STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145968	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kewanee Care Home	144 Junior Avenue Kewanee, IL 61443

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131 Based on observation, interview, and record review, the facility failed to maintain a working overhead light in the bathroom for one (R20) of sixteen residents reviewed for environment in a sample of 43 residing in the facility. Findings include: Facility Maintenance Person, undated, documents The Maintenance Person maintains all building, equipment, systems and grounds in good, safe, and presentable condition. Regularly inspects and maintains electrical, signaling, and cooling and protection systems. Maintains furniture, fixtures, and furnishings in a clean, safe, attractive, and repaired manner. On 6/02/24 at 8:46 AM, R20's bathroom light switch was flipped on, and the light did not work. After flipping the light switch a few times the light came on but was dim and flickering. At that same time, R20 stated My bathroom light doesn't work, it has been a couple months, the maintenance guy knows and was gonna fix it, and I was told the ballast is bad. You have to flip the light switch about five times, and it usually works. I wish my light was fixed it is kind of a pain. On 6/04/24 at 9:00 AM, V16 (Maintenance) stated I have been here since March 2024, I will replace it. V16 verified R20's light did not come on right away when the light switch was flipped on, and the light flickers when on. At that same time, it took three times switching the light switch on and off before it came on and continued to [NAME] when on. On 6/4/24 at 9:02 AM, R20 stated I brush my teeth in the bathroom, and I have to switch the light about five times before it will work.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 33970 Based on record review and interview the facility failed to report an injury of unknown injury to the local state agency for one resident (R11) of four reviewed for accidents in a total sample of 44. Findings Include: The Facility's Abuse Prevention Program dated 11/28/2016 documents This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our resident. The Facility's Abuse Prevention Program dated 11/28/2016 documents Regardless of the specific nature of the allegation (physical, sexual, verbal/exploitation/mental, theft or neglect), the investigation shall consist of: A review of the initial written reports, Completion of a written report on the status of the investigation of the occurrence, an interview with person(s) reporting the incident, interview with any witnesses to the incident, An interview with the resident, where appropriate, an interview with the resident's attending physician or psychiatrist, a review of the medical records of any residents involved in the occurrence, if the accused individual is an employee, review the personnel file to check for references, background check, and documentation of orientation and training, An interview with the staff members having contact with the resident and accused individual during the period of the alleged incident, where appropriate, interviews with resident's roommate, family members, visitors or others who were in the vicinity of the incident, Interviews with other residents to which the accused individual has regular contact, interview with other employees to determine if they have ever witnessed other incidents of mistreatment involving the accused individual and a review of all circumstances surrounding the incident. The Facility's Abuse Prevention Program dated 11/28/2016 documents the summary, conclusions, and results of the investigation will be recorded on a final written incident report and submitted to the administrator or designee within five days of the occurrence. After reviewing the final report, the administrator or designee is responsible for forwarding an approved copy of the final report to (State Reporting Agency) within five working days of the occurrence. The administrator or designee will also notify the resident's representative of the results of the investigation. On 6/5/24 at 1:30 PM V1 (Administrator in Training) stated Injuries of unknown origin should be investigated as possible physical abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Event Record dated 3/19/24 documents that R11 had e.) unwitnessed injury-unknown origin. The Event Record documents Resident noted to have 4 scattered areas of open purpura (purple, red or brown spots and patches on the skin) and one area of superficial scratch to left upper arm. The Event record documents that V1 (Administrator in Training) was notified of the injury of unknown origin on 3/19/24 at midnight. On 6/2/24 at 11:00 AM V13 (R11's Spouse/Legal Guardian) stated I have a lot of concerns regarding (R11)'s bruises. I have told V1 (Administrator in Training) that I think the aids are grabbing him by the arms instead of using the gait belt. (V1) does not answer emails and when I am in the facility, she makes sure she is busy, so she does not have to deal with me. (R11) does bruise easily, which is why they should not be grabbing him by the arms, they should be transferring him correctly. At this point I don't think they (facility) are investigating anything that I request. On 6/5/24 at 9:00 AM V1 (Administrator in Training) stated I did not do an investigation into (R11)'s areas on left upper arm because he always gets marks on his arm, I don't think it is anything to worry about. V1 confirmed that she had done two previous investigations (one on 2/19/24 and one on 4/30/24) for bruising to R11's arms. V1 was unable to voice what the difference between the two previous investigations that she did believe need investigated and the occurrence on 3/19/24. V1 confirmed that she did not notify (State Reporting Agency) of R11's injury of unknown origin.