STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145906	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Rehab & Hcc	800 Division Street Dixon, IL 61021

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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 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. 34490 Based on interview and record review that facility failed to ensure a resident with a diagnosis of congestive heart failure had daily weights performed as ordered for 1 of 18 residents (R15) reviewed for quality of care in the sample of 18. The findings include: R15's Face Sheet shows that she has diagnoses of acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (CHF), myocardial infarction, atrial fibrillation, chronic kidney disease, shortness of breath, hypertension, chronic obstructive pulmonary disease and atherosclerotic heart disease. R15's Physician's Order Sheet shows an order dated 2/28/24 for daily weights for a diagnosis of CHF. R15's Weights and Vitals summary printed on 10/22/24 shows that between 7/13/24 and 10/22/24, R15 did not receive a weight on 7/13, 7/14, 7/15, 7/18, 8/7, 8/15, 8/16, 8/24, 8/29, 9/6, 9/14, 9/16, 9/26, 9/27, 9/28, 9/29, 10/2, 10/6, 10/8, 10/9, 10/13, 10/14, 10/16, 10/17, 10/19 and 10/21/24. On 10/22/24 at 12:58 PM, V2 (Director of Nursing) said that if weights are ordered daily for a resident, they should be done daily and recorded in the electronic medical record. V2 said that it is important to get ordered weights for CHF residents to assess for weight gain or fluid overload due to their heart failure. The facility's Weight Assessment and Interventions Policy dated 1/2017 shows, Weights will be recorded in the individual's medical record.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 34117 Based on observation, interview and record review the facility failed to ensure pressure ulcers were assessed, prescribed treatment orders were transcribed and provided, and treatment dressings were in place for residents with pressure ulcers. These failures apply to 4 of 5 (R179, R6, R66, R55) residents reviewed for pressure ulcers in the sample of 18. The findings include: 1. R179's face sheet shows she is a [AGE] year old female admitted to the facility on [DATE], from another facility. Her diagnoses include COPD, unspecified dementia without behavioral disturbance, type 2 diabetes, multiple sclerosis, gastrostomy status, unspecified cerebral infarction. On 10/21/24 at 9:24 AM, V7 (Licensed Practical Nurse/LPN) provided wound care to R179. V7 removed the soiled dressing from her coccyx. A round open area to her coccyx was observed. V7 cleansed the wound, applied calcium alginate and foam dressing but did not apply the medicated cream to the wound bed. V7 said R179's treatment order was santyl and calcium alginate. R179's Wound Assessment form dated 10/2/24 documents a stage 3 coccyx pressure ulcer measuring 3.8 cm (centimeters) x 5.8 cm x 0.9 cm. R179's Treatment Medication Administration Record shows orders to cleanse the wound with normal saline, to irrigate and scrub the wound bed, the apply collagenase santyl, nickel thick (2 millimeters) topically to entire wound bed, edge to edge. Apply calcium alginate to wound bed, cover with foam dressing. R179's Nursing Admission/Readmission Data Collection report dated 10/9/24 documents an open area to her coccyx but it does not include measurements of the wound. R179's EHR (electronic health record) does not show an assessment of R179's wound after 10/9/24. On 10/22/24 at 1:17 PM, V2 (Director of Nursing/DON) said she is the DON and the wound nurse. She has been doing both positions since November 2023. Wounds should be assessed on admission and weekly. The physician prescribes the wound treatment and staff should follow the treatments orders. 