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	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Meadowbrook	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.

(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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40385 Based on observation, interview, and record review the facility failed to respect residents' right to be treated with dignity and respect for seven (R10, R31, R19, R29, R37, R45, R57) of seven residents reviewed for resident rights in the sample list of 39. This failure resulted in psychosocial harm of R10 and R57 causing R10 and R57 to be visibly upset and tearful. Findings include: The undated Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities documents Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. 1.) The facility's Resident Council Minutes dated 9/19/24 document call lights need answered timely and Certified Nursing Assistants (CNA) say not my resident when asked to provide care or answer call lights for unassigned residents. The facility's Resident Council Minutes dated 10/17/24 document concerns with CNAs and Nurses needing attitude adjustments and using phrases not my job, not my resident. The facility's Resident Council Minutes dated 11/21/24 document concerns that kitchen staff refuse things when asked. The facility's Resident Council Minutes dated 12/20/24 document the CNAs need attitude adjustments and concerns with CNAs being on their cellular phones and not answering call lights timely. The Resident Council Minutes dated 2/20/25 document concerns with CNA, nurses and dietary staff needing attitude adjustments, and residents have to call the nurse's station due to call lights not being answered. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/09/25 at 2:07 PM a resident council meeting was conducted. R29, R57, R37, R19 and R45 all confirmed call light wait times have been an ongoing problem with call lights being on for 45 minutes to an hour. R29 stated R29's main concern is that CNAs say I'll be right back or I'm not your CNA. R57 stated the CNA attitudes are atrocious and all residents agreed staff attitudes have been an ongoing problem. R29 and R57 stated when the residents complain about staff, the staff then intentionally don't answer their call lights, but were unable to identify which staff. R37 stated about a month ago R37 fell on the floor in his bathroom and waited for an hour and half with the call light on. R37 stated no staff came to answer R37's call light so R37 had to self transfer off of the floor and R37 reported this to unidentified staff. R29 stated V9 [NAME] had R57 in tears yesterday because R57 asked what the alternative was for dinner. R57 stated V9 said it's soup and sandwich and then V9 turned to an unidentified coworker and said V9 was tired of this and V9 was ready to clock out and go home. R57 stated staff, including V16 CNA, witnessed this incident. R57 stated R57 didn't feel V9's actions were considered abuse but more of a dignity and respect issue. R57 stated R57 felt scolded like a child. R29, R57, R37, R19 and R45 all stated V9 has a terrible attitude and tells the residents take it or leave it when it comes to the food. These residents also stated V13 CNA is always on V13's phone, V13 is rude, V13 has an attitude and tells residents that V13 will be right back but then doesn't return to answer the call light. On 3/10/25 at 2:28 PM V16 CNA stated V16 witnessed the incident between R57 and V9 that occurred in the evening of 3/8/25. V16 stated R57 wanted to know what food was being served and V9 fired off at (R57) and was rude to R57. V16 stated V9 said R57 was getting on V9's nerves and V9 was ready to clock out and go home. V16 stated at that time R57 was upset/tearful and R57 didn't want anything to eat. V16 stated V16 reported this immediately to V1 Administrator. On 3/10/25 at 10:41 AM V12 CNA stated V9 is short with the residents, V9's tone is loud, and V9 does not always get the residents the foods that they request from the kitchen. On 3/10/25 at 2:09 PM V1 Administrator stated V1 had not been made aware of any concerns with V9's and V13's attitudes or dignity/respect. V1 stated V1 will need to follow up and do customer service education. On 3/11/25 at 10:37 AM V1 stated the dignity is part of the Resident Rights packet, which is what the facility uses as a policy. 2.) On 3/09/25 at 9:51 AM R31 stated CNAs (later identified as V16 and V15) got mad at R31's room mate, R10, causing R10 to cry. R31 stated R31 reported this to V8 Social Service Director who said V8 would follow up with V1 Administrator. R10 stated sometime last week the CNA (V16) came in to assist R10, this CNA was upset because night shift had not changed R10 or applied R10's lymphedema compression machine to R10's legs. R10 stated the CNA said night shift should have already applied R10's compression machine and changed R10. R10 told V16 that R10 was disgusted and V16 told R10 well it's my job. R10 stated the CNA caused R10 to cry, like I'm (R10) going to now. R10 was visibly upset and tearful. R10 stated R10 didn't feel abused by V16, but that it was more of a dignity/respect issue. R10 stated it was V16's tone of voice and R10 felt scolded by V16. R31's Grievance/Complaint Form dated 3/6/25 documents R31 reported the CNAs came in very early to wake up R10, the CNAs were loud and upsetting R10 while they assisted R10 out of bed. R31 had asked the CNAs why R10 had to get up so early and they replied that they had to, which caused R10 to be very upset. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/09/25 at 11:59 AM V8 stated on 3/6/25 R31 reported concerns that the CNAs had upset R10. The CNAs were complaining because R10 and R31 were complaining about getting up so early. V8 stated the CNAs told R31/R10 that was what they had to do. V8 stated this was reported to V1 on 3/7/25. On 3/10/25 at 10:41 AM V16 CNA recalled the incident with R10. V16 stated night shift had not completed their assigned tasks for R10 one day last week which caused more work for the dayshift. V16 stated V16 was frustrated and should not have vented to R10 because R10 took it personally. V16 stated R10 was upset/crying and V16 reassured R10 and apologized at that time. On 3/10/25 at 2:09 PM V1 stated V1 had not been made aware of any concerns with V15's and V16's attitudes or dignity/respect.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to ensure residents have access to their personal funds for four (R57, R14, R19, R37) of seven residents reviewed for personal funds in the sample list of 39. Findings include: The facility's Resident Personal Trust Funds policy dated 4/15/24 documents the resident personal funds will be maintained in the business office and social services staff can assist residents in obtaining funds from the business office. This policy documents residents may make deposits or receive funds at the business office during regular business hours Monday through Friday or at the specified times posted in the facility. Withdrawals for less than $60 will be made immediately and over $60 will require a 24 hour notice. 1.) On 03/09/25 at 9:19 AM R14 stated R14 has a $60 monthly income that the facility keeps in trust fund account. R14 stated R14 does not have access to R14's personal funds on the weekends when V17 Business Office Manager isn't in the facility, which isn't right. R14's Minimum Data Set, dated dated dated [DATE] documents R14 as cognitively intact. The facility's Trial Balance for resident trust fund accounts dated 3/10/25 documents R14 has a personal fund accounts at the facility. 