STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146017	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Illini Heritage Rehab & Hc	1315 Curt Drive, Suite B Champaign, IL 61821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35380 Based on observation, interview and record review, the facility failed to answer call lights in a timely manner for seven residents (R21, R29, R31, R37, R39, R40, R46) and failed to provide privacy while giving an insulin injection in the dining room for one resident (R40) of eight residents reviewed for dignity in the sample list of 32. Findings include: Resident Council Meeting Minutes document the following: 6/23/2023, call lights need to be answered more timely; 7/21/2023, call lights are not being answered timely due to staff availability; 10/20/2023, call lights not being answered timely; 11/17/2023, second shift late answering call lights; 2/15/2024, answering call lights late; 3/21/2024, need to be more prompt answering call lights; 4/18/2024, call lights need to be answered sooner. On 5/7/24 at 3:01 PM, during the resident council interview, R21, R29, R31, R37, R39, R40, R46, all stated call lights are not answered timely (on each shift). R40's Physician Order Sheet (POS) dated 5-1-24 - 5-31-24, documents Insulin Lispro 100unit/milliliter - inject 5 units subcutaneous before meals. On 5/8/24 at 12:17 PM, V14 Licensed Practical Nurse (LPN), administered insulin to R40 in which V14 injected insulin into R40's abdomen while in the dining room while other residents were present. At this same time V14 LPN stated we always do it this way in the dining room, no one has told me (V14) any different. The facility's Residents' Rights pamphlet dated Revised 11/2018, documents you should receive the services included in the plan of care, your facility must provide services to keep your physical and mental health at their highest practical level, and you have a right to privacy.

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

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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. 34058 Based on interview and record review, the facility failed to provide a resident with an Advance Beneficiary Notice (ABN) at the termination of a Medicare Part A covered stay, thereby nullifying the resident's right to continue therapy services at their own expense, or decline therapy services. This failure affects one resident (R5) out of a sample of three reviewed for Beneficiary Notices on the sample of 32. Findings include: R5's Beneficiary Protection Notification Review (undated) documents R5 began a Medicare Part A covered stay at the facility 3/26/24, with a last covered date of 4/4/24. There was no evidence that R5 received an Advance Beneficiary Notice of her options to decline to receive further therapy, or to continue therapy services at her own expense. On 5/8/24 at 11:06 AM, V4, Business Office Manager, stated, I use the ABN notice for Medicare Part B. V4 then located ABN notices for two other residents discharged from Medicare Part A and stated, I don't know why I didn't make out an ABN for (R5).

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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. 35380 Based on interview and record review, the facility failed to report and notify the Administrator and a supervisor of injuries of unknown origin and failed to notify the administrator of a resident to resident incident for three of three (R11, R31 and R17) residents reviewed for Abuse Allegations in the sample list of three. Findings include: R11's undated Face Sheet documents R11's diagnoses as Acute Metabolic Encephalopathy, History of falling, repeated falls, need for assistance with personal care. R11's Physician Order Sheet (POS) dated 5/1/24-5/31/24, documents R11's diagnoses as Anxiety, Bipolar, Depression, Vertigo, Vitamin D Deficiency, Fibromyalgia, Chronic Back Pain. R11's Nursing Notes dated 5/2/24 at 10:00 AM, document some bruises noted to A (anterior) R (right) and L (left) hands and upper stomach - resident (R11) denies hitting somewhere. There is no further documentation in R11's medical regarding this finding. On 5/8/24 at 11:30 AM, facility Abuse allegations were reviewed. There is no documentation of R11's bruising being investigated. R17's undated Face Sheet documents R17's diagnoses as Rheumatoid Arthritis,unspecified, need for assistance with personal care, Muscle