2. R6's face sheet shows he is a [AGE] year old male with diagnoses including dysphagia, CHF, atrial fibrillation, acquired absence right leg below knee amputee, type 2 diabetes, depression, and adult t-cell lymphoma/leukemia in remission. On 10/21/24 at 10:38 AM, R6 was lying in his bed. He said he has a wound on his bottom with no dressing on. On 10/21/24 at 1:58 PM, V6 (Registered Nurse/RN) and V8 (CNA-Certified Nursing Assistant) entered R6's room to provide wound care. V7 rolled R6 on his side, there was no treatment dressing to his open wound on his right buttock. Bloody drainage was noted on the incontinent pad. At 2:08 PM, V6 said she was not sure why R6 did not have dressing on, she thinks because R6 had a bed bath earlier but was not sure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/22/24 at 1:17 PM, V2 (DON) said R6 has a stage 2 on his buttock, he should have a treatment dressing in place. R6's Minimum Data Set assessment dated [DATE] shows he has stage 2 pressure ulcer. R6's Wound Progress note dated 10/9/24 documents his right buttock wound measuring 6.8 cm x 0.2 cm x 5 cm with treatment orders including to cleanse wound with hydrochlorous, apply calcium alginate to wound bed and apply foam dressing daily. 3. R66's face sheet shows he is a [AGE] year old male with diagnoses including muscle wasting, encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below the knee, type 2 diabetes, peripheral vascular disease, and non-pressure chronic leg ulcer of right lower extremity. On 10/21/24 at 1:45 PM, V6 (RN) said R66 was admitted with a pressure wound to his sacrum and left below knee amputation. R66 was lying in bed. To his right lower extremity, an ace wrap was in place and left below knee amputee. V8 (CNA) assisted him on side. Two foam dressings were in place to the right and left sacrum. V6 removed the old dressing, cleansed the wound and applied medi-honey, calcium alginate and foam dressing. On 10/21/24 at 2:08 PM, V6(RN) said the floor nurses do the treatment orders on wounds, but she was not sure who is measuring wounds and wounds should be measured weekly. R66's Wound Weekly Report dated 9/5/24 documents left sacrum wound measuring 4.5 cm x 6.0 cm and right sacrum measuring 2.0 cm x 3.5 cm. R66's Pressure Ulcer Weekly Wound Evaluation report dated 10/14/24 documents stage 2 sacrum pressure measuring 2.3 cm x 1.7 cm x 0.1 cm signed by V2 (DON) on 10/22/24. The same report does not include the two open areas to his sacrum. R66's EHR does not show documentation of the sacral wounds after 9/5/24 to 10/22/24 approximately six weeks. On 10/22/24 at 1:17 PM, V2 (DON) said she has been the wound nurse and DON since November of last year. Wounds should be assessed weekly to ensure wounds are not getting worse. She got behind on things and did not measure R66's wound until today. 4. On 10/21/24 at 10:01 AM, R55 was observed sitting in her wheelchair, she said she has wound on her bottom with a dressing in place. R55's Physician Wound Assessment report dated 10/9/24 documents a stage 3 sacrum pressure ulcer measuring 4.5 cm x 3 cm x 0.2 cm. Treatment orders include cleanse wound with hypochlorous acid, apply skin prep to wound, apply calcium alginate to wound bed, and cover with bordered foam daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R55's Treatment Administration Record (T.A.R.) shows orders to cleanse sacral wound with wound cleanser, apply medihoney, calcium alginate and bordered gauze daily and as needed. The T.A.R did not show orders were changed until 10/22/24 (13 days later) with orders to cleanse wound with hypochlorous acid, apply skin prep to wound and apply calcium alginate to wound bed, cover with bordered foam daily. On 10/22/24 at 1:17 PM, V2 (DON) said the wound physician comes weekly, she receives the wound report that day or the day after, and she changes the orders if needed. She confirmed R55's treatment orders were not changed until today and she was not receiving the prescribed treatment. The facility's Pressure/Wound List provided on 10/22/24 does not include R179, R6, R66 and R55's pressure ulcers. The facility's Pressure Ulcer/Pressure Injury Prevention Policy dated 2022 states, A facility must identify whether the resident is at risk for developing or has a pressure ulcer upon admission and thereafter, evaluate resident specific risk factors and changes to the resident condition that may impact the development and;/or healing of pressure ulcer, implement, monitor and modify interventions .provide treatment .