2.) On 3/9/25 at 2:07 PM, during the resident council meeting, R57, R19, and R37 stated they aren't able to obtain money from their personal funds account on the weekends and when V17 isn't at the facility. They stated they have to wait for V17 to return in order to get their money from their accounts. The facility's Trial Balance for resident trust fund accounts dated 3/10/25 documents R19, R37, and R57 have personal fund accounts at the facility. The facility's Resident Council Minutes dated 2/20/25 documents concerns that residents need to know how to get money from the business office when the manager has a day off. On 3/10/25 at 10:48 AM V17 stated V17 manages the resident trust fund accounts and V1 Administrator is the only other person who has access to these accounts. V17 stated V17 only works one Saturday per month. On 3/10/25 at 10:54 AM V1 Administrator stated V1 has access to the resident trust funds, but no one is here on the weekends to access these accounts.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to provide quarterly statements for personal fund accounts for four (R1, R7, R14, R18) of seven residents reviewed for personal funds in the sample list of 39. Findings include: The facility's Resident Personal Trust Funds policy dated 4/15/24 documents the resident personal funds will be maintained in the business office and quarterly statements for all transactions will be provided to the resident or legal representative. 1.) On 03/09/25 at 9:19 AM R14 stated R14 has a $60 monthly income that the facility keeps in trust fund account. R14's Minimum Data Set, dated dated dated [DATE] documents R14 as cognitively intact. The facility's Resident Council Minutes dated 2/20/25 document concerns that residents need account statements for what they are paying for. R14's Resident Statement dated 3/10/25 documents transactions between 1/1/25 and 3/5/25, with a remaining balance of $2,496.20. 2.) R7's Resident Statement dated 3/10/25 documents transactions between 1/2/25 and 3/3/25, with a remaining balance of $5, 199.75. 3.) R1's Resident Statement dated 3/1/25 documents transactions between 12/18/25 and 3/3/25, with a remaining balance of $381.00. 4.) R18's Resident Statement dated 3/10/25 documents transactions between 12/18/25 and 3/5/25, with a remaining balance of $2,078.69. On 3/10/25 at 10:48 AM V17 Business Office Manager stated V17 manages the resident trust fund account and V17 has not provided quarterly statements to the residents after the facility's change of ownership on 11/1/24. At 1:20 PM V17 confirmed R1, R7, R14, and R18 all have personal funds accounts.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 40385 Based on observation, interview, and record review the facility failed to follow up on grievances and document actions taken for six (R19, R29, R36, R37, R45, R57) of six residents reviewed for grievances in the sample list of 39. This failure has the potential to affect all 51 residents in the facility. Findings include: The facility's undated Resident Council Policy documents the purpose of the council meeting is to protect and preserve resident rights and for residents to discuss grievances/problems and to participate in the resolution of these concerns. This policy documents suggestions and complaints will be presented in writing to the facility's Administrator, Social Services Director, and other facility staff to review and implement follow up actions. The Concern/Suggestion form will be used to document concerns and the Administrator will respond to all council recommendations and complaints in writing, and per the facility's grievance policy. The facility's Grievance policy dated November 2016 documents the facility will post information on how to file a grievance and the contact information for the grievance official. This policy documents grievances will be submitted in writing to the Administrator within five working days, the Administrator may delegate grievance investigations to relevant staff, and the Administrator will review the findings to determine corrective actions. This policy documents the resident or person who filed the grievance will be informed of the investigative findings and actions taken to correct the concern. The facility's Resident Council Minutes dated 9/19/24 document concerns with locating work order forms for repairs, wanting day and night snacks, repetitive meals, missing laundry items, overlapping times for medication passes, Certified Nursing Assistants (CNAs) not answering call lights timely, timely toileting/incontinence cares, trash cans not being emptied and liners not replaced. The Resident Council Minutes dated 10/17/24 document concerns with housekeeping not changing mop heads between rooms, missing laundry items, CNA and nurse attitudes, staff sleeping on the job, and prompt medication times. The Resident Council Minutes dated 11/21/24 document concerns with kitchen staff refusing to provide requested items, posting menus, laundry sent to the wrong closet, replacing trash can liners, and late medications. The Resident Council Minutes dated 12/20/24 document concerns with wanting larger portions for meals, meals being cold and not served on time, changing mop heads between rooms, laundry items need marked, replacing trash can liners, CNA attitudes, call lights, and staff sleeping on the job. The Resident Council Meeting dated 1/16/25 documents concerns with meals being late and cold, laundry being returned to the wrong closet, trash can liners not being replaced, and CNAs saying they will be back but not returning. The Resident Council Minutes dated 2/20/25 document concerns with dietary/CNA/nurse attitudes, food being cold, missing meals, larger portions of food, trash cans not being emptied, call lights, and medications being on time. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Grievance Log ranging from 11/29/24-3/6/25 only documents grievances for resident council on 1/16/25 for laundry not being marked or returned, and on 2/20/25 for items not being returned timely or to the wrong closet. The Grievance/Complaint Report dated 1/16/25 documents concerns with housekeeping staff mopping restrooms and using the same mop head to mop the rest of the room. This form documents V1 Administrator spoke with the housekeeping supervisor, staff were re-educated on appropriate cleaning method, and this will be monitored by the housekeeping supervisor. The Grievance/Complaint Report dated 1/16/25 documents meals are served late and cold, V1 spoke with the kitchen staff about serving meals timely, and this will be monitored through ongoing observation and education. There are no other documented follow up actions for the concerns mentioned in the Resident Council Minutes. On 3/09/25 at 2:07 PM, during the resident council meeting, R29, R19, R37, R45, and R57 reported ongoing concerns with not being able to access their money on the weekends, call light wait times, medications being late, staff attitudes, replacement of trash can liners, evening snacks/coffee, V9 [NAME] attitude, V13 CNA attitude, and meals being served late/cold. R37 stated R37 has a pair of pants that have been missing for over two months, this was reported to V21 Housekeeping Supervisor and V21 searched and was unable to find R37's pants. R57 stated R57 has been missing a pillowcase from R57's bedding set for about a month, V21 was aware, but the pillowcase was never found. These residents were unsure who to report grievances/concerns to other than bringing it up during the council meetings and were unsure of what actions the facility was taking to follow up on their reported concerns. On 03/10/25 at 10:36 AM V33 Licensed Practical Nurse stated V33 is usually done with the morning medication pass by 10:00 AM. V33 stated the morning medications are scheduled to be given at 8:00 AM. At this time V33 was observed passing medications to R36. V33 