Weakness, unsteadiness on feet, Anemia. R17's Care Plan dated 3/25/24, documents R17 has a diagnoses of Depression. R31's undated Face Sheet documents R31's diagnoses as Multiple Sclerosis, Muscle Weakness, Heart Failure, Adult Failure to Thrive, Dyspnea, Ataxia. R31's Care Plan dated 3/22/24, documents R31 uses an antidepressant medication. R31's Nurses Notes dated 4/12/24 at 4:30 PM, documents patient (R31) upset and arguing about her (R31's) television, she (R31) hid the remote after changing the sound to Spanish to upset her (R31's) roommate (R17). There is no documentation of R31 and R17's incident being investigated. On 5/8/24 at 3:25 PM, V1 Administrator stated V1 did not know about either incident with R11, R17, or R31. V1 stated staff did not report anything to V1 and staff should have reported these incidents to V1 to be investigated. The facility's Abuse Prevention Program Policy dated 2/2019, documents the facility will orient and train employees on how to recognize and report occurrences of abuse immediately to supervisory personnel; this facility is committed to protecting the residents from abuse by anyone. This same policy documents employees are required to immediately report any occurrences of potential/alleged abuse of residents to a supervisor and the administrator.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on interview and record review, the facility failed to complete comprehensive Minimum Data Set assessments (Resident Assessment Instrument) in the required time frames. This failure affects two residents (R14 and R39) out of two reviewed for assessment timing on the sample list of 32. Findings include: 1. R14's comprehensive Admission Minimum Data Set (MDS) dated [DATE], section A1600 documents R14 was admitted to the facility 12/21/23. This same MDS section A2300 documents an Assessment Reference Date of 12/28/23. This MDS documents the Care Area Assessments section V0200B2, and Care Plan Completion date section V0200C2, were signed as completed 3/27/24. This MDS section Z0500B documents the signed completion date as 3/27/24. 2. R39's comprehensive Admission MDS dated [DATE], section A1600 documents R39 was admitted to the facility 12/20/23. This same MDS section A2300 documents an Assessment Reference Date of 12/27/23. This MDS documents the Care Area Assessments section V0200B2, and Care Plan Completion date section V0200C2, were signed as completed 3/27/24. This MDS section Z0500B documents the signed completion date as 3/27/24. The Centers for Medicare and Medicaid Long Term Care Facility Resident Assessment Instrument 3.0 Users Manual dated effective 10/1/23 documents the timetable for a comprehensive Admission MDS completion date (Z0500B), and Care Area Assessment completion date (V0200B2) must be no later than the fourteenth day from the admitted . This same manual documents the Care Plan Completion date must be no later than 7 days after the MDS completion date and Care Area Assessment completion dates. On 5/10/24 at 9:23 AM, V21, Minimum Data Set reimbursement Specialist, stated, When a resident is admitted to a facility, we set the ARD (Assessment Reference Date) for 14 days after the admitted , then we do the MDS the next day, so day 15 would be the completion date.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on interview and record review, the facility failed to encode and transmit residents' Minimum Data Set Assessments (Resident Assessment Instrument) within the required time frame. This failure affects two residents (R14 and R39) out of two reviewed for assessment transmissions on the sample list of 32. Findings include: 1. R14's Admission Minimum Data Set (MDS) dated [DATE] section A2300 documents an Assessment Reference Date of 12/28/23. This same MDS section Z0500B documents the signed completion date as 3/27/24 (reference F636). 2. R39's Admission MDS dated [DATE], section A2300 documents an Assessment Reference Date of 12/27/23. This same MDS section Z0500B documents the signed completion date as 3/27/24 (reference F636). The Centers for Medicare and Medicaid Long Term Care Facility Resident Assessment Instrument 3.0 Users Manual dated effective 10/1/23 documents the timetable for transmitting a completed MDS is no later than twenty-one days after the completion date. On 5/10/24 at 9:23 AM, V21, Minimum Data Set reimbursement Specialist, stated, When a resident is admitted to a facility, we set the ARD (Assessment Reference Date) for 14 days after the admitted , then we do the MDS the next day, then to transmit the MDS we get another 14 days after that.