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview and record review the facility failed to ensure a resident received Passive Range of Motion (PROM) to her left upper and lower extremity and failed to ensure a splint was applied for 1 of 4 residents (R27) reviewed for range of motion in the sample of 18. The findings include: R27's Minimum Data Set assessment dated [DATE] shows that her cognition is intact, she has an impairment of one side of her upper and lower extremity and has no rejections of care. On 10/21/24 at 9:00 AM, R27 had a contracted left hand. There was no splint in place on R27's left hand. R27 said that she is unable to move her left arm or left leg due to a stroke. On 10/22/24 at 8:45 AM, R27 was laying in bed. R27 did not have a splint on her left hand. On 10/23/24 at 8:40 AM, R27 said that they do not do exercises (ROM) on her left arm or left leg. R27 said that she did have a brace for her left hand in the past but they have not put it on her recently. R27 said that she would love exercises done to her left arm and left leg because she can not yet move them herself. On 10/22/24 at 1:40 PM, V10 (Restorative Aide) said that R27 is not on his assignment for ROM. V10 said that R27 likes to do it herself. V10 said that R27 used to have a splint but she didn't like it so he never put it on her. V10 said that if R27 wants ROM, he will do it but he didn't think that she wanted it. On 10/23/24 at 8:45 AM, V9 (Physical Therapy Assistant) said that R27 can not move her left arm and left leg on her own due to them being flaccid. V9 said that they have tried a splint on R27's left hand in the past but she did not like it. R27's Care Plan printed on 10/22/24 shows, Resting hand splint when in bed. If resident complaints of pain, may remove .Active Range of Motion .Cue [R27] to perform AROM exercises to right arm and right leg, 3 sets of 10 repetitions .Passive Range of Motion .Assist [R27] with PROM exercises to left arm and left leg, 3 sets of 10 repetitions. The facility's Restorative Nursing Policy and Procedure revised on 7/1/24 shows, It is the policy of this facility to provide restorative nursing which promotes the resident's ability to adapt and adjust to living as independently and safely as possible. Restorative nursing focuses on achieving and/or maintaining optimal physical, mental, and psychological function of the resident.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on observation, interview and record review the facility failed to ensure effective fall interventions were in place for resident's safety who is a high risk for falls and has a history of falls. This failure resulted in R45 falling out of bed and sustaining a left hip fracture needing surgical repair for 1 of 18 residents (R45) reviewed for safety in the sample of 18. The findings include: R45's Physician Order Sheet show R45 is [AGE] year old with diagnoses of vascular dementia, hypertension, weakness and left hip fracture R45's facility assessment dated [DATE] show R45 is severely cognitively impaired (BIMS of 1) R45's fall risk assessment dated [DATE] show R45 as a high risk for falls. On 10/21/24 at 9AM, R45 was in bed moaning I am sore. V19 (Registered Nurse) was with R45 at this time and said R45 has a hip fracture due to fall. On 10/21/24 at PM, V20 (R45's daughter) said she was very disappointed at the facility. My mom has had four (4) falls. All of these falls were her trying to go to the bathroom. Staff knew this is what she does so they needed to check on her often to see if she needed to use the bathroom. Staff should have made a schedule for her to go to the bathroom before she even tries to get up on her own. She (R45) had injuries due to these falls. She (R45) had large cut in her forehead when she fell late last year. She fell face forward while in the bathroom. This latest fall, last week, had resulted in her breaking her hip and had to have surgery to fix her broken hip. Again she was trying to go to the bathroom. V20 said [R45] has dementia and reminders for her not to get up by herself does not work, she won't remember that. R45 is weak and unsteady, she needs her device (walker) and a staff to bring her to the bathroom. Review of R45's fall incident reports show: 11/7/2023-(fall with injury) R45 self transferred from her bed into the bathroom .she lost her balance falling forward striking her head on the floor. Laceration to forehead, nose and right hand . Careplan documents intervention as follows: Do not leave resident in bathroom unattended. 