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 33970 Based on interview and record review the facility failed to investigate an injury of unknown origin for one resident (R11) of four residents reviewed for accidents/injuries in a total sample of 44. Findings Include: The Facility's Abuse Prevention Program dated 11/28/2016 documents This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our resident. The Facility's Abuse Prevention Program dated 11/28/2016 documents Regardless of the specific nature of the allegation (physical, sexual, verbal/exploitation/mental, theft or neglect), the investigation shall consist of: A review of the initial written reports, Completion of a written report on the status of the investigation of the occurrence, an interview with person(s) reporting the incident, interview with any witnesses to the incident, An interview with the resident, where appropriate, an interview with the resident's attending physician or psychiatrist, a review of the medical records of any residents involved in the occurrence, if the accused individual is an employee, review the personnel file to check for references, background check, and documentation of orientation and training, An interview with the staff members having contact with the resident and accused individual during the period of the alleged incident, where appropriate, interviews with resident's roommate, family members, visitors or others who were in the vicinity of the incident, Interviews with other residents to which the accused individual has regular contact, interview with other employees to determine if they have ever witnessed other incidents of mistreatment involving the accused individual and a review of all circumstances surrounding the incident. On 6/5/24 at 1:30 PM V1 (Administrator in Training) stated Injuries of unknown origin should be investigated as possible physical abuse. On 6/2/24 at 11:00 AM V13 (R11's Spouse/Legal Guardian) stated I have a lot of concerns regarding (R11)'s bruises. I have told V1 (Administrator in Training) that I think the aids are grabbing him by the arms instead of using the gait belt. (V1) does not answer emails and when I am in the facility, she makes sure she is busy, so she does not have to deal with me. (R11) does bruise easily, which is why they should not be grabbing him by the arms, they should be transferring him correctly. At this point I don't think they (facility) are investigating anything that I request. R11's Event Record dated 3/19/24 documents that R11 had e.) unwitnessed injury-unknown origin. The Event Record documents Resident noted to have 4 scattered areas of open purpura (purple, red or brown spots and patches on the skin) and one area of superficial scratch to left upper arm. The Event record documents that V1 (Administrator in Training) was notified of the injury of unknown origin on 3/19/24 at midnight. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 9:00 AM V1 (Administrator in Training) stated I did not do an investigation into (R11)'s areas on left upper arm because he always gets marks on his arm, I don't think it is anything to worry about. V1 confirmed that she had done two previous investigations (one on 2/19/24 and one on 4/30/24) for bruising to R11's arms. V1 was unable to voice what the difference between the two previous investigations that she did believe need investigated and the occurrence on 3/19/24.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. 30899 Based on observation, interview, and record review the facility failed to provide an ongoing program of a variety of activities for all residents. This failure has the potential to affect all 43 residents in the facility. Findings include: Facility Activity Policy dated 9/17 documents: It is the policy of the facility to provide an ongoing program of activities to meet the interests and the physical, mental, and psychosocial wellbeing of each resident. The program is under the Direction of an Activity Director, who shall have a specific planned program of group and individual activities based upon the resident's needs and interests. The facility will provide a program of activities which includes a combination of large and small group, one-to-one and self-directed activities; and a system that supports the development, implementation, and evaluation of the activities provided to the residents in the facility. All residents shall be offered the opportunity, and encouraged to participate in activities, but shall not be required to participate. For residents with no discernable responses, the facility shall provide one-to one activities. The activity program shall include, but not limited to the following: Recreational, Crafts and Gardening, Religion, Intellectual, Service Activities and Community Involvement. In addition, the facility will provide the following activities to be provided under certain circumstances that are identified through resident assessment: One-to one activities, End of Life Activities, Room Activities, Young Age Group Activities and Diverse Ethnic or Cultural Background Activities and Activities for residents with Behavioral or Cognitive Deficits. On 6/4/24 at 1:55pm V1 (Administrator in Training/AIT) stated we do not currently have a licensed or certified Activity Director We are looking to hire. On 6/5/24 at 9:10am V1 (AIT) stated we haven't had an Activity Director since 10/27/23. