STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145903	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vandalia Healthcare & Senior Living	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 0791 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide dental services for 1 of 1 resident (R33) reviewed for dental services in the sample of 29. This failure resulted in R33's cavity and broken teeth going unaddressed and R33 acquiring an abscess requiring antibiotic treatment and ongoing pain. Findings include:R33's admission Record documents an admission date of 10/23/2013, with diagnoses including in part type 2 diabetes, longstanding persistent atrial fibrillation, and hypertension. R33's admission documents R33's payer source is listed as Medicaid. R33's Minimum Date Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) of 14, indicating R33's cognition is intact. R33's Physician's Order Summary documents R33 has and order for Acetaminophen 500 MG (milligrams) tablet, given 2 tablets orally as needed for mild pain up to 3 times a day, with a start date of 8/1/23. On 11/17/2025 at 11:20 AM, R33 stated he has had a tooth pain and a cavity for about a year that he has been asking to get fixed. R33 stated he has been asking since the beginning of the year. Doctors note, dated 5/14/25 written by V16 (Physician), documents under HPI (History of Present Illness); (R33) is complaining of a cavity in his right upper molar area. We are getting him setup to see a dental appointment. Doctors note, dated 7/2/25 written by V16, documents under HPI; (R33) complains of a dental cavity in his right lower jaw area. We are going to get him a dental appointment. Doctors Progress Note-Acute Care, dated 10/29/25 written by V17 (Nurse Practitioner), documents under History of Present Illness,(R33) presented with acute dental pain localized to the left lower gums, accompanied by gum swelling. Examination revealed broken and carious teeth. In the same document under Assessment/Plan, periapical abscess without sinus acute, new order for clindamycin 300 milligrams to be taken three times a day for seven days, refer to dental evaluation, and acetaminophen as needed. On 11/18/25 at 1:03 PM, V14 (Social Services Director) stated she doesn't make appointments, she gives the referral to V8 (Activities Director), and she makes the appointments. V14 stated she doesn't know anything about making R33 a dentist appointment, stating she would have made a note about it in his chart, while she searched through R33's chart and through her filling cabinet. V14 stated she can't find any evidence that she had been working on getting an appointment for R33. On 11/18/25 at 1:28 PM, V15 (Business Office Manager) stated she received a list of residents the week prior that V8 was having problems finding appointments for, and R33 was on it. V8 stated she hadn't started on trying to find a dentist for R33 yet. On 11/18/25 at 1:37 PM, V8 stated she was told the beginning of the prior week that R33 needed an appointment with a dentist, and she was trying to find a dentist that accepts his insurance. V8 stated she gave R33's name to V15 so she could help her fine a dentist. On 11/20/25 at 11:20 AM, V12 (Cook/Certified Nursing Assistant) stated she was the Activities Director/Transport until around the end of August, when she transferred to the kitchen as a cook. V12 stated she was first told to refer R33 to a dentist on 3/18/25, stated she called five different dentist offices, and they were either not taking new patients or would not take his insurance. V12 stated she called another dentist office the end of March and got an appointment for R33 on 4/24/25. V12 stated she took R33 to the dentist on 4/24/25, and they wouldn't see him because no one from the facility confirmed his appointment prior to his scheduled appointment, so the dental office canceled his appointment. V12 stated V13 (continued on next page)

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

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F 0791 Level of Harm - Actual harm Residents Affected - Few	(Former Administrator) was responsible for confirming R33's appointment and she did not do it. V12 stated they rescheduled R33's appointment for 8/6/25 and 8/20/25. V12 stated the dental officed called and canceled R33's appointment for 8/6/25 due to personal reasons, then the called again and canceled the other appointment for 8/20/25 due to the dentist had a family illness. V12 stated when the dental office called and canceled the appointment for 8/20/25, they stated they would call back with a new appointment, and they never called back, so on 9/12/25, she called to make another appointment, and the dental office would not schedule any appointment due to the dentist family illness. V12 stated on 9/12/25, she was no longer in the position to handle appointment, so she gave all of the information about R33 needing a dental appointment to a nurse, but she doesn't remember which nurse she gave it to. On 11/19/25 at 11:52AM, V2 (Director of Nursing) stated when a resident needs a dentist appointment, the referral should be made as soon as possible.