1/31/24-resident audibly moaning, and door was shut . at 23:15 resident was on the floor in her bathroom . resident was sitting on the floor in front of her toilet, with her legs stretched out in front of her . Careplan documents intervention as follows: Call don't fall sign. Make sure R45's call light is within reach and encourage to use it for assistance as needed. (R45 has dementia) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	9/8/24-This writer was notified by 200 hall nurse resident was in bathroom floor lying on her stomach with her head near the doorframe . Careplan documents intervention as follows: Encourage leaving bedroom door open for increased visualization and safety. R45's latest fall dated 10/16/24 (fall with injury) timed at 5:35 AM Residents roommate came out of the nurses station to say resident had fallen in her room. Resident was lying at the foot of the bed on her left side .complained of left hip pain .resident sent to ER. Hospital records dated 10/16/24 show, Fall at (nursing home), patient was getting to go to the bathroom when she fell and landed on her left side. Radiology report dated 10/16/24 show acute comminuted left intertrochanteric fracture. 10/17/24 [R45] had surgery for the left hip fracture. On 10/23/24 at 9 AM V1 (Administrator) and V2 (DON) said they completed R45's investigation and concluded that R45 was attempting to go to the bathroom again and not waiting for assistance. A Facility Reported incident sent to the state agency with date of incident 10/16/24 shows, Resident noted by roommate attempting to self-ambulate from bed. Roommate states she told resident to wait for help and use call light, resident continued to attempt self-transfer and subsequently fell . Resident noted to have her one slipper on and one off. Resident did not use her assistive device. Roommate notified nurse of fall. Injury: Closed intertrochanteric fracture of left hip. . Resident readmitted to facility (10/19/24) s/p surgical hip pinning for closed intertrochanteric fracture of left hip and new diagnosis of UTI. R45 is alert and oriented x 1. Upon investigation of fall, it was determined that resident did not use her call light or wait for assistance despite reminders to do. On 10/22/24 at 2:24 PM, V21 (CNA) said she was R45's CNA on 10/16/24. R45 gets up to go to the bathroom and does not wait for assistance even when told repeatedly. R45 was toileted at 3:30 AM. V21 said at 5AM, she started to get up other residents. At around 5:30 AM, she heard R45 fell trying to get up unassisted. V21 said R45 might be trying to go to the bathroom at that time, that's also 2 hours after she was toileted earlier. V21 said R45 has dementia and forgets reminders. On 10/22/24 at 12:45 PM, V22 (LPN) said she was R45's nurse on 10/16/24. She last saw R45 around midnight and R45 was asleep. At around 5:30 AM, R18 (roommate) came to the nurses station and said R45 fell . R45 was at the foot of her bed lying in her left side. R45 got up from her bed unassisted. R45 was sent to the hospital due to left leg pain. She was found to have left hip fracture. V22 said R45 has been reminded to ask for assistance. V22 confirmed R45 has dementia and reminders for her to wait for staff do not work. R18 (R45's roommate) alert and oriented said she heard a loud sound. She saw R45 on the floor at the foot of R45's bed saying help me! R18 said she put her call light on and waited, then went to the desk and said. Please help she's on the floor! Two of them (staff) came and lifted her to bed then she left to go to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	This surveyor clarified with V1 (Administrator) and V2 (DON) R45's fall interventions and their effectiveness. V2 confirmed that all of R45's four falls involved R45 trying to go to the bathroom unassisted. R45 has dementia (BIMS of 1). V2 (DON) said more frequent checks and toileting schedule would have been more appropriate interventions for R45 to prevent these falls. V1 (Administrator) said they recognized that residents interventions in the careplan were not specifics and resident centered. V1 said they have a started working with their Nurse Consultant regarding this matter. The facility's Fall Policy dated 9/17/19 shows, The purpose of the fall management program is to develop, implement, monitor and evaluate an interdisciplinary team fall prevention approach and manage strategies and intervention that foster residents independence and quality of life.