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	April, May, and June 2024 Activity Calendars reviewed and found very little variety from month to month. The majority of activities were card or board games and Bingo. Televised church service was scheduled every Sunday at 9:30am followed by Resident Pick at 2pm. Room visits were scheduled three times in May and June and four times in April. Saturdays had the same card game scheduled at 10am on every Saturday for all three months, followed by Resident Pick. There were no scheduled activities for residents that were unable to participate in card games, board games or word games. Sit & Fit (an exercise activity) was scheduled twice in April, once in May and June. On 6/4/24 at 12:45pm V19 (Certified Nurse Assistant/Activity Aide) stated I was the interim Activity Director for four months, but I had no formal training. I wasn't certified and I have no degree. V19 stated she had one day of formal training at one of their other facilities. V19 stated she only helps with activities now three days per month. V19 stated V20 (Activity Aide) works Tuesday and Thursdays from 7:30am to 3pm and V32 (Community Relations Coordinator/CRC) comes in on Mondays and Wednesdays. V19 stated there are no activity staff in the facility on weekends. V19 stated she never had any input into care planning. V19 stated the lack of variety in activities is due to no Activity Director and stated, The whole activities program has fallen down since there has been no Director. V19 stated that the televised religious program on Sundays is mostly watched by residents in their rooms. V19 confirmed there are not specific activities for cogently impaired residents and the morning card games are mostly resident directed, not organized by activities. On 6/4/24 at 9:15am V1 (AIT) stated that she was disappointed when she saw the lack of variety of activities on the activity calendars when comparing month-to month. On 6/4/24 at 9:04am V2 (Director of Nursing) stated there is no activity staff on weekends and the residents have maybe one activity per day - including weekdays. 1. On 6/2/24 (Sunday) at 9:30am R4 was in bed under the covers. R4 stated there are no activities on weekends and no activity staff. R4 stated she would like more to do on the weekends. 30678 2. On 6/4/24 at 9:00 am, R12 stated she does not get up from bed except when the CNA (Certified Nursing Assistant) from hospice comes to give her a shower. R12 stated she watches television and has puzzle books she likes to do and occasionally has visitors. R12 stated there are no activity staff that come to her room. On 6/2/24 through 6/4/24 there were no visible Activity staff seen providing activity services to R12. 3. On 6/2/24 at 9:46 am and 6/4/24 at 9:00 am, R40 was sitting in the dining room with other residents playing cards. R40 stated they don't have activities here and some of the residents meet in the dining room and play cards but not because it is an activity.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 30899 Based on interview and record review the facility failed to have a qualified Activities professional to direct the provision of activities to all residents. This failure has the potential to affect all 43 residents in the facility. Findings include: Federal Form 671 dated 6/3/24 indicates there are 43 residents in the facility. Facility Job Summary/Activity Director (undated) documents: The Activity Director plans, schedules, and implements an ongoing program of activities designed to meet the physical, mental, and psychosocial needs of each resident. Residents are engaged in a meaningful, varied program of activities that meets the individual residents. The activities are conducted with individuals or in groups, according to the residents Plan of Care. The Activity Director completes the activity assessment for each resident and participates in developing the Interdisciplinary Care Plan. Qualifications: Completion of a State approved Basic Orientation Course will be required. Facility Activity Policy dated 9/17 documents: It is the policy of the facility to provide an ongoing program of activities to meet the interests and the physical, mental, and psychosocial wellbeing of each resident. The program is under the Direction of an Activity Director, who shall have a specific planned program of group and individual activities based upon the resident's needs and interests. On 6/4/24 at 12:45pm V19 (Certified Nurse Assistant/Activity Aide) stated I was the interim Activity Director for four months, but I had no formal training. I wasn't certified and I have no degree. V19 stated she had one day of formal training at one of their other facilities. V19 stated she only helps with activities now three days per month. On 6/4/24 at 1:55pm V1 (Administrator in Training) stated we do not currently have a licensed or certified Activity Director We are looking to hire. On 6/5/24 at 9:10am V1 stated we haven't had an Activity Director since 10/27/23.

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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. 33970 Based on observation, interview, and record review the facility failed to implement a restorative walking program for one resident (R43) of three residents reviewed for mobility in a total sample of 44. Findings Include: R43's Physical Therapy discharge date d 5/30/2024 Summary documents Functional Maintenance: Ambulation Program Established/Trained: Recommend for patient to participate in walk to dine program to prevent decline in function and mobility. Throughout the survey R43 was never observed walking with his walker at any time. On 6/2/24 R43 stated I never walk anymore. They don't have enough help to do it (assist resident to walk). On 6/4/24 at 10:25 AM V2 (Director of Nursing) stated I didn't even know (R43) was on a walking program. To my knowledge he does not walk to or from meals. On 6/5/24 at 9:30 AM V11 (Certified Nurse Assistant) stated (R43) usually propels himself in his wheelchair to wherever he wants to go. He can walk with his walker in his room to toilet.

