STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146033	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elms, The	1212 Madelyn Avenue Macomb, IL 61455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31283 Based on interview, observation, and record review, the facility failed to assess, monitor, and document ongoing status of a venous stasis ulcer for one of one residents (R18) reviewed for non-pressure wounds in the sample of 28. Findings Include: The facility's Wound Care policy (dated 2010) documents the following: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. This policy also documents, Documentation- The following information should be recorded in the resident's medical record: The type of wound care given; The date and time the wound care was given; The name and title of the individual performing the wound care; Any change in the resident's condition; All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound; Any problems or complaints made by the resident during the procedure; If the resident refused the treatment and the reason(s) why; The signature and title of the person recording the data. R18's current care plan documents the following focus: (R18) has a high risk for impaired skin integrity related to edema, obesity, fragile skin, limited mobility, use/side effects of medications, history of MASD (moisture-associated skin damage). She is currently being treated for stasis ulcer on right calf. R18's Current Physician's Order Sheet documents the following order: Cleanse RLE (right lower extremity) with soap and water and clean wounds with saline and gauze. Place Adaptic or (Non-adherent) Not Telfa, or Xeroform to wounds and then place silver calcium alginate over this, apply ABD (abdominal) pad, then wrap with kerlex clear to the toes. Change on Thursdays and Saturdays, and prn (as needed) when soiled. Assume treatment to right lateral ankle, also. Patient is to wear (pressure relieving) boots at all times. On 04/22/24 at 10:52 AM, R18 was lying in bed partially covered with a blanket. A dressing was in place on R18's right lower leg, and R18 stated she has a venous stasis ulcer, It started as a scratch. I've had it for a while. Several years now. R18 stated she is seen at the wound clinic weekly, and facility staff change her dressing, every few days. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/24 at 10:06 AM, V2 (Director of Nursing) and V3 (Assistant Director or Nursing) stated they are both working the floor providing direct patient care. V2 and V3 applied a gown and gloves prior to entering R18's room to perform a dressing change to her right lower leg wound. V2 assisted R18 to hold her right leg up while V3 removed the current dressing in place. R18 had scattered reddened areas with multiple open areas present around the circumference of the lower half of her lower leg. R18's right lower leg had a large open area extending up the duration of her lower calf with a moderate amount of sanguineous drainage noted. V3 then cleansed the intact skin on R18's right lower leg with soap and water, and cleaned R18's wounds with saline, and applied a new, clean dressing. R18 tolerated the dressing change well and physician orders were followed for the wound care and dressing change. R18 stated she has had her wound for several years, It started as just a little scratch. R18's medical record does not contain any wound measurements, wound assessments or wound progress notes documented by facility staff. On 04/24/24 at 2:10 PM, V3 (Assistant Director of Nursing) stated the facility does not conduct ongoing wound measurements or any type of wound assessment on R18's right lower leg venous stasis wound. V3 stated, (R18) is seen weekly at the local wound clinic. We just keep a copy of their documentation. On 04/25/24 at 09:55 AM, V2 (Director of Nursing) reviewed R18's medical record and confirmed the facility does not conduct ongoing assessments or wound measurements in R18's medical record. V2 stated, We do the dressing changes as scheduled, but do not document anything other than it was completed. The wound clinic does all of that.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49187 Based on observation, interview, and record review, the facility failed to develop and implement pressure relieving interventions to prevent pressure wound development, develop a pressure relieving care plan, and implement a physician-ordered treatment for a deep tissue injury for one of two residents (R31) reviewed for facility acquired pressure ulcers in the sample of 28. These failures resulted in R31 developing a painful, unstageable right heel pressure ulcer and a deep tissue injury to the left great toe. Findings include: The facility's Support Surface Guidelines policy, dated 9/2013, documents, Purpose: The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing relieving devices for residents at risk for skin breakdown. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. Steps in the Procedure: Guidelines for Selecting Appropriate Pressure-Relieving Devices- 2. Use a pressure ulcer risk scale such as the Braden Scale to help determine need for an appropriate type of pressure-relieving devices. The facility's Prevention of Pressure Injuries policy, dated 4/2020, documents, Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment: 1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 2. Use a standardized pressure injury screening tool to determine and document risk factors. Skin Assessment: 1.Conduct a comprehensive skin assessment up (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. Device-Related Pressure Injuries: 1.Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application an ability to secure the device. 2.Monitor regular for comfort and signed of pressure-related injury. Monitoring: 2. Review the interventions and strategies for effectiveness on an ongoing basis. R31's Hospital Discharge Orders, dated 3/15/2024, documents R31 had surgery with orthopedics for a right hip repair and needed to be placed in a facility. R31's Admission Record documents R31 was admitted on [DATE]. This same form documents R31 has the following, but not limited to, diagnoses: Fracture of Unspecified Part of Neck of Right Femur, Unsteadiness on Feet, Generalized Muscle Weakness, Difficulty in Walking, Repeated Falls, and Hypertension. R31's MDS (Minimum Data Set) Assessment, dated 3/22/24, documents R31 is cognitively intact. This same assessment documents R31 requires total assistance for bed mobility and transfers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R31's Admission/Readmission Assessment, dated 3/15/24, documents R31 did not have any wounds upon admission to the facility, except for a right hip repair incision. This same assessment documents R31's initial Braden scale for skin integrity risk score of 15, indicating R31 is at risk for developing pressure ulcers. R31's Care Plan dated, 4/9/24, was not updated to indicate R1 was at a high risk of pressure ulcer development with pressure relieving interventions, after R1's initial Braden scale for skin integrity assessment, dated 3/15/24, indicated R1 was at risk for pressure ulcer development. R31's Wound Management note, dated 3/19/24, and signed by V23/Wound Physician documents, (R31) seen today for reports of a large blister to (R31's) right heel. Upon assessment (R31) has a large stage two PI (pressure injury) to her right heel presenting as a serous-filled blister. Stage two pressure ulcer to the right heel, Progress: Initial Exam, Wound Size: 6cm (centimeters) x 6cm x 0cm. Treatment orders updated 3/19. Recommend bilateral offloading bootie (heel protector) to right heel and floating heels with pillows while in bed. (R31) had a recent hip fracture. Encourage nutrition as appropriate. R31's Wound Management note, dated 4/2/24, and signed by V23/Wound Physician documents, (R31) seen today for large stage two PI (Pressure Injury) to her right heel previously presenting as a serous-filled blister that has erupted and is now open. Unstageable Pressure Ulcer to the right heel, Progress: Deteriorating, Wound Size: 5cm (Centimeter) x 6cm x 0.1cm. Treatment orders updated 4/2. Upon assessment 4/2, (R31's) wound bed is covered completely with unstable eschar, treatment orders updated. Please only cleanse wound with NS (normal saline) when using Santyl products. Recommend to continue bilateral offloading (heel protector) to right heel and floating heels with pillows while in bed. (R31) had a recent Right Hip Fracture. Nutritional consult recommended if not already completed, encourage high calorie high protein diet. R31's Wound Management note, dated 4/16/24, and signed by V23/Wound Physician documents, Unstageable Pressure Ulcer to the right heel, Wound Size: 3cm x 4.2cm x 0.1cm. Treatment Plan: Apply (Collagenase) once a day and wrap with (gauze roll). This same note documents a DTI (Deep Tissue Injury) to R31's left great toe, Etiology: Pressure, Progress: Initial Exam,Wound Size: 1cm x 1.5cm x 0cm. Treatment Plan: Apply (Povidone-iodine) to R31's left great toe once a day. Treatment orders updated 4/16. Presence of a new PI to R31's left great toe found upon assessment 4/16/24. Recommend continuing bilateral offloading (heel protectors) and floating heels with pillows while in bed. R31's TAR (Treatment Administration Record), dated April 2024, does not document a treatment order to R31's left great toe from 4/16/24 to 4/24/24. On 4/22/24 from 9:53 AM through 10:03AM, R31 was sitting in her wheelchair in her room. R31 was groomed and dressed appropriately with nonskid socks applied to both feet. R31's right heel was resting directly on the floor. R31's left foot was resting directly on her wheelchair pedal. R31 stated, Prior to coming back to (this facility) I was getting around great. I ended up falling and breaking my right hip and had to get surgery and had to be admitted at (the facility) for therapy.I just broke my left hip last month. I require assistance with everything now. That is why I got my sores after I admitted here. My right heel hurts pretty bad, especially when the staff changes my dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/24/24 