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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** 34117 Based on observation, interview and record review the facility failed to accurately assess a residents weight loss and ensure nutritional interventions were implemented for a resident with significant weight loss. This failure resulted in R66's significant weight loss. This applies to 1 of 5 residents (R66) reviewed for weight loss in the sample of 18. The findings include: R66's face sheet shows he is a [AGE] year old male admitted to the facility on [DATE] with diagnoses including muscle wasting, encounter for orthopedic aftercare following surgical amputation, acquired absence of left leg below the knee, type 2 diabetes, peripheral vascular disease, and a non-pressure chronic leg ulcer of right lower extremity. R66's weight report provided on 10/22/24 documents: 8/27/24- 208.8 lb (pounds) 9/24/24- 184 lb 10/8/24- 186 lb 10/17/24- 182.2 lb R66's electronic health medical record documents Regular Diet, Regular Texture, Regular liquid Consistancy. Needs double portions of meat, eggs and milk at each meal for wound healing, start date: 8/26/24. R66's Dietary Note dated 10/10/24 documents he triggered significant weight loss of 6% in one month and 11% weight loss since admission. R66 had a left below knee prior to admission, was admitted with a cast to leg per DON (Director of Nursing). Currently has a stage II pressure ulcer to sacrum per DON. Diet regular, double meats, eggs and milk all meals .weight loss may be partially related to cast removal . will advise to increase liquid protein to 30 ml (milliliters) twice a day and continue to monitor weight. R66's weight report shows he lost 4 additional pounds since 10/10/24. On 10/21/24 at 12:02 PM, R66 was in his room eating in bed, using his right hand to feed himself. On 10/22/24 at 8:55 AM, R66 was in his room lying in bed. He said he noticed he has been losing weight but not sure why. An elastic bandage was wrapped to his right leg and left leg below knee amputee. He said he never had a cast on his leg and he has not been seen by V24 (Dietitian) recently. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 at 9:47 PM, V24 said nutrition assessments are done on admission, quarterly and if a resident triggers for weight loss. She monitors the weight report, if a resident triggers for weight loss the resident should be re-assessed with interventions implemented. She is at the facility twice a week but it could take up to two weeks or longer before she assesses the resident. R66 triggered for significant weight loss last month, he had double proteins in place and she recommended increasing his liquid protein from daily to twice a day. She said she did not physically see him, she was told he had a cast on his leg and contributed part of his weight loss to that. She said she sends the recommendations to V2 DON. R66's EHR (electronic health record) does not show documentation of a cast to his leg. R66's Physician Order Sheets dated October 2024 shows orders for liquid protein daily (not twice a day). The facility's Nutrition (Impaired)/Unplanned Weight Loss Policy states, The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month -5% weight loss is significant, greater than 5% is severe .the staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis and treatment wishes .the staff will implement appropriate general or cause-specific interventions, as indicated .