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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. 30678 Based on observation, interview, and record review the facility failed to ensure an indwelling urinary catheter tubing and collection bag were not placed on the floor to prevent infection for one (R40) of four residents reviewed for indwelling urinary catheter care in the sample of 44. Findings include: The facility's Catheter Care policy and procedure, dated 2/2018, documents Catheter care is provided daily and as needed to all residents who have an indwelling (urinary) catheter to reduce the incidence of infection. The Centers for Disease Control and Preventions documents Appropriate Urinary Catheter Use documents: Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. The Face Sheet for R40 includes the following diagnoses: Retention of Urine, Urinary Device and history of Sepsis (life threatening complication of an infection). The Order Summary Report for R40, dated 6/524, documents Urinary Catheter Care - Drainage Bag - Change every night shift every Saturday for catheter care related to Obstructive and Reflux Uropathy and Benign Prostate Hyperplasia; Urinary Catheter Care 16 fr (French) 10 cc (cubic centimeter) change tubing monthly every night shift once a month on the 21st every night shift starting on the 21st and ending on the 21st every month. The current Care Plan for R40 documents R40 has an (indwelling urinary catheter) for Obstructive Uropathy and BPH (benign prostatic hyperplasia) with goal to be/remain free from catheter-related trauma. The interventions include Catheter care every shift, position catheter bag and tubing below the level of the bladder, check tubing for kinks each shift, and to monitor/record/report to physician any signs or symptoms of urinary tract infection. On 6/2/24 at 9:46 am and on 6/4/24 at 7:30 am, R40 was lying in a low bed, lowered to the floor and R40's uncovered indwelling urinary catheter collection bag and tubing was resting on the floor. On 6/4/24 at 9:36 am V10 (Certified Nursing Assistant) stated catheter bags and catheter tubing should not touch the floor. R40 is pretty independent when he is up, transfers himself usually, and will move his catheter himself if we aren't there. On 6/5/24 at 9:31 am, V8 (Minimum Data Set) Assessment and (Care Plan Coordinator) stated she was unaware of R40 putting his catheter bag on the floor and it shouldn't be. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 9:40 AM, V2 (Director of Nursing) and V3 (Resident Care Coordinator) confirmed indwelling urinary catheter collection bags and catheter tubing should not touch the floor and the collection bag should be in dignity bag. V2 stated R40 insists that his bed be lowered all the way to the floor and his indwelling urinary catheter tubing and bag should not be on the floor and R40 has been educated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 30678 Based on observation, interview, and record review the facility failed to ensure oxygen was being infused correctly, ensure oxygen tubing was dated, and ensure oxygen tubing was not resting on the floor for one (R40) of two residents reviewed for respiratory care in a sample of 44. Findings include: The facility's Oxygen Therapy policy and procedures, dated 8/2003, documents Oxygen therapy may be used provided there is a written order by the physician. The order must state liter flow per minute, mask or cannula, time frame. Change oxygen tubing/mask/cannula and/or tracheostomy mask on a weekly basis. Date tubing changes and document on the treatment sheet. The Face Sheet for R40, includes the following diagnoses: Acute Respiratory Failure with Hypoxia, COPD (Chronic Obstructive Pulmonary Disease) with acute exacerbation, Centrilobular Emphysema, and Oxygen Dependent. The Order Summary Report for R40, dated 6/5/24, documents the following physician orders as: Oxygen at 2L (liters) per NC (nasal cannula) as needed; Oxygen - tubing and humidifier change every night shift every Saturday. The current Care Plan for R40 documents R40 has shortness of breath and has oxygen therapy related to COPD and Respiratory Failure. Interventions include to Use Universal Precautions as appropriate and Oxygen settings: O2 (oxygen) via nasal cannula at 2L PRN (as needed)/Pulse ox (oxygen level) below 90. On 6/2/24 at 9:46 am, R40 was lying in bed with oxygen concentrator infusing at 3L per minute via nasal cannula. There was no date on R40's oxygen tubing. R40 stated he has COPD and has to have the oxygen to be able to breathe ok. On 6/2/24 at 11:31 am, 6/3/24 at 7:30 am, 6/3/24 at 10:33 am, 6/4/24 at 8:15 am, R40 was sitting in a wheelchair with an oxygen cylinder tank hanging from the back of the wheelchair and was infusing at 2L per nasal cannula and tubing was undated. On 6/4/24 at 9:36 am V10 (Certified Nursing Assistant) stated R40 will transfer to his wheelchair by himself, shut off his concentrator and turn on his oxygen tank by himself at times. On 6/5/24 at 9:31 am, V3 (Resident Care Coordinator), stated (R40) does mess with his oxygen flow at times. He changes it himself from the concentrator to the tank when he gets up and when he goes to bed. R40 has been educated and his oxygen tubing and nasal cannula should not be on the floor. On 6/5/24 at 9:38 am, V2 (Director of Nursing) stated Oxygen tubing is to be changed weekly by the third shift nurse, the tubing should be dated, and should not be on the floor.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kewanee Care Home	144 Junior Avenue Kewanee, IL 61443

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 30678 Based on interview and record review the facility failed to perform registry verification for five Certified Nursing Assistants prior to hiring. These failures have the potential to affect all 43 residents residing in the facility. Findings include: On 6/5/24 at 2:00 pm, V1 (Administrator in Training) stated she does not have any documentation that the Nurse Aide Registry was checked for V10 CNA (Certified Nursing Assistant), V24 CNA, V25 CNA, V27 CNA, and V28 CNA prior to hiring for employment. V1 stated due to staffing problems she has not had anyone to do the verifications, does not have any documentation prior to January 2024, and is having to go back and do the checks herself. 1. V10 CNA was hired on 3/22/24 and Nurse Aide Registry was not checked until 6/4/24. 2. V24 CNA was hired on 5/15/24 and Nurse Aide Registry was not checked until 5/16/24. 3. V25 CNA was hired on 1/5/24 and Nurse Aide Registry was not checked until 6/4/24. 4. V27 CNA was hired on 10/25/23 and Nurse Aide Registry was not checked until 11/10/23. 