STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145975	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Rehab & Health Care Center	900 North 3rd Street Rochelle, IL 61068

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 34491 Based on interview and record review, the facility failed to ensure residents were provided an advanced beneficiary notice prior to therapy discharging them for 3 of 3 residents (R13, R75, R226) reviewed for advanced beneficiary notice in the sample of 12. The findings include: On 4/24/24 before 8:00 AM, V1 (Administrator) was asked for the Advanced Beneficiary Notices for the last three residents admitted to the facility. At 1:03 PM, V1 stated they are still working on the advanced beneficiary notices that were requested first thing that morning. At 2:28 PM, V1 and V22 (Administrator from a sister facility) said they did not have any documents to provide regarding advanced beneficiary notices being given to R13, R75, and R226. V1 said the business office manager and the Social Services Director were not here (employed) at that time and they do not know if the advanced beneficiary notices were done or not. V1 and V22 said they did not have any documentation to provide showing they were provided to R13, R75 and R226. On 4/25/24, the facility provided instructions for the Advance Beneficiary Notice of Non-Coverage (ABN) form. The instructions showed The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. The instructions showed Medicare inpatient hospitals and skilled nursing facilities (SNF) use other approved notices for Part A items and services when notice is required in order to shift potential financial liability to the beneficiary; however, these facilities must use the ABN for Part B items and services. The instructions showed The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice .In all cases, the notifier must retain a copy of the ABN delivered to the beneficiary on file.

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: 145975	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on interview and record review, the facility failed to ensure a resident was referred to a heart specialist as ordered and failed to document an assessment of a new skin condition for 2 of 2 residents (R7, R3) reviewed for quality of care in the sample of 12. The findings include: 1. R7's face sheet showed R7 is a [AGE] year-old female with diagnosis of congested heart failure, hypertension, atrial fibrillation, diabetes, a history of a transient ischemic attack (TIA), respiratory failure, chronic obstructive pulmonary disease, obstructive sleep apnea, morbid obesity, and cerebral vascular disease. R7 was noted to have oxygen on at 4 liters per nasal cannula during daytime observation hours on 4/23, 4/24, and 4/25/24. R7 was observed becoming short of breath while ambulating to and from the toilet on 4/23 and 4/24/24. R7 did not have oxygen on during toileting. On 4/25/24 at 8:30 AM, V5 Director of Nursing (DON) stated she made an appointment for R7 to see the cardiologist today. The appointment is for August 2024. I agree it should have been made more timely. This could cause a delay in care, increase in symptoms, and exacerbation of disease to the residents. R7's 3/11/24 facility assessment showed she was not cognitively intact. R7's hospital paperwork showed admission to a local hospital from 11/3/23 to 11/4/23 for chest pain. R7's hospital paperwork showed admission to a local hospital 12/28/23-12/31/23 for chest pain and heart failure. R7's physician orders showed a 2/6/24 order to refer to cardiology for a consult. R7's hospital paperwork showed admission to a local hospital from 2/23/24 to 2/25/24 for respiratory failure and heart failure. On 04/25/24 at 11:38 AM, a policy for consults and referrals was requested from V1 Administrator and V2 Administrator from local sister facility. None was received. 31615 2. R3's admission record shows R3 was admitted to the facility on [DATE]. The same record shows a diagnosis of cellulitis of the left lower limb with an onset date of 4/20/24. The April 2024 Medication Administration Record documents R3 began Clindamycin 300 mg three times a day beginning on 4/20/24 and was indicated to be for a rash. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress notes for April 2024 were reviewed and show no assessment of a rash or any inflammation of R3's leg. The notes show no progress notes for 4/20/24 or 4/21/24. The note of 4/22/24 shows an administration note for Clindamycin. No assessment of the area was noted. On 4/24/24 at 10:10 AM, R3 stated she had a rash on her leg from her hip down past her knee. R3 stated when it first started it was fire red and warm to touch but now it is better since being on the antibiotic. R3 stated when it started, the nurse came in to look at it and she took a picture to send to the doctor. R3 stated she did not have any concerns with pain or discomfort. On 4/25/24 at 8:22 AM, V25 RN (Registered Nurse) stated R3 had a red area on the lower part of her leg. V25 stated she snapped a photo and sent it to the physician, and he ordered Clindamycin. V25 stated when she assessed the area, she did not get any vital signs or check R3's temperature. V25 stated she did not document the assessment anywhere. V25 stated the assessment and vital signs should have been documented. V25 stated when a resident is on an antibiotic they are monitored for any adverse reactions and temperature monitoring. On 4/25/24 at 8:30 AM, R3 was observed to have a large, reddened area on the outer left knee, and some redness on the upper thigh. V25 placed her hand on the reddened area and said it was still warm to touch. On 4/24/24 at 10:43, V6 RN stated R3 was on an antibiotic for cellulitis of the left lower extremity. V6 stated when a nurse get orders for an antibiotic and a resident has an inflamed area there should be an assessment note in the chart. V6 stated the note should include the skin assessment and mark the area on the resident where the edges of the inflammation to assess if it improves. V6 should have documented her temperature, and blood pressure. V6 stated anytime a physician is called for orders there should be a progress note. V6 stated infection notes should be every shift and include a temperature and if there are any reactions to the antibiotic. On 4/25/24 at 9:49 AM, V5 stated V25 should have documented the assessment, her actions of calling the doctor, the results, and the ordering of the antibiotic. V5 stated there should also be shift charting, including a temperature and if there are any adverse reactions to the antibiotic. The nursing documentation guidelines: 1. Every shift documentation is required for problem areas for a minimum of 24 hours or until symptoms have resolved. A. Any time physician is called C. skin problems.