to position a resident in an upright position and follow swallowing precautions per orders during meals to prevent choking episodes for one (R6) of 12 residents reviewed for dining on the sample list of 27. Findings Include: R6's Diagnosis Report, dated 7/31/24, documents a diagnosis of Dysphagia. R6's July 2024 Order Summary documents an order for swallow precautions and a Carbohydrate Controlled/No added Salt diet of pureed texture with pudding/extremely thick consistency liquids. R6's Care Plan, updated 7/24/24, documents R6 requires a pureed diet with pudding thick liquids and is dependent on staff assistance for feeding. R6 is to stay awake/alert during meals; staff are to provide small bites and alternate liquids and solids, monitoring for aspiration such as coughing, congestion, and watery eyes. R6's head of bed is to be elevated after meals. Along with the care plan is an undated instruction sheet with R6's name at the top that documents, Honey pudding thick puree with honey thick liquids, supervise during all oral intake, sit up with hips flexed at 90 degrees for all intake, take small bites and sips, no straws, no ice chips, crush medications in pudding, make sure awake and stay awake while eating and drinking. On 7/29/24 at 12:10 PM, R6 was reclined back in a reclining wheelchair, to approximately 60 degrees, in the dining room. R6 was being fed by V8, CNA (Certified Nursing Assistant). R6 noted to be coughing occasionally during the meal. V8 stated V8 felt like the texture of the pureed green beans and peaches were making R6 cough. On 7/30/24 at 12:23 PM, R6 was reclined back in reclining wheeled chair, to approximately 45 degrees, in the dining room. R6 was being fed by V15, CNA. R6 started coughing/choking and R6's face turned red. At this time, V15 confirmed R6 had choked, and stated it was when V15 was feeding R6 the pureed turkey. R6 also confirmed R6 was not sitting up at a 90 degree angle, but instead reclined back when R6 began to choke. V15 stated, This is how we always feed (R6). On 7/30/24 at 12:43 PM, V19, COTA (Certified Occupation Therapy Assistant), stated with R6 having swallowing issues, R6 should be sitting at a 90 degree angle while eating. On 7/30/24 at 1:39 PM, V13, MDS/Care Plan Coordinator, stated R6's physician ordered swallowing precautions means R6 is to be sitting in an upright position while eating. V13 also stated the Informational page included in R6's care plan regarding R6's eating/swallowing would have come from a Speech Therapist, but isn't sure which one or when that was placed in with R6's care plan due to the Informational Page not being signed or dated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Based on observation, interview, and record review, the facility failed to follow professional standards to prevent the development of an open wound for one resident (R32) reviewed for professional standards in the sample of 27. Findings Include: R32's Face Sheet, dated 08/01/24, documents R32 was admitted to the facility on [DATE], with diagnoses of metabolic encephalopathy, gastrostomy status, neuromuscular dysfunction of bladder, cognitive communication deficit, lack of coordination, abnormal posture, and muscle weakness. R32's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 15, which indicates R32 is cognitively intact. R32's MDS also documents R32 is dependent with toileting and showering, R32 requires substantial/maximal assistance with rolling left and right, and R32 is at risk of developing pressure ulcers. R32's Braden Assessment, dated 07/05/24, documents a score of 14, which indicates moderate risk. R32's Physician Orders document on 06/17/24, MASD (Moisture-Associated Skin Damage) to left buttock, apply barrier cream BID (two times a day) and after every loose stool, until healed. R32's Care plan, with a revised date of 06/04/24, documents a Focus Area of, Enhanced Barrier Precautions: Implementation of Enhanced Barrier Precautions due to indwelling medical devices of indwelling (brand name) catheter and gastric tube without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO (multidrug-resistant organisms). Resident history of ESBL (Extended Spectrum Beta-Lactamase) in urine. The interventions listed for this Focus Area include Enhanced Barrier protection during high contact care activities, e.g. (for example) dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, wound care. R32 also has a Focus Area of Pressure Ulcers/Skin: The resident has potential for pressure ulcer development r/t (related to) history of ulcers and impaired physical mobility. Interventions listed for this Focus Area include: Administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing weekly and as needed. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to MD (Medical Doctor). Monitor/ document/report PRN any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length X width X depth), stage. The resident needs moisturizer applied to skin each shift and as needed. R32's care plan documents a Focus Area of Skin: Resident has other actual impairment to skin integrity of the right inner buttocks and left inner buttock r/t (related to) MASD. Interventions include in part: follow facility protocol for treatment of injury, keep skin clean and dry, monitor/document location, size and treatment of impairment. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD; treatment as ordered. Cleansing, application of medication, packing and/or dressings change w/wound status and progress-See Orders in chart/eTAR for current treatments; Treatment as per order. Monitor for s/s of infection until healed. Follow up with Wound Care Physician. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's Progress Note, dated 07/26/24 at 11:56AM, documents, QA (Quality Assurance) team reviewed current skin impairment of MASD of left buttocks and right inner buttocks and blister to right hip. Area healing with no s/s (signs and symptoms) of infection noted. Scabbed area remains of absorbed right hip blister. Continue treatment as per order. Monitor for s/s of infection until healed. Continue with preventative skin care and continue to encourage resident (R32) with turning and repositioning. 07/26/24, QA team reviewed indwelling (brand name) Catheter r/t neurogenic bladder was removed on 07/19/24 per R32 request when catheter was being changed per nurse. R32 voiding without difficulty. No s/s of infection or retention noted. Continue to monitor. On 07/31/24 at 09:37 AM, V21 and V20 (both Certified Nursing Assistants/CNA's) were providing incontinence care to R32. While providing care, V21 noted an area to the middle of R32's right buttocks that was open and bleeding. The area was approximately 1cm (centimeter) in diameter. R32's right and left buttocks had a white cream noted to both sides. V21 wiped all of the white cream off both the right and left buttocks areas. V21 did not dry R32 after incontinent care, leaving R32's buttock and the open area wet. V20 and V21 did not apply any kind of barrier cream to R32's buttocks or open area. R32's open area to the middle right buttock was actively bleeding when V20 and V21 placed a new incontinent brief on R32. V20 and V21 did not remove contaminated gloves prior to placing the new incontinent brief on R32. On 07/31/24 at 1:25PM, V22 (Registered Nurse/RN) stated R32 is on Enhanced Barrier Precautions. V22 stated V20 and V21 did not notify her R32 had an open area on her middle right buttocks that was bleeding. V22 said she knew R32 had some MASD to her right and left buttocks, but did not know about any of those areas being opened. V22 said the Certified Nurse Assistants are to apply barrier cream to R32's buttocks that has zinc in it after every incontinent episode. V22 stated she would go down and assess R32's right buttock and see if the area needs a different treatment besides barrier cream, since it was bleeding and open. On 08/01/24 at 1:35PM, V22 stated she did look at R32's right buttock on 07/31/24 at around 2:00PM. V22 said the area wasn't bleeding at the time she observed it. V22 said the area was open and it did have some barrier cream on it when she looked at it. V22 did not know who put the barrier cream on R32 or when they applied it. V22 stated she did not change the treatment to R32's buttocks even though the area is open. V22 said she was going to add R32 to the wound doctor list to have the wound doctor evaluate the open area.