5. V28 CNA was hired on 12/15/23 and Nurse Aide Registry was not checked until 6/4/24. The Long Term Care Facility Application for Medicare and Medicaid, CMS (Central Management Services) Form 671, signed and dated on 6/2/24 by V2 (Director of Nursing), documents there are 44 residents currently residing in 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. 50430 30899 Based on observation, interview and record review the facility failed to attempt non-pharmacological interventions prior to implementing psychotropic medications, failed to identify target behaviors for the use of antipsychotic medications, and failed to assess use psychotropic medications for two residents (R19, R39) of five residents reviewed for unnecessary medications in a sample list of 44. Findings include: The Facility Policy titled Psychotropic Medication Policy last revised on 11/28/2017 documents, It is the policy of this facility that residents shall not be given unnecessary drugs. Unnecessary drug is any drug used without adequate indication for its use. Policy further documents the definition of an antipsychotic drug is A neuroleptic drug that is helpful in the treatment of Psychosis and has the capacity to ameliorate disorders. Any resident receiving such medications shall have a psychiatrics diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others, destructive to property, or if emotional problems exist which cause the resident frightful distress. 1. R19's Medication Administration record (MAR) shows an order for Seroquel (antipsychotic)12.5 mg (milligrams) twice a day for a diagnosis of Psychosis on 10/24/23. On 6/4/24 at 10:00 AM R19's Electronic Record documents behavior occurred on 10/9/23 and 10/10/23 prior to starting medication. On 6/4/24 at 10:13 AM V2 (Director of Nursing) confirmed there is no behavior charting for September 2023. V2 also confirmed no other behavior tracking was documented prior to start of Seroquel. On 6/3/24 at 11:30 AM R19 was observed self-propelling in her wheelchair. R19 was talking as she was going through the hallway and appropriately interacting with other residents. R19's Electronic Medical record did not contain any documentation that non-pharmacological interventions were attempted prior to the start of an antipsychotic medication and also no documentation of targeted behaviors for Seroquel. 2) Physician Order Summary Report (POS) indicates R39 has orders for Quetiapine (antipsychotic) 25mg (milligrams) every evening (start date 4/30/24) and 12.5mg every morning (start date 11/18/23) for stimulant induced psychotic disorder with hallucinations. The POS also indicates R39 was admitted to the facility with diagnosis of Dementia Other Behavioral Disturbance. R39's Current Care Plan indicates R39 uses psychotropic medication: Quetiapine related to behavior management for behaviors of resisting care, self isolation, negative talk and aggression towards staff (revised 5/10/24). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan indicates to monitor R39 for target behaviors of repetitive questions,anxiousness and worrisome. R39's Behavior Monitoring March, April, May, June 2024 indicates No behaviors observed for all days reviewed. On 6/2/24, 6/3/24 and 6/4/24 R39 was seen at various times of the day, smiling easily engaged and appropriate in responses and behavior. Psychotropic Medication Consent Misc. Used for Behaviors dated 6/7/23 indicates a consent was signed by R39 for Quetiapine 25mg twice daily. R39's Consent form: Medication Used for These Identified Behaviors and Diagnosis was left blank. No diagnosis or target behaviors were documented on the consent. On 6/05/24 at 9:31am V2 (Director of Nursing) stated R39 came in on the medication, (Quetiapine) and stated, I don't know what her psychosis or behaviors are. V2 stated they had to have a new consent filled out because the first one (dated 6/7/23) didn't include a diagnosis. V2 stated they completed a new consent on 6/3/24. The Pharmacy Consultation Report dated 6/8/23 indicates If the antipsychotic order (for R39) is to continue, please update the medical record to include: - the specific diagnosis/indication requiring treatment that is based upon an assessment of the resident's condition and therapeutic goals. - a list of target behaviors (e.g. hallucinations) including their impact on the resident (e.g. increased distress, presents a danger to the resident or others, interferes with his/her ability to eat) AND - documentation that other causes (e.g. environmental) and medications have been considered, that individualized non-pharmacological interventions are in place, and ongoing monitoring has been ordered. Report indicates physician response (7/11/23) as: (R39) also has psychosis NOS (Not Otherwise Specified) with Hallucinations; (R39) also has Dementia with behavioral issues which are managed by Seroquel (Quetiapine). On 6/05/24 at 10:10am V7 (Licensed Practical Nurse) stated I've never seen (R39) exhibiting any behaviors other than not wanting to take showers. She's a model resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 30899 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5%. This failure affects two residents (R29, R35) of 10 residents reviewed for medication pass. This failure was the result of two medication errors out of 25 opportunities for a total medication error rate of 8%. Findings include: Facility Policy/Medication Administration dated 7/3/2013 documents: Medications must be identified using the six rights of administration: Right resident, Right drug, Right dose, Right time, Right route, Right documentation. Facility Policy/Oral Medication Administration dated 10/07 documents: To ensure the administration of oral medications is performed according to procedure. Procedure: Remove the correct amount of medication for the individual dose to be given at this time. 1.) On 6/3/24 at 11:20am V22 (Licensed Practical Nurse/LPN) administered Carbidopa-Levodopa (anti-Parkinson's) 25-100mg (milligram) one and one-half tablets for a total dosage of 37.5-150mg