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to implement interventions to minimize the risk of elopement for 1 of 4 residents (R20) reviewed for elopement in the sample of 12. The findings include: R20's face sheet shows R20 is a [AGE] year-old female with diagnoses of dementia, Alzheimer's Disease, hypertension, osteoporosis, and malnutrition. On 04/24/24 at 08:35 AM, R20 was standing in the dining room with her purse over her shoulder. R20 walked to the front door, pushed it open to exit, and the door alarm sounded. At 1:22 PM, R20 walked to end of the south hall and stood looking out the exit door. There was a safety banner with a stop sign on it across the doorway. Exit doors were not disguised. Exit doorknobs (non-existent) and handles (present on exit doors) were not disguised. The floors at the exits were not taped. On 04/24/24 at 11:40 AM, V5 Director of Nursing (DON) stated R20 is an elopement risk. V5 said a couple of weekends ago (on 4/14/24), R20 went out the front door and came back in and later (the same shift) went out the side door. I followed and walked with her until I could persuade her back into the facility. V5 confirmed there was no documentation of either incident in R20's medical record. On 04/25/24 at 11:40 AM, V29 Minimum Data Set (MDS) Coordinator stated the last date R20's interventions were reviewed was 4/12/24. Per record review 10/11/23 was the last date interventions were added to R20's wandering care plan. When a resident had an attempted elopement, 15-minute checks are put in the resident's care plan interventions and Certified Nursing Assistants (CNAs) have the task added to their documentation requirements. R20 does not have the task in her chart showing the CNAs needed to do frequent checks on her. It's important to implement interventions after exit seeking episodes for her safety, so she doesn't wander into the street and get hit by a car. Incidents of exit seeking should be recorded in the progress noted. It's important to implement care plan interventions and update them for resident safety and to decrease the likelihood of continued exit seeking and elopement. The facility's 5/21 Missing Resident Policy showed reasonable precautions are taken to minimize the risks of resident elopement attempts. R20's 4/12/24 Wandering-Elopement Evaluation showed she was a high risk to wander/exit seek. R20's risk for wandering/elopement care plan showed to identify if there are triggers for wandering/eloping, identify if there is a certain time of day wandering/elopement attempts occur, identify if there is a pattern and purpose of wandering. These 10/11/23 interventions did not identify any of these triggers, times, patterns, or purposes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's 10/20/23 behavior problem, agitation care plan showed R20 will have fewer episodes of wandering. There were no updated interventions since the care plan was initiated on 10/20/23. R20's 10/20/23 wandering behaviors care plan showed to disguise exits cover doorknobs and handles and tape floor. Identify pattern of wandering. No patterns were identified. R20's 4/12/24 facility assessment showed moderate cognitive impairment. R20's behavior monitoring showed elopement/exit seeking behaviors on 3/25/24, twice on 3/30/24, 4/12/24, and 4/14/24 (only once). R20's progress notes had no documentation of elopement/exit seeking incidents on 4/12 or 4/14/24.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to ensure a resident with a feeding tube had placement checked prior to administration of medications and feedings, The facility also failed to ensure a resident with a feeding tube had a nutritional assessment on admission for 1 of 1 resident (R13) reviewed for feeding tubes in the sample of 12. The findings include: R13's face sheet showed R13is a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of gastrostomy status, pneumonitis due to inhalation of food and vomit, encephalopathy, sepsis, peripheral neuropathy, cervical disc disorder with myelopathy, epilepsy, and chronic pain syndrome. On 04/23/24 at 09:50 AM, R13 was in bed with no shirt on. A feeding tube was present to his left upper quadrant of the abdomen. There was a clean dressing covering the insertion site. There were two open cans of cream soda, a thermos, and a cup with a straw on the bedside table. R13 was alert and oriented X/times3. On 04/24/24 at 09:10 AM, V6 Registered Nurse (RN) administered R13's morning medications and bolus tube feeding through R13's feeding tube. V6 did not check for tube placement or residual before giving medications or tube feeding administration. When asked about checking placement and for residual, V6 said R13 drinks water so every time he checks residual, there is about 70 milliliters (ml). R13's 3/30/24 physician order showed to check enteral tube residual volume four times daily before bolus and record, hold feeding if residual is over 150 milliliters (ml). R13's care plan showed to check for tube placement and gastric contents/residual volume per facility protocol . R13's physician orders showed he had been on tube feedings since admission. The facility's 2/08 Enteral Feedings Policy showed placement of tube will be via aspiration of residual. If unable to confirm placement via aspiration, air instillation method may be used. Placement will be confirmed prior to initiating a flush and prior to instillation of flush/medication administration. On 04/24/24 at 11:55 AM, V1 Administrator said R13's 4/19/24 dietitian review note was the only nutritional assessment done since his admission. He should have had one completed sooner. R13's 4/19/24 dietitian review showed he was dependent on enteral (tube) feedings which put him at risk for weight loss and gain. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 2/08 Enteral Feedings Policy showed the Dietician/Consultant will monitor all diet orders for tube feedings and will recommend as appropriate changes in product according to resident need. The fluid intake for the resident receiving tube feeding should be equivalent to the fluid needs as assessed by the Dietician. Fluid needs may not be met by product alone in which case water flush ordered may be recommended to meet the needs of the tube fed resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to administer oxygen as ordered for 1 of 1 resident (R7) reviewed for oxygen in the sample of 12. The findings include: R7's face sheet shows R7 is a [AGE] year-old female with diagnoses of respiratory failure, chronic obstructive pulmonary disease, obstructive sleep apnea, congested heart failure, hypertension, atrial fibrillation, diabetes, a history of a transient ischemic attack (TIA), morbid obesity, and cerebral vascular disease. R7 was noted to have oxygen on at 4 liters per nasal cannula during daytime observation hours on 4/23, 4/24, and 4/25/24. R7 was observed becoming short of breath while ambulating to and from the toilet on 4/23 and 4/24/24. R7 did not have oxygen on during toileting. Staff would remove R7's oxygen in the dining area, take her by wheelchair to a bathroom on the north hall, and have R7 ambulate from the wheelchair in the hall to the toilet (at least 10 feet) and back before returning her to the dining room and putting the oxygen back on. On 4/23/24, V7 CNA supervisor toileted R7 without her oxygen on. On 4/23/24, V7 CNA supervisor stated R7 uses her oxygen prn (as needed) and can have it off when we toilet her. On 04/24/24 at 09:40 AM, V11 CNA was outside a bathroom in the north hall. V11 stated R7 was on the toilet. R7's oxygen concentrator was in the dining room. V11 assisted R7 from the toilet to the wheelchair outside the bathroom. R7 had no oxygen on for at least 10 minutes and was short of breath. V11 pushed R7 in her wheelchair to the dining room, turned on the oxygen concentrator, and applied the nasal cannula to R7's nose. On 04/24/24 at 03:17 PM, V5 Director of Nursing (DON) stated staff should not remove R7's oxygen especially when she is exerting herself. R7 should not be walking to the bathroom without oxygen on. V5 stated it could result in hypoxia, heart attack, or fainting. They aren't going to be able to pick her up of she falls. It should be on all the time. It's ordered to be on all the time. She (R7) has a lot of comorbidities. The nurses should be turning the oxygen on and off not the CNAs. R7's care plans showed a history of heart failure, respiratory failure, chronic obstructive pulmonary disease and altered cardiovascular status. These care plans showed to administer oxygen per doctor orders. R7's 2/25/24 physician order showed to administer oxygen at 4 liters. R7's 11/2/23 health status note showed R7 complained of severe shortness of breath and chest pain. R7 had wheezing in both upper lobes. Oxygen was started at 2 liters. R7's hospital paperwork showed admission to a local hospital from 11/3/23 to 11/4/23 for chest pain. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's 11/6/23 health status note showed R7 had knocked her oxygen off in her sleep. R7 complained of shortness of breath and chest pain. R7's oxygen saturation was 48%. R7's 12/28/23 health status note showed R7 complained of left arm pain, chest pressure and shortness of breath. R7 was sent to a local emergency room . R7's hospital paperwork showed admission to a local hospital 12/28/23-12/31/23 for chest pain and heart failure. R7's 12/31/23 health status note showed R7 was sweating profusely and not answering questions. The oxygen humidifier was not bubbling and R7's oxygen saturation was 77%. The facility's 8/03 Oxygen Therapy Policy showed oxygen is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress.

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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. 34491 Based on observation, interview, and record review, the facility failed to ensure prescribed medications were available for 1 of 1 resident (R3) reviewed for medication availability in the sample of 12. The findings include: R3's Admission Record, printed by the facility on 4/25/24, showed she had diagnoses including heart failure and hypertension. R3's Order Summary Report, printed by the facility on 4/25/24, showed an order for Mexiletine 150 mg capsules. Give one orally three times a day for heart failure. R3's heart failure care plan, with a revision date of 2/22/24, showed she has heart failure. The care plan showed Give cardiac medications as ordered. On 4/24/24 at 1:51 PM, V6 (Registered Nurse-RN) was looking through the medication cart and stated he could not find one of R3's medications that was due. V6 identified the medication as Mexiletine 150 mg capsules (an antiarrhythmic medication used to correct irregular heartbeats to a normal rhythm). V6 stated R3 takes the medications three times daily and the medication is for R3's heart. V6 stated the last dose administered to R3 was prior to him starting his shift at 6:00 AM. V6 looked in the medication room and could not find the medication. V6 asked V5 (Director of Nursing-DON) if she could check on the status of R3's medication from the pharmacy. V5 told V6 the medication was in route. V5 stated the pharmacy delivers medications anytime between then and supper time. V6 said the previous day the pharmacy delivered medication around 6:00 PM. At 1:58 PM, V6 stated he sent a request to the pharmacy the previous day (4/23/24) and he does not know why it was not delivered on 4/23/24. V6 was observed administering R3's other medications to her and informing her that he did not have the medication for her heart and is waiting on the pharmacy to deliver the medication. At 3:30 PM, V6 (RN) said the pharmacy has not delivered R3's Mexiletine yet. V6 said the medication had not been delivered by the pharmacy because it needed the physician to reauthorize the medication. At 4:35 PM, V6 said R3's Medication was delivered about 10 minutes after this surveyor spoke with him last time. V6 showed this surveyor the medication that was delivered for R3. No pills were removed from the medication cards. V6 stated he called R3's physician and informed him of the situation and was told to hold the dose that was due earlier and just give her the scheduled PM dose, when it is due. On 4/25/24, V5 (DON) provided R3's Reorder form showing R3's mexiletine order was sent to the pharmacy on 4/24/2024 at 5:08 AM. V5 also provided a progress note written by V6 on 4/24/24 showing the Mexiletine did not come in time to give within a safe window. MD notified and gave order to hold. R3's April 2024 Medication Administration Record (MAR) showed an order for Mexiletine 150 mg capsule. Give one capsule orally three times a day for heart failure. The MAR showed the scheduled times for R3 to receive the medication is 5:00 AM, 2:00 PM and 9:00 PM. The MAR showed R3 did not receive the 2:00 PM dose on 4/24/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 7:47 AM, V1 (Administrator) said if a resident takes a medication three times a day, she expects the nurse