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on observation, interview and record review the facility failed to ensure residents pain was managed after undergoing hip surgery. This failure resulted in R45 experiencing severe pain to 1 of 18 residents (R45) reviewed for pain management in the sample of 18. The findings include: R45 has diagnoses that include fractured left hip undergoing hip surgery, dementia, hypertension and weakness. R45 was readmitted to the facility on [DATE] after undergoing surgical repair to her left hip fracture caused by a fall. On 10/21/24 at 9AM, R45 was in bed moaning I am sore. V19 (Registered Nurse/RN) was with R45 at this time and said R45 has a hip fracture due to fall. On 10/21/24 at 12 PM, R45's room was closed but can hear audible moaning. This surveyor entered R45's room. R45 was in the bathroom sitting in the toilet seat. V18 (Certified Nursing Assistant) was with R45. R45 was crying in pain. It's sore!, it is so painful! I can't take this please, I can't, please help me, it hurt's so bad. V18 asked this surveyor to get the nurse. When V19 (RN) was in the room, she asked R45 what's wrong? R45 responded, this is so painful! pointing to her left hip. It is so sore, please help. V19 told R45 you had hip fracture! of course it will hurt!, do you want to go back to the hospital ? R45 answered I don't think that was necessary but my hip hurts so bad, I just want to go lay down!. V17 and V18 (both CNAs) tried to lift R45 up using using a gait belt to her wheelchair. R45 cannot bear weight and cried out I cannot move!, no please! this is sore touching her left hip again it is so painful! A walker was then placed in front of R45. R45 was directed to use the walker to get up. R45 said she cannot move, her legs hurts. V3 (Assistant Director of Nursing) came in the room. R45 said she cannot take the pain in her hip any longer. V3 informed R45 she understood R45 was experiencing severe pain and will try to put R45 to bed. V3 (ADON) was able to transfer R45 via sit to stand and R45 was placed in bed. R45 continued to moan. V19 (RN) then gave a pill to R45 and left the room. At 12:30 PM, This surveyor asked V19 (RN) what did she give R45. V19 said she gave R45 her pain medication. V19 said R45 has an old order of pain meds even before having surgery given four times a day 8AM, 12PM, 4PM, 8PM. Date of order 5/1/24. V19 said R45's pain is increased at this time due to hip surgery. R45's pain level was 6 (severe pain) At 2PM V3 ADON said R45 was definitely experiencing severe pain after this hip surgery At 2:48 PM, V18 (CNA) said R45 does this whimpering sound but earlier when R45 was toileted she had this excruciating pain in her hip that she cannot even move. R45's pain had definitely increased. R45's hospital discharge orders dated 10/19/24 after having hip surgery show a new pain med order of Norco 5/325 (Narcotic pain medication) 1 tab every four hours (approximately 3 days ago). (continued on next page)

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	145906	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Rehab & Hcc	800 Division Street Dixon, IL 61021

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of R45's Physician Order sheet dated 10/24 and R45's medication administration sheet (MAR) still has R45's old order (5/1/24) of Norco 1 tab four times a day. The new order of R45's Norco (every 4 hours) was not carried out. On 10/22/24 at 1:10 PM, V2 (DON) said when residents were readmitted , medications were reviewed to ensure all the ordered medications were carried out. R45's careplan with a revision date of 10/21/24 show R45 has pain whimpering .further risk for pain related to recent fall with left hip fracture. R45 does complain of pain during transfers. With intervention that include, monitor residents complaint of pain. Notify physician if intervention are unsuccessful or if current complaint is a significant change from residents past experience. On 10/23/24 at 9AM, V2 (DON) confirmed to this surveyor that R45's pain med from the hospital discharge orders had been corrected to reflect the correct order for R45's pain medications order last 10/19/24. (Norco 5/325 1 tab every 4 hours.)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview and record review the facility failed to ensure a resident who was experiencing increased depression received psychiatric services timely as prescribed. This applies to 1 of 18 residents (R29) reviewed for behavioral services in the sample of 18. The findings include: R29's face sheet shows he is a [AGE] year old male with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, restlessness and agitation, calculus of kidney, unspecified psychosis, insomnia, hypertension and anxiety. On 10/21/24 at 10:25 AM, R29 was observed sitting in his wheelchair outside of his room with his call light on. He said he needed to use the bathroom. V7 and V18 (Both Certified Nursing Assistant's) assisted R29 to the bathroom using the mechanical stand lift. R29 did not express any concerns or behaviors. On 10/22/24 at 3:00 PM, R29 was observed in his room lying in bed. He said has made self-harm threats in the past, but says he was joking and is seen by psych. On 10/22/24 at 11:49 AM, V6 (RN-Registered Nurse) said R29 has been pleasant towards me, but has had behaviors in the past of making self-harm statements, hitting himself, and staff found him with a garbage bag over his head at one time. He has a history of kidney stones and several months ago he decided he was not going to follow up with the urologist, he