to R35. Medication card indicated to give 2.5 tablets for total dosage of 62.5-250mg. At that time, V22 stated We just give 1.5 tablets. That's what everybody gives. R35's Current Physician Order Summary Report indicates order for: Carbidopa-Levodopa 25-100mg tablet, give 2.5 tablets by mouth three times per day for Parkinson's Disease. On 6/3/24 at 3:20pm V2 (Director of Nursing) stated Yes, the correct dosage for (R35's) Carbidopa-Levodopa is 2.5 tablets. I passed her meds before and that's what she's supposed to get. 2.) R29's Current Physician Order Summary Report indicates order for: Gabapentin 100mg capsule, give 2 capsules orally three times per day related to polyneuropathy. On 6/3/24 at 11:30am V22 administered Gabapentin (anticonvulsant) one 100mg capsule to R29 along with two Tylenol (analgesic) 325mg tablets. R29 swallowed the three medications and V22 went on to pass medications to the next resident. On 6/3/24 at 3:15pm V22 stated she didn't calculate the total dosage and thought one and on-half tablets of the Carbidopa-Levodopa was the correct dosage for R35. V22 also stated that she thought she gave R29 two tablets of Gabapentin.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 34131 Based on interview and record review, the facility failed to have qualified dietary staff. This has the potential to affect all 43 residents in the facility. Findings include: Facility Food Service Manager, revised 10/2020, documents Manages all aspects of the Food Service Department. Manages nutritional care of all residents in the facility. Must have or be willing to take the Dietary Managers Course. Must have passed the sanitation test or willing to take the course approved they the state for the facility within 60 days of hire. Certified Dietary Manager preferred. On 6/2/24 at 8:58 AM, V12 (Dietary Manager) verified the facility does not have a dietician employed full time. V12 also verified she is not certified as a dietary or food service manager, does not have a certification nationally recognized in food service management, is not currently enrolled in a course, does not have a degree in food service management, and started the position as the dietary manager in 2024, but was a dietary aid before. On 6/04/24 at 8:36 AM, V12 stated, We have a qualified dietician that comes in twice a month. Facility Long Term Care Facility Application for Medicare and Medicaid, dated 6/3/24, documents 43 residents currently live in the facility.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 34131 Based on observation, interview, and record review, the facility failed to have an alternatives or always available menu posted for residents during mealtimes. This has the potential to affect all 43 residents in the facility. Findings include: On 6/2, 6/3, 6/4, and 6/5/24, the dining room had the meal posted with one alternative food choice posted on the meal board. No other food choices were posted for residents to choose from if they did not like the main meal, or the alternative meal choice option. The facility was unable to provide an alternative, or always available food menu. Facility Diet Type Report, dated 6/4/24, documents all 43 residents have diet orders. V12 confirmed all 43 residents have a diet ordered and eat from the kitchen. On 6/02/24 at 8:58 AM, V12 (Dietary Manager) verified they did not have other food options posted other than one alternative food choice which is always leftovers, and they did not have a menu or list of foods always available for the residents to choose from for meals posted. At that same time, V12 stated she did not know how residents would know what their food choices could be if they were not posted. V12 stated they have cottage cheese, cold sandwiches, peanut butter and jelly, soups, and cereal on hand that residents can have but is not posted anywhere in the facility, or on the residents' food menu which is distributed to each resident. Facility Long Term Care Facility Application for Medicare and Medicaid, dated 6/3/24, documents 43 residents currently live in the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33970 Based on observation, interview, and record review the facility failed to serve palatable food at lunch time on 6/3/24. This failure has the potential to affect all 43 residents who currently reside in the facility. Findings Include: The Facility's Menu documents that on 6/3/24 for lunch a pork fritter with gravy, scalloped potatoes, green beans, and peaches was served. On 6/3/24 at 12:00 PM R18 stated This food is disgusting. I am just going to eat my snacks I have in here (in resident's room). The food here is usually awful. Sometimes if we get (a cook) who knows how to cook it can be ok. But this (pork fritter) is over cooked and tasteless. On 6/3/24 at 12:05 PM R3 stated The meat is rubbery and difficult to cut. I have drowned it in gravy, and it is barely edible. The food here is a constant problem. I think they (facility) buy the cheapest food available whether it has taste or not. On 6/3/24 at 12:08 PM R6 stated Thank God I have snacks in my room. This (lunch) is disgusting. I am not eating that. R6 stated the food at the facility is hit and miss. R6 stated I don't think anyone really even tries to dress up the food that we get. It is slop. On 6/3/24 at 12:12 PM R36 stated I can't eat the lunch. The meat is hard, and I can't chew it. On 6/3/24 at 12:20 PM The pork fritter was hard on the edges, could not be bitten into pieces, required sawing back and forth with knife to cut off pieces. The meat was not easily chewable and had no taste. On 6/3/24 at 1:00 PM V12 (Dietary Manager) stated We have been getting complaints about the food. They (residents) state that it depends on who is cooking. V12 stated that she thought that the cook may have over cooked the meat today in the convection oven. V12 confirmed that multiple residents had complained about the meat on 6/3/24 lunch time. The Facility's room roster dated 6/2/24 documents that 43 residents currently reside in the facility.