to request a refill from the pharmacy early enough so that if the medication needs physician reauthorization, there will be enough time to get the authorization before the facility runs out of the medication. The facility's policy and procedure titled Medication Administration, with a revision date of 11/18/17, showed Procedure .3. Medications must be prepared and administered within one hour of the designated time or as ordered (i.e., Medication time is 9:00 AM. The medication can be administered as early as 8:00 AM and as late as 10:00 AM) . The facility's policy titled Conformance with Physician Medication Orders, with a revision date of 10/2006, showed All medication, including cathartics, headache remedies, or vitamins, etc., shall be given only upon the written order of a physician .These medications shall be given as prescribed by the physician and at the designated time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34491 Based on observation, interview and record review, the facility failed to ensure the treatment cart was locked when not in view of the nurse on duty, failed to ensure controlled medications were under a double lock in the medication cart, and failed to ensure the keys for the medication cart were not accessible to residents and staff. This failure has the potential to affect all 22 residents in the facility. The findings include: The Long-Term Care Facility Application for Medicare and Medicaid form dated 4/23/24 showed 22 residents resided in the facility. On 4/23/24 at 1:43 PM, the treatment cart, located next to the nurse's station was not locked. V6 (Registered Nurse-RN on duty) was not in sight of the treatment cart. This surveyor was able to open the drawers to the treatment cart. Inside the cart there were several topical creams for multiple skin conditions such as 2 tubes of Santyl (a debridement cream used to remove non-viable skin tissue). Two tubes of Mupirocin (used to treat skin infections) a tube of Benadryl (to relieve itching), a container of Nystatin powder (used for a yeast infection on the skin) a tube of Silvasorb gel (an antimicrobial wound gel) a container of Iodoform packing strips (used to pack the inside of wounds), three tubes of Medihoney (used for wound healing), one tube of Triad hydrophilic wound dressing pansement hydrophile (a sterile coating that can be used on broken skin that covers and protects the wound), two containers of SSD -1% silver sulfadiazine (a topical cream used to treat and prevent wound infections), a container of Sunmark medicated chest rub (a mentholated chest rub) a box containing a bottle of fungi nail (for fungal infections on nails), a box containing 8 large toenail clippers and another box with about 14 smaller nail clippers in it, a tube of Hydrogel amorphous wound gel (an aloe-based hydrating wound gel that protects the wound bed and enhances the moist environment essential to the healing process). The cart contained Recticare lidocaine 5%, two tubes of Hydrocortisone, and two tubes of Triamcinolone Acetonide cream (a topical corticosteroid cream). The cart had a bottle of 70% Isopropyl Alcohol Povidone iodine surgical scrub, Povidone iodine swab sticks and a container of Urea 40% lotion (a lotion to treat dry/rough skin conditions such as eczema, psoriasis, corns, and may also be used to remove dead tissue in some wounds to help wound healing). The treatment cart also contained a basket of lancets used to obtain blood sugar levels. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rochelle Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 North 3rd Street Rochelle, IL 61068	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/23/24 at 2:12 PM, V5 (Director of Nursing-DON) stated it is important to keep the treatment cart locked when not in your site because it has medications in it and the residents can get into it. V5 stated leaving it unlocked is dangerous because the facility has some residents with dementia. At 2:14 PM, V5 unlocked the medication cart so this surveyor could perform the medication storage task. The metal compartment for the controlled medications was not closed completely. V5 was standing next to this surveyor and was asked if this surveyor should be able to open it without a key. V5 said Absolutely not. the controlled medications should be double locked. V5 said she was going to find the nurse (V6) and speak to him right away. At 2:20 PM, V6 returned to the nurse's station. V6 said he should have locked the treatment cart and the controlled medications should be double locked. The medications in the controlled substance compartment were reviewed with V6. The medications in the controlled substance compartment included Norco (pain medication), Alprazolam (an antianxiety medication), Lorazepam (a medication used to treat seizure disorders and to relieve anxiety), Tramadol (a medication for moderate to severe pain), Lacosamide (a medication to treat seizures), Briviact (a medication used to treat seizures), Clonazepam (a medication used to treat seizures, panic disorder, and anxiety), Zolpidem (a sedative used to treat insomnia), and Morphine (a narcotic used to treat moderate to severe pain). On 4/24/24 at 2:33 PM, a set of keys were on the top counter at the nurse's desk. This surveyor was able to pick up the keys, take a few steps over to the medication cart, and use the keys to open the medication cart. This surveyor took the keys to V5 (Director of Nursing) and informed her that the keys were left on the counter at the nurse's desk accessible to the residents and staff. V5 said she was the one that left the keys on the counter. At 2:58 PM, V5 was asked if it was acceptable to leave the keys on the nurse's counter. V5 said it is never okay, for the same reasons we discussed the previous day when the nurse left the treatment cart unlocked and the controlled medications were not double locked. On 4/25/24 at 8:47 AM, the treatment cart, by the nurse's desk was unlocked. V25 (RN on duty) was not within site of the treatment cart. The facility's policy and procedure titled Medication Administration, with a revision date of 11/18/17, showed 5. Keep the medication cart in view at all times. If it is likely the medication cart will be out of visual control at any time, it must be locked. The facility's policy and procedure titled Procurement and Storage of Medications, with a revision date of 11/6/18, showed 8. All medications, except those requiring refrigeration, shall be kept in the locked medicine room or locked medication cart .10. Schedule II drugs are to be stored under double-lock subject to different key.