confirmed V33's medications were R36's scheduled 8:00 AM medications. V33 stated R36 was the last resident for V33's morning medication pass. R36's March 2025 Medication Administration Record documents Amlodipine 10 milligrams (mg), Aspirin 81 mg, Multivitamin, Duloxetine 60 mg, Famotidine 20 mg, Ferosul 325 mg, Pregabalin 75 mg, Timolol 0.5% eye drops, Vitamin C 500 mg, Brimonidine 0.2% eye drops, Dorzolamide/Timolol eye drops, Sodium Bicarbonate 650 mg, Lisinopril 10 mg, and Torsemide 40 mg are scheduled to give at 8:00 AM. On 3/11/25 at 10:49 AM V7 Registered Nurse confirmed medications are suppose to be given within an hour window before/after the scheduled time. V7 stated once or twice a week there are times when V7 hasn't been able to give medications within that time frame. On 3/09/25 at 3:18 PM V18 Activity Director confirmed the repeated issues brought up in the resident council meetings. V18 stated V1 Administrator is notified of these concerns and V18 thought V1 documents the follow up actions. V18 reviews the concerns from the prior month at each meeting, but was unaware that V18 needed to have documentation on follow up actions taken for the concerns. On 3/10/25 at 9:43 AM V18 confirmed there were no documented follow up actions taken for the September 2024-February 2025 council meeting concerns, besides the 1/16/25 and 2/20/24 grievance forms. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/09/25 at 3:33 PM V8 Social Services Director stated she receives the final grievance forms for concerns brought up during the council meetings. V8 stated V8 conducted the January 2025 council meeting. On 3/11/25 at 9:50 AM V8 stated V8 was unable to locate documentation of any grievances for September 2024-November 2024 that were not listed on the provided grievance log. V8 stated V8 is the person that grievances, including missing items, should be reported to and is responsible for ensuring grievances are be followed up on. V8 reviewed council minute concerns from the January and February 2024 meetings and confirmed the only grievances documented were on 1/16/25 and 2/20/25 regarding housekeeping, meals being late, and missing items. V8 stated V8 may have to start reviewing the resident council meeting minutes after each meeting to ensure the concerns are being followed up on and documented as grievances. V8 stated V21 Housekeeping Supervisor has a list of missing laundry items and V8 should get that list to ensure follow up actions are taken and documented. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 3/9/25 documents the facility has a census of 51 residents.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. 40385 Based on observation, interview, and record review the facility failed to have a physician order for medication found at the bedside for one (R39) of one resident reviewed for self administration of medications in the sample list of 39. Findings include: The facility's Medication Administration policy dated 11/18/17 documents medications will not be kept at the bedside unless there is a physician order to do so. On 3/09/25 at 8:50 AM there was a Combivent inhaler on R39's overbed table. R39 stated R39 self administers the inhaler, two puffs, two to four times per day and the inhaler is always kept in R39's room. R39's March 2025 Physician Order Summary does not document an active order for the Combivent inhaler or for R39 to keep this medication at the bedside prior to 3/9/25. On 3/9/25 between 12:48 PM and 12:52 PM V7 Registered Nurse stated R39 has an inhaler that R39 keeps in her room and self administers. V7 reviewed R39's active physicians orders and Medication Administration Record and confirmed there is no order for the Combivent inhaler. V3 Assistant Director of Nursing stated residents need an assessment and physician's order to keep medications at the bedside and self administer. V3 instructed V7 to follow up and get a physician's order for the inhaler.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to provide numerous showers as scheduled for dependent residents. These failures affect two residents (R9, R43) of three reviewed for activities of daily living in the sample list of 39. 1. On 3/9/25 at 9:00am R10 stated that R9 is R10's Husband and R9 does not get two showers a week. R10 stated that R9 needs help from staff to get a shower, due to R9's not knowing how to take one without someone helping R9. On 3/11/25 at 9:15am V3 Assistant Director of Nursing (ADON) stated all residents are scheduled for two showers a week, and if a resident refuses a shower after three attempts a bed bath is offered. V3 stated if the resident still refuses, a nurse is notified and documents it in the resident's chart. V3 stated after giving the resident a shower, the Certified Nursing Assistant (CNA) documents it on a shower sheet. V3 stated all showers must be documented on a shower sheet whether the resident receives a shower, bed baths or refusals. On 3/11/25 at 12:15am V29 Certified Nursing Assistant (CNA) confirmed that R9 has not had any documented showers in February or March 2025. V29 stated that V29 could not locate any shower sheets that document that R9 received a shower or bed bath and only one refusal was found. V29 stated R9 should be getting two showers a week, and if R9 gets a bed bath or refuses staff should be completing a shower sheet. R9's Facility Census documents R9 was admitted to the facility on [DATE] and has the following medical diagnoses; Cognitive Communication Deficit, Need for Assistance with Personal Care, Unsteadiness on Feet, Dementia, Depression. R9's Minimum Data Set, dated dated dated [DATE] documents R1's Brief Interview for Mental Status (BIMS) score six, severe cognitive impairment, and needs substantial assistance with showers. R9's Care Plan dated 3/15/24 documents R1 requires extensive assist of 1 and gait belt transfers. R9 requires assistance from staff to complete Activities of Daily Living. The facility's shower schedules document R9's showers are scheduled twice per week on Wednesdays and Fridays. R9's February and March 2025 shower sheets provided by V3 Assistant Director of Nursing (ADON) and V29 Certified Nursing Assistant documents R9 has not received any showers in February and March and refused one shower on 2/17/25. There are no other documented showers, bed baths or refusals. 35380 2. R43's undated Face Sheet, documents R43's diagnoses as Acute and Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, unspecified, Cognitive Communication Deficit, Muscle Weakness, generalized, unspecified Dementia,unspecified severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R43's Physician Order Sheet (POS) dated 12/1/24-12/31/24, documents R43 is on Hospice. This same POS documents R43 was sent to the Emergency Department on 12/1/24 and returned to the facility on [DATE]. R43's shower sheets for December 2024, documents only three showers given on 12/10/24, 12/13/24, 12/31/24 and R43 should have had six showers; January 2025, documents only four showers given on 1/9/25, 1/18/25, 1/26/25, 1/31/25, and R43 should have had six showers; and February 2025, documents only two showers given on 2/2/25 and 2/18/25, and R43 should have had eight showers. On 3/11/25 at 9:15am V3 Assistant Director of Nursing (ADON) stated all residents are scheduled for two showers a week, and if a resident refuses a shower after three attempts a bed bath is offered. V3 stated if the resident still refuses, a nurse is notified and documents it in the resident's chart. V3 stated after giving the resident a shower, the Certified Nursing Assistant (CNA) documents it on a shower sheet. V3 stated all showers must be documented on a shower sheet whether the resident receives a shower, bed baths or refusals.