was complaining of pain and making statements of self-harm. He was sent out to the local hospital, physician was notified, and recommended he follow up with the urologist and psych. He did have a kidney stone that was removed sometime in October 2024. He has a history of not getting along with his roommates and is on his third roommate. On 10/22/24 at 1:17 PM, V2 (DON) said R29 is being seen by psych services, he had increased behaviors due to pain and has followed with urology. On 10/23/24 at 8:39 AM, V5 (SSD-Social Service Director) said R29 has behaviors of getting angry, has had suicidal thoughts, and history of not getting along with his roommates. When he does not get his way or is having pain he makes statements of self-harm. He has told me he does not mean what he says it's just he's having pain. She talks to R29 weekly and does not think he is at risk for self-harm R29's Nurse Practitioner (NP) progress note dated 9/9/24 documents, R1 seen today for nursing concerns of increased depression/concern for self harm. He complains of bilateral low back pain that started a couple of days ago. R1 states, it is kidney stone pain.Nursing reports that two nights ago a staff person walked into his room and he had a garbage over his head and stated he wanted to die at that time. During my visit with him today he denies self harm however states he did that with the garbage bag because he was in pain .will address pain and have psych see him today .he does follow up with urology tomorrow. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29's Physician Orders dated 9/9/24 documents please have psych see today for increased depression. R29's Psych Progress note dated 9/16/24 (7 days later) documents chief complaint: depression, anxiety and insomnia staff reports of wanting to give up this is related to patient reported kidney pain .he reported not wanting to live due to pain and expressed no plans for self-harm. On 10/23/24 at 11:10 AM, V2 (DON) said on 9/9/24 there was an order for him to be seen by psych. We sent the referral, she did not know the order was for him to be seen that day. He would have been sent to the ER to be seen by psych because they do not come out on emergent cases. Psych usually comes to the facility on Mondays and the provider was on vacation that week. She did not call R29's NP to inform her psych was not available. R29's careplan initiated on 3/14/22 documents he has a history of suicidal ideation's with a known plan with interventions including try to reason with him, remove any threatening or potentially harmful objects and notify nurse, MD, NP and POA, monitor behavior, and intervene as necessary. His careplan also shows he has depression related to loss of independence with interventions offer him mental health services, including individual counseling, arrange for psych consult and follow up as indicated. The facility's Behavioral Assessment, Intervention and Monitoring Policy states, The staff will identify, document and inform the medical practitioner about specific details regarding changes in an individuals mental status, behavior, and cognitive .interventions will be individualized to provide the highest level of well being .

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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. 34490 Based on observation, interview and record review the facility failed to ensure a resident's medications were administered according to standards of practice for 1 of 18 residents (R15) reviewed for storage of medications in the sample of 18. The findings include: On 10/21/24 at 9:03 AM, R15 was sitting in a chair in her room eating breakfast. R15 had 8 pills in a medication cup on her bedside table. R15 stated, Those are my morning pills. There was no nurse present in the room. On 10/21/24 at 9:13 AM, V6 (Registered Nurse) said that she administered R15's morning medications already so she does not know what medications would have been on R15's bedside table. V6 said that medications should never be left in a resident's room and the nurse should always ensure that the resident takes the medications before leaving the resident. On 10/21/24 at 9:15 AM, V6 entered R15's room. The pills that were on R15's bedside table were gone. R15 stated, I just took my morning pills that you left, you know that I don't take them until after I am done with breakfast. On 10/22/24 at 12:58 PM, V2 (Director of Nursing) said that the nurse should make sure that the resident takes their medications before they leave the room . V2 said that it is not a practice of the facility to just leave them in the room. V2 said that if they are left, the nurse can not ensure that the medication was taken. R15's Nursing Notes dated 10/21/24 shows, This nurse administered resident AM medications. At approximately 0905 it was reported to this nurse that resident had a cup with medication at her bedside. When this nurse entered resident's room there was no cup with medications present. Resident stated to this nurse that she had just taken this cup of medications, but this nurse had observed resident take AM medications with nurse present. No such cup of medication was at bedside after administration of medications. MD (Physician) updated on probable ingestion of additional unknown medications of unknown quantity. The facility's Administration of Medications Policy revised on 4/21 shows, The nurse's station shall have necessary items and equipment available for proper administration of medications, and current standards of practice should be followed.