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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. Based on observation, interview, and record review, the facility failed to ensure a resident's wound dressing was changed in accordance with physician's orders for 1 of 1 resident (R20) reviewed for wounds in the sample of 29. Findings include:R20's admission Record documents an admission date of 10/19/25, with diagnoses including in part cellulitis of right lower limb, local infection of the skin and subcutaneous tissue, morbid (severe) obesity due to excess calories, prediabetes, and personal history of methicillin resistant staphylococcus aureus infection. R20's Minimum data Set (MDS) documents a Brief Interview of Mental Status (BIMS) of 14, indicating R20's cognition is intact. R20's Care Plan documents R20 is on antibiotic therapy related to right leg cellulitis and R20 has actual impairment to skin integrity of right posterior lower leg related to cellulitis. R20's Order Summary documents, cleanse wound to right lower extremity with wound cleanser, apply zinc barrier cream, apply calcium alginate over open areas, wrap with gauze then (elastic compression) wrap daily and as needed at bedtime for wound care with a start date of 11/6/25.R20's Wound Assessment and Plan, dated 11/6/25, documents apply zinc barrier cream to periwound. Apply calcium alginate to open wound beds, then wrap lower extremity with kerlix and (elastic compression) wrap daily and as needed. R20's Wound Assessment and Plan, dated 11/13/25, documents apply moisturizing cream or ointment to intact skin of lower leg (such as A&D or vaseline). Cleanse wound beds with Dakins 1/4 strength solution. Apply calcium alginate to open wound beds, then wrap lower extremity with kerlix and elastic compression) wrap daily and as needed. On 11/19/25 at 2:14 PM, V6 (Registered Nurse) changed the dressing on R20's right lower extremity. V6 cleansed the wound with normal saline wound cleanser and gauze, wiped barrier cream in the wound on the wound bed and around the wound, placed calcium alginate over the barrier cream on the wound, then wrapped the leg with an (elastic compression) wrap. On 11/19/25 at 2:20 PM, V6 stated she put the barrier cream in the wound bed because she thought that was the treatment order. V6 looked at the treatment orders in the recent Wound Assessment and Plan, dated 11/13/25, and noted she should have used Dakins solution to cleanse the wound and not the normal saline wound cleanser and V6 stated the barrier creams should have been applied to the intact skin around the wound and not directly on the wound bed because the calcium alginate should be placed on the wound bed. V6 stated she did not round with the wound doctor on 11/13/25, so she doesn't know why the treatment order in the electronic medical record was not updated with the new orders. A facility policy titled Wound Care, dated October 2010, documents under Purpose, the purpose of this procedure is to provide guidelines for the care of wounds to promote healing.

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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** Based on observation, interview, and record review, the facility failed to notify the doctor and obtain treatment orders when the presence of a pressure area was detected for 1 of 3 residents (R4) reviewed for pressure areas in the sample of 29.R4's admission Record documents an admission date of 11/11/2024, with the following diagnoses in part: early-onset cerebellar ataxia, unspecified, sepsis, unspecified organism, and acute respiratory failure with hypoxia.R4's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 2, indicating R4 is severely cognitively impaired. R4's care plan documents a focus area of has impairment to skin integrity. with interventions including, Monitor/document/report PRN (as needed) any changes in current wound and/or skin status: appearance, color, wound healing, s/sx (signs and symptoms) of infection (such as redness, swelling, drainage, foul smell, decline in function) and reduced mobility, wound size (length X width X depth), stage. Report adverse findings to practitioner.R4's physician order sheet, dated 11/19/2025, documents an order for Right Hip - cleanse with wound cleanser and apply skin prep daily at bedtime for wound care, with an initiation date of 11/6/25. There were no additional orders noted for any other wounds located on R4's right buttock or back. R4's Treatment Administration Record (TAR) documents R4's right hip was cleansed with wound cleanser and skin prep was applied at bedtime on 11/18/25. R4's TAR does not document any treatment orders for any other wounds located on R4's right buttock or back. On 11/19/25 at 1:11 PM, observation of R4's right hip revealed a dressing dated 11/17 on R4's right hip and right upper buttocks/back also dated 11/17. V6 (Registered Nurse) removed the dressing to right hip; it was noted to have a scant amount of drainage on the bandage. There appeared to be some cream applied to the wound also. Wound bed was open. Bandage was removed from right upper buttocks/back, there was a quarter sized amount of drainage on the bandage and appeared to have cream on it. On 11/19/25 at 1:11 PM, V6 confirmed both wounds were open. On 11/19/25 at 1:45 PM, V6 confirmed there was no new documentation or dressing change orders for these two open areas. On 11/19/25 at 2:43 PM, V3 (Corporate Nurse) stated her expectation of nursing staff if they find a new wound would be to measure it and contact the physician for orders. V3 stated her expected timeline for that would be by the end of the shift. Facility Policy titled Prevention of Pressure Injuries, dated 2001, documents under the section titled Monitoring, Evaluate, report and document potential changes in the skin.Facility policy titled, Wound Care, dated 2001, documents under the section titled Preparation, Verify there is a physician's order.