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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** 40385 Based on observation, interview, and record review the facility failed to implement physician's ordered treatments, monitor daily weights, report weight gain, and develop a care plan for lymphedema and congestive heart failure (CHF) for one (R10) of two residents reviewed for edema in the sample list of 39. Findings include: On 03/09/25 at 9:51 AM R10 stated R10's legs are suppose to be wrapped every morning and removed every night, but that doesn't always get done. R10 stated R10's leg wraps have been on for several days. R10 stated R10 was hospitalized in November 2024 for cough and lymphedema. R10's legs had lymphedema and the leg wraps were sliding down onto R10's feet. R10's Minimum Data Set (MDS) dated [DATE] documents R10 is cognitively intact. R10's active care plan lists diagnoses of Lymphedema and CHF, but does not document a problem, goal, and interventions to address R10's CHF and Lymphedema. R10's January 2025 Physician's Order Summary documents an order to monitor weight daily, notify physician of 3 pound (lb) weight gain in one day or 5 lb gain in three days. R10's Physician Order dated 2/15/25 documents to apply leg wrap in the morning and remove at bedtime. This order has not been transcribed onto R10's March 2025 Treatment Administration Record (TAR). R10's After Visit Summary dated 12/9/24, recorded by V23 Cardiologist Advanced Practice Registered Nurse, documents R10 has CHF, monitor weights daily, report gain of 2-3 pounds (lbs) in 24 hours or 5 lb in one week. There is no documentation in R10's medical record that daily weight monitoring was initiated prior to 1/3/25. R10's Progress Note dated 1/8/25, recorded by V32 Physician, documents R10 was hospitalized in November 2024 and diuresed more than 60 lbs, R10's legs are swollen again and R10 has gained 36.8 lbs over the past month. R10's Progress Note dated 2/7/25, recorded by V32 documents R10 has a long history of lymphedema, R10's legs are dependent, R10's legs are heavy and thick, and R10 now has lymphedema wraps. This note documents R10 had lost 61 lbs of water weight and has now gained over 38 lbs back again. R10's Monthly Weight and Vitals form ranging September-December 2024 documents R10's December weight as 292.8 lbs. R10's December 2024 and January - February 2025 Daily Weight Logs documents only one recorded weight of 248 lbs on 12/3/24. There are only 15 recorded weights between 1/1/25 and 2/28/25. R10 weighed 245.8 lbs on 1/3/25 and 258.8 lbs on 1/7/25, a 13 lb gain in one week. R10 weighed 248.6 on 1/9/25 and 263.6 on 1/14/2, a 15 lb gain in five days. R10's March 2025 Daily Weight Log documents R10 weighed 243.2 on 3/2/25, 245.4 lbs on 3/6/25, 249.2 lbs on 3/7/25 (3.8 lb gain in one day), and 250.1 lbs on 3/8/25 (6.9 lb gain in one week). There is no documentation in R10's medical record that V23 was notified of R10's listed weight gain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/09/25 at 10:09 AM V7 Registered Nurse stated R10 has a lymphedema compression machine that stopped working two days ago and the company has been notified. V7 stated sometimes night shift wraps R10's legs in the morning otherwise the day shift nurse wraps R10's legs. V7 stated the compression wraps are suppose to be removed at night and reapplied in the morning, and this should be documented on R10's TAR. V7 reviewed R10's March 2025 TAR. V7 stated there is nothing documented about applying R10's leg wraps only applying the lymphedema compression machine. On 3/10/25 at 12:52 PM V3 Assistant Director of Nursing stated the nurses should document R10's leg wraps and lymphedema compression machine on R10's TAR. V3 stated R10's weights should be monitored daily. At 1:10 PM the weight log book was reviewed with V3. V3 confirmed the Daily Weight Logs were missing entries between December 2024 and February 2025. V3 stated R10's daily weights were initiated in January 2025. At 2:18 PM V3 stated R10 should have been weighed daily in December 2024 but the staff did not record R10's daily weights. V3 confirmed all of R10's weight documentation was provided. On 3/11/25 at 8:45 AM V3 stated the nurses should document physician notification in the nursing notes. V3 stated according to R10's January 2025 physician order, the nurses should notify V23 of a 3 lb weight gain in one day and 5 lb gain in three days. V3 reviewed R10's nursing notes and confirmed there is no documentation that R10's weight gain between January 2025-March 2025 was reported V23 after 1/9/25. On 3/11/25 at 10:25 AM V22 Registered Nurse at V23's office stated R10 has been V23's patient since March 2024 and at that time R10 had lymphedema but did not have CHF. V22 stated there were no orders for monitoring R10's lymphedema or weights prior to R10 being hospitalized in November 2024 when CHF was added as a new diagnosis. V22 stated R10 was evaluated in the office by V23 on 12/9/24 and 1/9/25, and R10's next appointment is scheduled for 4/23/25. V22 stated per V23's notes, R10 should be weighed daily and the facility should notify V23's office of a 2 lb gain in one day and 4-5 lb gain in one week. V22 stated V22 did not see documentation that the facility had notified the office of R10's weight gains after 1/9/25. On 3/11/25 at 12:48 PM V30 MDS/Care Plan Coordinator confirmed R10's care plan does not have a problem, goals, and interventions to address R10's lymphedema and CHF.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35380 Based on observation, interview, and record review, the facility failed to obtain a treatment order for a newly discovered pressure area, monitor the area and follow manufactures recommendations for a treatment application for one resident (R43) of two residents reviewed for pressure ulcers in the sample list of 39. Findings include: R43's undated diagnoses list documents R43's diagnoses as: Acute and Chronic Respiratory Failure without Hypoxia, Type II Diabetes Mellitus without complications, Chronic Obstructive Pulmonary Disease, and Cognitive Communication Deficit. Pressure Wound is not listed as a diagnosis in R43's medical record. R43's Hospice notes dated 12/19/24, document redness to buttocks. R43's medical Record has no other documentation regarding this area until another Hospice note dated 1/2/25. This Hospice note documents a stage II wound measuring 2 centimeters (cm) by 2 cm and recommended a treatment. A telephone order written on 1/8/25, was given with treatment orders for R43's pressure wound. R43's Treatment Administration Records (TAR) for December 2024 has no documentation for the red area on R43's buttocks to be monitored, and the January 