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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. 34490 Based on interview and record review the facility failed to ensure an as needed antipsychotic was limited to 14 days and failed to ensure an as needed antianxiety medication had a stop date for 1 of 5 residents (R69) reviewed for psychotropic medications in the sample of 18. The findings include: R69's Physician's Order Sheet (POS) shows an order dated 8/30/24 for: Haloperidol Lactate (antipsychotic)-Give 0.25 ml (milliliters) by mouth every two hours as needed for agitation. There is no end date documented on the POS. R69's POS shows an order dated 8/30/24 for: Lorazepam (antianxiety) 0.5 mg (milligrams)-Give one tablet by mouth every two hours as needed for shortness of breath, air hunger or anxiety. There is no end date documented on the POS. R69's POS shows an order dated 10/8/24 for: Lorazepam 2 mg/ml-Give 0.5 mg by mouth every two hours as needed for restlessness or anxiety. There is no end date documented on the POS. On 10/22/24 at 1:35 PM, V2 (Director of Nursing) said that all psychotropic medications are ordered for only 14 days. V2 said that if after the 14 days, the physician feels that the resident needs the medication for longer, they can extend the duration. V2 said that the orders should always have a stop date entered that should be either 14 days or what the physician wants but it has to have an end date entered in the order. V2 said that the facility does not use as needed antipsychotics. R69's 9/9/24 Pharmacy Medication Regimen Review shows, Resident has the following PRN (as needed) antipsychotic without a stop date. Haloperidol as needed for agitation .CMS instituted a 14 day limit on PRN antipsychotic orders. If the medication is necessary beyond 14 days, the the prescriber must directly (in person) evaluate the patient, document the specific diagnosed condition and indication, and write justification for writing a new order Resident started on Lorazepam PRN .CMS instituted a 14 day limit on new PRN psychotropic orders. If the order is to extend beyond 14 days, the prescriber must directly or indirectly evaluate the patient, then document the specific diagnosed condition and indication as well as a specific duration that the medication will continue. The facility's Psychotropic Medication Use Policy dated 9/2022 shows, The timeframe for PRN psychotropic medications, which are not antipsychotic medications, will be limited to 14 days unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner. The timeframe for PRN psychotropic medications which are antipsychotic medications will be limited to 14 days. A new order will not be entered without the physician or prescriber first evaluating the resident.

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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. 35541 Based on observation, interview and record review the facility to ensure dishes were handled in a sanitary manner to prevent cross contamination. This failure has the potential to affect all 89 residents in the facility. The findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 10/21/24 showed the facility's resident census as 89 residents. On 10/22/24 at 9:32 AM, R15 Dietary Aide placed dirty dishes and cups onto a dishwasher rack and pushed the rack into the dishwasher to be cleaned. Without washing her hands, R15 then walked over to a tray of dry, clean dishes and began placing those dishes onto a storage rack. R15 repeated the same process again, of loading dirty dishes into the dishwasher and immediately touching clean dishes without washing her hands. On 10/22/4 at 11:44 AM, V16 Dietary Manager stated, if one staff member is operating the facility's dishwasher, the staff member is to wash their hands after touching dirty dishes and before touching clean dishes. V16 stated, If they don't wash their hands in between, I would be worried about cross-contamination. The facility's Dish Machine Operation policy (undated) showed, The Dining Services staff shall maintain the operation of the dishwashing machine according to established procedure and manufacturer guidelines posted or contained in this guideline to ensure effective cleaning and sanitizing of all tableware and equipment used in the preparation and service of food . Use clean, washed hands to pull out clean racks, and allow to air dry .