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on observation, interview, and record review, the facility failed to provide necessary services consistent with professional standards of practice to prevent the worsening of pressure ulcers for one (R4) resident reviewed for pressure ulcer care in the sample of 27. Findings Include: The facility's Quality Assurance (QA) Weekly Skin Eval Documentation List, dated 7/26/24, documents R4 has a Stage III Pressure Ulcer to the lower right buttock. R4's Minimum Data Set (MDS), dated [DATE], documents R4 is at risk for pressure ulcers and has one Stage III Pressure Ulcer. R4's Care Plan, dated 4/25/24, documents R4 is at high risk for pressure ulcers according to R4's Skin Risk Assessment. This Care Plan was updated on 6/27/24, and documents R4 has a stage III pressure ulcer to the right lower buttock with an intervention to complete pressure ulcer treatments per physician orders. R4's Medical Record {computerized or paper} does not contain any pressure ulcer assessments. On 7/30/24 at 12:13 PM, V2 (Director of Nursing/DON) stated R4 has a pressure ulcer on R4's bottom that Hospice is saying is mostly closed. V2 stated R4's treatment consists of a barrier cream only now, and the CNA's (Certified Nursing Assistants) apply the barrier cream, not the nurses. V2 stated R4 is not seen by the Wound Physician due to being on hospice, therefore R4's wound isn't being assessed/measured weekly, explaining the Wound Physician is who does that. On 7/30/24 at 2:38 PM, V8 (Certified Nursing Assistant/CNA) and V15 (CNA) entered R4's room to check R4's buttocks for pressure ulcers. V8 and V15 removed R4's brief to reveal an approximately 1 cm (centimeter) by 1 cm superficially opened wound to the right lower buttock without a dressing in place. The wound bed was shiny and pink with granulation tissue. Both V8 and V15 confirmed R4's right buttock pressure wound is healing and improved, however is still open. On 7/31/24 at 9:00 am, V1 (Administrator) provided an ongoing Wound Record Report provided to the facility by Hospice, dated 7/31/24, that documents on 6/26/23, R4 developed a full thickness stage III pressure ulcer to the right lower buttock with orders given for facility staff nurse to cleanse stage III ulcer to the right lower buttocks with wound cleanser or normal saline, pat dry with clean gauze, apply a thin layer of barrier cream over the area twice daily and as needed for incontinent episodes. Nurse to instruct caregiver on wound care. R4's June and July 2024 Physician Order Sheets do not document any pressure ulcer treatment orders. R4's June and July 2024 Treatment Administration Record (TAR) does not document any pressure ulcer treatment being completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 11:47 AM, V13, MDS/CP (Care Plan) Coordinator, confirmed the hospice order is not transcribed or being signed out as completed. V13 also stated it's okay for the CNA's to apply barrier cream if it is being used as a preventative measure, however, with R4 having an actual pressure ulcer, The nurses should be completing the treatments and assessing the wound for changes. The facility's Decubitus Care/Pressure Areas Policy, dated January 2018, documents, It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored. Upon notification of skin breakdown, the pressure area will be assessed and documented on the TAR or the Wound Documentation Record. Complete all area on the TAR or Wound Documentation Record including: size, stage, site, depth, drainage, color, odor, and treatment after obtaining the order from the physician. Documentation of the pressure area must occur upon identification and weekly and include the following characteristic (size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.), the current treatment and response to ordered treatment. 34201

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356 Based on observation, interview, and record review, the facility failed to assess a resident after a fall and failed to implement interventions for one (R28) of eight residents reviewed for falls in a sample of 27. The findings include: R28's Face Sheet, dated 08/01/24, documents an admitted [DATE], with diagnoses in part of unspecified dementia, vascular dementia, diabetes mellitus, major depressive disorder, anxiety disorder, brief psychotic disorder, intermittent explosive disorder, dementia in other diseases with other behavioral disturbance, pseudobulbar affect, unspecified lack of coordination, difficulty in walking, unsteadiness on feet, and muscle weakness. R28's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 8, which indicates R28 has moderate cognitive impairment. R28's MDS documents he is dependent for toileting, showering, and upper and lower body dressing. R28 requires substantial/maximal assistance with rolling left to right, sit to lying, sit to stand, and transfers. This MDS also documents R28 had one fall with no injury and one fall with injury (not major) since last assessment admission/entry or reentry or prior assessment. R28's Fall Risk Evaluation assessment completed on 07/31/24 documents a score of 20, indicating R28 is a high risk for falls. R28's Care plan, with a revision date of 07/30/24, documents a Focus Area of Risk for falls with interventions that included: assist resident with ambulation and transfers, utilizing therapy recommendations, determine resident ability to transfer, evaluate fall risk on admission and PRN (as needed), if fall occurs, alert provider, if fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol, all initiated on 9/12/23. On 03/11/24, the following interventions were listed as initiated: evaluate resident's environment to identify factors known to increase risk of falls, properly identify resident to indicate a fall risk to caregivers, and utilize devices as appropriate to ensure safety (i.e. Bed mats, sensor alarms, etc.). R28's Care Plan documents a Focus Area of Problem Restraint/Enabler: Least restrictive measure to insure (sic) safety include use of device/enabler that does not limit movement/accessibility (does not meet definition of physical restraint) Device in place personal alarm in bed and wheelchair, floor mat while resident in bed r/t (related to) confusion, Mobility Decline and Muscle Weakness. This focus area includes an Intervention of check placement and function of personal alarm each shift, initiated on 9/12/23. R28's Care Plan also documents a Focus Area of Behavior Management and lists a history of crawling on floor with an intervention that includes Ensure the safety of Resident and others and Offer Resident to ambulate with walker and staff assistance when resident is restless. (continued on next page)

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	145903	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vandalia Rehab & Health Care C	1500 West St Louis Avenue Vandalia, IL 62471

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/30/24 at 3:00PM, R28 was crawling on the floor out of his room into the hallway carrying a pillow with him. V25 (Certified Nurse Assistant/CNA) saw R28 crawling down the hallway and went into R28's room to get his wheelchair. V25 attempted to get R28 off the floor without any assistance. V25 had R28 grab the handrail to assist with standing him up. She then placed wheelchair behind R28 for him to sit in. R28 was not assessed by nursing at this time. V25 said R28 did not fall, that he just crawls out of bed on to the floor. V25 did not observe how R28 got onto the floor and into the hallway as she was coming from the dining room when she observed R28 crawling on the hallway floor. On 07/30/24 at 3:02PM, V25 assisted R28 back into his bed and placed a full-size mattress next to his bed and applied a personal alarm on R28. On 07/30/24 at 3:15PM, R28 again got out of bed and the personal alarm was sounding. R28 was kneeling on the mattress next to his bed. The personal alarm pull cord was behind the head of R28's bed and the personal alarm device was lying in R28's bed. V25 and V26 (CNA's) arrived and assisted R28 up from the mattress on the floor back into his bed again. On 07/30/24 3:18PM, V25 and V26 both stated R28 crawls out of bed often. V25 and V26 stated R28 will just crawl around on the floor. V25 and V26 said they don't usually see R28 crawl out of bed onto the floor, and that's why he has a mattress next to his bed. V25 and V26 both stated when they see R28 crawling around on the floor, they will just pick him up and put him back into bed or into his wheelchair. On 07/30/24 from 3:00PM to 3:20PM, V25 and V26 continued working and were not observed to leave the hall to alert a nurse of R28 being found on the floor. During this time, no nurse was observed to go into R28's room to assess him. In addition, R28 was never offered to ambulate with his walker and staff assistance in accordance with his care plan. On 07/31/23 at 11:03AM, R28 was in the dining room halfway out of his wheelchair with the top of his shoulders in the seat of the wheelchair and his feet on the ground. R28 was trying to push the wheelchair back with his head and shoulders. R28's wheelchair did have anti-roll backs observed on the chair. R28's personal alarm was in place, but was still connected so it was not sounding. No staff were in the dining room at this time. This surveyor alerted staff for assistance to prevent R28 from falling out of his wheelchair. V23 (CNA/Business Office Manager [BOM]) and V24 (Social Service Director/SSD) came over and assisted R28 back into his wheelchair to prevent him from sliding out. On 7/31/24 at 11:05AM, R28 was again observed attempting to slide out of his wheelchair. V23 and V20 (CNA) assisted R28 back into a sitting position in the wheelchair. On 07/31/24 at 11:06AM, R28 slid out of the wheelchair on to his knees and was again assisted back into the wheelchair by V24 (SSD) and V20 (CNA). R28 was not assessed by nursing at this time. R28 was again not offered to ambulate with his walker and staff assistance in accordance with his care plan. On 07/31/24 at 11:08AM, V23 (CNA/BOM) stated R28 crawls around on the floor all the time. V23 said R28 often slides out of his wheelchair or crawls out of bed. V23 stated they will look at the video cameras if they are questioning whether R28 fell or slid out of his wheelchair. V23 stated R28 does not have any video cameras in his room. V23 said if R28 is crawling on the floor in his room and staff does not know if he fell or crawled out of bed, it should be considered a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 11:10AM, V20 stated R28 crawls around on the floor often. V20 said she hasn't been on the