2025 TAR documents the treatment ordered on 1/8/25 did not start until 1/9/25. There are no skin assessments for pressure wounds documented in R43's medical record. R43's Minimum Data Set (MDS) has no documentation for a significant change for R43. R43's Care Plan dated 6/6/24, has no documentation for a pressure wound and no interventions for wounds. On 3/10/25 at 10:30 AM, V6, Licensed Practical Nurse (LPN), while providing a pressure wound treatment, did not cut the prescribed Calcium Alginate treatment to fit the wound bed. V6 cut the Calcium Alginate bigger than the wound bed including placing the Calcium Alginate over unaffected skin. On 3/10/25 at 3:19 PM, V3 Assistant Director of Nursing (ADON) stated the Calcium Alginate should have been cut to the wound bed size and not covering good (unaffected) skin. On 3/10/25 at 3:30 PM, V6 LPN stated the wound bed includes the entire area of the wound including peri-wound and wound bed. V6 stated if V6 tried to cut the Calcium Alginate to the wound bed size she would have contaminated the area. The facility's undated package insert for Calcium Alginate wound dressing documents dressing may be cut to size prior to application and apply dressing to moist wound bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Prevention of Pressure Wounds dated January 2017, documents to review the resident's Care Plan to assess for any special needs of the resident. This same policy documents a pressure injury is usually formed when a resident remains in the same position for an extended period of time causing increased pressure or decrease of circulation to the area and subsequent destruction of tissue. This same policy documents the facility should have a system/procedure to assure assessments are timely and appropriate, and changes in condition are recognized, evaluated, reported and addressed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to provide complete and hygienic catheter care, failed to maintain the urinary catheter tubing and drainage bag off the floor, failed to have a physician order for a urinary catheter and failed to record catheter care and urinary output for two (R31, R36) of two residents reviewed for urinary catheters in the sample list of 39. Findings include: The facility's Catheter Care policy dated February 2018 documents for female catheter care, separate the labia and wash the perineal area prior to cleansing the urinary catheter. 1.) On 3/09/25 at 9:51 AM R31 stated staff doesn't always empty R31's urinary catheter drainage bag when requested. R31 stated R31 has had the urinary catheter for about a month and that no staff provide routine cleaning of the catheter. R31 stated the hospital staff cleaned R31's urinary catheter when R31 was at the hospital. R31 stated R31 has a history of bladder infections and urinary retention, which is why the catheter was inserted. On 3/10/25 at 8:48 AM R31 stated the Certified Nursing Assistant (CNA) last evening did not empty R31's catheter bag and urine leaked all over R31's bed. On 3/10/25 at 9:15 AM R31 self propelled R31's wheelchair down the hall. R31's urinary catheter tubing was dragging the ground and the wheels of R31's wheelchair rolled over the tubing. On 3/10/25 at 11:30 AM V12 and V5 CNAs entered R31's room. V12 provided R31's urinary catheter care and did not spread and clean R31's labia/perineal area. V12 only cleansed R31's catheter. R31's urinary catheter was wound around the securement device that was attached to R31's thigh in a knot formation, confirmed with V12 and V5. During R31's cares, R31's urinary drainage bag was on the side of the bed and touching the floor. V5 confirmed R31's drainage bag should not be touching the floor. At 11:56 AM R31's catheter drainage bag was still touching the floor. V12 stated a privacy bag is used for the wheelchair, but not when R31 is in bed. V12 confirmed V12 did not cleanse R31's labia/perineal area as part of R31's urinary catheter care. V12 stated V12 usually does that as part of catheter care and confirmed it should have been done. R31's Minimum Data Set, dated dated dated [DATE] documents R31 as cognitively intact. R31's March 2025 Physician Order Summary does not document an active order for a urinary catheter and size. R31's March Treatment Administration Record (TAR) does not document any routine catheter care/cleaning. This TAR documents to empty urinary catheter every shift, but does not consistently document the amount of urine output. R31's Care Plan dated 11/21/24 documents urinary catheter use and an intervention to check tubing for kinks every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 12:21 PM V3 Assistant Director of Nursing stated R31 returned from the hospital on 2/21/25 with a urinary catheter due to retention. R31 has a urology appointment tomorrow and it may be removed, which is why there were no orders for urinary catheter size or changes. V3 stated the labia should be cleaned as part of female urinary catheter care. On 3/11/25 at 8:45 AM V3 stated the CNAs should empty the catheter every shift and the nurses record the amount of urine output every shift on the TAR. V3 stated catheter cleaning is done by the CNAs and should be documented on the TAR. V3 stated V3 will need to update R31's TAR to include catheter care. 20892 2. The Medical Diagnosis sheet from the EMR (Electronic Medical Record) for R36 dated 3/11/25 documents the following diagnosis: Type 2 Diabetes Mellitus with Hyperglycemia, Urinary Retention and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms. R36's current Medical Record documents R36 has a supra pubic catheter. March 10, 2025 at 10:53 AM V5, CNA (certified nurse assistant) performed catheter care for R36. V5 use the no rinse disposable peri wipe cloths to clean R36. V5 washed her hands and put on a pair of gloves. V5 took a peri wipe cloth and started wiping R36's penis going in down strokes from the top to tip of the penis. V5 held the penis in one hand and started wiping R36's penis without changing the area of the cloth. V5 went over the same area two to three times not changing out the area on the peri wipe. V5 threw away the wipe and obtained another one and cleanse the other side of the penis doing the same procedure as before not changing the area. V5 then took a wipe and went around the head of the penis. V5 took another wipe and cleaned the catheter tubing starting at the top and went down the tubing 2 to 3 times using the same cloth and the same area. V5 then cleansed the insertion area of the catheter with a new peri wipe. V5 stated she was done with catheter care and went into the bathroom to wash her hands. V5 stated at 11:05 AM on 3/10/25 I should of used a new wipe each time I cleaned him.