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on interview and record review, the facility failed to encode residents' Minimum Data Sets (Resident Assessment Instrument) to accurately reflect residents' health status. This failure affects two residents (R13, R34) out of ten reviewed for Minimum Data Set accuracy on the sample list of 32. Findings include: 1. R13's Minimum Data Set (MDS) dated [DATE] section M0100 documents R13 had a pressure ulcer. This same MDS section M0300 documents R13's pressure ulcer as a stage 3, full thickness of skin loss with underlying fatty tissue exposed, that was not present on admission to the facility. This same MDS section M1040 documents R13 had 2 venous or arterial ulcers present. This MDS section A1600 documents R13 was admitted to the facility 9/16/23. On 5/8/24 at 09:38 AM, V14, Licensed Practical Nurse, stated, (R13) never had a pressure ulcer since he was admitted , he is mobile, gets himself up and down, and changes position on his own. (R13) did have some venous ulcers on both lower legs but that has all resolved. V5, Resident Care Coordinator, confirmed V14's statements by stating, (R13) never had any pressure ulcers. R13's Treatment Administration Record dated for February 2024 documents the treatments for R13's venous ulcers were resolved as of 2/12/24. There was no documented evidence in R13's Treatment Record for January, February, March, nor April 2024 that R13 had ever received any treatment for a pressure ulcer. R13's comprehensive Medical Record including Nurses Notes, Pressure Ulcer Risk Assessments, Physician and Nurse Practitioner Notes, Registered Dietician Evaluations, and Care Plans, were likewise absent of any documentation about a pressure ulcer. On 5/9/24 at 12:52 PM, V5, Resident Care Coordinator, again stated, After some further review of (R13's) record, (R13) never had a pressure ulcer since he has been here. V5 stated, (R13's) venous ulcers were resolved months ago in February (2024). 2. R34's Minimum Data Set, dated dated dated [DATE] section K0520B documents R34 had a feeding tube (either naso-gastric or abdominal) while a resident of the facility. This same MDS section A1600 documents R34 was admitted to the facility 10/19/22. On 5/8/24 at 8:32 AM, V15, Certified Nursing Assistant, stated, I remember (R34) had a (urinary) catheter when he first got here, but I don't think he ever got any tube feedings. V5, Resident Care Coordinator, stated, I don't think (R34) ever had a g-tube (gastrostomy tube). On 5/9/24 at 12:50 PM, V5 provided R13's History and Physicals dated 10/20/22, 10/25/22, and 11/7/22, directly after R34's admission, conducted by R34's Nurse Practitioner (V18). All three of these comprehensive physical assessments and clinical histories did not document R34 had any kind of feeding tube. The history and physical dated 10/20/22 documents R34 and a family member (V19) were considering hospice care due to Metabolic Encephalopathy, but R34 was still sitting up and eating and drinking well. This History and Physical documented that R34 and V19 would not want any heroic measures taken to prolong life and wanted to focus on comfort care.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 34058 Based on interview and record review, the facility failed to obtain a Level 2 Pre-Admission Screening and Resident Review (PASARR) for a resident diagnosed with severe mental illness while residing in the facility. This failure affects one resident (R40) out of three reviewed for Pre-Admission Screening on the sample list of 32. Findings include: R40's Level 1 PASARR dated 10/6/22 documents a Level 2 screen was not required because R40 was not diagnosed with any SMI (Severe Mental Illness), ID (Intellectual Disability), nor RC (Related Condition). R40's Cumulative Diagnosis Log (undated) documents R40 has a medical diagnosis of Schizophrenia, a severe mental illness (SMI). R40's current Physician Order Sheet (POS) dated for May 2024 documents R40 has a medical diagnosis of Psychosis, a severe mental illness (SMI). This same POS documents R40 was admitted to the facility 10/7/22. On 5/8/24 at 4:07 PM, V4, Business Office Manager, stated, Usually the way it works is the information for the residents' screens are put in while the resident is in the hospital before they come here, so it is the hospital that puts the residents' information into the system. Maybe the hospital didn't have the mental illness diagnosis.