locked memory care unit long (where R28 resides). V20 said R28 crawls on the floor a lot and they will assist him into his wheelchair from the floor. V20 said they usually try to lay him down if R28 is tired, but if he is trying to crawl out of the bed on the floor then they will get him up and place him in the wheelchair. On 07/31/24 at 11:15AM, V14 (Registered Nurse [RN]/Care Plan Coordinator [CPC]) stated R28 does like to crawl around on the floor. V14 said R28 slides out of his wheelchair and crawls around on the floor often. V14 said she has it care planned under behaviors that R28 likes to crawl around on floor. V14 said R28 also crawls out of his bed often and that is why they have a mattress next to his bed. V14 stated if R28 is on the floor in his room and it is not witnessed, it should be considered a fall. V14 said if staff sees R28 crawling around on the floor, they should notify the nurse before getting him up if they did not witness how R28 got onto the floor. On 07/31/24 at 1:35PM, V22 (RN) stated if she doesn't see R28 put himself on the floor, she treats it as a fall. V22 said if she is unsure if it's a fall, she will look at the video camera footage to see if R28 put himself on the floor to crawl around or if he fell . V22 said R28 often slides himself out of the wheelchair and usually when he does, his wheelchair cushion will come with him. V22 said R28 usually lands on the cushion when he tries to get out of the wheelchair. V22 stated if she sees him land on the cushion when he is trying to slide out of the wheelchair, she will not consider this a fall. V22 stated if she sees R28 slide down to the floor out of the wheelchair, she doesn't consider it a fall, but if she doesn't see it, she considers it a fall. V22 stated staff did not notify her on 07/30/24 that R28 was crawling in the hallway from his room. V22 said R28 crawls around on the floor often. V22 said if R28 slides down or crawls out of bed and she sees it, then she won't list it as a fall unless he is standing and goes down, then it's a fall. V22 said she will assess R28 and list it as a fall only when she has not observed it, or if she observes it and R28 hits the floor hard. On 07/31/23 at 2:40PM, V1 (Administrator) stated the video cameras in the facility are only live feed. V1 stated nursing staff does not have access to the video cameras because they are locked in her office. V1 said nursing cannot go back and look at anything on the video cameras. On 08/01/24 at 10:30AM, V22 stated she does not remember saying she could go back and watch the video cameras to see if R28 fell or slid out of the wheelchair. V22 said she thought they could watch the video footage of the facility. V22 said she guesses she misspoke when she said she watches the video footage to see if R28 fell or slid out of his wheelchair. The facility policy titled Fall Prevention, revised 11/10/08, documents, Policy: to provide for resident safety and to minimize injuries related to falls, decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Procedures document in part: immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. Under Fall Prevention Interventions, the following are listed: 14. Ambulate with walker .42. Engage in preferred activities.

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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** 34201 Based on observation, interview, and record review, the facility failed to ensure a urinary catheter was secured in accordance with the plan of care, and failed to complete incontinence care and catheter care in accordance with standards of practice to prevent irritation and cross contamination for two (R6 and R32) of two residents reviewed for incontinence/catheter care in the sample of 27. Findings Include: 1. R6's Care Plan, dated 4/27/24, documents R6 has an alteration in bladder elimination which resulted in R6 having a Suprapubic Catheter being placed by an unidentified Urologist on 6/19/23 for Obstructive Uropathy. This care plan documents to complete catheter care and maintenance per orders and secure catheter to avoid tension. R6's July 2024 Physician Orders document an order for Suprapubic Catheter Care every shift. On 7/31/24 at 10:19 AM, V17 (Licensed Practical Nurse/LPN) entered R6's room to provide catheter care. V17 obtained an over bed table from R6's roommate, which had food crumbs/debris on it. V17 cleansed the table with wound cleanser and a paper towel. After cleansing the table, V17 placed wash cloths, gloves, sterile gauze and a basin filled with soapy water onto the over bed table. V17 donned gloves from the over bed table and removed the gauze that was in place around the Suprapubic insertion site. R6's catheter tubing was not secured to R6's body. The gauze dressing had a scant amount brownish/yellowish drainage on it. V17 changed gloves and completed hand hygiene. V17 proceeded to cleanse around the catheter insertion site using a wet/soapy wash cloth by moving from one side of the abdomen/insertion site to the other, then going back over the already cleaned area, without changing the contact point on the wash cloth to a clean area. Once V17 finished cleaning around the insertion site and down the catheter, V17 dried the area with the sterile gauze, while wearing the same gloves. V17 then changed gloves and performed hand hygiene. V17 applied a new sterile gauze to the Suprapubic insertion site and pulled scissors out of V17's uniform pocket to cut the tape to secure the gauze dressing. V17 repeated this action three times until the gauze dressing was totally covered in tape. At this time, V17 confirmed V17 used V17's personal scissors, which were in V17's uniform pocket to cut the tape to secure R6's dressing. V17 also confirmed R6's Suprapubic catheter was not secured as Care Planned. On 7/31/24 at 11:20 AM, V13 (Minimum Data Set/Care Plan Coordinator) stated any catheter tubing {Suprapubic or indwelling} should be secured due to running the risk of the tubing being pulled out. V13 also stated the manner in which V17 provided catheter care was not appropriate, explaining V17 should have cleansed from point of entry outward and using a new point of contact on the wash cloth or a new cloth, with each swipe, to prevent cross contamination. 2. R32's Face Sheet, dated 08/01/24, documents R32 was admitted to the facility on [DATE], and lists diagnoses that included gastrostomy status and neuromuscular dysfunction of bladder. R32's Minimum Data Set (MDS), dated [DATE], documented at risk of developing pressure ulcers and dependent with toileting. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's Care plan, with a revised date of 06/04/24, documents a Focus Area of Enhanced Barrier Precautions: Implementation of Enhanced Barrier Precautions due to indwelling medical devices of indwelling (brand name) catheter and gastric tube without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO (multidrug-resistant organisms). Resident history of ESBL (Extended Spectrum Beta-Lactamase) in urine. On 07/31/24 at 09:37AM, R32 was noted to have Enhanced Barrier Precautions signage on her door. V21 (Certified Nurse Assistant/CNA) and V20 (CNA) donned gowns and gloves prior to entering R32's room. R32 was noted to have a gastrosomy tube, however, R32 did not have a catheter in place at this time. V20 and V21 began incontinence care. V21 had incontinent wash and water on a clean washcloth and cleansed R32's groin area. V21 did not dry R32's groin area after washing area off. V21 then rolled R32 over onto her right side. R32 had a large amount of loose stool. V21 started to clean stool away from rectum area. V21 did not change gloves or perform hand hygiene, then started to wash buttocks area that had a large amount of white cream noted to right and left buttocks. V21 did use a new washcloth with incontinent wash and water and wiped all the white cream off of R32's right and left buttocks. At this time, R32 was noted to have a 1 centimeter (cm) open area to her right middle buttocks that started bleeding. V21 finished washing R32's right and left buttocks, not drying buttocks, then assisted V20 with rolling R32 on to her left side without changing gloves or performing hand hygiene. V20 then used a washcloth with incontinent wash and water to wash off R32's right hip. V20 and V21 placed a new adult incontinent brief on R32. V20 and V21 never changed gloves or performed any hand hygiene. V21 then grabbed R32's gown and covers with contaminated gloves and placed them on R32. V20 and V21 removed contaminated gloves as they were leaving R32's room and used hand sanitizer in the hallway. On 07/31/24 at 10:00AM, V20 and V21 both stated they should have changed their gloves and performed hand hygiene after cleaning R32 up after incontinence care, before placing a new adult brief on R32, and before touching R32's gown and covers. On 07/31/24 at 1:25PM, V22 (RN) stated R32 is on Enhanced Barrier Precautions. V22 stated residents who are on Enhanced Barrier Precautions are residents who have wounds, gastrostomy tube, or any kind of open area that led to the skin or inside of a resident. V22 said the precautions are there to protect the resident from infection. V22 said the Certified Nurse Assistants should have known to change their gloves and perform hand hygiene after they were done with incontinence care. The facility policy titled Perineal Cleansing, with a review date of 12/17, documents under procedure: Female-without catheter: 4. wet washcloth with cleansing agent chosen, 5. Wash pubic area including upper inner aspect of both thighs and frontal portion of perineum. 