from 10:50 AM through 11:00AM, R31 was sitting in her wheelchair with non-skid socks applied to both feet. R31's right heel was resting directly on her wheelchairs foot pedal, and R31's left foot was resting directly on her other foot pedal. On 4/24/24 at 12:03 PM, V27/Registered Nurse lifted R31's right foot and assessed R31's right heel. R31's right heel had a golf-ball sized area that was soft and mushy. The area was black in color. V27 stated, We (the facility) are applying (Collagenase) to R31's right heel wound bed and wrapping it with (gauze roll). While V27 was applying R31's right heel pressure ulcer treatment, R31 was crying out in pain stating the area was extremely painful. V27 stated she had given R31 Tylenol 40 minutes prior to the wound treatment so it would lessen the pain during R31's wound care. V27 then assessed R31's left great toe. R31's left great toe had a black dime sized area noted with a small pinpoint area open in the center. V27 stated, We (the facility) are currently applying (Povidone-iodine) to the area. On 4/24/24 at 10:05AM, V3/Assistant Director of Nursing stated, We (the facility) did not implement any pressure relieving interventions prior to (R31) developing a facility acquired right heel pressure ulcer or left great toe deep tissue injury. (R31's) right heel and left great toe wound development was caused by pressure. (R31's) right heel and left great toe should always be offloaded. V3/Assistant Director of Nursing also verified that R31's plan of care was not updated with pressure relieving interventions after R31's Braden scale indicated R31 was at risk for pressure ulcer development. On 4/24/24 at 11:03AM, V23/Wound Physician stated, (R31's) right heel wound was avoidable and was caused by pressure after (R31) sustained a right hip fracture. The heels should always be offloaded with (heel protectors) as per my recommendations in (R31's) wound notes. The (heel protectors) would help assist to prevent the pressure ulcers from worsening or new pressure ulcers from developing. V23/Wound Physician also stated R31's left great toe deep tissue injury was avoidable and was also caused by pressure. On 4/25/24 at 11:00AM, V26/Infection Preventionist verified R31's physician order for betadine to be applied to R31's left great toe did not get processed correctly, therefore it was not on the TAR for the nurses to complete the treatment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38396 Based on observation, interview, and record review, the facility failed to ensure a gait belt was in place during a transfer of a resident who requires staff assistance with transfers for one of four residents (R29) reviewed for ADL (activities of daily living) assistance in the sample of 28. Findings Include: The facility's Transfer Belt Policy, dated 12/2013, documents, Transfer belts are to be applied to any resident that requires hands on assist unless the careplan gives a reason not to use the belt. R29's current care plan, dated 3/29/24, documents, (R29) needs assistance with ADL's (Activities of Daily Living) and mobility related to decreased mobility, poor cognition, poor activity tolerance,behaviors, and balance deficits. I have ROM (Range of Motion) deficits bilateral upper and bilateral lower extremities. I also have dysphagia (difficulty swallowing). Restorative: Transfer Program: (R29) has the ability to move between surfaces with Substantial/Maximal Assistance, usual performance one person assistance. (R29) does not use an assistive device. Lock wheels on wheelchair, apply gait belt and stand in front of her and lift pivot transfer her. She does not bear weight well. Be aware (R29) is not always willing to participate and it may be necessary to re-approach or to get extra help for transfer. On 4/22/24 at 10:23 PM, V8 (Certified Nursing Assistant) was in R29's room and assisting R29 with making her bed. V8 asked R29 if she wanted to get into bed and R29 nodded her head yes. At this time, V8 placed her forearms under R29's armpits and lifted her up from her wheelchair then placed her in her bed. V8 then stated she doesn't use a gait belt (transfer belt) when she transfers R29. V8 stated, She doesn't usually get up on her own. I don't usually use a gait belt with (R29). She doesn't put much support on her legs. I just usually help her transfer like that (by carry, under arms). On 4/24/24 at 8:25 AM, V24 (Licensed Practical Nurse) stated, (R29) does not transfer herself. She requires the assistance of one staff usually to transfer. We do not use a machine to assist with her transfer, but we use a gait belt for her transfers.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30224 Based on observation, interview, and record review, the facility failed to address a significant weight loss, develop, and implement interventions to prevent further weight loss, and to ensure dietitian assessment with significant weight loss for one of one resident (R9) reviewed for weight loss in the sample of 28. Findings include: The Facility's Nutritional Assessment, dated 10/2017, states, 1. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition. 2. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. 4. The multidisciplinary team shall identify, upon the resident's admission and upon his or her change of condition, the following situations that place the resident at risk for impaired nutrition: a. Cognitive or functional decline; b. Chewing or swallowing abnormalities; c. Pain; d. Medication changes; e. Environmental factors; f. Increased need for calories and/or protein; g. Poor digestion or absorption; h. Fluid and nutrient loss; i. Inadequate availability of food or fluids. 7. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risk for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences. 8. Individualized care plans shall address, to the extent possible: a. the identified causes of impaired nutrition; b. the resident's personal preferences; c. goals and benchmarks for improvement; and d. time frames and parameters for monitoring and reassessment. On 4/23/24 at 11:00 AM, R9 was in a reclining wheelchair in his room. R9 was alert with confusion. R9 appeared thin and frail. R9's Minimum Data Set assessment, dated 3/9/24, documents R9 is a [AGE] year-old resident with severely impaired cognition. R9 weighs 109 pounds; R9 had a significant weight loss and was not on a physician ordered diet. R9's current computerized Care Plan does not include any documentation of R9's significant weight loss, R9's risk for impaired nutrition, or any interventions to prevent further weight loss. R9's current computerized Physician Order's documents R9 is on a regular diet with nectar thick liquids and Ensure (nutritional supplement) three times per day (started 10/2023). R9's computerized weight record, dated 11/13/23 through 4/22/24, documents the following weights: 11/13/23=134 pounds, 12/18/23=122.3 pounds (8.7% loss in one month), 1/26/24=119.4 pounds, 2/19/24=107.2 (10.2% loss in one month/20% loss in three months), 3/18/24=117.4 pounds, 4/22/24= 113.2 pounds (15.5% in six months). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's Nutritional Assessment, dated 11/21/23, states R9 is on a general diet and receiving Ensure three times per day. This same Assessment states, Would recommend offering a high protein milkshake, as a higher calorie alternative (once a day) to give (R9) variety and hopefully increase overall calorie and protein intake. Will continue to monitor, as (R9) is on the low end of a normal (Body Mass Index) for adults (older than) [AGE] years. (Dietitian) available (as needed) and will reassess according to review schedule. R9's Medical Record does not document any further documentation regarding R9's nutrition, including dietitian assessment/recommendations. R9's Physician Progress Notes, dated 12/2023 and 3/2024, do not address R9's significant weight loss. R9's situation(s) putting him at risk for impaired nutrition, or interventions to prevent further weight loss. On 4/24/24 at 2:30 PM, V3 (Assistant Director of Nursing) stated R9 has had a significant weight loss the past six months, and R9's medical record does not include any documentation/assessment of R9's significant weight loss since 11/21/23. V3 stated no additional interventions have been developed as R9 continues to lose weight. V3 stated the Dietitian should have been notified each month R9 had significant weight loss so a new assessment could be completed and recommendations given to prevent further weight loss. V3 did not know why the Dietitian had not been notified, and why R9's care plan did not document R9's significant weight loss and interventions to prevent further weight loss. On 4/25/24 at 1:34 PM, V28 (Registered Dietitian) stated the facility has not notified her of R9's weight loss since the last nutritional assessment in November 2023. V28 stated if she would have been notified of R9's weight loss, she would have recommended different interventions to try to improve his caloric and protein intake. V28 stated, There is no guarantee that anything we attempted would have worked, but it should have been attempted. V28 stated due to R9's age and overall declining health, she could not say that R9's weight loss was unavoidable.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 31283 Based on interview, observation, and record review, the facility failed to provide ongoing communication with the dialysis center and ensure a care plan was implemented regarding monitoring, care and emergency management of a dialysis access site for one of one (R46) resident reviewed for dialysis in the sample of 28. Findings Include: R46's current medical record documents R46's diagnoses to include: End Stage Renal Disease and Dependence on Renal Dialysis. On 04/23/24 at 09:40 AM, R46 was sitting in a wheelchair in her room watching television. R46 stated she attends hemodialysis at a local dialysis facility on Mondays, Wednesdays, and Fridays. R46 pointed to her dialysis access site located in her left upper arm and stated that dialysis staff are the individuals that monitor and care for her access site. R46 stated the staff nurses at the