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on interviews and record reviews, the facility failed to follow its shower and bathing policy and procedures to ensure all residents received a bath/shower at least once a week. This failure affects two residents (R21 and R23) out of 3 residents reviewed for activities of daily living assistance from a total sample list of 32. Findings include: 1. On 5/8/24 at 9:30am, R23 stated R23 needs total assistance from staff, which includes showers. R23 stated R23 is suppose to get 2 showers a week, but only gets them every once in a while. R23 stated R23 does not get 2 showers a week, and maybe gets 2 showers in a whole month. On 5/9/24 at 1:30pm, V17 Certified Nursing Assistant stated when a resident receives a shower whether they are total dependent on staff or set up/supervision, a Shower/Abnormal Skin Report should be completed. V17 stated when the resident is completed with the shower, the Shower/Abnormal Skin Report is completed by the CNA assisting the resident and is placed in a box at the nurses station. V17 stated all residents are scheduled for 2 showers a week. V17 stated if a resident refuses a shower, the assigned CNA should still be completing a Shower/Abnormal Skin Report. On 5/9/24 at 1:56pm, V15 Certified Nursing Assistant stated when V15 gives a resident a shower, after the shower is completed, V15 completes a Shower/Abnormal Skin report and places it in a box behind the nurses station. V15 stated that the nurse reviews and signs the Shower Sheet. V15 stated all residents are scheduled to receive 2 showers a week. On 5/8/24 at 1:48pm, V5 Resident Care Coordinator stated that all residents are scheduled to receive 2 showers a week. V5 stated that after the residents receive their shower, the Certified Nursing Assistant completes a Shower/Abnormal Skin Report and they place it in the box behind the nurses station. V5 stated the nurse reviews the report and signs it. V5 stated that even if a resident refuses their shower, they must complete the Report. R23's Facility Census documents R23 was admitted to the facility on [DATE] and has the following medical diagnoses; Atrial Fibrillation, Malignant Neoplasm of Prostate, Anemia, Type 2 Diabetes, Depression, Essential Primary Hypertension, Cardiac Arrhythmia, Insomnia, History of Extended Spectrum Beta Lactamase, Difficulty in Walking, Chronic Respiratory Failure with Hypoxia, Gastro-Esophageal Reflux Disease, Chest Pain, Atrial Flutter, Obstructive Sleep Apnea, History Pulmonary Embolism and Pulmonale. R23's Minimum Data Set (MDS) dated [DATE] documents R23's Brief Interview for Mental Status (BIMS) score 14, cognitively intact. R23's Care Plan dated 3/11/24 documents R23 requires extensive assist from staff to complete Activities of Daily Living (ADL) and transfers. R23's Shower/Abnormal Skin Report documents from 4/1/24 till present, R23 received a shower on 4/17, 4/24 and 5/9/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 5/9/24 at 9:01am, R21 stated that R21 is scheduled to receive 2 shower a week and is lucky to get 1. R21 stated R21 needs assistance from staff with R23's lower extremities and getting dressed. R21 stated that R21 has not been getting showered regularly. R21's Facility Census documents R21 was admitted to the facility on [DATE] and has the following medical diagnoses; Post Traumatic Stress Disorder, Chronic Kidney Disease, Acute Kidney Injury, Obesity, Diabetes, Congestive Heart Failure, Sinusitis, History of Tracheostomy, Glaucoma, Coronary Artery Disease, Hypertension, Status Post Coronary Artery Bypass Graft, Atrial Fibrillation, Chest Pain, Ischemic Cardiopathy, Automatic Implanted Cardio Defibrillator, Obstructive Sleep Apnea, Hypertriglyceridemia, Unstable Angina, Myocardial Infarction, Hyperlipidemia, Peptic Ulcer, Elevated Troponin, Gerd, Chronic Obstructive Pulmonary Disease, Hypothyroidism, Vitamin D Deficiency, Anxiety, and Cholelithiasis. R21's Minimum Data Set (MDS) dated [DATE] documents R21's Brief Interview for Mental Status (BIMS) score 14, cognitively intact. R21's Care Plan dated 3/12/24 documents R21 requires stand by to limited assistance from staff at times to complete Activities of Daily Living (ADL). R21 requires 1 person assist to stand. R21's Shower/Abnormal Skin Report documents from 4/1/24 till present, R21 received a shower on 4/17, 4/24 and 5/1/24. Facilities Bath/Shower Policy dated 3/20/23 documents: Policy To ensure adequate hygiene needs are met. A bath/shower is scheduled for all residents in the facility at least weekly.