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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. 34491 Based on observation interview and record review, the facility failed to ensure the ceiling over the serving window and the dish washing area was free from damage and falling debris. The facility failed to ensure a thermometer was in one of the refrigerators to ensure proper working order of the refrigerator, and to ensure food was kept at a safe temperature. The facility failed to use a thermometer that measures internal food temperatures to obtain temperature readings prior to serving. The facility also failed to ensure staff were filling out the food temperature logs and the dish machine's chemical sanitation levels per their policies and procedures. This failure has the potential to affect all 22 residents in the facility. The findings include: The Long-Term Care Facility Application for Medicare and Medicaid form dated 4/23/24 showed 22 residents resided in the facility. On 4/23/24 at 9:05 AM, V20 (Dietary Cook) was asked where the temperature gauge for the refrigerator in the kitchen was located. V20 looked for several minutes, moving items in the refrigerator around and could not find the temperature gauge. At 9:08 AM, V20 stated she did not know what they did with it. V20 got out a new one and placed it inside the refrigerator. At 9:16 AM, V20 was talking with V8 (Newly hired Dietary Manager-DM-in training) about not being able to locate the temperature gauge. V20 said They do that to me all the time. On 4/23/24 at 12:00 PM, V20 stated she always takes the temperature of the foods on the stove before she covers the food and puts it on the steam table. V20 stated she does not check the temperatures on the steam table. V20 checked the temperature of the Salisbury steak with a thermometer, then switched to a laser radiation (laser radiation gun type) device to take the temperatures of the remaining food items to be served for the lunch meal. The information on the side of the laser radiation device showed Avoid exposure. Laser radiation is emitted from this aperture (opening, hole, or gap) . Do not stare into beam. V20 was asked why she used a different device instead of the thermometer she used to obtain the temperature of the meat. V20 said We only use the thermometer for the meats. We use the gun thermometer for all the other foods. V20 took the temperature of the carrots using the laser radiation device showing a temperature of 158 degrees Fahrenheit. V20 was asked to take the temperature using the same thermometer that was used for the meat. The temperature using the meat thermometer was 174 degrees Fahrenheit. V20 obtained the temperature of the spinach using the laser radiation device showing a temperature of 158 degrees Fahrenheit. V20 obtained the temperature using the meat thermometer. The temperature was 169 degrees Fahrenheit. At 12:20 PM, V8 (DM) said he has never seen food temperatures obtained with that type of thermometer before. V8 said he was wondering the same thing as this surveyor. V8 confirmed that there was at least a 10-degree difference between the meat thermometer and the laser device. V8 said You would want to be consistent with food temperatures. V20 showed V8 and this surveyor the case the laser radiation device came in and it showed on the case Not for internal temperatures. V8 told V20 to him that means it is only measuring the surface temperature and not the internal temperatures of the foods, adding You would want the internal temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/24/24 at 9:40 AM, V8 (DM in training) said he spoke with V19 (Maintenance Director) and V1 (Administrator) about the thermometer gun. V8 said he does not think it is for food. It is not for internal temperatures. Probably something maintenance would use. On 4/24/24 at 8:30 AM, V20 said when she first started working for the facility in 2004, she was trained to take the food temperatures with the laser gun and use the regular thermometer to take the temperatures of the meat. During the interview, V20 was asked about the damage to the ceiling in the kitchen that extends from the serving window (above the steam table) to above the dish washing area. V20 said they are supposed to be fixing the ceiling this week. V20 said a leak in the roof caused the ceiling damaged. V20 said it has been like that for years too. V20 confirmed the ceiling was missing drywall and paint, and there was a large hole above the serving window showing exposed lumber, and the roof of the building was visible. The area with paint chipping and damage ran along the ceiling from the serving window to the dish wash area. There was a smaller hole over the dish wash area in the ceiling. V20 said When it rains, it leaks. That does not seem sanitary for a kitchen; paint chips or little pieces of plaster from the ceiling will fall down onto the workspace when it rains, and it gets wet. V20 said When it gets really bad, we put a bucket under the area by the service window and take the steam cart out to the dining room to serve. On 4/24/24 at 9:36 AM, V8 said he was told that they sealed the roof where the leak was. They thought they had it fixed, but it rained, and they found out it was not fixed. V8 said they are trying to locate where the leak is coming from, then they will seal the roof and repair the ceiling in the kitchen. V8 said he inquired about that on his first day. V8 said he saw the huge hole. V8 said There is a hole above the food area, any debris could contaminate the food or injure staff. That is not safe. V8 said there are pipes in that area. If damaged, it could halt the dietary process. On 4/23/24 at 9:27 AM, V21 (Dietary Aide) showed this surveyor the binder where dietary staff log the results for the testing of the dish machine. Several boxes had no information documenting a test had been performed. V21 said They don't always fill out the logs on the weekends. V20 showed this surveyor where the food temperatures were documented. The April Food Temperature Chart also had several boxes with no information documenting the temperatures had been obtained. V20 verified on 4/21/24 ham was served for the lunch meal so there should have been an entry for the ground meat on that day. V20 said for the dinner meal on 4/21/24 French Dip Sandwich was served. V20 said the meat would have to ground for the mechanical diets so there should be a temperature entered into the ground meat box for the dinner meal on 4/21/24 as well. V20 confirmed that neither the lunch, nor dinner meal had entries in the ground meat boxes. On 4/23/24 at 9:34 AM, V8 said there should be entries in all the applicable boxes for the food temperatures, the dish machine chemical tests, and the refrigerator temps. The facility's April 2024 Food Temperature Chart showed no entries for the ground meats for the lunch and dinner meals on 4/21/24. The log showed no entry for the ground meat served for the dinner meal on 4/22/24. V20 reviewed the menu with this surveyor and said ham, a French dip sandwich and barbecued pulled pork were served for those meals so the meat would have to be ground for all of them for the residents receiving a mechanical soft diet. On 4/24/24 at 8:45 AM, V8 said all food items served would have to have a temperature logged on the Food Temperature Chart. V8 said he is going to instruct the staff regarding consistent documentation across all shifts for documenting on the food temperature chart. V8 said there should be a temperature logged in the boxes for ground meats, and all foods served. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/25/24 at 8:44 AM, V8 said a thermometer should always be in the refrigerators and freezers so we know that the food is kept at a safe level, out of the danger zone where bacteria grow, to prevent foodborne illness. The facility's January 2024 Dishwasher Temperature/Sanitizer Log showed missing entries for 16 out of the 31 days. The facility's February 2024 Dishwasher Temperature/Sanitizer Log showed missing entries for 5 out of the 29 days. The facility's March 2024 Dishwasher Temperature/Sanitizer Log showed missing entries for 20 out of the 31 days. The facility's April 2024 Dishwasher Temperature/Sanitizer Log showed missing entries for 8 out of the 23 days so far this month. On 4/25/24 at 10:50 AM, V19 (Maintenance Director) said since he started on 2/2/24, he is not aware of anything being done with the ceiling in the kitchen. V19 confirmed that there was a hole in the drywall above the service window with insulation showing, not all the insulation was intact. V19 confirmed lumber and the facility's roof were visible through the hole in the ceiling. V19 said he sent an email to V23 (the regional maintenance person) regarding the ceiling. V19 said he is not aware of any work being done to the ceiling since he started working at the facility. On 4/25/24 at 11:40 AM, V19 provided a copy of the email he sent to V23 on 3/14/24 updating V23 about the leak in the kitchen ceiling. V19 said V23 called him and said he was going to come to the facility and decide what steps to take. V19 said V23 never came to the facility, and he has not received any other direction regarding the leak. The 3/14/24 email sent to V23 by V19 showed Update on our leak in the kitchen ceiling. After applying the leak stop, it is still leaking from an unknown location. I found a product on (a big chain store's) website that could possibly help by resealing all the seams on the roof .I can't patch the ceiling inside (until) the leak is fixed. I'd like to get this taken care of due to the fact it's being requested by the Health Department. The facility's Diet Type Report, printed by the facility on 4/23/24, showed all residents except R13 take food by mouth. The document showed R13 does drink regular thin liquids. The facility's policy and procedure titled Food Temperatures, with a revision date of 04/2017, showed It is the policy of (the facility) to ensure that food is served at a temperature that is proper to prevent the growth of harmful bacteria and other food borne illnesses .1. The cook is responsible for taking and recording the temperatures for all hot and cold food at each meal. 2. The cook is responsible for taking the temperature of hot food after removing the hot food from the oven to ensure the appropriate temperature .3. Properly sanitize thermometer between each food item tested .4. Food temps should be taken prior to the meal service and recorded on the Food Temperature Chart. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy and procedure titled Equipment Temperatures, with a revision date of 09/2008, showed It is the policy of (the facility) that all refrigerator and freezers shall be monitored regularly to ensure that they are working properly and to correct any mechanical difficulties quickly to prevent food spoilage .1. Monitor all refrigerators and freezers daily to ensure that they maintain the correct temperatures. 2. Obtain the temperature from a thermometer located inside each refrigerator .4. Record the temperatures on the Refrigerator Temperature Chart. The facility's policy and procedure titled Ware-washing-Dish machine, with a revision date of 10/2009, showed It is the policy of (the facility) that utensils and dishes washed by mechanical dishwasher will be clean and sanitized .3. For Low Temperature Dish machines .Before washing anything, use a test strip to check the sanitizer level .4. Record either the temperatures or sanitizer level on the Dish machine Temperature/Sanitizer Log.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on interview and record review the facility failed to provide therapy services as ordered for 1 of 1 resident (R13) reviewed for therapy in the sample of 12. The findings include: R13's face sheet showed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of gastrostomy status, pneumonitis due to inhalation of food and vomit, dysphagia, encephalopathy, sepsis, peripheral neuropathy, cervical disc disorder with myelopathy, epilepsy, and chronic pain syndrome. On 04/24/24 at 08:10 AM, R13 was in bed with his eyes closed. R13 stated he doesn't remember the last time he had therapy at the facility. He said he went to an orthopedic appointment; therapy was ordered, and he never received any. On 4/24/24 at 10:15 AM V9 Director of Therapy stated she was going to do a swallowing/speech evaluation on R13 today. V9 stated she did not have a referral for physical (PT) or occupational therapy (OT) for R13. V9 stated her company took over providing therapy services at the facility in mid-March. V9 stated this was her second visit to the facility and she did not have any current orders to evaluate and treat R13 for PT or OT. On 04/24/24 at 11:55 AM, V1 Administrator stated R13 did not have any therapy notes from February, March, or April 2023 because he did not receive therapy services during that time. On 4/25/24 at 8:30 AM, V13 Activity Director stated we did not have therapy services during the time the February (February 29) and March (April 2) resident council meetings were held. I do the minutes and that's why it was noted that it did not apply for those meetings. At 9:10 AM, V1 Administrator stated she was unsure of the dates therapy services were not available here but will check. V1 again confirmed R13 did not receive therapy services February-April 2024. At 10:00 AM, V1 said therapy services ended here on February 18, 2024, and started again on March 12, 2024. At 10:04 AM, V2 sister facility Administrator said when therapy services ended, the residents were discharged either due to a failure to progress, having reached their prior level of functioning, or given a NOMNC (Notification of Medicare Non-Coverage) if they wanted to continue services. She will check the reason R13's therapy was discontinued. This surveyor was not given a rationale for R13's therapy being discontinued. At 11:05 AM, V1 said therapy services were stopped at the facility due to the corporation which owns the facility filed for bankruptcy. At 11:38 AM, a policy for consults and referral was requested from V1 and V2 local sister facility Administrator. V1 said they did not have one. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:56 AM, R13 said when he was first admitted his plan was to be discharged to a more independent setting. Now, he guessed he would stay here. R13 said he can't get out of bed by himself. R13 was in his room in a wheelchair. R13 moved the chair using his feet. At 11:05 AM, V1 said therapy services were stopped at the facility due to the corporation which owns the facility filed for bankruptcy. V1 said if there is therapy ordered, therapy should be provided. R13's 12/21/23 at 12:00 AM progress note showed he was transferred from a sister facility in the same city via facility van. R13's 12/26/23 physician note showed R13's prior facility had some trouble meeting all his needs regarding his medical issues. He (R13) is on tube feeds and needs significant physical therapy. He now presents to this facility to continue his rehab. R13's 2/6/24 physician note showed R13 requested an ortho appointment for his bilateral knees. R13 had generalized weakness and was complaining of bilateral knee pain, right worse than left. A referral to orthopedics was placed. Continue with physical therapy. R13's 1/25/24 physician order showed to continue physical therapy 5 times a week for 4 weeks to include therapeutic exercises, therapeutic activities, neuromuscular reeducation, gait training, manual techniques, group therapy, wheelchair (w/c) assessment and management. R13's 12/28/23 physician orders showed to provide occupational therapy (OT) 2 times a week for 4 weeks for therapeutic exercise, group therapy, therapeutic activities, self-care/home management training, and wheelchair assessment and management. R13's physical and occupational therapy orders were discontinued on 4/23/24. R13's 2/5/24 physician order showed to refer to see ortho. R13's 2/23/24 ortho referral note showed he was seen for pain; physical therapy was ordered, and he was to follow up after physical therapy. R13's 3/20/24 facility assessment showed he was cognitively intact. R13's care plan showed he had self-care deficits and a total mechanical lift and two staff were needed to transfer and was unable to reposition himself without assistance. The facility's February 29, 2024, Resident Council Meeting Minutes showed therapy concerns were not applicable. The facility's March Resident Council Meeting Minutes dated April 2, 2024, showed there was no therapy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precautions were in place, failed to implement their Legionella program, and failed to test facility water for Legionella. These failures have the potential to affect all 22 facility residents. The findings include: The facility's 4/23/24 application for Medicare and Medicaid showed there were 22 residents in the facility. On 04/23/24 at 09:24 AM, R8 was in bed in her room. There was a continuous positive airway pressure (CPAP) machine and tubing on her bedside table. R8 said she uses her CPAP every night. There were no enhanced barrier precaution signs posted and no available PPE outside the room. On 04/23/24 at 09:35 AM, V6 Registered Nurse (RN) changed R4's infected pressure injury dressing to his right foot. V6 did not wear a gown during the procedure. There were no enhanced barrier precaution signs posted and no available PPE outside the room. At 10:50 AM, V6 administered a tube feeding to R13. V6 did not wear a gown. There were no enhanced barrier precaution signs posted and no available PPE outside the room. On 04/24/24 at 09:06 AM, V6 administered medications and a tube feeding for R13 through his gastric tube. V6 did not wear a gown during the procedures. There were no enhanced barrier precaution signs posted and no available PPE outside the room. On 4/23/24 and 4/24/24, V6 was the only nurse on duty during the day shift providing care to all facility residents. On 04/25/24 at 07:56 AM, V1 Administrator/Infection Preventionist (IP) stated enhanced barrier precautions should be used if there are symptoms of contagious disease like covid or flu. V1 said there currently aren't any residents on isolation including enhanced barrier precautions. Enhanced barrier precautions are important to prevent the spread of infection and for resident and staff safety. Precautions that should be used when caring for residents with gastric tubes (g-tubes), wounds, and CPAP machines includes hand washing and glove use. V1 was asked if special precautions should be used for residents who use CPAP, have wounds, or g-tubes. V1 responded I would think so. I'm not sure. I'll look into this and get back to you. The facility's enhanced barrier precautions policy was requested. At 8:30 AM, V5 Director of Nursing (DON) stated she was not aware of what enhanced barrier precautions were or what precautions should be in place for residents who it would apply to. V5 said she just knew to use isolation for COVID. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

At 9:10 AM, V1 said she found out when providing care to wounds, g-tubes, and providing CPAP care to residents, enhanced barrier precautions should be implemented. This would include room signage showing what PPE (personal protective equipment) should be used. PPE should be available near the room and usually gowns and gloves should be worn.

The facility's 7/13/23 Enhanced Barrier Precautions Policy showed the purpose of the policy was to reduce transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) should be used when contact precautions do not apply for residents with any of the following: open wounds that require a dressing change, indwelling medical devices .Enhanced barrier precautions require use of a gown and gloves during high-contact resident care activities that provide opportunities for the transfer of multidrug-resistant organisms 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. High-contact care activities include caring for medical devices (i.e. feeding tubes), and wound care. Identify residents with medical devices or chronic wounds that do not require contact precautions. Post approved EBP signage that indicates high-contact activities. Ensure that disposable or washable isolation gowns and gloves are available to healthcare personnel (HCP), where high-contact resident care activities may be required. Keep a container or hamper inside resident's room for HCP to dispose of PPE.

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2. On 4/24/24 before 8:00 AM, V1 (Administrator) was asked for the facility's water system's flow diagram for their Legionella program, documentation to show that the facility assessed their risk for Legionella, and any testing that the facility had done for Legionella.