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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. 41002 Based on observation, interview and record review the facility failed to employ a Director of Nursing and failed to provide the services of a registered nurse for eight consecutive hours seven days a week. This failure has the potential to affect all 51 residents residing in the facility. Findings Include: On 3/9/25, 3/10/25 and 3/11/25 there was not a full time Director of Nursing working in the facility. The resident roster dated 3/9/25 documents 51 residents reside at the facility. The facility's nursing working schedule from 2/24/25 to 3/10/25 documents the facility did not have the services of a Registered Nurse (RN) for eight consecutive hours on 2/24/25, 2/27/25, 2/28/25, 3/1/25 and 3/2/25. On 3/10/25 at 9:00am V3 Assistant Director of Nursing stated the facility has not had a Director of Nursing (DON) since 1/31/25 when the pervious Director of Nursing took another job. V3 stated the facility does not always have Register Nurse coverage for eight consecutive hours seven days a week. V3 confirmed the documentation on the working schedule provided was an accurate record of RN coverage and that there has not been a full time Director of Nursing working in the facility since 2/1/25. On 3/11/25 at 10:00am V1 Administrator confirmed that the facility has not had a full time Director of Nursing working in the facility since 2/1/25, and that they don't always have a Registered Nurse working every day. The Facility's Assessment (no date) documents the Facility will Provide a full time Director of Nursing and proper nursing coverage.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 20892 Based on observation,interview and record review the facility failed to administer medications according to physician orders and manufacturer recommendations for two of five residents (R30 and R31) reviewed for medication administration on the sample of 39. The facility had two errors out of 28 opportunities resulting in a medication error rate of 7.14 percent. Findings include: The facility's policy titled Medication Administration revision date 11/18/17 states Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given. 1.) R30's March 2025 Physician Order Sheet (POS) documents an order for Lisinopril 2.5 mg (milligram) once a day. The order continues to read to hold if systolic BP (blood pressure) is less than 100. On 3/10/25 at 8:45 am V6, LPN administered R30's Lisinopril V6 did not check R30's blood pressure before giving the medication. V6 stated the BP was 132/70 when asked where the BP could be found she stated I took it off the vitals form when it was taken earlier on night shift. V6 stated they did not have a form to document blood pressures. On 3/10/25 at 10:30 AM , V3 Assistant Director of Nurses stated the BP is to be taken and written down before administering the medication Lisinopril. 2. R31's March POS documents an order for Zofran disintegrating tablet 8 mg every 6 hours as needed for nausea and vomiting. On 3/10/25 at 9:00 am V6 took R31's Zofran and put it in the medication cup along with the other medications (R31) was taking. The March 2025 Medication Administration Record documents Zofran is to be put under the tongue to dissolve and not swallowed. When V6 was asked about the Zofran not being separated from the other medications when returning to the medication cart on 3/10/25 at 9:10 AM V6 stated the resident usually picks the medication out of the med cup and leaves for last but R31 swallowed the medication whole this time.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on observation, interview, and record review, the facility failed to employ a clinically qualified Director of Food and Nutrition Services. This failure has the potential to affect all 51 residents in the facility. Findings include: On [DATE] at 11:15AM and [DATE] 11:30am V3 Dietary Manager was actively supervising dietary operations in the facility kitchen. On [DATE] at 11:04am V3 Dietary Manager stated that V3 was hired a couple of weeks ago as Dietary Manager. V3 stated that V3's Food Safety/Dietary Manager Certificate expired over a year ago, and V3 is scheduled to take the test next month. V3 stated at this time V3 fails to meet the State of Illinois standards to be a food service manager or dietary manager. On [DATE] at 2:02pm V1 Administrator confirmed that V3 Dietary Manager does not currently have a valid Food Safety/Dietary Manager Certificate as required. The Facility Assessment (not dated) documents a full-time dietician or other clinically qualified nutrition professional to serve as the director of food and nutrition services is needed to provide competent support and care for the facility's resident population every day and during emergencies. The facility Long-Term Care Facility Application for Medicare and Medicaid ([DATE]) documents 51 residents reside in the facility.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on observation, interview, and record review, the facility failed to employ dietary support staff with the appropriate competencies to carry out the functions of the food and nutrition service. This failure has the potential to affect all 51 residents residing in the facility. Findings include: On 3/10/25 at 11:00am V26 Dietary Aide was preparing residents food, assisting with plating and distributing resident's meals. On 3/11/25 at 3:30pm V19 Dietary Aide was preparing residents food, assisting with cooking residents food and preparing residents drinks. On 3/10/25 at 11:00am V26 stated that V26 does not have any training in food service or nutrition and does not have a food handlers certificate. On 3/11/25 at 11:04 am, V4, Dietary Manager, stated, We have six employees on the kitchen staff, four of those employees do not have a Food Handler's certificate. Those employees are (V19, V26, V27 and V28). On 3/11/25 at 11:26 am, V1, Administrator acknowledge that V9, V26, V7 and V28 do not have a current Food Handlers Certificate. The Illinois Public Act [PHONE NUMBER] documents, Anyone working with unpackaged food, food equipment, utensils, or food contact surfaces is defined as a food handler. Food handlers working in non-restaurants (nursing homes and long-term care facilities) must have the training completed, with enforcement to begin January 1, 2017. The facility's Resident Census and Conditions of Residents dated 3/9/25 documents 51 residents reside in the facility.