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on interview and record review the facility failed to follow physician orders in obtaining oxygen saturation levels and documenting them on the residents Treatment Administration Record (TAR). This failure affects one resident (R23) reviewed for following physician orders from a total sample list of 32. Findings include: R23's Facility Census documents R23 was admitted to the facility on [DATE] and has the following medical diagnoses; Atrial Fibrillation, Malignant Neoplasm of Prostate, Anemia, Type 2 Diabetes, Depression, Essential Primary Hypertension, Cardiac Arrhythmia, Insomnia, History of Extended Spectrum Beta Lactamase, Difficulty in Walking, Chronic Respiratory Failure with Hypoxia, Gastro-Esophageal Reflux Disease, Chest Pain, Atrial Flutter, Obstructive Sleep Apnea, History Pulmonary Embolism and Pulmonale. R23's Minimum Data Set (MDS) dated [DATE] documents R23's Brief Interview for Mental Status (BIMS) score 14, cognitively intact. R23's Physician Order Sheet (POS) dated 4/1/24 to present documents Oxygen Saturation to be taken and charted every shift. R23's Treatment Administration Record (TAR) documents R23's Oxygen saturation was not documented on 4/16/24 (6:00am-6:00pm), 4/17/24 (6:00am-6:00pm), 4/18/24 (6:00am-6:00pm and 6:00pm to 6:00am), 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25, 4/26 and 4/27/24 (6:00pm-6:00am), 4/28, 4/29, 4/30/24 (6:00am-6:00pm and 6:00pm-6:00am), 5/1 and 5/24/24 (6:00pm-6:00am), 5/3, 5/4, 5/5, 5/6/24 (6:00am-6:00pm and 6:00pm-6:00am). R23's Care Plan dated 3/11/24 documents R23 has shortness of breath related to Chronic Obstructive Coronary Disease (COPD). R23 uses oxygen via nasal cannula continuous and that R23 also is administered inhalers. On 5/8/24 at 9:30am, R23 stated that staff doesn't always check R23's oxygen level. R23 stated they do it occasionally, but not every day. On 5/8/24 at 1:48pm, V5 Resident Care Coordinator confirmed that R23 has an order for R23's oxygen saturation level to be checked every shift. V5 said, after the nurse takes R23's oxygen saturation it should be documented in R23's Treatment Administration Record (TAR), per R23's Physician Orders. V5 confirmed that R23 was missing the following documentation in R23's TAR: 4/16/24 (6:00am-6:00pm), 4/17/24 (6:00am-6:00pm), 4/18/24 (6:00am-6:00pm and 6:00pm to 6:00am), 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25, 4/26 and 4/27/24 (6:00pm-6:00am), 4/28, 4/29, 4/30/24 (6:00am-6:00pm and 6:00pm-6:00am), 5/1 and 5/24/24 (6:00pm-6:00am), 5/3, 5/4, 5/5, 5/6/24 (6:00am-6:00pm and 6:00pm- 6:00am).

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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. 20892 Based on observation, interview and record review the facility failed to correctly perform supra pubic catheter care for one of one residents (R101) reviewed for catheter care in the sample list of 32. Findings include: The Physician's Order Sheet (POS) dated 5/1/24 for R101 documents the following diagnosis: Chronic Obstructive Pulmonary Disease, Urinary Tract Infection, Chronic Heart Failure, and Neuropathy. The same POS documents catheter care to be provided by staff every shift for R101. R101 requires total assistance for all activities of daily living and requires a mechanical lift transfer with two assist. On 5/8/24 at 10:10 AM, Certified Nurses Assistants (CNA) V7 and V10 provided catheter care to R101. V7 explained to R101 they were going to clean his supra pubic catheter and V10 was doing the actual care for the procedure. V10 while cleaning the supra pubic catheter continued to go over the same area three times without changing the position of the wash cloth. V10 stated on 5/8/24 at 10:30 AM, I did not realize I did that, you are to change the cloth each time you wash the catheter. The facility's policy titled Catheter Care dated 3/15/23 documents to #7 to wash the catheter tubing from the opening of the urethra (supra pubic) outward 4 inches or farther if needed. Do not pull on the catheter. V12, Regional Support stated on 5/8/24 at 11am, We do not have a separate policy for supra pubic catheter, the procedure will be the same.