On 4/24/24 at 10:30 AM, V19 (Maintenance Director) stated he gave V1 the facility's policy and procedures for Legionella. When asked if he knew what caused legionella, he said water not moving-stagnant. V19 stated he is not aware of any assessment or testing of Legionella. V19 stated he started in February and was not provided any training when he first started. V19 stated he was not aware that there was supposed to be a Legionella program. V19 said he just met with the maintenance man from a sister facility last week and that is when he found out that the facility should have a Legionella program. V19 said they ordered the Legionella testing kit last Friday (4/19/24) and it should be here any time. V19 said he was not aware of anything else that has been done as far as the Legionella program goes. V19 said he does take the water temperatures monthly and documents them on his log. V19 said he found out yesterday that he should be taking the water temperatures weekly, so he changed it too weekly. V19 said he looked back and did not find any testing for legionella in the last couple years.

On 4/25/24 at 10:50 AM, V19 (Maintenance Director) said he started working at the facility on 2/2/24, V19 was asked to provide anything he had regarding the facility's Legionella program and anything the facility was doing regarding their Legionella program. At 10:54 AM, V1 (Administrator) was asked to provide anything she had concerning the facility's Legionella Program including a diagram showing the flow of water in the facility to assess places in the system that would be susceptible to Legionella, and anything the facility was doing to monitor and prevent Legionella.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145975	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Rochelle Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 North 3rd Street Rochelle, IL 61068	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V19 provided Monthly Water Temp Logs from 10/11/2022 through 4/15/24. The logs showed temperatures taken in resident rooms, in the kitchen (Dishwasher, prep sink, and hand wash station), and in the therapy department on 4/15/24, 3/14/24, 2/21/24. The most recent date on the remaining Monthly Water Temp Logs was 6/13/23. The facility's Facility Assessment Tool, with a review date of 4/8/2024, did not address the facility's risk for Legionella or the Legionella Program at all. The facility's undated Legionella Policy and Procedure, provided by the facility on 4/24/24, showed Legionella is a bacterium that is common in the natural water system (ponds, [NAME], lochs, etc.) and Legionella are widespread in the environment. They may contaminate and grow in artificial water systems such as cooling towers, hot and cold-water systems, storage tanks, pipe work, taps and showers. The policy showed Legionella survive at relatively low temperatures between 20 degrees Celsius (68 degrees Fahrenheit) and 45 degrees Celsius (113 degrees Fahrenheit). The policy showed High temperatures of 60 degrees Celsius (140 degrees Fahrenheit) and above will kill the Legionella bacteria. The policy showed Legionella bacteria thrive and multiply in hot or cold-water systems and storage tanks and then spread through spray from showers and taps. The policy showed Should concerns (be) identified, the following measures may be initiated to minimize and control the risks: Have the water system inspected, maintained and cleaned -annually. Ensure water cannot stagnate anywhere in the system. Remove redundant pipe work .Run through taps and showers no longer in use or used infrequently for a minimum of one minute X times a week. Check hot and cold water temperature after water has been running for one minute. Take shower heads apart every three months clean and disinfect (Quarterly). Keep water tanks and cisterns covered, clean and free from debris. Insulate tanks and pipe work. Ensure water stored in the hot water tank or cylinder is above 60 degrees Celsius. Annual servicing of boiler and thermostatic mixing valves (Annual). On 4/25/24 at 12:42 PM, V1 (Administrator) and V19 (Maintenance Supervisor) brought in an email from V24 (Corporate Consultant) attached to a copy of the Legionella Policy and Procedure previously provided by V1. V19 had a box in his hand that he identified as the testing kit for Legionella that was delivered. V1 said they are going to do testing even though they do not have to because they run all vacant faucets to flush out the system. The email from V24 showed We follow our policy and run all vacant faucets so we do not need to test. V1 and V19 were again asked for anything they had regarding their Legionella program showing a diagram of the building water flow system to identify areas in the system at risk for Legionella growth, any assessment done of the facility's risk, the temperature logs and anything they have showing they have implemented their Legionella program. Neither of the two policy and procedures provided by V1 had the Risk Assessment filled out. The facility's Water Management Plan effective 11/1/2019, showed The Legionnaires Management team responsibilities: 1. Identify and assess the risks of legionella bacteria in water systems. Devise a scheme for eliminating or controlling the risk. Manage the risk, selection and training of competent personnel. Keep up to date records .Procedures: 1. Develop a Management Team to review the temperatures at the hot and cold outlets (monthly). 2. Cleaning and disinfection of shower heads (quarterly). 3. Flushing of infrequently used outlets (weekly). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145975	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Legionella Management Procedure dated 8/10/2018, showed The Legionella Management Team duties and responsibilities include Corporate Maintenance Director .2. Ensuring that all staff within the team are kept fully informed of developments in Legislation and good practices relating to the management of legionella .Maintenance Director: 1. Carry out weekly/monthly checks as required. 2. Update log book with information gathered in weekly/monthly checks .Legionella Risk Assessment: A risk assessment shall be undertaken of all water storage tanks, calorifiers and associated pipework which are susceptible to colonization by Legionella .Total Viable Cell Counts (Dip Slides) shall be taken during each risk assessment. If and when Legionella water samples are required, the contractor shall obtain two-one liter water samples in a sterile container, one from the hot water distribution system and one from the cold water distribution system .On completion the risk assessment should include identification and evaluation of potential sources of risk and the particular means by which exposure to legionella bacteria is to be prevented. Or if prevention is not reasonably practical, the particular means by which the risk from exposure to legionella bacteria is to be controlled .Monitoring .Sites shall have personnel who have been instructed, trained and who are competent to carry out the weekly, monthly and quarterly monitoring regimes in-house .Suitable training and equipment will be provided to ensure the works are carried out correctly and safely. No other documentation was provided regarding implementation of the facility's Legionella Program.