facility, Don't really mess with it at all. R46's current care plan has no mention of R46's dialysis access site, or interventions in place regarding monitoring, care, or emergency management of R46's dialysis access site in her left upper arm. On 04/24/24, V3 (Assistant Director of Nursing) provided copies of R46's Hemodialysis Communication Forms (dated 02/01/24 - 04/19/24). V3 confirmed she could not provide record of the Hemodialysis Communication Forms for R46's dialysis appointments on the following dates: 02/14/24, 02/16/24, 02/21/24, 02/26/24, 02/28/24, 03/01/24, 03/04/24, 03/18/24, 03/29/24, 04/03/24, 04/10/24, and 04/15/24. V3 also confirmed R46 has not had a care plan in place regarding monitoring or emergency management of R46's dialysis access site in place since R46's date of admission to the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 30224 Based on observation, interview, and record review, the facility failed to document and monitor residents target behaviors with the use of an antipsychotic medication for two of two residents (R8, R52) reviewed for antipsychotic medications in the sample of 28. Findings include: The Facility's Psychotropic Drug Policy (undated) states, 6. Residents placed on Antipsychotic medication will have target symptoms tracked every shift and non-pharmacological interventions tracked for effectiveness every shift by nursing staff in behavioral notes in (the facility's medical record software). 1. R8's Minimum Data Set assessment ,dated 1/22/24, documents R8 has severely impaired cognition and a diagnosis of Dementia. R8's current computerized Physician Orders document R8 takes Zyprexa (Antipsychotic) 2.5 mg (milligrams) by mouth one time a day and Zyprexa 5 mg by mouth at bedtime for Severe Depressive Disorder. R8's current computerized Care Plan documents R8 has a behavior problem related to her diagnosis of Dementia. R8 can be verbally and physically aggressive at times. R8 has the potential to be verbally and physically aggressive due to her diagnosis of Dementia; R8 has periods of anger and frustration when she sees male visitors and believes they are her husband.; and R8 uses psychotropic medications (Zyprexa) related to behavioral or psychological symptoms of Dementia. R8's Psychiatric Note, dated 3/13/24, states, Staff report (R8's) behaviors have improved greatly overall. Denies feeling of harming self or others. Denies Auditory Hallucinations or Visual Hallucinations. R8's current electronic medical record does not document what R8's target behaviors are or monitor R8's behaviors every shift. R8's Behavioral Progress Notes, dated 1/22/24 through 4/11/24, do not document R8 has behaviors to justify the use of antipsychotic medication. On 4/24/24 at 10:38 AM, V2 (Director of Nursing) stated there is no specific behavior tracking forms completed by staff. V2 stated the nurses document resident behaviors in Behavior Progress Notes. V2 stated he didn't believe target behaviors were tracked every shift. V2 stated, I think they monitor them for 14 days when starting a new psychotropic medication, but I'm not sure after that. 2. R52's Minimum Data Set assessment, dated 4/11/24, documents R52 has moderately impaired cognition with a diagnosis of Dementia. This same assessment documented R52 had no behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R52's most recent computerized Care Plan documents R52 has a Diagnosis of Dementia and uses psychotropic medications (Seroquel/Antipsychotic) related to disease process (Delusional Disorder). R52's current computerized Physician Orders document R52 receives Seroquel (Antipsychotic) 12.5 mg by mouth in the evening for Delusional Disorder. R52's medical record does not document R52's target behaviors for the use of an Antipsychotic medication. R52's Behavioral Progress Notes, dated 1/1/24-4/25/24, does not document R52 exhibits behaviors to warrant the use of the Antipsychotic medication. On 4/22/24 and 4/23/24, during random observations, R52 was observed with no behaviors exhibited. On 4/24/24 at 1:30 PM, V3 (Assistant Director of Nursing) stated the nurses document in the behavioral progress notes if a resident has a behavior. V3 stated Nurses are not documenting resident behaviors every shift. V3 stated the Certified Nurse Aides do not document resident behaviors. V3 stated R52 does not have any behaviors that justify the use of an antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146033	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elms, The	1212 Madelyn Avenue Macomb, IL 61455