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	146017	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Illini Heritage Rehab & Hc	1315 Curt Drive, Suite B Champaign, IL 61821

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 38780 Based on interview and record review, the facility failed to provide sufficient Registered Nursing (RN) hours on four of eighteen days reviewed for RN staffing. This failure has the potential to affect all 49 residents in the facility. Findings include: The facility Nursing Schedules from April 23, 2024 through May 10, 2024 were reviewed for RN staffing. The Facility Nursing Schedule (April 23, 2024 through April 30, 2024) documents on 4/23/24, 4/25/24, and 4/27/24, the facility scheduled four (4) hours of RN coverage for a 24 hour period. This same record documents on 4/29/24, the facility scheduled zero (0) hours of RN coverage for a 24 hour period. On 5/9/24 at 1:32pm, V5 Resident Care Coordinator confirmed the hours listed on the facility nursing schedule were correct and the facility failed to have sufficient RN coverage on 4/23/24, 4/25/24, 4/27/24, and 4/29/24. The Long-Term Care Facility Application for Medicare and Medicaid report dated 5/8/24 documents 49 residents reside in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 35380 Based on observation, interview, and record review, the facility failed to label insulin pens after opening for five residents (R5, R15, R16, R27, R40) of five residents reviewed for insulin storage in the sample list of 32. R5's Physician Order Sheet (POS) dated 5-1-2024 - 5-31-24, documents Insulin Glargine-YFGN Units 100 inject 15 units subcutaneous (SQ) two times a day; Fiasp 100 units/milliliter (ml) 3 ml pen inject 5 units SQ three times daily before meals and Insulin Fiasp 100ml 3 ml per sliding scale four times a day. R15's POS dated 5-1-2024 - 5-31-24, documents Insulin Glargine -YFGN U100 inject 15 units SQ at bedtime, Insulin Lispro 100units/ml inject four times a day per sliding scale. R16's POS dated 5-1-2024 - 5-31-24, documents Insulin Lispro 100u/ml SQ before meals four times a day. R27's POS dated 5-1-2024 - 5-31-24, documents Novolog 100 units/ml per sliding scale four times a day, Insulin Aspart 100units/ml 3 ml four times a day. R40's POS dated 5-1-2024 - 5-31-24, documents Insulin Lispro 100units/ml inject 5 units SQ before meals per sliding scale, Levemir 100units/ml inject 10 units SQ at bedtime. On 5/8/24 at 12:17 PM, V17 Licensed Practical Nurse (LPN) was preparing to give insulin and the surveyor observed no open dates documented on the insulin pens for five residents (R5, R15, R16, R27, R40). V17 was asked about if and when the insulin pens should be dated when opened and V17 stated and pointed to the delivery received dates as the date of opened. On 5/8/24 at 12:35 PM, V5 LPN/RCC (Resident Care Coordinator) stated the insulin pens should be dated when they are opened. The facility's Procurement and Storage of Medications Policy dated 11/6/18, documents all medication containers shall be labeled with the date opened by the person breaking the seal.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 35380 Based on observation, interview, and record review, the facility failed to ensure that food served was palatable and attractive. This failure affects seven (R21, R29, R31, R37, R39, R40, R46) residents reviewed for dining services. Findings include: On 5/7/24 at 3:01 PM, resident council interview was held. At this time, R21, R29, R31, R37, R39, R40, and R46 all stated the food is terrible, doesn't look appetizing, is either hot or cold when not supposed to be, and they have the same things. Resident Council Minutes document: 6/23/24, food needs to be cooked more thoroughly; 9/15/23, cold food, want more fried chicken and magic cups; 12/21/23 cold food in dining room; 1/18/24, cold food all three shifts; 3/21/24, change meals, more coffee, too much butter; 4/18/24, hall trays for three meals are cold when they reach the residents, no coffee available to drink, more salt, pepper, sugar to be available, want alterations with how the food is being cooked. On 5/8/24 at 12:30 PM, surveyor asked V1 Administrator to come to dining room. At this time, surveyor and V1 observed at least 7 lunch plates with yellow and orange carrots not eaten. When speaking to R21, R29, R31, R37, R39, R40, R46, all stated the carrots are hard and cold and afraid they will break their teeth if they eat them.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34058 Based on observation, interview, and record review, the facility failed to serve a physician ordered diet texture to a resident who required mechanically altered food. This failure affects one resident (R18) out of ten reviewed for diet textures on the sample list of 32. Findings include: On 5/7/24 at 12:35 PM, R18 was seated at a dining room table being assisted to eat by V7, Certified Nursing Assistant (CNA). R18 had a sandwich on his plate consisting of 2 slices of bread with thick slices and chunks of roast turkey. R18 had not eaten any of the sandwich since it was served at 12:22 PM. On 5/7/24 at 12:35 PM, R18's tray card had a blue sticker with the word mechanical on the sticker. When asked, V7, CNA, used a fork to lift the top piece of bread from the sandwich, then stated and confirmed, No that sure is not mechanical. V7 then went to the kitchen service window and obtained a new plate of lunch for R18 including mechanical texture of the roast turkey. R18 consumed approximately 90% of the mechanical texture turkey. R18's current physician order sheet dated for May 2024 documents R18 has a physician order to receive mechanical soft diet texture. R18's Nutritional assessment dated [DATE] documents R18 needs a mechanical texture diet due to having few teeth in poor condition which cause chewing or swallowing difficulties.