8. Dry thoroughly, 15. Remove gloves and wash hands with soap and water, cleansing gel or Theraworx (Hygiene foam) 16. Apply new incontinent product, clothes and reposition comfortably, and 17. Wash hands with soap and water, cleansing gel or Theraworx. 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 policy titled Infection Control Surveillance and Monitoring, revised 04/11/24, documents under procedure: E. Maintains and enforces hand washing by all staff after each resident contact for which hand washing is accepted as medical practice.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on observation, interview, and record review, the facility failed to provide nutritional supplementation as recommended for three (R3, R15, and R4) of six residents reviewed for nutrition in a sample of 27. This failure resulted in significant weight loss for R3. Findings include: 1. R3's face sheet documents an admitted [DATE], with diagnoses including: acute kidney failure, chronic atrial fibrillation, chronic venous hypertension with inflammation of bilateral lower extremity, anxiety disorder, hyperuricemia without signs of inflammatory arthritis and tophaceous disease, malignant neoplasm of colon, type 2 diabetes mellitus without complications, and osteoarthritis. R3's Care Plan documents a focus area titled Nutrition, dated 04/24/24, documents: the resident has potential nutritional problem r/t (related to) diet restrictions with an intervention dated 02/27/24 stating: RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). R3's Dietician Review, dated 03/22/24 at 10:05 AM, documents: risk factors for weight loss may include advanced age and restrictive diet order, BMI (Body Mass Index) is calculated as 22.8. BMI evaluation is > 65 y/o (years old), underweight (<23.0) factors affecting nutritional needs include: intake is fair-good, stage 3 wound left buttocks, left hip surgical wound, stage 2 wound coccyx, own teeth, ambulatory/wheelchair, normal weight, independent, alert, advanced age. (V14) (Regsitered Dietician/RD) reviewed evaluation of current condition includes: nutrition/weight does not require additional diagnosis at this time. Additional recommendations may be necessary. 2020 calories, 88 grams protein - 1.2 g/kg, 2020 ml fluids - 1 ml/calorie. V14 (RD) initial assessment. R3's Nutrition/Dietary Note, dated 05/24/24 at 10:44 AM, documents, Note text: weight loss note: Ht (height): 66 in (inches), wt (weight): 112 lbs (pounds) (mechanical lift) BMI (body mass index): 18.1 indicates underweight. Admission weight was 141.2 lbs (wheelchair). This indicates a weight loss of 21.1% (30 lbs) x 2 months. Spoke with (V3, Dietary Manager) regarding inconsistent weight methods. States that current weight seems accurate. Will monitor next month weight to assess weight trends. Current diet: CCD (consistent carbohydrate diet)/NAS (no added salt), regular texture and regular liquids, intakes are mostly 76-100% per documentation, feeds self, no reports of chewing/swallowing difficulties. Meds (medications), labs, and skin reviewed above. Pt (patient) has multiple wounds - stage 3 to left buttock, stage 2 coccyx and surgical wound. Per (V3) pt refuses supplements. Supplements recommended due to skin breakdown and weight loss. Goals: 1. Maintain adequate nutrition/hydration, 2. stable wt/<5% change within 1 mos (month) period, 3. Labs acceptable to MD (medical doctor) 4. Improved wound healing. Plans: 1 continue CCD-NAS/Reg (regular)/thin liquids. 2. Provide extra oz (ounce) protein with meals to aid with wound healing. 3. Monitor wt intake, labs, and skin 4. Refer to RD (Registered Dietician) PRN (as needed). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R3's Nutrition/Dietary Note, dated 06/21/24 at 10:37 AM, documents, Note text: weight loss follow up/wound Note: Ht: 66 in, Wt: 110.4 lbs (mechanical lift) BMI: 17.8 indicates underweight. Admission weight was 141.2 lbs (wheelchair). This indicates a weight loss of 21.8% (30 lbs) x 4 months. Current diet: CCD/NAS, ground meat and regular liquids, intakes are mostly 76-100% per documentation, feeds self, no reports of chewing/swallowing difficulties. Meds, labs, and skin reviewed above. Pt has multiple wounds - stage 3 to left buttock, stage 2 coccyx and surgical wound. Per (V3) pt refuses supplement. Supplements recommended due to skin breakdown and weight loss. Goals: 1. Maintain adequate nutrition/hydration, 2 stable wt/<5% change within 1 mos period, 3. Labs acceptable to MD 4. Improved wound healing. Plans: 1 continue CCD-NAS/Reg /thin liquids. 2. Provide extra oz protein with meals to aid with wound healing. 3. Monitor wt intake, labs, and skin 4. Refer to RD PRN. R3's Nutrition/Dietary note, dated 07/19/24 at 11:51 AM, documents, Note text: weight loss follow up/wound note: Ht:66 in, Wt: 110.4 lbs (mechanical lift) BMI: 17.8 indicates underweight. No weight for July. Current diet: CCD/NAS, ground meat and regular liquids, intakes are mostly 76-100% per documentation, feeds self, no reports of chewing/swallowing difficulties. Meds, labs, and skin reviewed above. Pt has multiple wounds - stage 3 to left buttock, stage 2 coccyx and surgical wound. Per (V3) pt refuses supplement. Supplements recommended due to skin breakdown and weight loss. Goals: 1. Maintain adequate nutrition/hydration, 2. stable wt/<5% change within 1 mos period, 3. Labs acceptable to MD 4. Improved wound healing. Plans: 1 continue CCD-NAS/Reg /thin liquids. 2. Provide extra oz protein with meals to aid with wound healing. 3. Monitor wt intake, labs, and skin 4. Refer to RD PRN. R3's Order Summary Report, dated 8/1/24, under Dietary orders document active orders of regular diet, ground meat texture, regular/thin consistency, dated 04/24/24 and carb controlled diet/ no added salt, dated 3/14/24. There was no order for added protein noted on R3's Order Summary Report. The facility document titled, week 3 Monday documents: mechanical soft diet: 1 each ground pork fritter with gravy, sauce, 4 ounce scalloped potatoes, 4 ounces green beans, and 4 ounces peaches. On 07/29/24 at 12:10 PM, R3 received a #10 scoop (3.25 ounces) of ground pork fritter, R3 did not receive the extra ounce of protein with his meal. R3's dietary card did not document extra protein for R3. On 07/29/24 at 12:21 PM, V6 (Cook) stated they substituted mashed potatoes for the scalloped potatoes and the #10 scoop is what is listed for the mechanical soft residents to receive for the pork fritter. The facility document titled, week 3 Tuesday documents: mechanical soft diet: 3 ounces ground roast turkey with gravy, 2 ounces poultry gravy, #8 scoop mashed potatoes, 4 ounces Brussel sprouts, 1 each moistened roll/margarine, # 12 scoop warm blueberry cobbler. On 07/30/24 at 12:05 PM, R3 received 3 ounces of ground turkey. R3 did not receive extra protein with his lunch. The facility document titled, week 3 Wednesday documents: mechanical soft diet: 6 fluid ounces choice of juice, 1 serving moistened choice of cereal, 2 each eggs, 1 each soft cinnamon rolls with icing, 8 fluid ounces milk. On 07/31/24 at 8:12 AM, R3 received cereal and a cinnamon roll for breakfast. There were no eggs observed on R3's tray. R3's food intake record documents on 07/31/24 a 3 for breakfast indicating R3 consumed 75 - 100% of R3's breakfast. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility document titled, week 3 Thursday documents: mechanical soft diet: 6 fluid ounces choice of juice, 1 serving moistened choice of cereal, 1 slice sausage breakfast pie with gravy, 1 slice softened toast, 1 teaspoon margarine/jelly, and 3 fluid ounces milk. On 08/01/24 at 8:04 AM, R3 received 2 sausage links and toast for breakfast. There were no eggs observed on R3's tray. On 07/29/24 at 1:17 PM, R3 stated, The food is horrible here. I will leave a note to tell staff to put my food on the table and wake me up if I'm sleeping and they will not do it. I will wake up and my food is sitting there and is cold, and it is already bad enough. The scrambled eggs are horrible, they are watery and make with that liquid egg stuff. The fried eggs are ok sometimes, sometimes they are brown, who knows what kind of oil they are using back there to cook with. Sometimes the omelets are ok, and sometimes not, it is not hard to make an omelet or fry an egg. R3 said he does not know where the cook learned to cook, but it's not right. He stated some of the food here is tough and he cannot chew it, he has no teeth, what do they expect? He eats what he can deal with. He feels like they are trying to starve him here, he is used to eating more. R3 was alert to person, place, and time. On 08/01/24 at 8:07 AM, V15 (Certified Nurse Aide/CNA) stated R3 did not get the eggs that were served because he does not like the scrambled eggs, she stated they do not bring anything else in place of the eggs if the resident does not want the eggs. R3 received two sausage links, the same as everyone else. On 08/01/24 at 9:39 AM, V27 (Dietary) stated she is not aware of any supplements for R3 or any extra protein; they do not offer him a different protein if he does not like the one they are serving. R3 does eat eggs, just not scrambled, he is ok with fried and omelets. On 08/01/24 at 11:07 AM, V3 (Dietary Manager) stated she is not aware R3 is supposed to receive extra protein with any meals. The extra protein is not on his dietary card because she was not aware of it, and no recommendation has been given to nursing by her to be given to the physician because she was not aware. She would have to look through his dietary notes and talk to V14 (Registered Dietician/RD) to find out about that. If the resident does not like scrambled eggs, they will send the plate out without the scrambled eggs, they do not put anything else in the place of them. They tried a few supplements with R3 once, super cereal, gelato and the health shake she believes, and he didn't like them. They tried all three on the same day and did not try them again. There was no order for them, or probably documentation because they just tried them once. V3 stated they substituted the eggs and sausage links breakfast for the sausage pie breakfast today, which was 2 eggs and 2 sausage links. On 08/01/24 at 2:20 PM, R3 stated he tried something similar to ice cream once, but it got melty while he was eating his food. It could have been better if it was frozen. On 08/01/24 at 11:40 AM, V22 (Registered Nurse) stated she believes any recommendation from V14 (Registered Dietician) goes to V3 (Dietary Manager) first, then to the nurse on duty who would then notify the doctor. On 08/01/24 at 12:20 PM, V3 stated any recommendations from the RD should come to her first then go to the nurse and then to the doctor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vandalia Rehab & Health Care C	1500 West St Louis Avenue Vandalia, IL 62471