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 38396 Based on observation, interview, and record review, the facility failed to ensure a medication to lower blood pressure was accurately administered according to the Physician's Order for one of five residents (R1) reviewed for medication administration in the sample of 28. Findings Include: The facility's Medication Administration policy, dated 4/2019, documents, It is the policy of (the facility) to ensure that medications are administered safely and accurately to residents for whom they are prescribed. The facility's Medications Errors policy, dated 10/2017, documents, It is the policy of (the facility) that all medications be given as ordered by the resident's physician. The resident will be closely monitored for negative effects. R1's Physician Order Sheet, dated 4/24/24, documents R1 has an order for, Labetalol Hydrochloride oral tablet 200 mg (milligrams): Give 1 tablet by mouth two times a day for HTN (Hypertension, high blood pressure). On 4/24/24 at 8:33 AM, V24 (Licensed Practical Nurse) prepared medications for R1's morning medication administration. V24 placed two 200 mg Labetalol tablets in the medication cup and stated, (R1) takes two Labetalol 200 mg. At this time, V24 was asked if R1 takes two tablets of the Labetalol in the morning, and V24 stated Yes. On 4/24/24 at 8:45 AM, V24 finished preparing the medications for R1 and closed her medication drawer and computer. As V24 turned to walk towards R1, the surveyor asked V24 to recheck R1's Labetalol order again. V24 then opened her computer and and confirmed R1 should receive one 200 mg tablet of Labetalol, not two as she had prepared. V24 removed the second tablet from the medication cup to discard and stated, It should be one tablet, not two like I prepared. V24 then confirmed if she was not asked to recheck R1's medication order for her Labetalol, she would have administered a double dose of R1's Labetalol, and completed a medication error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38396 Based on observation, interview, and record review, the facility failed to apply gloves prior to providing high-contact care and ensure appropriate isolation precautions were in place for one of four residents (R19) reviewed for infection control practices in the sample of 28. Findings include: The facility's Enhanced Barrier Precautions policy, dated 8/2022, documents, Enhanced barrier precautions (EBP's) are utilized to prevent the spread of multi-drug resistant organisms (MDROs). EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: Dressing, Bathing/Showering, Transferring, Providing Hygiene, Changing Linens, Changing Briefs or assisting with toileting, Device care, Wound care. The facility's Isolation- Categories of Transmission- Based Precautions policy, dated 12/8/22, documents, Contact Precautions- In addition to Standard Precautions, Contact Precautions will be implemented for residents known to be infected with microorganisms that can be transmitted by direct contact with the resident of indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether contact precautions are necessary will be evaluated on a case-by-case basis. Examples of infections that may require Contact Precautions include, but are not limited to Infections with multi-drug resistant organisms. R19's Physician Order Sheet, dated 4/25/24, documents R19 has a medication order for, Macrobid (antibiotic) Oral Capsule 100 mg (milligrams), Give 1 capsule by mouth two times a day for ESBL (Extended Spectrum Beta-Lactamase) E. coli (Eschericha Coli) related to Urinary Tract Infection, for seven days and give one capsule by mouth at bedtime. (order implemented on 4/23/24). R19's current Care Plan, dated 3/14/24, documents, (R19) has a chronic indwelling (urinary catheter) with history of chronic urinary tract infections. Enhanced Barrier Precautions due to (urinary catheter): Wear gloves and gown for High-Contact Resident Care Activities. (Dressing, Bathing, Transfers, Linen changes, Hygiene, Toileting, Wound care, and/or device care such as catheter, feeding tube, tracheotomy, central line). On 4/22/24 at 11:00 AM, R19 was in his room sitting in a wheelchair. R19's door has a sign posted that documents he is on Enhanced Barrier Precautions. R19 had a indwelling urinary catheter bag hanging below his wheelchair in a dignity bag. On 4/24/24 at 1:08 PM, R19 was sitting in his wheelchair in his room. R19's entryway had a sign posted indicating Enhanced Barrier Precautions were in place. V15 and V25 (Certified Nursing Assistants) entered R19's room to provide cares, with gowns on. V15 applied a gait belt to R19's upper abdomen and transferred R19 to bed without ever applying gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 9:25 AM, (V26 Registered Nurse/ Infection Control Preventionist) stated, With the new EBP precautions a resident should be in placed in those precautions if they have a (indwelling urinary catheter) or invasive line, wounds or any colonized MDRO's. Once we find out they have an active infection, we would switch them over to contact or whatever the isolation requires for the type of bacteria. When they are on enhanced barrier precautions, staff should wear a gown and gloves with high-touch cares like dressing, transferring and catheter care. For contact isolation precautions, they should be wearing a gown and gloves in the room always and mask if needed for splashes. (R19) should be in contact isolation precautions since he is actively infected. I haven't been here as much the last couple weeks, so I am not sure why it wasn't put into place for him.