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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. 34131 Based on observation, interview, and record review, the facility failed to have a clean sanitary oven, failed to develop a cleaning schedule for the dietary department, and failed to have dishwasher detergent in the dish machine. This has the potential to affect all 43 residents in the facility. Findings include: Facility Ware-Washing- Dish machine, revised 10/2009, documents It is the policy that utensils and dishes washed by the mechanical dishwasher will be clean and sanitized. Facility Kitchen Sanitation, revised 10/2020, documents The Food Service Manager will monitor sanitation of the Dietary Department on a daily basis. The Food Service Manager will develop a cleaning schedule for the department and ensure that dietary employees complete cleaning tasks as scheduled. The Food Service Manager shall provide cleaning instructions for each area and piece of equipment in the kitchen and specify which chemical and personal protective equipment should be used for each task. Facility Cleaning Schedule, dated 10/2014, documents It is the policy to provide a system for determining the frequency of cleaning and to document the completion of a particular cleaning task. The Food Service Manager shall develop a cleaning rotation form that lists all cleaning tasks required for proper sanitation of the food preparation and serving areas. Tasks must be completed daily, weekly, and monthly. Each position in the dietary department is assigned certain cleaning tasks to be completed. Facility Diet Type Report, dated 6/4/24, documents all 43 residents have diet orders. V12 confirmed all 43 residents have a diet ordered and eat from the kitchen. Facility was unable to provide any cleaning schedule/completed tasks for the dietary department. On 6/02/24 at 8:58 AM, a tour was conducted of the kitchen with V12 (Dietary Manager/DM). During the kitchen tour, there was no dish detergent in the container under the dishwasher that automatically feeds into the dishwashing machine. At that same time, both V12 and V15 (Dietary Aide) confirmed there was no dishwashing detergent in the container for the dishwashing machine, and they were responsible for monitoring and changing/filling the detergent. The kitchen has two ovens with stove burners over top. Upon opening the oven doors there was a buildup of a black sticky substance up and down the sides and from the front to the back with tin foil stuck in the sticky/greasy substance. V12 confirmed the ovens needed cleaned and are supposed to be cleaned every day at the end of the day. V12 also stated the facility does not have a cleaning schedule/task for the dietary employees to complete, and stated she has to write the task assignments every day on what is expected from staff on each shift. Facility Long Term Care Facility Application for Medicare and Medicaid, dated 6/3/24, documents 43 residents currently live in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 30899 Based on observation, interview, and record review the facility failed to monitor active infections, failed to identify transmission-based precaution needs and failed to have Personal Protective Equipment (PPE) available to all staff. These failures have the potential to affect all 43 residents who reside in the facility. Findings include: The Facilities Infection Control Policy Surveillance and Monitoring last revised 5/2007 documents It is the policy of the facility to do routine surveillance and monitoring of the facility to determine compliance with work practices. The policy further documents Monitoring of the day-to-day operation of the infection control program will be conducted by the Director of Nursing (DON), Director of Nursing will determine and direct correct procedures necessary for the prevention of infections. The policy also states the DON will prepare the Infection Tracking Log on a monthly basis for quarterly presentation to the Quality assurance committee. The DON will ensure Isolation techniques are instituted and followed by evaluation of parameters involved in assessment of physical condition are evaluated and reported as appropriate. The Facilities Policy Enhanced Barrier Precautions last revised 7/13/23 documents Enhanced Barrier Precautions (EBP) should be used when contact precautions do not apply, for residents with any of the following: indwelling medical devices. 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. EBP is primarily intended to use for care that occurs within a resident's room, when high contact resident care activities are bundled together. The policy also documents that a sign for (EBP) is posted near resident room door and gown and gloves will be readily available to the staff entering the resident's room. Signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of precautions and the recommended PPE to be worn when caring for the resident. The EBP sign should also include a list of the high contact resident care activities for which PPE (gown and gloves) should be worn. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure EBP are followed. Signs should not include information about a resident's diagnosis or the reason for the use of EBP (e.g., presence of a resistant germ, wound). PPE supplies should be well stocked and easy to access prior to room entry: Ensure that healthcare personnel have immediate access to and are trained and able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Policy Contact Precautions last revised 12/2009 documents In addition to Standard precautions, or the equivalent for specified residents 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 are items in the residents environment). The policy further documents In addition to wearing gloves as outlined under standard precautions, wear gloves (clean nonsterile gloves are adequate) when entering the room. During the course of providing care for a resident, change gloves after having contact with infective material that may contain high concentrations of Microorganisms (fecal material or wound drainage). Remove gloves before leaving the residents environment and wash hands immediately with antimicrobial agent or waterless antiseptic agent. In addition to wearing a gown when entering the room if you anticipate that your clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room, or if the resident is incontinent or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing. Remove gown before leaving environment. The facility's Long Term Care Facility Application for Medicare and Medicaid, Form 671, dated 6/3/24 and signed by V1 (Administrator in Training), documents 43 residents currently reside in the facility. On 6/2/24 at 11:00 AM the Resident Infection Control and Antimicrobial logs for January 2024 through May 2024 do not document signs and symptoms of infection, if infections were facility acquired or if infections were cultured. On 6/2/24 at 1:30 PM V2 (Director of Nursing) confirmed that neither she nor V3 (Infection Preventionist) had been tracking resident infections. 1.On 6/4/24 at 2:00 PM R40's door sign documented Enhanced Barrier precautions. There was no PPE available outside of R40's room. There were no disposal bins inside R40's room to dispose of PPE. R40's Physician Order Sheet dated June 2024 documents that R40 has an indwelling catheter in place. 