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 08/02/24 at 3:50 PM, V14 (Registered Dietician) stated she did put a recommendation in for an extra ounce for protein for R3 in May, she has the report where she sent it to V3 (Dietary Manager), when she generates her recommendations, the program automatically generates a report that can be sent to the physician by the facility. V14 stated with his weight loss and wounds, she would expect him to receive the extra protein, and she was not aware he was not. V14 stated she was unaware the supplements were only offered to R3 one time at the same time, she would have expected them to be offered more than once. V14 stated she would expect if there was a protein item being served that R3 did not like, she would expect something different offered in its place, especially since she recommended extra protein. V14 stated if a resident is not served the full meal and only receives a couple items of the meal, she would not consider that to be a 75 - 100% intake. She stated she uses all that information that is documented on a resident to make her recommendations. The facility policy, dated 10/13, titled, Nutrition Supplements and Nourishments documents; It is the policy of (this health care facility) to provide additional calories and/or protein to residents who cannot and/or are not capable of consuming adequate nutrients through their regular meals. It is also the policy of (this health care facility) to provide guidelines for the selection, ordering, use, and monitoring of nutrition supplements and nourishments. Procedure: 1. The need for a nutrition supplement and/or nourishment should be determined by the physician, nursing staff, dietitian, and/or interdisciplinary team (IDT). 5. Nutrition supplements and/or nourishments must be ordered by the physician and are part of the resident's diet order. Nutrition supplements are medical nutrition products and are to be served only with a physician's order. 8. The volume and frequency of supplement is based on the resident's needs. The policy titled, Resident Weight Monitoring, dated 03/19, documents: Procedure step 7. If there is an actual significant weight change (i.e. (in example) +/-5% x 1 month, +/-1 7.5% x 3 months, +/- 10% x 6 months), the resident, POAHC (Power of Attorney for Health Care)/family/guardian, physician and dietitian are notified. The physician shall be notified using the MD (physician) notification of weight change form. 8. The Food Service Manager and interdisciplinary team review the resident's weights and nutritional status, and make recommendations for intervention. 9. The Dietitian shall review and document all significant weight changes along with any recommended nutritional interventions in the dietary progress notes in the medical record monthly. 10. Nursing contacts the physician to convey recommendations from the interdisciplinary team and/or dietitian, and obtains any new orders. 11. Significant weight changes are reviewed in the weekly weight committee meeting. The weight committee will also identify and trends of gradual weight loss or gain. Significant changes in weights are documented in the care plan with goals and approaches/interventions listed. 48356 2. R15's Face Sheet, dated 08/01/24, documents R15 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, chronic kidney disease stage 3, major depressive disorder, anxiety, hyperlipidemia, and constipation. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R15's Care Plan, with a revised date of 05/15/24, documents a focus area of ADL (Activities of Daily Living) function rehab: dependent for ADL's- assists only minimally. Not a candidate for restorative programming. Further decline in ability/participation likely due to cognition and end of life care. Documented interventions include serve diet as ordered and tolerated, see POS (Physician Order Sheets) or tray card for current diet, set up tray per R15 preference, feed R15 meal, record intake for each meal offer subs for foods not eaten. R15's Care Plan also documents a Focus area of Nutrition: the resident has a potential nutritional problem r/t (related to) dementia. Documented interventions include provide and serve supplements as ordered, provide, serve diet as ordered, monitor intake and record every meal, RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed). R15's Order Summary Report, dated 8/1/24, documents active orders of regular diet, mechanical soft texture, nectar/mildly thick consistency, dated 9/14/23, may participate in meal of the month, special occasion and holiday meals, using diet consistency, Lip plate for all meals, Supercereal at breakfast, Magic cup (Nutritional Supplement) at lunch and supper dated 8/23/23, 2.0 calorie Supplement three times a day 90 cc (cubic centimeters) dated 4/2/24, and Hospice care/services, dated 7/18/23. R15's Minimum Data Set (MDS), dated [DATE], documents in Section C, a Brief Interview for Mental Status (BIMS) score of 03, indicating R15 has severe impaired cognition. Section GG documents R15 is dependent for eating. R15's weight summary documents the following weights: 02/16/24 125.6 lbs. (pounds), 03/05/24 123.2 lbs., 04/02/24 118.8, 05/09/24 116.0 lbs., 06/03/24 114.9 lbs., and 07/04/24 116.5 lbs. On 07/29/24 at 11:50AM, R15 was served mechanical soft pork fritter, mashed potatoes with gravy, green beans, peaches with nectar thickened juice and water. There was no magic cup (Nutritional supplement) observed on R15's tray. On 07/30/24 at 11:45AM, R15 was served mechanical soft turkey, mashed potatoes with gravy, mixed vegetables, cobbler, nectar thickened water and juice. There was no magic cup (Nutritional supplement) observed on R15's tray. On 08/01/24 at 9:34AM, V3 (Dietary Manager) stated no resident on 07/29/24 and 07/30/24 received a nutritional supplement at lunch. V3 stated V27 (Dietary Aide) told her she forgot to send out the nutritional supplements on 07/29/24 and 07/30/24 at lunch. V3 said V27 talked to her about it, and told her she forgot the nutritional supplement both days at lunch meal. V3 said she educated V27 about making sure they are served. V3 said all residents who are to receive the nutritional supplement should have received them. V3 said R15 should have received her nutritional supplement, but stated she doesn't eat the nutritional supplement a lot. V3 stated R15 receives nutritional cereal at breakfast, and if R15 doesn't eat well, they will make her the nutritional cereal at lunch and supper as well. V3 said she knows R15 has had a weight loss, but R15 is on hospice care, and it is expected for her to lose weight. On 08/01/24 at 9:40AM, V27, (Dietary Aide) stated she did not serve any resident a nutritional supplement on 07/29/24 and 07/30/24 at lunch meal. V27 said on 07/29/24 she was nervous with serving, and she forgot all about the nutritional supplements. V27 stated on 07/30/24, the day was very crazy, and she didn't think about the nutritional supplement at all. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	34201 3. R4's July 2024 Physician Orders document a diet order for a regular diet, pureed texture, pudding thick liquids, and high calorie/high protein supplement BID (twice a day) served with lunch and supper. On 7/29/24 at 12:08 PM, R4 was sitting up in a reclining wheeled chair being fed by V8 (CNA). R4's meal consisted of pureed pork fritter, mashed potatoes with gravy, green beans, peaches, pudding thick cranberry juice and water. R4 did not have a high calorie/high protein supplement, which V8 confirmed. On 7/30/24 at 12:30 PM, R4 was being fed by V16, CNA. R4's meal consisted of pureed turkey, mashed potatoes with gravy, peas, cake, dinner role, pudding thick tea and water. V16 stated R4 gets a high calorie/high protein supplement at times, and had one last night for supper. V16 confirmed R4 did not receive a supplement at lunch today. On 7/30/24 at 12:35 PM, V6 (Cook) stated R4 gets the high calorie/high protein supplement at supper, but V6 was not aware R4 was supposed to get it at lunch too. On 7/31/24 at 8:44 AM, V14 (Registered Dietician) confirmed R4 is to be receiving the ordered nutritional supplements BID due to a history of weight loss.