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 40385 Based on observation, interview, and record review the facility failed to follow a diet order for thickened liquids for one (R210) of 24 residents reviewed for meals in the sample list of 39. Findings include: The facility's Diet Orders policy dated June 2006 documents the physician should be contacted to receive diet orders, nursing notifies the dietary department in writing of the correct diet order using the Diet Order Form, and the food service manager is responsive for reviewing the resident's medical record to ensure a written order exists and matches the diet order. This policy documents Diet Order Forms are kept on file in the dietary department for staff to reference. On 3/09/25 at 9:26 AM R210's breakfast tray contained regular consistency water and juice. V5 Certified Nursing Assistant (CNA) stated R210 refused breakfast, but R210 drinks a lot of water that is supposed to be thickened. V5 confirmed R210's breakfast tray contained regular consistency liquids. On 3/09/25 at 1:27 PM R210 was in bed and R210's noon meal tray was at the bedside. R210's meal consisted of regular consistency water and lemonade. R210's meal tray card did not document thickened liquids. This was confirmed with V14 CNA. V14 stated R210 has been in the facility for approximately two weeks, R210 receives hospice care and has vomiting and congestion at times. V14 stated the CNAs know that R210 is suppose to have thickened liquids. R210's March 2025 Physician Order Summary (POS) documents R210's diet as regular and does not list thickened liquids. R210's Nursing Note dated 2/20/25 at 9:00 PM documents gurgling oral care was provided, Atropine was given, and R210 remains on hospice care. On 3/09/25 at 1:32 PM V19 Dietary Aide stated the nurses give diet orders to the dietary department and there should be a pink sticker documenting thickened liquids on the resident's tray card. V19 stated V19 was unable to locate any diet orders for R210 and will follow up. At 1:39 PM V20 [NAME] provided R210's Diet Order Form dated 2/22/25 for nectar thickened liquids. This form is signed by V7 Registered Nurse. V20 confirmed dietary staff should be serving R210 nectar thickened liquids. On 3/9/25 at 1:37 PM V3 Assistant Director of Nursing stated R210's family had requested thickened liquids due to R210 coughing, but R210 is on a regular diet with regular liquids. On 3/9/25 at 3:16 PM V7 Registered Nurse stated V7 received R210's diet order for thickened liquids from the hospice nurse. V3 stated R210's POS will need to be updated with the diet order and told V7 that V7 should have obtained a physician order for the diet change from hospice.

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	146017	A. Building B. Wing	03/11/2025

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40385 Based on interview and record review the facility failed to annually implement and evaluate the effectiveness of a performance improvement plan. This failure has the potential to affect all 51 residents in the facility. Findings include: The facility's undated Quality Assurance Performance Improvement (QAPI) Plan documents the QAPI committee will conduct a self assessment of the facility on an annual basis and prioritize activities, policies and procedures and continually monitors for improvement through the use of self assessment. The facility will consider input from staff, residents, and family members, adverse events, performance indicators, survey findings, and complaints/grievances. Root Cause Analysis will be used for identifying contributing causal factors designed to get to the underlying cause of a problem, which leads to identification and effective interventions to make improvements. Measurements are used by gathering data and analyzing trends and implementation of interventions will be evaluated to ensure continuation and progress is continued or sustained. On 3/11/25 at 12:08 PM V1 Administrator stated V1 became the facility's administrator in December 2024. V1 stated the facility did a PIP (Performance Improvement Plan) in April on preventative skin care and showers. At this time V1 provided the QAPI Plan 1 PIP - Preventative Skin Care and QAPI 2 PIP-Showers/Baths. The Preventative Skin Care PIP documents the goal is to provide preventative skin care through repositioning and hygienic skin care, and the facility will provide adequate interventions to prevent skin breakdown for residents identified to be at high or moderate risk. This PIP lists interventions, including staff training on skin care, preventative pressure ulcer care, and wound care; skin assessments will be completed for all residents upon admission, then weekly for four weeks, and then annually, quarterly, and with significant changes; the facility will ensure a proper treatment program has been implemented and closely monitored to promote healing or pressure ulcers; nursing staff will complete a QA form for newly identified skin conditions, this form will be given to the Director of Nursing and the wound will be documented on the Treatment Administration Record; and to re-evaluate treatment response at least every two to four weeks, review nutritional status monthly, and implement additional interventions and update the care plan to prevent worsening or re-occurring pressure ulcers. The Shower/Baths PIP documents the goal to ensure hygiene needs are met and showers/baths are scheduled at least weekly for all residents. This PIP lists interventions to formulate a current shower schedule for all resident rooms, formulate a tracking form to review and monitor showers weekly, in-service licensed staff on completing and documenting showers, and the QAPI team will continue to assess and monitor the shower process. There is no documentation of any follow up for these PIPs that includes monitoring, tracking, and evaluating the implementation for the listed interventions. On 3/11/25 at 12:15 PM V1 stated the PIP provided is the only one V1 could locate for the last year. V1 Stated this documentation was found with the 4/26/24 QA meeting. At this time V1 was requested to provide documentation of implementation and evaluation of the April PIPs. At 12:35 PM V1 stated V1 was unable to locate any documentation of implementation and evaluation of the April PIPs. V1 stated the former Administrator was known to throw things away. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Long Term Care Facility Application for Medicare and Medicaid dated 3/9/25 documents the facility has a census of 51 residents.

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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 40385 Based on interview and record review the facility failed to have quarterly Quality Assurance meetings. This failure has the potential to affect all 51 residents in the facility. Findings include: The facility's undated Quality Assurance Performance Improvement (QAPI) Plan documents the facility will take a proactive approach to improve the care provided and will create systems to achieve compliance through tracking, investigating, and trying to prevent recurrence of adverse effects, investigating complaints, seeking feedback from residents and staff, setting targets for quality, and striving for deficiency free surveys. This plan documents the interdisciplinary team will ensure resident's needs are met through QA meetings. QA meeting documented 1/9/25. All required members present. On 3/11/25 at 12:08 PM V1 Administrator provided the facility's QAPI meeting dated 1/9/25. V1 stated V1 has been the Administrator since December 2024 and has only had one QA meeting in January 2025. At 12:15 PM V1 provided additional QAPI meeting sign in sheets dated 4/26/24 and 9/5/24. V1 stated the facility should have had QA meetings in July and October 2024. At 12:35 PM V1 stated V1 was unable to locate any additional QA sign in sheets for the last year. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 3/9/25 documents the facility has a census of 51 residents.