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administrator intravenous medications safely for 1 of 1 (R25) resident reviewed for intravenous medication administration in a sample of 29. Findings include:R25's admission Record documents an admission date of 11/7/25, with diagnoses including in part infection following a procedure, encounter for surgical aftercare following surgery on the genitourinary system, peritoneal abscess, and long-term use of antibiotics. R25's Minimum Date Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) of 15, indicating R25's cognition is intact. R25's Care Plan documents implementation of enhanced barrier precaution due to R25 has surgical wounds with wound vacuum and/or dressing and secretions or excretions that are unable to be covered or contained and R25 is on intravenous medications and has a peripherally inserted central catheter (PICC) line related to wound infection. R25's Order Summary Report, dated 11/19/25, documents micafungin sodium intravenous solution reconstituted 100 milligrams (mg), use 100 mg intravenously in the afternoon for candidiasis with a start date of 11/9/25. Sodium chloride injection solution 0.9 % use 5 milliliters intravenously every day shift for PICC (peripherally inserted central catheter) line maintenance before and after intravenous infusion-micafungin with a start date of 11/8/25. The same Order Summary Report documents PICC line single lumen to upper extremity, monitor site for signs and/or symptoms of infection or migration with a start date of 11/7/25 and a discontinue date of 11/18/25 and PICC line double lumen to right chest, monitor site for signs and/or symptoms of infection or migration with a start date of 11/18/25. On 11/17/25 at 10:50 AM, R25's door did not have an enhanced barrier sign on it and there was no PPE available at the door or in the room. On 11/17/2025 at 10:58 AM, V6 (Registered Nurse) administered intravenous Micafungin Sodium reconstituted 100 mg medication to R25 through double lumen midline in R25's right chest. V6 cleaned her hands with hand sanitizer then donned gloves. V6 then mixed the IV medication, hung it on the IV pole, then programed the pump. V6 then removed the end cap on one lumen without changing her gloves and cleaned the end cap with alcohol, then attached a 10-milliliter syringe of normal saline and flushed the line then put the same end cap back on the lumen. Then V6 cleaned the other lumen end cap with alcohol without changing her gloves, attached a 10-milliliter syringe of normal saline, and flushed the line with the normal saline. After flushing the line, V6 removed the syringe and attached the medication intravenous line and started the medication at 100ml/hr. V6 did not pull blood back prior to administrating the medication on either lumen to check to patency, and V6 did not don a gown for this procedure. V6 did not change her gloves during this observation when moving to cleaning the catheter lumens and hooking up the IV line after programing the pump. On 11/17/25 at 2:20 PM, V2 (Director of Nursing) stated R28 was admitted with a single lumen PICC line in her upper extremity, but she wasn't sure which arm it was in. V2 was informed the line is in her chest and not her arm and it is a double lumen. V2 stated she wasn't sure what kind of line it was because she thought it was a PICC line in her arm. V2 stated she would try to find documentation on what type of line it is. On 11/19/25 at 11:52 AM, V2 stated V6 should be on enhanced barrier precautions due to her central line and a gown and gloves should be worn when administrating intravenous medication. V2 stated she was able to find that R25's line in her chest is a double lumen tunneled central catheter in her discharge documents from her recent hospital stay. On 11/20/25 at 10:45 AM, V2 stated prior to administrating intravenous medication into the central catheter in R25's chest, it should be flushed and aspirated for blood return prior to each infusion to check catheter patency. A facility policy titled Central Venous Catheter Flushing and Locking, dated June 2025, documents under General Guidelines, Frequency, 1. Flush the catheter and aspirate for blood return prior to each infusion to assess catheter function. Under Flushing when giving medications: 1. Perform hand antisepsis, don non-sterile gloves, 2. Disinfect needleless access device with disinfecting wipe, 3. Attach prefilled saline syringe to needleless access device, 4. Unclamp catheter or lumen, 5. Aspirate slowly for blood return to ensure patency of catheter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record revied the facility failed to administration medication according to the standards of practice for 1 of 5 (R18) residents reviewed for medication administration in a sample of 29. Findings include:R18's admission Record documents an admission date of 7/28/25, with diagnoses including in part type 2 diabetes, hypertension, hypothyroidism, atrial fibrillation, weakness, chronic kidney disease, and depression. R18's Minimum Date Set (MDS), dated [DATE], documents a Brief Assessment of Mental Status (BIMS) of 14, indicating R18's cognition is intact. R18's Medication Administration Record (MAR), dated 11/1/25-11/30/25, documents R18 was given absorbic acid, levothyroxine, metoprolol succinate, modafinil, multivitamin, omeprazole, potassium chloride, sertraline, colace, eliquis, tylenol, and meclizine with his morning medication pass on 11/17/25. On 11/17/25 at 10:39 AM, there were cup of pills sitting on the bedside table beside R18's bed. R18 stated the nurse didn't wake him up to tell him they were there, so he doesn't know how long they've been sitting there. On 11/18/25 at 12:45 PM, V5 (License Practical Nurse) stated she doesn't usually wake R18 up when she takes him his medication if he is sleeping, and she will leave the cup of pills on his bedside table. V5 stated she usually would try to go back into R18's room to check to see if he took his pills, but on 11/17/25, she documented she gave the morning medication at 9:09 AM then she did not go back into the room until 11:21 AM to give his lunch time medication, and when she went in his room at 11:21 AM the pills were gone. On 11/19/25 at 11:52, V2 (Director of Nursing) stated if a resident is sleeping when the nurse goes to give them medication, they should be woken up and given directly to the resident and not left on the bedside table. A facility policy titled Administering Medication, dated April 2019, documents under Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. 20. For residents not in their rooms or otherwise unavailable to receive medications on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication.