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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. 34201 Based on observation, interview, and record review, the facility failed to have a full time Director of Nursing and to ensure Registered Nurse coverage 8 consecutive hours a day, seven days a week. This failure has the potential to affect all 33 residents who reside at the facility. Findings Include: The facility's Social Service Need Notice, dated 6/12/24, documents residents concern of the Administrator not being out on the floor more. V28 (Former Administrator) documented on this form, the Administrator does make daily rounds however is needing to do other things due to V2 (Director of Nursing/DON) being on the floor. On 7/29/24 at 12:09 PM and 7/30/24 at 12:13 PM, V2 (DON) was working the floor as a floor nurse and passing medications to residents. V2 was the only nurse on the unit both days at these times. On 7/30/24 at 12:13 PM, V2 stated V2 used to be the DON, but has not had any office time as DON for two months due to working 12 hour days, 3 days a week on the floor as a floor nurse. V2 stated V2 recently submitted V2's resignation from that position due to not having time to do the duties of a DON. V2 also explained for the last two years, V2 has worked the floor as a nurse more than working as DON. On 7/31/24 between 8:30 AM - 3:30 PM, V2 was not in the building. During this time, V22 (Registered Nurse [RN]/Assistant Director of Nursing [ADON]) was working the floor as a nurse. On 7/31/24 at 11:12 AM, V1 (Administrator) confirmed V2 has not performed DON duties over the past couple of months due to working the floor. On 7/31/24 at 3:15 PM, V13 (Minimum Data Set/Care Plan Coordinator [MDS/CPC]) stated when V22 (RN) is in the building, V22 is working the floor as a nurse, as is V2. On 8/01/24 between 8:00 AM - 12:45 PM, V2 was not in the facility. During this time, V22 (RN/ADON) was working the floor as the nurse. On 8/02/24 at 11:03 AM, V22 (RN/ADON) stated V22 was just a regular floor nurse, not the ADON. The Facility Assessment, dated 7/31/23, documents the facility will have one full time DON and if the DON has other responsibilities, more RN's (Registered Nurses) will be added to the schedule to assist the DON as to equal a full time employee. The facility Room Roster, dated 7/25/24, documents 33 residents reside at the facility. 41610 (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/30/24 at 10:20 AM, V1 (Administrator) stated the provided schedule was the up to date schedule for the facility. On 07/30/24 at 12:13 PM, V2 (DON) stated she has been working the floor due to not having enough RN's to work. The schedule, dated June 2024, documents no Registered Nurse hours worked for 6/2, 6/6, 6/13, 6/16, 06/19, and 06/30. The Long Term Care Facility Application for Medicare and Medicaid (Form CMS 671), dated 07/29/24, documents 33 residents residing at the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34201 Based on interview and record review, the facility failed to ensure as needed psychotropic medications were limited to 14 days for one (R4) of six residents reviewed for unnecessary medications in the sample of 27. Findings Include: R4's Pharmacy Consultation Report, dated 1/10/24, documents R4 received Lorazepam {Benzodiazepine} 0. 5 mg (milligrams) BID (twice a day) and 1 mg every four hours as needed for anxiety. This report documents to please assess R4's medication dosage (s), condition, behaviors, and if clinically appropriate consider reducing a medication in modest increments. On 2/14/24, V18 (Physician) is documented to have declined this recommendation, however, did not document a resident specific rationale why this GDR (Gradual Dose Reduction) was not attempted. R4's July 2024 Physician Order Sheet documents an order received on 8/1/23 for Lorazepam {Benzodiazepine} 1 mg (milligram) every four hours as needed for Anxiety. R4's July 2024 MAR (Medication Administration Record) does not document R4 has received any as needed doses of Lorazepam. On 7/30/24 at 2:53 PM, V13, Minimum Data Set/Care Plan Coordinator, stated as needed psychotropic medications are limited to 14 days, and there is no exceptions for that here in this facility. In order for the order to continue past 14 days, the physician would have to re-evaluate the resident and re-write the order. V13 confirmed R4's as needed Lorazepam should have been discontinued after the 14 days (back in 2023). The facility's Psychotropic Medication Policy, dated 6/17/22, documents residents of this facility shall not be given unnecessary drugs. Unnecessary drugs include any drug used for an excessive duration. As needed psychotropic medications, excluding antipsychotics, may be extended beyond 14 days if the physician or practitioner believe it is appropriate to extend the use but should document a rationale for the extended time period and indicate a specific duration.