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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. 34058 Based on observation, interview, and record review, the facility failed to maintain the range hood in a sanitary condition to protect food being prepared on the range, and failed to maintain the commercial dishwasher sanitizer levels to sanitize meal service wares and utensils. These failures have the potential to affect all 49 residents residing in the facility. Findings include: 1. On 5/7/24 at 9:28 AM, the range hood in the facility kitchen had a dull appearance and there was a general coating of a dull light brown colored greasy substance with darker brown grease trails running down the interior surface of the range hood. There was a pot of Brussels sprouts cooking on the range, as well as a cooked blueberry cobbler cooling on the side of the range, both items being directly underneath the hood. On 5/7/24 at 9:28 AM, there was an applied sticker on the outside of the range hood which documented a last cleaning date of 6/27/23. V6, Dietary Manager, stated, That sounds about right. I have been trying to keep it clean myself, but we need to get the cleaning service to come back in here again. 2. On 5/7/24 at 9:36 AM, the facility commercial dishwasher was in active operation with V16, Dietary Aide, washing resident dish wares and utensils. V6, Dietary Manager, confirmed the dishwasher used chlorine to sanitize the dishes. V6 then tested the sanitation cycle with a chlorine test strip which resulted in the test strip showing a slight tinge of gray color, indicating a chlorine level of 10 parts per million (ppm) or less. V6 repeated the dishwasher cycle and tested a second time with the same results. V6 stated, The same thing happened back in February when the County Public Health was here, but we moved the tubing around and it was fine after that. After moving the tubing around and running 2 additional cycles, testing each cycle, the test result remained at 10 ppm or less. V6 stated, I will call the service company and get them to come out. V16, Dietary Aide, receiving no further instruction from V6, continued to run dishes through the dishwasher to complete the remainder of the breakfast dishes. The facility's policy Ware-washing - Dishmachine dated 10/2009 documents, Before washing anything, use a test strip to check the sanitizer level, for chlorine sanitizers the level should be 50 - 100 ppm. On 5/7/24 at 10:20 AM, V6, Dietary Manager, stated, I called the service company and they can't come today but said they would make it a priority to come tomorrow. We will start sanitizing the lunch dishes in the 3 compartment sink. The facility's Resident Roster dated 5/7/24 and Form 671, Long Term Care Facility Application for Medicare and Medicaid dated 5/8/24, both document 49 residents reside in the facility.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 20892 Based on interview and record review the facility failed to conduct quarterly Quality Assurance (QA) meetings. This failure has the potential to affect all 49 residents residing in the facility. Findings include: The facility's Quality Assurance meeting sign in sheets for the last year were requested and were provided by V1 (Administrator). The facility had a documented meeting on 4/26/2024. The QA Meeting sign in sheet dated 4/26/2024 documents the facility reviewed information from the months of January, February and March 2024. There are no documented QA meeting sign in sheets for any other quarterly committee meeting. On 5/9/24 at 9:15 am, V1 Administrator and V12 Regional Support confirmed there were no more sign in sheets for the Quarterly Committee Meetings. V1 on 5/10/24 at 9:45 am, confirmed the meeting sheet dated 4/26/24 covered the months of January, February and March 2024. The facility's undated policy titled Quality Assurance Plan documents the facility will have quarterly meetings. The facility's Resident Roster dated 5/7/24 and Form 671, Long Term Care Facility Application for Medicare and Medicaid dated 5/8/24, both document 49 residents reside in the facility.