2. On 6/4/24 at 2:00 PM R12's door sign documented Contact Precautions. V2 and V3 stated R12 was placed on Contact Precautions for a wound infection on Admission (1/5/2024). R12's Physician Order Sheet dated March 2024 documents that R12 received Gentamycin (antibiotic) 40 mg (milligram) daily for ESBL (Extended Spectrum Beta-Lactamases) in her urine on 3/14/2024 and Amoxicillin (antibiotic) 875-125 mg (milligram) twice daily for ESBL in her urine until 3/15/24. On 6/4/24 at 1:30pm V3 (Licensed Practical Nurse/Infection Preventionist) confirmed that no follow up culture was done on R12's urine after completing both antibiotics. V3 stated I guess we aren't sure if R12 should be in Contact Precautions or just Enhanced Barrier Precautions. It will depend on what her urine culture results will be. On 6/4/24 at 2:00 PM there was no PPE available outside of R12's room and there were no disposal bins inside of R12's room to dispose of used PPE. 3. On 6/4/24 at 2:10 PM R15's door sign documented Enhanced Barrier Precautions. V2 (Director of Nursing) and V3 (Licensed Practical Nurse/Infection Preventionist) both stated they are unsure of why R15 would need to be in Enhanced Barrier Precautions. There was no PPE available out of R15's room and there were no disposal bins inside of R15's room for the removal of PPE. R15's Physician Order Sheet dated June 2024 documents that R15 has an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. On 6/4/24 at 2:12 PM R17's door sign documented Enhanced Barrier Precautions. There was no PPE (Personal Protective Equipment) available outside of R17's room. There were no disposal bins inside of R17's room for the removal of PPE. On 6/4/24 at 1:30 V3 (Licensed Practical Nurse/Infection Preventionist) stated that R17 is on (EBP) for colonized ESBL (Extended Spectrum Beta-Lactamases) in her urine. 5. On 6/4/24 at 2:13 PM R36 door sign documented Enhanced Barrier Precautions. There was no PPE available outside of R36's room. There were no disposal bins inside of R36's room for the disposal of PPE. R36's Physician Order Sheet documents that R36 has a wound on her coccyx. 6. On 6/4/24 at 2:14 PM R37 door sign documented Contact Precautions. On 6/4/24 at 1:30 PM V3 stated that R37 should not be on Contact Precautions but should be on Enhanced Barrier precautions instead for an indwelling catheter. There was no PPE available outside of R37's room. There were no disposal bins in room to dispose of PPE. 7. On 6/4/24 at 2:15 PM R1's door sign documented Enhanced Barrier Precautions. There was no PPE available out of R1's room. There were no disposal bins inside of R1's room for disposal of PPE. R1's Physician Order Sheet dated June 2024 documents that R1 has an indwelling urinary catheter in place. 8. On 6/4/24 at 2:16 PM R6's door sign documented Enhanced Barrier Precautions. There was no PPE available outside of R6's room. There were no disposal bins inside of R6's room for disposal of PPE. R6's Physician Order Sheet dated June 2024 documents that R6 has a colostomy and a urostomy. On 6/4/24 at 8:45 AM the clean supply room had no gloves available and one half of a box of gowns. V3 stated the rest of supplies are kept in a locked storage room and are only accessible by managers with keys. V3 confirmed that on duty staff would need to call an on-call manager to access those supplies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145968	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kewanee Care Home	144 Junior Avenue Kewanee, IL 61443

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 30899 Based on interview and record review, the facility failed to ensure their Antibiotic Stewardship program was implemented. This failure has the potential to affect all 43 residents residing at the facility. Findings include: The facility's Antibiotic Stewardship Program policy dated 11/1/2017 documents the following: Assessing antimicrobial use is essential for determining antimicrobial use trends. Antimicrobial use assessment should be conducted regularly to measure progress of antimicrobial stewardship activities. After completing the assessment, the facility should be able to describe who is getting antibiotics and why. Additionally, the results are useful to identify gaps in communication, inconsistencies in documentation, and compliance with facility policies and evidence-based recommendations for antimicrobial prescribing. The policy further documents to address these issues Kewanee care home has developed an antibiotic stewardship program. Antibiotic stewardship is the act of using antibiotics appropriately that is, using them only when truly needed and using the right antibiotic for each infection. This program includes tools policies and procedures that aim to guide our staff toward more responsible and effective use of antibiotics. Our leadership team is committed to improving the use of antibiotics in order to protect our residents reduce the threat of antibiotic resistance and adverse events associated with antibiotic use. The facility's Long Term Care Facility Application for Medicare and Medicaid, Form 671, dated 06/03/24 and signed by V1 (Administrator in Training), documents 43 residents currently reside in the facility. On 6/2/24 at 1:30 PM V2 (Director of Nursing) confirmed that neither she nor V3 (Infection Preventionist) had been tracking resident infections. On 6/2/24 at 1:30 PM both V2 and V3 confirmed that the facility staff had not been using a set of standards to define infections or encouraging physicians to wait for culture results prior to starting any antibiotics. On 6/2/2024 at 11:00 AM The Resident Infection Control and Antimicrobial logs for January 2024 through May 2024 do not document signs and symptoms of infection, whether infections were house acquired or if infections were cultured.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145968	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kewanee Care Home	144 Junior Avenue Kewanee, IL 61443

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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 0912 Level of Harm - Potential for minimal 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. 30899 Based on observation, interview, and record review the facility failed to ensure greater than 80 square feet per resident in multiple resident rooms. This failure affects 16 residents (R3, R4, R6, R8, R15, R18, R21, R22, R25, R26, R27, R31, R32, R37, R39, R41) of 34 residents reviewed for resident rooms in the sample of 44. Findings include: On 6/3/24 at 8:30am V8 (Minimum Data Set Coordinator) stated the facility does have rooms that do not meet the 80 square foot per resident requirement. On 6/4/24 (R3, R4, R6, R8, R15, R18, R21, R22, R25, R26, R27, R31, R32, R37, R39, R41) were noted to all occupy rooms with a roommate in rooms identified as less than 80 square feet per resident according to facility floor plan. Undated Letter signed by V1 (Administrator in Training) indicates the facility has submitted a waiver to the State Agency regarding the square footage of their resident rooms as they are slightly under the 80 square foot per resident requirement. On 6/4/23 at 11am V1 stated the waiver gets sent every year to the State Agency. V1 was unable to provide information regarding when the waiver was last sent.