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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. 35380 Based on observation, interview, and record review, the facility failed to implement their water management plan, prevent potential cross contamination of a pressure sore and the treatment cart, and implement Enhanced Barrier Precautions. These failures have the potential to affect all 51 residents residing in the facility. Findings include: The facility's Water Management Plan-Legionella Bacteria Risk Management Policy dated 11/17/24, documents the facility will develop the following documents and process as components of the Water Management Plan which includes: identify the end user of water to determine at risk consumers, identify all areas where water is processed after entering facility, develop process flow diagrams to describe how water is processed at the facility, verify that the process flow diagrams are accurate by on-site verification, perform a Hazard Analysis based on process flow diagrams, and identify critical points. This policy states hot water tanks will have temperature checked everyday, deliverable hot/cold water temperatures checked weekly, hot water distribution checked weekly, eye wash station, tanks for house, kitchen, and laundry check flush for two minutes weekly. The facility's Pressure Wound Treatment Policy dated January 2017, documents pressure injury treatment requires a comprehensive approach that includes: managing infections and maximizing the potential for healing. 1. On 3/11/25 at 10:20 AM, V24 Maintenance Director stated V24 does not have a test kit for testing the water and has no idea where to get them. V24 stated V24 started here 12/31/24 and the only book he has is the life safety book that has some Legionella stuff in it. V24 stated V24 is not doing the hot water distribution, eye wash station, not flushing hot water tanks, domestic hot water tanks for house, kitchen and laundry. V24 stated he needs some items that they do not have and, there is no floor plan for Legionella places. The facility's Long Term Care Facility Application for Medicare and Medicaid dated 3/9/25 documents the facility has a census of 51 residents. 2. On 3/10/25 at 10:30 AM, V6 Licensed Practical Nurse (LPN), rolled the entire treatment cart into R43's room to complete a treatment on R43's pressure wound. 3. On 3/10/25 at 10:30 AM, V6 LPN placed wound cleanser on a 4 by 4 gauze pad and proceeded to wipe R43's pressure wound over and over using the same side of the 4 by 4 pad and never changing sides. On 3/10/25 at 3:19 PM, V3 Assistant Director of Nursing (ADON) stated V6 should have changed sides of the 4 by 4 gauze while cleaning the wound and stated the treatment cart should not be brought into a resident's room. 40385 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4.) On 3/09/25 at 9:51 AM there was no EBP signage posted on R31's room door and no cart containing personal protective equipment (PPE) near R31's room doorway. R31 stated R31 has had a urinary catheter for about a month and R31 has a history of urinary tract infections related to urinary retention prior to the catheter being inserted. On 3/10/25 at 11:30 AM as V12 Certified Nursing Assistant (CNA) entered R31's room to provider urinary catheter care, V5 CNA told V12 don't forget to wear a gown, don't make the same mistake I (V5) did. I (V5) just found out I'm suppose to wear a gown (for catheter care). There was no EBP signage on R31's room door and there was no cart containing PPE. V12 obtained a gown from a cart located a few doors down the hall. V5 and V12 confirmed they look for EBP signage and PPE carts to identify when PPE is needed. V5 and V12 confirmed there was no EBP signage posted or PPE cart for R31's room. At 11:56 AM V12 stated V12 had not received any training on EBP and was unsure of what cares required gowns to be worn for EBP. On 3/10/25 at 12:21 PM V3 Assistant Director of Nursing stated R31 returned from the hospital on 2/21/25 with a urinary catheter. V3 confirmed R31 should be on EBP due to the catheter, EBP signage should be posted, and a cart for PPE should be outside of R31's room. The facility's Enhanced Barrier Precautions (EBP) policy dated 7/13/23 documents EBP will be used to reduce the transmission of multidrug-resistant organisms and includes the use of gown and gloves when providing high-contact resident care activities for residents with open wounds and indwelling medical devices. This policy documents to post EBP signage and ensure disposable or washable gowns and gloves are available where high-contact resident care activities may be required. 20892 5. The Medical Diagnosis sheet from the EMR (Electronic Medical Record) for R36 dated 3/11/25 documents the following diagnosis: Urinary Retention and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms. R 36 has a supra pubic catheter with signage on his door stating Enhance Barrier Precautions (EBP) and placed in front of his door is a 3 drawer chest with gowns, masks and gloves in the drawers for staff and visitors to use before entering the room. On 3/10/25 at 10:53 AM V5, CNA (certified nurse assistant) prepared to complete suprapubic catheter care for R36. R36 has signage on his door stating Enhance Barrier Precautions (EBP) and placed in front of his door is a three drawer chest with gowns, masks and gloves in the drawers for staff and visitors to use before entering the room. Before entering R36's room V5 did not put on a gown or mask. V5 placed gloves on her hands after entering the room and washing her hands at the resident's bathroom. V5 stood next to R36's bed and stated I am going to perform catheter care on you to clean you up. V5 did not wear a gown or mask during the entire procedure.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 35380 Based on interview and record review, the facility failed to offer immunization education, immunization consent forms, and vaccinations for five residents (R9, R28, R41, R52, R160) of five residents reviewed for immunizations in the sample list of 39. Findings include: R9, R28, R41, R52, and R160 have no documentation of education for vaccinations, no consents for vaccinations, and no documentation of vaccines being offered or administered in their medical records. On 3/11/25 at 2:30 PM, V2 Corporate Nurse stated there is no documentation for immunizations for the five residents (R9, R28, R41, R52, R160) requested. The facility's Immunization of Residents Policy dated Revised 1/23/20, documents this facility will offer immunizations and vaccinations that aid in the prevention of infectious diseases unless medically contraindicated or otherwise ordered by the resident's attending physician or the facility's medical director.