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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. 41610 Based on observation, interview, and record review, the facility failed to store and serve food in a safe and sanitary manner in accordance with professional standards. This has the potential to affect all 33 residents residing at the facility. Findings include: On 07/29/24 at 9:51 AM during the initial tour of the kitchen, there were three containers of thickened juice, one kiwi and strawberry flavored and two orange flavored, opened and in the refrigerator with no dates on them. There were two bags of cereal, one whole grain toasted oats and one bran flakes, that were opened with no dates on them. There was a bag of dried milk opened with no date on it. There were also two containers of liquid eggs opened with no dates on them and one package of lunchmeat ham opened with no date on it in the walk in cooler. On 07/29/24 at 9:51 AM during the initial tour of the kitchen, there was a scoop inside the sugar bin laying on top of the sugar and a scoop in the container of coffee laying on top of the ground coffee. On 07/29/24 at 11:35 AM during lunch service, V27 (Dietary) touched the counter, the cart, the plastic wrap box, a pad of paper, and the door handle and then transferred residents drinks by the rim where the resident drinks from. On 08/01/24 at 11:07 AM, V3 (Dietary Manager) stated the opened items in the kitchen, especially in the walk in cooler and refrigerator, should be dated, and there should be no scoops in any of the bins or containers. V3 stated staff shouldn't be transferring glasses by the rims, it should be by the middle or towards the bottom of the glass. The Long Term Care Facility Application for Medicare and Medicaid (Form CMS 671), dated 07/29/24, documents 33 residents residing at the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Based on observation, interview, and record review, the facility failed to follow current standards and practices for infection control regarding handling of soiled linens, hand hygiene, Enhanced Barrier Precautions, and Contact Isolation Precautions to prevent the spread of infection. This failure affects 3 (R6, R13 and R32) of 3 residents reviewed for infection control on the sample list of 27. Findings Include: 1. R6's July 2024 Physician Orders document an order for a Suprapubic Catheter size 16 French and for Suprapubic Catheter Care to be completed every shift. R6's Care Plan, dated 7/24/24, documents R6 has a Suprapubic Catheter due to a diagnosis of Obstructive Uropathy and is on Enhanced Barrier Precautions (EBP). On 7/29/24 at 11:01 AM, R6 was sitting up in a reclining wheelchair in the room. There was no EBP signage hanging outside of R6's room, no Personal Protective Equipment (PPE) outside of R6's room, and no hamper or container inside of R6's room for PPE to be disposed into. On 7/31/24 at 10:19 AM, V17 (Licensed Practical Nurse/LPN) entered R6's room to provide Suprapubic Catheter Care without wearing any PPE. On the wall outside of R6's room, there was a sign hanging on the wall that documents, Enhanced Barrier Precautions: Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing lines, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. There was also a supply cart outside of R6's room that contained PPE. Prior to starting catheter care, V17 donned gloves, but did not don a gown. V17 removed the dressing covering R6's Suprapubic Catheter, which contained a scant amount of brownish/yellowish drainage. After changing gloves and performing hand hygiene, V17 cleansed the area around the Suprapubic catheter with soapy water and a wash cloth, throwing the soiled wash cloth onto the floor when finished. V17 cleansed the area a second time, and then also threw that soiled wash cloth onto the floor. V17 completed care, then picked up the soiled linen from the floor with V17's bare hands. V17 stated V17 never wears any PPE other than gloves when completing R6's Suprapubic Catheter Care. When questioned if R6 was on EBP, V17 walked outside of R6's room, looked at the signage hanging and stated, Yes he is, but he doesn't currently have any infections or anything. On 7/31/24 at 11:20 AM, V13 (Minimum Data Set/Care Plan Coordinator - MDS/CPC) confirmed R6 is on EBP and V17 should have worn gloves and a gown when providing Suprapubic Catheter care. V13 also stated V17 should have been placing the soiled wash clothes into a bag, not throwing them on the floor to then contaminate the floor. 48356 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R13's Face Sheet, dated 08/01/24, documents an admitted [DATE], with diagnoses in part of type 2 diabetes mellitus with diabetic neuropathy, thromboangitis obliterans, adult osteomalacia, acquired absence of other left toe, acquired absence of right toe, local infection of the skin and subcutaneous tissue, and personal history of other disease of the musculoskeletal system and connective tissue. R13's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 15, which indicates R13 is cognitively intact. This MDS also documents R13 is independent with toileting and requires set-up and supervision with bathing, dressing, and personal hygiene, and R13 is independent with transfers. R13's Care Plan, with revised date of 06/11/24, documents a Problem/Need Area of: Alteration in comfort/pain related to absence of toes on left foot as evidenced by R13 asking occasionally for PRN (as needed) medication. Interventions include in part, 01/13/24 TX (Treatment) to diabetic ulcer L (Left) foot, as ordered, Mx (monitor) for s/s (signs and symptoms) of infection t/h (til healed). Enhanced barrier precautions. F/U (Follow Up) with wound care Physician. An additional intervention listed with a date of 07/24/24 documents R13 was placed on Contact Isolation precautions r/t (related to) positive ESBL (extended spectrum beta-lactamase) of Left foot wound. R13's Physician Orders document on 07/25/24 Levofloxacin oral tablet 500mg give 1 tablet by mouth one time a day for wound for 7 days. R13's Progress Note, dated 7/25/24 at 1:28PM, documents R13 continues on levaquin for ESBL of wound to left lateral foot. Contact isolation in place. On 08/01/24 at 10:00AM, V22 (Registered Nurse/RN) provided a dressing change and treatment to R13's left foot. R13's door had signage documenting Enhanced Barrier Precautions with a bin on the outside of the door with gloves, masks, and gowns. V22 walked in R13's room without donning a gown. V22 did put gloves on before entering R13's room. V22 had treatment supplies in her hands. V22 performed treatment to R13 as ordered. R13's wound to the left foot had no surrounding redness, dressing was saturated with blood-tinged exudate. V22 placed the soiled dressing in a clear trash bag liner that was on the end of R13's bed. V22 placed the trash bag liner with soiled dressing in R13's trash can, then left R13's room and applied sanitizer to her hands. On 08/01/24 at 10:30AM, V22 stated she should have donned a gown before entering (R13's) room. V22 did not realize R13 was on contact isolation along with Enhanced Barrier Precautions. V22 stated R13 should have had a red barrel in R13's room to be able to place soiled dressings in the barrel and not carry them out of the room or place in a regular trash can. V22 stated she looked in R13's medical record and it stated R13 was still on contact isolation. V22 stated she will place a contact isolation sign on R13's door, along with placing barrels in the room for soiled linens and trash. V22 stated she screwed up regarding not donning a gown and using a red barrel for isolation. 3. R32's Face Sheet, dated 08/01/24, documents R32 was admitted to the facility on [DATE], and lists diagnoses that included gastrostomy status and neuromuscular dysfunction of bladder. R32's Minimum Data Set (MDS), dated [DATE], documented at risk of developing pressure ulcers and dependent with toileting. (continued on next page)

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Vandalia Rehab & Health Care C	1500 West St Louis Avenue Vandalia, IL 62471

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 09:37AM, R32 was noted to have Enhanced Barrier Precautions signage on her door. V21 (Certified Nurse Assistant/CNA) and V20 (CNA) donned gowns and gloves prior to entering R32's room. R32 was noted to have a gastrosomy tube. V20 and V21 began incontinence care. V21 had incontinent wash and water on a clean washcloth and cleansed R32's groin area. V21 then rolled R32 over onto her right side. R32 had a large amount of loose stool. V21 started to clean stool away from rectum area. V21 did not change gloves or perform hand hygiene, then started to wash buttocks area that had a large amount of white cream noted to right and left buttocks. V21 did use a new washcloth with incontinent wash and water and wiped all the white cream off of R32's right and left buttocks. At this time, R32 was noted to have a 1 centimeter (cm) open area to her right middle buttocks that started bleeding. V21 finished washing R32's right and left buttocks, then assisted V20 with rolling R32 on to her left side without changing gloves or performing hand hygiene. V20 then used a washcloth with incontinent wash and water to wash off R32's right hip. V20 and V21 placed a new adult incontinent brief on R32. V20 and V21 never changed gloves or performed any hand hygiene. V21 then grabbed R32's gown and covers with contaminated gloves and placed them on R32. V20 and V21 removed contaminated gloves as they were leaving R32's room and used hand sanitizer in the hallway. On 07/31/24 at 10:00AM, V20 and V21 both stated they should have changed their gloves and performed hand hygiene after cleaning R32 up after incontinence care, before placing a new adult brief on R32, and touching R32's gown and covers. On 07/31/24 at 1:25PM, V22 (RN) stated R32 is on Enhanced Barrier Precautions. V22 stated residents who are on Enhanced Barrier Precautions are residents who have wounds, gastrostomy tube, or any kind of open area that led to the skin or inside of a resident. V22 said the precautions are there to protect the resident from infection. V22 said the Certified Nurse Assistants should have known to change their gloves and perform hand hygiene after they were done with incontinence care. The facility policy titled Perineal Cleansing, with a review date of 12/17, documents under procedure: Female-without catheter: 4. wet washcloth with cleansing agent chosen, 5. Wash pubic area including upper inner aspect of both thighs and frontal portion of perineum. 