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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** Based on observation, interview, and record review, the facility failed to post enhanced barrier precaution signage and provide PPE (Personal Protective Equipment) for a resident and failed to follow proper infection control practices during resident care, for 2 of 2 residents (R4, R25) reviewed for infection control in a sample of 29. Finding include:1. R4's admission Record documents an admission date of 11/11/2024, with the following diagnoses: early-onset cerebellar ataxia, unspecified, sepsis, unspecified organism, and acute respiratory failure with hypoxia.R4's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 2, indicating R4 is severely cognitively impaired.R4's care plan documents a focus of Implementation of Enhanced Barrier, with an initiation date of 9/17/25, with interventions including Use enhanced barrier protection during high contact care activities. R4's Physician's order sheet documents an active order for Enhanced Barrier Precautions, with an initiation date of 7/31/25.On 11/18/25 at 2:56 PM, enhanced barrier precaution sign was posted outside of R4's door, Personal Protective Equipment was stored just inside the door. On 11/18/25 at 2:57 PM, wound care was observed on R4. Wound care was performed by V6 (Registered Nurse) and assisted by V5 (Licensed Practical Nurse). Neither V5 nor V6 donned a gown to perform wound care.On 11/18/25 at 3:15 PM, feeding tube flush was observed on R4. Flush performed by V5 (Licensed Practical Nurse) and assisted by V6 (Registered Nurse). Neither V5 nor V6 put on a gown to perform flush. V5 performed hand hygiene and applied gloves, V6 did not. On 11/19/2025 at 1:10 PM, V6 donned a gown before proceeding with R4's dressing change. V6 stated she was putting a gown on because R4 is on enhanced barrier precautions, and a gown should be worn when providing care for a resident who is on enhanced barrier precautions. 2. R25's admission Record documents an admission date of 11/7/25, with the following diagnoses: chronic kidney disease, stage 2 (mild), essential (primary) hypertension, and pseudomonas.R25's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 15, indicating R25 is cognitively intact. R25's care plan documents implementation of Enhanced Barrier Precaution, with an initiation date of 11/12/25. With interventions including, use enhanced barrier protection during high contact care activities.R25's Physician's order sheet does not document an order for enhanced barrier precautions. On 11/17/25 at 10:50 AM, R25's door did not have an enhanced barrier sign on it and there was no PPE available at the door or in the room.On 11/17/2025 at 10:58 AM, V6 (Registered Nurse) administered intravenous (IV) Micafungin Sodium reconstituted 100 mg medication to R25 through double lumen midline in R25's right chest. V6 cleaned her hands with hand sanitizer then donned gloves. V6 then mixed the IV medication, hung it on the IV pole, then programed the pump. V6 then removed the end cap on one lumen without changing her gloves, cleaned the end cap with alcohol, then attached a 10 ml syringe of normal saline and flushed the line then put the same end cap back on the lumen. Then V6 cleaned the other lumen with alcohol, attached a 10 ml syringe of normal saline, and flushed the line with the normal saline. After flushing the line, V6 removed the syringe and attached the medication IV line and started the medication at 100ml/hr. V6 did not pull blood back prior to flushing with normal saline on either lumen. V6 did not don a gown for this procedure. V6 did not change her gloves during this observation when moving to cleaning the catheter lumens and hooking up the IV line after programing the pump.On 11/19/25 at 11:52 AM, V2 (Director of Nurses) stated V6 should be on enhanced barrier precautions due to her central line, and a gown and gloves should be worn when administrating intravenous medication.Facility Policy titled, Enhanced Barrier Precautions, dated 2001, documents under Policy Interpretation and Implementation. 1. Enhance barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities.b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that cannot be covered or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contained. 5. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies Gloves and gown are applied prior to performing the high contact resident care activity. 17. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE (Personal Protective Equipment) required.