8. Dry thoroughly, 15. Remove gloves and wash hands with soap and water, cleansing gel or Theraworx (Hygiene foam) 16. Apply new incontinent product, clothes and reposition comfortably, and 17. Wash hands with soap and water, cleansing gel or Theraworx. 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 policy titled Infection Control Surveillance and Monitoring, revised 04/11/24, documents under procedure: E. Maintains and enforces hand washing by all staff after each resident contact for which hand washing is accepted as medical practice. The Policy titled Enhanced Barrier Precautions, dated 07/13/23, document's purpose: To reduce transmission of multidrug-resistant organisms (MDRO). Enhanced Barrier Precautions (EBP) should be used when contact precautions do not apply for residents with any of the following: open wounds that require a dressing change, indwelling medical devices, and infection or colonized with a MDRO. Examples of MDRO's list in part, ESBL (Extended-Spectrum Beta-Lactamases) Enhanced barrier precautions require use of a gown and gloves during high-contact resident care activities that provide opportunities for the transfer of MDRO's to staff hands and clothing. High-contact care activities include in part: wound care (pressure ulcers, diabetic ulcers, unhealed surgical wounds, chronic venous stasis wounds). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Policy titled Contact Precautions, reviewed 12/07/18, documents under policy: In addition to standard precautions, use contact precaution, or the equivalent for specified resident known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident (hand or skin to skin contact that occurs when performing resident care activities that require touching the residents dry skin) or indirect contact (touching with environmental surfaces or resident care items in the residents environment).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to follow the Influenza Immunization Policy to ensure an influenza vaccine was offerred/provided for one (R21) of five residents reviewed for Influenza Immunizations in the sample of 27. Findings include: R21's Care plan documents an admitted [DATE], and diagnoses including: frontotemporal neurocognitive disorder, dementia, Alzheimer's disease, major depressive disorder, anxiety disorder, and muscle weakness. R21's Physician Order Sheet documents an order dated 11/27/23 of Immunization: may have annual flu vaccine with consent unless contraindicated with an order status of active. R21's current medical record contained a section titled, Immunizations, and under the category labeled Influenza is documented the date of 10/20/22. On 07/30/24 at 10:10 AM, V1 (Administrator) stated she printed off a list of all the current immunizations for all the residents. V1 provided this list and it was titled, Covid Vaccine. This document has a column titled, Influenza and documents R21's most current influenza vaccination was dated 10/20/22. On 08/01/24 at 10:17 AM, V22 (Registered Nurse) stated she can not find anymore information regarding R21's influenza vaccination or documentation regarding a refusal or consent. She stated she does not know if it was offerred to R21 or why she didn't receive it. The facility policy titled, Immunization of Residents documents: Procedure: 3. Obtain permission/consent from the resident, resident's guardian or the resident's durable power of attorney for health care to administer the ordered vaccine, unless contraindicated. 5. Offer the influenza immunization annually from September 1st thru March 31st (with physician order) or as directed by the medical director. Through the time of mass immunization (until March 31st), all new admissions should be assessed from present season immunization, and immunized as appropriate. In the event that an epidemic is occurring after March 31st, immunization should be offered until the epidemic is under control. Contraindications to Influenza vaccine include but are not limited to: severe egg allergy, severe allergy to vaccine components (i.e.: thimerosal, mercury), severe reaction following previous dose of influenza vaccination, diagnosis of Guillain Barre Syndrome - use with caution. 9. Document immunization on the resident's medication administration record and on the resident's immunization record.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 39744 Based on observation, interview, and record review, the facility failed to provide at least 80 square feet per resident bed in multible occupancy resident bedrooms. This failure affects four (R7, R10, R15, R21) of four residents reviewed for environment in the sample of 27. Findings include: Observations on 8/1/2024 at 9:00 AM, revealed R7 resided in a room certified for double occupancy. This room contained two beds, a dresser, two bedside tables and one over the bed table and had limited area to move around inside the room. V4 (Maintenance Director) used a tape measure and measured R7's bedroom. The bedroom measured 136 inches by 151 inches which equals 142.61 total square feet, and equals 71.31 square feet per resident bed. Observations on 8/1/2024 at 9:10 AM, revealed R10 resided in a room certified for double occupancy. This room contained two beds, two bedside tables, one over the bed table, three trash cans, one isolation supply cart, one bedside commode and one dresser, and had limited area to move around inside the room. V4 used a tape measure to measure R10's bedroom. The bedroom measured 141 inches by 151 inches, which equals 147.85 total square feet, and equals 73.93 square feet per resident bed. Observations on 8/1/2024 at 9:20 AM, revealed R15 resided in a room certified for double occupancy. This room contained two beds, two bedside tables, one over the bed table, a trash can, a geriatric reclining chair and a wheeled walking assistive device and had limited area to move around inside the room. V4 used a tape measure to measure R15's bedroom. The bedroom measured 142 inches by 151 inches, which equals 148.9 total square feet, and equals 74.45 square feet per resident bed. Observations on 8/1/2024 at 9:30 AM, revealed R21 resided in a room certified for double occupancy. This room contained two beds, two bedside tables, one dresser, one supply cart for personal belongings, one trash can and one wheelchair with limited area to move around inside the room. V4 used a tape measure to measure R21's bedroom. The bedroom measured 143 inches by 150 inches, which equals 148.96 total square feet, and equals 74.48 square feet per resident bed. On 8/1/2024 at approximately 10:15 AM, V1 (Administrator) was asked if residents were notified during admission that some of the rooms in the facility did not meet the requirement of having 80 square feet of floor space per resident. V1 stated no. V1 said rooms 3-14, 16-23 and 28-31 did not meet the required 80 square feet of floor space per resident bed, and all are certified for double occupancy. V1 stated none of these rooms currently had more than one resident residing in them, but that could change at any time. The facility's Daily Midnight Census sheet (undated) documents R7, R9, R10, R15, R21, R22, R26, R28 and R32 currently reside in the waivered rooms, and none were interviewable. Observations and measurements of these rooms during the survey determined adequate space exists to meet the medical and personal needs of the residents living in these waivered rooms. (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Council Minutes from the past 6 months indicated no concerns related to the size of the rooms included in the waiver.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 41610 Based on observation, interview, and record review, the facility failed to provide an accessible call system for residents in the shower room or the community bathroom. This failure has the potential to affect all 33 residents residing at the facility. Findings include: On 07/29/24 at 1:35 PM, the hall bathroom/shower room on E-Hall was noted to have a call light box on the wall, but no pull cord was observed to be attached to the toggle switch. Thus, the call light near the toilet was not accessible as it could not be reached from the toilet or the floor without a pull cord. The shower stall in this bathroom/shower room also did not contain any call system. On 07/29/24 at 1:39 PM, the hall bathroom/shower room on the D-Hall was noted to have a call light box on the wall, but no pull cord was observed to be attached to the toggle switch. Thus, the call light near the toilet was not accessible as it could not be reached from the toilet or the floor without a pull cord. The shower stall did not contain any call system. On 07/29/24 at 2:17 PM, the hall bathroom/shower room on A-Hall did not have an accessible call light system in the shower stall. On 08/01/24 at 9:10 AM, the hall bathroom/shower room on E-Hall was noted to have a call light box on the wall, but no pull cord was observed to be attached to the toggle switch. Thus, the call light near the toilet was not accessible as it could not be reached from the toilet or the floor without a pull cord. The shower stall did not contain any call system. On 08/01/24 at 9:13 AM, the hall bathroom/shower room on D-Hall was noted to have a call light box on the wall, but no pull cord was observed to be attached to the toggle switch. Thus, the call light near the toilet was not accessible as it could not be reached from the toilet or the floor without a pull cord. The shower stall did not contain any call system. On 08/01/24 at 9:17 AM, the hall bathroom/shower room on A-Hall did not have an accessible call light system in the shower stall. On 08/01/24 at 10:35 AM, V4 (Maintenance) stated he can put a string to make the call light accessible from the toilets in the bathroom/shower rooms on the D and E Hall bathrooms. He stated he will have to figure something out since the shower stalls do not have a call light system. He stated he does not know how long they have been without strings by the toilets, no one had told him about them. On 08/01/24 at 1:37 PM, V1 (Administrator) stated there are two bathrooms/shower rooms on this side of the building (D and E Halls) and one bathroom/shower room on the other side (A-Hall). V1 stated she does not know why they do not have call lights that are accessible from the toilets but she will have V4 fix them today. V1 said she will have to call someone about there not being a call system in the shower stalls for either shower rooms, but they will get it corrected. On 08/01/24 at 4:21 PM, V1 stated she does not have a policy on call light systems. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Long Term Care Facility Application for Medicare and Medicaid (Form CMS 671) dated 07/29/24 documents 33 residents residing at the facility.